Hitting Bottom:
Two Nurses Share Their Stories of Addiction and Recovery

CWC Nursing Students in the Simulation Lab
A Rare Opportunity to Become a Part of Nursing Excellence

Our nurses enjoy a low nurse-to-patient ratio, a warm, family-oriented environment, state-of-the-art facilities, and an emphasis on balancing work and life.

Maybe that’s why our hospital receives near-perfect patient satisfaction survey scores every month!

We are currently accepting applications for RNs trained in the following specialties: Surgical • ICU/Critical Care • ER • CNAs • Full-Time and PRN Positions Available
Welcome to Summer! Or at least the Summer issue of Wyoming Nurse Reporter since we never quite know if it is Summer in Wyoming! This issue will focus on compliance and discipline, an area that occupies much of the time and most of the resources of WSBN. Since we had so much content on this important topic for WNR, I will devote this column to explaining the discipline process rather than my usual editorial.

Questions brought to the board overwhelming involve compliance and discipline. Therefore, in conjunction with the Wyoming Hospital Association, I have been doing "Tour de Hospital" in order to personally address our administrators, employers, and nurses in an educational format. So far, I've been able to visit Laramie, Kemmerer, Casper, Cheyenne and Gillette. Trips to Lander, Cody and Riverton are in the works. If your facility wishes for me to do a presentation, please contact the Wyoming Hospital Association or WSBN.

Since the most pressing and recurrent question centers around the length of time it takes to resolve a complaint and what the process actually is, I will speak to both of those issues in this quarter's column.
Most of this information is available on our website, as well.

Anyone may initiate a complaint; employer, nurse co-worker, CNA, physician, family member, any healthcare employee or member of the public, and even the licensee herself. However, most of our complaints are generated by employers. WSBN cannot accept anonymous complaints because the accused nurse (Respondent) has the constitutional right to “face the accuser.” However, in certain situations, if WSBN has knowledge and evidence of a violation, board staff may initiate the complaint.

Once we have the complaint, Compliance and Discipline (C&D) staff triage it as Immediate, Moderate or Minimal category based on the perceived risk to the public if the nurse remains in practice under the present conditions. For example, a complaint that involves a nurse who is impaired in the workplace is triaged as Immediate and referred for consideration of Summary Suspension. A complaint alleging a CNA abandoned his patients by leaving work without notice would be triaged as Moderate.

A self-disclosure of a conviction for insurance fraud would be triaged as Minimal. Next, the Respondent is sent a Notice of Complaint (NOC). This usually happens within 1-2 weeks of WSBN receiving the complaint, depending upon the triage level and workload of C&D staff. A copy of the actual complaint is attached so that the Respondent has all of the information WSBN has in order to make a proper response. The individual who made the complaint (Complainant) is usually sent an acknowledgement as well as a request for more information since the Complainant almost never provides all of the necessary information with the initial complaint.

Documents required to investigate the complaint include the following, based on the type of complaint: employee’s personnel records, training records, record of counseling, corrective action plan, termination, the facility’s applicable policies and procedures, patient records including Medication Administration Record (MAR), physician order sheet, nurses’ notes, flowsheets, eyewitness statements, PYXIS records, employee’s duty schedule, time sheets, and any other pertinent documents. If the case involves a patient’s death, a death certificate and autopsy report, if one was done, is also required. Any police investigation or court documents involved in a complaint are also requested and reviewed. Expert consultants are hired by the board to provide independent opinions on complex standard of care issues and for licensees with Substance Use Disorder or sexual boundary violations. As you might imagine, it takes a significant amount of time for the Complainant and C&D staff to gather all of the evidence, reports, and documents. If there is any time lapse from the incident to when the Complainant submits the complaint, it can be very difficult to track down witnesses and documents. KEY POINT: Initiate the complaint as soon as possible after the incident.

Depending upon the licensee’s response, any number of things can happen. If there is NO response, C&D will send one more request for response statement or attempt to contact the licensee by phone or email. Without any response, the investigation will continue but obviously, it is in the licensee’s best interest if we have their side of the story. If the Respondent’s answer indicates any physical, emotional, or mental health impairment, she will be ordered to obtain the appropriate examination from a physician or mental health professional. For example, one Respondent stated that medication for migraine headaches was the reason that she made multiple medication errors, so she was ordered to obtain a neurological exam and obtain a “fitness for practice” evaluation. If substance use, abuse or misuse is indicated in the response, the licensee will need a Substance Abuse Evaluation (SAE). If the SAE indicates a need for further evaluation for a co-occurring mental health condition such as depression or anxiety (this happens frequently), the licensee will need to obtain the follow-up treatment or evaluation. A Prescription Drug Monitoring Profile (PDMP) will be requested from the Board of Pharmacy to review all prescriptions for Controlled Substances (CS). The Respondent will be asked to sign a release to provide supporting medical and mental health records. In some cases, there may be over a hundred prescriptions from a dozen different providers that C&D has to investigate. The length of time it takes to gather all of the evidence and round up documents can be extensive. KEY POINT: Respond promptly, sign the releases, provide as much of the supporting evidence as soon as possible. Responding promptly and complying with reasonable requests of the board will help the investigation progress and resolve more quickly.

Once all of the evidence has been received and evaluated for relevance to the complaint, the case may be dismissed for lack of clear and convincing evidence or because the allegation, even if true, is not a violation of the Nurse Practice Act (NPA) or Administrative Rules & Regulations (AR&R). Examples of this would be complaints against a nurse for too many attempts to start an IV, child custody and workplace disputes, or disgruntled patients unhappy about their treatment. If there is evidence of a violation that may require formal, reportable discipline, C&D forwards the case to the Disciplinary Committee (DC). The DC is usually comprised of two members of the board who are assigned the case based on their specialty (i.e., APRN board member for complaint against an APRN). Based on the triage level of the complaint, the DC will review the entire case and respond to C&D with a decision in 2-4 weeks. Why so long? Because all of the board members work full-time and at any one time are juggling several disciplinary matters as well as all of their other board work. Cases involving standard of care issues may involve hundreds of pages of medical records that require review. KEY POINT: Each and every case is reviewed with care and respect for both Respondent and Complainant. That takes time.

Once the DC has made a decision that requires discipline, the case is forwarded to the Attorney General’s (AG) office for review and discussion. If the AG’s office concurs with the DC that a violation has occurred, they will work together to draft a Notice of Warning (non-reportable discipline) or a Settlement Agreement (SA) for reportable discipline. Levels of reportable discipline run the gamut from a Letter of Reprimand (LOR), Conditional license (typically for Substance Use Disorder, but could be for further education, precepting or monitoring requirements for nurses with sexual boundary violations), Suspension, Summary Suspension, request for the licensee to Voluntarily Surrender (VS) or Revocation. Conditions for training, education or ongoing mental health or physician evaluations can be included with any level of reportable discipline. KEY POINT: No formal, reportable discipline is proposed until the AG’s office has reviewed the case and established that there is clear and convincing evidence of a violation of the NPA or AR&R.

Once the Respondent receives a Letter of Intent (LOI) that the board intends to pursue formal reportable discipline and a SA (these go out together), the licensee has
three options: 1) sign the SA and accept the discipline; 2) contest the decision and invoke his right to a hearing before the full board; or 3) not respond at all and accept a default judgment from the full board. Once the full board is involved, they have the option of accepting the DC’s recommendation or imposing a different decision involving anything from dismissal to revocation. At ANY point in the process, the licensee may engage legal counsel. It is a myth that the licensee who hires an attorney is admitting guilt or angering the board. The board always respects that the licensee is taking the complaint seriously and wants to work with us toward a mutually acceptable resolution of the complaint. KEY POINT: Read everything very carefully and consult with an attorney to be sure you understand the potential consequences of signing, contesting or not signing.

Being involved in a complaint can be a very painful and difficult experience for everyone. The length of time it takes to resolve the issue, even when the end result will be a dismissal, can be a source of anguish for the licensee. C&D’s caseload presently exceeds 100 and approximately 15-18 new complaints are filed per month. I hope that this explanation of the process sheds some light on why it takes so long to resolve a case. C&D staff (four individuals) work diligently to investigate and process cases and respond to your phone calls as soon as possible, but the workload is overwhelming. We can never lose sight of the fact that we are balancing public safety, the licensee’s right to due process and the Complainant’s concern for resolution.

When a case is resolved, both the Respondent and Complainant are notified in writing. Additionally, if the case is dismissed, board staff will personally phone the licensee. (This is perhaps one of our more rewarding tasks.) If the case results in formal reportable discipline, once the final board order is in place, we report the discipline in accordance with all mandates: Healthcare Integrity Protection Databank (HIPDB) (all levels of licensees), National Practitioners Databank (NPDB) (APRNs only), Nursys (nurses only; National Council State Boards of Nursing databank for boards of nursing), CNA Registry (CNAs employed in long-term care, home health or skilled nursing facilities with substantiated complaints of abuse, neglect or misappropriation of patient property), and the publications of the board (WNR and our website). KEY POINT: No licensee is reported until all avenues of due process are fulfilled. The AR&R require that your current address and contact information are up-to-date in the board office. If you fail to notify the board of a change of address, you may never know a complaint has been filed against you and have the opportunity to respond.

In closing, the mission of the board is to PROTECT THE PUBLIC. Compliance and discipline figure prominently in our ability to meet that mission by assuring the public that every licensed nurse and certified nursing assistant is able to provide safe and competent nursing care. Fulfilling that charge takes an enormous amount of resources in time, cost and personnel. KEY POINT: Protect your patients, your license and the integrity of the profession by practicing with skill, safety and ethics.
Meet Your Board

In this issue we introduce you to Tracy Wasserburger

It is our intention to provide at least a peek into the personalities of the individuals who share so generously of their time, talent and energy to further and strengthen the WSBN.

Name: Tracy Wasserburger

Occupation: Neonatal Nurse Practitioner

Organization: Campbell County Memorial Hospital, Gillette, WY

Description of Organization: Campbell County Memorial Hospital (CCMH) is a healthcare system consisting of a 90-bed acute care hospital, 150-bed long term care facility and seven outpatient clinics; primary care, urgent care, OB/GYN, orthopedics urology and otolaryngology. Accredited by DNV, CCMH serves patients in Campbell County and the surrounding region with a medical staff of over 60 physicians in 15 specialties.

Professional background: Staff RN, School Nurse, Nurse Manager of Maternal Child Services for 21 years, Adjunct faculty for UW

Education: Diploma degree as Registered Nurse; BSN through University of WY, Laramie, WY; Masters in Nursing Education through University of Mary, Bismarck, ND; Neonatal Nurse Practitioner degree through East Carolina University, Greenville, NC

Residence: Gillette, WY

What would you like to see as a legacy of your service to the WSBN? That the bridge of customer service was met for those that we serve.

