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Washington NURSING COMMISSION NEWS

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

Washington State Department of Health

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The Washington State Nursing Care Quality Assurance Commission regulates the competency and quality of licensed practical nurses, registered nurses and advanced registered nurse practitioners by establishing, monitoring and enforcing qualifications for licensing, consistent standards of practice, continuing competency mechanisms, discipline, and education. The commission establishes standards for approval and evaluation of nursing education programs.

Executive Director
Paula R. Meyer, MSN, RN

Editor
Mindy Schaffner, PhD, MSN-CNS, RN

Message from the Chair

By Suellyn Masek, MSN, RN, CNOR

Happy New Year! Here we are again; another year has come and gone. I can hear myself saying, "How does it seem possible?" It is true, the older you get the faster the years go, but actually, New Year's Day is my favorite holiday. I have always approached this day as one of promise, hope and planning.

The Nursing Commission team has adopted an aggressive strategic plan with some high expectations for 2014. In fact, we accomplished one of our goals with the completion of the SSHB 1518 report. Essentially, the report compares our licensing, education and discipline performance measures as well as financial outcomes with the state boards of nursing in Arizona and North Carolina. You may request a copy of the report by contacting *nursing@doh.wa.gov*. We used this "best practice" information to create a very aggressive strategic plan touching on several domains such as the Nursing Commission's internal organization, technology, discipline procedures, rules process, education, licensing procedures and practice standards. We hope this plan will allow us to become more efficient, better collaborators with medical and chiropractic commissions, as well as with the Department of Health. The plan will increase the transparency of use and distribution of your licensing fees. Anyone who has ever taken on a major home renovation project knows what a monumental and unpredictable task it can be; this is what we are doing at the Nursing Commission. This is a very exciting time of change for us. We expect good things in 2014. I will gladly give updates as the year progresses.

I encourage you to get involved with your commission. Please visit one of our business or subcommittee meetings, attend a rules workshop, or even just send a letter. You can do something to make your voice heard.

Enjoy the newsletter and as always, please help us promote and engage in life-long learning with fellow nurse peers.

Suellyn

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Message from the Executive Director

By Paula R. Meyer, MSN, RN, NCQAC

As I prepared to write this article, I wanted to give you a topic that would spark your interest and be thought-provoking. I was seeking more information on the responsibility for nursing in providing healthcare for our great nation. The healthcare needs of our society are fundamental to nursing and nursing education. In addition, the Nursing Commission is beginning the process to revise the nursing education and continuing competency administrative rules. I began with a search of the literature on the social responsibility of healthcare. I was encouraged and energized by the publications I found, and want to share some citations and quotes that I found useful.

Nursing's Social Policy Statement: the Essence of the Profession clearly provides a framework for nursing's role and responsibilities in our society.[1] "The nursing profession fulfills society's need for qualified and appropriately prepared individuals who embrace and act according to, a strong code of ethics, especially when entrusted with the healthcare of individuals, families, groups, communities, and populations." This statement captures the need for nurses to adopt an ethical framework to provide care. People trust nurses at the most vulnerable points in their lives and the lives of their loved ones. Nurses earn the trust of our society. This trust demands that nurses meet very high standards in providing care and protecting patients. This responsibility continues to be a precious gem treasured by our profession.

In *The Guide for the New Healthcare Professional*, Scott states "Social responsibility entails concern for society and its people and positive actions in support of that concern, especially for the disadvantaged. Healthcare professionals, like other licensed professionals, have a strong duty of social responsibility."[2] Many nursing philosophers capture the virtue of caring for others and the responsibility it brings. Nurses care for others when they cannot provide for themselves. Describing where nursing begins and ends is not easy. Through a series of workshops, the Nursing Commission will gather information about the needs of our society. The Nursing Commission seeks input to translate the societal needs into requirements for nursing education. There are two parts to every workshop. The first focus will be on the initial education of nurses and the second part will focus on continuing competency. The purpose of each workshop is to listen to many perspectives that will assist the Nursing Commission in defining regulatory standards for nursing education, from initial nursing education to continued growth as a nurse.

Nursing employers perform a crucial role in social responsibility and often define the demands for initial nursing education as well as continuing competence. Nursing leaders can use the views of achieving socially responsible care. Such a strategic vision creates a direction for the healthcare system to perform at a level of excellence, and easily meets current and future needs of the organization. Nursing leaders play a pivotal role in capturing the needs of the people in the communities they serve. They can convert the needs into services provided by facilities, and determine the type of nursing care needed. This requires information gathering, evaluating, and making decisions.

The Nursing Commission needs and values your input and looks forward to meeting the needs of the people of Washington. Please see the Nursing Commission website for more information on the dates and locations for upcoming workshops and how to submit comments on the rules.[3] Our responsibility to society is clear - safe nursing practice.

REFERENCES:

[1]Nursing Leader: Managing, Succeeding, Excelling, Kleinberg, M.; Dirschel, K., 2010. Jones and Bartlett Learning: Sudbury MA, p. 57.

[2]Guide for the New Healthcare Professional, R.W. Scott, 2007. Jones and Bartlett Publishers: Sudbury MA, p. 32.

[3]*http://www.doh.wa.gov/LicensesPermitsandCertificates/NursingCommission.aspx*

By John Wiesman, DrPH, MPH
Secretary, Department of Health

HEALTH ISSUE

LEADING THE WAY –
Protecting Your Own Health to Protect Community Health

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We've all heard the cliché, "If you're going to talk the talk, you have to walk the walk." Clichés often become clichés because there's some element of truth or fact in them. I believe in leading by example — rather than another old cliché, "Do as I say, not as I do."

That's one of the reasons I went to our agency flu vaccination clinic for my annual flu shot. The other reason is simple: It's good for my health, and for those around me. Every year we tell the people of our state about the need to protect themselves against the flu. The more people in our community who are vaccinated, the better chance we all have of avoiding this nasty illness. Yet, our state's annual flu vaccination rate is usually under 50 percent.

Public health works to protect and improve the health of all people in Washington, and that starts with each of us. It takes one person to get things started — we're accustomed to showing the way, and flu vaccination is no different.

As public health professionals, we also have the opportunity to advocate for disease prevention. Each of us can serve as a public health spokesperson by reminding people that it's time to get vaccinated against the flu, and referring them to the Department of Health's agency website (*www.doh.wa.gov*) for helpful information.

Another way you can help your patients is to tell them where to find information on health care reform and how it may affect them.

The Patient Protection and Affordable Care Act is the most comprehensive national health reform legislation enacted in decades. Along with improving healthcare access and quality, the act's goal is to help our health system continue to move its focus from treating disease to preventing disease.

As health reform rolls out in Washington, your patients may wonder what this all means to them. Some will want information or help finding the right healthcare plan. They can find answers on the "Coverage is Here" (*coverageishere.wa.gov*) website. It's a new online resource to help with education and outreach. The site provides other links to help people compare and enroll in health insurance plans. In addition, you can use the site to keep current on the latest health care reform news. Check out the online outreach tools and resources.

