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Greetings
From Mary Kay Goetter
Executive Director

Happy Nurses Week!
Belated, I know, because by the time you are reading this, the celebrations for Nurses Week will already be over. The preparation for this summer issue coincides with that annual occasion to reflect on what it means to be a nurse and, hopefully, to have experienced some gratitude and recognition for being part of the nursing profession. That is why we dedicate this issue of the Wyoming Nurse Reporter to celebrate nurses, particularly the leadership role of nursing.

Several months ago, we put the call out to nurse leaders and employers, asking for nominations of both recognized and aspiring nurse leaders to feature in this issue. We received six nominations for individuals who demonstrated nursing leadership and while we would have wished for more, this relatively small number meant we could print all six articles. I hope you will all join me in thanking and recognizing these nurses, as well as those nurse colleagues you work with every day for their leadership and service in the profession.

On May 4, I had the privilege to speak at the Sigma Theta Tau induction ceremony at the University of Wyoming. Sigma Theta Tau International is the honor society for nursing,

Continued on next page
In our hectic workload, clocked in at busy offices, hospitals, schools, or agencies, it is all too easy to focus merely on the job at hand. There is always a to-do list, medications to be passed, treatments due or coursework to be covered and it may be difficult to see honor and integrity in the mundane. Yet, in even those most ordinary of tasks, there is always a larger purpose: the underpinning of integrity, or honor.

As a regulatory board, we often concentrate our time and attention to those nurses who have had a failure of integrity, who have strayed from a “keen sense of ethical conduct” and brought dishonor to themselves or their profession. I am frequently told by nurses around the state that the first thing they do upon receiving their copy of the WNR is to turn to the back pages and read the discipline report. This time, if you have not done so already, I ask you to read through the entire publication (maybe even in order!) and read the stories of leadership, courage, integrity and honor first. Perhaps by grounding ourselves first in the honorable part of the profession, we can reclaim the awareness of honor in our own daily practice.

I borrowed heavily from “The Founding Fathers on Leadership” when I spoke to the inductees at Sigma Theta Tau and I would like to conclude with a quote from Abraham Lincoln:

“I am not bound to win, but I am bound to be true. I am not bound to succeed, but I am bound to live by the light that I have. I must stand with anybody that stands right, and part with him when he goes wrong.”

Even though Nurses’ Week is past, I extend my sincere appreciation and regard for each one of Wyoming’s nurses. May you always stand true, with honor and integrity for yourself and for the profession.

A Message from Tracy Wasserburger
President of Wyoming State Board of Nursing

Recently, I was lucky enough to go away for a very enjoyable weekend with four of my favorite girlfriends. There is a group of us that try to craft out time away every couple years with each other and imagine the fun we have when all nine of us get to be there! Given the dynamics of this group, there is always a “self-help” project that seems to edge its way in to what was supposed to be a fun, non-working, quiet get away (in what can be a very loud group!). We’ve tackled topics such as politics, movie reviews, life and love, to actually taking on educational growth where we’ve had presentations on nutrition, women’s health, exercise, and the art of choosing a good, cheap wine. One year a cookbook was actually produced! This year though, it was decided that we should complete the “Strengths Finder 2.0” based on the “Discovering your Strengths” developed by Gallup. The purpose of this exercise was to help us do some soul searching, help us to capture and recognize our strengths and use these strengths in our careers and with our families. It now seems ever so timely with the WNR capitalizing on the theme of “Leadership” for this edition.

The purpose of my note to you is not to provide yet another lecture on the attributes and philosophies of leadership, but to encourage you to take the time to look inward to see what strengths you possess. These strengths then can be used whether you are a formal leader (actually have a job that dubbed you with the title of leader), or informal leader (a member of a team). We can’t always control or influence who we work for, but each of us can use our strengths no matter what role we may carry professionally. This is the true premise of intrinsic leadership. Harold Gennen sums this idea up well with the statement “Leadership is practiced not so much in words as in attitude and in actions.”

How many times in our lives have we heard “You can be anything you want to be, if you just try hard enough!”? I spent countless hours growing up ice-skating with my sister during the long winter season in WY. Bear in mind, this activity was on the frozen creek on our ranch, riddled with frozen cat tails and cotton wood trees. We had numerous hours of fun dreaming of how fun it would be to skate like Peggy Fleming (showing my age there!). Needless to say, I did NOT get to be the romantic, graceful skater that I dreamt of, despite believing I really had given it a hard try. Embracing the “you-can-be-everything-you-want-to-be” mantra is something we never outgrow. We need to allow for an entire lifetime of progression with specific roles that fit our talents.

“A good leader is someone who will inspire us to be what we know we could be,” as said by Ralph Waldo Emerson. You certainly do not have to be in a position of true authority to inspire others. This can simply be applied in any day to day context both at home or at work. When we focus our energy into developing our own natural talents, or recognizing those of others, extraordinary room for growth exists. Developing our strengths gives us the ability to best see “where we can fit in” and contribute to the team. Strength based approaches uses the positives to improve our confidence, direction, hope and kindness towards others.

There is a difference between leadership and management. Management is of the mind, more a matter of accurate calculation, of statistics, of methods, timetables and routine. Its practice is a science. Leadership is of the spirit, compounded of personality and vision. Its practice is an art. “Managers are necessary; leaders are essen-

founded in 1922 at Indiana University by six students who sought to bring recognition for nursing as a science. The society has grown since then—360,000 inducted and 125,000 currently active members. Their mission is to build nursing scholarship and leadership, two areas of immense need in the nursing profession today as it strives for relevance and voice in the current climate of healthcare reform. The name, Sigma Theta Tau comes from the Greek words Storge, Tharsos, and Time (love, courage and honor).

The presentation I gave to the inductees focused on leadership, but also spoke to the concept of honor. If you read any list of leadership characteristics you won’t find love, you might see courage, but you will definitely see integrity; and honor is closely related. In fact, the Merriam Online Dictionary defines honor as “a keen sense of ethical conduct” and lists “integrity” as a synonym. It would be to skate like Peggy Fleming (showing yet another lecture on the attributes and methods, timetables and routine. Its practice is a science. Leadership is of the spirit, compounded of personality and vision. Its practice is an art. “Managers are necessary; leaders are essen-
Dear Editor,

A couple of months ago I was sitting in my room unwinding from my day and was overcome with the desire to express, in writing, what I was feeling at the moment. I wrote the following, I guess it’s my first poem, although it doesn’t rhyme. It sat buried in paperwork on my desk until today. A friend phoned just as I finished reading it. Although embarrassed, because it’s sharing at a pretty deep level for me, I read it to him. He also being a Nurse appreciated what I had written and felt a little inspired. My friend suggested I share this with other Nurses and encouraged me to mail a copy to you, Mary Kay Goetter at the Wyoming Nurse Reporter. If you would like to share this by publishing in the Reporter, I approve and consent. If not, I hope you enjoy the read:

The moon sets, the sun rises, My day begins.
My Armor...Strength, Compassion, Empathy and Love.

Each day is like painting a new masterpiece full of Color, Life and Death.
Each day holds Smiles, Laughter, Tears and Pain.
I give everything, at times, more than I have. No greater blessing than to share in part of people lives, especially when they need it the most. Throughout my day, I am a pillar to all.
The sun sets, the moon rises, my day is ending.
My armor gently lowers.
The strength, the shoulder to cry on can feel human once again.
It is ok to be weak and weep now, no one is watching.
God, my family, my friends, they are the pillars, the strength, the shoulders I fall upon.
They replenish my soul and allow me to rise again each day.

Sincerely,
Charlie Schoenwolf LPN
pecialty nursing certification has become increasingly popular. Since 1990, more than 250,000 nurses and more than 80,000 advanced practice nurses have received certification from the American Nurses Credentialing Center, the Silver Spring, Md.-based organization reports. Nurses may wonder whether the benefits outweigh the costs, or if specialty certification is necessary. With some advocates of specialty nursing certification claiming it is practically a requirement, must an RN be certified to compete for jobs?

**Value of Certification**

“Specialty nursing certification is voluntary,” said Ellen Swartwout, RN, MSN, NEA-BC, director of the ANCC Certification Program. “But at ANCC we have seen a trend toward increasing popularity for specialty nursing certification. RNs want to validate their specialty skills and experience.”

Some studies indicate earning specialty nursing certification has potential benefits that include greater job satisfaction. Research studies reported in the American Journal of Critical Care’s May and November 2010 issues found certified nurses have greater job satisfaction than their non-certified peers and certification boosts a nurse’s professional confidence and sense of workplace empowerment.

One nurse found certification validated her knowledge among co-workers. “Once I passed my certification board exam, the physicians seemed more respectful of my opinions,” said Becky Lasley, RN, BSN, ONC, a certified orthopedic nurse at Forsyth Medical Center, Winston-Salem, N.C. Lasley, president of the board of directors for the Orthopaedic Nursing Certification Board, said certification showed her commitment to lifelong learning and she expected no financial benefit from it.

Data are mixed on whether certified nurses earn a higher salary. A Nursing 2006 salary survey of more than 1,100 nurses who subscribe to the publication found RNs who hold certification in a specialty area earn $7,300 a year more on average than uncertified RNs. However, a study in the September 2011 Journal of Continuing Education in Nursing reported pediatric nurses perceive a lower relationship between salary and certification than other measures, such as enhanced professionalism.

Anecdotally, some healthcare facilities give a bonus for earning certification and some nurse managers prefer to hire certified nurses. “Certification is definitely a plus

Continued on page 8>>
Wyoming Nurse Reporter

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when I am reviewing nursing applications for my unit and the candidates are otherwise equal,” said Kim Saxton, RN, nurse manager of the medical ICU at Ohio State University Medical Center in Columbus.

