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2014 WYOMING STATE BOARD OF NURSING MEETINGS

All Board meetings are held in accordance with Wyoming Public Meetings Statutes and are open to the public. Unless otherwise specified, all Board meetings are at 130 Hobbs Avenue, Cheyenne, WY 82002.

Please feel free to join us in person or via teleconference at the regularly scheduled quarterly meeting or interim teleconference meetings. Minutes of past meetings are available on the WSBN website under “Board Meetings.”

Requests for agenda items must be submitted at least two business weeks prior to the scheduled Board meeting. If you have questions regarding a Board meeting or agenda item, or if you have special needs for access to a Board meeting, please contact our Executive Assistant at 307-777-3425.

Board Meetings
Days Inn Thermopolis, 115 E Park St, Thermopolis, WY
October 7-9, 2014

Teleconferences
(Dial In 877-278-8686 Pin 517378)
October 29, 2014
Greetings

From Cynthia LaBonde, MN, RN
Executive Director

The TIMING of this fall issue is IMPECCABLE! My message will arrive in your mailbox mid to late September. Perfect timing for yet another reminder of the on-line licensure/certificate RENEWAL period which launches October 1, 2014 and runs through December 31, 2014. The Board office has engaged in several new “renewal reminder” tactics to “get the word out” ie mass emails, Facebook and Twitter messages and more WNR cover notices. I hope you have received at least ONE of these reminder attempts. Word of mouth (and FACEBOOK!) is also effective! I challenge you to share the renewal dates with your nursing and nursing assistant colleagues, employers, nursing associations and others. Post the WNR covers on your communication boards. Be creative, leave no stone unturned!

Linked with the renewal period is the Board’s submission of proposed changes to Chapters 2 & 5 of the Nurse Practice Act and Administrative Rules and Regulations (NPA). In these proposed amendments, the Board has recommended removal of language and associated “late fee” related to the renewal “grace period” and to establish “recertification” for the CNA.

The major changes to Chapter 2 relate to the renewal “grace period.” The renewal period for nursing licensure/certification occurs every even year between October 1 and December 31. Any practice after December 31 with an expired license is considered unlicensed practice. The current rules allow a “grace period,” January 1 through March 1, after the initial renewal period, during which time the licensee/certificate holder can still renew without having to complete a relicensure/recertification application; however, the licensee/certificate holder would incur a late fee. If renewal does not occur during the “grace period,” or by March 1, the license/certificate is considered “lapsed” and the licensee/certificate holder cannot continue to practice. After a license is “lapsed,” the licensee/certificate holder must complete a relicensure/recertification application to obtain a license/certificate. If the licensee/certificate holder practices during the “grace period” before renewing his/her license/certificate OR after a license is “lapsed,” he/she is engaging in unlicensed practice, which is a ground for discipline.

The current Rules cause confusion because the Rule is being interpreted as allowing continued practice during the “grace period,” before and/or while renewing the license/certificate. This interpretation is incorrect and results in a violation of the NPA, specifically engaging in unlicensed practice, which, again, is a ground for discipline.

The changes made to Chapter 5 were the deletion of the “late fee,” which is directly linked to the grace period, and the addition of the word “recertification” and corresponding $60.00 CNA fee for “recertification.” The $60.00 CNA recertification fee is the same amount as the CNA fee for certification by exam or endorsement. The CNA fees in these categories align with the RN and LPN fees in these same categories i.e., the RN and LPN relicensure fees are the same as the RN and LPN exam and endorsement fees.

Deletion of the “grace period” and “late fee” language and addition of the CNA “recertification” language removes the ambiguity of the renewal process by providing CNA “recertification” and a single clear-cut timeframe for renewal with no “late fee,” thus reducing the potential for unintentional unlicensed practice due to confusing “rules.”

The proposed rules amendments for Chapters 2 & 5 are currently in the 45-day public comment period. If you have a concern regarding the proposed changes identified above, be sure to send me an email at cynthia.labonde@wyo.gov. After the 45-day public comment period closes, the Board will review comments at their October Board meeting and approve (or not) the proposed amendments. If approved, the amendments will be forwarded to the Governor’s office for a 75-day review/approval period. If the Governor approves the proposed amendments, the amendments to Chapters 2 & 5 will become effective prior to December 31, 2014. If that is the case, the “grace period” language and late fee will be removed. This will mean that a license/certificate will EXPIRE on December 31, 2014 and LAPSE on January 1, 2015. Renewal will no longer be available after January 1, 2015. To obtain a new license or certificate, one will have to submit a relicensure or recertification application and associated fees. Either way, REMEMBER you absolutely MAY NOT practice after December 31, 2014 until you obtain a NEW license or certificate. At the Board, we hope this absolute bar reduces the number of unlicensed practice violations.

As the adage goes..."DON’T DELAY, RENEW TODAY!"
Wyoming Healthcare Solutions Grant CFDA 17.268

This federally funded grant program provides career training for healthcare occupations, computer-related occupations and petroleum pump process operators. The target population includes unemployed, underemployed, longterm unemployed and veterans. Some training is available statewide via on-line curriculum. On-site classroom training is held in Casper, Cheyenne, Jackson, Lander, and Riverton. Most training programs are six months or less. Degree programs and career pathway options may be four semesters.

Statewide training is available for the following occupations:
- RN refresher course - designed for nurses who have been out of the workforce and whose license has lapsed. Course length: six months, on-line curriculum through Casper College.
- IV Certification - designed for LPN’s who require or desire the IV certification. This weekend course is 16 hours and the participant must travel to Casper.
- Health Information Technology and Medical Office Support Assistant are offered through Central Wyoming College.
- Computer Programmer/Network Technician/Web designer and certification courses in A+, Cisco, C++, and Certified Clinical Medical Assistant are offered through Laramie County Community College.

The following trainings are available in Cheyenne, Casper, Jackson, and Riverton/Lander, through the colleges listed:
- Casper Community College, Casper: RN refresher (for RN’s who have been out of the workforce), Clinical Medical Assistant, Dental Assistant, IV certification: 16-hour weekend course for LPN’s and the participant is required to travel to Casper to complete this training.
- Central Wyoming College, Riverton/Lander: Certified Clinical Medical Assistant, Registered Nurse, Athletic Trainer, Dental Assistant, Health Information Technology/Electronic Health Record, Social Work/Human Services Assistant, Counselors, Behavior Specialists, CNAII/Medication Assistant, and Pre-Health Professional - this curriculum includes career pathway training and a transfer degree for: medicine, chiropractic, physical therapy, dentistry, optometry and pharmacy.
- Jackson campus: Health Information Technology, and Registered Nurse.
- Laramie County Community College, Cheyenne: Certified Medical Assistant, Dental Assistant, Pharmacy Technician, Professional Medical Coder, Professional Medical Biller, Surgical Technician, Registered Nurse, Electronic Health Records, Health information Technology and Management, Computer Programmer/Network Technician/Web Developer, and Petroleum Process Technician.

For additional information, please contact the college directly:
- Casper: Casper College, Ann Dalton 307.268.2085; email: adalton@caspercollege.edu
- Cheyenne: Laramie County Community College, Jeanine Steele 307.772.7351; email: jsteele@lccc.wy.edu
- Riverton/Lander/Jackson: Central Wyoming College, Janet Webb 307.855.2044 email: jwebb@cwc.wy.edu

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Nurses Returning to School

by: Patrick Harris, Principal Analyst
Study from Wyoming Department of Workforce Development, Research & Planning

Introduction
The growing number of pressures placed on the occupation of nursing and the healthcare industry has been significant. These pressures include nursing shortages, educational attainment, and quality of care. Two recommendations by the Institute of Medicine (IOM) deal specifically with the education level of nurses (2010). The first is increasing the number of nurses with a baccalaureate degree by 80% and the second is to double the number of nurses with doctoral degrees by 2020. The chief arguments for increasing the educational level of the nation’s nurses are to enable them to care for an increasingly diverse population and to contribute to the research and scientific community.

Overview
Spencer (2008) suggests that increasing enrollments in nursing programs will help combat future nursing shortages; however, she cautions that these new enrollments will be mostly concentrated at the associate degree (ASN) level. The increased emphasis on earning a bachelor of science degree in nursing (BSN) is not new (American Nurses’ Association, 1965) and has recently gained momentum with evidence-based practices within the field of nursing becoming dominant (IOM, 2010; Tri-Council for Nursing, 2010). Further, the level of change in technology and the complexity of medical and surgical care are common in a clinical workforce requiring a more advanced skillset (Aiken, Clarke, & Sloane, 2002). More than a quarter of the general public recognizes that nurses should have four years of education in order to fulfill their job duties (Mattson, 2002). The Affordable Care Act (ACA) of 2010 outlines the need to enhance the health care workforce through education and training to improve the delivery of health care services.

Nurse Job Satisfaction
To further advance the knowledge of job satisfaction in nurses, Zurmehly (2008) asked nurses to rate the job characteristics they were most satisfied with in descending order. Results from this study suggest that autonomy, recognition, and critical thinking abilities were variables which influenced higher levels of job satisfaction. However, ability and compensation were variables that were negatively associated with their job satisfaction. Finally, job advancement opportunities were strongly associated with satisfaction (e.g., the more opportunities for advancement, the higher the job satisfaction).