Your patients will find specific enrollment and plan information on the Washington Health Benefit Exchange "Health Plan Finder" website (*www.wahealthplanfinder.org*). They can compare health plans, side-by-side; learn about eligibility requirements for tax credits or financial help; get answers to specific questions; and review options and enroll. I hope you will encourage them to take advantage of these online resources. They're good tools that I'm sure patients will find helpful and informative.

State agencies in Washington are working together to help people find support for healthier lifestyles and better overall access to the health care system. The Washington State Department of Health plays an important role in disease prevention, and in helping to build healthier communities. Our agency works to ensure the quality of our health system, and provides the data and information necessary for research and resource planning. We also provide funding and technical assistance to partner organizations working on key prevention issues. Learn more about the state public health role on the Department of Health website.

Meet the New Commission Members

Mary Baroni, PhD, RN
NCQAC Commission Member, NPAP Chair

This is an extraordinary time to be a nurse as we move forward in implementing much-needed healthcare reform in the U.S. The IOM Report on the Future of Nursing, "*Leading Change, Advancing Health*" (2010) challenges us to contribute to this reform by practicing to the scope of our abilities, continuing our education and leading change in collaboration with other health professions. It is truly an honor to serve on the Nursing Commission at such an extraordinary time. In attending my very first Nursing Commission business meeting on November 8, I was so impressed with the quality and commitment of my fellow commissioners. It is a privilege to join this distinguished group and I hope that I can contribute to the important work in protecting the well-being of the citizens of our state.

My interest in serving on the commission is based on my long-standing commitment to assuring that we educate the most competent and compassionate nursing workforce necessary to provide care to individuals, families and communities that we serve. Much of my career has been dedicated to bridging the essential connections between practice, education and research in an applied practice discipline such as nursing. Dr. Loretta Ford deeply influenced my early professional career. She is the former dean of the University of Rochester, which is where I completed my master's degree. Dr. Ford later hired me into my first joint appointment as a new pediatric nurse practitioner and novice nurse educator. Dr. Ford was the co-founder of the very first nurse practitioner program in the country more than 40 years ago in collaboration with her physician colleague, Dr. Henry Silver at the University of Colorado. She passionately believed in working across disciplines, as well as embracing the necessary integration of practice, education and research.

I have practiced as an RN in five different states (North Carolina, Michigan, New York, Wisconsin and Washington) during my nursing career, which spans more than 36 years. I have held faculty positions in a range of academic institutions including private non-sectarian (University of Rochester), private sectarian (Marquette University) and public universities (University of Wisconsin-Madison and the University of Washington Bothell).

I held joint academic-practice appointments multiple times during my career. My strong commitment to bridging gaps that can arise between education and practice, or across types of educational institutions, has never wavered. Over the last decade, I had the privilege of serving as professor and nursing program director at the University of Washington Bothell. This evolving institution began as an upper division transfer and graduate level institution until 2006, which allowed for the development of very effective partnerships with our regional community and technical colleges. Over the last two years, I had the unique opportunity to provide consultation services to Western Washington University as it moved forward in developing a new RN-to-BSN program that successfully launched this fall.

I hope that my varied experiences will allow me to represent nursing education across both private and public universities as well as collaborate with colleagues representing community and technical colleges, nursing practice and community members on the commission. I believe that bridging education, practice, research and policy is an essential skill to advancing the overall purpose of the Nursing Commission in assuring the highest quality nursing care for the citizens of our state.

Jeannie Eylar, MN, RN
NCQAC Commission Member

Jeannie M. (Dellwo) Eylar MN, RN graduated with a bachelor of science in nursing in 1981 and a master of nursing in 2005, both from Washington State University. She has had a career in acute care nursing with the opportunity to do some lecturing at schools of nursing in the region she has lived. She has been a staff nurse, department manager, house supervisor and is currently a chief nursing officer at Pullman Regional Hospital. As a clinical nurse, she has experience in oncology, nephrology, postanesthesia recovery, and post-surgical care units. She has also had experiences in nursing practice from large urban facilities to 25-bed critical access hospitals. With more than 30 years as a registered nurse in Washington State she has been involved in hospital licensing RCW revisions, standards of practice questions, disciplinary issues, developing nursing competency programs and overseeing departmental and hospital-wide competency and quality

care programs. She is especially interested in serving on the Nursing Commission to be a part of discussions and decisions to assure that the quality of nursing care in Washington State remains at a very high level, and uses recent research and evidence to meet the professional roles of the registered nurse for the future.

Stephen J. Henderson, JD
NCQAC Commission Member

I am honored to serve as a new member of the Nursing Commission. My connection to nursing stems from my time as a medic in the Army Reserve (1969-1975). As an Olympia lawyer in private practice for 38 years, I read a considerable amount of medical and nursing charts. I have also represented many nurses in various cases. When I have been a patient, I have always appreciated the care, concern, and hard work of the nursing staff.

I have served on several boards in the past, including the Washington State Bar Disciplinary Board and the Board of Governors representing the 3rd Congressional District in Southwest Washington. I enjoyed the exchange of ideas with fellow members who at times had different views and perspectives on an issue. The goal was always to reach a consensus and move forward.

I am very active in my local West Olympia Rotary Club. For the past 18 years, I have chaired the West Olympia Rotary Nichols Award, overseeing scholarships given to outstanding local high school students. My wife Judy and I will soon travel to Ethiopia with the Rotary Polio Plus Project giving polio vaccine drops to the native children.

In my free time, I play the bagpipes and serve as the pipe major with the Olympia Highlanders Bagpipe Band. I look forward to serving on the commission.

Donna Poole, ARNP
NCQAC Commission Member,
Chair ARNP Subcommittee

Nursing has been a rich and rewarding career for me. I have worked in academia and staff development; I have been a staff nurse and an advanced practice nurse; I have been a manager and a consultant. For the past 13 years, I have been at Kitsap Mental Health Services providing direct service as well as serving in a managerial role. Most recently, I have been providing psychiatric consultation to primary care providers through a Center for Medicare and Medicaid Services (CMS) grant. Additionally, it is my great privilege to serve as a preceptor and mentor for those learning the advanced practice nursing role.

Although I have been a Washingtonian most of my life, for the first half I was from the other Washington. Chances are I will finish my work life in Washington State, my home for the past 35 years. However, if I want to return to the East Coast where most of my family resides, could I practice there like I practice here? I could if I were a medical doctor. My options are limited as a nurse practitioner. These limitations exist in part because I am a certified clinical nurse specialist and partly because of differences in states' scope of practice. I would like advanced practice nurses to be able move from state to state at will, with the same title and scope of practice. There is a model for this known as the Consensus Model for APRN Regulation. As a member of the

continued on page 10

Nursing Commission, I hope to contribute to the implementation of this model.