Your mentors: Personally- my dad. Clinically- The physicians and the nursing staff of the Maternal Child unit at Campbell County Memorial. Academically- my nursing faculty, Garris Conner at ECU

Word that best describes you: Sensitive

Most important lesson learned serving on the WSBN Board of Directors: There is a process to everything--and sometimes, those processes take time, thought, commitment and energy.

Person you are most interested in meeting: I would have loved to have met Princess Diana

Pet peeves: Personality trait of those who see the glass as always half empty instead of half full.

Greatest passion: Taking care of moms and babies. And secondly- cooking.

First choice for a new career: Running a bed and breakfast where I can meet new and interesting people and create great meals for them. However, I will need someone hired to do all the cleaning.………..

Favorite quote: “It’s not how much you do, but how much love you put in the doing. It’s not how much you give, but how much love you put in the giving” Mother Teresa

Most influential book: the Holy Bible

Favorite website: Pretty much any website that has “Add to Cart” option.

Favorite cause: March of Dimes

Favorite movie: The Boy in the Striped Pajamas

Favorite musician: There are just too many to name------ I love pretty much all music, especially today’s country.

Most treasured possession: The youth saddle that my dad gave me when I was 3.

Favorite vacation destination: Anywhere that I could hang out with my family and friends. Doesn’t have to be a specific time or location. But where family and friends gather is the best vacation to me.

Favorite way to spend free time: Anywhere, any time that I get to be with my kids- Jory, Trey and Hayley
Meet Your Board

In this issue we introduce you to Sean Chambers, Senior Assistant Attorney General, Board Counsel to the WSBN

Sean Chambers at NCSBN with Mary Kay Goetter (left) and Tracy Wasserburger (right)

It is our intention to provide at least a peek into the personalities of the individuals who share so generously of their time, talent and energy to further and strengthen the WSBN.

Name: Sean Chambers

Occupation: Senior Assistant Attorney General; Board Counsel to the WSBN

Organization: Wyoming Attorney General's Office

Description of Organization: Among the myriad of the duties of the Wyoming Attorney General’s Office, we provide legal services to every professional licensing/regulatory board in the state, including the WSBN. I represent the WSBN in a day-to-day advisory function and my colleague in the office, Bob Walters, represents the Disciplinary Committee of the WSBN in disciplinary cases which come before the WSBN.

Professional background: I was admitted to the Wyoming Bar in 2005 and worked in private practice for about 3 years with a small firm in Cheyenne. I came to the Civil Division of the Attorney General’s Office in the fall of 2008. I primarily represent the Boards of Nursing, Medicine, Dental Examiners, Chiropractic Examiners, and Midwifery, though I get involved with many other, and varied, state agencies.

Education: I attended the University of Wyoming for both my undergraduate education (BA Philosophy, BA Psychology, 2002) and my legal education (JD, 2005).

Residence: Cheyenne

What would you like to see as a legacy of your service to the WSBN? I hope I have instilled in the WSBN the value in asking “why!” We have a tendency to trust institutional knowledge and to adhere to certain paradigms and long-held positions. Sometimes we have to ask why we do some of the things we do and ask ourselves if there is a better way. I have encouraged the WSBN to ask questions and to look for authority to support its practices and if it cannot find adequate authority, to have the courage to seek better practices.

Your mentors: The Attorney General’s Office has some very talented and well rounded attorneys. I am honored to work with them, to seek their advice, and to call them mentors.

Word that best describes you: Patient

What you like best about WSBN Board of Directors work: The WSBN as a whole is very passionate about the nursing profession and about its role in public safety.

Most important lesson learned serving on the WSBN Board: I am not on the Board, I merely advise the Board. The lesson that I am continually reminded of is the value of clear and effective communication.

Person you are most interested in meeting: Though not living, Leonardo Da Vinci.

Pet peeves: Being late

Greatest passion: Books and Reading

Favorite website: wikipedia

Favorite cause: education

Favorite movie: I have many, I am a big movie buff, but I have a particular liking for 1940s American film noir - Double Indemnity, The Maltese Falcon, The Big Sleep, Sunset Boulevard, etc.

Favorite musician: Bob Dylan

Most treasured possession: My house

Favorite vacation destination: Anywhere near the water (stream, creek, river, pond, lake, ocean, etc.)

Favorite way to spend free time: With my three year old daughter, Charlotte.

EOE

Behavioral Health
Nursing Supervisor

Rapid City Regional Hospital, a 417-bed Regional Referral Center located in the beautiful and historic Black Hills of South Dakota, has a full-time opening for a Nursing Supervisor in Behavioral Health.

This position exists within the Behavioral Health Child/Adolescent inpatient unit, and will manage the clinical program through staff supervision, quality leadership, continuity of workflow, patient care and safety. Position requires current RN license with a Bachelors Degree in nursing or related field and at least three years' clinical experience.

RCRH offers a competitive salary and an excellent benefit package, including relocation assistance.

Apply on-line at www.regionalhealth.com for IRC5134 and upload or fax a resume.

Regional Health

Attn: Judy McCarthy, Recruiter
Rapid City, SD 57701
Email: jmcCarthy@regionalhealth.com
(800) 865-2638
Fax: (605) 719-5500
The use of clinical simulation in nursing education is not a new concept. Nursing faculty have long been simulating low fidelity client experiences and routine nursing procedures. Remember learning how to give a SQ injection using an orange? Similarly, I have seen nursing faculty use a shoebox and a computer image of an infusion pump when the real thing was not readily available. Such innovative and creative approaches to learning are historically embedded in years of clinical teaching and learning.

In an era of decreasing clinical practice sites and scarce numbers of nursing faculty, nursing programs have turned to technology to assist in educating students. Central Wyoming College (CWC) in Riverton, WY has developed a flexible, state-of-the art simulation lab that mimics an acute care hospital setting. Over the past year the faculty at CWC has integrated simulation throughout the Associate Degree curriculum. Fundamentals students learn the routine approach to a head-to-toe assessment and how to communicate with a client. Consistent standards of care, such as washing your hands, introducing yourself, taking a focused health history, and properly identifying the client are incorporated in each simulation activity.

As students move to the next semester, they experience routine nursing care of clients throughout the lifespan, including a pregnant mother and a healthy newborn, as well as learn how to identify a mother experiencing a life-threatening complication, such as a postpartum hemorrhage. Although clinical scenarios are “simulated”, the use of carefully moulaged assessment findings, such as bleeding with a boggy fundus and diagnostic data add realism to the learning experience. It is amazing how strawberry gelatin, hair gel, and corn starch can actually resemble bleeding with clots present!

In the second year of the program, students participate in simulated clinical experiences related to Medical Surgical concepts involving clients of all ages, including the older adult. In regard to these more advanced nursing concepts, the nursing faculty at CWC has determined that timing concepts recently covered in the classroom with simulated clinical experiences is very effective for direct application of knowledge. For example, students learn about the neurovascular complications associated with orthopedic surgeries and how to assess for and prevent these complications. However, in rural acute care settings how often do students really have the opportunity to assess, diagnose, plan and implement appropriate interventions, and evaluate a compartment syndrome while in clinical? Again, the timing of direct application of knowledge is a crucial component that allows the learning of a single concept to infiltrate related concepts and client conditions.

Scenarios are created to give students the opportunity to identify those subtle changes in a client’s condition and properly inter-
vene before a crisis ensues. Alternatively, if the students do not properly identify a client in trouble, they can reflect on the scenario as it unfolded through a multimedia debriefing playback, obtaining the feedback that allows direct application of the concepts in a safe environment. Students can then go back and repeat the scenarios as different client variables are incorporated, building on prior knowledge. Procedures that cannot be practiced on human clients, such as actual defibrillation, can be honed to enhance user comfort and understanding of not only the procedure itself, but of safe use of the equipment as well. Allowing the student to experience a crisis in a safe learning environment builds self-confidence and competence in clinical judgment and reasoning.

Although many positive outcomes of clinical simulation were expected prior to its implementation, the faculty reports many unexpected advantages that were not anticipated. Students rotate their roles as various healthcare providers and client family members, reporting a broader perspective not previously encountered in traditional clinical rotations. As a student plays a distraught family member observing their family member experience a complication, they find themselves prodding their peer “nurse” for adequate and appropriate teaching and updated communication. When they observe the care they provided in the debriefing playback, they share their thoughts and emotions for the group to experience. As student observers critique the care provided by a healthcare team, they can provide reflective feedback on where nursing standards of care may or may not have been appropriately applied. When observing student clinical performance in a clinical simulation, faculty report discovering gaps in knowledge previously assumed to be intact during traditional clinical formats. Providing feedback in a real-time format eliminates incorrect assumptions and opens doors to essential teaching and learning opportunities.

Benefits to student learning outcomes are not the only advantages of incorporating simulated learning into a nursing curriculum. Faculty has expressed enhanced satisfaction of using creative and innovative teaching methods to facilitate full-circle learning. Although faculty report they have to be subject matter experts on the concepts incorporated into simulation, they feel they directly benefit as nurse educators. Current trends in nursing education, such as decreasing clinical practice sites and limited access to nursing faculty, have been the driving factors for fundamental changes in how we educate students. The implementation of simulated clinical experiences has paved the way for comprehensive practical and realistic learning that models the most effective strategies in adult teaching and learning. Simulation technology has transformed the nursing program curriculum at Central Wyoming College, creating opportunities for increased student enrollments for the fall 2011 semester, as well as to expanded faculty roles in nursing education.

Kathy Wells MSN, RN is the CWC Nursing Program Director

Student Profile

Jessika Mayes Finds Extra-curricular Activities Ease Rigors of Nursing Program

Jessika Mayes is not just a face in the crowd at Sheridan College. In fact, that’s part of the reason Mayes, a first-year nursing student from Houston, Texas, chose Sheridan College.

In Texas, she attended a high school with more than 700 students per class. At Sheridan College, she has 23 classmates in her nursing program classes.

“At Sheridan College I have the opportunity to get to know both my classmates and my instructors. That small-town feel and connection are important to me,” said Mayes, whose mother grew up in the Clearmont area.

Nursing has become a perfect fit for Mayes, who said she enjoys the program even though it is quite rigorous.

“I have a passion for working with people,” Mayes said. “The medical field is appealing because the opportunities are great.”

Though her studies keep her busy, Mayes is also active in intramural sports and is currently running for student body treasurer. Staying involved in activities has been important to Mayes during her college career. Last year Mayes played Titania in the Sheridan College No Frills Theater Production “A Midsummer Night’s Dream...abridged.”

