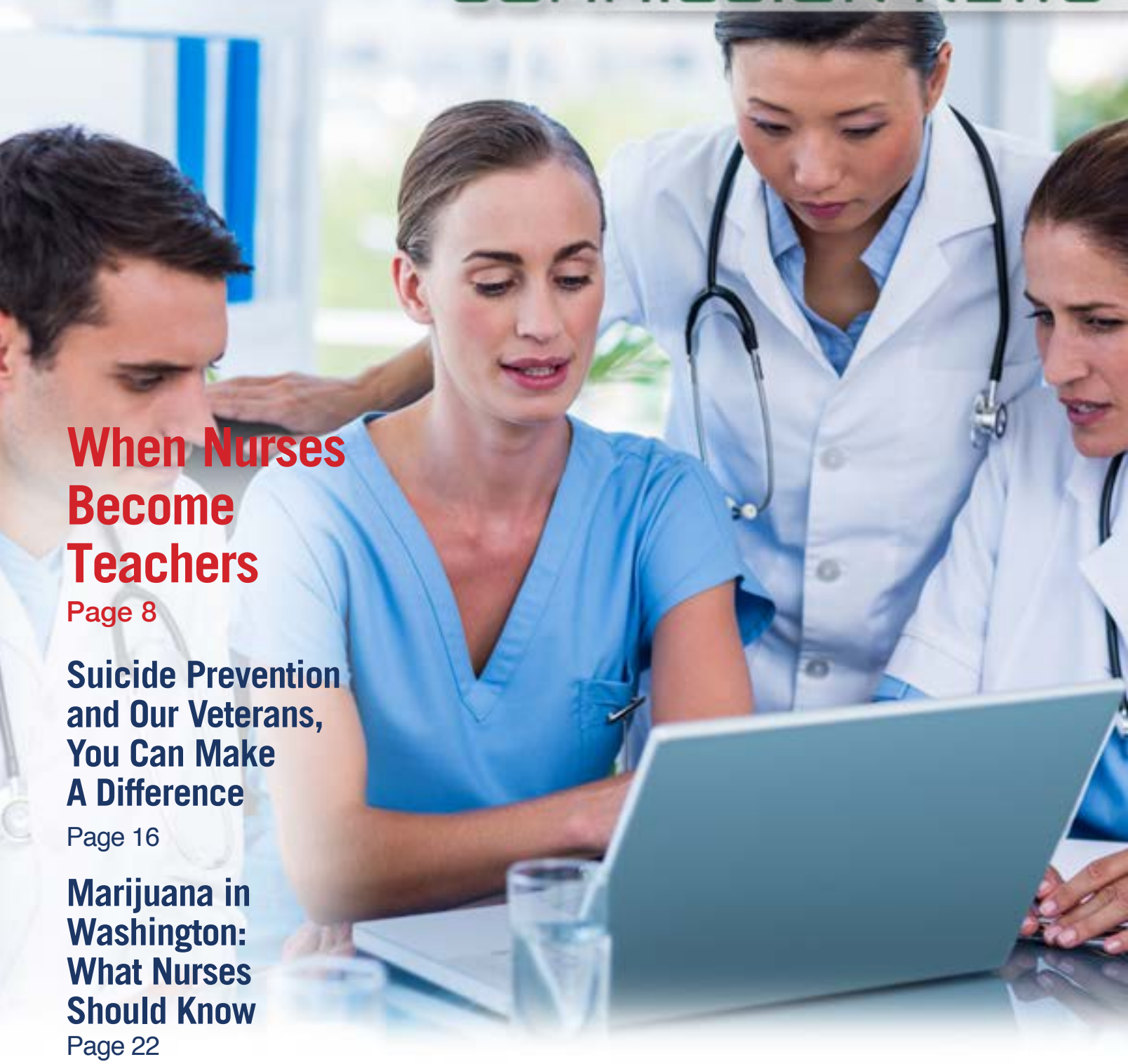
WINTER 2017 • VOLUME 10. N°3. EDITION 27

# 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 Nursing Commission News circulation includes over 100,000 licensed nurses and student nurses in Washington.

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, FRE

**Editor**
Mindy Schaffner, PhD, MSN-CNS, RN

# Secretary of the Department of Health

By John Weisman, DrPh, MPH

## Dear Nurses of Washington State,

As I see children on playgrounds and aboard school buses, I'm again appreciative of our colleagues in pediatrics. Nurses truly play a key role in ensuring that our youngest Washingtonians are prepared to have a healthy start in life!

At the Department of Health we've been thinking about youngest Washingtonians as well. In particular, DOH staff members, along with our partners, are busy examining the health effects of a bill that will be submitted for the legislature's consideration this winter. This bill proposes to raise the legal age of purchasing tobacco and vaping products in Washington up to 21.

No single policy the legislature could adopt this coming session would do more to protect the health of our kids than to move the purchase age of tobacco and vaping products to 21.

The effects of nicotine present real concerns for many of our high school-aged Washingtonians. The percentage of 10th graders who used cigarettes, smokeless tobacco, or e-cigarettes increased from 12.1 percent in 2012 to 20.4 percent in 2014. That's a frightening 67 percent jump in just two years! And more people in our state die from tobacco-related illnesses each year than from alcohol, drug use, car crashes, suicide, homicide, AIDS, and fires combined.

This coming year we have an opportunity to stand together, public health professionals, nurses, and doctors, as members of the health community to support Tobacco 21. From nurses who work with newborns, to those who practice in geriatrics, you each have stories to share about why the next generation deserves to grow up free from addiction.

So, in the coming months please take some time to listen and learn about this policy. And don't just take my word for it. Read the Institute of Medicine's report on Tobacco 21 and the case studies in peer reviewed journals.

*Each of you is a valuable and trusted member of your community, and you have a unique opportunity to help explain to your patients, to your friends, and to your neighbors how this change is important in raising Washington's healthiest next generation!*

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**www.GHCares.org**

# Message from the Executive Director

By Paula R. Meyer, MSN, RN, FRE
Executive Director, Nursing Care Quality Assurance Commission

## The purpose of the Nursing Care Quality Assurance 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]"*

The Nursing Commission's work depends on the fees collected through licensing of registered nurses, licensed practical nurses, advanced registered nurse practitioners and nursing technician. All of the expenses of the Nursing Commission come from licensing fees. This includes all licensing, nursing education program approvals, nursing assistant training program approvals, discipline, practice opinions and employee expenses to support the Nursing Commission and its members.

Over the past year, the Nursing Commission studied trends in our state nursing population and the expenses associated with Commission work, and compared our licensing fees with other professional licensing fees in Washington and other states. The Nursing Commission recommended a fee increase for advanced registered nurse practitioners and registered nurses. The Nursing Commission also recommended a fee decrease for licensed practical nurses and nursing technicians. The Commission held a hearing in late November to present the fees.

**To prepare for this article, I used the following definitions:**

***Nurse:*** a person formally educated and trained in the care of the sick or infirm.
***License:*** formal permission from a governmental or other constituted authority to do something, as to carry on some business or profession.
***Privilege:*** a right, immunity, or benefit enjoyed only by a person beyond the advantages of most.

To be a nurse and care for people in Washington State, the person must meet the minimum qualifications for a license. The nursing license then gives that person the privilege to care for some of our most vulnerable people, the very people who trust us. When that trust is questioned, the Nursing Commission investigates and evaluates if the nurse acted within accepted standards of care. Outcomes of Nursing Commission members' work include safe nurses, prepared to comfort and care for our loved ones. Nursing Commission members describe their work as some of the most rewarding of their careers.

The Nursing Commission and staff members achieve excellent outcomes on our performance measures in licensing, discipline, rules, staff satisfaction and finances. The Nursing Commission desires to continue this level of service for you and the people of Washington State. This level of commitment to customer service is one of the main reasons the Nursing Commission seeks an increase in our fees. If you have any questions, please contact our office at ***nursing@doh.wa.gov***. We will be happy to provide you with all of the documents and evaluation methods used to make the fee decisions.

