Role of The Professional Nurse

Role Differentiation: What’s the Problem?

Focus on Practice: Nursing research clarifies best practices for blood pressure measurement
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Nursing Practice

The Summer 2009 issue of the Wyoming Nurse Reporter (WNR) is dedicated to the practice of nursing in the state of Wyoming. The staff of the Wyoming State Board of Nursing (WSBN) have been calling our telephone and e-mail logs for the most common questions and pressing issues related to nursing practice. Several of these practice issues brought forth to the board have been highlighted in the articles of this issue. Usually, questions posed to the WSBN are in regards to whether some specific task or skill is within the scope and standards of nursing practice, as determined by the Wyoming Nurse Practice Act ("Nurse Practice Act," 2005) and Administrative Rules and Regulations (Wyoming State Board of Nursing, 2003). However, before plunging into specific questions related to scope and standards of nursing practice in this state, let’s first look at the definition of nursing practice.

A quick review of one of my favorite references, Encarta online dictionary and thesaurus, defines practice as “to do something repeatedly in order to improve performance in a sport, art or hobby…to do something as an established custom or habit…to work in a profession, especially law or medicine…[and] the process of carrying out an idea, plan or theory” (Microsoft Corporation, 2009). Synonyms listed for repetition (as it relates to practice) are rehearsal, exercise, preparation, training, run-through and drill. Synonyms for habit (as it relates to practice) are custom, tradition, way, system, routine, ritual, manner, praxis and method. I would like to take this opportunity to pose a question to each of Wyoming’s practicing nurses. Which definition best describes your nursing practice: 1) doing something repeatedly to improve your performance in the art of nursing, or 2) doing something by established custom or habit?

Nursing has a long-standing reputation for practicing our profession by tradition, intuition, and ritual. There is evidence to support that there are different ways of practicing nursing, or 2) doing something by established custom or habit?...
When I first began my practice as an Intensive Care Unit nurse just 8 months after graduation from nursing school, one of my preceptors was fond of reminding everyone she worked with (and me in particular) of how long she had been an ICU nurse. In my first days on that unit, she would often preface a declarative statement with, “Well, I’ve been an ICU nurse for seven years, and in that time I’ve learned…” and she would go on to make some definitive policy, standard, or procedural claim. At that time in my life, 7 years of experience seemed astronomical! I could hardly wait to make the same claim. However, now that I could begin a sentence with, “Well, I’ve been a nurse for almost 30 years and I’ve learned…” I would have to think long and hard on how to end that statement. I think now I would have to say now that I am nearing my 30th anniversary as a nurse, what I have learned is that there is so much more knowledge to explore and so many ways my practice could be enhanced. Just as the Olympic medalist or advanced yogi or accomplished musician still embraces regular, deliberate, and mindful practice to seek excellence, so must a nurse.

Several years ago, a colleague and I were having a discussion about trying to implement an evidence-based practice change on a nursing unit where many of the staff had longevity in that specialty area and often resisted opportunities for growth and improvement. I stated that it was difficult to argue with someone who had over 20 years of experience in that specialty. My colleague made a snappy and immediate comeback, “OK, so that is 20 years of growth moving to expert practice, or is it the same first year of practice repeated over and over for 20 more?” We laughed at the time, but since then I have often thought about that idea and believe it is true for many nurses. Just as the nurse who precepted me as a novice and sought to impress me with her years of experience—and succeeded—there are those who rest on their tenure in the profession as the only criteria for being expert in their practice.

Each specialty practice area has its own professional organization that provides publications, guidance, and pertinent research. I urge each of you to seek out the evidence and knowledge you need to support your own practice to improve the performance of your art. Thank you for the invaluable service you provide to Wyoming.

References


The Wyoming State Board of Nursing wishes to congratulate all new graduates! We welcome you into the practice as well as the profession of nursing! If you have questions about your application, please contact the Licensing and Exam Coordinators:

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**Practice and Education Consultant**

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Do not forget that our Web site has many answers to your questions: [http://nursing.state.wy.us](http://nursing.state.wy.us)
Role Differentiation: What’s the Problem?

Do nursing schools educate students about the differences in the role and scope of practice between a licensed practical nurse (LPN) and registered professional nurse (RN)? Are new graduates “educated” by the existing nursing staff who may never have read the Nurse Practice Act (NPA)? Do agencies and administrators place nurses in situations that create confusion? There are no easy answers to these questions, but the problem seems to stem from a combination of underlying factors. As the Education and Practice Consultant, I receive questions on a daily basis such as whether an LPN can serve as a unit manager, be the sole nursing professional in the emergency room, complete an Outcome and Assessment Information Set (OASIS) on a home health client, or complete the Resident Assessment Protocols (RAPs), which is used to assess conditions identified by the Minimum Data Set (MDS) triggering mechanism. This set of circumstances makes me realize that RNs and LPNs (as well as their administrators) often do not understand the differentiation in the levels of nursing that are directly related to scope of practice.

Nursing education programs and competency testing (NCLEX-RN and NCLEX-PN) are designed to differentiate the levels of nursing practice. The mission of the Wyoming State Board of Nursing (WSBN) is to serve and safeguard the people of Wyoming through the regulation of nursing education and practice and our vision is to provide the framework and essential support to the growth of the nursing profession. Therefore, reviewing the Wyoming Nurse Practice Act (NPA)(2005) and the Administrative Rules and Regulations (ARR) as they relate to scope of practice and applying the law to day-to-day situations encountered in healthcare will further the mission and vision of the WSBN.

The definitions of the different levels of nursing are found in the Nurse Practice Act (33-21-120). (*x*) “Practice of practical nursing” means the performance of technical services and nursing procedures which require basic knowledge of the biological, physical, behavioral, psychological and sociological sciences. These skills and services are performed under the direction of a licensed physician or dentist, advanced practice registered nurse or registered professional nurse. Standardized procedures that lead to predictable outcomes are utilized in the observation and care of the ill, injured and infirm, in provision of care for the maintenance of health, in action directed toward safeguarding life and health, in administration of medications and treatments prescribed by any person authorized by state law to prescribe and in delegation to appropriate assistive personnel as provided by state law and board rules and regulations;(*xi*)

(*x*) “Practice of professional nursing” means the performance of professional services requiring substantial knowledge of the biological, physical, behavioral, psychological and sociological sciences, and of nursing theory as the basis for applying the nursing process which consists of assessment, diagnosis, planning, intervention and evaluation. The nursing process is utilized in the promotion and maintenance of health, case finding and management of illness, injury or infirmity, restoration of optimum function and achievement of a dignified death. Nursing practice includes but is not limited to administration, teaching, counseling, supervision, delegation, evaluation of nursing practice and execution of the medical regimen. The therapeutic plan includes the administration of medications and treatments prescribed by any person authorized by state law to prescribe. Each registered professional nurse is accountable and responsible for the quality of nursing care rendered; (pg. 3 of 18)

Because the LPNs “skills and services are performed under the direction of a licensed physician or dentist, advanced practice registered nurse or registered professional nurse,” it is not within the LPN’s scope to serve as a unit manager or charge nurse or as a sole nursing provider in an emergency room. These roles require triage and clinical decision-making (Emergency Nurses Association,1999) that are not included in the scope of practical nursing but are covered in the RN’s scope of practice as defined through the use of the words, “administration,” “supervision,” “evaluation of nursing practice.” The Administrative Rules and Regulations (ARR) go further to explain how the law held by the Nurse Practice Act. The internal boundaries include those forces which fall within the practice of professional nursing.

Chapter III, Section 3 (a)(C)(III) in the ARR further outlines LPN practice with the mandate that in “complex patient care situations” (acute care setting, for example) the care provided by the LPN must be under the supervision of a licensed physician, dentist or licensed professional nurse (pg 3-5). “Supervision” means the immediate availability of a licensed physician, dentist or registered professional nurse in the same patient care unit to continually observe, assist, coordinate and evaluate in person the practice of another” (Chapter I,(a)(1x) pg 1-8). For example, if an LPN is to work in a labor and delivery area or intensive care unit, continuous supervision must be available.

In other situations, like long term care, LPNs “provide care for clients in basic patient care situations under the direction of a licensed physician, dentist or licensed professional nurse. Basic patient care situations as determined by a licensed physician, dentist or licensed professional nurse mean the following three (3) conditions prevail at the same time in a given situation: (1.) The client’s clinical condition is predictable and the responses of the client to the nursing care are predictable; (2.) Medical or nursing orders do not change frequently and do not contain complex modifications; and (3.) The client’s clinical condition requires only basic nursing care” [Chapter III, Section 3 (a)(C)(II) pg 3-5].

Thus, in basic care situations, the word “direction” is applicable.

“Direction” means the intermittent observation, guidance and evaluation of the nursing practice of another by a licensed physician, dentist or registered professional nurse who may only occasionally be physically present; or joint development of a plan of care in advance by those individuals involved which will be implemented by others without the physical presence of a licensed physician, dentist, or registered professional nurse. In the former situation, a licensed professional, dentist or registered professional nurse shall be available for consultation in the event circumstances arise that cause consultation to be necessary. The degree of direction needed shall be determined by evaluation of the patient care situation, and the educational preparation and demonstrated proficiency of others” (Chapter I,(a)(xx)iii pg 1-3).

Another issue that frequently comes to my attention is the LPN’s scope of practice as it relates to assessment. Chapter 3 (Standards of Nursing Practice), Section 3 (a) indicates that it is within the LPN’s scope of practice to:

“A)Contribute to the nursing assessment by: (1) Collecting, reporting and recording objective and subjective data in an accurate and timely manner. Data collection includes: (1.) Observation about the condition or change in condition of the client (2.) Signs and symptoms of deviation from normal health status” (pg. 3-4).

“Contributing to the nursing assessment” means that there must be an initial assessment completed by the RN, APRN or physician. In addition, federal rules associated with RAPs and OASIS specifically indicate that a registered professional nurse must complete these assessments. Collecting vital signs, allergies, medications and chief complaint is within the LPN’s scope of practice. However, the rest of the assessment must be done by the RN. It is never appropriate to “co-sign” unless both parties have witnessed and done the same thing—for example, wasted a portion of a narcotic dose. Does this mean that the LPN’s contribution to care is less valued? Absolutely not! Once the initial assessment is completed, the LPN’s technical skills are invaluable in monitoring the client’s condition.

Laws that govern nursing practice are based on educational level and the national competency exam (NCLEX). It is each licensee’s responsibility to know and work within their scope of practice. Administrators are held to the additional standard of knowing the scope of practice, as well as the unique skill set, experience and potential contributions that each member of the nursing care team provides.

Dr. Mary Beth Stepans is the assistant executive director and the practice and education consultant for the Wyoming State Board of Nursing. References
NPA
Rules & Regs
Emergency Nursing Association http://www.ena.org/publications/scopes/
Focus on Practice: Nursing research clarifies best practices for blood pressure measurement

After noticing that colleagues were measuring blood pressure on two different parts of patients’ arms, a team of Christiana Care Health System nurses questioned whether the practice yielded accurate results. Staff members sometimes took readings on the forearm instead of the upper arm, the location considered optimal by the American Heart Association, because a large cuff was unavailable or they perceived patient discomfort.

The initiative of these nurses resulted in a research project that led to improved patient care and expanded the profession’s understanding about how to accurately measure blood pressure.

“It has made nurses see we can do studies, too, and we have something to add to the body of knowledge on blood pressure,” says Kathleen Schell, RN, DNSc, assistant professor at the University of Delaware in Newark and lead author of two articles about the study published in the American Journal of Critical Care. “Blood pressure is viewed as a mundane task,” Schell says. “Yet it’s so important. I cannot tell you how many beta blockers or heart medications are given based on blood pressure.” Nurses use blood pressure readings to make decisions about holding medications or adjusting dosages, and the readings help determine whether nurses need to call the physician for further consultation, says Linda Bucher, RN, DNSc, nursing research facilitator at Christiana Care Health System in Wilmington, Delaware, and associate professor of nursing at the University of Delaware.

Tackling a research question

The first step for the research team—composed of staff nurses, advanced practice nurses, staff development nurses, and university faculty members—was to do a review of the literature. They found limited data about the practice of taking blood pressure in the forearm. The nurses formulated a research question, obtained institutional review board approval, and began collecting data at the Wilmington Hospital and Christiana Hospital emergency departments.