“Every semester I try to take a ‘fun’ class. The rigor of the nursing curriculum is crazy and I try to always find time for something extra,” Mayes said. “This semester I am taking private lessons on piano. Last semester it was voice lessons. This is just an outside interest, a passion.”
Hello. My name is Lila Zwemer, RN, CDDN. I am employed by the Wyoming Department of Health in the Developmental Disabilities Division. I work at the Wyoming Life Resource Center (WLRC), an ICF-MR certified facility here in Lander, Wyoming. WLRC is the only ICF-MR facility in Wyoming. WLRC provides homes to live in, work opportunities and health services for people with Developmental Disabilities and Acquired Brain Injuries. I have been working here at this wonderful facility for 23 years this August, but not always as a Nurse.

My husband and I had moved to Lander along, with our 2 daughters, earlier in July of that same year, for his job with the Wyoming Transportation Department. I had been fortunate, up until that time, to be, for the most part, a stay at home Mom. As the girls were now growing up, we decided that I would get a full-time job and help supplement the family income. So, I began as a Direct Support Professional (DSP) in August of 1988 working with people with moderate to profound developmental disabilities here at WLRC. At that time, WLRC was still called the Wyoming State Training School (WSTS).

When I began working at WSTS in 1988, I worked in several departments across the facility for approximately 3 years, at which time, being unable to recruit and staff an adequate number of Nurses, the Administration of WSTS offered to send 8 people from the staff at the facility to Nursing School at Central Wyoming College (CWC) in Riverton, Wyoming. Anyone could apply for that program if you worked at this facility. There were 50 or more people who were interested in trying for this wonderful opportunity and, upon meeting the rigorous criteria set forth, taking (and passing with high grades) certain pre-requisite classes, and agreeing to continue to work as a Nurse at WLRC for 4 years after attaining my Nursing Degree, I was fortunate to be one of the 8 who qualified. I began Nursing School in the fall of 1991 and graduated with an ADN in May of 1993 from CWC. I began immediately working as a Nurse at the Horizons Healthcare Center here on our campus.

We essentially have 4 specific areas of nursing here at WLRC. The Horizons Healthcare Center (HHC) houses a 14 bed, hospital-type setting where we provide basic hospital care as needed for the 94 clients who presently live on our campus. We have 10 full-time and 2 part-time Nurses on staff at the HHC who provide nursing services that include IV therapy, respiratory monitoring, seizure monitoring, post-surgical care or -hospital stay monitoring as well as many other nursing skills. We currently have 5 of our most fragile clients living fulltime at HHC as they require numerous skilled nursing services throughout their day. One has been on a ventilator since the spring of 1995. I worked as a staff Nurse on the floor of HHC from May of 1993 until March of 1995.

Another aspect of nursing here at WLRC is what we call Program Nursing. Our Program Nurses are very much like Home Health Nurses. We have 18 homes on the campus of WLRC in which our clients live. The houses are divided, for the most part, according to their proximity to each other (areas) and each area has an assigned Interdisciplinary Team (IDT) which is overseen by a Qualified Intellectual Disability Professional (QIDP). A QIDP is much like a Social Worker for that area. A Program Nurse is assigned to each Team and oversees the health of each client on their caseload on a daily basis. She makes rounds every morning on each house, “eyeballing” each person on her caseload, checking and double checking to assure that all medications from seizure and behavioral to cholesterol and bowel are working as we would want. She checks for any health concerns that might have been noted. She writes Nursing Care Plans for each client and trains/mentors DSPs and answers any questions they might have as needed to assure optimal health for each client is maintained. She writes and trains Self-Medication Administration Programs for each client on her caseload, assuring that each of those clients have an active part in their own medication regimen. The Program Nurses are an active member of each client’s IDT. As part of that team, the Program Nurse attends all

Taking on this responsibility has widened my horizons and I now see how much I enjoy the teaching/mentoring part of nursing. What wonderful future nurses I get to meet and I hope that I contribute a small part to their education. I hope that they learn that just because a person can’t communicate their needs, doesn’t mean that the needs aren’t there and that, as Nurses, we can meet those needs if we but look past the outside body and focus on the life and soul behind those bright and very alert eyes.
works in the clinic, scheduling the annual
H&Ps and all general clinic appointments,
as well as, scheduling and preparing the
clients and paperwork that is required for
the referrals to outside doctors.

The final area of Nursing on the campus
of WLRC is a highly specialized aspect
of nursing. We have a Medication Aide
Nurse. This Nurse trains and oversees all
and even re-trains the Medication Aides
if she feels it is necessary to assure safe
medication passes. Each Medication Aide
must pass an annual observed med pass,
an annual observed Skills Lab, remain
current in CPR, and also complete 6 hours
of “CEUs” to remain a Medication Aide.
These classes are taught by the Medication
Aide Nurse, as well as some of our other

Nurses, including myself, who volunteer in
teach these classes to lighten the teaching
load of the Medication Aide Nurse. I was
the Medication Aide Nurse from January

Each Nursing Department that
we do have at WLRC works in close
collaboration with the other Nursing
Departments to insure a continuity of
care is given our clients, no matter what
the need may be. Program Nurses follow
the clients on their caseload into HHC if
there is an illness that needs 24 hour care
and then the HHC Nurse take over. The
Program Nurses check in with the HH
Nurses daily and on the admitted client as
long as their HHC stay is. They offer any
assistance that the HHC Nurses may need,
such as what position gives the client the
most therapeutic comfort or how they
best take their medications. The Program
Nurse also attends any Clinic visits that
are schedule and offer help to the Clinic
Nurses as needed.

Every Nurse on staff collaborates with
the Allied Health departments in the
Horizons Healthcare Building as well as
the numerous other departments across
campus. Our Allied Health staff consists

I truly enjoyed being a Program Nurse. I felt I was a true
“advocating” Nurse for the clients on my caseload. This was
where “the rubber meets the road” so to speak. Most of our clients
are non-verbal so it is really hard to ascertain what is wrong with
someone if they can’t tell you what hurts or what they feel like. My
assessment skills went through the roof. I began listen a little closer
to lung, heart and abdomen sounds. I watched for changes in vital
signs and began to notice the look in my clients’ eyes or the way they
held their body, or a grimace on their face that would clue me into
the fact that they didn’t feel well.

The third type of nursing practiced at
WLRC is the Clinic Nurse. We have a
part time MD and a fulltime PA/C on staff
at our clinic here on campus. They see
our clients on an as needed basis as well
as complete the ICF-MR required annual
history and physical. The providers may
do refer our clients to any outside and/or
specialty doctors for further care. We have
2 Nurses and a Records Specialist who
weekly Team meetings, Quarterly Review
meetings, and annual Individual Personal
Plan (IPP) meetings to help plan and set
reasonable and attainable work, home and
leisure goals for each one on her caseload.
Each Program Nurse attends all MD
appointments and consults that involve
the clients on her caseload to ascertain
a continuity of care is assured each one.
She is an integral part of and available for
any health and/or medical needs that may
arise throughout each day for every one on
her caseload. I was a Program Nurse from

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the look in my clients’ eyes or the way they
held their body, or a grimace on their face
that would clue me into the fact that they
didn’t feel well. I began to watch more
closely their medications, studying them,
looking for interactions and side effects
that might be a problem. These were long-
term clients who needed long term health
“care” not a quick fix for the immediate
crisis. It became my passion. I remained a
Program Nurse for 8 years. During those 8
years, I became a Certified Developmental
Disabilities Nurse (CDDN) and became
an active member of the Developmental
Disabilities Nursing Association. I attend
the Annual DDNA (Developmental
Disabilities Nurses Association) and
AADMD (American Academy of
Developmental Medicine and Dentistry)
Education Conference presented by
the Developmental Disabilities Nurses
Association as often as I can to remain
current in my nursing specialty field.

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2 Nurses and a Records Specialist who

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of the afore mentioned providers, 2 part time Dentists, 2 Laboratory staff who are MT (ASCP) certified, a Registered Dental Hygienist and a Dental Assistant, a Respiratory Therapist, 2 Registered Pharmacists and a part time Pharmacy Technician, as well as 2 part time X-ray Technicians. On any given day we are a very busy group of people.

One of the other departments on the campus of WLRC is a Therapy Department. On staff in that department are 3 Physical Therapists and a Physical Therapy Aide, 3 Speech Therapists, and 4 Occupational Therapists and a Certified Occupational Therapy Aide. We also have 6 general Therapy Aides to assist the Therapists as needed. We also have on-campus Horse Therapy and Swim Therapy available for our clients. The Nurses work very closely with all members of the Therapy Department to assure the health and welfare of each client is taken into account in every aspect as they participate in the activities of daily life.

In July of 2003, I applied for and received the Program Nurse Supervisor position. I was back where I belonged, assuring that quality care is given to even our most fragile of clients. I now mentor 5 fantastic Program Nurses on a daily basis. In my opinion, they are the “cream of the crop”. As a team, we try our very best to assure that top quality health care is given to our clients.

Of course, as with most places of employment, there are often “other duties as assigned”. I am also Infection Control Nurse for the campus. This involves many hours tracking, trending and monitoring infections of all types for the clients who live here. I teach 3 or more Infection Control Classes a month to new staff and annual review Infection Control Classes to existing staff as a requirement from OSHA.

I am a member of the Nutritional Risk Committee here on our campus. Members of this team consist of Nurses, Therapists, Therapy Aides, the dietitian, kitchen staff and QIDPs. We oversee the overall nutrition of each client on campus, anything from oral motor difficulties, choking and aspiration issues to unexplained weight gain or loss. With the collaboration of all these professions, we feel the best nutritional care is available for each of our clients.

Each spring, I teach Clinical to the BRAND Student Nurses from the University of Wyoming. BRAND stands for Bachelors Reach for Accelerated Nursing Degree. The BRAND Program is an accelerated nursing program that is offered to people who already have a degree in another field but are looking to change careers. This 6 week period of time is a very stressful but satisfying part of my life. I must continue with my usual job responsibilities and take on 4-5 different students each week and integrate them into this unusual way of nursing here at WLRC. They see and do so many different things that they don’t and won’t in a hospital or doctor’s office or even in their home health rotation. Taking on this responsibility has widened my horizons and I now see how much I enjoy the teaching/mentoring part of nursing. What wonderful future nurses I get to meet and I hope that I contribute a small part to their education. I hope that they learn that just because a person can’t communicate their needs, doesn’t mean that the needs aren’t there and that, as Nurses, we can meet those needs if we but look past the outside body and focus on the life and soul behind those bright and very alert eyes.

When I’m not working, I’m a wife, a mother, and a grandmother. I’ve been married to my husband, Zan, for 34 years this May. We have 2 grown daughters and 2 wonderful grandchildren. Our oldest daughter, Cindi, lives in Bakersfield, CA with our grandson, Jarrett, who is 8. We visit when we can. I don’t know what she was thinking moving out of the beautiful state of Wyoming and taking our grandson with her. We miss seeing them frequently but savor the times we do have together. Our youngest daughter, Melissa, lives here in Lander. She has a daughter, Mya, who is 9, and we, of course, enjoy seeing them often. I’ve found that being a grandmother is what God intended for me. It is a great joy.