Saxton said almost 50% of the nurses on her unit have certification in critical care or progressive care nursing. “Families seem to feel more confident about a nurse’s ability to care for their loved one once they understand that the initials [on the nurse’s identification badge] mean their nurse is an expert,” Saxton said.

Indeed, certification may lead to improved patient outcomes. A study in the June 2011 issue of the Journal of Nursing Scholarship shows a link between nursing specialty certification and better clinical outcomes, including lower inpatient mortality. Other studies have found that certification is associated with fewer medical errors, according to ANCC.

“Certification indicates your commitment to patient care. It’s something nurses are very proud of,” ANCC’s Swartwout said.

An ongoing study should shed more light on whether certification affects clinical outcomes. The American Board of Nursing Specialties is sponsoring a study of trends in specialty certification of RNs in acute care hospitals and the connection between certification and specific patient outcomes. According to the ABNS, the research project uses the National Database of Nursing Quality Indicators.

How to Search For a Certification Program

Nurse experts recommend the following steps in beginning the journey toward certification:

• Ask advice from a board-certified colleague or supervisor.
• Search your specialty nursing organization’s website. It may have a certification link.
• Search among the member organizations of credentialing bodies. Those for nursing certifications include the American Board of Nursing Specialties (NursingCertification.org/membership-directory-regular.html) and the Institute for Credentialing Excellence (CredentialingExcellence.org/NC-CAAccreditation/AccreditedCertificationPrograms/tabid/120/Default.aspx)
• Search certification review materials. At PearlsReview, a subscription-based collection of nursing specialty certification reviews from Gannett Education (PearlsReview.com/courses.aspx), each specialty review page contains links to the certifying organizations for that specialty’s exams.

Some certifying programs and specialty nursing associations have volunteers who help peers through the certification process…"

What’s Standing in the Way

Despite the benefits, most U.S. nurses are not certified. Among the barriers to pursuing nursing certification is the cost of the exams, an ABNS survey found in 2006. Initial certification exams in 2011 typically cost several hundred dollars or more, although discounts are available for members of the board’s affiliated nursing organizations, such as the American Nurses Association for ANCC exams.

Nurses also must meet eligibility requirements, which vary by certification. Generally, licensed RNs must have a certain amount of nursing experience and clinical and continuing education hours to be eligible for ANCC specialty nursing certification. For instance, ANCC criteria for certification in med/surg nursing requires candidates to have worked two years as full-time RNs and have 2,000 clinical hours and 30 continuing education hours in the field in the past three years. Other organizations may have no continuing education requirement. Eligibility criteria to sit for the CCRN certification exam from the American Association of Critical-Care Nurses Certification Corp. include 1,750 hours in bedside care of acutely or critically ill patients during the prior two years, with no requirement for continuing education. Advanced practice certifications have educational requirements as well.

Study Guides

For some nurses, the concern is how to find the time and discipline to study for the exam while juggling work and family responsibilities. Nurses can make their study goals more attainable by studying over a longer period, Saxton recommended. The ANCC suggests about six months of study before taking the certification exam.

However, ONCB’s Lasley said how long to study is an individual matter and that some orthopedic nurses have found six weeks is enough time to prepare for the ONC exam.

Saxton suggested a peer study group to prepare for a board exam. “Having a support system helps nurses achieve their goal. It gives them accountability,” she said.

Finding a mentor also is recommended. Some certifying programs and specialty nursing associations have volunteers who help peers through the certification process, such as the ONCB’s certification mentors called Ambassadors.

Review seminars are available at hospitals and nursing schools across the country as well as online sites including NurseCredentialing.org for some ANCC specialty certification exams. The credentialing center gives applicants a 90-day window to take the exam after deeming them eligible.

ANCC nursing certifications are valid for five years before requiring renewal. Swartwout said most nurses renew their certification through professional development rather than testing.

Kathleen Louden is a freelance writer. Post a comment below or email specialty@nurse.com
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May we hope that when we are all dead and gone, leaders will arise who have been personally experienced in the hard, practical work, the difficulties and the joys of organizing nursing reforms, and who will lead far beyond anything we have done
— Florence Nightingale

On April 11, 2012, 50 health care and nursing leaders gathered in Casper in a “Day of Dialogue” to talk about the future of nursing and nursing leadership in Wyoming. Most nurses already have experience, intelligence and creativity to provide exceptional patient care. Yet, the future of our health care delivery system requires something more. The transformation of our health care delivery system requires nurses to become exceptional leaders ready to advance care across the entire health care continuum. The overall purpose of the Day of Dialogue, sponsored by the Wyoming Center for Nursing and Health Care Partnerships (WCNHCP) and the Wyoming Nurses Association (WNA), was to begin the process of creating a preferred future for nursing leadership in Wyoming. More specifically, the Day of Dialogue will help the WCNHCP and WNA build on the successes of the Wyoming Nursing Leadership Institute (WNLI) and expand the leadership competencies and curriculum to prepare future Wyoming nurse leaders.

It was a fantastic day with a constant chatter and a continual buzz as people discussed their ideas of what nursing leadership could look like in Wyoming. The morning started off with a thought provoking presentation by Dr. Susan Hassmiller, the Robert Wood Johnson Foundation Initiative on the Future of Nursing at the Institute of Medicine (IOM), providing a national perspective on nursing and nursing leadership. She provided background on the IOM Future of Nursing report overall recommendations, which focus on education, practice, collaboration, leadership and workforce data (see http://thefutureofnursing.org/ for more information about the recommendations).

In order to reach these goals, the RWJF and AARP have partnered to develop the Future of Nursing Campaign for Action. She highlighted the need for nurses to bring their voice and point of view to management and policy discussion. She also emphasized the need to develop nurses to provide leadership at every level, specifically lead efforts to improve health care quality, safety, access and value. She challenges the participants with the paradox that while nurses are routinely viewed as very trustworthy and are the largest group of health care professionals, very few nurses serve as hospital board members. Opinion leaders in a recent Gallup poll noted that nurses should have more influence in reducing errors, increase the quality of care and promoting wellness. She ended up giving us a clear challenge…. To take up the mantle of leadership and follow Florence Nightingale’s charge!

Following Dr. Hasmiller’s presentation, Jean Scholz, consultant to the Wyoming Nurse Leadership Institute, lead the group through a very interactive process to create a new vision for Wyoming nursing leadership. Participants started by discussing what the future would look like if we just kept doing what we are doing now. While
there were some positive things about this future, e.g., the increased use of APRNs, there were many not so positive things as well, such as continued lack of nursing presence at key tables. Ms. Scholz dramatically tore up this expected view of the future, and the group settled down to create a preferred vision for nursing leadership. This preferred vision for nursing leadership includes a variety of different components:

- Clear recognition of nursing’s professionalism
- Advancement in the use of technology
- Stronger nursing leadership, e.g., policy makers using nurses as a top resource when making health care related decisions.
- Nursing education is transformed through ReNEW
- Collaboration across all members of the health care team using evidence-based practices
- APRNs and care managers provide and share access to health care through a nursing model
- Nursing mentorship and support.

The next steps are to develop a “Design Team” to work towards implementing this preferred vision of nursing and nursing leadership. This vision of what nursing could be will be critical as we work to continually improve the Wyoming Nurse Leadership Institute. What kind of curriculum and experiences do WNLI participants need in order to provide “health care through a nursing model?”

If you have input or want to be involved, please let us know. We’d love to involve you!

The WCNHCP is the nursing workforce center and Action Coalition 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.
Wyoming Nurse Reporter sought nominations for this issue on Great Nurse Leaders in Wyoming from hospitals and nurses around the state. In this issue you will meet 6 nurses who were recognized for their leadership qualities by their colleagues.

Great Nurse Leaders in Wyoming

Stacy Legler

Jenea Goddard RN, BSN, CCRN, WMC Intensive Care Unit Manager at Wyoming Medical Center wished to recognize Stacy Legler RN.

Jenea told us, “Stacy Legler has been a nurse since May 2009. She works on both the Progressive Care Unit and the Intermediate Care Unit. She is a great team player and has great respect from her co workers as well as the physicians at Wyoming Medical Center. Stacy is definitely a patient advocate with compassion and a heart of caring for her patients. She has a great sense of humor and helps lighten the mood when needed around the units. Her laugh is contagious as well as her smile.

Stacy personally engages with her patients and the families and has been recognized in many WOW cards and other letters. She is able to keep her biases to herself and not judge. She is a true professional with a caring heart and has been seen talking, laughing, crying, and being authentically present with each of her patients. She has moved into a mentor role and is a resource for newer nurses as well as a great preceptor. Stacy was born to be a nurse and she is an awesome one!! WMC is truly blessed to have her.

We asked Stacy to tell us about her leadership style and who was instrumental in her life in developing it and this is what she told us:

I don’t often think of myself as a mentor or leader. As I am still a fairly new nurse and do not always see myself filling those roles. I’ve had some great leaders in my life though. The most influential leaders for me have been my family, and as I have grown I have encountered a few others who have inspired me in one way or another. Some of the top traits I find inspiring in a leader include the ability to be respectful and respected, leading by example, continuing education, and dedication and accountability.

I believe that leadership, like so many other things in life, is learned. I had the privilege of growing up in a large, close-knit family, surrounded by incredible role models. When my parents married they joined two tremendous families anchored by my grandparents. These two women were tremendous examples of what it meant to be respectful and kind. They met people with a genuine smile, and they weren’t afraid to get their hands dirty. They showed respect to all people and were, in turn, well respected in their communities. As author and public speaker Steve Farrar once said, “Every significant relationship in your life has your fingerprints all over it- the fingerprints of your character. And those impressions on another person’s life are true indications of what your character is really like.” I know that as a nurse, how I choose to interact with people can leave a lasting impression. What that impression will be is ultimately my decision.