Blood pressure readings were obtained from 204 clinically stable patients, following the 1993 American Heart Association standards—the patient sitting up with the arm at heart level. Trained data collectors measured the upper arm and forearm circumferences and used appropriately sized cuffs to take measurements in the upper arm and lower arm. When the nurses analyzed their findings, they discovered the readings were not interchangeable.

“We found significant differences between the two numbers,” Bucher says. “We didn’t expect to see as large a difference as we did. Some of the [systolic] readings were as much as 30 mmHg different. You might have 130 mmHg in the upper arm and 100 mmHg in the forearm, or vice versa. There was no way to predict.” The Christiana Care-University of Delaware team then conducted a second study, comparing forearm and upper arm blood pressure measurements in 221 medical/surgical inpatients positioned supine—flat in bed, with the head of bed elevated 45 degrees. The nurses again found wide variations and concluded the measurements were not interchangeable.

Research changes practice

Based on this evidence, Christiana Care developed a clinical practice guideline for nurses and techs outlining how to take blood pressure readings. The hospital developed an Internet-based educational module and required all nurses and techs to complete it. Nurse managers purchased cuffs in different sizes to make upper arm measurements more comfortable, as well as more accurate, for patients. If a valid reason still exists for taking a forearm reading, the nurse or tech must document the reason and site of the measurement in the patient’s chart. Subsequent blood pressure measurements should be done using the same location so clinicians can evaluate trends.

To follow up on the new guideline, Christiana Care completed a performance improvement project about a year after implementation to determine employee compliance. Departments with low rates of compliance were targeted for a re-education campaign.

Research has broader application

The nurses’ research served as a basis for a practice alert about noninvasive blood pressure monitoring issued by the American Association of Critical-Care Nurses (AACCN) in 2006. The Christiana Delaware team helped draft the alert, based on its project, which was funded in part by a grant from the AACCN's Southeastern Pennsylvania chapter, and other studies. Honor Society of Nursing, Sigma Theta Tau International awarded the team the prestigious Research Dissemination Award, which recognizes a major contribution to the dissemination of research for use in clinical nursing practice, education, administration, research or public knowledge.

Christiana Care values nursing research, Bucher says. “When nurses are taking care of you 24/7, you hope what they are doing is research-based and reflects best practice. And when there are questions, those nurses know how to turn those questions into research studies and find the answers, so the quality of care at the bedside is the best we can offer.”

Debra Ansombe Wood, RN, is a freelance writer.
The spring 2009 issue of the Wyoming Nurse Reporter presented the WSBN’s decision to use the Decision Model to guide and direct nursing practice. In addition, licensees were notified that the board rescinded a number of practice decisions. This article will further explain the application of the decision model and demonstrate that while the use of the Decision Model replaces the need for the majority of advisory opinions, it does not really change many of the practice decisions. When each of the practice advisory opinions was reviewed within the context of the Decision Model, only a few were retained because the Decision Model led the Practice Committee members to the same conclusion. For example, one might ask, “Why would the board rescind the final version of the advisory opinion Peripheral Insertion of Central Venous Catheters with or without the Modified Seldinger Technique (MST) with Ultrasound Guidance, RN (07-177) after putting in so much effort to ‘get it right!’ How would using the Decision Model lead to the same or better conclusion?” To answer these questions, the decision-making process will be illustrated using the PICC line insertion topic.

**Define the Activity/Task**

a. **What is the problem or need?**
   i. Using the “old” method of placing PICC (peripheral inserted central catheter) lines (Advisory Opinion 94-58) utilizing a 14g introducer needle in the antecubital space is no longer considered the best practice in the PICC line insertions. Studies have shown a decrease in complications and a much improved success rate utilizing the Modified Seldinger Technique (MST) with ultrasound guidance (LaRue, 2000; Runde, 2007). The question is “are Wyoming RN’s allowed to use ultrasound and MST for PICC placement?”
   ii. Insertion by a physician is expensive for clients and requires much “wait time” (Kokotis, 2005).

b. **Who are the people involved in the decision?**
   i. Registered professional nurses (RNs) and physicians as well as administrators in the acute care setting should be involved.
   c. **What is the decision to be made and where will it take place?**
   i. The decision is whether (RNs) may use the MST with ultrasound guidance to insert PICC lines.
   d. **Why is the question being raised now?**
   i. There is new technology available making the PICC line insertion procedure safer, more successful and less expensive for clients.

2. **Is the activity permitted by Wyoming Nurse Practice Act?**
   i. Since PICC line insertion is permitted using Advisory Opinion 94-58, the activity is permitted.

3. **Is the activity/task precluded under any other law, rule or policy?**
   i. No law or rule precludes performance of this task by RNs.
   ii. **Note:** check agency policy to determine whether there is an agency policy that precludes the performance of this task by a RN.

4. **Is the act supported by the Standards of Nursing Practice (ANA), basic education preparation, or position statements from the professional organization most relevant to the practice question being asked, and research data in nursing and health related literature?**
   i. Radiology Nursing: Scope and Standards of Practice (2007) do not specifically address the RN’s role in insertion of PICC lines using MST. However, the document does address the RN’s role in knowing about technological advances that affect patient care.
   ii. The Association for Vascular Access and Infusion Nurses Society position statements endorse placement of PICC’s using MST by RNs who have demonstrated appropriate training (Association for Vascular Access, 2005; Infusion Nurses Society, 2003).
   iii. Research supports this technology to improve patient outcomes (McMahon, 2002).

   *If the decision is to proceed, the next step is to write a policy that uses the content of the Association for Vascular Access’s position statements and/or Infusion Nurses Society’s practice standards outlining optimal training, validation of competency, and requirements for ongoing competency & skills assessment.*

5. **Has the nurse completed special education if needed?**
   i. Training programs for this technique are often offered at the annual conferences of the American Radiology Nurses Association and Association of Vascular Access. Many private teaching companies, such as “PICC Excellence” are available. Also, many PICC manufacturers (Bard, Boston Scientific etc.) provide training classes.
   *The policy should include a statement about required education.*

6. **Does the nurse possess appropriate knowledge?**
   i. The Infusion Nurses Society generated a competency checklist for the RN to perform this procedure (Infusion Nurses Society, 2003).
   *The agency policy should include a competency checklist.*

7. **Is there documented evidence of experience and initial and continued competence?**
   i. As above.
   *The agency policy should establish criteria for initial and continued competence. This becomes crucial when a highly technical skill that may be used infrequently is considered. For example, the WSBN felt that 25 documented successful insertions per year on a specific patient population (adult or pediatric) were necessary to maintain competence. This should be based upon national guidelines or research.*

Once appropriate knowledge, experience and continued competency are established to be adequate, the following questions apply to the particular situation with a particular client: 8. Would a reasonable & prudent nurse perform the act?

9. **Is patient safety assured?**
10. **Is the nurse prepared to accept the consequences of action?**

**Summary**

Using this Decision Tree Model process led us to the same conclusion that was agreed upon in the practice advisory opinion issued by the WSBN in October 2008. When nurses in each agency use this process, they become familiar with how to access and utilize information and make decisions about their scope of practice based on best nursing practices. By using this model for practice decisions, the WSBN contributed to their vision: To provide the foundation and framework essential to support the growth of the nursing profession. Become empowered and grow in your profession! Develop an agency policy using the Decision Tree! And don’t forget to add a reference list at the end of the policy so that you’ll know when to perform another literature review!!

**Acknowledgements:** Nina Elledge, RN, CRNI, MBA and Arlis Wozniak, RN provided much of the information for this article when they wrote to the Wyoming State Board of Nursing requesting revisions of Practice Advisory Opinion 07-177. Their work on this topic is reflective of the process that must be used in guiding practice. They used the same process that is outlined by the Decision Tree Model when they prepared materials for the board to consider!

Dr. Mary Beth Stepans is the assistant executive director as well as the practice and education Consultant for the Wyoming State Board of Nursing. Arlis Wozniak is a registered nurse working in the Radiology Department at Memorial Hospital of Sheridan County.

**References**


Wyoming State Board of Nursing (2009). Scope of practice decision tree model.
Scope of Practice Decision Making Model

Define the Activity/Task, Identify, Describe, Clarify Problem/Need.

Can task be delegated?

Is the activity consistent with Wyoming Nurse Practice Act/Advisory Opinion?

Is the activity precluded under other law, rule or agency policy?

Is the act supported by Standards of the Nursing Practice, basic educational preparation, or scope of practice statements from professional Nursing organizations, and research data in nursing and health related literature?

Has the nurse completed special education if needed?

Does the nurse process the appropriate knowledge?

Is there documented evidence of experience and initial and continued competence?

Would a reasonable and prudent nurse perform the act?

Is patient safety assured?

Is the nurse prepared to assume accountability for the act or delegation and for the outcome of the care?

Nurse may perform the activity/task according to acceptable and prevailing standards of safe nursing care

If you answered NO to any of the above questions, defer to a professional qualified to do the activity or task. OR Defer to the Wyoming State Board of Nursing for an Advisory Opinion
The primary objective of the Wyoming Nurse Practice Act is to ensure that anyone who practices the art and science of nursing is legally authorized to do so, and to protect the public from unqualified practitioners. The act specifically delineates the responsibilities and limitations of different nursing titles, including registered nurse (RN), licensed practical nurse (LPN), graduate practical nurse (GPN), professional nurse (GN), and graduate advanced practice registered nurse (GAPRN). Each title carries distinct qualifications and restrictions, ensuring that the public is protected from misuse of titles or fraudulent representation.

The Wyoming Nurse Practice Act indicates the following:

(a) No person shall:
   (i) Engage in the practice of nursing as defined in this act [§§ 33-21-119 through 33-21-156] without a valid, current license or temporary permit, except as otherwise permitted under this act;
   (ii) Practice nursing under cover of any diploma, license or record illegally or fraudulently obtained or signed or issued unlawfully or under fraudulent representation;
   (iii) Use any words, abbreviations, figures, letters, titles, signs, cards or devices tending to imply that the person is a registered nurse, licensed practical nurse or advanced practice registered nurse unless the person is duly licensed as a registered nurse, licensed practical nurse, or recognized as an advanced practice registered nurse under this act; (33-21-14, pg 12 of 18).

There is also a section in the Wyoming Nurse Practice Act that protects the titles of registered nurse (RN), and advanced practice registered nurse (33-21-134), licensed practical nurse (LPN) (33-21-135), graduate professional nurse (GN) and graduate advanced practice registered nurse (GAPRN)(33-21-136) as well as graduate practical nurse (GPN)(33-21-137). However, this may not be enough to prevent one from using the term “Christian Science Nurse” in Wyoming.

The qualifications of a licensed nurse and a Christian Science Nurse are not to be confused. The difference is formal education and established competency. This article will describe the history and educational background of Christian Science Nursing.

History

Mary Baker Eddy, because of her own personal experiences of achieving healing through the Divine Mind, God, wrote a book in 1875, now known as Science and Health with Key to the Scripture. In 1879, she founded the Church of Christ, Scientist. It is a Christian denomination based on Jesus Christ’s teachings and works. Believers choose to heal themselves and their children through prayer, rather than through the use of conventional health care. The believer prays for himself but may utilize a practitioner to give prayer assistance. A “practitioner” is a full-time believer who provides assistance to the ill. The “practitioner” does not heal, but seeks the guidance of God (Robinson, 2007, p. 3).


Eddy states that “the nurse should be cheerful, orderly, punctual, patient, full of faith,—receptive to Truth and Love” (Eddy, 1895, p. 395). The role of the Christian Science nurse is to provide physical care, comfort, and a normalcy for the patient. The sick person’s role is to grow spiritually in order to heal himself. In order for this to take place, an atmosphere free of fear and conducive to faith in God must be maintained. The Christian Science nurse supports the patient’s reliance on spiritual healing. The Christian Science nurse does not make a record of symptoms or physical therapy; does not give advice, nor become involved in the relationship between the patient, the Christian Science practitioner, nor his family.