I learned early in my career the differences and similarities between a professional association and professional regulation. I am an active participant in professional associations and continue to maintain memberships. My experiences have led me to be interested in nursing regulation. I achieved my advanced registered nurses practitioner (ARNP) license through on the job training, and I am able to continue to do what I have learned as regulations grow and evolve because of the tradition of grandfathering.

A primary role of the Nursing Commission is to protect the public, and to further that duty, I am a reviewing commission member for disciplinary cases. Commission members take our role in discipline very seriously. We want to dismiss complaints that are unfounded, and to rehabilitate nurses where needed. We provide restrictions to practice when warranted and seek to make decisions using the principles of just culture.

Initially Governor Gregoire appointed me to the Nursing Commission and Governor Inslee has since reappointed me. I am grateful for their confidence in me and I look forward to serving the people of Washington State. As chair of the advance practice subcommittee and one of two ARNPs on the commission, I have the ambition to make nursing regulation just a little bit better for nurses in practice and for those who follow me on to the commission.

Tracy Rude, LPN
NCQAC Commission Member

I am honored to be serving on the Nursing Commission as a licensed practical nurse. I have been in healthcare for some time and have enjoyed working in a variety of areas. My family and I have been proud Washingtonians since 1986, when we moved from North Dakota. I am currently working for Evergreen School District at the Clark County Skills Center in Vancouver where I am a member of the general advisory committee. I teach applied medical sciences and nursing assistant skills to high school students. I am a volunteer for the Medical Reserve Corps and the Trauma Intervention Program and spend my precious free time with my husband and grandchildren.

Having followed the work of the NCQAC and the positive impact to healthcare for some time, I look forward to working with the commissioners to ensure the safety of the public we serve. I expect it to be the most rewarding and challenging work that I have ever done.

Laurie A. Soine PhD, ARNP
NCQAC Commission Member

Governor Inslee appointed Laurie Soine to the Nursing Commission in June. She is an adult nurse practitioner and has practiced for more than a decade at the University of Washington Medical Center. She earned her bachelor of science in nursing from Pacific Lutheran University in 1988.

She began her nursing career in the cardiovascular intensive care unit at the University of Washington Medical Center. While working as an intensive care unit nurse she completed her master of nursing from University of Washington in 1991. Her thesis explored the link between heart transplant recipients and their knowledge about infection, rejection, and immunosuppression and its impact on rehospitalization. Her work demonstrated a link between patient knowledge and clinical outcomes such as hospitalization. She then accepted a clinical nurse specialist position with the heart failure-transplant program caring for hundreds of patients with end-stage heart failure awaiting transplant. In 1997, she returned to school to complete a post-masters nurse practitioner program, eventually becoming board certified as an adult and acute care nurse practitioner. After completing her nurse practitioner program, she accepted a newly created position in nuclear cardiology at the University of Washington Medical Center, where she continues to practice.

In 2009, she earned a doctorate (PhD) in nursing science from the University of Washington. Her research explored the historic roots of clinical practice guidelines, including their application and effect on clinical practice. Laurie has collaborated on many clinical research projects over her years of practice. Her most recent works include a study exploring faculty physician knowledge about advanced registered nurse practitioner (ARNP) practice; and a study exploring patient knowledge about radiation from diagnostic imaging.

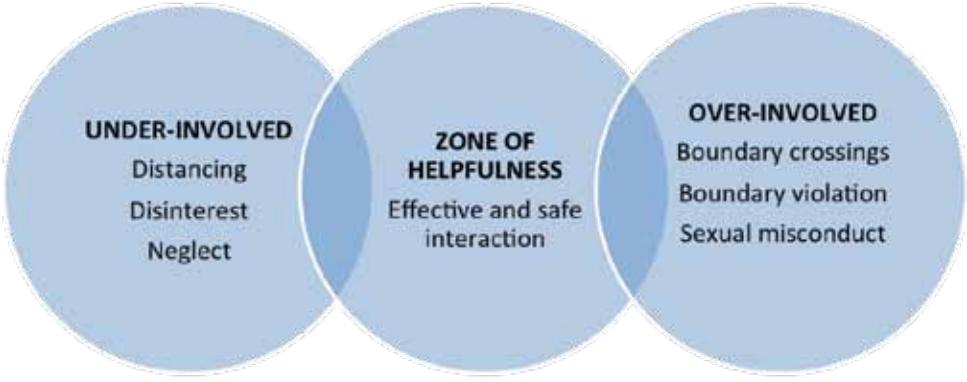
The Nursing Commission appointed Laurie as a pro-tem member in 2010. As a pro-tem member, she spent the last year drafting the state's first set of ARNP disciplinary sanctioning guidelines, adopted by the Nursing Commission in March. Laurie looks forward in continuing her work with the Nursing Commission to assure the highest quality of nursing care to the people of Washington State.

By Margaret Holm, JD, RN
Nurse Practice Consultant

Professional Boundaries

What is the meaning of professional boundaries? Do you know your professional boundaries? Who is responsible for maintaining professional boundaries? Let us take a closer look.

Professional boundaries is a term used to describe the complex relationship that nurses share with a patient. Nursing allows for intimate entry into another person's life based upon our professional, licensed status. That entry may involve access to private health status, confidential healthcare information, and personal information such as family relationships, financial condition and assets. Entry into the privacy of another's life creates a power differential between the patient and the nurse. In order to maintain a therapeutic relationship, professional boundaries must be maintained. The National Council of State Boards of Nursing (NCSBN) has defined professional boundaries as spaces between the health giver's power and the patient's vulnerability. Accordingly, a zone of helpfulness must be established and maintained in order to provide safe and effective nursing care.



Nurses working in more independent and less supervised environments, such as home health, hospice or school nursing, must be especially careful to safeguard professional lines of behavior. These settings create a greater risk for blurring the lines of over-involvement. In contrast, some nurses move toward under-involvement with patients. Such nurses might distance themselves from assigned patients or show disinterest.

What are examples of boundary violations that could constitute unprofessional conduct? Some examples include discussing your intimate or personal issues with a patient, keeping secrets with a patient, spending a great deal of time with a particular patient or visiting the patient while off-duty. Other examples might include agreeing to act as a power-of-attorney for a current patient, entering into a romantic relationship with a patient or social networking with a patient. Many times boundary violations occur when there is confusion between the needs of the patient and that of the nurse. Professional sexual misconduct is an extreme form of boundary violation.

Nurses working in more independent and less supervised environments, such as home health, hospice or school nursing, must be especially careful to safeguard professional lines of behavior. These settings create a greater risk for blurring the lines of over-involvement. In contrast, some nurses move toward under-involvement with patients. Such nurses might distance themselves from assigned patients or show disinterest.