Nurses Returning to School: Motivation, Benefits, and Barriers
The motivators and barriers to continuing education are often thought to be multidimensional. Using a sample of working nurses in Ireland, Murphy, Cross, and McGuire (2006) developed a questionnaire consisting of both potential motivators and inhibitors to continuing education. The authors found numerous factors among the set of questions. For the motivators, two factors were identified: job-related and personal. The job-related construct is thought to tap into how returning to school would increase a person’s professional development in the field of nursing. The personal motivators construct is the motivation necessary to feel an increased sense of competence and importance as a nurse. For the inhibitors, three factors were identified: time-related, outcome-related, and employer-related. The time-related construct is believed to tap into the inhibitors associated with the amount of time available for both work and personal obligations if one returned to school. The employer-related construct taps the perception of a lack of support from employers when deciding to return to school. In the current study, we did not examine the outcome-related construct as all items were theoretically thought to be a part of the other four constructs.

Methodology
Sample
Of the 5,212 employed nurses in fourth quarter 2012 (2012Q4) with an active license with the Wyoming State Board of Nursing, a stratified random sample based on seven separate regions of the state was selected for a total survey sample of 2,086. Each of the selected participants was mailed a packet of questionnaires (described in the measures section below) to their home address as indicated on the Wyoming State Board of Nursing licensing file.

Participants were instructed to return their completed questionnaires by mail, fax, or to call R&P staff and give their responses over

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the phone. A total of 796 nurses completed the questionnaire for a response rate of 38.2%. An additional 298 participants (14.2%) did not have a forwarding address and were not sent another questionnaire packet. The response waves for the 796 nurses were as follows: 50.6% of participants completed the packet during the first mailing, 35.2% completed the packet during the second mailing, and 14.3% completed the packet during the third mailing. Four participants asked to not be included in the study. The vast majority (99.5%) returned their completed packet by mail.

Due to the interest in the attitudes regarding returning to school for nurses currently employed in the health care industry, only those nurses employed full-time or part-time (35 hours or less) in health care were included in the analysis, which resulted in 142 participants being excluded. A total of 159 participants were removed from the analysis because they indicated that they did not know if they planned to return to school or did not respond to the question. Due to the low response rate of the first and second waves of mailings, a shorter questionnaire was created which excluded important questions used in the present analysis. Ninety-four participants who completed this shorter version were excluded from the analysis. Finally, missing data on the questionnaire led to the removal of 98 participants. After all exclusion criteria were imposed, the sample was comprised of 305 participants.

**Measures**

The motivation and inhibitor questions from Murphy, et al. (2006) were included in the questionnaire. Participants answered the questions based on the following instructions:

Continued on page 8>>

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One item was used to assess the individual's intent to return to school. Respondents were asked, "Do you plan to return to school to further your education?" The responses were in the form of time intervals. Intent was measured with the following four options: "Yes, within the next 3 years"; "Yes, in 3 to 5 years"; "Yes, in more than 5 years"; and "No." Responses were coded from 0 (No) to 3 (Yes, within the next 3 years) with higher numbers indicating a more immediate goal of returning to school. It was thought that as nurses endorsed a shorter timespan (e.g., within 3 years) to return to school, the intent to return was greater.

Table 1 shows the demographic characteristics of the participants included in the analysis. In order to test the hypotheses outlined in the introduction, a structural equation model (SEM) approach was employed. SEM uses both observed and unobserved characteristics (e.g., job satisfaction, personal motivation) to predict other characteristics (e.g., intent to return to school).

The hypothesized model was found to adequately fit the data, and the final model is presented in Figure 1. All paths were statistically significant at the p < .05 level except for the paths from professional motivation to intent to return, and from time constraints to intent to return. All paths were in the expected direction except for the path from professional motivation to intent to return (which was negative instead of the expected positive). The path coefficients in Figure 1 are standardized and can range from -1.0 to 1.0. The closer the path coefficient is to 1 (either positive or negative) indicates a greater effect.

On the basis of our estimated paths, as perceived employer discouragement increased personal motivation (.29) and professional motivation (.33) to return to school increased while job satisfaction (-.30) decreased. The estimated paths from time constraints indicated that as perceived time constraints increased, professional motivation (.30) and personal motivation (.37) increased.

Figure 1. Structural Model of Motivation and Job Satisfaction as Mediators between Inhibition and Intent to Return to School.

Note: Measurement model is excluded for simplicity. 
ns = p > .05. Standardized coefficients are shown.
The direct path from time constraints to intent to return was positive but did not have a statistically significant effect (.11). The direct path from employer discouragement to the intent to return was negative indicating that as perceived employer discouragement on returning to school increased the intent to return to school (-.24) decreased. Several indirect paths should be noted. As employer discouragement increased through both types of motivation and job satisfaction, the likelihood of indicating intent to return to school increased.

It should also be noted that this effect (.20) is slightly lower than the direct effect of employer discouragement on intent to return (-.24). Also, the mediated effect is positive (compared to the negative direct effect) which indicates that as motivation increases and job satisfaction decreases due to employer discouragement, the more likely an individual will return to school. Further, as time constraints increased through both types of motivation, a nurse’s intent to return to school increased. This effect was significant (p < .05) compared to the non-significant direct effect of time constraints on intent to return.

Overall, 31.0% of the variance in professional motivation was explained by the model. Our model explained 33.9% of the variance of personal motivation and 9.2% of the variance in job satisfaction.

Discussion
The goal of this study was to examine the structural relationship between the inhibitors (employer discouragement and time constraints) associated with the intent to return to school as mediated by motivation and job satisfaction. The hypothesis that employer discouragement has a significant negative effect on intent to return was supported. Time constraint had a slightly positive effect on returning to school but was not statistically significant. As expected, motivation and job satisfaction have a positive mediating effect between time constraints and employer discouragement and intent to return. These results suggest that as employers discourage their employees from returning to school (or to continue their education) and time constraints increase, a person is more likely to return to school if they are sufficiently motivated both personally and professionally.

The hypothesis that professional motivation had a positive relationship with intent to return was not supported. The negative effect of this relationship may indicate that professional motivation is playing a different role on returning to school.
However, in our analysis, the effect was not statistically significant so no conclusions could be drawn.

The direct relationship between employer discouragement and intent to return remained statistically significant. This result indicates that even though motivation and job satisfaction do play a role in overcoming perceived employer discouragement, the intent to return is still directly affected by perceived employer discouragement. However, the relationship between time constraints and intent to return was not statistically significant which indicates that time constraints were mediated by motivation.

The current study found that job satisfaction is being negatively influenced by employer discouragement. Past research suggests that the more opportunities there are for career advancement, the higher the job satisfaction (Zurmehly, 2008) and that as job satisfaction increases, nurses are less likely to leave their current employment in the nursing profession (van der Heijden, van Dam, & Hasselhorn, 2009). The findings in the current study support these conclusions. A significant factor in job advancement is often educational attainment. If employers are perceived to be discouraging a return to school (and thus potential job advancement), nurses are less likely to be satisfied on the job. Due to employers having such a significant impact on nurses deciding to continue their education, employers should take a more proactive role in promoting employee education support in the workplace and how a nurse’s own motivation can help overcome those barriers. It is evident that employer support plays a significant role in the motivation of a nurse to return to school both in direct and indirect ways. As policy-makers, national organizations, and healthcare employers continue to place more emphasis on nurses obtaining an increased emphasis on nurses obtaining a bachelor’s degree, a shift in continuing education support in the workplace environment may be warranted.

**References**


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The medical record has always been the means for communicating and managing the patient’s health care information. Concerns about patient safety, increasing healthcare costs and patients’ expectations have driven us to not only look at how we deliver care but question the adequacy of the paper medical record.

The paper record is no longer able to meet the demands required to improve patient safety and manage care. Information is difficult to find, illegible, outdated, filled with discrepancies, and not readily available when needed. In looking for solutions, computer technology has been utilized to transform the functionality of the medical record. A major benefit associated with the electronic medical record (EMR) is the use of clinical decision support systems (CDS) that supplement clinical decision making at the point of care.

For the last several years we have been experiencing the difficult transition from paper to a computer record. The initial electronic medical record (EMR) primarily stored and sorted data; its function was only to record information. Most recently with the Meaningful Use standards established by the American Reinvestment and Recovery Act of 2009 (ARRA), the EMR is moving beyond being a record. The nurse now has the benefit of evidence-based practice that is actively presented by integrated CDS to assist in decision-making and support of care delivery.

What does the nurse need to consider when evaluating the role of the EMR?

Patient safety is where this journey originally started. The nurse’s role is to provide safe, efficient, quality care. Let’s consider how the EMR supports quality care and how best to maximize the benefits.

Enter information as close to real time as possible

- Allergy, height and weight information becomes available to every clinician in all care setting immediately. Timely access to this information contributes to safe medication practices.
- Some systems provide alerts to warn the nurse when a patient is deteriorating. Research shows that a patient’s
condition generally deteriorates 6-8 hours prior to a code event. Vital sign and assessment information can start trending immediately to alert nursing of pending patient decline.

- Be familiar with the alerts and standards built in your system that provide valued information.
- All clinicians involved with the patients' care have timely access to the information.
- Using bar code medication administration to scan the patient and medication prior to administration of a medication adds another layer of protection.

**Physician Computer order entry**

- Information becomes available to the healthcare team as soon as it is entered.
- The risk of transcription errors is eliminated.
- The risk of over, under or missed medication dosing is reduced.
- Errors related to task duplication is reduced.
- The medication reconciliation process is the opportunity to clarify medications, reducing the risk for error.

**Avoid paper-based workarounds**

- Miscommunication is reduced.
- Eliminates the struggle of interpreting illegible hand writing.
- Frees the nurse from order transcription so they can focus on direct patient care.