On the other hand, Christian Science nursing care does include the idea that immediate healing will occur and encompasses giving spiritual reassurance; encouraging normal activity; reading from the Bible and writings by Mary Baker Eddy; communicating with the Christian Science practitioner and family members; giving personal care; giving mobility assistance, nourishment, instruction, and dressing wounds (2007, The Christian Science Nurse, pp. 1-2).

Fourteen programs, thirteen in the United States, were found that taught classes in Christian Science nursing. The education usually consists of classroom instruction and hands-on experience under the supervision of a mentor. The curriculum averages eighteen weeks in length. Topics of instruction include ethics, principles, and Christian Science nursing arts. One school offered one week of maternity care. Upon completion of a course of study, the Christian Science nurse may advertise as a Christian Science nurse. The term “nurse” is not necessarily protected in the state of Wyoming even though “RN”, “LPN”, “APRN”, “GN”, “GPN”, and “GAPRN” are protected titles. Using the nurse title is problematic because of the implications it has to members of the public.

Summary

The mission of the WSBN is to serve and safeguard the people of Wyoming through the regulation of nursing education and practice. This mission is jeopardized when the title “nurse” is used by those who lack both the education and competency to be licensed as such.

References


Certified Nursing Assistant II (CNA II) with Medication Administration Certification

During the regularly scheduled meeting the Wyoming State Board of Nursing (WSBN), the Board of Nursing approved the release of draft proposed rules “CNA II with medication certification” to provide education and get feedback from nurses, facilities and the general public, in preparation for adoption by the board.

Presentation Objectives:

- To present the proposed new role of CNA II with medication administration certification;
- Explain how expansion of CNA scope of practice can enhance patient safety and improve the working environment for nurses;
- Present research related to patient safety and evidence that supports expanding CNA scope of practice; and
- To solicit input and feedback from nurses and healthcare stakeholders throughout the state for the purpose of clarifying the proposed rules.

Stakeholders who may have questions or concerns with these draft rules and what it means to nursing practice here in Wyoming are invited to attend.

Schedule:

Wednesday June 10
1:30-3pm:  Laramie
Ivinson Memorial Hospital, Grand Room

Tuesday June 16th
8am-9am: Casper
Wyoming Health Care Association
Parkway Plaza, Champagne Room

Wednesday, June 17th
3- 4:30pm:  State Video Conferencing
System (see next page for locations)

Safe administration of medications by competent and trained personnel is the goal that brought these members of the committee together.

- Cheri Benander (Vice President, Resident Care Services, Powell Valley Health Care),
- LouAnn Carmichael (Director of Operations, South Lincoln Medical Center),
- JoAnn Farnsworth (Weston County Health Services),
- Mary Kay Goetter (Executive Director, Wyoming State Board of Nursing)
- Marguerite Herman (Consumer, Wyoming State Board of Nursing),
- Faith Jones (Vice President, Patient Care Services, Powell Valley Health Care),
- Tom Jones (Executive Director, Wyoming Health Care Association),
- Dan Lex (Executive Director, Quality Health Care Foundation),
- Chris Newman (Deputy Administrator, Division of Disabilities),
- Cyndy Rankin (Executive Director, Westview Health Care Center, Sheridan)
- Mary Beth Stepans (Practice & Education Consultant, Wyoming State Board of Nursing).

Current Administrative Rules and Regulations, lack of funding, and scarce resources force some agencies to “go around” the rules and use untrained personnel to administer medications under the "friend of the family” exemption to the Nurse Practice Act (33-21-154). Other agencies cannot use their professional staff to the fullest extent because of the time-intensive task of medication administration. Hospital and Nursing Home Administrators are strained by the need to adhere to overwhelming guidelines related to quality of care, control cost and maintain patient and staff satisfaction. Governor Freudenthal directed the WSBN to collaborate with multiple stakeholders to explore options for meeting Wyoming’s multiple healthcare challenges and economic realities while still fulfilling our mission of public protection. In answer to these issues, the CNA II with medication administration certification role was drafted, based upon the National Council of State Boards of Nursing (NCSBN) Model Rules for the CNA II and Medication Assistant-Certified (MA-C). The following information was provided by members of the committee to provide answers to questions that might be posed about this new role.

Long Term Care and Acute Care prospective
(Faith Jones - Powell Valley Health Care--acute care; LouAnn Carmichael-South Lincoln Medical Center- long-term care)

1. How does adding the CNA II benefit the nursing profession in Wyoming?

The CNA II is one forward-thinking solution to the long term problem of the nursing shortage. The CNA II provides a development path for the CNA as well as enhancing the leadership skills of the licensed nurse. The addition of these advanced skills will enable the CNA II to build confidence that can improve the likelihood of successful completion of an RN program in their future.

2. Can a CNA II be used in the acute care setting?

Yes, the CNA II with advanced skills can be delegated to provide care to stable patients in any setting. The delegation of these tasks is patient-centered and at the discretion of the licensed nurse.

3. Who will have control over the tasks that are delegated to the CNA II?

The licensed nurse will determine which tasks to delegate. By working in partnership with the CNA II, the licensed nurse will retain his/her autonomy of practice as manager of the patient’s plan of care.

4. How is this going to help the nurse in Long Term Care?

A CNA II will be able to help with those residents who require supervision and assistance during medication administration process.

5. How does this help the workload of the CNAs who already have too much to do?

Work flow for a CNA II should be enhanced. For example, a CNA II will be able to apply some topical medications, speeding up the process of resident care after a bath or during the rush of getting up for breakfast in the morning. CNA II’s will also be able to adjust oxygen flow rates that may have been inadvertently altered, thereby eliminating or reducing the need for interrupting the licensed nurse.

Assisted Living Perspective (Cheri Benander - Powell Valley Health Care)

1. In an Assisted Living facility, licensed nurses are not always onsite. Will this prevent CNA II’s ability to administer medications?

No. Detailed instructions developed by the licensed nurse will guide the CNA II in medication administration. In addition, directions for PRN medications must be in writing and include the parameters for provision of the PRN medication. Directions for observing, reporting, and monitoring medication must be in writing.

2. Can the CNA II administer all medications in all situations?

No. The delegating nurse determines which medications can be administered by the CNA II. In delegating, the nurse uses professional nursing judgment as well as the Administrative Rules and Regulations to guide decisions.

3. Will there be any type of grandfathering system developed for CNAs with several
years of experience?
No. The CNA II requires additional education above and beyond a CNA. All CNAs desiring to advance to the higher level of practice will be required to complete the additional course and testing. Additionally, a person cannot become a CNA II unless currently certified as a nursing assistant.

Home Health Perspective (JoAnn Farnsworth-WCHS)
1. What is the nurse’s liability if a CNA II does not follow instructions and harms a patient in their home when the nurse is NOT on site? The liability is the same as with any other duties delegated by a nurse to a CNA.

2. Would this phase out nurses? No. The CNA II is there to assist in the workload UNDER THE DIRECTION/SUPERVISION of a licensed nurse ONLY. CNA II scope of practice does not include assessments, interpretations or decision making at the level of the professional nurse.

Division of Disabilities Perspective (Chris Newman – Division of Disabilities)
Backgrounds:
The majority of community based services for people with developmental disabilities and acquired brain injuries are funded by home and community based waivers administered by the Wyoming Department of Health, Developmental Disabilities Division (the Division). Waivers provide federal funding for services to participants on the Children's DD Waiver. Eleven organizations and 35 independent registered nurses are certified to provide skilled nursing. Waivers for people with developmental disabilities and at risk of being placed in an institution so they can provide federal funding for services to participants on the waivers do not require medication administration, but most need some support and prompting to assure medications are taken.

Providers:
The Division certifies approximately 930 providers. Thirty of these providers are organizations who are required to meet national accreditation standards, including standards requiring comprehensive training and documentation of medication administration. These organizations employ direct support professionals (DSPs) to provide services around the clock, including habilitation services, personal care and respite. Approximately 900 providers are self-employed or independent providers, and over 400 of these providers provide respite and/or personal care services to participants on the Children's DD Waiver. Eleven organizations and 35 independent registered nurses are certified to provide skilled nursing.

Current issues:
For participants who require medication administration, it has been very difficult for Home and Community Based Waiver provider organizations to hire and retain nurses to meet the need 24 hours a day, seven days a week. According to providers, this difficulty is due to the nursing shortage, nurses wanting positions that involve more than administering medications, and the unavailability of nurses in the evening, overnight and on weekends. In order to meet the needs of participants in home and day settings, organizations (including those with nurses on staff) have developed training programs for direct support staff on medication monitoring and administration so that staff can administer medications around the clock.

Until recently it was understood that the majority of independent providers administering medications, especially those serving children, are doing so under the “Friends and Family” exemption on the Nurse Practice Act, under 33-21-154, that permitted “the incidental health care by members of the family and friends.” This incidental health care includes medication administration and in a handful of cases, more complex nursing tasks, including tube feeding and respiratory care.

The result is that Wyoming’s current system already has unlicensed “medication aides” (direct support staff and independent providers) and potentially some nurses working outside the rules, both within organizations and as independent providers. The Division has not been able to promulgate rules on medication administration that would cover minimum training requirements and documentation requirements, including medication errors, due to the restrictions in the Nurse Practice Act which do not allow nurses to delegate medication administration to CNAs or unlicensed personnel. Instead of working outside of the current system, the Division has instead been working with the Board of Nursing and other key stakeholders to develop a feasible solution to this issue. The CNA II would address these concerns for many organizations and would assure that the health and safety needs of waiver participants are being met.

Frequently Asked Questions related to the Division of Disabilities

State Video Conferencing Sites

Afton
Law Enforcement/Sherriff's Office
Public Health Nurses Office
421 Jefferson
Afton, WY 83110
Seating Capacity 10

Basin
Retirement Center
890 Why 20 South
Basin, WY
Seating Capacity 14

Buffalo
Veterans Home
700 Veterans Lane
Buffalo, WY 82834
Seating Capacity 20

Casper
Workforce Center
851 Werner Court, Suite 121
Casper, WY 82011
Seating Capacity 25

Cheyenne
City Center Building
1920 Thomas Avenue, Suite 410
Cheyenne, WY 82001
Seating Capacity 14

Cody
Workforce Center
1026 Blackburn
Cody, WY 82414
Seating Capacity 18

Evanston
Employment Services
98 Independence
Evanston, WY 82930
Seating Capacity 16

Gillette
Workforce Center
1901 Energy Court, Suite 230
Gillette, WY 82718
Seating Capacity 25

Jackson
Workforce Center
135 West Gill
Jackson, WY 83001
Seating Capacity 12

Kemmerer
Burgoo Building
136 Burgoo Drive
(Also known as 20 Advi Drive)
Diamondville, WY 83116
Seating Capacity 15

Lander
State Training School
Rothwell Building, Atlantic Room
100 Meadow View Drive
Lander, WY 82520
Seating Capacity 20

Laramie
Workforce Center
112 South 5th Street
Laramie, WY 82073
Seating Capacity 12

Newcastle
Workforce Center
2013 West Main St.
Newcastle, WY 82701
Seating Capacity 12

Pinedale
Pinedale High School
Basement
101 East Hennick
Pinedale, WY 82941
Seating Capacity 10

Rawlins
Employment Services Office
1703 Edinburgh
Rawlins, WY 82301
Seating Capacity 12

Riverton
Workforce Center
422 E. Fremont
Riverton, WY 82501
Seating Capacity 20

Rock Springs
Workforce Center
2441 Foothill Blvd.
Rock Springs, WY 82901
Seating Capacity 12

Sheridan
Workforce Center
61 South Gould
Sheridan, WY 82801
Seating Capacity 15

Torrington
Workforce Center
1611 18 East M. Street
Torrington, WY 82240
Seating Capacity 10

Wheatland
Workforce Center
956 Maple
Wheatland, WY 82201
Seating Capacity 8

Worland
Community Complex/Ag Extension
1200 Calberton, Suite G
Worland, WY 82401
Seating Capacity 1
1. Have there been negative outcomes with the current system? If not, why do we need to add requirements to it that may not be necessary?