When I’m not working or enjoying my family, I find time to do several other hobbies. I bake and decorate cakes for weddings, birthdays, showers and other events. I enjoy vegetable and flower gardening. Gardening brings the circle of life into perspective, don’t you think? I also enjoy numerous crafts, like sewing, painting and flower arranging, and relax by completing Sudoku and Crossword puzzles.

I’d like to finish with a poem that I feel epitomizes the kind of care that all the staff at WLRC (and I think especially the Nurses) strives to accomplish every day. It has no title and the author is unknown.

Blessed are you who take the time To listen to difficult speech, For you help me to know that If I persevere, I can be understood.

Blessed are you who never bid me to hurry up or take my tasks from me, For my failures will be outweighed By the times I surprise you and myself.

Blessed are you who ask for my help For my greatest need is to be needed.

Blessed are you who with a smile encourage Me to try once more.

Blessed are you who never remind me that today I asked the same questions twice.

Blessed are you who respect me and love me Just as I am.

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Application:
• Application reviews will start on July 1, 2011 and be ongoing until the position is filled.
• This is a benefitted, full-time, 12 month position with teaching, advising and service responsibilities.
• Position start date is August 2011.
• Please send your letter of application, vitae and arrange for three letters of reference to be sent to:
  Susan H. Steiner, PhD, APRN, FNP
  Chair, Search Committee
  Fay W. Whitney School of Nursing
  1000 E. University Ave., Dept. 3065
  Laramie, WY 82071
  Telephone: (307) 766-6753
  Email: ssteine1@uwyo.edu
  Website: www.uwyo.edu/nursing

The University of Wyoming is committed to diversity and endorses principles of affirmative action. We acknowledge that diversity enriches and sustains our scholarship and promotes equal access to our educational mission. We seek and welcome applications from individuals of all backgrounds, experiences, and perspectives. The University of Wyoming is dedicated to ensuring a safe and secure environment for our faculty, staff, students, and visitors. To achieve that goal, we conduct background investigations on prospective employees. An Equal Opportunity, Affirmative Action Employer.
The next WSBN board meeting will be held July 5-8 at the TA Ranch in Buffalo, WY. The public is always invited to attend and participate. Please consult the website for details and agenda as they become available.

WSBN Proposed Changes to Administrative Rules & Regulations

In early May, two separate changes to the Administrative Rules & Regulations were submitted to Governor Matt Mead for review. Meetings were held with the Governor's advisors prior to releasing them for public comment and approval.

The first rule change was a complete rewrite of Chapter 6, Standards for Nursing Education Programs. This chapter deals with regulation of all nursing education programs within the state. The Chapter was last reviewed in 2003 and many things have changed regarding education standards since then. Most important with this rewrite, was the involvement of the Nurse Educators of Wyoming (NEW) in the process. This group, consisting of the Directors from the nursing education programs at the state community colleges and the University of Wyoming, met for most of last year to oversee the rewrite of this chapter. Relying on model rules from around the nation, studies, and research into nursing education regulation, they helped craft the language that makes up the new chapter. Their hard work and commitment to this effort cannot be overemphasized.

The other rule change was more specific. Chapter 2, Section 9 (f) deals with Graduate Nursing Assistant Temporary licensing. This was rewritten to more closely mirror the language and intent of the temporary permit sections for graduate nurses. This rule change grants a temporary permit to nursing assistants when they finish the NATCEP training. It should give nursing assistant students the ability to work after finishing their CNA courses, earn money for final testing and licensing fees, and gain experience prior to their national exams. It also benefits employers by providing clear guidelines for using graduate nursing assistants, prior to their state certification, during the 120-day rule period.

Information regarding the status of these rules changes may be found on the WSBN website, http://nursing.state.wy.us

The Wyoming State of Nursing recognizes the passing of the following licensed nurses:

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evvalynda Hoover, RN</td>
<td>03/31/2011</td>
</tr>
<tr>
<td>Cynthia Pickering, RN</td>
<td>3/4/11</td>
</tr>
<tr>
<td>Margaret Ellis, APRN</td>
<td>2/26/11</td>
</tr>
<tr>
<td>Rebecca McClain, RN</td>
<td>2/12/11</td>
</tr>
</tbody>
</table>

A Touching Story

One of the Nurse Practitioners I work with shared a touching story I thought the WNR might be interested in and she has given me permission to pass it along to you.

I noticed this morning Shirley Schatza, Family Nurse Practitioner, had a large flower arrangement and I asked her who her secret admirer was. It turns out that 27 years ago while working in Lusk, WY Shirley treated and cared for a 16 year old girl who was gravely ill with an acute onset of V-Tach. For the last 27 years that patient has tracked down where Shirley is working and sent her flowers on Nurses Day. The patient went on to become a nurse herself based in part on the inspiration from Shirley.

Thanks again and feel free to contact me if you have questions or comments.

Bill C. Stewart RN,CEN

Survey Monkey

WSBN has a new feature on the website. In order to improve service and give our all of our customers, both nurses and the public, a means to provide feedback, there is a customer service survey on our main page. Please use this Survey Monkey option to let us know how your needs are being met.
Q! I am wondering if LPNs can draw blood without IV certification. Can you help me with this question?
A Thank you for writing to WSBN. This is an issue that I have been puzzling over for awhile. LPNs obtain an IV Therapy Certification. Phlebotomy is not IV therapy. Nothing is injected, just withdrawn. We allow phlebotomists to practice with much less education or training than an LPN. I am looking at clarifying this in rules later this year.

For now, I would say that if your facility policy allows the practice and the LPN has the necessary training, it would meet scope of practice.

Q I am seeking direction from the Nursing Board regarding if, when answering the following question on the Wyoming endorsement application, the nurse is supposed to include information on minor traffic violations:

“Have you been convicted, pled guilty to, nolo contendere to, or have charges pending, against you for any crime including felonies, misdemeanors, municipal ordinances, and any Uniform Code of Military Justice violations, including driving under the influence of any intoxication substance?”

Anthem defines minor traffic as:

“minor traffic violations” mean parking tickets, non-moving violations, and routine speeding tickets that do not amount to reckless driving. Although the laws vary depending upon the jurisdiction, “minor traffic violations” usually result in the issuance of citations (vs. arrests) and the payment of fines (vs. jail time). By contrast, “major traffic offenses” typically include those involving or resulting from the use of alcohol or illegal drugs, reckless driving, and other situations in which property damage or personal injury is likely to occur. In addition, driving on a suspended license or failure to appear in court to respond to a traffic violation should not be considered minor traffic violations.

Can you please advise if the nurse should disclose minor traffic in response to the above question on the Wyoming endorsement application?

A Thank you for contacting WSBN with your question about disclosing criminal background or mental health history. All applicants are required to be fingerprinted and have a criminal background check (CBC). If an applicant does not disclose something because they don’t think it is important or they don’t believe it needs to be disclosed and subsequently the CBC reveals ANYTHING, the applicant is at that point deemed as a “Failure to Disclose” (FTD). That is not a positive way to begin the process for applying for a nursing license.

If there is ANY doubt, the individual should disclose it, provide a personal statement (see our website for examples of an appropriate personal statement) and then our licensing specialists can review the application, personal statement, court documents if indicated, and the results of the CBC and make a decision if any further information or action is required. Providing this information in advance will always help speed the licensing process and make a more favorable impression.

SIMPLE speeding tickets that do NOT involve alcohol or chemical impairment and are NOT in connection with other violations (i.e., reckless driving, assaulting a peace officer, etc) do NOT need to be disclosed. Bottom line, it is better to disclose what did not need to be disclosed than FTD. Most applicants minimize past issues, like a “minor traffic violation” which in fact, shows up on the FBI CBC as something more serious than what an applicant remembers.

Q I enjoyed your Spring 2011 Greetings letter. May I suggest that you use the oft neglected grammatical convention of spelling out an acronym before using it? (i.e. MELAS, later stated as MYLAS). Thanks for the excellent nursing magazine.

A We apologize for not following our own rule in that letter. For the record, the correct acronym is MELAS Syndrome which stands for “mitochondrial myopathy, encephalopathy, lactic acidosis, and stroke”.

Q We’re revising our resuscitation order sheet. One issue relates to pushing IV meds when there is no pulse and chest compressions are not being done. I’m not familiar with any evidence saying that pushing meds is or is not effective without CPR. Anyone know of anything in the literature? Do you give IV meds to a pulseless patient who is not to receive CPR?

A I found this question posted on a Listserv for advanced practice nurses. This is just one example of how we can fall into a trap of searching for Evidence Based Practice (EBP) arguments when critical thinking skills can provide the answers. It also points out that new nurses are not the only ones that struggle in developing their critical thinking skills. The act of giving IV meds is to promote their rapid dispersal into the vascular system and uptake by the various organs affected by their action. If the patient is PULSELESS and CPR is not an option, how will the medication be circulated? If it doesn’t circulate throughout the body it won’t have any effect. (an exception would be epi directly to the heart but here we are talking about IV push very likely at a peripheral site). High concentration of a drug in a venous lumen will not reach the cellular target. This may be a dilemma in those instances when “chemical code only” orders are written and points out the ethical issue of providing treatment with little expectation of benefit. This also points out the questionable reasoning of relying on evidence based practice for things that are bound by rules of physics. EBP is the result of research and outcomes. Research studies are costly and time consuming. It would be hard to justify an examination of pushing IV medication to pulseless patients when the outcome is predictable. Evidence Based
Practice is important to providing scientific rationale for the decisions we make as nurses rather than the anecdotal methods of the past. Just don’t let EBP become a cliché.

Q I am a Medical Doctor from Armenia. Currently I live in Wyoming. Please help me to figure out what exams I need to take to work as a nurse in Wyoming. Should I study at nursing school to be eligible to take the exams? Are there any exams that I can take without studying anywhere? Please advise me what to do.

A Despite your previous medical education you would be required to complete a nursing program in order to take the NCLEX exam to become a nurse. This applies to all states. There are no provisions to simply take the test. It is only given to graduates of accredited nursing programs. Wyoming has several fine community colleges and the University of Wyoming which all offer Nursing Education Programs. I hope you can find one that suits your needs.

Q Hi, I work for a home health care agency and need some assistance in a few questions that we have:

1. Are there any regulations stating that an LPN can/cannot do a supervisory visit with a C.N.A? We are aware that an RN must perform the sup visit if the patient is a VA patient but is there anything for Medicare or Medicaid if the LPN is under RN supervision. The supervisory visit that I am referring to verify the CNAs are performing their duties for the patient according to the care plan that was set up. Federal regulations state that it must be an RN or PT, but I was wondering if the RN can delegate this to the LPN?