Part of earning and maintaining respect comes from leading by example. My parents made this value one of the key building blocks of my development into an adult. Both continually illustrated what “to lead by example” truly means. My father had tremendous leadership skills, which unquestionably stemmed from his work ethic. He gave 110% all the time, whether it was at work, at play, or at home with his family. Dwight Eisenhower said it best when he said, “The supreme quality for leadership is unquestionable integrity. Without it, no real success is possible.” My father was, in my eyes, a true example of integrity, dedication and accountability. These were traits he often spoke of throughout my childhood, and he set the bar high for us as adults. He and my mother encouraged me to get involved with the things I care about, and always be part of the solution to the problems I encounter. As a Nurse, I have been able to join several different specialty-based committees. Through these, my passion for nursing continues to increase, as I am able to be a part of solutions and help to improve patient care. My father showed me what it meant to be actively engaged in everything, he accomplished many things in his life and, like a true leader, inspired others to do the same.

My mother is and has been an incredible mentor to me throughout my entire life. My passion for nursing is due, in part, to her. She is also a nurse at Wyoming Medical Center. Through reading, researching, and teaching, my mother is the embodiment of continuing education. While there is no question that continuing education is vital to any leadership role, it is doubly important in healthcare. She taught me that as a nurse, I should always be learning—working to improve my practice through broadening my knowledge base. She encouraged me to see the questions that I have as opportunities to educate myself and learn. Most importantly, she has taught me that the ability to realize what you don’t know is invaluable in healthcare and necessary to become a great leader.

My family always stressed the importance of finding something to love, and to then dedicating your heart and time to it. In High School, I found that first something
was Track and Field. I had an inspiring coach who rewarded and respected hard work. He pushed me hard as an athlete, but always rewarded my efforts. He was the first person outside of my family to recognize me as a leader, and he helped me grow in that role. Through him, I learned how important it is to acknowledge the hard work of others. There is a quote by John Quincy Adams that states best what Coach Willy taught me. “If your actions inspire others to dream more, learn more, do more, and become more, you are a leader.”

The truth is, I have been graced to be raised by and live amongst inspirational leaders for my entire life. That tradition continues at Wyoming Medical Center, where I am surrounded by people who demonstrate the qualities that my parents have tried to instill in me. In my leadership endeavors, I will continue to learn from those people. We are always presented with opportunities to improve, and every day we set the example for each other. My dad loved a particular quote from Theodore Roosevelt. He said, “Far and away the best prize that life has to offer is the chance to work hard at work worth doing.” Nursing is most definitely work worth doing, and I am honored to have the opportunity to do it.

Stacy M. Legler BSN is a graduate of the University of Wyoming and works as an RN at Wyoming Medical Center on the Progressive Care Unit, and Intermediate Care Unit.

Heidi Tatum & Erin Rooney

Heidi Tatum and Erin Rooney lead the department of Women and Children’s Services at Cheyenne Regional together. They shared some of their toughest leadership dilemmas with readers.

Tell us about a situation where you solved a difficult problem. Why was it hard? What did you do? How did it turn out?

One of the hardest things to do as leaders in an environment that is constantly changing is to communicate necessary information to our team. We identified that the inability to communicate effectively with a large variety of staff on multiple shifts hindered moving our unit forward. We needed to assure that information that was communicated was consistent, correct, and timely. We had tried traditional methods of communication: staff meetings, emails, postings, but found that we continued to struggle in this area. We do feel that it is important for our team to receive information, also understanding that the lack of information or miscommunication can lead to frustration. We found that by time information had been disseminated, the message had been distorted and did not resemble the information that we originally shared. Because we wanted staff to have opportunities to ask questions about the information, we recruited the help of our charge nurse team. Each of our charge nurses act as a one-stop for individuals on our team to help relay information in a timely manner. We discussed with our charge nurses what tough questions that our staff might have and worked through messaging and solutions.

The first trial of our new communication flow was during an implementation of hospital behavioral standards. Sharing this information was vitally important, and our charge nurses were crucial in helping to disseminate the information. Each of them met with those on their ‘one-stop’ team and communicated the information that we had discussed. Within three days, we were so excited to celebrate that our entire team had received the information. Not only had they received the information, but our team was calm about the changes because they had the information that they needed and the opportunity to ask questions and talk about concerns.

Tell us about a time when you took a “well informed” risk. What was the downside? How did you sort out the risk? How did it turn out?

A time that we took a well-informed risk was during the implementation of bedside reporting. Receiving report in the break room had become a tradition among our nursing staff. Our unit had previously attempted to roll out bedside reporting but had been unsuccessful in sustaining it. Bedside reporting was viewed as being too difficult.

Understanding where our staff was coming from, we brought a small group together to discuss where the original process failed and what opportunities we could gain from this. We persevered, knowing that it was the right thing to do for our patients and our team.

We round on our team each month to gather feedback. During recent rounding, team members shared that they overwhelmingly support bedside report. Our team is more cohesive and has witnessed incredible success with our day/night collaboration. Nurses feel that they are able to provide safer care to their patients because the information they receive is more complete and accurate. At this time, our nurses involve the patients in their care and have an opportunity to ask them what other information is vital to their experience. We have also seen an increase in our patients’ perception of quality in communication among caregivers.

Describe how you manage the competing priorities at work and other life commitments. What do you do when there is too much to do?

As nurse managers, it can be difficult to find balance. However, it is so important to our well-being and impacts the ability to lead others. Both of us are moms of young children with multiple demands for our time. We struggled with balance early on in our leadership careers. As we have learned

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and grown in our leadership ability, we have found that extending trust to our team members has greatly impacted our ability to find balance. We trust that our team members have the skill and ability to help implement changes, monitor day-to-day activities and make independent decisions. This has allowed us to focus on other priorities, such as building our team and moving forward. As Grandma used to say, “Many hands make light work.” But this only works when you can trust your team and they can trust you.

Heidi Tatum, BSN, RNC-NIC
Clinical Nurse Manager Pediatrics, Special Care Nursery, Laramie County WIC Clinics Cheyenne Regional Medical Center

Erin Rooney, BSN, RNC-OB
Clinical Nurse Manager L&D, Mother/Baby Unit Cheyenne Regional Medical Center

Teresa Wright

“There was a time when I thought brains were everything. That view has dimmed recently. I think brains are important, but now I also look for good team-builders, good communicators, and courageous people who do not get stuck with an idea. You need people who are more nimble, who have the ability to lead organizations in changing and tumultuous times comfortably, without panicking.”

Larry Bossidy, CEO, Allied Signal, Inc.

What is leadership? Without thinking deeply about what constitutes an effective leader, I suspect we can all recall good and bad leaders whether in our past or currently.

The task of leading is changing. Gone is the traditional old-style command and control, autocratic model of leadership. Today there is a more inclusive style of leadership — one that abandons the hierarchical, secretive and change-adverse style to an open, collaborative and risk-tolerant model. Leadership is no longer about control, coercion and disempowerment but about inspiration, facilitation and empowerment. Leadership is consensual, relational, web-based, caring and transparent.

Leadership is now viewed as a series of concentric circles. No longer is a leader at the top of a pyramid. Rather he or she occupies an innermost circle where a leader must first know themselves to achieve self-mastery. Leadership is a journey that starts internally with self-control, initiative, adaptability and trustworthiness. A second circle, containing the first, represents the organization of which the leader is a part. After self leadership, a leader leads this larger group. The third, outer circle represents a multitude of organizations with which to cooperate, coordinate, and partner collaboratively. This form of leadership requires one to listen and learn from others around the outer circles and, most importantly, from those even completely outside the circle. These circles continue to ripple to denote levels of the individual, the organization, community, and society at large.

Leaders think globally and act locally. They should be good managers and possess leadership skills. Managers ensure smooth functioning of the system; leaders are the change agents. Leaders actually sell the vision and inspire others to also achieve and they practice through action planning. They should be systems thinkers as they set priorities. They try to prevent problems by being proactive and not reactive. They form leadership teams and coalitions to tackle issues while they share a strong belief in a sense of community as they work with a variety of community leaders to affect change.

And leaders practice what they preach. They try to balance work and home life, emulating the programs and policies they espouse. Leaders are committed to personal growth because high self esteem engenders the ability to inspire others.

Leaders must be knowledge synthesizers. They need to be creative. They should create, share and demonstrate a commitment to a vision. Leadership requires mentoring. Leaders foster and facilitate collaboration as they serve as colleague, friend, and advocate for others.

They need to possess entrepreneurial ability. They implement innovative ideas and they must be effective communicators.

Of the top eight leadership traits and abilities are technical skills, friendliness, task motivation and application, support for the group, social and interpersonal skills, emotional balance and control, leadership effectiveness and achievement, and administrative skills. The top ten characteristics of admired leaders are honesty, the ability to be forward-looking, inspiring, competent, and fair-mindedness.

My personal definition of leadership is one of team management. I feel I am very much the optimist and I’m extremely sensitive to those around me. I stay positive and focused. I am a visionary but I can also see the basic nuts and bolts of how to make things run smoothly. I enjoy collaborative, team efforts and I definitely see the importance of rewarding, retaining and recognizing others, valuing their judgment and skills. The leadership style that I support is when the level for employees and production is high, then trusting, secure relationships develop and most, if not all, employees feel a commitment to the organization.

A “best” leadership style does not exist. Rather situational leadership is a theory that adjusts to different situations, allowing different strategies for different employees. The leader matches the style of the current situation to maximize human productivity and satisfaction. Of the various leadership styles — coercive, authoritative, affiliative, democratic, pacesetting, coaching — coaching is the one that is highly supportive and highly directive.

And so, just how is leadership conceptualized and exercised? How
would you answer the following questions when considering your style of leadership?