*http://www.dictionary.com/browse/nurse?s=t*
*http://www.dictionary.com/browse/license?s=t*
*http://www.dictionary.com/browse/privilege?s=t*

By Kathy Moisio, PhD, RN
Nursing Education Consultant

# WHEN NURSES BECOME TEACHERS:

## Applying the Nursing Process to Effective Lesson Planning

*Nurses are often called on to teach colleagues or students entering the profession. While confidence in the professional nursing arena may be strong, confidence in lesson planning can vary among nurses.*

Perhaps you have been asked to provide staff in-service sessions or are planning to teach nursing assistants in your facility. Good news! Because you are a nurse, you can translate your expertise with the nursing process to the process of lesson planning for effective teaching and learning. To do so, here are some helpful tips from the Nursing Care Quality Assurance Commission's Education Unit:

**Assessment and Diagnosis**

Begin with an assessment of learners' needs and interests. The topic and overall goal you establish based on your assessment will represent your "diagnosis" and must be relevant for learners. If your topic has been pre-selected through an organizational assessment, then focus on how you can shape the topic for maximum relevancy. Ask the question, "How does the topic affect the learners?"

**Planning**

***Objectives:*** Again, just as you do with the nursing process, begin your detailed planning "from the end," articulating the outcomes to be achieved. In teaching, these outcomes are called "objectives" and can be derived from this question: "What do you want learners to be able to do to demonstrate their learning at the end of the lesson?" Tips for developing objectives include:

Write them in active verb form using behavioral terms such as: list, describe, explain, or compare and contrast. With a quick online search, you can find lists of verbs for objectives in the three learning domains, as identified by eductional psychologist Benjamin Bloom:

- the cognitive domain (knowing, mental skills);
- the psychomotor domain (doing, manual skills); and
- the affective domain (feeling, valuing, attitude).

You can find verbs for learning objectives that reflect various levels of complexity.

Be sure to address the affective domain in your lesson plan. The affective domain is responsible for human ethics, motivation, and caring and must be activated for learners to engage with what they learn (cognitive domain) in ways that become internalized meaningfully and acted upon behaviorally (psychomotor domain).

Teaching and Learning Activities: Teaching and learning activities are comparable to the "interventions" of the nursing process. What will you do – and what will learners do – to facilitate achievement of the lesson's objectives? What resources – such as reading materials, case scenarios, or video clips – will best support the teaching and learning activities? Tips to consider include:

Avoid allowing resources (such as a text or slideshow) to become your teaching plan; this can lead to a "read, test, repeat" cognitive-focused approach. Instead, consider resources as support materials for your larger teaching and learning plan. A question to ask is, "What can you add or do with the re-

sources, through your expertise and teaching approach, to help learners make meaning of the materials and apply them in ways that achieve the objectives of the lesson?"

*To promote active learning, incorporate Malcolm Knowles' principles of adult learning into your plans.* Examples include involving learners in the planning and evaluation of the lesson; providing experiences as the basis for learning activities; and structuring learning so it is problem-centered vs. content-oriented. A quick online search will give you more information about adult learning principles and how to incorporate them.

Use teaching and learning activities that support learners' *integration of all three learning domains*. Full integration is the most powerful use of learning domains as it helps to validate that learners know and understand what they are doing and why and that they are motivated with values that drive their actions. An example would be an exercise where the learner teaches another individual – providing relevant content, rationale, and significance with demonstration or modeling included. Activities that require full integration cause the three domains to become inextricably woven together – internally in learners' thoughts and feelings, and externally as expressed through learners' professional behaviors.

***Methods of Evaluation:*** Just as you evaluate nursing interventions, you evaluate the effect of the teaching and learning activities in education. The relevant question is, "How will you know that learners have achieved the objectives of the lesson?" Tips to consider include:

Think about a variety of options besides quizzes and tests. Examples include class discussions, role play, learner writing or presentations, and return demonstrations.

Evaluation does not always need to be graded or "high stakes." You can mix in opportunities for "no-stakes" and "low-stakes" assessments to evaluate progress, which allows you and the learners to make needed adjustments.

Create ways for learners to self-evaluate along the way (non-graded, no-stakes); this activates their sense of self-motivation and allows them to self-direct steps toward optimal learning.

Learn from your learners and their feedback. They can help you to identify areas for improvement in your teaching plans, approaches, and resources.

Time Management: Again, as in nursing, teaching requires effective use of available time. This means you need to lay out the timeline for your overall lesson plan as well as the breakdown of time for teaching and learning activities and evaluation processes. Tips to consider include:

Allow enough time and activity to support achievement of the objectives. Remember, multiple exposures via varied modalities reinforce learning. Examples include reading, hearing, seeing, discussing, demonstrating, reflecting, and writing.

Be prepared to expand or condense where learners need it. If you plan well, are clear about your objectives, aware of critical content, and aware of your audience – then you can flex your plan to meet learners' needs optimally.

**Implementation and Evaluation**

As is true in nursing, the major work of teaching comes with assessment and planning. A good lesson plan lays the foundation for a smooth "roll out" or implementation, and affords flexibility for ongoing assessment of progress and adjustments based on learners' responses. Just as you do in nursing, use evaluation of learners' achievement and their feedback for continuous quality improvement efforts in your future teaching endeavors.

By Debbie Carlson, RN, MSN
Associate Director Nursing Practice

# TRACK YOUR LICENSE STATUS

The National Council of State Boards of Nursing (NCSBN) provides automatic license status quickly, easily, securely, and free of charge to individual nurses through Nursys® e-Notify. This system is the only national database for licensure verification for registered nurses, licensed practical nurses, and advanced registered nurse practitioners. The Nursing Care Quality Assurance Commission is a participating member of the NCSBN and updates Nursys® with nursing licensing information through daily secured data transfers. Nursys® also provides online verification for endorsement or for anyone who wants to verify a nurse license.


In just a few minutes, you can enroll in Nursys® e-Notify and take advantage of a quick and convenient way to keep current with your professional license or to verify other nurse licensures. https://www.nursys.com/

By Margaret Holm, JD, RN, Nurse Practice Consultant
Nursing Care Quality Assurance Commissio

# COMING YOUR WAY: Scope of Practice!

The National Council of State Boards of Nursing conducted a very broad survey a few years ago regarding a variety of issues. Nurses, educators and employers completed the survey. One of the issues surveyed included scope of practice knowledge. We learned from the results survey that many of us need additional training and tools in order to evaluate scope of practice questions and concerns.

Over the next several months, I have the opportunity to work with a doctor of nursing practice candidate. He is working on his capstone project. We are going to develop strategies for broader outreach to our nurse population in an effort to encourage each nurse to examine scope of practice and its application to everyday practice.

Of course "in-person" presentations and webinars come to mind. We will develop additional educational presentations provided in-person to enhance dialogue and critical thinking skills. We hope to create training modules accessed on-line and offer continuing nursing education credits.

But what about using social media? Can we open nurses up to new ideas and opportunities through web- and mobile-based technology platforms? Shall we work with social media channels to train nurses regarding the use of our scope of practice decision tree? We will consider the "shared learning experience." Can we adapt social media as a strategy to connect with patient populations and those in the generational shift of the health care work force that is under way? We are looking at ways to connect, communicate, and collaborate.

Please share your ideas and thoughts regarding enhanced nurse outreach. We look forward to the project and especially want to include you! Please contact Margaret.Holm@doh.wa.gov with your ideas.

## Upcoming Nursing Care Quality Assurance Commission Meetings

**May 12, 2017**
Fountainhead NW
20819-72nd Ave. S.
Mt. Rainier Room
Kent, WA 98032

**July 14, 2017**
Department of Health,
Point Plaza East, Room 152/153
Tumwater, WA

**September 8, 2017**
Spokane, WA

**November 17, 2017**
Department of Health,
Point Plaza East, Room 152/153
Tumwater, WA

By Sofia Aragon, JD, BSN, RN, Washington Center for Nursing Executive Director and Washington Nursing Action Coalition (WNAC) Co-Lead
Katie Eilers, MPH, MSN, RN, WNAC Leadership workgroup co-lead
Dorene Hersh, RN, MN, WNAC Leadership workgroup co-lead
Sarah Wickenhagen, DNP, FNP, ARNP, WNAC Leadership workgroup co-lead
Kathy Mertens, MN, MPH, RN, WNAC Leadership workgroup member

# SOCIAL DETERMINANTS OF HEALTH:
## *WHAT NURSES NEED TO KNOW*

***"Why is Mrs. Smith in the hospital?***
*Because she has chronic bronchitis.*

***But how did she get chronic bronchitis?***
*Her cough persisted for a year, and she didn't seek treatment.*
***But why didn't she seek treatment?***
*She is homeless and doesn't trust providers because of how she has been treated in the past.*
***But why is she homeless?***
*Because she and her husband became unemployed a while ago. They couldn't keep up with their bills and lost their home.*
***But why are they unemployed?***
*Because neither of them have much education and couldn't find jobs.*
***But why …?"***

As a nurse, you have likely seen the same person re-admitted to your facility over and over again, or perhaps wondered what led to a certain patient's illness. What did the person do or didn't do to stay healthy?