The Division is not aware of situations where there have been adverse outcomes for a participant. However, through our current monitoring and provider recertification processes, the Division has identified concerns with the level of training and understanding providers and provider staff have concerning medication administration, side effects, etc. After reviewing these concerns the Division agreed to work with the Wyoming State Board of Nursing on an approach that would provide comprehensive, consistent and nationally recognized training and certification. The Division can then promulgate rules that can include grandfathering trained staff as CNAs (not CNA IIs), clarification on if and when a provider can work under the Friends and Family clause of the Nurse Practice Act and establish clear standards for medication administration.

2. It will be very difficult for organizations and independent providers to meet the number of hours and training requirements for CNA IIs. How are providers expected to provide the appropriate levels of service and to fund this additional training?

The Division acknowledges the constraints that providers are working under, including staff turnover, costs of training and requirements to meet specific supervision levels. The Division continues to work with the WSBN to provide flexibility in this program, by allowing organizations to become an approved CNA training location, and by building flexibility in the level of nursing direction needed by CNA IIs. The Division will continue to evaluate the impact on costs to providers and work with providers on a solution. The goal is to establish a system that assures the health and safety of participants but that does not adversely impact providers’ ability to provide required services to participants.

3. Would all providers and provider staff have to become CNA IIs?

No. This requirement would only be for staff administering medications. Many participants do not require medication administration, but do require some support and oversight when taking their medications. The Division plans to develop a Medication Administration Assessment Tool that would be used to determine the level of medication assistance needed by a participant. Those participants who do not require medication administration, but do need reminders or prompts to take their medications (what we consider medication monitoring) would not be required to receive care from staff trained as CNA.

Summary

Please plan to attend one of the information sessions as WSBN solicits input and feedback from nurses and healthcare stakeholders throughout the state for the purpose of clarifying the proposed rules.
Description of NCSBN’s Transition to Practice Model

NCSBN’s Transition to Practice model is intended to be collaboratively implemented with education and practice, but through regulation. Collaboration will be essential for this model to be successful. Educators are the experts in curriculum design and evaluation and will be able to assist with the design of the transition modules. Practice provides a crucial link that will provide new graduates with planned practice experiences with qualified nurses to mentor them. Nursing regulators provide new graduates with information on their scope of practice, the Nurse Practice Act, and maintaining their license throughout their careers. If adopted, regulation will be able to enforce the transition program through licensure.

This is an inclusive model, which would take place in all health care settings that hire newly graduated nurses and for all educational levels of nurses, including practical nurse, associate degree, diploma, baccalaureate and other entry-level graduates. The new graduate must first take and pass the NCLEX®, obtain employment and then enter the transition program.

The preceptors in this model will be trained and most will work one-on-one with newly graduated nurses, though in some settings team preceptorships may be used. This model is strongly dependent on a well-developed preceptor-nurse relationship. Novice nurses will learn the importance of being a seasoned, dedicated preceptor and the responsibility to transition new nurses into practice. In the future, becoming preceptors and mentors for new nurses will be an expected part of professional nursing.

In this model orientation is defined as teaching the policies and procedures of the workplace, as well as role expectations. Therefore, orientation is separate from the concept of transition to practice. Transition to practice is defined as a formal program designed to support new graduates during their progression into practice.

The eight transition modules for this model include delegating/supervising, role socialization, evidence-based practice, prioritizing/organizing, clinical reasoning, safety, communication, and specialty content. These were identified from the literature and from successful transition programs. These modules could be presented at the institution where the new nurse works, in a collaborative program with other institutions, or via the Internet. The Transition to Practice Committee is working with NCSBN’s E-Learning Department on the feasibility of developing a Web site with the online learning modules and with linking new nurses to preceptors.

Feedback and reflection are essential parts of this model and must be integrated throughout the entire transition program. This should be built into the preceptor-nurse relationship, but also should be maintained after the six-month transition period is complete.

The time period for this Transition Regulatory Model will be six months, though it is expected that the new graduate will have ongoing support for another six months. At the end of the year, the new RN is expected to have met the Quality and Safety Education for Nurses (QSEN) competencies. The QSEN competencies, developed by experts from across the health care disciplines, are based on the Institute of Medicine’s (IOM) recommended competencies for health care professionals and include patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics. The Transition to Practice Committee members already have developed some definitions of competencies for practical nursing, based on the QSEN definitions for RNs. The Transition to Practice Committee also has been working with NCSBN’s Research Department to develop outcome competency measures. If NCSBN develops a continued competency model, it is anticipated that there will be some changes in this model so that these two models will be congruent.
In order for the new graduates to maintain licensure after one year in practice, it will be incumbent upon them to provide the Board of Nursing with a Transition to Practice Verification (TPV) form, which will be signed by the new graduates, their preceptors and their supervisors, verifying the new nurse has met all the requirements of the jurisdiction's transition program. In many states new drivers have similar requirements for maintaining their license after their first year of driving. In 2008 the Commission of Collegiate Nursing Education (CCNE) has developed standards for accrediting transition programs that use the UHC/AACN model, and it is hoped that accreditation of transition to practice programs will continue, thus assisting with standardization.

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Mission: The National Council of State Boards of Nursing (NCSBN), composed of Member Boards, provides leadership to advance regulatory excellence for public protection.

For more information, please contact Nancy Spector, PhD, RN at 312.525.3657 or nspector@ncsbn.org.

### Invest in the Future

With the current state of the economy, various healthcare publications have had comments regarding the expense involved in hiring and orienting new graduate nurses. So why wait until they are new grads? Through the use of a nurse extern program, future grads can begin their orientation into the organization as part of their educational experience.

Three years ago, Northwest College (NWC), School of Nursing changed the curriculum for last semester students from traditional clinical rotations to a precepted model which includes two 12-hour shifts a week with a staff nurse preceptor. Although the change to the precepted model allows the student to further develop their professional practice by prioritizing and organizing their skills throughout an entire shift, the time commitment makes it difficult for students to work during this semester. In an effort to ease the stress of juggling multiple commitments, along with a potential financial impact on the students, Powell Valley Health Care set out to develop a program that would incorporate the educational process into a real-world mentored practice that offered the stability of employment.

Take a moment to reflect how you felt as a new graduate nurse during that first year. In a recent article which appeared in the March 2008 issue of Nursing Management, “From Novice to Expert: Transitioning Graduate Nurses”, Grochow summarizes a study that was conducted at University of California, Irvine using Benner’s theory. Her findings revealed that the graduate nurse reached the level of “competence” after gaining two to three years of experience.

Navigating the complexities of healthcare and putting new skills into practice is far less scary in a familiar environment where professional networks have already been established. Having an understanding of the culture, the tools to communicate effectively, and the ability to establish relationships allows the new grad the opportunity to learn in a safe environment.

PVHC, in partnership with NWC, has developed an educational program to assist in the enculturation process. Each fall, the Vice President of Patient Care Services and the Float Pool Director visit the sophomore class at NWC to present an employment opportunity. Students interested in pursuing employment with PVHC can begin their professional journey even before they have finished the nursing program.

Following the application and interview process, hiring selections are made. These job offers include full time pay and benefits beginning with the final semester as a nurse extern, followed by a 12-week graduate nurse orientation period, then as a registered nurse. As each level is achieved, additional pay is earned. The acceptance of this job offer comes with a few commitments including the intention to work at PVHC for a minimum of two years, agreeing to obtain a bachelor of science degree in nursing (BSN) within eight years of hire and fulfilling the nurse extern requirements. Once the job offer is accepted, the student is required to enroll in the nurse extern course offered by the NWC Workforce Alliance. This semester long class provides the students with the opportunity to work as a nurse extern in a precepted student role. It is during these shifts, in combination with the clinical shifts, that the students begin to learn the processes unique to PVHC and build relationships with staff who will soon be their peers. In addition to the work experience, the students meet weekly to discuss issues that arise, seek advice in networking, and learn about how they fit into the culture of PVHC. The materials for the nurse extern course that have been selected by PVHC and approved by the NWC Workforce Alliance Training and Development Programs Manager are: “Now, Discover Your Strengths” by Marcus Buckingham and Donald Clifton and “If Disney Ran Your Hospital, 9 ½ Things You Would Do Differently” by Fred Lee.

In this vulnerable learning time, the strengths discovery process builds confidence as it highlights that each student has innate strengths to bring to the bedside. Following the discussions, students write a self reflection paper outlining how they can leverage their strengths as they begin their new career. As the course progresses, the students are tasked to examine the cultural philosophy used at PVHC which is based on Fred Lee’s work. Each week, through journal entries and discussions, the students explore the expectations and behaviors that are exhibited in the culture of which they are becoming a part.

As the semester comes to a close and the students are preparing to take their next step up the ladder to becoming graduate nurses, it is our hope that the experiences and learning that has taken place throughout the nurse extern period laid the foundation for their future success in our organization. This program sets the stage to foster a culture of collaboration by identifying and sharing strengths, not necessarily to improve individual weaknesses, but to enhance our collective practice.

### References


NCSBN’s Transition to Practice Model: Frequently Asked Questions

1. Q. Why should Boards of Nursing consider regulating transition to practice?
   
   A. Please see our Fact Sheet, which outlines the compelling argument that transition to practice programs should be implemented through regulation: https://www.ncsbn.org/363.htm. As background to this work, NCSBN studies in the early 2000s found that new graduates and employers cited transition to practice as a problem. For example, one NCSBN study reported that new nurses were expected to practice independently in a mean of eight days after the first day of hire. Other NCSBN studies found that fewer than 50% of the employers reported that new graduates were prepared to practice safely and competently. In further studies NCSBN found that well-planned, post-hire transition programs had better outcomes than pre-graduation clinical immersion programs and were related to fewer practice errors and fewer risks for practice breakdown. In an extensive literature review NCSBN also found that post-hire transition programs were linked to fostering better practice outcomes and safer practice.

2. Q. How was the model designed?
   
   A. NCSBN’s Transition to Practice Committee spent a year analyzing the available evidence from transition to practice programs, published and unpublished. Data were retrieved from international, national, and individual studies and projects and were outlined in our Evidence Grid, available here: https://www.ncsbn.org/363.htm. The model was derived from the evidence and in concert with the Boards’ mission of public protection.

3. Q. Are you seeing this as a failure of education and/or practice in nursing?
   
   A. Absolutely not! Health care delivery in the U.S. is becoming increasingly complex, necessitating the use of sophisticated technologies and the need for systems thinking in order for nurses to practice safely. Further, more than ever before nurses are caring for sicker, older, and more diverse patients with myriad chronic conditions. In order to keep up with these changes, NCSBN is proposing that nursing needs to regulate that critical period between education and competent practice where the novice nurse needs practice experience and support from competent nurses in order to develop professionally.

4. Q. Are the modules “re-teaching” didactic content that you are assuming the newly licensed nurses did not effectively learn?
   
   A. No! The modules will not be designed as didactic courses. The modules will build on the nurse’s educational experiences, providing opportunities for deliberate practice. For example, there will be interactive practice exercises designed for newly licensed nurses in areas that are critical for public protection, such as experiences with: priority setting; delegating and supervising; making decisions in a fast paced environment; communicating with other healthcare professionals; and implementing risk management principles.

5. Q. What about cost?
   
   A. All published studies have shown positive return on investment for the workplace when well-planned transition programs are implemented. However, we recognize that the start-up of these programs might require some out-of-the-box thinking. We encourage partnerships between practice agencies, as well as between practice and education, in developing a transition program that would meet the jurisdiction’s criteria. NCSBN
is investigating the possibility of small start-up grants as well as federal funding for the employers. One of the purposes of NCSBN’s pilot studies will be to investigate the cost/benefit ratio for employers as well as the cost to Boards of Nursing.

Q. How can this be implemented in rural areas?

A. NCSBN is planning to develop online modules and online connections with preceptors that could be used if the facility does not have the resources to develop a transition to practice program. The online connection for preceptors would also be valuable in those settings where there might be a paucity of preceptors, such as correctional institutions or schools.

Q. What if an agency already has an excellent residency program?

A. As long as it meets the criteria of our model, it would be acceptable. Many of the current models out there meet our criteria. An underpinning of our model is that it was designed to be flexible (we won’t mandate the program to be used) and robust (inclusive of all settings and all education levels of nurses).

Q. What about preceptor training?

A. Our model has preceptor training built in. We will have set criteria for preceptor training, and we will develop modules for those agencies that do not have resources to train their preceptors. However, we absolutely think it’s essential for preceptors to be adequately trained.