2. Are there any regulations that state a FNP’s orders for a Home Health patient must be co-signed by a physician?

A Thanks for writing to WSBN. RNs may not delegate the nursing process to unqualified staff and LPNs do not perform evaluations. An LPN may delegate tasks to a CNA but the evaluation of the Plan Of Care is an RN responsibility and evaluating the CNA role in carrying out the POC would also be an RN responsibility. Since the Federal Regulations are clear about the RN or PT role, it would be best to follow their wording. Check with your agency to determine their specific policy and how it applies to LPN scope.

Regarding FNP practice, all APRNs are considered independent practitioners in WY and as such are not required to practice under supervisory or collaborative agreements.

There are some federal restrictions on certain types of orders an APRN can write in home health but no regulations for co-signing that I am aware of. CMS (federal Medicare and Medicaid agency) rules can be complex, especially regarding Home Health agencies. Check with your agency CMS specialist for details.

Q Hello - I am writing concerning various scope of practice questions that I have come up with and I need clarification on. I recently graduated from the Psychiatric Mental Health Nurse Practitioner program through UW. I am working in private practice and also obtained a prn position on the Behavioral Health Unit at a Wyoming Hospital. I will be seeing patients on the inpatient unit and wanted to know if the patients come in on various psychiatric medications as well as multiple medical medications (i.e. blood pressure, cardiac etc.) if I can continue these orders since these order were not initiated by myself as a provider. I also wanted to know if other medical issues arise while on the behavioral health unit, which of these we can treat if any. I would appreciate any clarification on these types of orders.

A Your question raises other questions that indicate you may need significant reflection and consultation with a mentor. It is essential that you become aware of your PMHNP standards and the scope of your practice BEFORE YOU BEGIN PRACTICE IN THIS ROLE. If you are not sure of what medical conditions you can cover you should absolutely consult with a mentor or other providers on the treatment team before you consider treating them. Your prescriptive authority is not restricted to only a certain classification of medications. If you are unsure of the exact pharmacological treatments required for a medical condition and the nature of these medications, common dosages, and their side effects, you would most certainly be outside your own scope of practice to continue them. But if you do not continue a patient’s medications, what would be the outcome? Insulin, Synthroid, Chronic high dose opioids, Coumadin, beta blockers, ACE inhibitors...would you consider discontinuing them because you did not initiate the treatment? Should another practitioner discontinue your prescriptions for psych meds because they did not originate them? Part of any nurse’s scope is only taking on assignments they are comfortable with and competent to perform. As a prescriber you are expected to review all medications for compatibility and synergy. If you cannot answer your own questions you probably should limit yourself to psych issues and leave the coordination of medical treatment and diagnosis to the admitting or attending providers. I would suggest seeking another PMHNP as an informal peer/mentor to assist you in discussing and understanding some of these issues. I would also suggest contacting the board of pharmacy for details on the prescribing laws in this state.

WSBN considers Scope of Practice to be individually determined based on Licensure, Accreditation, Credentialing, Education, and Experience. Please consult the decision tree on the WSBN website and determine if you need to reconsider your choices. This quote is from a journal article entitled Scope of Practice and the Nurse Practitioner: Regulation, Competency, Expansion, and Evolution. (Tracy Klein, FNP; Topics in Advance Practice Nursing eJournal 5(2): 2005 (Medscape).

“There have been several licensing disciplinary cases related to both FNP’s treating mental health conditions and PMHNPs treating primary care conditions... For the PMHNP, coordinating or initiating treatment for primary care conditions without the knowledge of a primary care provider can be a significant area of risk to the patient and to your license.”

Q I would like to find out if an RN licensed and employed by a company in another state that is contracted to provide primarily telephonic disease management services to health plan members, needs a Wyoming license to provide this service? Can an RN licensed and employed in another state provide onsite (in person) disease management in Wyoming if this is a job requirement of the out of state employer?

A Wyoming is a mandatory license state. Anyone providing nursing services to citizens of this state is required to have a Wyoming nursing license. That includes telephonic nursing services. We are not a compact state so outstate licenses do not automatically transfer but we do allow licensing by endorsement from another state. Please consult our website http://nursing-state.wy.us under forms for the Licensing by Endorsement application. It will explain what you need to do.

Q I was wondering about using Medical Assistants in WY but I was under the impression that our state did not license them

Continued on page 18
Our practice. I am wondering if the Board of Nursing as any guidelines or rules concerning
the storage of pre-packaged medications at
an outpatient clinic as well as the labeling
and dispensing of these pre-packaged sealed
medications. My main focus is who can label
give the medications to the client once the
physician or advanced nurse practitioner
has written the order for the prescription.
Currently only the prescribing provider can
label and give the medications to the patient.
Can a licensed registered nurse or a licensed
practical nurse label and give out the pre-
packaged sealed medication to a client during
their clinic visit once it has been prescribed
by the provider or is this considered
dispensing? I would like your advice on the
initial prescription as well as authorized refills.
Where can I find this topic covered in the
Nurse practice Act?
In speaking with the Board of Pharmacy I
have the following clarification:
Nurses are licensed to administer, pharmacists
to dispense, and prescribers to diagnose-
prescribe-dispense-administer. That is why
your prescribing provider is currently the one
to label and give the meds to the patient....
they are doing 3 of their 4 authorizations.
“Administer” means the direct application of
a drug ....to the body of a patient.....
“Dispense” means to prepare prescription
medication “...under the lawful order
of a practitioner in a suitable container
appropriately labeled for subsequent
administration.....
WSBN is concerned with the standards
that apply to safe administration of
medication. Your issues are not covered in
the Nurse Practice Act. If you need further
clarification on prescriptions and refills I
suggest you contact the Board of Pharmacy –
634-9636.
I have a question about practice. During
a recent site review, the reviewers had a
question about RN scope of practice. In family
planning clinics, RNs perform assessment on
female clients, but the site reviewers wanted
to clarify that they were able to perform a
physical assessment on male clients as well.
I am fairly certain this is not a problem, but
wanted to verify with the WSBN.
A RNs perform nursing assessments on all
patients. Family planning exams for male
patients may consist of a review of performance
or function issues, genital exam for lesions
or evidence of STDs, documentation of
abnormalities (cryptorchidism, prostate or
urinary problems). If you are talking about
gynecological exams or full physical exams,
that is generally in the scope of an APRN.
But many of the male patient issues can be
assessed and documented by an RN.
I work as a RN at a pulmonary clinic. We
currently have a respiratory therapist who
performs spirometry and EKGs. Can a CNA
be trained to do these tests? I cannot find
anything specific on your website. Any help
would be appreciated.
Chapter 7 of Rules and Regulations specifies
that a CNA performs the following functions
under the delegation of a supervising nurse:
A) Basic Nursing Skills, B) Personal Care
Skills, C) Basic Restorative Skills Assistance,
D) Mental Health and Psychosocial Skills,
E) Communication Skills. Nowhere does
it make allowances for providing diagnostic
testing. A CNA can be trained to do many
things but it is the scope of practice that
determines what they may do.
I am seeking to obtain information regarding
the Nurse Practice Act for Registered Nurses.
Is an RN allowed to order blood work in your
state? If so, could you please provide the
citation that allows such activity?
In addition, it is my understanding based
on the Scope of Practice statement for Nurse
Practitioners published from the American
Academy of Nurse Practitioners that an
Advanced Nurse Practitioner is allowed to
order lab work. I would like to know if a
Collaborative Agreement is required by the
state in order for the ANP to function in this
capacity. If so, could you please provide the
citation that allows such activity?
I would also like to know if the Board
of Nursing has a rule or regulation and/or
position statement on the practice of
Telephonic Nursing.
Any assistance you could provide to me
regarding the above questions is appreciated.
If you need to contact me, my demographic
information is listed below. Thank you in
advance for your response.
A 1) RNs may not order blood work. Lab
tests are diagnostic and RNs do not diagnose.
Orders must generate from a physician or
APRN.
2) APRNs are primary care providers in
Wyoming and as such may order lab tests and
other billable diagnostics.
3) APRNs are independent providers and
are not required to work under collaborative
agreements.
4) Wyoming is a mandatory licensure state.
RN providing care to citizens in this state

and instead used CNAs in that position. If
the CNA has been properly trained by a
physician, are they allowed to provide these
services without a physician’s presence?
Also, who is held responsible if an MA does
something wrong with a patient, since they
are unlicensed—the physician? Can this be
clarified for me?
A The WSBN certifies and regulates Nursing
Assistants. They practice under the direction
of licensed nurses and are involved in multiple
aspects of basic patient care as delegated by
the supervisory nurse. WSBN sets standards
for CNA practice and one of those is that the
CNA is under the direction of a nurse. CNAs
provide basic nursing care, personal care,
and restorative skills assistance. They also
receive training in certain psychosocial and
communication skills. The tasks and skills
that may be delegated to a CNA are outlined
in Chapter 7 Section 7 of the WSBN Rules
and Regulations which can be found on our
website under information. These skills are
designed to assist nurses in caring for patients.
CNAs take direction from licensed nurses,
not from physicians, and if they do they may
not represent themselves as CNAs. If they
do not work as a CNA their certification will
lapse.
Medical Assistants are not licensed or
under the governance of a board in Wyoming.
Theirs is a vocational training and they may
work under the supervision of a physician.
MAs often receive training that is not within
a CNA scope such as giving injections. Some
CNAs think that by getting MA training
they will be able to do more things but they
still need to practice within their scope and
MA training is not nursing based.
It comes down to a public safety issue
regarding an unlicensed, unregulated, health
technician providing care often under the
perception of being a nurse. This is not to
say that MAs are unskilled. Many of them
are very good at what they do. It is just that
CNAs are regulated and can be removed from
practice if they violate nursing standards.
MAs are not held to that requirement or
oversight. I cannot tell you how to utilize an
MA. It is up to the person that hires them.
Their liability is an issue with their facility
and supervisor. I realize the MA/CNA role
responsibility can be confusing but the rules
are clear about CNA scope. Read the Rules
and Regulations I referenced for a detailed
description.

My outpatient clinic is currently in the
process of rewriting policy and procedures for

Wyoming Nurse Reporter
Let’s Be Clear...

More and more I get calls asking for clarification regarding a CNA scope of practice. “Can a CNA give shots?” “Can the CNA pass medication?” “Can a CNA call in orders for the doctor?” The short answer is a resounding, “NO!” I often hear, “…but I got extra training and my boss says I can.”

Let’s be clear; a Certified Nursing Assistant by rule (Chapter 7), “regardless of title or care setting, shall be under the direction of a licensed nurse.” It does not say “under the direction of a nurse or physician.” The duties of a CNA and the training they receive are designed to provide support and assistance to nurses and patient care being overseen by a nurse. The skills training they receive is designed to provide and augment basic nursing care to a patient, not medical treatment. If recognition as a certified nursing assistant (CNA) is a requirement for employment the CNA must ensure they will be taking direction from a nurse. If a nurse is not also employed at the facility and involved in the delegation of duties for the CNA, then the CNA cannot practice within their legal scope. A nurse would not ask a CNA to administer injections or pass medication and an employer that does is asking the CNA to violate their scope of practice and risk losing their certification. If a person giving shots or passing meds identifies themselves as a CNA, they risk practicing outside their scope and losing their certification. A CNA working in a setting without an RN providing direction cannot claim those employment hours for renewal. If you are not working as a CNA you cannot renew as a CNA.