For all the money the United States spends on health care (we are at about $3 trillion a year), we should be the healthiest people in the world. Yet on some of the most important indicators, such as life expectancy, we're not even in the top 20 developed countries. Surely we have been overlooking something.

Nurses are well positioned to help their facilities meet the Triple Aim – reduce costs, improve outcomes, and improve patient experience of care. But to more successfully reform the health care system, it's crucial to understand – and articulate to others – what are the most important contributors to a person's health, why some people are healthier than others, and how we can ensure health equity for everybody and address health disparities.


### FACTORS THAT DETERMINE HEALTH

Most people do not think about health in terms of social factors. In fact, research has found that most Americans tend to view their health as something largely under their control and for which they have to take personal responsibility.

The real answer is more complex. We know that conditions in which people are born, grow, live, work and age, known as the **social determinants of health**, combine to affect the health of individuals and communities.

These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. We know that a person's level of education, employment and income is the single biggest predictor of that person's health status – more so than healthy behaviors, access to and use of clinical care, and the physical environment.

On the same note, these social determinants are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries.

Understanding that the context of people's lives determines their health proves that blaming individuals for having poor health, or crediting them for good health won't move our needle on outcomes on the national scale.

## WHAT NURSES SHOULD KNOW

Acknowledging that health starts in our homes, schools and communities is the first step toward building a culture of health. So what can nurses in acute care or non-community positions do? Asking your patients the right questions about some social factors that affect their lives can shape more effective interventions. ***Do they have access?***

- Educational, economic, and job opportunities
- Housing
- Fresh food
- Public safety
- Other factors?
- Health care services
- Clean drinking water
- Transportation
- Social support

Understanding that the context of people's lives determines their health proves that blaming individuals for having poor health, or crediting them for good health won't move our needle on outcomes on the national scale.

As the advocate for your patients, you have the opportunity to be their link to better health. Are you aware of social service agencies around you? Can you connect your patients to a service they need?

Look beyond your patients. Are you aware of the social inequalities people are experiencing in your community? How do programs, practices, and policies in the area affect the health of individuals, families and communities? Are there agencies working to tackle broad social issues? Do they need board members or committee members? Lend your expertise! As a nurse, you are solution-oriented and equipped with valuable knowledge, and can offer great insight.

Learn more – find great resources on the Healthy People 2020 website: http://bit.ly/1RjVZUH . Educate your colleagues about how social factors that lead to health disparities.

Let's help others stop thinking of health as something we get in a hospital or clinic, but instead as something that starts in our homes, in our schools and workplaces, and in our playgrounds and parks. Our opportunities for health start long before we need medical care. Let's ensure all Americans are as healthy as they can be.

By Kathy Moisio, PhD, RN
Nursing Education Consultant

# The Nursing Commission "TEAMS" with Other Organizations for a Healthy Aging Project

*In collaboration with six organizations, the Nursing Care Quality Assurance Commission (NCQAC) is launching the expansion of a healthy aging program in Washington. The program is called **"TEAMS for Healthier Living"** or TEAMS. TEAMS, developed by staff members from the NCQAC's Education Unit, stands for:*

**T**ogether
**E**ating better
**A**ctively living
**M**onitoring health
**S**elf-managing risk

The **TEAMS** expansion project, sponsored by MultiCare Health System through its Community Partnership Fund, is slated to launch in January 2017, at three Washington community-based sites: Auburn Senior Activity Center (Auburn), Mountain View Community Center (Edgewood), and Sunset Gardens (SHAG) (Puyallup). Nursing students from Green River College and Pacific Lutheran University – along with occupational therapy assistant students from Green River College – will work with their clinical instructors and program staff members at the community sites to implement and evaluate **TEAMS**.

**TEAMS** integrates evidence-based biopsychosocial approaches in a unique, holistic manner to elicit and positively reinforce healthy lifestyle behaviors, and to mitigate the effect of chronic illness. Each week, **TEAMS** provides:

- healthy snacks supported by recipes and health education;
- group exercise and holistic activity, such as watercolor painting and progressive relaxation;
- basic health monitoring, such as blood pressure and weight checks, with health education; and
- one-to-one action planning and positive reinforcement toward individualized goals.

Since 2013, **TEAMS** has been implemented on a small scale; program evaluation results to date have shown the program to be cost-effective with positive health outcomes for older adults and positive learning outcomes for nursing students – a win, win, win by all accounts. The current project, which runs through June 2017, is intended to further expand **TEAMS** and its evaluation as a program.

Because **TEAMS** has the potential to expand clinical learning experiences and contribute to greater capacity for nursing education programs, the NCQAC's Education Unit is facilitating the **TEAMS** expansion project. While participation in the project was available to all nursing education programs in Washington, the programs at Green River College and Pacific Lutheran University were the ones who opted to participate in this initial expansion attempt.

Over the past year, the project has involved the NCQAC's development of a **"TEAMS Toolkit."** and provision of a one-day **TEAMS** training for the nursing education programs and other collaborators implementing the project.

The Department of Health also provided its one-day "SAIL" program training to all collaborators; SAIL stands for "Stay Active and Independent for Life" and is a well-developed, evidence-based exercise program that **TEAMS** incorporates into its framework each week.

**TEAMS** collaborators will evaluate their efforts in June 2017. If project results are promising, next steps could include involvement by additional nursing education programs, community-based sites, and interdisciplinary educational programs across the state. The addition of a variety of social and health "wrap around" services by community-based outreach agencies, health providers, and health systems is also a possibility.

**If you would like more information about TEAMS, please contact Kathy Moisio at* Kathy.Moisio@doh.wa.gov

By John Furman PhD, MSN, COHN-S
Director, Washington Health Professional Services

# SELF-REPORTING to the WASHINGTON HEALTH PROFESSIONAL SERVICES PROGRAM (WHPS)

Substance misuse is defined as any use of drugs in a manner deviating from medically approved or socially acceptable patterns of use either on a single occasion or episodically. Healthcare professionals are estimated to misuse drugs and alcohol at the same rate (10 to 15 percent) as the general population. That means if you work with 10 nurses, one of them is likely to be struggling with a substance use disorder. (National Council of State Boards of Nursing).

A complaint of "unprofessional conduct" involving substance misuse will more than likely cause an investigation to be opened by the Nursing Commission for practicing while potentially impaired. The investigation and legal review process may result in formal discipline taken against the nurse's license. All disciplinary action is part of the public record and is available through the department's Provider Credential Search engine http://www.doh.wa.gov/SearchResults?tag=ProviderCredential Search

The legislature, in RCW 18.130.175, allows for nurses' participation in WHPS who are not being investigated or monitored by the Nursing Commission for substance misuse. Nurses self-reporting to WHPS without being referred by the Nursing Commission will, in most cases, be provided the opportunity to voluntarily participate in monitoring. They will not be subject to disciplinary action, and will not have their participation known to the Nursing Commission if they comply with the requirements of the WHPS program and are able to continue to practice with reasonable skill and safety.

WAC 246-16-220 allows health care professionals and employers to submit reports of substance misuse directly to WHPS (or one of the other approved programs for physicians, pharmacists, and allied health professionals) "when there is no patent harm." "Patient harm" is not defined. However, a good way to think about it is when a nurse diverts medication that would otherwise be administered to a patient, harm has occurred. On the other hand, if the nurse diverts waste medication, no patient harm has occurred. When a nurse self-reports to WHPS, or is persuaded to do so by an employer, WHPS will evaluate the circumstances. If patient harm has occurred, this will cause a report to be made to the Nursing Commission.

Self-reporting to WHPS is designed to encourage early identification, assessment, and treatment of nurses with substance use disorder. Another major advantage is the savings in legal resources that would otherwise be expended as part of the investigation and disciplinary process. Nurses may self-report to WHPS by simply calling 360-236-2880. A case manager will promptly return the call and begin the intake process.

WHPS is also available to present on substance use disorder, diversion, and the disciplinary process. Call WHPS at 360-236-2880 to schedule a presentation at your facility or nursing program.