Q. During the time of the 6-month preceptorship is the newly licensed nurse considered part of the work schedule?

A. At the beginning of the relationship the preceptor will work very closely with the newly licensed nurse, providing much support and feedback. However, as the relationship develops (and this will be on an individual basis), that newly licensed nurse will be supported to work more independently since the goal of this relationship is to foster safe and competent practice by allowing for experiential learning.

Q. Must it be a one-to-one preceptor relationship?

A. While some research has found the one-to-one relationship between preceptor and newly licensed nurse to be more effective than multiple preceptors, this might not always be feasible. Furthermore, new studies have found that team preceptorships can be effective. Therefore, a one-to-one preceptorship won’t be required; the workplace should decide what works better for their situation.

Q. Will NCSBN mandate transition to practice programs across all Boards of Nursing?

A. No! Because of state’s rights, NCSBN does not have the authority to mandate regulation in the Boards of Nursing. If our members support this initiative, we will make the recommendation and will assist those Boards that want to implement transition to practice to do so.

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For more information, please contact Nancy Spector, PhD, RN at 312.525.3657 or nspector@ncsbn.org.
Parish Nurse Health Ministry

Parish nursing is a unique, specialized practice of nursing that is a health promotion, disease prevention ministry based on the total health healing of a person – body, mind and spirit. The spiritual aspect is central to parish nursing. Although this is a new specialty in nursing only approved by the American Nurses Association in 1997 it is based on old traditions of the Christian church to care for the sick and those in need. Its roots are in many religious traditions, especially Jesus’ healing ministry reflected in one fifth of the gospels. Parish nursing also reflects the core philosophy of nursing which is to care for others through teaching, counseling, advocating, referring and including family and others in the provision of care. Parish nursing requires additional training after which the nurse is commissioned and receives a certificate. This can be done through the Wyoming Health Council in cooperation with Carroll College in Helena, Montana. The parish nurse works in collaboration with the pastor, priests, church staff and local resources to improve the health and wellness of the parish as well as the local community. The Parish nurse may also work under the guidance of a health ministry team. The team can consist of the pastor, pastoral, medical, nursing, social work, legal, business and lay members dedicated to helping guide, direct, expand and evaluate the program.

As a health educator and counselor, the parish nurse helps parishioners explore ways to cope with physical problems, safety concerns, relationship concerns, and stressful life transitions (birth, retirement and loss). The nurse assists parishioners evaluate signs and symptoms of disease that may need to be acted on promptly and helps those in need to understand their diagnosis, lab results and medications. Caregivers are also assisted with education and support. The parish nurse may write health articles for the Sunday bulletins as well as arrange or provide classes on health topics. They also conduct health fairs and health screenings.

As health advocates, parish nurses help parishioners to understand and navigate the health care system, help those in need access a health care provider or health care when medical help is needed. The parish nurse can be a voice for those who cannot act on their own behalf and a health resource for families in need. They can accompany parishioners to their health care provider visits and explain their concern or situation to the health care provider if requested. They can direct parishioners to resources for insurance, medications or health care.

As a referral person, the parish nurse can guide, refer and direct the parishioners to the resources in the community, when they do not know where to go or what is there for them.

They can refer parishioners to health care providers and community agencies and collaborate with members of the health care system.

The parish nurse meets with parishioners upon their request or when referred by friends, family or parish staff in a variety of settings. They visit in the home, hospital, nursing home, rehab unit, parish building and the office as well as communicate by phone, e-mail or regular mail depending on the need of the parishioner. Many parish nurses do weekly rounds visiting parishioners while they are in the hospital.

Today there are thousands of nurses in many denominations working as parish nurses across the country. They are reclaiming the old tradition of health ministry in the church, to meet unmet health needs and support the journey towards wholeness. The ultimate goal of parish nursing is to improve the whole person health of the parish and community and strengthen the awareness of the connection between faith and health. The emphasis of spiritual health care combined with other parish nurse roles offers a unique service to the parishioners not available anywhere else.

Flossie Vance is a Catholic Community Parish Nurse in Cheyenne Wyoming

HEALTH CARE WITHOUT HARM AND NURSES ALL OVER THE WORLD PARTNER FOR AN ENVIRONMENTAL HEALTH CARE

In celebration of the International Nurses Day, Health Care Without Harm and nurses all over the world partner to create a cleaner, healthier and more environment-friendly health care system.

In the Philippines, HCWH-Southeast Asia and the Philippine Nurses Association (PNA) signed a memorandum of understanding detailing the work to phase-out mercury in the health care setting.

According to Merci Ferrer, Executive Director of HCWH-SEA, “for so many years in the history of HCWH, the nurses have always been in the forefront of environmental health campaigns. Nurses are first to demand for occupational safety practices in the hospitals and also the first to ask that mercury devices be phased-out.”

“We are glad that in the Philippines, it is not just individual nurses who are taking the lead for change but the nurses as a collective, as an organization,” she added.

As part of the MOU, PNA will join the Mercury Free Health Care Global Initiative led by the World Health Organization (WHO) and HCWH. This Initiative aims to substitute mercury-based medical devices with safer, accurate and affordable by 2017.

“The mercury phase-out is number one issue,” said PNA President Tita Barcelo. “We have Administrative Order 21 which mandates the phasing-out of all mercury-containing devices in all hospitals by 2010 here in the Philippines. The PNA definitely support a global phase-out. This is for the welfare of the patients who visit the hospitals and the nurses and other health workers who spend 40 hours a week on duty.”

PNA’s support to global mercury phase-out does not stop with the MOU. They likewise aim for a virtual elimination of mercury-based thermometers and sphygmomanometers over the next decade, substituting these items with accurate, economically viable alternatives and enjoining all PNA members, chapters and affiliates in the country to help promote the advocacy to eliminate mercury in health care.

PNA is also supporting the call for the Department of Environment and Natural Resources (DENR) to provide an intermediate storage area for phased-out mercury devices from hospitals.

“As for all items that are to be phased-out, there must be a corresponding storage area. Thus, we are urging the DENR to be dutiful enough and provide a temporary storage,” Barcelo added.

HCWH-SEA, on the other hand will organize mercury-free health care information and education programs to be disseminated to PNA regional offices; national and local activities for nurses on the promotion of mercury-free health care devices; and promote through its website and the national media the various activities done by the PNA and the partnership.

Continued on next page
“This is what partnership entails. Each has its own duty. You excel in the work assigned to you. You share resources. And when it’s harvest time, all the members reap the benefits,” said Ferrer.

“In this case, it is not just the Philippine nurses and hospitals who will benefit but nurses, health care workers and practically every human all over the world.”

PNA has a membership of over 105,000.

Health Care Without Harm (HCWH) is a global coalition of more than 400 organizations in more than 50 countries working to protect health by reducing pollution in health care sector. For more information, visit www.noharm.org. (30)

For other HCWH-nurses partnership projects, visit http://noharm.org/globalsoutheng/press-room/latestNews.cfm

If you feel you may have a substance abuse problem, reach out to the Wyoming Professional Assistance Program (WPAP). This program is officially recognized by the Wyoming State Board of Nursing as an effective intervention, referral and monitoring program.

Don’t face your addiction alone. Learn more by calling, in confidence, 307.472.1222 or wpapro@wyonet.net.

Are you up to the challenge of coordinating and leading a new Practical Nursing Program? Eastern Wyoming College seeks a Practical Nursing Program Coordinator/Instructor for its Douglas Campus.

The Nursing Program Coordinator/Instructor will:
- oversee and establish a classroom-based curriculum consistent with Board of Nursing guidelines
- structure and implement a hands-on internship based program
- recommend appropriate equipment and staff

This person will oversee a program that prepares students with the knowledge, skills, values, and attitudes essential to a successful nursing career. Most of all, this person will exemplify the high standards of compassion and care that are at the core of professional nursing.

**REQUIREMENTS:** Master’s degree in Nursing. Have, or obtain before employment, a current Wyoming RN license. Supervisory experience, computer proficiency, excellent interpersonal and communication skills a must. Submit letter of application, resume, three letters of reference, OFFICIAL graduate and undergraduate transcripts to the Personnel Office 3200 West C St. Torrington, WY 82240

For a more information contact:
Tom McDowell, HR Director, 866.327.8996 or Tom.McDowell@ewc.wy.edu.

Visit www.ewc.wy.edu

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This project is funded through the Children’s Bureau of the Department of Health and Human Services.
## Advanced Practice Registered Nurse in a Specialty clinic?

I work in a cardiology practice where I have privileges for in-patient care, noninvasive testing supervision and outpatient clinical care; that is within my scope of practice. How can that be, since my training as a family nurse practitioner and a doctor of nursing practice was for basic family care and care of chronic stable patients? However, a 37-year old patient with premature coronary artery disease and post-operative pericarditis and a 78-year old patient with non-ischemic cardiomyopathy, apical ballooning and heart failure are two of the many wonderful patients for whom I provide care.

Advanced Practice Registered Nurses (APRNs) work in specialty clinics within their scope of practice. This is accomplished by virtue of advanced and continuing education, communication skills, teamwork, partnerships and investing time in building trust among the referring providers to the specialty clinic. It is important to understand that the unique paradigm of the APRN compliments the care provided in specialty clinics where sicker patients with greater fears and a need for understanding come for intense healthcare treatments. APRNs learn patient care through a bio-psycho-social paradigm (Bock, 2006; Kleiman, 2004). Consider the 82-year old male who presented to the ER with shortness of breath. He actually had severe coronary artery disease which was treated by several intracoronary stents, but later was found to have a large abdominal aortic aneurysm. However, he developed renal failure before he could have a repair completed.

The APRN must think of him not as all of those parts, but as a wonderfully delightful father and devoted husband who (inspite of everything) is feeling quite well and happy. Nurses think of the patient as a person, whereas the medical paradigm was built upon theories developed by Plato and Hippocrates who studied specific parts of each problem (Bock, 2006). The APRN still comes up with a similar plan of care and still follows the guidelines...we just do it differently. Ultimately, APRNs in specialty clinics take time to listen in order to develop strong relationships and patient trust. That trust must be extended to other providers in the specialty clinic and, ultimately, to the referring providers (truly the hardest to achieve) (Carroll, Rankin, & Cooper, 2007).

At my place of employment, Cheyenne Cardiology Associates, there is tremendous support for me as a Doctor of Nursing Practice (DNP) and for the Physician’s Assistant (PA). We are team members building a practice and foundation of cardiovascular excellence for our patients, their families and referring providers. Through continuing education we have developed a sound understanding of cardiovascular care. Physicians in this practice trust us to know when we need to seek their opinion and guidance in more complex care. The decision to seek peer consultation and to refer appropriately is important. Understanding the limits of personal knowledge and skills are critical in maintaining trust, relationships, and ultimately, in preserving patient safety.

In my opinion, the hardest part of being a team member in a specialty clinic as an APRN is developing a trusting relationship with referring physicians. Could a physician be comfortable in sending their complex and ill patients to the APRN in a specialty clinic? Could the APRNs know anything more than the referring physician! Well, yes, the APRN can grow in skills and knowledge in a specialty clinic that is supported by a team of physician peers who are eager to provide support and guidance (Carroll, Rankin & Cooper, 2007; Hooker, 2006). Again, yes we could, because we look at the patient through a bio-psycho-social model. APRNs alleviate fears, obtain a comprehensive history and physical, order appropriate diagnostic tests, provide individualized patient education, and develop a plan of care. All of this consultation needs to be articulated concisely, professionally and promptly to the referring provider. All of these activities are well within the scope of practice of APRNs. Remaining within your scope requires you to always know your limits. Be consistent, persistent, trustworthy, maintain integrity and always use a nursing perspective by treating your patient as a person first and you will find working in a specialty clinic immensely satisfying!

Maria Kidner is the nurse practitioner for Cheyenne Cardiology Associates, the President of District #1 Wyoming Nurses Association, and is Wyoming representative to the American Academy of Nurse Practitioners.