In order to achieve a zone of helpfulness, nurses must understand that the boundaries are dynamic and may constantly change in response to multiple circumstances. In order to respond to the dynamic nature of the patient-nurse relationship, it is important to consider whether the care you are about to give is a benefit to the patient or meeting a personal need. The nurse is responsible to establish and maintain the therapeutic boundary. Here are some guidelines. Treat all patients with dignity and respect. Inspire confidence by being professional. Motivate co-workers and colleagues to treat patients and families respectfully. Be fair and consistent with each patient. Understanding and maintaining professional boundaries are fundamental to establishing a therapeutic relationship with your patient.[1,2]

REFERENCES:
[1]*https://www.ncsbn.org/ProfessionalBoundaries_Complete.pdf*
[2]*https://www.ncsbn.org/Professional_Boundaries_2007_Web.pdf*

By Tommy Simpson
Department of Health Military Program Manager

Helping Military Service Members, Veterans and Eligible Beneficiaries Transition

When military personnel stationed in Washington leave the service, plenty of them want to stay in the Evergreen State. For those in the health professions, it can be a challenge to make sure the training and experience they have gotten in uniform match up with the credentials they need to practice as civilians. A Washington State Department of Health initiative aims to make the transition smoother.

The goal of health profession licensing is to protect public health and safety. Legislatures enact statutes and licensing boards make rules with that purpose. At times, though, laws and rules, inadvertently or not, erect obstacles that impede the public's ready access to safe, affordable care. The Department of Health is committed to identifying some of the barriers that regulations can create. The agency intends to highlight innovative regulatory policies and programs that will overcome impediments, and to propose additional ideas to ease access.

Tommy Simpson III, a 26-year U.S. Army veteran, joined the department in August 2013 as military programs manager. Tommy brings a wealth of knowledge and experience to this key strategic position. In addition to his honorable service as an enlisted health professional, immediately upon retirement, he worked for Community Health Care for about 16 months as a float licensed practical nurse, co-manager for both the Lakewood and downtown Tacoma or *Hilltop* family medicine clinic, call center triage nurse, and primary call center customer service-quality assurance representative.

Tommy served at every echelon of military healthcare, from layperson to middle to upper and senior management, stateside

and overseas, including the Global War on Terrorism and Bosnian War.

Before his May 2012 retirement, he held the military occupational specialty of healthcare specialist, qualified for the National Registry of Emergency Medical Technicians, and is a licensed practical nurse. He holds Washington LPN credentials. Tommy also maintains current American Heart Association basic life support and advanced cardiac life support certifications. In addition, he achieved his bachelor's and master's of business administration degrees, while still serving on active duty.

In the Department of Health's Office of Health Professions and Facilities, Tommy serves as program manager, facilitator and link for service members, veterans, and eligible family members transitioning in or out of Washington State, and more importantly, those who want to transition directly into the civilian workforce.

Tommy works with Department of Health program managers representing boards, commissions and the secretary of health. He has already begun working on an enlisted health professions military-to-civilian crosswalk. Once completed, it will help people (specifically military-affiliated) identify equivalent and transferable skills that can expedite credentialing. He also works to identify education or training deficits while offering support and suggestions for priority credentialing processing.

Tommy has already established working relationships with key internal and external stakeholders and partners across the state. They include the Nursing Commission and Health Systems Quality Assurance credentialing committees, the Veterans Employment Resources Group, the Washington State Department of Veterans Affairs, the Western Washington Area Health Education Center, Hire America's Heroes, local colleges and universities, and finally military transition assistance centers across the state.

In the next five years, an estimated 50,000 to 80,000 veterans are projected to return to Washington State seeking employment. Of this number, an estimated 500 to 600 monthly will be health professionals. Finding jobs for these veterans and their eligible dependents will be a top priority. The Department of Health remains dedicated to providing both proactive assistance for veterans and their families with their transition back into the civilian workplace, and assistance for companies with open positions in fulfilling their recruitment needs, including our very own agency.

"These are men and women who've sacrificed a lot for this country and to this state to keep us safe," Tommy says. "I think we owe it to them as a state and an agency to do everything that we can to make sure they have a place in the workforce."

Deborah Carlson, MSN, RN
Nurse Practice Advisor

Linda Patterson, BSN, RN
Nurse Practice Consultant

Margaret Holm, JD, RN
Nurse Practice Consultant

The New *Rules of Engagement*

Patient engagement is a hot topic in healthcare as systems strive to achieve better outcomes. Patient engagement puts patients and families at the center of care. A provision in the Affordable Care Act (ACA) encourages using shared decision-making for healthcare. Patient and family engagement takes center stage as one of those strategies. Studies find that engagement prevents harm, reduces readmissions, and improves patient safety at lower costs. Patient advocacy is the key to engagement and has long been a role of nursing as defined in the Washington State laws and rules. The new rules of patient and family engagement include informed decision-making supported by nurse advocates.

Shared decision-making has the potential for increasing patient knowledge, improving health outcomes, reducing errors in care, reducing costs, and aligning the care with patient values. As professional nurses, we must hone our skills in patient advocacy from novice to expert to be an advocate for the patient and family, and must empower patients and their families to be active in making healthcare decisions.

The Nursing Alliance for Quality Care released the *Guiding Principles for Patient Engagement* in 2012. More information is at *http://www.naqc.org/*

1. There must be active partnership among patients, families and providers.
2. Patients are the best and ultimate source of information about their health status and retain the right to make their own decisions about care.
3. There are shared responsibilities and accountabilities among the patient, the family and clinicians that make it effective.
4. Clinicians must respect the boundaries of privacy, competent decision-making and ethical behavior in all their encounters and transactions with patients and families that protect the recipient and care providers. This relationship involves confidentiality, as the patient defines the scope of confidentiality.
5. The relationship appreciates the patient's rights and expands on the rights to include mutuality. Mutuality includes sharing of information, creation of consensus and shared decision-making.
6. Clinicians must recognize the extent to which patients and families are able to engage or choose to engage may vary greatly based on individual circumstances, cultural beliefs and other factors.
7. Advocacy for patients who are unable to participate fully is a fundamental nursing role. Patient advocacy is the demonstration of how all of the components of the relationship fit together.
8. Acknowledgement and appreciation of culturally, racially, or ethnically diverse backgrounds is an essential part of the engagement process.
9. Health literacy and linguistically appropriate interactions are essential for patient, family and clinicians to understand the components of patient engagement. Providers must maintain awareness of the language needs and healthcare literacy level of the patient and family.

Examples of promoting patient engagement include using technology such as interactive technology, telehealth, patient tracking systems and patient portals. Software programs allow patients to practice going to a healthcare provider visit. Bedside huddle shift change reports that include the patient, family and providers, open lines of communication which promote safer patient handoff, and foster patient and caregiver trust. Removing visiting policy restrictions is a way to allow the family to participate in care. In community settings, providing health education and healthy literacy classes, using patient navigators, and involving patients and families in advisory councils and policy changes are also effective strategies.