By Peter G. Schmidt, Psy. D., LMHC
Behavioral Health Program Director
Washington Department of Veterans Affairs

# SUICIDE PREVENTION & OUR VETERANS

## You Can Make a Difference

**With 20 veteran suicides every day nationwide and one every 1.6 days in Washington State, Washington Department of Veterans Affairs Director, Alfie Alvarado-Ramos, recently described the importance of asking whether a patient has served in the military. Veterans are not only a higher risk for suicide, but often have access to and training on the use of weapons as well.**

As a health care professional you can make a difference and potentially save a veteran's life. As you would with any patient, watch for the following warning signs:

- Hopelessness, feeling as if there's no way out
- Anxiety, agitation, sleeplessness or mood swings
- Feeling as if there is no reason to live
- Rage or anger
- Engaging in risky activities without thinking
- Increasing alcohol or drug abuse
- Withdrawing from family and friends
- Thinking about hurting or killing themselves
- Looking for ways to die
- Talking about death, dying or suicide
- Self-destructive or risk-taking behavior, especially when it involves alcohol, drugs or weapons.

Second, if you see any of the above signs, ask any one of the following questions (and it will be important for you to practice and become confident in asking them):

- Are you thinking about killing yourself?
- Are you thinking of suicide?
- Have you had thoughts about taking your own life?

Ask the question in a way that is natural and flows within the conversation. Don't ask as though you are looking for a "no" answer i.e., "You aren't thinking of killing yourself are you?" Ask the question directly with genuine compassion and concern.

Third, when speaking with the veteran who is at risk, remain calm, maintain eye contact, listen more than you speak, don't argue, act with confidence and use open and attentive body language. Use supportive, encouraging comments, limit questions and let the veteran do the talking. Be honest and say there are no quick solutions, but do say that help is available.

Fourth, encourage treatment and expedite getting help. Don't keep the suicidal behavior a secret and don't leave the person alone. Given the setting, seek assistance from the person's doctor, the nearest ER and/or by calling 911. The Veterans Crisis Line is also available at 1-800-273-8255, Press 1(veteran preference). Chat and text options are also available: http://www.veteranscrisiline.net/ and texting to 838255. The local VA suicide prevention coordinator will be notified and also follow up with the veteran. The resource locator can help you identify a local resource: http://www.veteranscrisisline.net/

Worth Noting: Almost 70 percent of male veteran suicide deaths are by firearm and 35 percent for females. In addition to the previous questions on suicide, you can also help reduce the potential for use of lethal means by asking the following:

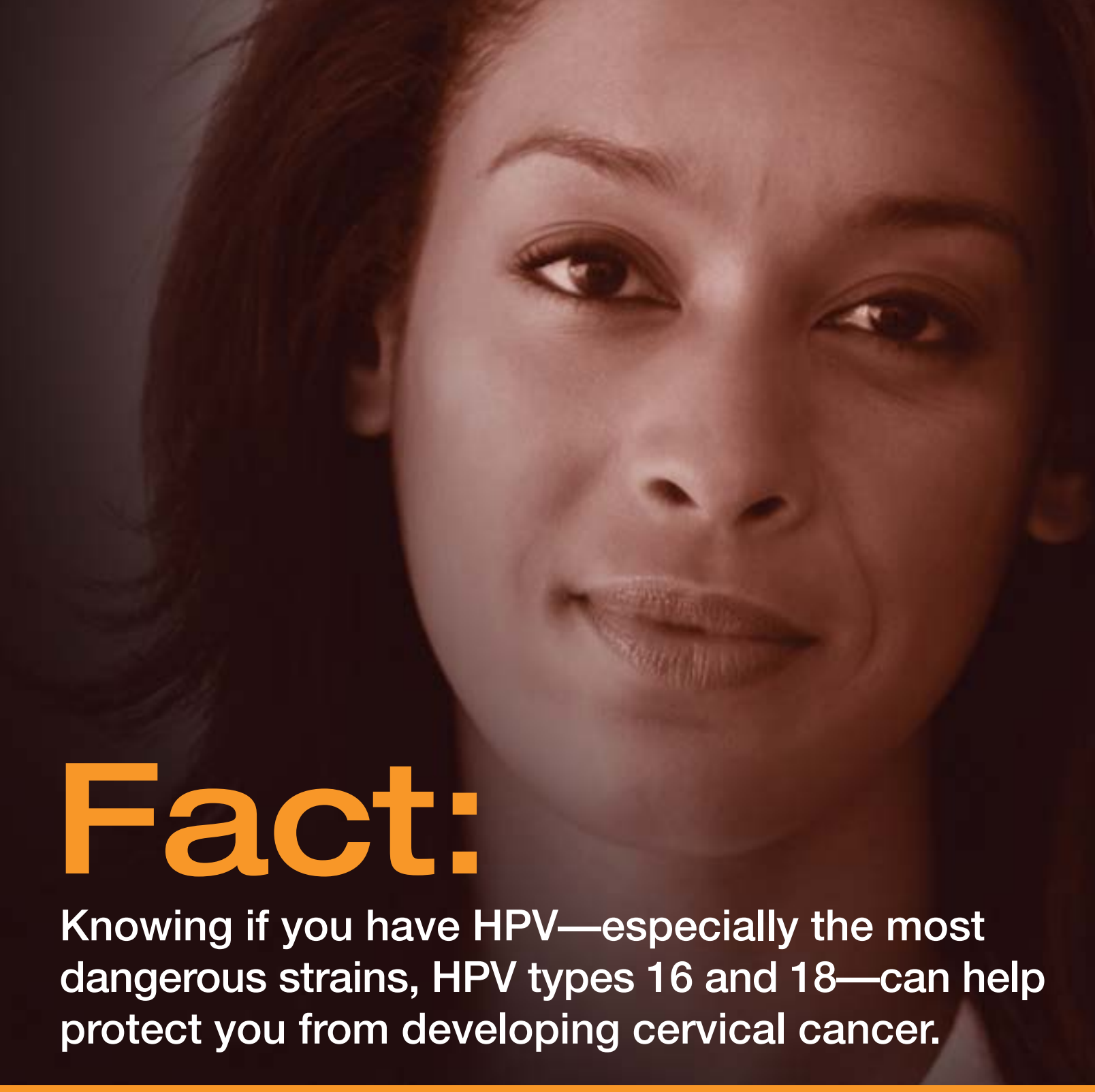
- Do you own a firearm?
- What other means do you have access to and may use to attempt to kill yourself?
- How can we go about developing a plan to limit your access to these means?

Finally, keep in mind the following protective factors. Does the veteran feel connection to social support and is there a sense of belonging? Is there a sense of responsibility to loved ones, especially children? Are there reasons for living or a sense of purpose? What cultural and spiritual beliefs exist that are deterrents to suicide? Is there receptiveness about seeking care, a positive rapport and belief it will help? Might the person have any inkling to future orientation and making goals and plans?

Answers to any of these questions can make a huge difference in the life of veterans and their family members. By virtue of the relationship you have with your patients who are veterans, you can make a significant difference in their lives.

By being mindful of the signs and symptoms, by asking questions, by validating the veteran's experience and exploring resources and protective factors, **you will make a difference for a veteran in need.**

**Washington Department of Veterans Affairs has made available a list of counselors throughout the state to whom veterans can self-refer. To view this list, please visit: http://www.dva.wa.gov/program/counselors**



# Fact:

Knowing if you have HPV—especially the most dangerous strains, HPV types 16 and 18—can help protect you from developing cervical cancer.

If you are 30 or older, ask your health care provider about getting an HPV test with your Pap test. Learn more at www.healthywomen.org/hpv.

This resource was created with support from Roche Diagnostics Corporation.

healthy women
informed. empowered.
www.healthywomen.org

By Debbie Carlson, MSN, RN
Nursing Education Consultant

# Suicide Prevention Training

Engrossed Substitute House Bill 1424 modified the law enacted in 2014 (RCW 43.70.442) establishing suicide prevention training requirements for health care providers including licensed practical nurses, registered nurses, and advanced registered nurse practitioners. The law requires a one-time training course (at least six hours long) in suicide assessment, treatment, and management. The law exempts certified registered nurse anesthetists.

The Washington State Department of Health developed rules establishing the minimum standards for training programs **(http://app.leg.wa.gov/documents/laws/wsr/2016/14/16-14-048.htm)**. Beginning July 1, 2017, nurses must take a training course from the Department of Health's approved training list.

The Nursing Care Quality Assurance Commission revised the continuing competency rules WAC 246-840-220 to address the new requirements. A summary includes the following key points:

- Training will be accepted between June 12, 2014 and June 30, 2017, as long as it includes content about assessment, treatment, and management-training may be from a program on the current model list or from other training programs with appropriate content;
- Beginning July 1, 2017, nurses must complete a suicide prevention training from the Department of Health's approved list of training programs.
- The six-hour training may be done in one or more sessions;
- Training is required during the nurse's next new three-year continuing competency cycle. The new cycle starts on the nurse's birthday in 2017. The requirement for suicide prevention training would be at the end of that three-year cycle on the nurse's birthday in 2020;
- Training may count as part of the 45 hours of continuing education required every three years; and
- Nurses will not need to send documentation of training unless selected for our continuing competency requirement random audits.