### References

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Introduction

A friend of mine recently had a planned home birth. When she called the newspaper to ask how she would go about getting the birth announcement published, the person from the newspaper office paused, cleared his throat and then finally asked, “Well isn’t it illegal to have your baby at home anyway?” With so much publicity about home births and illegal midwives lately, it seems as if much has been misunderstood. This article will highlight the history of midwifery in America, the differences among the types of midwives and what research tells us about the safety of homebirth. Then we will hear from a family who just had their fourth baby at home, a Certified Nurse Midwife doing home births in Wyoming and an Obstetrician and Gynecologist’s (OB/GYN) perspective on how we can keep home birth safe in Wyoming.

History of midwifery in America

Early on in America, midwives were respected as vital members of the community (Rooks, 1997). In fact, during the first 250 years of our history as a nation, midwives provided almost all the care to pregnant women (Rooks, 1997). Prior to 1760, childbirth was virtually never seen nor attended to pregnant women (Rooks, 1997). By 1820, MCA had public health nurses working under physician supervision to provide prenatal care and education to pregnant women and their families, mostly in their homes, in 30 neighborhood centers (Rooks, 1997, p. 38). MCA formed the Association for Promotion and Standardization of Midwifery in 1930 (Rooks, 1997). The organization opened the first school of Nurse-Midwifery in the nation, the Lopenstine Nurse-Midwifery School, in 1931 (Rooks, 1997). The school ran for 26 years, and attended 7,099 births, mostly in the woman’s home (Rooks, 1997). The maternal mortality rates for these births were ten times lower than the nation’s average during this period (Rooks, 1997).

In 1918, an American named Mary Breckinridge volunteered to go to France to care for children in the war torn country (Breckinridge, 1981). She observed excellent training in midwifery in France, with a lack of nursing education; in America, the opposite existed (Breckinridge, 1981). She met British nurse-midwives during her work in France and her visits to London, who were both nurses and midwives (Breckinridge, 1981). She had the epiphany that Nurse-Midwifery was the answer to the health care needs in rural America (Breckinridge, 1981, p. 111).

Breckinridge began to form a plan for what would become Frontier Nursing Services (FNS). She had spent much time in the mountains of Kentucky, and she knew the desolation of those who lived there (Breckinridge, 1981). After becoming a nurse-midwife in England, and with much preparation as well as fundraising, Breckinridge returned to Kentucky and started FNS in 1925 (Breckinridge, 1981). The nurses working for FNS rode on horseback to attend to pregnant and laboring women (Breckinridge, 1981).

With great foresight, Breckinridge hired the Metropolitan Life Insurance Company to keep statistics for the service (Rooks, 1997). The statistics demonstrate the incredible quality of care provided (Rooks, 1997). As a testament to this, Dr. Louis Dublin who worked for the insurance company wrote that if the rest of the country implemented similar programs, the lives of thousands of women and children would be saved (Rooks, 1997).

Breckinridge started the second nurse-midwifery school in the nation, the Frontier School of Midwifery and Family Nursing (FMSFN), in 1939 (Breckinridge, 1981). FNS and FMSFN are still in operation today, offering distance education to nurses around the world.

With nurse-midwives finding a niche in multiple settings, the scope of nurse-midwifery has expanded. A 1994 survey of nurse-midwives found that some were performing many skills outside of their original training, as well as treating women for health problems unrelated to reproduction (Stone, 2000). To support the progress, the American College of Nurse Midwives, founded in 1955, issued a statement that Certified Nurse-Midwives are primary health care providers for women and newborns, and changed the Core Competencies’ for Basic Midwifery practice in 1997 to include areas outside of reproduction (Stone, 2000). Certified Nurse-Midwives are also required to complete continuing education programs to maintain their knowledge and skills (ACNM Web site, 2008).

So…did I understand that there’s more than one kind of midwife?

In part, the confusion over midwives is in the title. “Midwife,” meaning “with women” (ACNM website, 2009) is in the title of four separate and very distinct groups providing care for birthing women. To try and simplify, there are midwives who are nurses and midwives who are not nurses. Those who are NOT nurses are generally referred to as direct entry midwives. There is much misinformation on the world wide web about the differences in midwives, the outcomes of midwives and who is more qualified to do what and in what setting. I have tried to simplify for you here the types of midwives, primarily with information available from the American College of Nurse Midwives (ACNM website, 2009).

Certified nurse-midwives are master’s prepared registered nurses who have graduated from a nurse-midwifery education program accredited by the American College of Nurse-Midwives and have passed a national certification examination to receive the professional designation of certified nurse-midwife. Nurse-midwives have been practicing in the U.S. since the 1920s and work in clinics, hospitals, birthing centers and attend home births (ACNM website, 2009).

Direct Entry Midwives: There are three types of “direct entry” midwives; certified midwives, certified professional midwives and lay midwives. Certified midwives, popular in Europe, are individuals who have or receive a background in a health related field other than nursing and graduate from a midwifery education program accredited by the ACNM. Graduates of an ACNM accredited midwifery education program

Why all the Confusion about Midwives and Home Birth?

Isn’t home birth illegal in Wyoming anyway?
don’t know the differences. To simplify: It’s all very confusing and most people, even those about what’s legal and what’s not; from state to home births.

Certified professional midwives (NARM) and is qualified to provide the midwifery model of care. No college degree is required for this designation. Certified professional midwives work primarily in out of hospital settings.

A Lay Midwife, sometimes called a “direct entry” midwife, is an independent practitioner who has learned midwifery through study or apprenticeship. A direct entry/lay midwife may work to meet standards for certification set up by NARM and become a certified professional midwife. No college degree is required for this designation. Direct entry/lay midwives attend home births.

So what does all this mean? I’m still confused…. Unfortunately, there seems to be confusion about what’s legal and what’s not; from state to state, and certainly within the state of Wyoming. It’s all very confusing and most people, even those in health care and many midwives themselves, don’t know the differences. To simplify:

- Certified Nurse Midwives are legally authorized to practice in every state in the US and in the District of Columbia.
- Certified Midwives are currently legally authorized to practice in New York, New Jersey and Rhode Island.
- Twenty-six states now recognize direct-entry midwives in statute, and 24 states license direct entry midwives. States with active direct-entry midwifery licensure, certification, or registration at the time of this printing were California, New York, South Carolina, Utah, Alaska, Colorado, Florida, New Hampshire, Oregon, Vermont, Wisconsin, Arizona, Louisiana, Montana, New Jersey, Tennessee, Virginia, Arkansas, Delaware, Minnesota, New Mexico, Rhode Island, Texas, Washington (ACNM Web site, 2009).

The take home message, however, is simple. There is one type of midwife that can legally practice in the state of Wyoming: a Certified Nurse Midwife (CNM). All other types of midwifery are illegal in the state of Wyoming. Having a baby at home, however, is NOT illegal. But is it safe, you ask? Let’s look at the research.

Safety of Homebirth

The debate over the safety of homebirth has been argued in the literature for years. In more recent years however, there have been several high quality and controlled studies that have established that home birth is safe, with the correct parameters in place. Home births generally result in fewer cesarean births, less narcotic and epidural analgesia use during labor and delivery, less electronic fetal monitoring, and reduced risk of amniotomy and episiotomy (Durrand, 1992; Janssen, Ryan, Etches, Klein and Reime, 2006; Olsen, 1997). Data from a large North American study demonstrates few differences in planned home births and planned hospital births with lower rates of medical intervention when selection criteria is used and physician consultation is available (Janssen et al, 2006).

Why would someone want to have a baby at home?

An interview with Michelle Swanson, married mother of four, recently delivered her fourth baby at home, Cheyenne, Wyoming.

Tell me about your previous birth experiences.

Michelle: My first birth (at a hospital), eight years ago included every intervention except a c-section; I got an epidural, additional IV pain medication, an episiotomy and then a forceps delivery, despite my labor from start to finish, lasting less than four hours. The OB/GYN believed my son to be in a dangerous situation with the cord around his neck, so did everything in his power to deliver him quickly. Unfortunately, I spent the recovery time vomiting in the bathroom because of the IV medication, instead of holding/nursing/bonding with my son during the first hour after his birth. It took much longer than the allotted six week period to recover from that first birth experience. I remember it as a very scary time, with over 10 strangers in the room during the exposed pushing stage, alarms and monitors screaming and terrible nausea because of all of the medication in my body.

My second birth was an induction because of kidney trouble (stones and a never ending kidney infection). My labor again was very quick and my daughter was caught by a nurse in the room because no one else was there. While I enjoyed the fast labor (it was over quickly) I was worried for the nurse, knowing that she could get in trouble for catching the baby, even though it would have been unethical for her to leave the room to find a doctor while the baby was being delivered. Because my baby didn’t spend much time in the birth canal, she was born with a lot of fluid still in her tummy and lungs. But because there were so many births that day, she didn’t get “in to the system” and see a doctor until more than six hours after her birth. I held her in my arms and watched her gag and gasp for breath for a long time. Even after bringing this to the attention of several nurses, they said they couldn’t do anything about it, until she was “in the system” and we would just have to wait until it was less busy to see a doctor. She was fine in the end, but we were definitely “just another number” during that hospital stay.

My third and last hospital birth was the best experience of the three. My doctor knew that I didn’t want any interventions, so she told the nurses to leave me alone, which they did, for the three hours I labored at the hospital until my daughter was born. The doctor made a hurtful comment though, as to the amount of noise I was making during transition, and I’m still hurt by that comment. After my baby was born and the doctor was assessing for [perineal] tearing, she had a resident doctor with her, to whom I hadn’t been introduced. He was cleaning the area very roughly, when I startled in pain. She had to remind him that I was not numb and he needed to be much more gentle. I was the first patient he had cared for who had delivered a baby without an epidural. We checked out and went home only 18 hours after her birth, so that I could rest! We had hospital staff in and out of our room, interrupting our resting, nursing or sleeping time, every 30 minutes or so; all wanting something else...to check a temp, to prick a heal, to get our supper meal order, to see if we needed a prayer, etc., etc., etc. It is impossible to recover from childbirth in a place where the mama and the baby can’t bond and rest undisturbed.

When did you decide you wanted a home birth for your current pregnancy?

Michelle: Before I conceived I knew I wanted to have a baby at home.

What factors led you to seek a home birth?

Michelle: There were several factors I took into consideration; my previous hospital birth experiences; the movie “The Business Of Being Born;” my work with counseling breastfeeding mothers and always talking to them about the importance of a non-intervention birth and its effects on breastfeeding; and the fact that a very good friend had just had a safe and satisfying home birth, here in Cheyenne, the previous summer.

Who have you hired to attend your home birth?

Michelle: My CNM Janet Schwab, and her labor assistant, who is also a doula.

What kind of research did you do to find a home birth attendant?

Michelle: I don’t think that I did any specific research about the safety of home births before I decided I wanted one. It was more like an intrinsic belief or understanding that home birth was a safer, MORE NATURAL, form of birth, compared to the over-“medicalized” hospital approach to birth. Because I am a strong supporter/educator of breastfeeding and used much of my time emphasizing to mothers that breastfeeding is a normal, natural process, believing that birth too, is a normal and natural process is just an extension of those philosophies. While some births do require hospitalization and medical interventions, the majority of births does not and should not be treated as though they do. I am familiar with Ina May Gaskin and her books/research, plus the overall outcome of home birth in other countries, such as New Zealand, which furthered my convictions that the USA’s approach to birth and its overall health care system is a convoluted mess, driven by a fear of lawsuits. Money and fear do not contribute to a good overall quality of care and commitment to the patient and her needs, especially during such an emotional and climatic time as childbirth. I wanted someone attending me who knew me as a person, as a friend, as a woman. Someone who knew the names of my children, who remembered (without looking at my chart) the ups and downs of this pregnancy; someone who really wanted me to have the most
What have been the reactions of your family and friends to your impending home birth?

Michelle: Yes, in the very beginning of the home birth discussions between my husband and me, he was concerned about safety, especially because we had so many seemingly necessary interventions during our first birth. My husband believed that had we not had those interventions with my first pregnancy, the baby would have died. So we did a lot of talking about that first birth, and how one intervention led to another, then to another and to another. The biggest intervention I received during that birth, was an epidural, which put me on my back for the rest of the delivery. As a result I was unable to move into a more comfortable position, or one that could have expedited the delivery. This led to prolong pushing, additional strain on the baby, and the eventual use of forceps. Had I not been numb and flat on my back, I believe the birth would have been normal and safe. My husband was still concerned with these 'safety' issues, so during our initial interview with our midwife, he was able to ask her questions about the overall safety of a home birth with my history. My husband felt reassured by Janet's answers and by her credentials, and her ability to use medication during the delivery for both me and the baby, should the need arise. Had we been given the choice between a CNM and a CPM, we would have chosen the CNM because of the additional training, credentials and availability of medications, especially because of my history of hemorrhaging.