Do the members of my team trust me and each other?
Are my actions consistent with my words?
Are my team members and I honest with one another?
Is information readily shared?
Do I keep my commitments to team members?
Do they keep their commitments to each other?
Do my team and I listen effectively to one another?
Do we address disagreements and other conflicts proactively and responsibly?
Do we value differences?
Is my work environment inclusive, engaging, and empowering versus exclusive, controlling and patronizing?
Do I foster cooperation and information sharing with other departments?
Does my team have fun at work?
Do we celebrate together as a team?

There is dire need for a new definition of leadership to include cooperation, flexibility, egalitarian team playing, and broader perspectives. Nurses, and I feel women in particular, make good, even great, leaders because they are ideally suited to this evolving leadership style. As Sally Hegelsen says in The Female Advantage, “women are knocking on the door of leadership at the very moment when their talents are especially well matched with the requirements of the day.” And it was Albert Einstein that said, “The significant problems we face today cannot be solved by the same level of thinking that created them.”

Teresa Wright, BSN, MPH, CHES, is a Robert Wood Johnson Foundation Scholar and a 2011 graduate of UWs Fay Whitney School of Nursing BRAND Program. She resides in Cheyenne, WY & Steamboat Springs, CO as she pursues her nursing interests in prevention, promotion and public health nursing.

Dani Johnson

Dani Johnson will be a senior this fall at the Fay W. Whitney School of Nursing at the University of Wyoming where she’s currently serving as president of the Student Nurses Association on campus, is involved with “The Betty’s” women’s a capella group, team leader of an Alternative Spring Break trip, leader in Navigator’s campus ministry, and works as a CNA. Dani was nominated based on her current leadership skills and her future leadership potential. We asked Dani to tell us about her vision for the UW Student Nurse’s Association and her own leadership style.

Tell us about a time where you had to set a vision. What was the issue facing the organization? How did you develop the vision? How did you deploy? What did this change?

The biggest vision I have set is for the UW Student Nurses Association (UWSNA). The past presidents and officers have done great work and grown our group by leaps and bounds, but Wyoming still has a long way to go in expanding this professional organization. Our vision for UWSNA is to serve those in our community, increase our knowledge and experience in the field of nursing, and begin building relationships and networking through this professional organization at a collegiate, state, and national level. The issues we have facing our organization are:

• the small number of people in our school and state
• the fact that we are not tax exempt
• at times, a lack of interest in joining the group

Our vision began its development when the new officers were elected in January and has continued to expand as we have had more experiences at a larger level. The officers of UWSNA travelled to Pittsburgh, PA for the National Student Nurses Association Annual Convention in April. We learned so much and brought back new and exciting ideas to complete the vision we have set for our group:

• We are going to be bringing in speakers to our meetings from different areas of nursing
• We will be helping out with orientation when the first-year nursing students come in

• And one of our biggest projects we are working on is developing a Wyoming State Student Nurses Association, since Wyoming is one of the only states that currently does not have one

I have discovered that we have complete support from our faculty -- which is incredible

• There is more and more interest from students in joining as we continue developing this new vision.
• There is much more positivity throughout members, faculty, and the school, and while we have seen so much change from January, we still have so far to go.
• I look forward to seeing the vision of UWSNA continue to further develop and make a difference in Laramie and right here on campus!

How would you describe your leadership style?

My leadership style is definitely leading by example. I believe that people in a group are going to follow what you are doing instead of what you are saying. I make it my goal to work hard at everything I do, and encourage others to do the same and work alongside me in this!

I also believe that it all comes down

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to love, and this is shown in two ways: first of all it is shown to the people your group is serving, and second of all it is shown to those involved in the group. People can tell when you genuinely care about them, and as a leader I strive to make sure everyone knows that they are cared for and appreciated.

I am a firm believer in open and honest communication. While leading this group, I do my very best to communicate effectively with everyone involved and facilitate open communication between all members.

And of course, there is always the fun side. As a leader, you have to make time for fun and laughter for the group to really bond and work well together. I do my best to make service projects enjoyable and schedule time to have a good time and form relationships.

Finally, as a leader you have to be real. You need to be able to be honest about what you have gone through to get to where you are and be relatable to those in the group. This will help you form genuine relationships with people and be able to make a difference together!

Nancy Wright

I retired two months ago after working 30 years at Riverton Memorial Hospital. Nursing was a second profession for me but it certainly was what I was called to do after teaching elementary education and working in the corporate business sector for a few years. My only regret is that I didn’t go into nursing right out of high school, but with so many decisions in life it takes maturity to realize your direction.

In 1985 I graduated from the first nursing class at Central Wyoming College and went to work in the ICU at Riverton Memorial Hospital. I always knew I wanted to be an ICU nurse even before I started nursing school. I was the first new graduate that was hired for ICU and was interviewed by the whole ICU staff. This was the first test of my ability to survive under stress. I knew I was going to work with some experienced nurses whom I respected for their years of clinical knowledge.

In those days orientation was done by way of on the job training. None of the wonderful programs we currently have existed at that time. My orientation was exactly thirty days and then onto the night shift with a peer to answer my questions and oversee my job performance. I knew that in order to survive, provide excellent care to my patients, and not disappoint those nurses that put their faith in my abilities I had to do more than just listen and observe to learn Critical Care nursing. So to lessen my anxiety I enrolled in a pathophysiology course, pharmacology course and a graduate level nursing assessment class from the University of Wyoming outreach program. I also read the entire Critical Care Nursing text that the AACN had written just in case I missed something. I learned to develop a clinical curiosity about each patient and to try and assess what was happening on the cellular level so that I could develop a plan of care during each shift I worked. My daily personal goal was to make a difference in patient out comes, to support and educate the family and deal with each situation with respect and compassion.

I thrived and grew in this setting and starting taking more classes so that I could get my BSN.

In the spring of 1991 I graduated from the University of Wyoming with my BSN and that same spring I was selected to manage both the ICU and ER departments. The first month I was in my new position I lost one third of the staff to the new Home Health Agency the hospital had created, and found myself working 70 hour work weeks. I knew the only way to provide the FTE’s needed for ICU coverage and survive as a new manager was to make mandatory cross training between the ICU and ED nurses. Initially the idea of cross training was met with anger and threats of mutiny from the staff. I felt that if you sat down with the staff and explained your needs and listened to their concerns and wishes a solution can be obtained. Having just completed a short course on management in my BSN program I decided I needed to know what the barriers were to achieving my goal as a manager. So I developed a questionnaire regarding my management strengths and weaknesses. My boss as well as a nursing instructor I had in my BSN program told me I was extremely brave or crazy to have the staff fill out such a questionnaire, but this questionnaire was the icebreaker in a wonderful working relationship I developed with the staff and I used it yearly with modification to get an understanding of my growth as a leader as well as provide the staff with a confidential tool for communication. The questionnaire was tallied by our HR department and I went over the results with the staff in our staff meeting. The questionnaire helped develop a mutual trust between the staff and me. Within less than a year I was able to cross train the majority of the department, and from that cross training the ER nurses developed an ease with their MI patients and all the care involved. This was before Core Measures but within two years we had a door to drug time for thrombolitics of 26 minutes. I also encouraged the staff to obtain certification in either ED and/or ICU nursing I lead by example by obtaining both certifications. In a short period of time 100% of the ED nurses were certified and 50% of the ICU nurses and I started providing more opportunities for staff education and rewrote the job descriptions to reflect mandatory educational requirements for the ER nurses.

One of the most challenging goals I had as a leader was in 1994 when I was asked by our administration team to manager all the outpatient departments as well as the ER and ICU. The other departments were the laboratory as well as the imaging and cardiopulmonary departments. I jumped into this management challenge with the same attitude I had when I first went into management and that was to trust that each employee was there to do the best job they could and I was there to
provide them an environment where they could function to their highest level of expertise. Outpatient departments are driven by not only the revenue that they generate from inpatients but more so by the out patient referrals from physicians. In an effort to provide good customer service to the physicians’ offices I first had to understand what they needed from us for their patients. I visited each referring physician office in our community and once again asked the hard questions regarding what they needed from us to provide good customer service. Each office had some unique needs but the main complaint had to do with making numerous calls to schedule their patients’ tests. I then met with our receptionists and outpatient clinical staff and we set up a central scheduling line for one stop shopping. This was the first and probably the most important change I made for the patient and their physician. Over the next five years I made additional visits to the physicians’ offices to resolve problems and to assess what they needed in their practices that we could offer. Managing that number of departments certainly presented daily stress but I found that every day was different and that what I liked best was that everyday was going to be different. During this time I was selected as the Department Manager of the Year for our hospital corporation and I was very humbled but honored that hard work, respect and trust in your employees pays off for the patient, the community and for yourself.

In 2000 I left management and went back to bedside nursing and at the same time became the Staff Education director for the hospital. In a small rural hospital you are always asked to multi task whether it is in management or patient care. I felt I had gone full circle and was back to teaching only this time it was nursing not elementary education. I expanded the clinical education department and starting offering more in house education opportunities to all clinical staff as well as physician CME. I had taught BLS since 1977 and ACLS since 1991 in addition to my other jobs but saw a need to become an instructor trainer for the AHA in BLS as well as ACLS. This helped our hospital provide more classes on a routine basis and I was able to mentor more instructors in BLS, ACLS and eventually PALS that benefited our programs.

Always wanting to try something different I started doing Infection Control in 2004 along with staff education. I continued these jobs along with a couple of interim management positions until the day I retired. Infection control and prevention is an academic clinical practice based on the cellular level. It demonstrates how clinicians affect patient outcomes by the simple procedure we do daily and when these procedures are done incorrectly or without regard to the process we can cause harm to the patient, ourselves and the community. I loved Infection Prevention and found it to be extremely interesting. It put me into a different type of management because as the infection prevention and control nurse you manage the whole hospital and keep it and the staff safe.

Nursing is a diverse profession and can take you in many directions and hospital nursing can be as diverse as you want to make it. I have had wonderful experiences in nursing by just staying in one place for thirty years. It certainly has provided me an interesting nursing career with no regrets.