**Keep current with your EMR's benefits**

- Physician Computer order entry
  - Information becomes available to the healthcare team as soon as it is entered.
  - The risk of transcription errors is eliminated.
  - The risk of over, under or missed medication dosing is reduced.
  - Errors related to task duplication is reduced.
  - The medication reconciliation process is the opportunity to clarify medications, reducing the risk for error.

- During system upgrades become aware of patient safety enhancements, application of new standards of care and incorporation of research based practices.
- Clinical decision support systems integrated in the EMR can provide us with expert recommendations. We still must rely on the wisdom of expert practitioners to apply them.

**Use EMR resources to improve patient satisfaction**

- Use the resources provided by the system to enhance patient safety, improve quality of care and provide health maintenance information to the patient.
- The EMR's accessibility provides the patient with the ability to share information in a timely manner with all their providers.

Deborah Lockman is the Clinical Informatics Nurse at Platte County Memorial Hospital in Wheatland.

Deborah’s 39 years of nursing experience includes acute care, LDRP, surgery, PACU, ICU, emergency, long-term care and home care.

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Wyoming Medical Center: Our Transition from McKesson to Cerner

By Angela LeDoux, Crystal Alberts & Vanessa Sorensen, Clinical Informatics RNs

In May of 2011, Wyoming Medical Center (WMC) made a bold decision to switch vendors. WMC had a longstanding relationship with McKesson; however, after much consideration, the administrative team approved the transition to Cerner. The approval to change vendors was only the beginning.

WMC assembled teams to design how we would use the new EMR to coordinate and document our work. We asked staff from various units to step away from their daily routine of bedside practice and help us understand how the system needed to be built to support their clinical work. We looked at every aspect of patient care from admission all the way to discharge and we learned far more than we ever imagined.

In addition to designing the system to support documentation, the nursing teams also provided critical support to the implementation of CPOE (computerized provider order entry). We decided to implement CPOE at the same time across all departments, involving 100% of our providers. It was hard to envision how our work would change when providers entered orders directly into Cerner.

In the paper world, written orders for nursing care were transcribed onto what we called the Kardex in pencil. Pencil offered us the ability to change the plan of care fairly easily based on new orders or updates from the providers. When appropriate, we would erase what no longer applied in the plan of care. In essence, we kept our house clean. Nurses had responsibilities to look through the orders every shift and cross reference new and existing orders. We would sign our names to the written orders when to acknowledge we were aware of the task, and we documented completion of the task in our nursing notes.

When we tried to recreate this workflow electronically, we hit roadblocks. The paper world cannot be duplicated 100% in the electronic world. The most unexpected thing we learned was that the old way of managing paper orders had inherent problems, and trying to duplicate “the way we’ve always done it” created concern. We could have avoided some of those problems if we had envisioned how CPOE would change our workflow.

In the new electronic world, nurses tried to cling to old habits and “just take care” of the orders profile, rather than talking to the provider and asking them to do it. In Cerner, all orders stay active until acted upon. We found that nurses were manipulating orders throughout their shift, scrutinizing and clarifying what was intended. If a true duplicate order was noted, nurses would discontinue the duplicate. Procedural orders were discontinued after the procedure. If an order was created in error, they would discontinue or void the order. Orders that no longer applied to the plan of care were discontinued. Nurses identified the circumstances in which protocol orders were appropriate and initiated them. Nurses made these decisions, usually without clarification, because the provider’s intention was considered implicit in the new orders.

Unlike the paper world, every change in the electronic world is completely transparent. Because the nursing position is not authorized for direct order entry, every time a nurse modifies, discontinues or enters an order, the system requires documentation of his or her authorization to do so. This documentation was called a “communication type.” Some “communication types” routed to providers for co-signature while others did not. Whether or not an order routed to providers for co-signature was a decision made during the design phase of the EMR project.

After our Go Live, nursing leaders questioned whether nurses were within their scope of practice when manipulating orders that were duplicative, erroneous or no longer applicable. We contacted the Wyoming State Board of Nursing (WSBN) for guidance, met with state board leaders, and shared concerns. They advised us to make some changes. They reminded us that nurses must always call and clarify with the provider prior to changing or manipulating an order and that these changes must be routed back to the provider for co-signature. We were relieved we had done this when we learned the Joint Commission had cited other hospitals for similar issues.

As hospitals transition to electronic medical records and CPOE, nurses must set the standard for protecting our profession by carefully evaluating how new workflows stack up against our scope of practice. We found it very helpful to engage the WSBN in making these decisions. Nursing practice will evolve with changing technology. We have to stay alert and learn from each other to ensure that we are staying within our scope of practice.
The Wyoming Center for Nursing and Health Care Partnerships has several priority areas, including developing nursing leaders, enhancing talent pipeline development through sponsorship of the AHEC Health Care Careers Camp each summer, and facilitating academic progression in nursing from ADN to BSN and higher. For more information on the Center’s work on these priority areas, please see our Annual Report available on our website (go to http://www.wynursing.org/news/ and click on “WCNHCP Annual Report”).

One priority area that has been a major focus for the Center this year is data driven workforce planning. One of our key initiatives under this workforce planning priority area has been to establish metrics to track educational background and diversity of nurses in Wyoming. In other words, to develop a mechanism to collect ongoing data about nurses in Wyoming that can be analyzed anonymously and aggregated across the state to help ensure data driven workforce planning for Wyoming. This can help us answer lots of questions, such as “Is the proportion of men in nursing increasing?”, “Is the average age of RNs continuing to climb or is it starting to decrease?”, and “Are more nurses going on for baccalaureate or higher education?” And the answers to those questions can help us as we make decisions about nursing and nursing education.

In partnership with the Wyoming Department of Workforce Services (DWS), the Wyoming Survey and Analysis Center (WYSAC), and the Wyoming State Board of Nursing (WSBN), we reviewed national standards and recommendations for workforce planning data collection and evaluated existing sources of data on the nursing workforce in Wyoming. The National Forum of State Nursing Workforce Center developed recommended minimum nursing datasets that capture nursing supply and demand as well as data on nursing education, e.g., number of students. (See http://www.nursingworkforcecenters.org/minimumdatasets.aspx for more information about the minimum datasets). Licensure and renewal information provided by nurses to the WSBN and nursing education program reports submitted to the WSBN are key sources of data on the nursing workforce in Wyoming. Although the State of Wyoming captures much of the recommended minimum datasets, we found several gaps, e.g., educational background of RNs, and diversity of nurses, nurse educators and nursing students.

With funding from the Robert Wood Johnson Foundation and the Wyoming Workforce Development Council, we’ve worked closely with the WSBN to explore ways that the licensure renewal process would capture the recommended minimum dataset. The WSBN is in the process of finalizing the renewal process and if all goes as planned you’ll see a few new questions that when aggregated will give us some better information about the educational background and diversity of nurses in Wyoming. In addition, the Nurse Educators of Wyoming worked closely with the WSBN to modify the annual program reports so that they also address the minimum nursing education program dataset, e.g., age, gender and diversity of nursing students and nursing faculty. Again, when this data is aggregated it will give us a much clearer picture about the pipeline into nursing. Plus we’ll have a much clearer picture of the nursing faculty workforce in Wyoming.

In addition to our work to ensure that the state is collecting data on the licensing and renewal processes, the Wyoming Workforce Development Council funded the WCNHCP in 2013 to conduct a survey of nurses across the State of Wyoming to better understand the educational background and mobility of nurses. The survey was conducted in partnership with the DWS Research & Planning Office, WSBN, and the Wyoming Survey and Analysis Center (WYSAC) at the University of Wyoming. Initial results from the Research & Planning office have been released and are available at the following: http://doe.state.wy.us/lmi/nursing.htm. This report focuses on the impact of motivation and job satisfaction on nurses’ decisions to return to school. Of interest, is the role that employer support (or lack thereof) plays in nurses returning to school.

WYSAC also completed further analyses of the survey responses and their report, which should be released in late summer 2014, looks at educational mobility in nursing. Of the almost 800 RNs who responded to the survey, 46.6% had as their highest degree an associate degree or diploma, 65.5% worked as a staff nurse, and 72.5% were working full-time in nursing. Almost 56% earned their highest degree in Wyoming and for most of the respondents their most recent degree was in nursing. Interestingly, and probably no surprise, RNs reported having multiple associated degrees or multiple graduate degrees. Despite changing employment patterns in the US and in Wyoming with an emphasis on hiring nurses with baccalaureate degrees, only 10% of the RNs in this study were currently enrolled in a college program, typically a baccalaureate program. When asked about returning to school, 52% reported they were not interested in returning to school and almost 20% said they did not know.

Finally, the WCNHCP also collaborating with faculty at the University of Wyoming to capture the demographics and practice patterns of advanced practice registered nurses (APRNs) in Wyoming. This survey has been completed and results should be released in Fall 2014. Stay tuned!

The WCNHCP is the nursing workforce center for the State of Wyoming. The mission of the center is to strengthen the nursing workforce through on-going 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.
The License renewal period will begin October 1st. The following are the basic renewal requirements:

**APRN:** (License Fees = RN license $110 + APRN Recognition $70/each)
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
  - Provide proof of completion of 60 contact hours of continuing education in the last 2 years related to your specialty area(s) of advanced practice
  OR
  - 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:** (License Fee ~ $70)
- 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:** (License Fee = $110)
RNs 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:** (License Fee = $90)
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:** (Certificate Fee = $50)
CNAs must meet ONE of the following requirements:
- Complete a board approved nursing assistant training program and competency evaluation AND passed a national nursing assistant certifying examination within the last 2 years
  OR
- Worked a minimum of 16 hours as a CNA AND completed 24 hours of learning activities related to CNA practice since the last renewal
  OR
- Participated in direct patient care through an approved nursing program since the last renewal (transcript required)
All renewals are processed online and applications will be available online (http://nursing.state.wy.us) starting October 1.