References:
HB 2315 Concerning Suicide Prevention (http://apps.leg.wa.gov/billinfo/summary.aspx?bill=2315&year=2013)
HB 1424 Concerning suicide Prevention (http://apps.leg.wa.gov/billinfo/summary.aspx?bill=1424&year=2015)
Rules - Minimum Standards for Suicide Training Programs (http://app.leg.wa.gov/documents/laws/wsr/2016/14/16-14-048.htm)
Suicide Prevention Training for Health Professionals Model List http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/SuicidePrevention/TrainingPrograms)

**For questions or information about training program approval, contact: SuicidePreventionPlan@doh.wa.gov or 360-236-2803.**

**For questions, contact about suicide training requirements, contact the Nursing Care Quality Assurance Commission at NursingPracticeConsultation.NCQAC@doh.wa.gov or 360-236-4703**

# Suicide Prevention Training Timelines

# REQUIREMENTS FOR NURSES

## June 12, 2014

- House Bill 2315 requires a one-time training for six hours in suicide prevention assessment, treatment, and management
- Applies to licensed practical nurses (LPNs), registered nurses (RNs), and advanced registered nurse practitioners (ARNPs)
- Training may be from the Washington State Department of Health (DOH) Model List or from other Sources

## June 24, 2015

- House Bill 1424 changed the law
- Requires a one-time training for six hours in suicide prevention, assessment, treatment, and management that must include content specific to veterans and assessment issues related to imminent harm via lethal means or self-injurious behaviors
- Requires the DOH to develop rules establishing training courses minimum standards
- Requires the DOH to establish an approved list of training courses

## March 18, 2016

- Nursing Care Quality Assurance Commission (NCQAC) established rules for LPNs, RNs, and ARNPs
- Applies to licensed practical nurses (LPNs), registered nurses (RNs), and ARNPs except certified registered nurse anesthetists (CRNAs)
- Training may be from the DOH Model List or from other sources

## January 1, 2016

- Nurses begin a full three-year continuing competency cycle

## June 30, 2016

- Rules adoption to establish minimum training standards

## July 1, 2017

- Training course must come from the Washington State DOH approved list
- Applies to LPNs, RNs, and ARNPs (CRNAs are exempt)
- Requires a one-time training for six hours in suciide prevention assessment, treatment, and management with content specific to veterans and assessment issues related to imminent harm via lethal means or self-injurious behaviors
- Required for nurses completing their three year continuing competency cycle

By Debbie Carlson, RN, MSN
Associate Director Nursing Practice

# DO NURSES UNDERSTAND THEIR SCOPE OF PRACTICE?

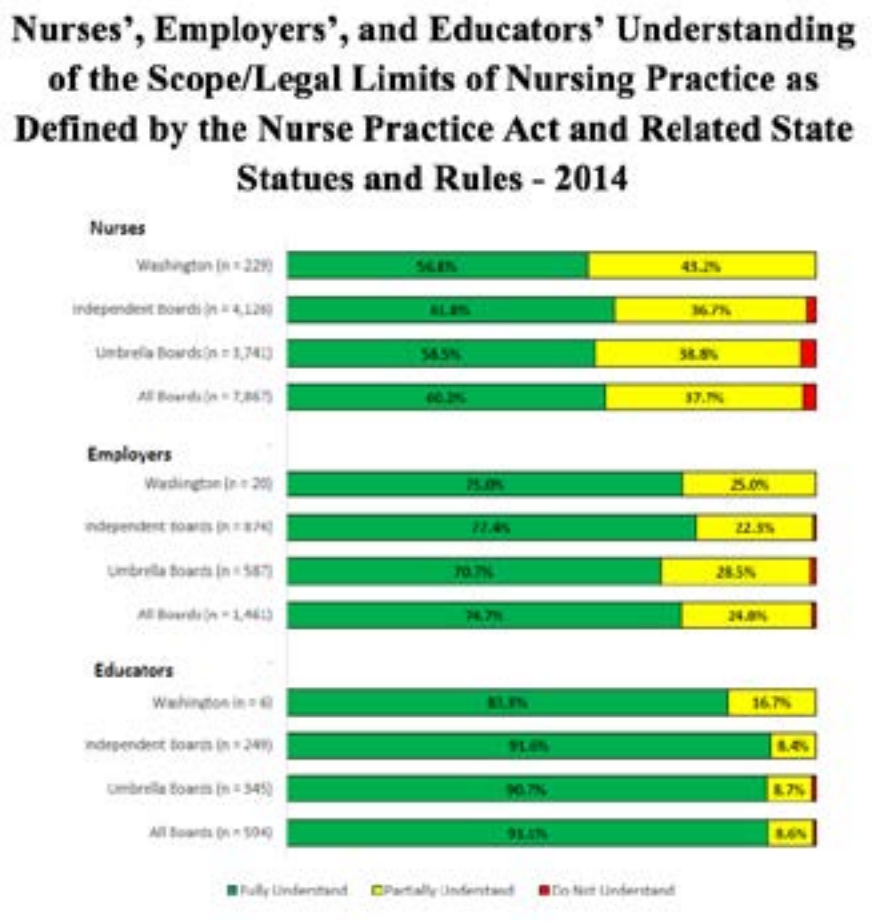
## FINDINGS FROM THE NATIONAL COUNCIL STATE BOARDS OF NURSING COMMITMENT TO ONGOING REGULATORY EXCELLENCE REPORT, 2014

The purpose of the Commitment to Ongoing Regulatory Excellence (CORE) report is to provide an ongoing performance measurement and benchmarking system for nursing regulators. The National Council of State Boards of Nursing (NCSBN) collects and analyzes data as evidence-based data for the Nursing Care Quality Assurance Commission (NCQAC) to help promote excellence with the overall goal of public protection. The data provides a comparison of Washington with other states in the areas of practice, education, licensure, discipline, and administration. The CORE survey included:

- Nurses with active licenses – A simple, random sample of 1,500 nurses with an active license from 43 boards of nursing with a response rate of 14 percent;
- Nurse employers – A simple random sample of employers selected from Medicare-listed nursing homes, the American Hospital Association, and Medicare-listed home health care programs with a response rate of 12 percent; and
- Nursing education programs – All nursing education programs in the United States with a National Council Licensure Examination (NCLEX) code with a response rate of 18 percent.

This article focuses on key findings about whether nurses, employers, and educators understand nursing scope of practice. Among nurses from all boards, 62.2 percent indicated they fully understand the scope and legal limits of nursing practice as defined by the Nurse Practice Act and related state statutes and rules. Only 56.8 percent (229 responses) of nurses in Washington indicated they fully understand the scope and legal limits. Employers reported a higher rate at 75 percent (20 responses) and educators reported at 83.3 percent (6 responses). WAC 246-840-700 requires nurses to know and understand the laws and rules regulating nursing, and to function within their legal scope of practice.

While we find these results concerning, we also recognize the low response rates to this survey (about 108,000 nurses are licensed in Washington). The NCQAC is planning to repeat the survey with hopes to improve the response rate. A thorough analysis will help the NCQAC to develop an improvement plan to ensure nurses, employers, and educators understand nursing scope of practice




References:
FY 2014 CORE State Report, Washington State Board of Nursing, Volume 4: Practice, National Council State Boards of Nursing

By Karl Hoehn, JD

# MARIJUANA IN WASHINGTON:

## *What nurses should know*

Legal medical marijuana (cannabis) is a fact now in a majority of states. Washington first voted by initiative in 1998 to allow medical marijuana for some serious health conditions, and the legislature has amended the law several times. In addition, recreational marijuana is legal in seven states (including Washington since 2012) as this article goes to press.

Regardless of the changes to state law, marijuana remains an illegal schedule I controlled substance under federal law. The Drug Enforcement Administration (DEA) reaffirmed the designation in August 2016. Schedule I substances, which includes substances such as LSD and heroin, are considered by federal law to have a high potential for abuse, no currently accepted medical use, and a lack of accepted safety for use. While marijuana advocates disagree that marijuana actually meets those criteria, it remains a fact that possession or distribution of any amount of marijuana is illegal under federal law. And because the healthcare system involves federal funding, accommodating any use of marijuana that could potentially jeopardize that funding means marijuana is off limits in most of the healthcare system.