Medical skills gained by the CNA, such as medical assistant training, cannot be used when they fall outside the CNA scope of practice. A medical assistant is not a CNA and a CNA is not an MA. They have different skill sets, different training, different scopes of practice, and different supervisory requirements. A CNA is certified by the Wyoming State Board of Nursing to have passed specific education and training requirements. An MA is unlicensed and unregulated and their training standards are inconsistent and ambiguous. A CNA works under a nurse, while a medical assistant works under the direct supervision of a physician or other provider. The physician may certainly hire an individual who happens to be a CNA. But at the point their duties violate the scope of practice they risk violating their certification and the right to claim to be a CNA, identify themselves as a CNA, or use their employment to fulfill CNA requirements. If the job description requires a CNA certification, the position is considered a CNA position and the Nursing Regulations apply to their scope of practice.

The CNAII and Medication Aide Certified (MAC) are separate programs adopted into rules in July 2010. They are designed to provide specific additional CNA skills for utilization in long term care settings with stable patients. Currently there is only one facility providing CNAII training and no MAC programs have been developed or approved at this time. CNAII and MAC program information will be posted on the WSBN website as it becomes available. For more clarity on CNA scope and duties see Chapter 7 of the Rules and Regulations, also on the WSBN website.

Todd Berger, MSN, APRN, ACNS-BC is the Practice and Education Consultant at the Wyoming State Board of Nursing.
“Mr. J is back.”

“Ugh, again? What is this, four times this month alone?”

“Yep, he swears this is his last time.”

“He just comes to get drugs, sleep off the alcohol and goes right back to drinking the minute he leaves.”

“I know, what a waste of time. “

What is the first thing you do when you pick up this magazine? Do you turn right to the back and see if you know any of the nurses or aides that have their names printed and a detailed account of the trouble they are in. I used to do that too. Then I became one of those names. I am not providing you my name because I want to be brutally honest with you. I was also one of those nurses who complained about the frequent flyers we got on the medical floor for detox. I would think things like: they could stop if they wanted to, don’t they see what they are doing to their families, and they are just here for drugs. I am taking a wild guess here that you became a nurse because you wanted to help people. Yes we all want the nice compliant cheerful patient, but sometimes we have difficult, angry noncompliant patients. I am hoping that after telling you my story, you will be encouraged to get help if you are suffering from an addiction and you will hopefully not judge the next addict you are assigned to take care of. I hope that you may be aware of nurses around you who may be suffering from addiction.

I was born in Miami, Florida, but moved to Wyoming shortly before my first birthday. The only Miami thing left in me is my devotion to the Miami Dolphins football team. My mom grew up in Florida and she got me hooked on sports at a young age. I am the oldest of three. My two brothers are ten and nine years younger than me. I became a little mom at nine years old, growing up fast. I used to resent it when strangers would come up to me and say “I bet you are mom’s little helper!” If you only knew, I would think to myself. I got my brothers up, fed them, dressed them and when they were older made sure they got off to school. My dad worked in the oilfield and was gone a lot for work. I was very angry at my mom growing up, I often felt like I was just a slave put on this earth to raise her kids. I had few friends and often would even stay home from school to help care for my brothers.

I remember lying in my bed one night at eight years old and going through the list of potential occupations. Firefighter? No, too hot. Lawyer? Too much arguing. Nurse? That’s it! I could be a nurse, my mind was made up. At 15 I volunteered at a hospital and began studying the NCLEX (nursing) exam. I would seek out any nurses I could find and quiz them on what it was like to be a nurse. I realized I was depressed at the age of 13. I had already held a loaded pistol to my head and contemplated pulling the trigger, I had run away from home and overall just felt an overwhelming feeling of despair that consumed me. I became promiscuous starting at age 13 and by 16 was pregnant. I had an abortion and shortly after that experience discovered how much God can really change my life. I started going to church and making new friends and for a short while felt more happy than I had ever been in my life. But then I started making bad choices again and I believed I wasn’t meant to be a good little Christian girl, I just couldn’t live up to that picture in my head I had, the one of the perfect Christian. I felt I had let God down. I graduated from high school and went to college in St. Paul Minnesota to an expensive all girls’ school. Unfortunately my mom did not fill out the paperwork for my scholarship.
and I was not able to go back to college my sophomore year. I came back to Wyoming and obtained my associates degree in nursing through a community college. I worked the first two years of my nursing career in a nursing home. I loved my job and the people I worked with. I was on several committees and prided myself on being a good charge nurse. My parents were very proud of me and often I would find myself blushing as my mom told a cashier, with great pride in her voice, “My daughter is a nurse!” Being a nurse was my whole identity.

There was another identity that was a part of me, but I denied it for a long time. I had never treated the depression I had identified at age 13 and now I was in physical as well as emotional pain. I was about to run head-on into a speeding train called addiction. I married my high school sweetheart the year I graduated from nursing school in 1998, after many years of infertility we finally had a son in 2003. Shortly after his birth I began to have many medical problems, stomach issues and endometriosis which led to a total hysterectomy. After my hysterectomy and the pain medications stopped being prescribed, I realized I had become dependent on pain medication. When I could not obtain a prescription for the medication, I began taking pills that would normally be thrown away. For the first 9 years of my nursing career, taking medication from work never crossed my mind. Within weeks of taking that first pill, I was injecting hundreds of milligrams of opiates into my vein. I never denied my patients pain medication; what I took was wasted medication, but that is just something I said to myself to justify my actions. I would walk around work and say, to myself, “What am I doing? Why am I doing this?” But deep down I did not want to stop, it was as if the sweet competent nurse everyone liked, had been replaced by a selfish monster that would stop at nothing to take the pain away. I realized I was trying to self medicate physical and emotional pain that had been there as long as I could remember. I knew I needed help, but I could not find the courage to reach out for help. I lived many years of my life with my hand on a hot stove, hurting myself, but too afraid to take my hand off the stove, because I was too afraid of change. Finally the pain was greater than the fear of change and I took that first step. It required “hitting bottom” as they say. One night I spent 12 hours in the

Continued on page 22
bathroom searching for a vein. At hour 12, after sticking myself at least 50 times, I found a vein, injected the opiate and it hit me, this was bottom. The next day I was fired. I admitted I had an addiction problem and off to treatment I went. It was the beginning of the rest of my life.

Through intensive outpatient treatment, going to meetings every day and finding a wonderful program called Celebrate Recovery, I found freedom. I began to realize resentments I carried about my mother were slowly killing me. I realized that I had never fully dealt with my abortion and that all my life I had been burying my emotions and feelings by ignoring problems or medicating myself with alcohol or drugs, so I wouldn’t have to feel. I was a good nurse, I took my job very seriously, and nursing was my life. Now that I have overcome my addiction, I am a better nurse than I ever was. I am happy and no longer depressed. I attend meetings every week, come rain or shine. I teach recovery lessons to a large group of people about once a month. I travel around the state sharing my story, hoping that someone is inspired to make a life changing decision and get help for their hurt, habit or hang-up. I sponsor many women in addiction and I have a sponsor. I have turned back to God and realize now how precious second chances are. I am not who I once was. I am not just a nurse. I am a child of God. I am a daughter, mother and wife. I have been clean and sober since September 21, 2007. My parents and I have mended our relationship. They are very supportive of my recovery and proud to see me finally happy and not depressed anymore.

I have a heart for addicts now. I remember being a nurse on the floor and rolling my eyes at the patient who was back again to detox. We make assumptions about people and sometimes we put others down to make ourselves feel better. We all experience the same emotions, loss, love, anger….. Some of us have great coping skills, some do not. Unfortunately many nurses are often predisposed to addiction because they tend to be codependent and feel the need to take care of everyone else, instead of themselves. If you are having any addiction problems, there is plenty of help no matter where you live.

You can make a change. Don’t be stuck in the same rut I was, feeling that your miserable life is never going to change and this helpless, dark depression will never go away. That is a lie. You can change for the better, but you cannot do it alone. Know the signs of depression and codependency. Watch your coworkers for these signs and talk to them, offer to help them. Don’t let any hurt, habit or hang-up you may have right now prevent you from becoming who you were created to be. I used to believe that lie; I was going to be miserable the rest of my life. It took a dramatic event for me to start over, but you can decide right here and now that you are no longer going to live this way. Please make the change before you run head-on into that speeding train. If you are reading this and have a well adjusted happy life, awesome; maybe you have something to share with a coworker who doesn’t possess those skills. Have compassion for all the Mr. J’s who are assigned to your care. Something you say to him just might give him the courage to make this relapse, his last. Thank you for letting me share my story with you.

My Story

The summer after the massive fires in Yellowstone Park I was part of a school group that toured Yellowstone. As I viewed acre after acre of charred devastation I found it hard to believe there had ever been anything beautiful there. Closer examination of the blackened ashes revealed the hopeful green sprouts of plant life and the promise of renewal. My name is Bill Stewart and this is my story.

Over the years as a healthcare provider I have thrown out labels like alcoholic, addict, drug seeker. Ironically, I held little regard for these “weak willed” patients. Addiction is a dubious, deceptive, multidimensional foe. I had dealt with addiction problems in my past and felt I was far too clever, far too strong to have problems again. I discussed my history of addiction with my provider and Ultram was considered a “safe” alternative to manage my pain.

Addiction is a cunning sort of devil. It’s hard to pin-point where things go completely side-ways. Its much more subtle than that. My best description of addiction is that of

Bill Stewart
but also an increased overall awareness of my place.

As part of my recovery program I participate in the Nurse Monitoring Program. In July of last year the NMP took on the responsibilities previously completed by the Wyoming Professional Assistance Program. The NMP serves as a conduit for nurses committed to a lasting quality recovery program. I view the NMP as an additional tool in my recovery program that exists to provide accountability and monitoring. The straightforward approach of the NMP serves not only to protect the public but also the basis by which the nurse can rebuild trust.

When I was approached by NMP and the Wyoming Nurse Reporter in regards to writing this article I was as you might imagine less than enthusiastic. Publishing your worst transgressions is a bit daunting. After a good deal of discussion with my wife and friends it became very clear to me that if I can in any way encourage a nurse out there that is suffering to seek help it would be more than worthwhile. Resources are available to help and please know you are not alone.
Nurse Educators and Nursing Education in Wyoming

As part of a grant from the Wyoming Workforce Development Council, The Wyoming Center for Nursing and Health Care Partnerships collaborated with the UW Nightingale Center for Nursing Scholarship to undertake a survey to gain a clearer picture of the status of nurse educators and nursing education in Wyoming.