Renewal items requiring documentation (CEs, National Certification, Refresher courses, etc) can be entered electronically. If there are questions regarding the information or you are chosen for audit, you may be required to send in the documentation.

Continuing education hours may be obtained from conferences, seminars, lectures, in-services, and online programs. Make certain you receive proof of attendance showing title, date, hours, provider, and contact information.

There is a $5 credit card processing fee. If you choose not to pay by Credit Card, complete the online application, print the payment page at the end, submit the application electronically, and send in payment (money order or cashier’s check) with the payment page. Cash, personal checks and prepaid debit cards are NOT accepted.

If you have a YES answer to a self-disclosure question, continue to submit the application and fees. Refer to the instructions regarding any additional documents needed. The application will be on hold until that material is received and a determination is made regarding the renewal request. Your license will not expire while under review.

If the WSBN Compliance and Discipline Department is investigating a complaint against you at the time your renewal application is received, you will receive a letter from our office indicating that you may continue to work under your current license or certificate, but your license or certificate will not be renewed until the complaint is resolved.

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NEW ADVISORY OPINIONS

Please note that there have been some recent additions to the advisory opinion list. New opinions from the July Board meeting are:

APRN Population Focus
- C-Arm Positioning and Operation
- Cervical Ripening Agents and Prostaglandin Suppositories
- Chest Tube, Mediastinal Tube and Pleural Drain Removal
- CNAs in Other Roles
- Cosmetic and Dermatologic Procedures
- Educational Preparations for Licensure, Certification and Recognition
- Licensed Nurse/CNA Functioning as Endoscopy Technician
- Exam by Sexual Assault Nurse Examiner
- Determination of Ruptured Membranes
- Gastrostomy Tube Reinsertion into Mature Site
- Intraperitoneal Catheters
- Intraventricular Implanted Devices and Temporary Intracranial

Catheters
- IV Chelation Therapy
- LPN and RN Scope of Practice
- Management of Analgesia by catheter in the Pregnant Client
- Medication Administration during Pandemic
- Nurse-Client Relationship
- Paid Feeding Assistant
- PCA by Proxy
- Central Lines and Peripherally Inserted Central Catheters
- Relaying Physician Orders
- Reversal of Advisory Opinions
- Rhogram Administration by the LPN
- Spirometry in Occupational Safety and Health

The link to the advisory opinions is: https://nursing-online.state.wy.us/Default.aspx?page=31. The Committee plans to add more opinions to the website by October 2014.
For most healthcare practitioners in Wyoming, prescribing can be a difficult challenge due to our state’s rural nature, diverse population, culture and limited accessibility. However, in Wyoming, practitioners have access to a unique 24/7 database for checking a patient’s controlled substance use. It is called the Wyoming Online Prescription Database (WORx) and is a tool used for checking a patient’s history of prescriptions for controlled substances, II, III and IV.

WORx is the Prescription Drug Monitoring Program developed in 2003 to help identify and prevent abuse, misuse and addiction. The program receives about 1.2 to 1.3 million scripts a year. The program originally started collecting data in the summer of 2004 with some of the first reports going to practitioners in October of that year. Since the database went online July 17, 2013, practitioners and pharmacists have searched over 71,000 patient profiles.

Is WORx working? According to the database, doctor shopping has fallen since 2009 starting with 318 doctor shoppers and falling to 169 by the end of 2013. If we compare the first six months of 2013 to the first six months of 2014, doctor shopping has dropped 49%. Practitioners can have a copy of the patient’s drug history at the point-of-care when patients are drug seeking. It could be 2:00AM at the emergency department and a patient is drug seeking. Practitioners could and should have a report ready in hand before they see the patient. Doctor shopping is defined by W.S. 35-7-1033 (a) (iii) (A) “Failing to disclose to a practitioner that a person has received the same or similar controlled substance or prescription for a controlled substance from another source within the prior 30 days.”

A Wyoming pharmacy has to, by law, download scripts to our vendor every 7 days and we do get 100% participation each week. A non-resident pharmacy who distributes controlled substances into Wyoming also has to be registered with the Wyoming State Board of Pharmacy and download each week to the Wyoming database. A practitioner’s search is defaulted to the last 12 months worth of a patient’s prescription history. If there are blanks or gaps in a patient’s report, please contact the pharmacy directly. The Board of Pharmacy cannot make any changes to the database.

Who can access the WORx reports? According to W.S. 35-7-1060 (c) (i) “the board may release information to practitioners and pharmacists when the release of the information may be of assistance in preventing or avoiding inappropriate use of controlled substances.” In Wyoming, there is no delegate access to these reports; only the practitioners and pharmacists can see the reports. Patient reports are federally protected health information which cannot be stored in a patient’s chart nor can the reports be shared with anybody. If there are patients of concern, the proper course of action is to “suggest” that the other practitioner request their own copy of the patient’s report.

The Wyoming Online Prescription Database (WORx) is a useful tool when properly accessed and it is a proven asset against drug seeking individuals. The next enhancement will be interstate data sharing to assist practitioners even more in the fight against prescription drug abuse, misuse and addiction.
The use of electronic medical records, or EMR, is expanding rapidly. Driven by federal mandates and payer incentives, health care providers are nearly being forced to move into age of electronic record keeping. While there are numerous benefits to EMR, it can also have its pitfalls.

A complaint the Board of Medicine often receives is that a physician or physician assistant “seemed more interested in the computer screen than in me!” The detail and depth of the data to be entered into EMR systems necessarily demands focus to ensure accuracy, but this can lead to a perceived divide between care giver and patient. The patient can occasionally be left feeling that he or she is trying to get the attention of a teenager playing a video game, rather than having a meaningful discussion of health issues with a caring professional.

The ability of EMR systems to require, or “force,” entries in fields can also slow down the health care process. What used to be a routine, ten-minute “med check” appointment can now stretch into twenty and even thirty minutes, as the physician or PA enters required data that may not materially relate to the patient’s current issues or the purpose of the visit. While this results in a robust body of data, it sometimes seems to be information gathering for the sake of gathering information.

Of course, no discussion of EMR would be complete without addressing the cost factor. As small, independent practices struggle with shrinking reimbursement rates, rising costs and increasing regulatory burdens, the expense of mandated conversion to EMR systems can be the last straw. Systems can cost tens, and even hundreds, of thousands of dollars; constant maintenance costs, updates and upgrades, and hardware requirements make EMR systems consume cash, sometimes at unsustainable levels. The high entry costs, and the ongoing expenditures to keep the EMR systems running, increase the pressure on independent practices to sell out to hospitals and their physician groups, which can better absorb them.

Finally, while EMR can enhance patient care, it can also foster complacency and sometimes, unfortunately, even laziness. Providers have been known, on occasion, to use the cut-and-paste function on their computer to duplicate data from one patient to another. This can lead to implausibly-detailed records from an appointment far too short to have actually included all of the diagnostics necessary to yield a report of that length. Conversely, it can result in sparse to non-existent narrative as the provider struggles to balance data entry with giving the patient the attention and care he or she deserves.

This is not to suggest, however, that all aspects of EMR are negative. The time-stamp function in EMR provides a (usually) unalterable record of patient care and the resulting data. Automatic cross-checks enhance patient safety even if they sometimes seem repetitive and annoying. The growing ability for systems to “talk” with each other also moves us closer to giving all providers – regardless of their location – rapid access to the same information about a patient, improving outcomes and perhaps reducing costs by eliminating redundant tests and procedures.

Moving forward, continuing improvements in voice recognition software and technology will make data entry easier for providers, reducing the need for “hunt and peck” typing on virtual keyboards and distraction from the patient. Medical practices will exchange the ubiquitous patient questionnaire on a clipboard for tablet computers that allow the patient to provide the same information, but eliminate manual data entry by staff and directly load the information into the EMR system. That will also help free physicians, PAs and nurses to give more direct attention to patients and less to screens and keyboards. Importantly, the ability to send prescriptions directly to pharmacies through electronic systems should dramatically reduce prescription forgery and alteration – especially for controlled substances.

While the road to adoption and integration of EMR into medicine has not always been smooth, and there will be challenges going forward, there’s no question it is here to stay. The trick will be to make the EMR into the tool that supports and enhances quality patient care, rather than the tail that wags the health care dog.

I am not telling you it’s going to be easy. I’m telling you it’s going to be worth it.
—Art Williams, motivational author
Nurses Adopt Electronic Health Records

(This piece originally appeared in Science of Caring, a publication of UC San Francisco School of Nursing.)

As health care reform and federal incentives for “meaningful use” of technology have hospitals, clinics and physicians’ offices racing either to transition from paper or to update existing electronic health records (EHRs), nurses are carefully monitoring the effects of this technology on their ability to serve patients.

Recent studies indicate that the challenges are many and the learning curve can be steep, but in the end, there are clear benefits. Nurses are especially appreciative of how more and better information often fosters measurable improvements in everything from pneumonia and pressure ulcer prevention to more appropriate screening and better outcomes for patients with chronic conditions. A University of Pennsylvania study found that nurses working with EHRs consistently reported more improvements to nursing care and better health outcomes for patients than nurses working in hospitals without this technology.