Patient engagement is a connection between the patient, family and health care providers. This fosters a trusted relationship and mutual respect. Shared decision-making has the potential for increasing patient knowledge, improving health outcomes, reducing errors in care, reducing costs, and aligning the care with patient values. As professional nurses, we must hone our skills in patient advocacy from novice to expert to be an advocate for the patient and family, and must empower patients and their families to be active in making healthcare decisions.

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http://www.doh.wa.gov/LicensesPermitsandCertificates/NursingCommission/PracticeInformation.aspx

Sign up for the Listserv:
http://listserv.wa.gov/cgi-bin/wa?SUBED1=nursing-qac&A=1

For questions, contact:
Debbie Carlson, MSN, RN, Nurse Practice Advisor
Debbie.carlson@doh.wa.gov
360 236-4725

Washington State Department of Health

By Martha Worcester, PhD, ARNP
ARNP Practice Advisor

Advanced Practice Corner
Expanding Horizons Beyond State Boundaries

Advanced practice registered nurse practitioners (ARNPs) in Washington State are far ahead of most states in achieving autonomy in practice and enhancing patients' access to care. It is easy to become overprotective of what we have gained and to resist further changes. Yet the ability to deliver care across state boundaries is essential to:

(a) Deliver care needed by mobile patients,
(b) Use healthcare technologies delivered by off-site practitioners, and
(c) Provide education through on-line programs.

The Affordable Care Act presents further challenges to us by putting into place a team approach to care with financial reimbursements based on health outcomes rather than individual provider fee for services. Regulations that keep ahead of current advances in technology and new federal legislation are challenging. This article raises questions that need answering to help us continue our legacy of providing safe care to patients.

Mobile Patients:

How can states work together so when a patient crosses state lines while traveling or relocating to another state, the advanced practice nurse can continue to provide care? Prescribing authority of the advanced practice nurse may be honored in one state and not another. A patient needing psychiatric care may relocate to another state and request continuing care through phone conversations or advanced technologies by the same provider. Disas-

ters occur and patients may relocate temporarily to be with family in another state. They will need to connect with their home state primary care provider. Differences in state licensure requirements create difficulties in treating patients in these situations.

Mobile Advanced Practice Nurses:

Advanced practice nurses frequently travel across state lines to deliver care in disasters, or may practice in one state while the patient lives just across the border in another state. Must the nurse then obtain a license in the state where the disaster is occurring, or the state where the patient has temporally located?

Online Cross State Education:

How do we assure quality advanced practice education when advanced practice nurses have their student internships in Washington and their education is delivered online outside our state boundaries?

Affordable Care Act:

How do we keep advanced practice nurses and other providers accountable for the care they provide when delivered with a team approach? How do we decide equitable pay when healthcare providers are paid for patient outcomes rather than for a particular type of service?

We cannot address these issues within a single state. Advanced practice nurses must work together across state lines to achieve the broader goals of enhancing access to safe care for patients, and maintaining the high quality of professional practice. Can we engage doctorate of nursing practice students to choose projects in their course work to help provide the direction for regulations and health care systems to address these issues? Let us all work together to answer these important questions of our day!

By Gene Pingle, BSN, CEN-BC, RN
Consistent Standards of Practice Sub-Committee Chair, NCQAC Member

Deborah Carlson, MSN, RN
Nurse Practice Advisor

Camp Nursing

The idea of camp nursing may sound like a relaxing vacation – taking care of a few bug bites, cuts, and scrapes! In reality, camp nursing is a specialty all on its own with twists and challenges in a unique environment. Camp nursing requires autonomy, flexibility, critical thinking, problem solving and creativity to promote and protect the health of the entire camp community. Camp nursing is multidimensional, including providing nursing care for campers and staff from routine, acute and emergency care; managing chronic conditions; giving medications and treatments; promoting health education and prevention; and establishing infection control and safety practices.

The many types of camp activities and situations make this a challenging and demanding role. The Nursing Commission approved a Camp Nursing Advisory Opinion to provide guidance and recommendations about the roles, responsibilities and practice standards in this setting. You may find a copy of the advisory opinion on our website.[1]

REFERENCES:
[1] *http://www.doh.wa.gov/Portals/1/Documents/6000/NurseCamps.pdf*

By Gene Pingle, BSN, CEN-BC, RN
Consistent Standards of Practice Sub-Committee Chair, NCQAC Member

Deborah Carlson, MSN, RN
Nurse Practice Advisor

Registered Nurse First Assistant

The registered nurse first assistant (RNFA) is an experienced perioperative nurse with advanced education and scope of practice. The increasing complexity of surgery provides the perioperative nurse with opportunities to practice in this specialty area during all phases of the surgical experience. As the scope of practice for nurses evolve, so will the RNFA role.

The Nursing Commission recognizes the unique contribution of nurses working in the RNFA role. The Nursing Commission recently revised the RNFA advisory opinion that provides guidance and recommendations for RNFAs to ensure the provision of safe and competent care. You may find a copy of this advisory opinion at our website.[1]

REFERENCES:
[1] *http://www.doh.wa.gov/Portals/1/Documents/6000/RN1AssistSurg.pdf*

By Catherine Woodard
NCQAC, Chief Investigator

Mary Dale
NCQAC Discipline Manager

Report on Investigation and Discipline Performance Measures: OCTOBER 2012 – SEPTEMBER 2013

The Nursing Commission continues to monitor progress on meeting various performance measures. The following measures and results for October 2012 to September 2013 are as follows:

Investigation Performance Measures FY 2013

Performance Measure 2.2:

Percentage of investigations completed within 170 days. The target is 77 percent.

On average, nursing investigators completed 72.5 percent investigations within timelines in the past 12 months. Note that in the last quarter, the three-month average was 90.8 percent completed within timelines.

Performance Measure 2.4:

Percentage of open cases currently in investigations over 170 days. The target is no more than 23 percent.

On average, 20.8 percent of nursing cases were over timelines. In the last quarter, the three-month average was 3.3 percent over timelines.

Performance Measure 3.1:

Completed investigations verses number of investigators.

On average, nursing investigators completed an average of seven (7) investigations per month.

Discipline Performance Measures FY 2013

Performance Measure 2.1:

Percentage of cases in which the intake and assessment step is completed within 21 days. The target is 77 percent.

The Nursing Commission not only met the target percentage, but also completed the process on time for 100 percent of reports received in the last year.

Performance Measure 2.3:

Percentage of cases in which the case disposition step is completed within 140 days. The target is 77 percent.

On average, 80.5 percent of cases in case disposition were completed within timelines. Case closures fluctuated between 71.5 and 90.5 percent.

Performance Measure 2.5:

Percentage of open cases currently in the case disposition step that are over 140 days. Target is no more than 23 percent over 140 days.

On average, 23 percent of cases were over the timeline of 140 days. This meets the target set by the Nursing Commission. The number of overdue cases has steadily dropped over the last several years.