While there are studies indicating benefits of marijuana, there are also some known risks. The American Nurses Association's recently revised position statement calls for increased study while supporting safe access to therapeutic marijuana. http://www.nursingworld.org/MainMenuCategories/EthicsStandards/Ethics-Position-Statements/Therapeutic-Use-of-Marijuana-and-Related-Cannabinoids.pdf


Because the laws and the research on marijuana evolve rapidly, nurses need to be up to date. Nurses regularly encounter marijuana issues in their practice. One issue is patients using marijuana as part of their medical regimen or who are using it recreationally. Another issue is marijuana use by nurses. Is it allowed or not? Finally, advanced registered nurse practitioners (ARNPs) can legally authorize the use of medical marijuana under state law, so it is critical for those practitioners to know all the new laws and follow them.

**Patient Marijuana Use**

Nurses who encounter patients using marijuana can face tough decisions. If a patient in long-term care claims a benefit from medical marijuana, will the facility even allow it in the building? If so, under what circumstances might it be allowed, and will it jeopardize the facility's federal funding? Marijuana does carry a risk of dependence. Is the patient using it appropriately, or is there an underlying substance use disorder needing attention? Because marijuana is not a part of traditional nursing education, nurses are trying to educate themselves to properly assess and educate patients. There are numerous CEs available, and a part of the taxes collected on marijuana sales go to providing medically and scientifically accurate

information about the health and safety risks of marijuana to the public. See http://learnaboutmarijuanawa.org/.

What if a nurse is called upon to administer marijuana? While the NCQAC has not taken an official position on administering marijuana, a nurse should consider how if "administering" marijuana is possible within the nursing standard of care. First, medical marijuana cannot be prescribed, only authorized, as writing a prescription for marijuana would violate federal law. Therefore, there is no valid order. As for the drug itself, does the nurse know the source, purity, and strength of the marijuana? What is the right dose? The marijuana plant contains more than 100 different cannabinoid compounds, and the amounts and proportions of those chemicals is variable. It is clear that marijuana is unlike any approved, prescribed drug.

Long-term care facilities across the country have taken a number of approaches for patients using medical marijuana, from outright bans, to strict limitations, to allowing the use as a patients' rights issue. The Washington Health Care Association has a sample medical marijuana policy, which requires and outside family member or other designated person visiting the facility to sign in at the facility, give a single edible serving to a resident who has a valid medical marijuana authorization, assure the resident consumes it, then sign out and leave the facility. Staff members cannot store marijuana for the resident nor have anything to do with the process of providing marijuana to a patient under the sample policy.

**Marijuana use by nurses**

A frequent question to the commission is whether it is acceptable for a nurse to use marijuana either medically or recreationally. The answer is complicated and depends on whose definition of "acceptable" is used. Under state law, adults 21 and older can legally use marijuana recreationally in private and possess certain amounts. While impairment by marijuana while on duty is certainly a violation of nursing law, even private, off-duty use can still raise many issues.

Employers are not required to accommodate the use of medical marijuana and many have very strict policies against it. Where there are federal funds, contracts, or facilities involved, employers are required to maintain a drug-free workplace.

Most often, urinalysis is used to test for the metabolite of THC, which may return a positive result for up to two months in some users. Such tests show use (either intentional or unintentional), but do not prove impairment. When the NCQAC receives a complaint that a nurse has a positive urinalysis screen for the THC metabolite, the complaint is usually closed unless there is also some evidence of on-the-job impairment. It is the responsibility of the nurse never to work while impaired.

Washington law prohibits impaired driving and defines that as a blood concentration of active delta-9-tetrahydrocannabinol (THC), the active ingredient of marijuana, of 5 ng/mL or more in blood. Recent research has questioned that limit, as it is unclear whether everyone testing at that level is in fact impaired.

**ARNP Authorization of medical marijuana for patients**

ARNPs, along with naturopathic, allopathic, osteopathic physicians, and physician assistants, may authorize medical marijuana as part of their practice. There are very detailed requirements in the law that must be followed to authorize medical marijuana legally. In order to work toward a common standard of care across professions, the four professional boards and commissions joined together to develop practice guidelines. The Department of Health has an excellent resource for providers, including the practice guidelines, at http://www.doh.wa.gov/YouandYourFamily/Marijuana/MedicalMarijuana

Reference: http://www.whca.org/files/2013/04/sample-medical-marijuana-policy.pdf

By Barbara Davis,
Washington State Department of Labor and Industries

# HEALTHY WORKER 2020

## *L&I Launches New Initiative to Improve Care for Workers and Partnership with Providers*

Getting hurt on the job can be traumatic. And while no one thinks it will happen to them, it does. Tens of thousands of workers are injured on the job every year in our state. The care and assistance they receive is critical to their recovery and their hopes of going back to work.

While some types of jobs see more injuries than others, no one is immune from getting hurt on the job. In 2015, the Washington State Department of Labor & Industries (L&I) accepted nearly 83,000 workers' compensation claims from injured workers. Of the total number of claims that year, 4,900 were filed by clinicians and other healthcare workers who got injured on the job or experienced an occupational illness. Nurses accounted for 800 of the claims.

To improve care for all of our state's workers—and the effectiveness of our partnership with nurses and other health-care providers — L&I kicked off an ambitious plan that's called "Healthy Worker 2020."

**What is Healthy Worker 2020?**

Modeled on a federal health promotion program, Healthy Worker 2020 is L&I's umbrella for projects aimed at improving health care for people hurt on the job.

Though the projects are diverse, many of them are focused on improving care early in a claim when there is the highest chance of patients' full recovery. It is vital to identify injured workers who are at risk of disability and chronic pain, and then to deliver effective treatments as quickly as possible.

"Our vision at L&I is for Washington State to lead the nation in quality of workers' compensation health care," said Dr. Gary Franklin, L&I medical director. "Through our Healthy Worker 2020 initiative, we are figuring out how to achieve the best outcomes for workers at the best value and using the simplest means."

Healthy Worker 2020 is divided up into five project areas focused on care for injured workers:

**1.** Primary occupational health care
**2.** Surgical care
**3.** Chronic pain and behavioral health care
**4.** Physical medicine
**5.** Catastrophic care services

**Improving care for workers**

To reach the goals of Healthy Worker 2020 projects, L&I is using information from its researchers and health care partners to create more tools and resources to help treat injured workers experiencing disability and chronic pain. The agency is also working directly with clinical leaders to help their organizations incorporate L&I's best practices into their processes.

As part of Healthy Worker 2020, L&I is focusing its purchasing power: we pay providers more for their care when they use best practices for occupational health. L&I offers financial and non-financial incentives, including resources for care coordination. L&I also offers simple, research-based tools to support the best practices. One example is the set of functional recovery interventions offered by L&I. These are simple prompts and exercises that a clinician can use with a worker who needs additional encouragement and assistance with recovery.

Some Healthy Worker 2020 projects are already under way, and will conclude within one or two years. Many of these are focused on increasing primary care doctors' use of best practices. Other projects will run through 2020.

Stay tuned as our Healthy Worker 2020 initiative unfolds. The treatment you provide could truly make a difference in the life and career of an injured worker. You can read more at www.Lni.wa.gov/HW2020.

By Rachel Meade, BA
Legal Assistant, Nursing Care Quality Assurance Commission

# NALOXONE: SAVING LIVES

You may have seen the shocking photo that went viral of the man and woman passed out in the front seat of a car, with a 4-year-old toddler in the back seat. They both had just overdosed on heroin and were saved by the police who administered naloxone. This scenario is becoming more and more common to first responders as our nation deals with the worst "man-made" epidemic of opioid abuse in the history of modern medicine.[1]

The Centers for Disease Control and Prevention (CDC) reported that opioid overdose deaths have nearly quadrupled since 1999 and killed more than 28,000 people in 2014. Seventy-eight Americans die every day from an opioid overdose. There were 979 opioid overdose deaths reported in Washington State alone in 2014.[2]

Naloxone is an FDA-approved opioid antagonist. It is available as a nasal spray or an injection. Naloxone temporarily stops the effect of opioids, allowing a person to resume breathing and awaken. Opioid overdose medication works by taking over the brain receptors and restoring breathing within two to five minutes. The overdose victim may feel withdrawals or become "dope sick" upon awakening. The naloxone wears off in about 30 to 90 minutes so the victim should get to a hospital immediately. Naloxone has been proven safe, and can also be administered to children and pregnant women if needed. [3]

Washington State law RCW 69.50.315 allows anyone who may be a witness to, or is at risk of an opioid overdose, to legally possess and administer naloxone. This law also protects the overdose victim and the person administering naloxone from prosecution for drug possession.