The challenge is getting there from here. That’s why faculty and alumni from UCSF School of Nursing are among those synthesizing an emerging set of best practices that can ease the learning curve for those starting out, and indicate promising areas for improvement.

Marilyn Chow (UCSF School of Nursing ’70, ’72, ’82), vice president, National Patient Care Services at Kaiser Permanente, continues to be instrumental in Kaiser’s most recent EHR implementation, which is often cited as a national model. She also co-authored a book chapter on nursing’s role in the ongoing project.

“Today, [the country’s health care system] is going through a period of transition to using new technology such as EHRs,” says Chow. “We are already changing nursing practice for the better and, over time, we will continue to add value to what nurses can do.”

But adding value, say Chow and others, depends on participants remembering that all health information technology (HIT) projects are a means to an end, catalysts for change in how clinicians and their supporting institutions organize and deliver care.

Adding value also depends on gleaning important lessons from some of the difficult early implementations. The following considerations seem especially important.

Have Clear Goals and a Sense of Where You Are

Successful EHR implementations, says Chow, begin with framing the goals properly. She is particularly focused on using data to improve care. “If you don’t have a plan for how to mine your data to create new, evidence-based practices, then your build may not enable you to change nursing practice. The design of the build must address how you can retrieve meaningful data,” she says.

UCSF faculty member Patricia Dennehy, who directs Glide Health Services, a UCSF nurse practitioner-managed clinic in San Francisco, recently co-authored a paper in the Journal of the American Medical Informatics Association about Glide’s
EHR implementation. She echoes what Chow has to say about the benefits of using data to improve care delivery.

Dennehy also notes the importance of understanding your existing system. “We were greatly hindered by a weak infrastructure in our implementation of an electronic system,” says Dennehy.

**Involve Clinicians and Clinical Informaticists from the Outset**

Another key lesson, say both clinicians and product vendors, is to involve doctors and nurses in product development from day one.

“I was called into one hospital system after its management and IT teams built their electronic record and then put it in front of the users,” says Terri Gocsik, an administrative nurse for many years, before becoming a consultant for Aspen Advisors, a firm that helps providers implement HIT. “They wound up pulling the plug and starting over with another vendor, this time involving clinicians in the design and build."

“For us, the RNs, NPs and nurse scientists are an integral part of the clinic,” says UCSF’s James Kahn, who directed development of both HERO (Healthcare Evaluation Record Organizer) – a web-based electronic medical record system used at San Francisco General Hospital (SFGH)’s AIDS ward – and its companion piece, myHERO, a publicly accessible personal health record linked to HERO, for patients to learn about their health.

Nurses’ involvement led to numerous modifications, including an urgent care note for a nurse-only visit. “We worked with nurses and certifying bodies to make sure we had all the different elements, populated with drop-down lists, and the note has made a real difference in nurse’s workflow and billing,” says Kahn.

Gina Wade (UCSF School of Nursing ’98), executive director for clinical informatics at Adventist Health – a large, integrated delivery system in the western United States – says that nurse informaticists can optimize the communications between clinical and IT teams, because they are taught to be the translator (read more about Gina Wade). Chow notes that Kaiser has had clinical informaticists aboard – both physicians and nurses – throughout its process.

**Strike a Balance on Customization**

Yet despite the importance of considering nurses’ workflow, all agree there is a tipping point beyond which further customization causes more problems than it solves.

“In some settings, the system was so customized that it became very slow,” says UCSF School of Nursing faculty member Joanne Spetz, who has run studies on the effect of HITs on nursing. “When a system changes workflow, the real need might be for better training, rather than more customization.”

Chow agrees and notes that without some careful, standardized elements, the goal of harvesting data is compromised. “Good analytics need the most discrete data element identified – not just apples to apples, but pippins to pippins,” she says. “I really pushed for a consistent build in our inpatient record and initial assessment across our 36 hospitals, so if we’re talking about pressure ulcers, stage 3 and 4, you can see what set of interventions actually led to a faster healing process.”

Besides, says Gocsik, with the pressures of federal “meaningful use” standards – the Centers for Medicaid & Medicare Services (CMS) requires providers to show they’re using federally certified EHR technology in measurable ways –
customization options are increasingly constrained. “Software vendors are trying to meet government-imposed regulations and timelines, which means they can’t focus as much on user-group feedback as they did in the past,” she says.

**Prepare the Staff**

Regardless of the degree of customization, all agree it’s important to do as much as you can ahead of time to prepare users for changing workflows. “You have to figure out how new technology will help or change clinical processes and train staff accordingly,” says Spetz. A combination of classroom education, self-directed practice, superusers and parallel workflow can all help in the preparation process so that when the system goes live, nurses are relatively comfortable and don’t need to take 10 steps back.

“We scheduled a number of ‘rah-rah’ meetings, but we were also very practical,” says Nurse Practitioner Darlene Lee, who manages the Rheumatology Clinic at UCSF Medical Center, where a new EHR system began operating in July 2011. “Each of my staff diagrammed their workflow and we identified where it would impact them, so they were fully engaged by the time the system actually came around.”

“I think it’s critical for nurses to get involved,” says Wade. “It’s also important for them to understand that often what is coming in EHR is driven by regulatory requirements. If you don’t keep up on what you need to do for certain disease conditions, you won’t understand why it’s in the system.”

**Anticipate Resistance**

While up-front preparation is critical, nurse administrators still need to anticipate resistance at every point along the way.

Sometimes that resistance stems from nurses’ sense that systems appear to be geared toward doctors’ workflows. Gocsik says that in many cases, that perception is reality.

“We’re asking physicians to do things that are coming right out of their pocket, and we have to look at minimizing the productivity risks for them,” she says. “That doesn’t mean we can’t listen to nurses or their concerns are unrelated, but there has to be sensitivity on nurses’ part…. The more we can have interdisciplinary teams, the more we can have a win-win situation.”

In addition, says Spetz, “We know there tends to be less resistance among nurses who are more tech savvy,” those who grew up with a computer, are able to type quickly and are comfortable clicking around a screen. “People need to understand their staff and bring the less tech savvy along.”

Part of that is helping people understand how the system will benefit them. “The value of the change needs to be understood, and that value is different for each person who touches the system,” says Dennehy.

Sometimes, however, understandable resistance can be addressed by a discussion of the greater good. At SFGH, clinician diagnoses automatically populate the patient’s personal health record, which raised concerns about patients viewing some more controversial clinician notes. Through open discussions, says Kahn, the team finally decided that the need for transparency outweighed the concern; the key was helping staff have appropriate discussions with patients.

**Gird for the Initial Weeks**

In the end, no matter how well prepared a team may be, people need to expect that the initial weeks will bring a drop in productivity. “We are continuously stunned that some people don’t assign any extra nursing staff during this time,” says Spetz. “Organizations should assume there needs to be a trainer or superuser on site 24/7 and at least one extra nurse for every shift.”

Esker-D Ligon, a nurse practitioner and director of behavioral health services at Glide, says, “At first, it really did impact the level of care we were able to provide. Along with hiring temporary staff to load up information from the paper charts, we had to take provider schedules down.”

The UCSF Rheumatology Clinic went to half-time schedules for a few weeks. “What you learned in class was nowhere near enough for what you needed in the real world,” says Lee. “Having trainers on-site helps, but when you have a live patient and feel pressured to make eye contact and do this at the same time… it’s a whole new way of dealing with the patient.”

**Understand the Impact on Patient Interactions**

The eye contact issue raises another concern many nurses have expressed: what are the subtle effects on patient interactions? Three overlapping challenges seem to be at play.

Time is one. Research has demonstrated that nurses spend more time inputting information with EHRs, but less time finding the information needed to make wise decisions. Usually, that clinical information is also more complete and more accurate than it was with paper records.

That said, for home health nurses who must race from one setting to the next over their day, the time issue can be particularly vexing. “The inputting of information definitely puts pressures on,” says Barbara Maury of UCSF Home Health Care. “But ultimately getting the data into the computer correctly will be the best for patient care, so we try to address the time pressures by carefully keeping our nurses in a certain geography to cut down on travel.”

A second concern is that computer screens could become physical barriers between nurse and patient. “I show both nurses and doctors how to create a triangle between you, the patient and
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the computer screen,” says Kahn. “You can then use the screen as a blackboard, a teaching moment, a way to actively engage patients in health care.”

Lee uses a similar approach, and Ligon says, “Patients aren’t that bothered if you explain you have to do the documentation on the computer…. They like the fact that you’re putting in information as you go along. They feel heard more.”

Third, some nurses have worried that templates will foster a robotic effect on their clinical judgment. Chow believes this can be addressed through time and education - and it is similar to some past challenges.

“When we would teach students in the pediatric nurse practitioner program, we’d find they were so worried about the physical exam – where they were placing a stethoscope - that they couldn’t focus on engaging with the mom. We realized we had to first get them comfortable with the physical exam,” says Chow. “It’s the same thing here. There will be a period of adjustment, but as we get better at streamlining the documentation, problems will ease and nurses may actually have more time to interact with patients.”

Strive for Interoperability Across Settings

To truly achieve the type of change that health care reformers seek, tighter clinical integration across practice settings is a must. Systems have to talk with each other to gather the clinical information they need. This is the thinking behind health information exchanges that will store and communicate patient data across multiple health systems.