I would also like to mention the financial/insurance aspect. We have health insurance but we still do not know if my home birth will be covered under our insurance plan. Choosing a home birth, for us, was a financial burden and caused us both stress. Janet requires her fee, of several thousand dollars, to be paid in full by 35 weeks. So we had to withdraw that money from my husband's 401K account. Although a home birth overall, is far less costly than a hospital birth, it is harder to afford for the average American family.

My parents were both concerned about the safety factor and my friends (outside of the breastfeeding counseling world) have all been uncomfortable with the thought of a home birth. Many think it is unsafe and illegal to have a home birth in Wyoming.

Whom do you plan to have present at your home birth?

Michelle: My husband, my sister (who has acted as my doula at my previous births, like I have been for her at her births), Janet and her assistant and my two closest girlfriends.

Do you have any concerns for your safety or that of your baby?

Michelle: Janet and I have talked about these things. Because I have a history of heavy bleeding after past deliveries, Janet will give me a shot of pitocin immediately after delivery and before the placenta is delivered. She will also have the IV assembled and ready in case the pitocin shot is not enough.

How much time has your midwife spent with you during your pregnancy and where did these visits occur?

Michelle: Janet came to my home every month for a prenatal appointment until week 28, when she came every two weeks, until week 34 when her visits increased to weekly, the same as if I were seeing a traditional OB for my prenatal care. Janet's visits lasted between an hour and a half and two hours. We spent a lot of time discussing, not just my physical preparation for childbirth, but also my emotional and spiritual preparation for childbirth. Janet's concern was for me as a whole person, a woman, not just how much weight I had gained or the size of my tummy at this prenatal visit. She supported me entirely, cared for my well-being completely, and gave me a type of care that I had never received with any of my other pregnancies.

After Delivery

Michelle: After I had the baby, she returned to check on us twice in those first few days following the birth. Janet's fee covers also a day one postpartum checkup for mom and baby and a day three postpartum checkup for mom and baby, and a six week postpartum checkup for mom.

Did your delivery go as you had hoped it would?

Michelle: Yes. It was not what I planned or imagined, but it was more than I had hoped for! Each birth is different. Because Janet (as a midwife) does little or no unnecessary intervention, she did not break my water during my labor. So my labor was slowed, considerably, compared to my labors at the hospital, where breaking a woman's water around 5cm is a routine intervention. This allowed me to stay in control of the pain and contractions, despite the longer labor, because my bag of water didn't break until my baby was crowning.

Were there any complications or problems? If so, how were they handled?

Michelle: My labor began during a blizzard, causing the Interstate to close and Janet to get snowed in another client's home, here in Cheyenne. It was very stressful to me. Janet remained in close phone contact with me, and kept me updated about when she expected to arrive at my house. Once she finally arrived though, my labor had stalled out because of my fear and anxiety about the blizzard. After staying the night on my sofa, Janet stripped my membranes the following morning and offered to me a dose of Castor Oil to get labor started again. Both of those techniques proved very effective, and I was in active labor less than two hours later.

How do you feel about your home birth overall?

Michelle: Despite the blizzard and the stalled labor, I still LOVED my home birth and would never deliver another child in a hospital unless it was medically necessary. I labored in a birthing pool for three hours, while I was surrounded by calm, supportive and loving people. There were no bright lights, beeping monitors or restrictions on eating (my husband made me a chicken broth - from scratch, to sip on during the last part of my labor, between contractions, to keep up my strength and stamina). The curtains were closed, I was able to vocalize without fear of repercussion, and labored under the calming glow of candlelight, without interruptions or interventions. When my baby was finally in my arms, she stayed there, learning to breathe, in peace and quiet until the cord stopped pulsating (about 10 minutes). Once I was out of the pool and had delivered the placenta, Janet tucked me into my own bed and stepped back allowing me to nurse my daughter and bond with her for an hour, in peace and quiet. While I rested and bonded, my husband made me a fabulous meal. Janet and her assistant started a load of laundry and cleaned up after the birth. Janet stayed for about three hours following the birth, to make sure that my daughter and I were stable. I couldn't have asked for more. It was the perfect end to a miraculous day!

Where can I find someone to deliver my baby at home?

An interview with Penelope Caldwell, Certified Nurse Midwife, attending home births in southeast, Wyoming.

Have you delivered babies in hospitals during your career?

Penelope: I've been doing home births for 10 years either working in a group with others or practicing independently.

How long have you been delivering babies at home?

Penelope: I've been doing home births for probably six years or more.

How much time has your midwife spent with you during your pregnancy and where did these visits occur?

Penelope: There is a huge difference in doing institutional births and home births—it's impossible to compare the two. The only thing that's the same is that a baby comes out. There are no interventions usually in a home birth and the chances of intervention are much less. The woman is at home in her environment where she is not inhibited, she can walk around, eat, be naked, tell people to leave; she has the people and things she needs, there are no strangers present. Birth happens in a very normal way, it's a very sacred space, it's palpable. You don't have that sacred sense or energy in a hospital. You can't. Hospitals are all about fixing things before they break, routine interventions, even if not needed or wanted. There's a lot of fear in the hospital, which will slow down labor or even stop it. There's just no comparison.

As a midwife, birth centers are the happy medium; you can have shifts and share the work. You can let it go once your shift is over. Women come to you, you don't have to travel so much. There's a lot less time involved. The environment is different but it feels safer than the hospital. No strangers, no lights, families move in and create their nest. People birth very well in birthing centers. It's a little easier for midwives to do the job. Like a homebirth practice, there's not much money in birth centers either. Many birth centers don't make it financially.

Would you ever go back into the hospital setting?

Penelope: I would go back to hospital for financial reasons only. Homebirths do not pay the bills; it's a labor of love. It's very time consuming.
and costs a lot in human hours. All the travel…
one prenatal visit might take all afternoon. You're
there for the whole labor and for several visits
later. And of course they never stop calling you.
The relationship never ends, it’s not like it’s over
once the baby’s born. It’s a very different kind of
career. It’s a very different kind of life. You’re
job is never finished when you’re a home birth
midwife. Historically, the midwife has always been
an integral part of the community, people come to
her for advice, whether they are pregnant or not.
It is still kind of like that.

**How can we keep home birth safe in Wyoming?**

An interview with Dr. Sharon Eskam, MD, Obstetrician
and Gynecologist, Cheyenne Obstetrics and
Gynecology, Cheyenne, Wyoming.

**How do we make homebirth safe?**

Dr. Eskam: Some patients will choose a home
birth and face any possible risks, regardless of
possible medical consequences, because they feel
so strongly about a loss of personal autonomy.
These patients are often religiously, culturally
or personally motivated. Even though as an
obstetrician I may not personally agree with that
choice, I have an obligation to support their
decision, and do anything that I can to make
their delivery as safe as possible. Among the most
important things that I can do is to make sure they
are aware of any risk factors that they may have
and to plan for possible problems related to these
risks. Patients need to be made aware of any risks
factors as they may need to re-think their decision
if the risks are significant. They also need to know
that if they choose a home birth, the hospital will
provide any emergency treatment they may need if
a hospital delivery is necessary, without prejudice
to their previous decision.

**What is your vision of safe homebirth?**

Dr. Eskam: While the American College of
Obstetricians and Gynecologists (ACOG) does
not take a black/white approach to home birth,
it does recognize that unexpected significant
problems may occur, making home birth inherently
more risky than a hospital birth, although neither
can guarantee an absolute outcome. Certainly the
better the training is for the home birth attendant,
the better would be the possibly for avoidance of
an adverse outcome by identifying risk issues as
early as possible.

One of the issues that obstetricians have
with home birth is one of liability concern. An
example of this would be if there was a hypoxic
event, which occurred at home during a home
birth attempt, and the patient was then brought to
the hospital course. The hospital course could appear
benign, but if the baby were later diagnosed with
a hypoxic encephalopathy, it would be difficult to
verify the timing of the event. This would probably
mean a lawsuit for the obstetrician, as obstetricians
usually have more malpractice dollars available for
recovery than a home birth provider. A statewide
program to provide recovery in the form of a birth
injury fund that would prohibit a lawsuit against
the hospital or the obstetrician assuming care from
a home birth attempt would go a long way towards
improving the opinion of obstetricians regarding
home births.

**Things to Ponder**

In writing this article, I found many
inconsistencies and blatant errors in websites that
are primary resources for families to use during
pregnancy. I found several states with models of
home birth and direct entry midwifery that are
working beautifully. For example, in Washington
state and Colorado, direct entry midwives are
licensed and regulated, just as physicians and
nurses are, and they attend home births and are
reimbursed by insurance and Medicaid. Everyone
has their niche and there are even some practices
with physicians, nurse midwives and direct entry
midwives all working together in the same practice.
It was amazing how well these systems are working
well for everyone involved and how well everyone
seems to be working together. Home birth isn’t
for everyone, but it will always be the choice
for some. Wouldn’t it be great if we could work
together and find a way to make Wyoming one of
the best places to have a baby, regardless of where
you wanted to deliver?

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Nursing research clarifies best practices for blood pressure measurement

Employers/Public
If you or your organization needs to increase your efficiency in verifying nurse licenses and/or checking a nurse’s discipline status for employment decisions, then look no further than the National Council of State Boards of Nursing’s secure, online verification system, Nursys® (www.nursys.com). The nursys.com web site contains data obtained directly from the licensure systems of the boards of nursing through frequent, secured updates.

Employers and the general public can now verify licenses and receive a report within minutes, free of charge. This report will contain the name, jurisdiction, license type, license number, license status, expiration date and any discipline against the license of the nurse being verified.

Nurses
When a nurse applies for endorsement into a state, verification of existing or previously held licenses may be required. A nurse can use Nursys.com to request verification of licensure from a Nursys licensure participating board. A list of licensure participating nursing boards can be found at Nursys.com.

Verifications can be processed by completing the online Nursys verification process. The fee for this service is $30.00 per license type for each state board of nursing where the nurse is applying. Nursys license verification is sent to the endorsing board immediately. Please visit www.nursys.com for more details.

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Wyoming Nurse Reporter
Vol. 5 number 2 Summer 2009
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Disciplinary Actions

Dorothy Barthel, CNA
April 9, 2009
Voluntary Surrender
Dorothy Barthel, CNA, voluntarily surrendered her certificate after she admitted having oral sex with an active client at an inpatient addiction recovery center.

Grounds for Discipline: Chapter VII, Section 11(b) of the Board’s Administrative Rules and Regulations: (i) Inability to function with reasonable skill and safety for the following reasons, including but not limited to: (G) Boundary Violations, including sexual boundaries; (iv) Failure to conform to the standards of prevailing nursing practice, in which case actual injury need not be established.

Amanda Carubie, CNA
April 8, 2009
Letter of Reprimand
Amanda Carubie, CNA was issued a letter of reprimand for her conduct in photographing a resident of a residential nursing facility. The resident was nude from the waist down. After Carubie took the picture, she showed the picture to three (3) other coworkers and indicated that she intended to forward the picture to her husband. When told that the picture was “illegal,” she deleted it from her phone. In response to the Board’s investigation, Carubie admitted her conduct and expressed regret.

Grounds for Discipline: Chapter VII, Section 11(b) of the Board’s Administrative Rules and Regulations: (i) Inability to function with reasonable skill and safety for the following reasons, including but not limited to: (D) Client abuse, including sexual abuse; (F) Client neglect; (G) Boundary violations, including sexual boundaries; (iv) Failure to conform to the standards of prevailing nursing practice, in which case actual injury need not be established.

Kevin Franke, RN
April 9, 2009
Voluntary Surrender
Kevin Franke, RN will voluntarily surrender his license as a result of his conduct in diverting Fentanyl by June 30, 2009. An internal investigation revealed discrepancies in the PYXIS and patient Medication Administration Records and the facility questioned Franke regarding his withdrawals of Fentanyl from the PYXIS. Franke admitted he relapsed during this time which violated a previous conditional licensing agreement by handling narcotics and diverting Fentanyl.