RCW 4.24.300 is Washington State's Good Samaritan Law and protects anyone who helps in a medical emergency from civil liabilities. RCW 69.41.095 authorizes a practitioner to prescribe, dispense, distribute, and deliver an opioid overdose medication directly to a person at risk of experiencing an opioid-related overdose. Washington State law allows pharmacists to prescribe naloxone directly to the public with a signed Collaborative Drug Therapy Agreement (CDTA). A standing order or protocol for naloxone may be established for a first responder or other healthcare provider. A pharmacist may dispense an opioid overdose medication and may administer an opioid overdose medication to a person at risk of experiencing an opioid-related overdose. At the time of dispensing an opioid overdose medication, a pharmacist must provide written instructions on the proper response to an opioid-related overdose, including instructions for seeking immediate medical attention.[4]


Naloxone is now available without a prescription at Walgreen's and other participating pharmacies under a CDTA. Most overdose rescue kits contain two doses of naloxone, a delivery device and overdose education materials. The cost of an overdose rescue kit can be from approximately $20 to $40. Washington State Medicaid will pay for naloxone under the person at risk's account.

Stopoverdose.org is an invaluable resource created by the Center for Opioid Safety Education at the University of Washington Alcohol and Drug Abuse Institute. Training videos, materials and toolkits are available for professionals to educate their staff members, patients and the community. This website offers information and guidance for Washington State individuals and communities to prevent opioid overdose.

We are not just fighting this epidemic but the stigma that comes with it. People are afraid to stay and help their friends when they overdose. Parents are embarrassed to talk about their addicted children, but almost everyone knows an addict; your child, your mother, your friend, your husband. It affects us all. We must have these conversations and educate the public. Addicts are people who have lives, families, hopes and dreams. Naloxone can stop an overdose and give someone the chance to get their life back.

References:
1. Harrison, P. US Opioid Epidemic Fueled by Prescribing Practices. Medscape. Sep 28, 2015. Retrieved from: http://www.medscape.com/viewarticle/851642
2. Centers for Disease Control and Prevention Injury Prevention & Control: Opioid Overdose. Drug overdose deaths in the United States hit record numbers in 2014. Retrieved from: http://www.cdc.gov/drugoverdose/epidemic/index.html
3. UW Alcohol & Drug Abuse Institute. Learn About Naloxone. Oct 6, 2016. Retrieved from: http://stopoverdose.org/section/learn-about-naloxone/
4. RCW 4.24.300. RCW 69.41.095. RCW 69.50.315. Washington State Legislature. Retrieved from http://apps.leg.wa.gov

By Lorie Wild, PhD, RN, NEA-BC
Dean of the School of Health Sciences, Seattle Pacific University

# The Clinical Nurse Specialist:

## IMPROVING PATIENT CARE AND NURSING PRACTICE

*If you love working with specialty populations, are an expert clinician and have a passion for ensuring quality care and cultivating practice environments where nurses, patients and the health care team can thrive —* ***the clinical nurse specialist (CNS) role may be for you.***

The CNS is one of four advanced practice nursing roles. While many are familiar with other advanced practice nursing roles such as nurse practitioner (NP), certified nurse midwife (CNM), and certified registered nurse anesthetist (CRNA), the CNS is an expert clinician whose specialty may be identified by patient populations (e.g., adults, geriatrics, pediatrics), care settings (e.g., oncology, critical care), or particular patient care problems (e.g., palliative care, diabetes).

Three "spheres of influence" frame CNS practice: patients (and families), nursing practice, and the health care system. As an advanced practice nurse, the CNS improves outcomes for patients and others through:

- **Direct care** of patients, families, and patient populations at an advanced level
- **Consultation and coaching** patients, families, staff, and health care leaders
- **Managing change and empowering others** to influence practice and policy using systematic inquiry and evidence
- **Collaboration** at an advanced level within and across the health care team and system to ensure optimal outcomes.

In practice, the CNS role is varied depending on the specialty population and setting. In some hospital-based settings the CNS may consult with bedside nurses to devise and implement individual care plans for complex patients. Clinical nurse specialists often lead interprofessional teams to design innovative and evidence-based pathways or programs to improve patient care quality and safety at the population level. As clinical experts, CNSs also enjoy sharing their expertise through teaching patients, families, nurses, and others. In many settings, the CNS works alongside staff nurses and colleagues in clinical inquiry and research to ensure that patients are receiving state-of-the-science care. For the CNS, each day brings new questions and opportunities to advance both patient care and the profession.

While the CNS role has been in place for decades, only recently have CNSs gained the opportunity to be licensed as an Advance Registered Nurse Practitioner (ARNP) in Washington and other states. The adoption of the APRN Consensus Model brought standardized criteria for ARNP licensure that allows a certified CNS with ARNP licensure to practice in an expanded role that may include prescriptive authority.

In Washington state, registered nurses who have completed formal graduate education in an accredited program (master or doctorate) and hold national specialty certification as a CNS through Commission-approved certifying bodies may apply for licensure as an Advanced Registered Nurse Practitioner or ARNP. Washington recognizes CNS specialty certification from the following certifying bodies:

- American Nurses Credentialing Center (ANCC)
- American Association of Critical Care Nurses (AACN)
- Oncology Nursing Certification Corporation (ONCC)

The rapidly changing health care delivery systems of today demand new knowledge and skill to ensure highest quality care for increasingly complex patient care. As an advanced registered nurse practitioner, the CNS is uniquely poised to meet these demands both now and into the future.

Reference:
Consensus Model for APRN Regulation, Licensure, Accreditation, Certification and Education (2008) https://www.ncsbn.org/Consensus_Model_for_APRN_Regulation_July_2008.pdf

# LICENSURE ACTIONS

The following is a list of formal licensure actions taken between June 21, 2016, and September 30, 2016. For more information, please visit Provider Credential Search (*https://fortress.wa.gov/doh/providercredentialsearch/SearchCriteria.aspx*) or contact the Nursing Care Quality Assurance Commission at 360-236-4700.