“Fully integrated systems like Kaiser and the VA have unique advantages addressing transitional care issues,” says Spetz. “At this point, the independent or rural hospital rarely can access what goes on in ambulatory settings and vice versa.”

Even at Kaiser, says Chow, the transition from hospital to ambulatory settings “is not as seamless as we’d like yet. We’re constantly asking, What is it that nursing needs to assure there is good transitional care between settings? I don’t know that any system has that fully figured out yet.”

Glide and other community clinics and hospitals in San Francisco are trying. “Right now, if we identify ourselves as the primary care provider within the San Francisco Community Clinic Consortium, we actually get email notification if a patient is in the ER, which triggers us to look for a report,” says Dennehy. “Hopefully, next year we would be notified that information was available and be able to log in to a secure portal for the information in a format that we could import directly into the patient’s health record.”

Keep an Eye on Information Overload

For all the advantages of having more information at one’s fingertips, nurses and others have begun to voice concerns about information overload.

“In designing these systems you have to think about our ability to retain and incorporate information; things can get to the point where a nurse isn’t seeing the important information clearly,” says Chow, who believes this is an important area for research. “We need to create [decision support] systems that have a limited number of logical triggers and alerts that focus entirely on what the nurse is going to need to know, so that the nurse can focus on the patient.”

Expect Nonstop Changes

All of the above concerns lead to one that many organizations tend to overlook: the need to see EHR/ HIT implementations as a process of continual quality improvement (QI).

“Ongoing training is a big concern and a hidden cost,” says Dennehy. Glide is especially affected by this because it’s a teaching facility, with 12 to 13 nursing students a quarter, and so has needed to retain someone full-time just to get those students on board with the new EHR system.

But more than that, in every setting, issues pop up regularly. To address this, a consistent theme is the need for open lines of communication, clear governance processes and regular meetings. “We find that until we talk about it, we may not know that my colleague next to me is doing something differently,” says Glide Nurse Practitioner Chenin Kenig.

“You have to make a commitment to an ongoing process, across the board and from all levels of participants,” says Dennehy. “We’ve had a QI team since our clinic opened; implementing this tool is not the only change event in our history, and we understand the commitment.”

Measure the Impact on Patient Care

The good news is that those who make the commitment are finding improvements in patient care. “The documentation has increased so much in the favor of patient care that any learning curve is worth it,” says Kenig. “Patients are 10-fold safer.”

At Glide, two years ago, diabetic patients’ HbA1c count was typically in the 8 percent range, with the national average around 9 percent. Today, at Glide, HbA1c counts are at 7.7 percent. In addition, says Dennehy, blood pressure screening has improved. Mammographies are up, as are colorectal exams, flu shots and screening for smoking and depression. Kaiser has had similar improvements in population care as well as at its hospitals, where
reductions in pressure ulcers have been documented, says Chow.

“It’s a tool for us to track chronic conditions in a way we never did before,” says Dennehy. “In one meeting, we can do short, PDSA (Plan-Do-Study-Act) cycles, notice that we haven’t tested lipids in a diabetic frequently enough, see why we fell off, and then quickly adapt. We could never do that when the information was buried on paper charts.” Moreover, she says, they can show trends on individual patient charts and share those with patients.

In addition, Kenig and Ligon talk about being able to compare their patients’ results with others at the clinic and then have a discussion about different patterns for different diagnoses and risk factors – and the effects on patient care. “We can really evaluate how we’re using our visits…. You have to have some strong providers and trusting communication, but this can have a very good effect on care,” says Kenig.

“I think we all have a stronger awareness of the whole patient; I can see what happens in the ER, in general medicine,” says Lee. She tells of a patient who had a rheumatoid arthritis flare the previous weekend, while Lee was out of the office. “I could just pull her chart electronically and e-prescribe prednisone; I could never have done that before.”

“I love the EHR,” says Maury. “Being able to extract information and communicate with other providers quickly, being able to print out a medication list with 15 meds with the press of a button is huge.”

Looking Ahead

Perhaps what’s most exciting is that EHRs still have an enormous amount of untapped potential. “As you get more and more sophisticated, you can use the system so much more efficiently,” says Lee. “Your understanding is constantly evolving.”

“Where we have to go is decision algorithms to digest all this information from so many sources. Researching how to do that effectively and the implications it will have for nursing care is very, very important,” says Chow.

Kahn believes there will be an enormous leap forward when patients become fully integrated with the system. “Until now, providers have had a choke point on health information, but if we can demystify health information through personal health records, we can help make patients more responsible for their own care,” he says.

Yet even in these relatively early days, with their many pitfalls, the universal sense from this group is that EHRs have already begun to transform nursing care and the entire health care system for the better.

“Even in our worst moments – we had some dreadful moments in terms of connectivity – there was a commitment to continue, because from the get-go, we knew it would be absolutely transformative,” says Dennehy. “Besides, there’s no turning back now.”

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Ten Key EHR Lessons for Nurses and Nurse Administrators

1. Make sure your current infrastructure can support robust, interoperable EHRs.
2. Involve nurses and nurse informaticists in design and implementation.
3. Strike a balance on customization.
4. Prepare the staff, but anticipate resistance.
5. Gird for productivity losses in the initial weeks.
6. Design a system focused on using data to improve care.
7. Understand and prepare for the impact on patient interactions.
8. Strive for interoperability across settings.
9. Guard against information overload.
10. Measure results and have a process in place for nonstop change.
Grounds for discipline for all licensees or certificate holders are found in Wyo. Stat. Ann. § 33-21-146, as well as located in the Administrative Rules and Regulations as follows: Chapter 8, Section 3. Grounds for Discipline include: (i) Inability to function with reasonable skill and safety for the following reasons, including but not limited to: (A) Physical or mental disability; (B) Lack of nursing competence; (C) Substance abuse/dependency; (D) Client abandonment; (E) Client abuse, including sexual abuse; (F) Fraud or deceit, including, but not limited to, omission of required information or submission of false information written or verbal; (G) Client neglect; (H) Violation of client boundaries, including sexual boundaries; (I) Performance of unsafe client care; or (J) Violation of privacy or confidentiality in any form, written, verbal, or technological; (ii) Misappropriation of client property; (iii) Criminal felony conviction; (iv) Drug diversion-self/others; (v) Sale, unauthorized use, or manufacturing of controlled/illicit drugs; (vi) Failure to comply with reasonable requests from the Board including, but not limited to: (A) Responses to administrative complaints; (B) Responses to formal pleadings such as notice of hearing and/or petition and complaint; (C) Written response to request for explanation for failure to disclose required information; (D) Failure to cooperate in investigation; or (E) Failure to appear at properly noticed hearings; (vii) Failure to conform to the standards of acceptable and prevailing nursing practice, nursing practice or the CNA role, in which case actual injury need not be established; or (viii) With respect to APRNs, failure to supervise or to monitor the performance of acts by any individual working under the direction of the APRN.

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

**KRISTINE SCOTT**
CNA #19728
**VOLUNTARY SURRENDER**
Kristine Scott, CNA, entered into a Settlement Agreement, Stipulation and Order for Voluntary Surrender of her Certified Nursing Assistant Certificate, approved by the Board on July 8, 2014 as a result of alleged violations of the Nurse Practice Act and Board’s Rules. Ms. Scott was previously the subject of a Conditional Certificate Order due to allegations of chemical dependency, and was subject to professional monitoring. Ms. Scott failed to comply with requirements and did not notify the Nurse Monitoring Program of required information. Ms. Scott requested to voluntarily surrender her CNA certificate.

**WHITNEY BARRETT**
RN APPLICANT
**CONDITIONAL LICENSE**
Whitney Barrett, applicant for licensure as a Registered Professional Nurse, entered into a Settlement Agreement, Stipulation and Order for Conditional License, approved by the Board on July 8, 2014, as a result of prior discipline by the Board, which was based upon a prior criminal conviction and substance abuse issues, constituting violations of the Nurse Practice Act and Board’s Rules. Ms. Barrett will be subject to professional monitoring by the Nurse Monitoring Program.

**ANDREA VANDERPOOL (BAKER)**
LPN #7694
**CONDITIONAL LICENSE**
Andrea Vanderpool (aka Andrea Baker), LPN, entered into a Settlement Agreement, Stipulation and Order for Conditional License of her Licensed Practical Nurse License, approved by the Board on July 8, 2014, as a result of alleged violations of the Nurse Practice Act and Board’s Rules, including drug diversion, chemical dependency, and failure to conform to the standards of prevailing nursing practice. Ms. Vanderpool (Baker) was previously the subject of a summary suspension order. Ms. Vanderpool (Baker) will be required to continue in treatment and be professionally monitored by the Nurse Monitoring Program (NMP), and have a worksite monitor when she obtains a nursing position, subject to additional limitations and restrictions.

**ABIGAIL WAGSTAFF**
GNA TEMP. PERMIT #1479
**LETTER OF REPRIMAND**
Abigail Wagstaff, GNA, entered into a Settlement Agreement, Stipulation and Order for Letter of Reprimand approved by the Board on July 8, 2014, as a result of alleged violations of the Nurse Practice Act and Board’s Rules. Ms. Wagstaff engaged in unlicensed nursing assistant practice by continuing to practice after expiration of her GNA temporary permit. Ms. Wagstaff will be required to undertake certain training prior to any approval of a permanent CNA certificate.