Grounds for Discipline: Chapter III, section 4(a) of the Board’s Administrative Rules and Regulations: (i) Inability to function with reasonable skill and safety for the following reasons, including but not limited to: (B) Substance abuse/dependency; (iv) Failure to conform to the standards of prevailing nursing practice, in which case actual injury need not be established.

Tyana Giesler, CNA
January 5, 2009
Letter of Reprimand
Tyana Giesler, CNA was issued a letter of reprimand for her conduct in “force feeding” a resident of a residential nursing facility. The resident was nude from the waist down. After Giesler took the picture, she showed the picture to three (3) other coworkers and indicated that she intended to forward the picture to her husband. When told that the picture was “illegal,” she deleted it from her phone. In response to the Board’s investigation, Giesler admitted that she was dismissive of the resident’s requests.

Grounds for Discipline: Chapter VII, Section 11(b) of the Board’s Administrative Rules and Regulations: (i) Inability to function with reasonable skill and safety for the following reasons, including but not limited to: (D) Client abuse, including sexual abuse; (F) Client neglect; (G) Performance of unsafe client care; (iv) Failure to conform to the standards of prevailing nursing and nursing assistant/nurse aid practice, in which case actual injury need not be established.

Susanna Herrman, RN
April 9, 2009
Conditional
Susanna Herrman, RN was granted a conditional license after her conduct in diverting Demerol from a medication cart. Ms. Herrman admitted to this conduct. Herrman enrolled in the Wyoming Professional Assistance Program (WPAP) in August 2006 and signed a WPAP monitoring agreement.

Grounds for Discipline: Chapter III, section 4(a) of the Board’s Administrative Rules and Regulations: (i) Inability to function with reasonable skill and safety for the following reasons, including but not limited to: (B) Substance abuse/dependency; (iv) Failure to conform to the standards of prevailing nursing practice, in which case actual injury need not be established.

Jill Johnson, RN
April 9, 2009
Voluntary Surrender
Jill Johnson, RN voluntarily surrendered her license as a result of her conduct in approaching a physician for a prescription of Ativan for a patient and after attempting to fill the prescription for herself at the pharmacy. Johnson pleaded guilty to one count of Possession of Controlled Substances Act, Prior Deception of a pharmacy. She was placed on three years of supervised probation. In a written statement provided to the Board office, Johnson admitted she had entered a plea agreement and received probation. Johnson also admitted to abuse of prescription medication and to altering the Ativan prescription by adding her name, address, age and date on the prescription, though she denied any willful wrongdoing and attributed her alteration to a “miscommunication” she had with the prescribing physician. Though Johnson verbally agreed to participate in the Hawaii Nurse Association Peer Assistance Program in June 2007, she did not sign a monitoring agreement.

Grounds for Discipline: Chapter III, section 4(a) of the Board’s Administrative Rules and Regulations: (i) Inability to function with reasonable skill and safety for the following reasons, including but not limited to: (B) Substance abuse/dependency; (iv) Failure to conform to the standards of prevailing nursing practice, in which case actual injury need not be established.

Kelly Johnson, RN
April 9, 2009
Voluntary Surrender
Kelly Johnson, RN voluntarily surrendered her license as a result of her conduct in diverting narcotics from the medication cart at a residential living center. Johnson was witnessed on several occasions crushing pills and then proceeding to the restroom for a period of time before leaving the room. Johnson was later charged in prescription fraud and was placed on probation following conviction. Johnson admitted to the Board that she diverted medications and admitted to a substance abuse problem. During the course of the Board’s investigation, Johnson enrolled in the Wyoming Professional Assistance Program (WPAP) which later advised that Johnson be restricted from direct patient care for a significant period of time. Also during the Board’s investigation, Johnson voluntarily surrendered her Colorado registered nurse license.

Grounds for Discipline: Chapter III, section 4(a) of the Board’s Administrative Rules and Regulations: (i) Inability to function with reasonable skill and safety for the following reasons, including but not limited to: (B) Substance abuse/dependency; (iv) Failure to conform to the standards of prevailing nursing practice, in which case actual injury need not be established.

James Judd, LPN
April 9, 2009
Conditional
James Judd, LPN was issued a conditional license as a result of his conduct in taking an Oxycodone pill from a resident at a residential care center. Judd enrolled in the Wyoming Professional Assistance Program (WPAP) and signed a monitoring agreement with WPAP. Judd was later convicted of acquiring a controlled substance by fraud or misrepresentation and possession of a controlled substance without a valid prescription. Judd was placed on supervised probation for these convictions.

Grounds for Discipline: Chapter III, section 4(a) of the Board’s Administrative Rules and Regulations: (i) Inability to function with reasonable skill and safety for the following reasons, including but not limited to: (B) Substance abuse/dependency; (iii) Criminal Conviction; (iv) Failure to conform to the standards of prevailing nursing practice, in which case actual injury need not be established.

Shellie Meyer, RN
April 9, 2009
Conditional
Shellie Meyer, RN was granted a conditional license after she was observed on video tape removing a single dose vial of Morphine Sulfate from the emergency use box and returning it later. It was later discovered, on or about October 11, 2005, that the Morphine Sulfate single dose vial had been tampered with. Meyer was arrested for acquiring possession of a controlled substance by deception or subterfuge and for omitting material information from any document or record required to be kept or filed under the Wyoming Controlled Substance Act. Meyer pled guilty to the charge of “Acquire Possession of a Controlled Substance by Fraud or Forgery or Deception or Subterfuge.” She was placed on three years of supervised probation. In Meyer’s response to the Board’s Notice of Complaint letter, she admitted she diverted Morphine Sulfate for her personal use.

Grounds for Discipline: Chapter III, section 4(a) of the Board’s Administrative Rules and Regulations: (i) Inability to function with reasonable skill and safety for the following reasons, including but not limited to: (B) Substance abuse/dependency; (ii) Misappropriation or misuse of property; (iii) Criminal conviction.
Denial of Licensure in California

Denial of 2005 & 2007 DUI Convictions  
April 16, 2009

Kristi Tomich, RN Applicant

Minor in Possession-Alcohol

Denial of Possession of a Controlled Substance  
April 16, 2009

Jessica Tjaden, CNA Applicant

DUI

Denial of Drugs –Unlawful Possession of Controlled Substance  
February 22, 2009

Ekaterina Inanova, CNA Applicant

DUI with Supervised Probation  
March 23, 2009

Denial of Assault & Battery with Probation  
April 16, 2009

Michael Bond, CNA Applicant

Assault & Battery with Probation

Denial of DUI with Supervised Probation  
December 25, 2008

Ekaterina Inanova, CNA Applicant

DUI

Denial of Drugs –Unlawful Possession of Controlled Substance  
February 22, 2009

Lacy Raney, CNA Applicant

DUI with Supervised Probation

Denial of Possession of a Controlled Substance  
March 23, 2009

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April 16, 2009

Kristi Tomich, RN Applicant

Denial of

The Nurse Practice Act, 33-21-146 identifies the following reasons that an application may be denied:

(a) The board of nursing may refuse to issue or renew, or may suspend or revoke the license, certificate or temporary permit of any person, or to otherwise discipline a licensee, upon proof that the person:

(i) Has engaged in any act inconsistent with uniform and reasonable standards of nursing practice as defined by board rules and regulations;

(ii) Has been found guilty by a court, has entered an Alford plea or has entered a plea of nolo contendere to a misdemeanor or felony that relates adversely to the practice of nursing or to the ability to practice nursing;

(iii) Has practiced fraud or deceit:

(A) In procuring or attempting to procure a license to practice nursing;

(B) In filing or reporting any health care information, including but not limited to client documentation, agency records or other essential health documents;

(C) In signing any report or record as a registered nurse or as a licensed practical nurse;

(D) In representing authority to practice nursing; or

(E) In submitting any information or record to the board.

(iv) Is unfit or incompetent to practice nursing by reason of negligence, habits or other causes including but not limited to:

(A) Being unable to practice nursing with reasonable skill and safety to patients by reason of physical or mental disability, or use of drugs, narcotics, chemicals or any other mind-altering material; or

(B) Performance of unsafe nursing practice or failure to conform to the essential standards of acceptable and prevailing nursing practice, in which case actual injury need not be established.

(v) Has engaged in any unauthorized possession or unauthorized use of a controlled substance as defined in the Wyoming Controlled Substances Act (§§ 35-7-1001 through 35-7-1057);

(vi) Has had a license to practice nursing or to practice in another health care discipline in another jurisdiction, territory or possession of the United States, denied, revoked, suspended or otherwise restricted;

(vii) Has practiced nursing within this state without a valid current license or temporary permit or as otherwise permitted under this act;

(viii) Has knowingly and willfully failed to report to the board any violation of this act or of board rules and regulations;

(ix) Has been found by the board to have violated any of the provisions of this act or of board rules and regulations; or

(x) Has knowingly engaged in an act which the licensee knew was beyond the scope of the individual’s nursing practice prior to committing the act, or performed acts without sufficient education, knowledge, or ability to apply nursing principles and skills; or

(xi) Has failed to submit to a mental, physical or medical competency examination following a proper request by the board made pursuant to board rules and regulations and the Wyoming Administrative Procedure Act.

(b) Upon receipt from the department of family services of a certified copy of an order from a court to withhold, suspend or otherwise restrict a license issued by the board, the board shall notify the party named in the order. No appeal under the Wyoming Administrative Procedure Act shall be allowed for a license withheld, suspended or otherwise restricted under this subsection (pg 12-13 of 18).

The following actions were taken on applications:

<table>
<thead>
<tr>
<th>Name</th>
<th>Denial</th>
<th>Date</th>
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<tbody>
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NCSBN Unveils New Nursys.com Web Site with Enhanced Nurse Licensure Verification Tools

Chicago - The National Council of State Boards of Nursing's (NCSBN) Nursys.com license verification Web site recently unveiled a new and improved verification process, which makes nurse license verification quicker, easier and free of charge to employers and the general public.

The Licensure QuickConfirm application allows employers and the general public to verify licenses from a public access Nursys licensure processing board of nursing. Within minutes, a detailed report is generated, containing the nurse's name, jurisdiction, license type, license number, license status, expiration dates, as made available by the board of nursing for all licenses held, and any discipline against the license.

In addition, Nursys.com also enables nurses to verify their license(s) from a Nursys license processing board of nursing** when applying for endorsement into another state by using the online Nurse Licensure Verification application. Nurses can verify their licenses by completing the verification process for $30.00 per license type, per each state board of nursing where the nurse is applying. The nurse's license verification is available immediately to the endorsing board of nursing.

“We feel that online nurse licensure verification is extremely important, especially in the evolving and often mobile world of health care,” said Kathy Apple, MS, RN, CAE, NCSBN CEO. “Nursys.com contains data obtained directly from the licensure systems of the boards of nursing. This allows nurses and employers to verify licenses in a secure manner while boards of nursing continue to protect the public.”

For those states participating in the Nurse Licensure Compact (NLC), which is a mutual recognition model of nurse licensure that allows a nurse to have one license (in his or her state of residency) to practice in multiple states, Nursys.com can be used to verify a nurse's NLC status (multistate/single state) and any discipline against privilege to practice from an NLC state. A nurse must legally reside in an NLC state in order to be eligible for a multistate license in the NLC. An active, unencumbered, multistate license allows the nurse to practice in all 23 NLC*** jurisdictions. Questions about NLC eligibility and legal residency can be directed to the state’s board of nursing. Currently, Nursys.com is the only verification tool available that provides the status of a multistate license's privilege to practice in NLC jurisdictions.

The National Council of State Boards of Nursing (NCSBN) is a not-for-profit organization whose members include the boards of nursing in the 50 states, the District of Columbia and four U.S. territories - American Samoa, Guam, Northern Mariana Islands and the Virgin Islands. The College of Registered Nurses of British Columbia is an associate member.

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Contact: Dawn M. Kappel Director, Marketing & Communications 312.525.3667 direct 312.279.1034 fax dkappel@ncsbn.org

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