Performance Measure 2.6:

Percentage of orders and stipulation to informal dispositions (STIDs) that comply with the sanction schedule. Target is 93 percent of orders and STIDs.

On average, 98.5 percent of nursing orders and STIDs complied with the sanctions schedule. Nursing orders and STIDs are well above the target measure.

Performance Measure 2.7:

Percentage of cases involving sexual misconduct cases transferred to the secretary within 14 days. Target is 95 percentage transferred within 14 days.

The Nursing commission transferred 23 of 24 cases to the secretary within timelines.

For more information on these performance measures, you may contact Catherine Woodard at *catherine.woodard@doh.wa.gov* or Mary Dale at *mary.dale@doh.wa.gov*.

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By Linda Patterson, BSN, RN
Nurse Practice Consultant

Early Remediation Program

Did you make a mistake with patient care? If you did, there is no need for panic. Your employer may help you remedy the situation. As long as you take responsibility for your actions and you did everything in your power to protect the patient, the situation will usually turn out all right. What happens when someone files a complaint or reports you to the Nursing Commission?

As with all reports the Nursing Commission receives, a panel of commission members will review the event. If the concern is significant enough to warrant commission attention, we may refer you to the Early Remediation (ER) Program. A concern may involve substandard nursing practice, failure to conduct patient assessment, document treatment, or administer medications. It may also include failure to comply with scope of practice requirements of delegation laws and regulations. The ER program was developed to protect patients by resolving less serious practice deficiencies with a formal action plan not to exceed six months. This plan may consist of remedial education, on the job training, and employment monitoring. The allegations may not include substance abuse, drug diversions, patient abuse, fraud, theft, deceit, other willful misconduct, or conduct resulting in more than minor patient harm.

After completion of the plan, if the commission believes the nurse has corrected the deficiencies and is unlikely to recur, it may close the case as otherwise resolved.

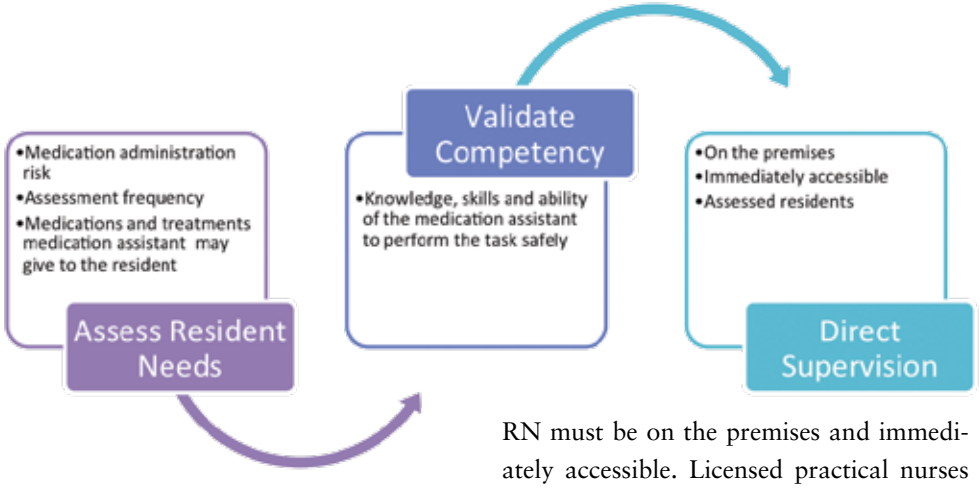
The nurse, the commission, and the nurse's employer will have to all agree to the ER plan. After completion of the plan, if the commission believes the nurse has corrected the deficiencies and is unlikely to recur, it may close the case as otherwise resolved. The specific rules regarding the ER program are WAC 246-840-581 to WAC 246-840-583.

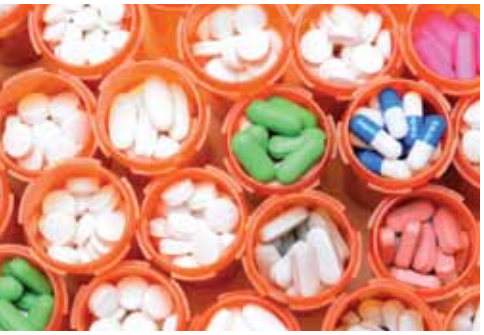
For more information, you may contact Linda Patterson at *linda.patterson@doh.wa.gov*.

By Deborah Carlson, MSN, RN
Nurse Practice Advisor

Medication Assistant Endorsement
Nursing Roles and Responsibilities

On July 1 2013, certified nursing assistants with specialized training through a nursing assistant program approved by the Nursing Commission were able to get an endorsement as a medication assistant. The certified nursing assistant may apply for endorsement once the medication assistant course and Nursing Commission's competency examination are successfully completed. The endorsement allows the medication assistant to give some medications and treatments in nursing homes under the direct supervision of a registered nurse (RN). The RN must assess the resident's needs, validate competency of the medication assistant and provide direct supervision. Direct supervision means the RN must be on the premises and immediately accessible. Licensed practical nurses (LPNs) may not direct medication assistants to give medications or treatments.





The RN may direct the medication assistant to give over-the-counter drugs and legend drugs orally, topically, or inhaled that do not require nursing judgment. The nurse may not direct the medication assistant to give injectable or intravenous medications, chemotherapeutic or experimental drugs, or medications via tubes (such as gastrostomy, jejunostomy, nasogastric, endotracheal tubes or urinary catheters). While the medication assistant may give Schedule IV and V controlled substances, counting or disposing of narcotics is not within the scope of practice of the medication assistant.

The RN may direct the medication assistant to give specific treatments: capillary blood glucose monitoring, pulse oximetry, oxygen administration and unsterile (noncomplex) dressing changes. The medication assistant may not perform sterile procedures.

Medication assistants do not replace the licensed nurses in the administration of medications and treatments, but provide an assistive role. Nurses must still exercise nursing judgment such as assessing and evaluating the resident's needs and response to the medication or treatment, calculating or converting drug doses, and giving "prn" drugs.

For more information about medication assistant training programs, see our website[1] or call Carole Knutzen at 360-236-4785.

REFERENCES:

[1] *http://www.doh.wa.gov/LicensesPermitsandCertificates/NursingCommission/MedicationAssistantEndorsement.aspx*

By Miriam Marcus-Smith, MHA, RN
Program Director, Washington Patient Safety Coalition

SUPPORTING MEDICATION RECONCILIATION

What is medication reconciliation (MR)?

The many definitions include this one from The Joint Commission: The process of verifying that a patient's current list of medications (including dose, route, and frequency) is correct and that the medications are currently medically necessary and safe. MR takes place during the patient's encounters with the healthcare system, (e.g., during an office visit), during admission to or discharge from a hospital, and when medications are changed during a hospitalization.

Why is it important?