Nancy Wright, RN, BSN
Grounds for discipline for Licensed Professional 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).

Finalized Board Orders are accessible under the “Discipline” tab at our website: http://nursing.state.wy.us.

Please be advised that several-licensees may have the same name and the only positive verification is by license number. Every discipline case is considered separately by the Board and multiple factors can affect the final disposition. The facts listed here are for summary information only. The Board is not bound by previous decisions and no single case establishes Board Policy.

**DISCIPLINARY ACTIONS**

Pursuant to WSBN Rules, 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.

AMY ELM  RN 21676  CONDITIONAL
Amy Elm, RN, entered into a Settlement Agreement, Stipulation and Order for Conditional License, approved by the Board on April 11, 2012, as a result of alleged violations of the Nurse Practice Act and Board’s Rules, including drug diversion, impairment, chemical dependency, violation of a previously entered Board Order and failure to conform to the standards of prevailing nursing practice. Ms. Elm previously was the subject of a summary suspension order for drug diversion and was required to be monitored by the Nurse Monitoring Program (NMP) and undergo treatment. Ms. Elm participated in treatment, has met treatment goals and has been reported compliant with NMP requirements, and requested consideration to return to practice under a conditional license. Ms. Elm will continue with treatment recommendations, as well as continue to be monitored by the NMP and have a worksite monitor when she obtains a nursing position, subject to additional limitations and restrictions.

ROUNDA SOCIA  RN 25470  CONDITIONAL
Ronda Socia, RN, entered into a Settlement Agreement, Stipulation and Order for Letter of Reprimand and Conditional License, along with a stayed suspension, approved by the Board on February 28, 2012, as a result of alleged violations of the Nurse Practice Act and Board’s Rules, including boundary violations and failure to conform to the standards of prevailing nursing practice. Ms. Socia engaged in a personal relationship with a patient while continuing to practice nursing. Ms. Socia will be restricted from practicing nursing in any traveling nurse practice, as well as any hospice, home health or community health care, as well as in a dialysis clinic or other nurse practice setting unless she is directly supervised by another registered nurse. Ms. Socia will be monitored by the Nurse Monitoring Program (NMP), will participate in treatment recommendations, and will have a worksite monitor for any nursing position.

SARA CAMERON  RN 14247  CONDITIONAL
Sara Cameron, RN, entered into a Settlement Agreement, Stipulation and Order of Conditional License, approved by the Board on April 11, 2012, as a result of alleged violations of the Nurse Practice Act and Board’s Rules, including criminal conviction and alcohol dependency. Ms. Cameron participated in treatment, has met treatment goals and participated in aftercare. Ms. Cameron will continue with treatment recommendations, as well as be monitored by Nurse Monitoring Program.

PAUL KREMPELS  RN 21959  LETTER OF REPRIMAND
Paul Krempeles, RN, entered into a Settlement Agreement, Stipulation and Order for Reprimand of his Registered Professional Nurse License, approved by the Board on April 11, 2012, as a result of alleged violations of the Nurse Practice Act and Board’s Rules. Mr. Krempeles engaged in the unlicensed practice of nursing, by practicing after his license expired.

CONSTANCE WISE  RN 10053  LETTER OF REPRIMAND
Constance Wise, RN, entered into a Settlement Agreement, Stipulation and Order for Reprimand of her Registered Professional Nurse License, approved by the Board on April 11, 2012, as a result of alleged violations of the Nurse Practice Act and Board’s Rules. Ms. Wise engaged in the unlicensed practice of nursing, by practicing after her license expired.

WILLIAM NUNEZ  RN 17247  SUSPENSION
William Nunez, RN, entered into a Stipulation for Summary Suspension of his Registered Nurse License, approved by the Board on February 28, 2012, as a result of alleged violations of the Nurse Practice Act and Board’s Rules, including violation of a previously entered board order. Mr. Nunez entered into a Stipulation for Summary Suspension of his Registered Professional Nurse License, approved by the Board on February 28, 2012, as a result of alleged violations of the Nurse Practice Act and Board’s Rules, including criminal conviction and alcohol impairment/abuse; and (ii) Failure to conform to the standards of prevailing nursing practice, in which case actual injury need not be established.

AMBER BEDOLLA-PEREZ  CNA 13888  VOLUNTARY SURRENDER
Amber Bedolla-Perez, CNA, entered into a Settlement Agreement, Stipulation and Order for Voluntary Surrender of her Certified Nursing Assistant Certificate, approved by the Board on April 11, 2012, as a result of alleged violations of the Nurse Practice Act and Board’s Rules, including impairment, chemical dependency and failure to conform to the standards of prevailing nursing practice. Ms. Perez reported for duty as a certified nursing assistant and co-workers reported erratic behavior and the smell of alcohol. A breathalyzer test confirmed the presence of alcohol and she admitted having drunk a beer earlier in the day before reporting for work. Ms. Perez’s certificate is suspended pending further investigation and also the requirement that she immediately enroll in the Nurse Monitoring Program.

KAYLA DALEY  CNA 20096  SUSPENSION
Kayla Daley, CNA, entered into a Settlement Agreement, Stipulation and Order of Suspension of her Certified Nursing Assistant Certificate, approved by the Board on April 11, 2012, as a result of alleged violations of the Nurse Practice Act and Board’s Rules. Ms. Daley disclosed an alcohol related criminal conviction on her renewal application and investigation indicated need for substance abuse evaluation. The Order suspends Ms. Daley’s certificate as a certified nursing assistant in order to complete the investigation and permit further determination of disciplinary action, if any.

JAYLENE EASTMAN  CNA 19459  VOLUNTARY SURRENDER
Jaylene Eastman, CNA, entered into a Settlement Agreement, Stipulation and Order for Voluntary Surrender of Certificate for Certified Nursing Assistant, approved by the Board on April 11, 2012, as a result of alleged violations of the Nurse Practice Act and Board’s Rules, including misappropriation of property, drug diversion, unauthorized use of controlled substance and failure to conform to the standards of prevailing nursing practice. Ms. Bedolla-Perez took Percocet pills from two patients and substituted the pills with over-the-counter medications.

LINDA WARD  CNA 13814  VOLUNTARY SURRENDER
Linda Ward, CNA, entered into a Settlement Agreement Stipulation and Order for Voluntary Surrender of her Certified Nursing Assistant Certificate, approved by the Board on April 11, 2012, as a result of alleged violations of the Nurse Practice Act and Board’s Rules, including violation of a previously entered board order. Ms. Eastman tested positive for a controlled substance while she was on a conditional certificate and enrolled in the Nurse Monitoring Program.

HEATHER WEBER  LPN 6207  VOLUNTARY SURRENDER
Heather Weber, LPN, entered into a Stipulation for Voluntary Surrender of her Licensed Practical Nurse License, approved by the Board on April 11, 2012, as a result of alleged violations of the Nurse Practice Act and Board’s Rules, including criminal conviction for driving while under the influence and potential impairment to safe nursing practice due to possible substance use disorder.
Medication Error: Court Approves Nurse’s Firing.

The Roxanol at the facility in liquid form contains 20 mg of morphine per ml. 5 ml of liquid Roxanol contains 100 mg of morphine, twenty times the 5 mg sublingual dose of morphine prescribed for the patient. When confronted about the error the LPN told her charge nurse she thought a ml and a mg were basically the same thing.

COURT OF APPEALS OF OHIO
February 27, 2012

An LPN was fired from her position in a nursing home after she transcribed via the facility’s computer system a telephone order into a resident’s chart from the resident’s physician for 5 mg of sublingual Roxanol q 4 6 hours PRN for pain as 5 ml instead of 5 mg. The Court of Appeals of Ohio ruled the nursing home had legal grounds to terminate the LPN for cause, that is, the LPN was not entitled to unemployment benefits. The Court said it was not a factor in the LPN’s favor that her charting error was discovered through the facility’s own internal system of checks and balances before any actual harm occurred to a patient. The LPN was not entitled to progressive discipline, that is, a write-up and plan of correction before being fired, as her error was so severe that it amounted to a violation of the law. By law all medications must be administered according to the physician’s directions and, by law, an LPN is required to have at least baseline competence in the administration of medications. The magnitude of the error, which could have caused a patient’s death, justified the decision to terminate her for cause, the Court concluded.

Hale v. Dept. of Job & Family Services, 2012-Ohio-626261 (Ohio App., February 27, 2012)

Abuse Reporting: Defamation Suit Dismissed.

Healthcare personnel are mandatory reporters of suspected abuse or neglect of a dependent adult by a caregiver. The law clearly gives mandatory reporters immunity from civil lawsuits over the making of such reports. Non-mandatory reporters are immune from suit unless it can be proven that the report was intentionally made with actual knowledge that it was false.

CALIFORNIA COURT OF APPEAL
March 21, 2012

The daughter met the definition of a dependent adult. Her mother was her caretaker. By law, healthcare personnel are mandatory reporters of suspected abuse or neglect of dependent adults by their caretakers. Failure to report is a criminal offense for a mandatory reporter. The other side of the coin is that the law gives mandatory reporters immunity from civil liability for reporting as they are required.


Emergency Room: Nurse Terminated For Failing To Take Report.

A hospital can terminate a nursing employee for failing to follow conduct and quality of work protocols designed to ensure the safety and proper care of its patients.

APPELLATE COURT OF CONNECTICUT
March 6, 2012

When a nurse arrived for her day shift in the E.R., she was alerted by the charge nurse that there was an acute MI in progress involving a patient in her assigned area of responsibility. The nurse went to the treatment room, saw that there were four night-shift nurses and two physicians in the room and simply walked away without entering the room to take report and become involved in the patient’s care. The nurse was terminated the next day and then sued the hospital for wrongful termination.