**MICHELLE TWEETER (McQUIRE)**
CNA #2482
**SUSPENSION**
Michelle Tweeter (aka Michelle McQuire) entered into a Settlement Agreement, Stipulation and Order for Suspension of her CNA Certificate, approved by the Board on July 8, 2014, as a result of alleged violations of the Nurse Practice Act and Board’s Rules, including criminal conviction, drug diversion, chemical dependency and failure to conform to the standards of prevailing nursing practice. Ms. Tweeter diverted controlled substances and pled guilty to fraudulently obtaining prescriptions related to her diversion of controlled substances from clients working as a Certified Nursing Assistant. Ms. Tweeter subsequently received treatment for her chemical dependency. Ms. Tweeter’s certificate was previously placed on summary suspension precluding her from practicing as a CNA. If Ms. Tweeter seeks to be reinstated, she will be required to cooperate in further investigation, including submitting to substance abuse evaluations and treatment, professional monitoring, as well as completion of indicated training, including meeting competency requirements for recertification.

**RACHAEL EASTMAN**
CNA #25660/ GNA TEMP PERMIT #2552
**LETTER OF REPRIMAND**
Rachael Eastman, CNA/GNA, entered into a Settlement Agreement, Stipulation and Order for Letter of Reprimand approved by the Board on July 8, 2014, as a result of alleged violations of the Nurse Practice Act and Board’s Rules. Ms. Eastman engaged in unlicensed nursing assistant practice, by continuing to practice after expiration of her Temporary GNA Permit. Ms. Eastman will also be required to undertake certain training.
LACEY BOEHME
CNA APPLICANT
LETTER OF REPRIMAND
Lacey Boehme, entered into a Settlement Agreement, Stipulation and Order for Letter of Reprimand, approved by the Board on July 8, 2014, as a result of alleged violations of the Nurse Practice Act. Ms. Boehme engaged in the unlicensed practice of a nursing assistant after her certificate expired. Ms. Boehme’s application for certification as a Certified Nursing Assistant was approved subject to the reprimand of her certificate and she will be required to complete certain training.

WHITNEY BORTON
GNA TEMP. PERMIT #3168
LETTER OF REPRIMAND
Whitney Benton, GNA, entered into a Settlement Agreement, Stipulation and Order for Letter of Reprimand approved by the Board on July 8, 2014, as a result of alleged violations of the Nurse Practice Act and Board’s Rules. Ms. Benton engaged in unlicensed nursing assistant practice, by continuing to practice after the expiration of her temporary GNA permit. Ms. Benton will be required to undertake certain training.

JAMIE WILLIAMS
CNA #25407/ GNA TEMP. PERMIT #1472
LETTER OF REPRIMAND
Jamie Williams, CNA/GNA, entered into a Settlement Agreement, Stipulation and Order for Letter of Reprimand approved by the Board on July 8, 2014, as a result of alleged violations of the Nurse Practice Act and Board’s Rules. Ms. Williams engaged in unlicensed nursing assistant practice, by continuing to practice after expiration of her temporary GNA permit. Ms. Williams will be required to undertake certain training.

SUSAN HUTCHINSON
LPN #6779
SUSPENSION
Susan Hutchinson, LPN, entered into a Settlement Agreement, Stipulation and Order for Suspended LPN License, approved by the Board on July 8, 2014 as a result of alleged violations of the Nurse Practice Act and Board’s Rules, including criminal conviction and substance dependency. If Ms. Hutchinson seeks to be reinstated, she will be required to cooperate in further investigation, including submitting to evaluations and recommended treatment, professional monitoring, as well as completion of indicated training, including meeting competency requirements for relicensure, if necessary.

STEPHANIE DUPREE
APRN #24481.1132
LETTER OF REPRIMAND
Stephanie Dupree, APRN, entered into a Settlement Agreement, Stipulation and Order for Reprimand and Suspension of Authority to Prescribe Controlled Substances through the Advanced Practice Registered Nurse License, approved by the Board on July 8, 2014, as a result of alleged violations of the Nurse Practice Act and Board’s Rules, including, substandard care, failure to meet acceptable standards applicable to advanced practice registered nurses, including those related to prescriptions of controlled substances. Ms. Dupree will be required to participate in coursework and in particular education related to prescription practices. Ms. Dupree will also be monitored by the Nurse Monitoring Program for compliance.

KIMBERLY GOOD
CNA #24481
VOLUNTARY SURRENDER
Kimberly Good, CNA, entered into a Settlement Agreement, Stipulation and Order for Voluntary Surrender of her Certified Nursing Assistant Certificate, approved by the Board on July 8, 2014, as a result of alleged violations of the Nurse Practice Act and the Board’s Rules, including drug dependency and unauthorized use of controlled substances.

SANDRA HAM
APRN #23899.0963
LETTER OF REPRIMAND
Sandra Ham, APRN, entered into a Settlement Agreement, Stipulation and Order for Reprimand of Advanced Practice Registered Nurse License, approved by the Board on July 8, 2014, as a result of alleged violations of the Nurse Practice Act and Board’s Rules, including, performance of unsafe client/patient care related to chronic pain management, failure to meet acceptable standards applicable to advanced practice registered nurses, including those related to proper documentation of prescriptions of controlled substances. Ms. Ham also was reprimanded for failure to renew her prescriptive authority. Ms. Ham will also be subject to supervision of prescriptive practices, including peer review or quality assurance requirements and reporting which shall be monitored by the Nurse Monitoring Program.

LESLIE RILEY
RN #29181
VOLUNTARY SURRENDER
Leslie Riley, RN, entered into a Settlement Agreement, Stipulation and Order for Voluntary Surrender of her Registered Professional Nurse License, approved by the Board on July 8, 2014, as a result of alleged violations of the Nurse Practice Act and Board’s Rules. Ms. Riley previously was the subject of a Summary Suspension Order for due to allegations of drug diversion and failure to meet acceptable nurse practice standards. Ms. Riley requested to voluntarily surrender her RN license.

JANAIL TRIMMER
RN #17222
CONDITIONAL LICENSE
Janail Trimmer, RN, entered into a Settlement Agreement, Stipulation and Order for a Conditional Registered Nurse License, approved by the Board on July 8, 2014, as a result of alleged violations of the Nurse Practice Act and Board’s Rules. Ms. Trimmer was licensed as a nurse in another jurisdiction and was the subject of disciplinary action related to her nurse license due to medication errors and substance use disorder issues. Ms. Trimmer will be required to continue in treatment and be professionally monitored by the Nurse Monitoring Program (NMP), and have a worksite monitor, subject to additional limitations and restrictions.

SOPHIA GALVIN
CNA #25633/ GNA TEMP. PERMIT #2553
LETTER OF REPRIMAND
Sophia Galvin, CNA/GNA, entered into a Settlement Agreement, Stipulation and Order for Letter of Reprimand approved by the Board on July 8, 2014, as a result of alleged violations of the Nurse Practice Act and Board’s Rules. Ms. Galvin engaged in unlicensed nursing assistant practice, by continuing to practice after expiration of her GNA temporary permit. Ms. Galvin will be required to undertake certain training.
PATRICIA COUSINS  
RN #16627  
VOLUNTARY SURRENDER  
Patricia Cousins, RN, entered into a Settlement Agreement, Stipulation and Order for the Voluntary Surrender of her Registered Professional Nurse License, approved by the Board on July 8, 2014, as a result of alleged violations of the Nurse Practice Act and the Board’s Rules, including unsafe client care, drug diversion and failure to meet acceptable nurse practice standards. Ms. Cousins requested to voluntarily surrender her RN license.

DAVID HICKS  
CNA #25718  
VOLUNTARY SURRENDER  
David Hicks, CNA, entered into a Settlement Agreement, Stipulation and Order for the Voluntary Surrender of his Certified Nursing Assistant Certificate, approved by the Board on July 8, 2014, as a result of alleged violations of the Nurse Practice Act and the Board’s Rules, including client abuse, including sexual abuse. Mr. Hicks requested to voluntarily surrender his CNA certificate.

PATTI GUYMON  
LPN #6567  
CONDITIONAL LICENSE  
Patti Guymon, LPN, entered into a Settlement Agreement, Stipulation and Order for Conditional License of her Licensed Practical Nurse License, approved by the Board on July 8, 2014 as a result of alleged violations of the Nurse Practice Act and Board’s Rules. Ms. Guymon committed unsafe client care and medication errors constituting a failure to conform to the standards of prevailing nursing practice and a violation of the Board’s Rules. Ms. Guymon will be professionally monitored, have a worksite practice monitor, and provide periodic reports. Ms. Guymon will also be required to undertake particular remediial training.

JESSICA LAMBSON  
CNA/GNA TEMP. PERMIT #2555  
LETTER OF REPRIMAND  
Jessica Lambson, CNA/GNA, entered into a Settlement Agreement, Stipulation and Order for Letter of Reprimand approved by the Board on July 8, 2014, as a result of alleged violations of the Nurse Practice Act and Board’s Rules. Ms. Lambson engaged in unlicensed nursing assistant practice, by continuing to practice after expiration of her GNA temporary permit. Ms. Lambson will also be required to undertake certain training.

ROBERT MATTHEW CLINE  
APRN #31373.1219  
SUMMARY SUSPENSION  
Robert Matthew Cline, APRN, entered into a Stipulation for Summary Suspension of his license as an Advanced Practice Registered Nurse, approved by the Board on July 8, 2014, as a result of alleged violations of the Nurse Practice Act and the Board’s Rules, including drug diversion and failure to meet acceptable nurse practice standards. Mr. Cline will be required to cooperate with further investigation, including a substance abuse evaluation and professional monitoring by the Nurse Monitoring Program pending further action by the Board.