| Licensee | Date of Action | Formal Action | Violation |
|---|---|---|---|
| Draper, Tamsen K., RN (RN60525036) | 06/23/16 | Suspension | Sexual misconduct; Violation of federal or state statutes, regulations or rules |
| Linvog, Erin L., RN (RN60245004) | 06/24/16 | Suspension | Violation of or failure to comply with licensing board order |
| Swenson, Linda A., RN (RN00114206) | 06/29/16 | Surrender | Violation of or failure to comply with licensing board order |
| Flanagan, Laura A., RN (RN00157933) | 06/29/16 | Surrender | License suspension by federal, state or local licensing authority |
| Henry, Anne F., RN (RN60606239) | 06/29/16 | Conditions | License suspension by federal, state or local licensing authority |
| Johnson, Sherrie A., LPN (LP00051705) | 06/30/16 | Suspension | License suspension by federal, state or local licensing authority |
| Lackie, Lisa L., LPN (LP60057592) | 06/30/16 | Reinstatement | Alcohol and other substance abuse; Violation of federal or state statutes, regulations or rules |
| Marengo, Suzette H., RN (RN00113821) | 06/30/16 | Reinstatement | Criminal conviction; Diversion of controlled substance; Narcotics violation or other violation of drug statutes |
| Morton, Dawn C., RN (RN00166764) | 06/30/16 | Conditions | Alcohol and other substance abuse; Diversion of controlled substance; Violation of federal or state statutes, regulations or rules |
| Noone, LeAnn C., RN (RN60020868) | 06/30/16 | Suspension | Alcohol and other substance abuse; Diversion of controlled substance |
| Nelson, James R., RN (RN60105802) | 06/30/16 | Reinstatement | Alcohol and other substance abuse; Narcotics violation |
| Parker, Rebecca S., RN, ARNP (RN00126126, AP30004962) | 07/01/16 | Reinstatement | License suspension by federal, state or local licensing authority |
| Bartholomee, Helen B., RN (RN00154163) | 07/01/16 | Suspension | License suspension by federal, state or local licensing authority |
| Holcombe-Hoag, Danielle A., RN (RN60335733) | 07/01/16 | Suspension | License suspension by federal, state or local licensing authority |
| Kimbell, Rebecca, RN applicant (RN60641862) | 07/05/16 | Licensure denied | Criminal conviction |
| Weathers, Gina M., LPN (LP00040977) | 07/14/16 | Reinstatement | Narcotics violation; Violation of or failure to comply with licensing board order |
| Bamberger, Christy L., LPN (LP00048539) | 07/14/16 | Reinstatement | License suspension by federal, state or local licensing authority |
| Taylor, Rebecca L., RN (RN60105132) | 07/14/16 | Conditions | Alcohol and other substance abuse; Narcotics violation or other violation of drug statutes; Violation of federal or state statutes, regulations or rules |
| Kimbley, Karen A., LPN (LP00059763) | 07/18/16 | Suspension | Alcohol and other substance abuse |
| Snoke, Dale A., RN (RN60551053) | 07/18/16 | Suspension | License suspension by federal, state or local licensing authority |
| Lane, Cheryl L., RN (RN00133057) | 07/19/16 | Suspension | Violation of or failure to comply with licensing board order |
| Watson, Andrea L., RN (RN00173703) | 07/19/16 | Suspension | Violation of or failure to comply with licensing board order |
| Munford, Tara L., RN (RN60140309) | 07/19/16 | Suspension | Violation of or failure to comply with licensing board order |
| Cook, Daniel W., LPN (LP60117443) | 07/20/16 | Suspension | Violation of or failure to comply with licensing board order |
| Schwab, Crystal L., RN (RN60249039) | 07/20/16 | Conditions | Alcohol and other substance abuse; Violation of federal or state statutes, regulations or rules; Violation of or failure to comply with licensing board order |
| DeMeerleer, Kimberly D., RN (RN60274352) | 07/20/16 | Suspension | Violation of federal or state statutes, regulations or rules |
| Stryker, Thomas L., RN (RN60085678) | 07/22/16 | Suspension | Violation of or failure to comply with licensing board order |
| Erickson, Rebecca G., RN (RN00151530) | 08/01/16 | Suspension | Violation of or failure to comply with licensing board order |
| Hansen, Leslie J., ARNP (AP60570002) | 08/10/16 | Probation | License suspension by federal, state or local licensing authority |
| Winston, Regina, LPN (LP60230105) | 08/10/16 | Probation | Negligence; Violation of federal or state statutes, regulations or rules |
| Usrey, Margaret G., RN (RN60288652) | 08/10/16 | Conditions | License suspension by federal, state or local licensing authority |
| Wayman, Mary J., RN (RN60089672) | 08/11/16 | Reinstatement | Violation of or failure to comply with licensing board order |
| Boundey, Carolyn J., RN (RN00060601) | 08/17/16 | Suspension | Violation of or failure to comply with licensing board order |
| Taylor, Betty L., RN (RN60255167) | 08/17/16 | Suspension | Violation of or failure to comply with licensing board order |
| Snow, Ambrosia C., RN (RN60297094) | 08/17/16 | Suspension | Violation of or failure to comply with licensing board order |
| Whitcher, Lea K., RN (RN00120104) | 08/18/16 | Suspension | Violation of or failure to comply with licensing board order |
| Walters, Yvonne K., RN (RN00066216) | 08/23/16 | Suspension | License suspension by federal, state or local licensing authority |
| Funk, Victoria L., RN (RN60176992) | 08/23/16 | Suspension | License suspension by federal, state or local licensing authority |
| Brightwell, Tina M., RN (RN00069951) | 08/24/16 | Reinstatement | Incompetence; Violation of or failure to comply with licensing board order |
| Carlton, Rachel B., RN, ARNP (RN60555170, AP60555171) | 08/25/16 | Surrender | License suspension by federal, state or local licensing authority |
| Krocker, Kelly L., LPN (LP00044713) | 08/25/16 | Probation | Negligence; Violation of federal or state statutes, regulations or rules |
| Huggett, Rose F., RN (RN00163533) | 08/25/16 | Reinstatement | Alcohol and other substance abuse; Failure to cooperate with the disciplining authority |
| Mattes, Aaron N., LPN applicant (LP60647531) | 08/29/16 | Licensure denied | Alcohol and other substance abuse; Criminal conviction; Unable to practice safely by reason of alcohol or other substance abuse |
| Strawn, William E., RN (RN60682468) | 009/01/16 | Conditions | License suspension by federal, state or local licensing authority |
| Mellon, Marilee J., RN (RN00110431) | 09/06/16 | Suspension | Violation of federal or state statutes, regulations or rules |
| Thaves, Amy J., RN (R00134256) | 09/08/16 | Suspension | Violation of or failure to comply with licensing board order |
| Stewart, Benjamin D., RN (RN00177048) | 09/08/16 | Suspension | Violation of or failure to comply with licensing board order |
| Evans-Smith, Mary K., RN (RN00085914) | 09/12/16 | Conditions | Alcohol and other substance abuse; Violation of federal or state statutes, regulations or rules |

| Licensee | Date of Action | Formal Action | Violation |
|---|---|---|---|
| Rios, Jennifer K., RN (RN00177082) | 09/12/16 | Conditions | Alcohol and other substance abuse; Narcotics violation; Violation of federal or state statutes, regulations or rules |
| Mendelow, Matthew D., RN (RN60021599) | 09/12/16 | Conditions | License suspension by federal, state or local licensing authority |
| Nettles, Monica C., RN (RN60428058) | 09/12/16 | Reinstatement | License suspension by federal, state or local licensing authority |
| Johnson, Robin N., RN (RN60290593) | 09/13/16 | Reinstatement | Negligence; Patient abuse; Violation of federal or state statutes, regulations or rules |
| Kimbell, Rebecca E., ARNP applicant (AP60641863) | 09/22/16 | Licensure denied | Criminal conviction; Unable to practice safely by reason of physical illness or impairment |
| Dizon, Al B., RN (RN60287770) | 09/22/16 | Suspension | Violation of or failure to comply with licensing board order |
| Hassan, Erika B., RN (RN60670390) | 09/22/16 | Conditions | Failure to meet initial requirements of a license; License suspension by federal, state or local licensing authority |
| Groom, Rebecca A., RN (RN00166087) | 09/30/16 | Probation | Alcohol and other substance abuse; Criminal conviction |

The following is a list of Stipulations to Informal Disposition taken between June 21, 2016, and September 30, 2016. A Stipulation is an informal disciplinary action where the licensee admits no wrongdoing but agrees to comply with certain terms.

| Licensee | Date of Action | Informal Agreement | Allegation |
|---|---|---|---|
| Henderson, Susan M., RN (RN00115312) | 06/30/16 | Probation | Fraud – unspecified; Negligence; Practicing beyond the scope of practice |
| Padayao, Christopher N., RN (RN60229659) | 06/30/16 | Probation | Violation of federal or state statutes, regulations or rules |
| Pampalos, Jessica J., LPN (LP00044056) | 02/01/16 | Conditions | Diversion of controlled substance; Violation of federal or state statutes, regulations or rules |
| Duffy, Teigen M., RN (RN60261073) | 06/30/16 | Probation | Unable to Practice Safely by Reason of Psychological Impairment or Mental Disorder |
| Bui, Lynn M., RN (RN60271490) | 07/01/16 | Conditions | Criminal conviction; License suspension by federal, state or local licensing authority |
| George, Lori K., LPN, RN (LP00044898, RN00176228) | 07/19/16 | Probation | Negligence; Violation of federal or state statutes, regulations or rules |
| Call, Stanford B., RN, ARNP (RN60241509, AP60423419) | 08/10/16 | Conditions | Violation of federal or state statutes, regulations or rules |
| Manneh, Fatou, LPN (LP00048759) | 08/10/16 | Probation | Negligence; Violation of federal or state statutes, regulations or rules |
| Jindra, Emily, LPN (LP00049159) | 08/10/16 | Probation | Negligence; Violation of federal or state statutes, regulations or rules |
| Valdez, Editha V., RN (RN00050781) | 08/10/16 | Surrender | Negligence |
| Lykins, Jodi K., RN (RN00137399) | 08/10/16 | Conditions | Diversion of controlled substance; Practicing beyond the scope of practice; Violation of federal or state statutes, regulations or rules |
| Wilson, Joan M., LPN (LP00032195) | 08/25/16 | Probation | Negligence |
| Moyer, Caroline D., LPN (LP00043748) | 08/25/16 | Conditions | Alcohol and other substance abuse; Diversion of controlled substance |
| Bukovi, Lauren E., RN (RN60547139) | 08/25/16 | Probation | License suspension by federal, state or local licensing authority |
| Holm, Karen J., RN (RN00051585) | 09/12/16 | Surrender | Negligence; Violation of federal or state statutes, regulations or rules |
| McCabe, Jennifer A., RN (RN00167669) | 09/12/16 | Probation | Criminal conviction |

Washington State Nursing Care Quality Assurance
Commission (NCQAC)
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