The Appellate Court of Connecticut ruled the hospital had just grounds to fire the nurse. The nurse was not covered by a union collective bargaining agreement that defined grounds for termination. She previously had been disciplined and suspended for two days for an episode of insubordination. She was expressly warned at that time that one more patient care infraction would result in her termination.

More importantly, the Court said, a nurse failing to take report when coming on duty adversely impacts patient safety. The Court discounted the argument raised by the nurse in her defense that she was fired in retaliation for her advocacy in favor of proper critical care for patients in the emergency room. That could care of the daughter in her home the mother called an ambulance to take the daughter to the hospital because she thought the daughter might be coming down with pneumonia. An advanced decubitus ulcer on the patient’s back caused personnel from the hospital to contact adult protective services whose investigation resulted in the daughter being removed from the home. The California Court of Appeal dismissed the lawsuit.

The daughter met the definition of a dependent adult. Her mother was her caretaker. By law, healthcare personnel are mandatory reporters of suspected abuse or neglect of dependent adults by their caretakers. Failure to report is a criminal offense for a mandatory reporter. The other side of the coin is that the law gives mandatory reporters immunity from civil liability for reporting as they are required.

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~Director of Nursing

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Emergency Room: Nurse Faulted For Child’s Death.

*It was below the standard of care for the nurse to obtain the child’s temperature of 103.6 at the time of discharge and fail to communicate that important fact to the E.R. pediatrician.*

COURT OF APPEALS OF GEORGIA
March 13, 2012

The parents took their seven-month-old to the E.R. because of a fever, rapid breathing and rapid pulse. The child was discharged three hours later, stopped breathing at home and was brought back to the hospital where she soon died. The Court of Appeals of Georgia upheld the jury's verdict which found no liability on the part of the emergency room pediatrician who examined and then discharged the child, even though the parents’ expert in emergency pediatric medicine testified that the pediatrician was negligent for discharging the child home in unstable condition.

The parents’ emergency-pediatrics expert also testified it was below the nursing standard of care for the E.R. nurse not to have informed the E.R. pediatrician that the child’s temperature was still markedly elevated and that her respirations were still abnormally rapid, data that would be very relevant to the pediatrician’s decision whether or not to send the child home. The jury apparently decided it was only the nurse’s and not the pediatrician’s fault that the child died. The hospital and the nurse were not sued by the parents as defendants in the lawsuit. The child’s temperature (103.6) was entered by the E.R. nurse into the child’s records on the hospital computer system shortly before the child was discharged but it was never expressly communicated to the pediatrician in the E.R.


Substandard Care: Court Upholds Verdict For Patient’s Family For Wrongful Death.

There were orders for the bed rails to be raised but a CNA testified they were left down on many occasions. There were two documented falls with the bed rails found down afterward. The right hand and wrist were noted to be swollen at one point, but no fall was actually documented by the nurses. A CNA also testified the nursing home was short-staffed much of the time she cared for the patient. Short-staffing meant she was not able...
said. Negligent breach of the standard of care, the Court family's experts' opinion. Failure to follow up was a data which required nursing follow-up, in the fluid disappearance were abnormal assessment tube than ordered. Weight loss and problematic documented he was getting more fluid through the tube than expected. The patient's mentally-challenged roommate was in the habit of going over and pulling out his PEG tube. The patient was not getting sufficient nutrition to meet his needs.

SUPREME COURT OF MISSISSIPPI
April 12, 2012

The $1.5 million verdict for the family against the nursing home was based on the jury's acceptance of the patient's family's experts' slant on the highly disputed medical evidence. The family's experts testified the elderly patient died from sepsis with a fracture of the right humerus and fluid accumulation in the lungs both caused by a fall in the nursing home as contributing factors. The nursing home's experts countered with testimony of their own that the humerus fracture could have happened after transfer to the hospital and that congestive heart failure caused the fluid in the lungs.

Widespread Substandard Practices
The Supreme Court of Mississippi resolved the conflict in the experts' opinions and upheld the jury's decision by pointing to testimony from the nursing home's care-giving personnel about widespread substandard nursing practices as ample evidence that could relate the patient's medical status to a fall and other lapses in his care at the nursing home. Turning and repositioning were not documented every two hours and likely were not done. One pressure sore was not spotted until Stage II and another was at Stage III or IV before it was noticed. The patient's nourishment through his PEG tube was not adequate to meet his needs. His mentally-challenged roommate apparently often pulled out the tube and the liquid nourishment spilled into the bed, while nothing was done to prevent that from recurring on a regular basis. He continued to lose weight even though he was supposed to be getting tube feedings and actually showed signs of de-hydration even though it was documented he was getting more fluid through the tube than ordered. Weight loss and problematic fluid disappearance were abnormal assessment data which required nursing follow-up, in the family's experts' opinion. Failure to follow up was a negligent breach of the standard of care, the Court said. Gibson v. Magnolia Healthcare, __ So. 3d __, 2012 WL 1216216 (Miss., April 12, 2012).

Drunk Driving: Court Upholds Discipline Against Nurse.
Unprofessional conduct for a nurse includes use of alcohol in a manner dangerous to oneself or others

CALIFORNIA COURT OF APPEAL
April 19, 2012

The state Board of Registered Nursing placed a registered nurse's license on three years' probation after he pled no contest to misdemeanor drunk driving after he lost control of his car one night on the way home from a party and collided with the center divider. His blood alcohol was 0.16. The nurse had an exemplary work record and, according to friends called as character witnesses, he rarely drank. In fact, a psychiatrist who evaluated him after the incident concluded he did not meet the diagnostic criteria for alcohol abuse or dependence. It was a single, isolated episode of poor judgment, in the psychiatrist's opinion.

The Board of Nursing never required further evaluation, treatment or counseling for chemical dependency. There was no direct evidence that consumption of alcohol in any way affected the nurse's ability to practice his profession.

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The California Court of Appeal upheld the disciplinary sanctions imposed by the Board of Nursing. Driving while intoxicated is a behavior which is dangerous to oneself and others. As such it fits the legal definition of unprofessional conduct for a nurse. The California courts have already reached the same conclusion for physicians. To be grounds for discipline with respect to a professional license it is not necessary to show that unprofessional conduct occurred during professional practice or had any effect on one's ability to practice or is evidence of an ongoing state of impairment that could have an effect on one's ability to practice as a nurse, the Court ruled. Sulla v. Board of Registered Nursing, 2012 WL 1355556 (Cal. App., April 19, 2012).

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Nursing Employment in Wyoming
Trends, demographics and turnover

(Editors note: Reprinted with permission from Research & Planning Division of Wyoming Department of Workforce Services. The full report with tables, references and definitions may be found online at: http://doe.state.wy.us/LMI/nursing/2012/DASHBOARDS COMPLETE_FEB2012.pdf)

Wyoming’s nursing workforce plays an important role in providing quality health care. As the baby boom generation ages, Wyoming’s health care needs will increase substantially, including the need for services provided by nurses. In order to plan for these future needs, it is important to understand trends in wages, turnover, demographics, and other variables in the nursing workforce.

The ability of Wyoming’s health care system to deliver high quality services to its citizens is of critical importance. A key part of the state’s health care system is its nursing workforce. This article presents a brief overview and update to the previously published nursing dashboard indicators (http://doe.state.wy.us/LMI/nursing/2012/DASHBOARDS COMPLETE_FEB2012.pdf). The tables provide information on trends in nursing wages, demographics, and turnover. Although this research focused on trends in the nursing profession, turnover and earnings analyses for other industries and statewide for comparison purposes are available at http://doe.state.wy.us/LMI/turnover.htm.

The enactment of the Health Information Technology for Economic and Clinical Health (HITECH) Act (Title 13) of the American Recovery and Reinvestment Act (ARRA, Public Law 111-5) and the Patient Protection and Affordable Care Act (PPACA, Public Law 111-148) will affect all aspects of health care delivery, including the nursing profession. Timely and regular reporting of these indicators will allow readers to better understand how these pieces of legislation and other factors affect this part of the health care system over time. This research is intended to provide a present-day description of the nursing workforce in addition to an analysis of trends affecting this component of the labor market. This analysis begins with a detailed review of the demographic and wage trends in ambulatory care, then transitions to a comparative analysis of all three health care industries (ambulatory care, hospitals, and long-term care), and ends with a health care-wide view of average wages by county of work. The reports generated in the publication of this article update prior research of the same type performed by Leonard (2008).

Data Sets Used and Methodology

The first data component used in the analysis was the Wyoming State Board of Nursing (WSBN) licensure files (WSBN, 2011). These files contain information on nurse license status and type, and demographics, plus a unique identifier (social security number), which is joined to other administrative databases in Research & Planning’s (R&P) possession. Other data sets used to construct the reports included the Unemployment Insurance (UI; R&P, 2011) Claims Database, the Workers’ Compensation (WC; R&P, 2011) database, the Wage Records (WR; R&P, 2011) database, and the Quarterly Census of Employment and Wages (QCEW; R&P, 2011) database. The QCEW provides employers’ industry assignments and their ownership codes (private, local, state, and federal government).

The licensure data were used to build a time series of the types of licenses nurses held in each calendar quarter. For the purposes of this analysis, R&P used a “once a nurse, always a nurse” methodology. This means that once a worker obtains a nursing license, that worker is counted as a nurse from that point forward. Such a distinction smooths the data from one quarter to the next while preserving overall trends.

Nurses were assigned to industries based on their primary employers’ North American Industry Classification System (NAICS; Census Bureau, 2007) and ownership codes (found in the UI tax system). Businesses in NAICS 621 are classified as ambulatory care services, while those in NAICS 622 are classified as hospitals and those in NAICS 623 are classified as long-term and residential care facilities. Employment data for nurses working in other non-health care industries were not shown in the dashboard output tables.

Nurses were assigned to industries according to their primary employer in WR. A nurse’s primary employer is then assigned to individual nurses. Earnings represent the total wage and salary payments to nurses without regard to the number or types of hours worked, since this information is not available from current administrative databases.