The survey targeted three different groups of nurses: nurse educators, nurses in direct patient care positions and nurse administrators. Each group was asked questions about their involvement in nursing education. For example, nurses in direct care positions were asked about whether they served as preceptors for nursing students and how they had been oriented to the preceptor role. Nursing administrators were asked what their organization’s current involvement was in nursing education. Nurse educators responded to questions about their teaching responsibilities and factors related to satisfaction as an educator.

Thanks to all of you who responded to the survey; 147 direct care nurses, 84 administrators and 71 educators returned the survey. In this column, we highlight some of the key findings. You will be able to find the full report on the WCNHCP website this summer. These findings are very useful as we work to transform nursing education in Wyoming.

Direct Patient Care Nurses and Nurse Administrators

Almost half of the nurses in direct patient care reported that they had served as a preceptor for nursing students, including LPN, RN and advanced practice nursing students. However, most nurses report that they do not receive formal preceptor training (73%). Nurses were asked if they thought their unit or facility could accept more students. Over a third (36%) of nurses reported there was more capacity while 36% said they weren’t sure. For the 28% that felt the unit/facility could not take more students, the most common reason was lack of space.

Nurse administrators reported that nursing students were being educated on a variety of units in their facilities, including medical, surgical, obstetrics, psychiatric, pediatric and intensive care units. Administrators were more likely than nurses in direct patient care to feel that their facility had additional capacity to take more students. Forty-seven percent reported they could take more students, while 31% were unsure. Similar to nurses in direct patient care, for those who felt their facilities could not take more students, lack of space was the biggest barrier.

Nurse Educators

Consistent with the demographics of nurse educators nationally, the typical nurse educator in Wyoming is white, female and between 55 and 64 years of age. The majority of the respondents worked in an associate degree program (63.5%) and estimated that they worked 47 hours a week. Most nurse educators reported teaching both didactic and clinical courses. Over 50% of nurse educators also have a second job as a nurse, usually in a clinical setting.

Nurse educators reported that they became nurse educators because they wanted to work with students, they were encouraged by others to become educators, and they desired to shape the profession of nursing. The intellectually stimulating environment, flexibility of the job, and working with students were factors that keep nurse educators in education. Workload, work hours and salary were the factors that would make nurse educators think about leaving education.

Almost two-thirds of nurse educators agreed or strongly agreed that they would choose to be in their current position in their current college/university. Nurse educators were generally satisfied with their positions in education. Nurse educators were satisfied with their opportunities for professional development, especially the opportunity to use their nursing skills and to learn new skills. Nurse educators were satisfied with interpersonal factors, especially the skill and knowledge of their co-workers. They were also satisfied with their compensation including salary and employee benefits. The only area that nurse educators were less satisfied with was the “amount of paperwork” required.

About 10% of nurse educators reported they were planning to leave their nurse educator position within the next 12 months, usually for further education or to take another position in nursing education.
Interestingly, nurse educators are strongly tied to their communities. Fifty-two percent agreed or strongly agreed with the statement, “I am tied to this community and can’t leave.” On average, nurse educators had lived in their current communities almost 21 years. The most frequent reasons for living in their communities included their own job, their spouse/partner’s job and proximity to family.

What do these findings mean for Wyoming nurses and nursing education? Clearly, we need to talk collectively about how to ensure that educational institutions and clinical facilities partner in a meaningful way to provide the best experiences for nursing students so that we develop strong nursing clinicians. In addition, we need to address the aging of nurse educators, focusing on maintaining strong satisfaction of the current nurse educators and simultaneously recruiting younger nurses into education.

The WCNHCP is the nursing workforce center for the State of Wyoming. The mission of the center is to strengthen the nursing workforce through ongoing collaboration, communication, and consensus building to meet the health needs of the people of Wyoming. For further information, please visit the WCNHCP’s webpage at wynursing.org.

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### Licensing Statistics 2010-2011

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A few years ago, the Wyoming Department of Health identified the need for geriatric mental health training in long term care facilities. Today, thanks to funding from the department’s Mental Health and Substance Abuse Services Division, this need is being addressed at many facilities in Wyoming.

Five mental health experts offer the four-hour class, Wyoming Caring with Confidence. It is targeted at certified nurse assistants, but facility administrators often invite other staff to join in.

“CNAs provide most of the direct care in a nursing home setting, but too often don’t receive the tools they need to manage challenging behaviors,” said Deb Fleming, director of the Wyoming Geriatric Education Center. WyGEC coordinates the work of the five trainers under the Department of Health grant.

The class covers factors that can influence a resident’s behavior, from the physical environment to dementia or delirium. Trainers offer tips to minimize anxiety, agitation and aggression, which may or may not be associated with dementia. Classes also include an opportunity for participants to seek advice in handling specific situations.

For the very confused resident, references to the past can be comforting because newer memories are often harder for them to retain. Tips can include placing a favorite picture near a person’s bed, or using a scent in their room that they like.

“I thought it was a very good class that offered some insight into things we see every day, but don’t always get a new perspective on,” said Michelle Oliver, director of nursing at Star Valley Care Center in Afton. About two dozen staff members attended the training this spring, she said.

The four-hour course includes a 40-minute video on bathing techniques, called Bathing without a Battle. Oliver said that portion of the class has already made a big difference in her facility.

“We had a resident who is very feisty and getting her bathed has been very difficult,” Oliver said. The woman suffers from dementia. She was constantly grabbing at her caregivers and at objects around her during bathing, requiring two aides to bathe her, Oliver said.

Then CNAs tried the techniques from the video, such as adding a child’s toilet seat to make the opening at the bottom of the bathing chair smaller and more comfortable. Aides also learned to keep the woman covered with towels whenever possible, Oliver said.

Aides saw an immediate change. The woman was no longer grasping at her aides or at objects around her. She now seems much more peaceful through the bathing process, Oliver said.

“She’s a very tiny woman and she must have felt like she was going to fall through the chair’s opening, but she couldn’t tell us that,” she said. Bathing her now requires one aide, not two.

In the past few years, Wyoming Caring with Confidence has trained more than 500 CNAs working in two dozen facilities around Wyoming. More than 150 other staff members, including nurses, administrators, exercise therapists and maintenance staff, have also participated in the training.

“I like knowing that I’ve improved someone’s quality of life,” said Wheatland CNA Brett Davis about his job. Davis added that challenging behavior, including confused residents who can become combative, contribute to job stress.

He attended a recent Wyoming Caring with Confidence training at Platte County Memorial Nursing Home, where he learned tips for maximizing those positive interactions that make his job rewarding, while minimizing situations that can cause stress for residents, and for CNAs.

The key is knowing the residents, Wyoming Caring with Confidence trainer Elaine Renfro told the group. Renfro is a licensed clinical social worker in Cheyenne. The best way is to get to know a resident, she said, is to visit their home when they are transitioning to long term care. Creating a booklet on each resident, with input from his or her family, can serve as a substitute for a home visit, she said.

“Look for what they surround themselves with,” she said. “What do they like to do? What do they like to eat and see? What do they like to talk about?”

For the very confused resident, references to the past can be comforting because newer memories are often harder for them to retain. Tips can include placing a favorite picture near a person’s bed, or using a scent in their room that they like.
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Grounds for discipline for Licensed Practical Nurses and Registered Professional Nurses are located in the Administrative Rules and Regulations Chapter 3, pages 3-13 through 3-15 and Certified Nursing Assistants Chapter 7, pages 7-16 and 7-17 (July 2010).

Grounds for Discipline are: (i) engaging in any act inconsistent with uniform and reasonable standards of practice, including but not limited to: (A) Fraud and deceit including, but not limited to, omission of required information or submission of false information written or verbal; (B) Performance of unsafe client care; (C) Misappropriation or misuse of property; (D) Abandonment; (E) Abuse, including emotional, physical or sexual abuse; (F) Neglect, including substandard care; (G) Violation of privacy or confidentiality in any form, written, verbal or technological; (H) Drug diversion-self/others; (I) Sale, unauthorized use, or manufacturing of controlled/illicit drugs; (J) Criminal conviction; (K) Unprofessional conduct; (L) Boundary violations, including sexual boundaries; (M) Failure to comply with reasonable requests from the Board including, but not limited to: (I) Responses to complaints; (II) Responses to formal pleadings such as notice of hearing and/or petition and complaint; (III) Responses to requests regarding application and/or renewal information; (IV) Written response to request for explanation for failure to disclose required information; (V) Failure to appear at properly noticed hearings; (N) Impairment. (I) Lack of nursing competence; (II) Mental illness; (III) Physical illness including, but not limited to, deterioration through the aging process or loss of motor skills; or (IV) Chemical or alcohol impairment/abuse. (ii) Failure to conform to the standards of prevailing nursing practice, in which case actual injury need not be established.

MICHAEL CARROLL RN 23683 VOLUNTARY SURRENDER Michael Carroll, RN, agreed to voluntarily surrender his license on April 11, 2011 following his violation of the terms and conditions of a criminal probation. Mr. Carroll’s license had previously been suspended following his plea agreement to a charge of Third Degree Sexual Assault of a Minor.

JULIE COOPER RN 21088 LETTER OF REPRIMAND Julie Cooper, RN, entered into a Settlement Agreement, Stipulation and Order for Letter of Reprimand on April 7, 2011. A complaint was filed by Ms. Cooper’s employer in July 2010, which generally alleged patient neglect and unprofessional conduct. Specifically, it was alleged that Ms. Cooper’s assessment and reassessment of a resident who had fallen was deficient or incomplete and resulted in a delay of medical treatment at the local hospital emergency room.

MARY GARDINER LPN 571 LETTER OF REPRIMAND Mary Ann Gardiner, LPN, entered into a Settlement Agreement, Stipulation and Order for Letter of Reprimand on April 25, 2011. A complaint was filed in September 2010 by Ms. Gardiner’s employer alleging Ms. Gardiner failed to follow established protocols of proper assessment, reporting, documentation, and interventions pertaining to a fall sustained by a resident.

BRIGETTE GREY RN 27606 LETTER OF REPRIMAND Brigitte Grey, RN, entered into a Settlement Agreement, Stipulation and Order for Letter of Reprimand on April 7, 2011. A complaint was filed in June 2010 following notification to WSBN by the Kansas Board of Nursing that Ms. Grey’s RN license had been suspended in April 2010.

CHRISTINA HAHN CNA 18830 REVOCATION On or about May 11, 2011, WSBN entered an Order of Default Judgment and an Order of Revocation against Christina Hahn, CNA. Pursuant to WSBN Rules and Regulations, Chapter 8, Section 7(a), WSBN may enter an order of default based on the allegations in a petition and complaint against a respondent/licensee who fails to appear for a properly noticed hearing. Ms. Hahn failed to appear at a properly noticed disciplinary hearing. Accordingly, based on the petition and complaint which alleged violations of the Nurse Practice Act through Ms. Hahn’s actions related to criminal convictions, unprofessional conduct, failure to conform to the standards of prevailing nursing practice and failure to comply with reasonable requests of the Board, WSBN revoked Ms. Hahn’s CNA certificate.