As a hospital-based example, patients admitted to a hospital commonly receive new medications or have alterations to their existing medication regimen. Clinicians may not be able to access patients' complete medication records and may be unaware of recent changes. Thus, the new medicines prescribed at the time of discharge may omit needed medications, duplicate existing medicines, or contain inappropriate dosages. If several providers, regardless of setting, care for a patient, it is even more likely that none of those providers will know all of the medications prescribed, recommended or used.

What can you do?

Knowing a patient's current medications is fundamental to MR. The patient (or family or caregiver) is the best source of that information. Even the best-integrated healthcare system may not know all the over-the-counter medications, vitamins, or herbals a patient is taking. While the process of MR

can be very complex, nurses can support it in several important and low-tech ways:

1. Teach your patients (and, as appropriate, their families and caregivers) what a medicine is. The Washington Patient Safety Coalition uses the more inclusive term medicine rather than medication, which may imply a prescription. One definition that may be useful with your patients is, "A medicine is any substance that is meant to change the way your body deals with an illness or injury, or to maintain health and well-being, no matter where you get the substance." Remind your patients that medicines come in many forms (e.g., pills, creams, liquids, lotions, inhalers, injections). In addition, there are many sources for medications including physicians, dentists, naturopaths and herbalists. Let them know that the Internet, the drug store or supermarket are all potential sources, and that herbals, vitamins, minerals, and nutritional supplements are all medicines. Have ready some quick example of interactions you can use to illustrate the point. Your pharmacist colleague may be helpful in identifying these interactions.
2. Encourage your patients to keep an up to date list of all medicines they are taking, and to show this list to their healthcare provider(s) at each encounter. The format of the list is not important, as long as it is complete, current, and includes the medicine and its route, between dose, and frequency, (e.g., aspirin and warfarin). If the provider does not ask for a list, your patients should offer it. When taking a medication history, be sure to ask specifically about complementary or alternative medicines.
3. Be mindful of your attitude and beliefs about complementary or alternative medications. Patients using them may think that their provider will not approve of their use, and thus may not share what might be very important information. Many patients also believe natural substances such as vitamins, herbals, or minerals are inherently safe and do not think they may interact in harmful ways.

Resources

The Washington Patient Safety Coalition provides free tools and resources to support the use of personal medicine lists on its My Medicine List webpages: *www.mymedicinelist.org*.

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Join hundreds of nurses and nursing students for incisive legislative and health policy analysis, breakout education sessions, and then meet with legislators and attend afternoon hearings at the state capitol.

February 24, 2014

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- Learn about critical nursing and health care legislation to be considered during the 2014 Legislative Session
- Visit with your state representatives and let them know which issues are important to you
- Unite with other nurses and educate lawmakers on nursing and health care issues

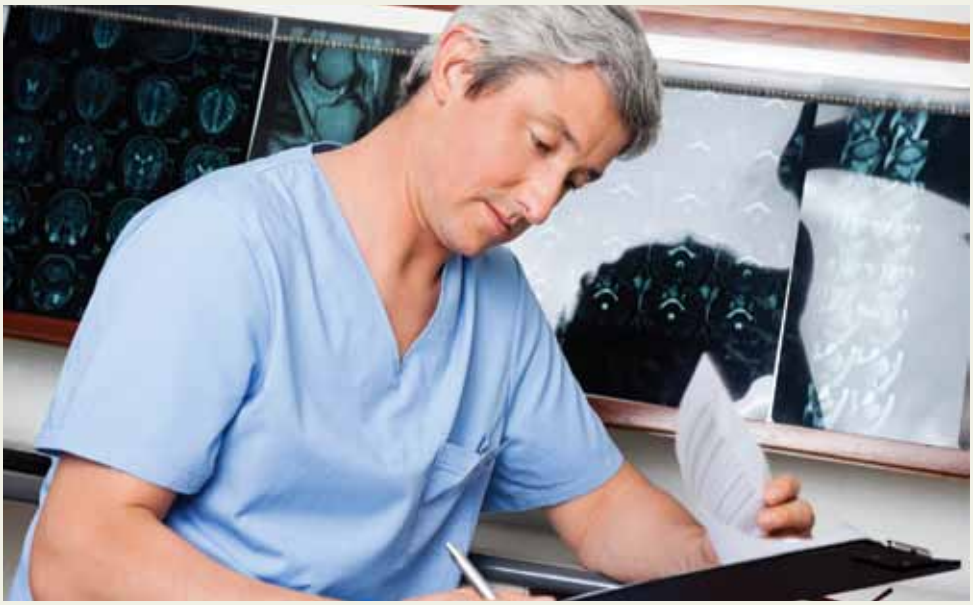
WSNA™ Washington State Nurses Association

www.wsna.org

By Susan Worthington
NACES

Nursing Assistant Competency Examination

Welcome to the Nurse Aide Competency Evaluation Service (NACES). The NACES Plus Foundation is part of the Texas Nurses Association. We contract with Pearson Vue and are responsible for administering the National Nurse Aide Assessment Program (NNAAP®) exam to graduates of state approved training programs for nurse aides. This is a national standardized exam. The NACES expectation for the evaluator is consistency and continuity for every test. NACES has administered these exams for 22 years in 10 different states. We contract with RNs in those states to administer the exam per NACES policies and protocols. In addition, NACES contracts and monitors testing sites to make sure they meet the testing standards.



Each RN evaluator is required to have one full verifiable year of hands-on care of the elderly or chronically ill of any age. They must be able to stand for extended periods, and to move freely and quickly around a room. They must be detail oriented and have good time management skills.

The NNAAP® exam is based on minimum competency for an entry-level nurse aide. The scoring of this exam is tight, as it should be; it is minimum competency or "do no harm." The National Council of State Boards of Nursing (NCSBN) developed the exam to make sure that the nurse aides will go to work knowing the basic skills before they are responsible to care for elderly residents or patients.

The best way for candidates to prepare is to study, understand and follow the instructions in the 2013 Washington NA Candidate Handbook. There is no charge for the handbooks. They are available through NACES or online for download or view at *www.pearsonvue.com*. There is a wealth of information in this handbook, and every skill is broken down into steps. The candidates are required to pass five out of five skills. The computer randomly chooses skills and assigns to each candidate. A scoring center receives the faxed answer sheets. Each candidate is given a score report before leaving the testing location.

The evaluators score the candidates on the skills and steps as listed in the handbook, nothing more, nothing less. The candidates can always do more during the skills exam, but they will be scored only on the steps as listed in the candidate handbook. Many of the steps have multiple components and candidates must do all of the components in order to get the step scored as a yes. The scoring is either a yes or no. There is no maybe or almost on the test.

Other tips for testing:

- Have training programs do some "mock" testing scenarios. Run the candidates through testing scenarios from start to finish using all the skills.
- Remind candidates to bring their ID's to the mock test. Have the instructor make sure IDs are not expired, have the same information (including name) on both IDs, and first and last names match the name they put on their application. There is a full list of approved IDs in the Washington Candidate Handbook.