Charts were generated for three nursing categories: registered nurses (RN), licensed practical nurses (LPN), and certified nursing assistants (CNA), although the focus of this article is RNs. The RN category includes Advanced Practice Registered Nurses (APRN) except where otherwise noted. Results tables for the other license categories are posted online at http://doe.state.wy.us/LMI/nursing/2012/DASHBOARDS COMPLETE_FEB2012.pdf. Definitions used in this article are shown in the Appendix.

Results

The first results section of this article focuses on ambulatory care only as a way of describing how readers may use the data as a stand-alone product. The second section provides a comparative analysis of RN and APRN statistics between ambulatory care, hospitals, and long-term care facilities to demonstrate a more in-depth analysis technique. The final section compares nurse wages by county of work.

Detailed Analysis: Ambulatory Care

The results for RNs and APRNs working in ambulatory care are shown in Table 1. The number of RNs working in ambulatory care increased from 802 in first quarter 2009 (2009Q1) to 911 in first quarter 2011 (2011Q1), an increase of 13.6%. The addition
of RNs was slower from 2009Q1 to 2009Q4. This was concurrent with the economic contraction Wyoming experienced during that time. Examples of how employment levels in the state changed overall and at the industry level, in addition to employment changes in other states, can be found at [http://www.bls.gov/ces/](http://www.bls.gov/ces/) or [http://www.bls.gov/cew/](http://www.bls.gov/cew/). The number of RNs working in hospitals the three health care industries studied, RNs employed during 2011Q1. Of this industry, they accounted for 27.4% of insufﬁcient.

The number of RNs working in hospitals in 2011Q1. As nurses “age out” and retire, the number and proportion of nurses 65 and older increased from 49 (1.8%) in 2009Q1 to 60 (2.2%) in 2011Q1. Part of the reason the average age of RNs and APRNs increased was that the number working in long-term care fell from 396 in 2009Q1 to 390 in 2011Q1, implying that younger nurses left employment in the industry. A similar increase was observed in hospitals (see Table 2), where the number and proportion of nurses 65 and older increased from 49 (1.8%) in 2009Q1 to 60 (2.2%) in 2011Q1.

Nurses working in hospitals in 2011Q1 had an average tenure of 7.0 years (see Table 2), the highest of the three industries. This was 3.3 years longer than nurses working in ambulatory care (3.7 years; see Table 2) and long-term care (3.7 years; see Table 3). This is consistent with exit rates of RNs and APRNs during 2010Q4. The exit rate for nurses working in hospitals (5.6%) was considerably lower than those seen in ambulatory care (10.9%) and long-term care (13.3%).

Wages by Work Status and County of Work

Table 4 illustrates how RN and APRN wages vary by county of work and employment status. Work county assignments were modeled using estimated commuting patterns (Leonard, 2011). Nurses’ work locations were estimated using the addresses contained in the employer UI tax ﬁles (QCEW). Work locations (latitude and longitude) were assigned based upon employers’ physical addresses. The statewide average wage for all continuously employed RNs & APRNs in health care during 2010Q4 was $16,771, while nurses experiencing other types of employment status (hire, exit, or hire and exit in the same quarter) earned considerably less ($11,161). Although the most RNs and APRNs were found to be working in Natrona County (847), the highest paid nurses (of the counties displayed) were found in Campbell County ($17,870 continuous; $17,369 average). The range for the published counties was from a high of $17,369 in Campbell County to a low of $14,524 in Fremont County. The difference could be accounted for by at least three factors: 1) more rural areas have less specialization or demand for nurse specialists or APRNs; 2) employers pay less because some local economies are not as robust as others; and 3) a greater proportion of nurses (33, or 12.7%) in Fremont County were in turnover status, or working less than a full quarter, compared to nurses in Campbell County (28, or 10.2%) of nurses.

Conclusion

This article examined how RN and APRN demographics and wages changed in the three health care industries between 2009Q1 and 2011Q1. The research was designed to update readers on wage and demographic changes in the nursing profession and to educate them in the use of the dashboard reports. The results indicate that both nurse wages and their average ages are increasing. This presents a challenge for Wyoming’s health care delivery system as more of the baby boom generation retires. How Wyoming’s health care system responds to competition that is not only local but global in nature will determine the quality of care delivered to the people of the state.

Douglas Leonard is a Senior Economist at the Wyoming Department of Workforce Services.
Rules
Chapter 2 and 5 rules revisions were posted for public comment until May 15. WSBN received around 50 comments from nurses across the state and each comment received a personal reply to their concerns. Understandably, some were not happy at the thought of a licensing increase but out of over 16,000 nurses and CNAs it seems that the vast majority was silent on the matter. At the time this went to press the Board was scheduled to meet and decide on the formal submission to Governor Mead. Updates on the rules will be available on the WSBN website.

APRN Roundtable
National Council of State Boards of Nursing (NCSBN) sponsored a conference to discuss the APRN consensus model. The consensus model for advanced practice nurses was developed in 2008 recognizing the barriers to practice due to a lack of uniformity in APRN regulation across the States. Each state independently determines the APRN legal scope of practice, the roles that are recognized, the criteria for entry into advanced practice and the certification examinations accepted for entry-level competence assessment. The consensus model seeks to provide consistent language and requirements for all areas of advanced practice nursing. Todd Berger, Practice and Education Consultant, represented Wyoming at the conference. Topics included a review of the states and the national implementation of the Consensus Model, criteria for accrediting and certifying APRN programs, and the Federal Trade Commission role in supporting APRN legislation. Wyoming is proud to be within 1 point of full compliance with the Consensus Model. The only deficiency is not having separate licensure of APRNs (who now license as an RN with APRN recognition). Legislative changes to the Practice Act and revisions to the regulations would be required to make this change.

MAC Graduates
The first class of medication aide certified (MAC) CNAs from Gillette took their national certifying exams in April and all passed. This group of 5 (Janet Buchman, Heather Whitt, Elizabeth Ciravolo, Christen Braaten, Tammy Caldwell) became the first in the nation to take the NCSBN designed MACE (MAC Exam). This is a tremendous accomplishment and represented over a year of work to bring the national test to Wyoming. More CNAII and MAC programs are being developed around the state. Look for these expanded scope CNAs to begin showing up in your facilities to assist nurses in patient care.

Nursing School Graduates
May signifies the beginning of a nursing career for over 400 graduates from Wyoming Nursing Programs. As always, the surge of license applications is a challenge but WSBN licensing staff strive to process completed applications within 10-14 business days. One of the biggest delays to licensing is incomplete applications. If you include a current email address, our licensing staff will inform you via email of any missing information. Background checks including fingerprints go through the Department of Criminal Investigations as well as the FBI and these agencies handle the surge from all 50 states, not just Wyoming. Many times the applicant has submitted all the necessary paperwork, transcripts, and taken the NCLEX only to find that the background check is still outstanding. Once the criminal background report is received a license will be issued. Until WSBN receives all the required material, we cannot begin processing the license application. Please be patient during this time. If you call to check on the progress of your application it will only slow the process even more. Instead, please visit our website and search by name on the blue On-line Verification box. Your license will be available to view as soon as it is issued.

APRN Pharmacology CEs
The 2012 Pharmacotherapy Conference, sponsored by the Wyoming Council for Advanced Practice Nurses (WCAPN), will be held September 27th & 28th at the Cheyenne Holiday Inn. For online registration go to www.wcapn.org or email wcapn@bresnan.net for more information. WCAPN is an independent, non-profit council promoting Advanced Practice Nursing in Wyoming.

### Licensing Statistics by Quarter

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<td>Unsafe Practice</td>
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<td>1</td>
<td>7</td>
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<td><strong>29</strong></td>
<td><strong>39</strong></td>
<td><strong>92</strong></td>
</tr>
</tbody>
</table>

**NEW EMAIL? NEW PHONE? NEW ADDRESS?**

Remember to notify us if your contact information changes. We primarily communicate through e-mail; however, we must have a valid address and phone number on file as well. You can simply e-mail us these changes by clicking on the e-mail link under the applications/forms tab on our website at http://nursing.state.wy.us

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### 1st, 2nd and 3rd Q 2012 Complaint Disposition

<table>
<thead>
<tr>
<th>COMPLAINT DISPOSITION</th>
<th>1st Qtr</th>
<th>2nd Qtr</th>
<th>3rd Qtr</th>
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<td>11</td>
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<td>Revocation</td>
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<tr>
<td>Voluntary Surrender</td>
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<td>7</td>
<td>8</td>
<td>26</td>
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<tr>
<td>Letter of Reprimand</td>
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<td>10</td>
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<td>Suspension</td>
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### 1st, 2nd and 3rd Q 2012 Cases Settled

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<th>2nd Qtr</th>
<th>3rd Qtr</th>
<th>Total To Date</th>
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</table>
Renewal Requirements

The License renewal period will begin October 1st. Following are the basic renewal requirements.