MARTA HEAP RN 18921 LETTER OF REPRIMAND Marta Heap, RN, entered into a Settlement Agreement, Stipulation and Order for Letter of Reprimand on April 7, 2011. A complaint was filed in August 2010 by Ms. Heap’s employer alleging medication errors, specifically incorrect dosages to infants.

KEVIN MADER RN 24869 VOLUNTARY SURRENDER Kevin Mader, RN, agreed to voluntarily surrender his license on April 6, 2011. Mr. Mader’s license was initially suspended based upon a December 2010 complaint from his employer generally alleging diversion of controlled substances for his personal use. Mr. Mader subsequently made the decision to voluntarily surrender his nursing license.

TRUDY NEWTON RN 12083 CONDITIONAL LICENSE Trudy Newton, RN, was issued a Conditional License on April 7, 2011. A complaint was filed by Ms. Newton’s employer in March 2010 based upon the complaint of co-workers who stated they could smell alcohol on Ms. Newton’s breath and she subsequently tested positive for alcohol.

MALORY PAYNE CNA 20078 LETTER OF REPRIMAND Malory Payne, CNA, entered into a Settlement Agreement, Stipulation and Order for Letter of Reprimand on May 10, 2011. The complaint was initiated by WSBN compliance staff based upon Ms. Payne’s self-report of a criminal conviction on her application for renewal of her CNA certificate for the 2011-2012 biennium.

CAROLYN RICHARDSON LPN 7219 LETTER OF REPRIMAND Carolyn Richardson, LPN, entered into a Settlement Agreement, Stipulation and Order for Letter of Reprimand on April 7, 2011. A complaint was filed in March 2010 alleging unprofessional conduct and failure to respond to reasonable requests of the Board based upon Ms. Richardson’s failure to provide additional information regarding a criminal conviction disclosed in her application for the 2009-2010 biennium.

SHIRLEY ROSE CNA APPLICANT CONDITIONAL Shirley Rose, CNA applicant, disclosed criminal convictions on her application for certification. Ms. Rose has entered into a Settlement Agreement, Stipulation and Order for Conditional Certification to monitor her for Substance Use Disorder.

LOIS SWISHER LPN 4206 LETTER OF REPRIMAND Lois Swisher, LPN, entered into a Settlement Agreement, Stipulation and Order for Letter of Reprimand on May 10, 2011. The complaint was initiated by WSBN based upon receipt of two reports from the Wyoming Department of Family Services (DFS) of verbal abuse to a vulnerable adult.

MALORY PAYNE CNA 20078 LETTER OF REPRIMAND Malory Payne, CNA, entered into a Settlement Agreement, Stipulation and Order for Letter of Reprimand on May 10, 2011. The complaint was initiated by WSBN compliance staff based upon Ms. Payne’s self-report of a criminal conviction on her application for renewal of her CNA certificate for the 2011-2012 biennium.

CAROLYN RICHARDSON LPN 7219 LETTER OF REPRIMAND Carolyn Richardson, LPN, entered into a Settlement Agreement, Stipulation and Order for Letter of Reprimand on April 7, 2011. A complaint was filed in March 2010 alleging unprofessional conduct and failure to respond to reasonable requests of the Board based upon Ms. Richardson’s failure to provide additional information regarding a criminal conviction disclosed in her application for the 2009-2010 biennium.

SHIRLEY ROSE CNA APPLICANT CONDITIONAL Shirley Rose, CNA applicant, disclosed criminal convictions on her application for certification. Ms. Rose has entered into a Settlement Agreement, Stipulation and Order for Conditional Certification to monitor her for Substance Use Disorder.

LOIS SWISHER LPN 4206 LETTER OF REPRIMAND Lois Swisher, LPN, entered into a Settlement Agreement, Stipulation and Order for Letter of Reprimand on May 10, 2011. A complaint was filed in October 2010 by Ms. Swisher’s employer, which alleged Ms. Swisher failed to follow established protocols of proper reporting, documentation, and interventions pertaining to a fall sustained by a resident on September 30, 2010.

JESSE TACHIQUIN-FRIAS RN 25440 CONDITIONAL LICENSE Jesse Tachiquin-Frias, RN, was issued a Conditional License on May 11, 2011, following his self-disclosure of a substance use disorder to his employer and indicating he could not work due to his alcohol withdrawal.

LAURIE TUTOR RN 19592 LETTER OF REPRIMAND Laurie Tutor, RN, entered into a Settlement Agreement, Stipulation and Order for Letter of Reprimand on April 7, 2011. A complaint was filed in February 2010, in which Ms. Tutor’s employer alleged she gave medications without an order from a physician, failed to perform complete assessments, and failed to properly document in the resident’s chart.

AMBER VARNER CNA 13154 REVOCATION On or about May 11, 2011, WSBN entered an Order of Default Judgment and an Order of Revocation against Amber Varner, CNA. Pursuant to WSBN Rules and Regulations, Chapter 8, Section 7(a), WSBN may enter an order of default based on the allegations in a petition and complaint against a respondent/licensee who fails to appear for a properly noticed hearing. Ms. Varner failed to appear at a properly noticed disciplinary hearing. Accordingly, based on the petition and complaint which alleged violations of the Nurse Practice Act through Ms. Varner’s actions related to criminal conviction and failure to comply with reasonable requests of the Board, WSBN revoked Ms. Varner’s CNA certificate.

28 WYOMING NURSE REPORTER
Insubordination: Aide’s Firing Upheld By Court.
A CNA was fired from her job for refusing to give a patient a shower as she was instructed by a nurse.

The CNA based her refusal on two reasons, which she communicated to the nurse: the patient was sick with cramps and vomiting; the patient refused a shower.

The CNA sued claiming her termination went against public policies against mistreatment of vulnerable patients.

The US District Court for the District of Nevada dismissed her case.

According to the Court, it is not necessarily wrong to give a patient a shower just because the patient has signs or symptoms of illness.
A certified nursing assistant does not have the education and training comparable to that possessed by a licensed practical nurse or registered nurse to be able to dispute the nurse’s judgment as to what is in the best interests of a patient.

A CNA flat-out refusing to follow direction from an LPN or RN on a patient-care issue is common, garden-variety insubordination, the Court said.

In this case the CNA did not have an employment contract or a union collective bargaining agreement.

As a common-law employee-at-will she had no legal protection against being fired on the spot at her supervisor’s discretion, regardless of the reason, assuming she was not being fired for refusing to perform an illegal act or an act which went contrary to public policy, which was not the situation in this case. Andrews v. HCR Manor Care, 2011 WL 1303230 (D. Nev., March 30, 2011).

The aide’s refusal to shower the patient based on her disagreement with the nurse over the patient’s best interests is common, garden-variety insubordination.

Skin Care: Large Verdict For Nursing Negligence.
The patient was fifty-five years old when he was hospitalized for hip surgery.

He developed bed sores on his heels during a re-admission to the hospital from a nursing home to treat an infection of the surgical wound. The lesions took more than fourteen months to heal.

The jury in the District Court, San Miguel County, New Mexico awarded the family $10,345,000 in a trial which took place two years after the patient had died from causes unrelated to his pressure sores.

$9,750,000, the bulk of the verdict, was punitive damages. The jury reportedly flatly rejected the argument that the inconsistencies in the chart were mere documentation errors as opposed to intentional falsifications. Gonzales v. Christus St. Vincent, 2011 WL 1491815 (Dist. Ct. San Miguel Co., New Mexico, February 18, 2011).

The hospital’s nurses failed to identify the risk of pressure sores and put in place a pressure ulcer prevention protocol. The patient should have been repositioned regularly and boots provided for the heels to relieve pressure. His nutrition was not monitored, nor were supplements provided as ordered by his physician. The medical chart was doctored in some places to indicate there were no sores while other entries indicated the sores were being treated, both of which were false statements.

Strep Infection: Misdiagnosis By Nurse Practitioner Leads To Large Settlement.
The patient received a settlement of $1,000,000 after having to have aortic valve replacement surgery after a lengthy and complicated bout with a bacterial infection.

Any details of the case which could possibly lead to identification of the patient or the defendant clinic or nurse practitioner
are to be kept confidential according to the terms of the settlement.

The gist of the negligence case against the nurse practitioner was that she neglected to do the research to make herself aware of the true nature of the bacterial infection which was revealed several times by the blood tests she was ordering.

The nurse practitioner apparently confused Strep viridans which showed up on the test results with Staph aureus, a bacterium common on the skin which can show up as a stray contaminant in lab draws.

Had the true nature of the infection been discovered in time it could have been treated with specific antibiotics and the patient would not have suffered heart complications. Confidential v. Confidential, 2010 WL 6442667 (Superior Court, Washington, November 7, 2010).

Lab tests ordered by the clinic nurse practitioner came back positive for Strep viridans. Strep viridans is often associated with bacterial endocarditis, a condition entirely consistent with the patient’s ongoing symptoms which were not yielding to the packet of antibiotics that she was being given.

Understaffing: Help To Bathroom Not Adequate On Night Shift, Patient Falls, Has Head Injury.

After hospitalization for pneumonia an elderly woman was admitted to a rehab facility for physical and occupational therapy and assistance with her ADL’s.

She had been living with her son and the plan was for her to return home with him when she was ready.

Four days into her stay she fell during the early a.m. hours while trying to make it unassisted to the bathroom.

She sustained several subdural hematomas which rendered this once basically independent person now wheel-chair-bound and dependent on others for 24/7 care.

The jury awarded her more than $2.2 million from the director of nursing, the administrator and the owner of the facility. The Court of Appeals of California upheld the jury’s verdict.

In court the jury trial lasted more than six weeks. The case delved into every aspect of the patient’s care including fall-risk assessment, care planning, medication management, use and non-use of restraints, diet, charting, bed height and the call button.

In the end, however, the jury’s decision reportedly turned on the simple fact the facility deliberately only put one person on the night shift, resulting in no one being available to help her to the bathroom when she needed to go.

The facility’s caregiving staff was fully aware of her fall risk, yet failed to provide sufficient staff to meet her safety needs.

The Court did reduce the jury’s verdict to $1.27 million pursuant to California’s damage-cap statute. Saucedo v. Cliff View Terrace, 2011 WL 680212 (Cal. App., February 28, 2011).

The jury heard expert testimony that the patient’s fall was caused by the facility’s practice of deliberately understaffing the night shift. Although two aides were needed on the wing where this patient was housed, only one was employed.

This practice of deliberate understaffing prevented the patient’s need for safety being met when she had to use the toilet, despite her known risk of falling.

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