Preparation is the key to success for the skills exam. The candidate handbook is the best resource for exam preparation. It tells you what to expect, what to bring and who to contact for questions. The NACES team is available to help with any questions or concerns. You may contact us at *naces@texasnurses.org*.

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

PROGRESS ON NURSING EDUCATION STREAMLINING!

Moving from an associate degree in nursing (ADN) to a bachelor's degree in nursing (BSN) and higher is not always as smooth as it could be. Students get stuck repeating classes, waiting for electives, and muddling through confusion.

Help is on the way.

A group of innovative nurse educators from the Council on Nursing Education in Washington State (CNEWS) used the nursing process to go after this:

1. Assessment

The problem is bottlenecks and unnecessary redundancy resulting in slow academic progression.

2. Outcomes

The desired outcomes are reduction of repetition of classes, reduction of delays in ADN to the BSN, and student-centered programming.

3. Options

Create consistent pre-requisites across all schools, develop a direct transfer agreement (DTA) between ADN programs and BSN programs, and examine what other states are doing.

4. Implement

The Joint Transfer Council in Washington State approved the DTA. It has two more hoops to jump through at the state level before final approval. The implementation goal is set for fall 2015.

5. Evaluate the process and outcomes

This plan is a best practice in educational progression, and something other healthcare professions should consider. This has been no minor effort. Having 46 ADN, BSN and RN-to-BSN programs work collaboratively to identify the minimal critical educational content, compare curricula, and design new plans to eliminate or minimize unnecessary variation in educational programs was challenging. Nursing educators in Washington State are committed to making the Master Plan for Nursing Education work for students. One pillar of the plan was increased access to nursing education. This does not mean more buildings, but better distance learning opportunities and elimination of random variations in nursing education that is not supported by evidence. Agreement that quality nursing education is what students need to be successful.

Nursing educators in Washington State are committed to making the Master Plan for Nursing Education work for students. One pillar of the plan was increased access to nursing education.

You thought your nursing process applied only to patient situations!

For more information, see the Washington Center for Nursing website.[1] A new video titled Be a Nurse can also be found at this site.[2]

REFERENCES:
[1] *http://wacenterfornursing.org/*
[2] *http://www.youtube.com/watch?v=gJlxRGFGlbQ*

Local Partnerships Foster Leadership Within Western's RN-to-BSN Program

By *Casey Shillam, PhD, RN*
Director of Western Washington University's RN-to-BSN Program

Transforming nursing education to develop tomorrow's leaders requires students with a passion for healthcare and a vision to lead. It also requires a community committed to provide support. Western Washington University's RN-to-BSN program has combined a rigorous curriculum with a strong foundation of community-based partnerships to prepare leaders within the healthcare field. Debuted in the fall of 2013 through Western's Woodring College of Education, the program's feasibility is based directly on the collaboration between multiple educational institutions, healthcare advocates, and practice partners.

As a result of these collaborations, Western's students are experiencing a needs-driven, community-built model that provides a high quality baccalaureate education. Students are responding to current health care needs and are planning for the future as they develop strategies to implement recommendations from the 2010 Institute of Medicine's report: *The Future of Nursing: Leading Change, Advancing Health*.

The learning scope goes beyond a clinically-based focus, incorporating wide-ranging perspectives that challenge students to redefine leadership in innovative ways. Looking to the future of healthcare, students are engaging with the public to address issues of social justice and devise new ways of delivering nursing care. These conversations are preparing a diverse nursing workforce that can manage the health care needs of the changing demography of Washington.

It is through strong partnerships that Western's RN-to-BSN program will make great strides in meeting the goals of providing the leaders of tomorrow and improving access to high-quality healthcare.

Western's RN-to-BSN program also speaks to the university's long-standing dedication and commitment to supporting the needs of the local community. Western's expanding reach into the community is already having immediate benefits. Most recently, the Palliative Care Initiative was introduced and fostered with multiple organizations throughout the community to transform palliative care and support the human response to living and dying.

This collaborative spirit is gaining national recognition as a state-of-the art approach to nursing education. It is through strong partnerships that Western's RN-to-BSN program will make great strides in meeting the goals of providing the leaders of tomorrow and improving access to high-quality healthcare.

CURRENT AND UPCOMING VACANCIES ON THE NURSING COMMISSION

The Nursing Commission is currently seeking nurse leaders for the following commission member positions:

1. A representative who is from the general public and not a nurse,
2. A representative who is a staff nurse providing direct care,
3. A representative who is a nurse educator from a community college nursing program, and
4. A representative who is a licensed practical nurse, and
5. An advanced practice registered nurse.

All Nursing Commission members are appointed by the Governor. If you have interest in applying for a position on the commission, please visit the Governor's website to obtain an application: *http://www.governor.wa.gov/boards/application/application.asp*.

To apply, submit a cover letter addressed to the Governor. Include a current resume and your application. Send your completed application packet to the address listed on the application. Please submit your application by April 1, 2014 for the positions being vacated on June 30, 2014.

Nursing Commission Work

The Nursing Commission protects the public's health and safety by regulating the competency and quality of licensed practical nurses, registered nurses, advanced registered nurse practitioners and nursing technicians. The purpose of the NCQAC includes establishing, monitoring and enforcing licensing, consistent standards of practice, continuing competency mechanisms, and discipline.

Duties:

- Establish qualifications for minimal competency to grant or deny licensure of registered nurses, practical nurses, advanced registered nurse practitioners and nursing technicians.
- Ensure consistent standards of practice:
  - Develop continuing competency standards.
  - Develop rules, policies and procedures to promote quality healthcare and nursing education for the residents of the state.
  - Investigate complaints against nurses.
  - Serve as a reviewing member on disciplinary cases.
  - Serve as a member of disciplinary hearing panels.
  - Revoke, suspend, restrict specific practice or place probationary conditions on nursing licenses.
- Approve curricula and establish criteria for nursing schools, both new and existing.
- Approve nursing assistant education training programs per RCW 18.88A.060.

Qualifications

The Nursing Commission is comprised of 15 governor-appointed members. These include three public members, two advanced registered nurse practitioners, three licensed practical nurses, and seven registered nurses. All members must be citizens of the United States and residents of Washington.

Nursing members must have been licensed to practice nursing in Washington with at least three years of experience.

Public member representatives may not:

- Be a member of any other healthcare licensing board or commission.
- Have a fiduciary obligation to a facility rendering health care services.
- Have a financial interest in the rendering of health services.

Estimated Time Commitment

Meetings/Conferences:
8 to 9 days per year

Meeting Preparation:
1 to 2 hours per meeting (or the equivalent of about 1 day per year)

Complaint file review:
2 to 3 hours per month (about 24 hours per year)

Case Disposition Panels:
2 hours per month

Hearing Panels:
2 to 4 days per year

Sub-committee meetings:
1 to 2 hours per meeting

For more information, please send your questions to *nursing@doh.wa.gov* or call 360-236-4700.

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