DAVID CATON  
CNA #17909  
SUMMARY SUSPENSION  
An Emergency Hearing was held on July 2, 2014 and David Caton, CNA being properly noticed did not appear to the hearing. The Board found the alleged violations including misappropriation of client property, drug diversion, unauthorized use of a controlled substances and drug dependency presented a clear and immediate danger to the public health, safety and welfare if Mr. Caton were allowed to continue to practice while under investigation. The Board concluded that Mr. Caton’s Certificate should be summarily suspended pending a contested case hearing. On July 9, 2014, the Board approved the order for Summary Suspension of David Caton, CNA #17906, Pending Further Board Action and Order.

MEGAN PICKREN  
RN #21422  
REVOCATION  
On August 19, 2013, the Board received an administrative complaint against Megan Pickren, RN, alleging drug diversion. On September 19, 2013, Ms. Pickren executed a settlement agreement for Summary Suspension Order pending further investigation and Board action. Within that 2013 Summary Suspension Order Ms. Pickren was required to enroll in the Nurse Monitoring Program (NMP) within 15 days of executing the agreement and submit to random drug screens. Ms. Pickren did not enroll in the NMP program until February 14, 2014 and did not complete the required paperwork to submit to random drug screens. On April 14, 2014, Ms. Pickren was sent Petition and Complaint, alleging that she violated the Wyoming Nurse Practice Act and the Board Rules through her actions related to drug diversion and her failure to comply with a Board Order. Ms. Pickren did not respond to the Petition and Complaint. On July 8, 2014, the Board held an administrative hearing and Ms. Pickren did not appear. The Board found that Ms. Pickren was given proper notice and the Disciplinary Committee’s Motion for Default Judgment should be granted. On July 28, 2014, the Board approved the Order for her Wyoming Registered Professional Nurse License to be revoked.
SHAYCIE OGDEN
GNA TEMP. PERMIT # 2163
LETTER OF REPRIMAND
On March 12, 2014, the Board received information that Shaycie Ogdan, Graduate Nurse Aide (GNA) may have been working with an expired GNA temporary permit which expired on October 12, 2013. On March 12, 2014, a cease and desist letter was sent to Ms. Ogdan requesting her to respond. On March 26, 2014, the Board received an unsigned response from Ms. Ogdan, in which she acknowledged the allegations and provided explanations. Specifically that she was unaware that her Temporary GNA Permit had expired. On June 11, 2014, the Board office served Ms. Ogdan a Petition and Complaint, alleging that she violated the Wyoming Nurse Practice Act and the Board Rules through her actions related unlicensed practice. Ms. Ogdan did not respond to the Petition and Complaint. On July 8, 2014, the Board held an administrative hearing and Ms. Ogdan did not appear. The Board found that Ms. Ogdan was given proper notice and the Disciplinary Committee’s Motion for Default Judgment should be granted. On July 28, 2014, the Board approved the Order for her Wyoming Graduate Nurse Aide Temporary Permit to be reprimanded.

Reinstatements
NATALIE CARTER
RN #24048
CONDITIONAL LICENSE UPON REINSTATEMENT
Natalie Carter, RN, entered into a Settlement Agreement, Stipulation and Order for a Conditional License upon Reinstatement of her Registered Professional Nurse License, approved by the Board on July 8, 2014 as a result of alleged violations of the Nurse Practice Act and Board’s Rules. Ms. Carter previously voluntarily surrendered her RN license related to a disciplinary complaint involving unsafe care and fraud and deceit. Once reinstated, Ms. Carter will be required to be professionally monitored by the Nurse Monitoring Program (NMP), and have a worksite monitor when she obtains a nursing position, subject to additional requirements, including a worksite monitor, and restrictions. Ms. Carter will also be required to complete a refresher course within a designated period of time.

CONNIE MILLER
APRN 20234.0234
FULL REINSTATEMENT
Connie Miller, APRN was previously the subject of discipline by the Board in which Ms. Miller’s APRN recognition and prescriptive authority was suspended and under peer review requirements as a result of alleged violations of the Nurse Practice Act and Board’s Rules, including unsafe practice and failure to conform to the standard for prevailing nursing practices; as reflected in the Settlement Agreement, Stipulation and Order for Reprimand and Limited Suspension of Authority to Prescribe Controlled Substances through Advanced Practice Registered Nurse License of 2011 and the Recommendation and Order of Reinstatement of Ms. Miller’s prescriptive authority, requiring Ms. Miller to submit peer review reports monthly. On April 8, 2014, the Board received Ms. Miller’s application for reinstatement of her APRN recognition in full. On July 9, 2014, the Board found that Ms. Miller had complied with all the requirements of her 2011 Order and on July 28, 2014 the Board approved the Order for Reinstatement of Connie Miller, APRN.

AMANDA OBERTAL
LPN #6265
FULL REINSTATEMENT
Amanda Obertal, LPN was previously the subject of discipline by the Board in which Ms. Obertal voluntarily surrendered her LPN license as a result of alleged violations of the Nurse Practice Act and Board’s Rules, including criminal conviction, boundary violation and failure to conform to the standard for prevailing nursing practices; as reflected in the Settlement Agreement, Stipulation and Order for Voluntary Surrender of 2011. On January 8, 2014, the Board received Ms. Obertal’s application for full reinstatement of her LPN license. Within the application Ms. Obertal indicated that she has completed twenty hours of RN/LPN continuing education in the last two years which included attending a two day course in maintaining professional boundaries, completed the recommended treatment, and completed a substance abuse evaluation at the request of the Application Review Committee (ARC). On July 9, 2014, the Board found that Ms. Obertal had complied with all the requests of the ARC and on July 28, 2014 the Board approved the Order for Reinstatement of Amanda Obertal, LPN.

ERICA CURRY
RN #21954
FULL REINSTATEMENT
Erica Curry, RN was previously the subject of discipline by the Board in which Ms. Curry’s Registered Nurse License was under a conditional license as a result of alleged violations of the Nurse Practice Act and Board’s Rules, including drug diversion and substance use; as reflected in the Settlement Agreement, Stipulation and Order for Conditional License approved by the Board on January 13, 2011. Within the 2011 Conditional License Order, Ms. Curry was required to participate in treatment recommendations, undergo random drug testing and be monitored by the Nurse Monitoring Program. On March 21, 2014, the Board received Ms. Curry’s application for full reinstatement of her RN License. On July 9, 2014, the Board found that Ms. Curry had complied with and completed all the requirements of the 2011 Conditional License Order. On July 28, 2014 the Board approved the Order for Reinstatement of Erica Curry, RN.

JODY SIEVERS
CNA #21796
FULL REINSTATEMENT
Jody Sievers, CNA was previously the subject of discipline by the Board in which Ms. Sievers’ Certificate as a Certified Nursing Assistant was under a conditional certificate as a result of alleged violations of the Nurse Practice Act and Board’s Rules, including substance use and criminal conviction; as reflected in the 2010 Order Granting Petitioner’s Application for Certification with Conditional Certificate. Within the 2010 Conditional Certificate Order, Ms. Sievers was required to participate in treatment recommendations as well as to be monitored by the Nurse Monitoring Program. On February 11, 2014, the Board received Ms. Sievers’ application for full reinstatement of her CNA Certificate. On July 9, 2014, the Board found that Ms. Sievers had complied with and completed all the requirements of the 2010 Conditional Certificate Order. On July 28, 2014 the Board approved the Order for Reinstatement of Jody Sievers, CNA.
The Drug Enforcement Administration has reclassified tramadol as a Schedule IV controlled substance effective August 18, 2014. In Wyoming, tramadol has held this classification since 2011 and has been reported to the prescription drug monitoring program (WORx) since 2007.

Tramadol is a centrally acting opioid analgesic that has been widely used in Europe since the mid-1970s. It was first approved for use in the United States by the U.S. Food and Drug Administration (FDA) in 1995 under the trade name Ultram, but was not scheduled under the Controlled Substances Act (CSA) at that time. Subsequently, the FDA approved for marketing generic, combination, and extended release tramadol products including Ultracet, Ultram ER, ConZip, Ryzolt and Rybix ODT. The rescheduling of tramadol comes at a time of growing concern relating to abuse and misuse of opioid analgesics.1

The Drug Enforcement Administration’s decision follows the September 2010 scheduling recommendation by the Assistant Secretary of the Department of Health & Human Services (HHS). After assessment of tramadol’s abuse potential, legitimate medical use, and dependence liability, it was recommended that tramadol be scheduled as a Class IV substance. After a review of the available data, including the scientific and medical evaluation, the DEA concluded that tramadol has an abuse potential and meets the requirements for schedule IV controls under the CSA.1

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For more information on a career as an Army Nurse, visit goarmy.com/armynurse14 or call SFC David Barnett at 303-873-0491.
Wyoming’s Cancer Consortium recommends the following screenings:

**Colorectal Cancer:** Colorectal Cancer screening beginning at age 50 with a colonoscopy every 10 years.

**Breast Cancer:** Women age 40 and older should consider having a mammogram every 1-2 years.

**Cervical Cancer:** Women should initiate Pap tests at age 21 and repeat every three years, or as recommended by their healthcare provider.

Encourage your patients to be proactive and schedule their screenings today. EARLY DETECTION SAVES LIVES!

Low or no-cost cancer screening services are available statewide for Wyoming residents who meet certain eligibility criteria.

Be a hero. Save a life.

For information, call (866) 205-5292 or visit www.fightcancerwy.com