**APRN:**
APRNs must meet ONE of the RN requirements and:
- Provide proof of National Certification
  OR
- If recognized as an APRN prior to July 1, 2005, and has maintained continuous recognition but is not nationally certified
  1. Provide proof of completion of 60 contact hours of continuous education in the last 2 years related to your specialty area(s) of advanced practice
  AND
  2. Have 400 hours of employment as an APRN in the last 2 years in your specialty area(s) of advanced practice

**APRNs with Rx Authority must also:**
- Complete fifteen contact hours of education in pharmacology and clinical management of drug therapy or pharmacotherapeutics within the last 2 years (proof required). (The CEs must specifically identify the hours applicable to pharmacology)

**RN:**
RN must meet ONE of the following requirements:
- Worked a minimum of 500 hours as an RN in the last 2 years
- Worked a minimum of 1600 hours as an RN in the last 5 years
- 20 RN continuing education hours in the last 2 years (proof required)
- Complete a refresher course in the last 5 years (proof required)
- Certification in a specialty area of nursing practice by a nationally recognized accrediting agency accepted by the board in the last 5 years (copy required)
- Pass the NCLEX in the last 5 years

**LPN:**
LPNs must meet ONE of the following requirements:
- Worked a minimum of 500 hours as an LPN in the last 2 years
- Worked a minimum of 1600 hours as an LPN in the last 5 years
- 20 LPN continuing education hours in the last 2 years (proof required)
- Complete a refresher course in the last 5 years (proof required)
- Certification in a specialty area of nursing practice by a nationally recognized accrediting agency accepted by the board in the last 5 years (copy required)
- Pass the NCLEX in the last 5 years

**CNA:**
CNAs must meet ONE of the following requirements:
- Worked a minimum of 16 hours as a CNA AND completed 24 hours of in-service education in the last 2 years
  OR
- Complete a board approved nursing assistant training program and competency evaluation AND passed a national nursing assistant certifying examination within the last 2 years

YOUR FUTURE AWAITS

PREPARE FOR IT!
- CNA certification
- Math placement status
- Additional requirements: www.uwyo.edu/nursing/BasicBSN

Fay W. Whitney
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Q Our facility is considering sending a few CNAs to classes to become CNAIIIs and then on to become MA-Cs. I was wondering if MA-Cs can pass scheduled opioids to stable residents? Can they also pass PRN opioids if the nurse/physician give clear instructions or guidelines to follow? I didn’t see anywhere in the regulations that addressed this.

A WSBN regulations do not address this specific question of which drugs a Medication Assistant Certified (MAC) may pass. It would be the facility policy which determines who has access to controlled substances. There are restrictions for the MAC about giving meds that require assessment and with most opioids a pain assessment and reassessment may be required. The RN that delegates the duties to the MAC should understand their medication limitations. In general if this is a stable patient and the med is scheduled and does not require assessment or calculation of dosage or conversion of the dosage, the MAC should be able to administer as delegated by the nurse.

Chapter 7 Section 11 states: Direction for PRN medication must be in writing and include the parameters for provision of the PRN medication (i.e. Tylenol 500mg/2 caps PO q 8hr PRN for temp > 101F). Direction for observing and reporting for monitoring medication must be in writing and include the parameters for the observation and reporting. A MA-C shall comply with the written directions. CNAII and MAC are new designations to the CNA role that encompass some limited skills and actions traditionally limited to nursing scope. It will take some time for nurses to assimilate them into the workplace and understand and utilize their expanded roles. Please refer to the WSBN website, Rules and Regulations Chapter 7, Sections 10, 11, and 12 for details on the requirements for CNAII and MAC certification. Licensed Nurses should also review Chapter 9 on delegation.

Q I am inquiring if you know if there is any protocol for doing orientation for nurses before they take a unit to care for 25-30 residents. I have been told that I would have to take a unit if nurses call in and they cannot be replaced. I have never been oriented and feel this is unsafe for the residents and not a wise choice just to get a body with RN placed. I am afraid my license will be in jeopardy, especially if there is any type of med error, or other mistake. Please let me know what my options are, as I am not comfortable, and do not wish to lose my job over it.

A WSBN rules regarding Implementation of the Nursing Process; Chapter 3, Section 2 (b)(ii) states: (C) Accepts only client care assignments for which educationally prepared and adequately trained;

Many facilities have policies regarding specific staffing needs and these can require considerable flexibility. Taking an assignment you are not adequately prepared for can put the patients at risk but having no one available for the assignment creates even more problems. If no one is available to take the patient assignment the on duty nurse would face the dilemma of continuing until relieved or abandoning her patients. There is no violation of WSBN rules to refuse an assignment based on (C) but once you accept the assignment you would be responsible for providing care according to nursing standards. It is the facility prerogative to terminate if refusing an assignment violates their expectation. It is a devil's option to choose between your license or your job. Orientation policy should be discussed with your employer before the situation arises.

Q The issue with CNAs working within their scope continues to be tested. The question comes up in whether a CNA can be in the room with the doctor doing a Pap Smear? Can she hand instruments, hold brushes, label swipes and labs and be within her scope?

A Yes, the CNA should be able to assist the MD with his procedures and provide female presence during the exam. Again, it comes down to delegating to a competent other and providing for patient safety.

Q I have a question about nurses taking verbal and written orders from a physician’s assistant, and if the sponsoring MD has to sign off these orders. We have a new PA in the office here and we have not worked with one previously. In order to protect our licenses we need to know how to proceed when we are given verbal orders, or even written scripts and asked to call them in to a pharmacy. In addition, can she alone sign off a progress note where we have documented calls and actions taken upon her verbal order, or does the MD need to do this?

A The PA works as an agent of their supervising physician. It is up to the Physician/PA collaboration agreement how often the PA orders are cosigned or checked off. Some do a percentage of all orders while others may want to sign off on everything. Your facility should have policy in place regarding taking verbal orders (read back designation, signed within specific number of hours, etc.) but in general you may take orders from a PA the same as you would a physician or APRN.

Q Our hospital has some confusion whether or not an LPN may pick-up blood from the Lab for the RN? This would mean the LPN would only be retrieving it from the lab, the RN would be administering it. Basically if we are really busy, can LPN’s pick it up for us?

A WSBN has no rules that regulate what an LPN may or may not carry. Their only restriction in our rules is on administering blood products. Transport of blood products is dependent on facility and lab policy.
**Q** I have a question about physician orders. I’ve heard lots of rumors, but would like for you to verify for me. WHO is allowed to take a physician order in the state of Wyoming; RNs, LPNs, MAs, Pharmacy Techs, CNAs, etc? Do you happen to know how long we have to get the order documented after the service was complete at our physician office?

**A** Nothing in our Rules speaks directly to this specific question. Facility Policy dictates who they believe is qualified to accurately take and understand physician orders. These are determinations normally based on risk management. RNs and LPNs as licensed nurses have standards relating to communication with other health team members and have the training and education to understand and perhaps question orders that do not seem appropriate or clear. CNAs are only trained in basic patient care and do not have the training to do this. WSBN has no position on anyone other than the people we regulate. Facility policy should address the legal aspects of signing orders. WSBN does not regulate this.

**Q** When a person is licensed as a CNA or LPN and they either get their GN temp license or their RN license can they still practice as an LPN or CNA until they start into the hospital’s orientation as a RN? Do they lose that licensure status ever or in this example with another type of licensure? Thanks.

**A** Nothing in a CNA scope is outside an RN scope of practice. The question is whether a nurse may accept a job that limits their work duties below their level of licensure. The distinction is between employment status and licensure. These are two separate issues. Employment status is determined by the hiring facility but licensure is granted by the state board. An RN is fully capable of performing CNA duties and could work with an RN license under the facility terms of employment with job duties restricted to the CNA scope. But they can be held to the standards of their license despite their working title in certain circumstances when not acting could put a patient at risk. The License recognizes their training and educational achievement. WSBN does not revoke an earlier license but it becomes expired when not renewed. So a CNA that finishes nursing school in May has an active CNA certification until it expires but may also have an active RN license as well. They may continue to work in whatever capacity they were employed in prior to getting their RN license but their job description would limit what they were expected to do.

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The Wyoming Center for Nursing and Health Care Partnerships hosted a very successful ReNEW Kick Off at Laramie County Community College in Cheyenne on February 22nd… despite road closures, gale force winds, blizzard conditions, and lots of snow! Never doubt the ability of hearty Wyoming folks to battle the elements to do what needs to be done! All ReNEW committee members were invited to help launch this incredible statewide initiative and about 45 people attended. Deb Center, from the Colorado Center for Nursing Excellence, facilitated the meeting focusing on community building, consensus decision-making, and handling “hot button issues” and conflict. We also took a few minutes to celebrate the Initiative parts to a tag:

- **Observation:** A solution-focused statement related to what you have observed, see currently or think is happening to affect performance.
- **Pause and Request for Feedback:** Is done in the form of question, intended to seek feedback and gain clarity.
- **Suggestion:** A solution-focused idea of something to try. This may be brainstormed with the person being tagged.
- **Goal:** A solution-focused statement of what you want and why it is important.

Ms. Center taught the participants a negotiation tool, called “Tagging.” “Tagging is surfacing or raising an issue that needs to be discussed and resolved because it is impacting a group’s or team’s performance. When you raise an issue to a more conscious level, point to it, or call attention of others, you are tagging it” (Carl Larson, Negotiator). There are four parts to a tag:

- **Goal:** A solution-focused statement of what you want and why it is important.
- **Observation:** A solution-focused statement related to what you have observed, see currently or think is happening to affect performance.
- **Pause and Request for Feedback:** Is done in the form of question, intended to seek feedback and gain clarity.
- **Suggestion:** A solution-focused idea of something to try. This may be brainstormed with the person being tagged.

Participants took several different potential “hot button” issue for ReNEW, e.g., CNA requirement for nursing school admission, and practiced tagging in groups. As we move forward with ReNEW, we will continue to develop our skills in consensus building, negotiation and handling conflict.

In an effort to increase the visibility of ReNEW around the state, the ReNEW Steering Committee has been working with Warehouse 21, a marketing firm in Cheyenne, to develop a logo. The logo is bright to grab people’s attention, uses the abstract circle of hands to represent unity with so many people involved in ReNEW, and includes the Nightingale lamp to signify nursing.

RENEW is sponsored by the Wyoming Center for Nursing and Health Care partnerships (WCNHC). If you have questions about RENEW, please feel free to contact the WCNHC at 307-766-6715 or info@wymunursing.org. Or visit the WCNHC website at http://wymunursing.org.

Mary E. Burman is Co-Chair of the WCNHC Advisory Board and Matt Sholty is an Office Associate at WCNHP.
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