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Debra Scott, MSN, RN, FRE
Executive Director

Roseann Colosimo, PhD, MSN, RN
Education Consultant, Editor
888-590-6726

nursingboard@nsbn.state.nv.us

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CONTACT

NEVADA STATE BOARD OF NURSING
5011 Meadowood Mall Way, Suite 300
Reno, NV 89502-6547
phone—888-590-6726
fax—775-687-7707
nursingboard@nsbn.state.nv.us

4220 S. Maryland Pkwy., Suite B-300
Las Vegas, NV 89119
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MESSAGE

● FROM THE EXECUTIVE DIRECTOR

Debra Scott, MSN, RN, FRE

By the time you receive this edition of the NSBN News Magazine, it will be March 2014. 2013 was an eventful year for the NSBN—a year full of anniversary celebrations, changes to the Nurse Practice Act, and nurturing and cultivating of important relationships with nursing stakeholders.

Our last 3 editions of the magazine have focused on some of the Board's 90th Anniversary events to celebrate nursing regulation in Nevada. Again, thank you for celebrating with us.

The 2013 Legislative Session was grueling, exasperating, and an interesting combination of validation and a vote of confidence for our Board. The NSBN did not sponsor any legislation but was intimately involved in the grassroots campaign to bring Nevada into compliance with the Consensus Model for APRN Regulation. During the 2011 Legislative Session, the Board supported a bill which would require all APRNs who graduated from their advanced practice nursing program after June 2014 to hold national certification. At that time Nevada was one of only 4 states which didn't require national certification for APRNs. The bill was evidence of the profession's and the regulatory board's investment in patient safety and professionalism. Even though the vast majority of Nevada APRNs hold national certification, we believe that it was important to require it by law. The bill passed. Then, in late 2011, the nurse practitioners in Nevada decided to form the Nevada Advanced Practice Nursing Association. This professional association's mission was to advance evidence based quality practice for NPs in Nevada. It is this group that was the spark that ignited the campaign to bring full practice authority to Nevada APRNs. I was privileged during 2013, and continue to be engaged with, this amazing group of professionals. They deserve the thanks for seeing AB170 signed into law by the Governor in 2013.

There was other legislation passed during the 2013 Session that impacts nursing, but none really changed the landscape of our profession. AB456 requires all practitioners to clearly communicate to their patients their title and type of licensure. Nurses have always been required to wear nametags indicating their licensure status, so this was nothing new. Moreover, the NSBN has seen in the past that the problem has often been that there are individuals working in healthcare settings, calling themselves "nurse" who are not licensed as nurses. "Nurse" is a protected title and representing oneself as a nurse when not licensed as a nurse is a violation of the Nurse Practice Act and is subject to citation and fine. Very rarely do licensed nurses represent themselves as anything other than a nurse. Nurses with doctoral degrees may use the title "Dr." as long as they are clear with their patients that they are "Dr. Smith, your nurse practitioner" or "Dr. Lewis, your nursing professor." We, as nurses, owe it to our patients to be clear and concise about our credentials.

2014 presents new challenges for nursing with the implementation of the Affordable Care Act. I believe that nursing professionals have an opportunity to better define...and perhaps, redefine...the nursing profession. We must be at the table for all discussions so that the nursing perspective is clearly communicated. Who better than nurses to provide the data for policy decisions and regulatory solutions to address how to improve the delivery of health care in our state, our nation, and the world? It is our responsibility to seek out those opportunities to collaborate with all health care providers to provide the best that is possible in the most efficient and safe manner.

Sincerely,



WORDS

● FROM THE PRESIDENT

Tish Smyer, DNSc, RN, NSBN President

In December 2013 the Gallup survey again identified and ranked the nursing profession as number one in honesty and ethical standards. A full 12 points above the next profession identified, nursing continues to carry public trust. In the last Nevada State Board of Nursing (NSBN) Nursing News President's Message I described the behaviors of the NSBN members and how we make decisions. Trust in each other along with accountability and respect were foremost board attributes that allow us to function. In the day to day work of hospital nursing or as a nursing student or faculty member, these attributes are equally important. When these attributes disappear in the workplace, we can find ourselves in a working environment unhealthy and unsafe not only for us and but also for the patients as well.

Breaches of trust, accountability, and respect are painful topics to discuss about my chosen profession because it is so well-regarded, but discussion is critical in relationship to the NSBN's mission, which is to protect the public's health, safety, and welfare through effective regulation of nursing. For more on civility in the workplace, I urge you to read a recent article published in *The American Nurse* (2014) about a healthy work environment. Additionally, The Joint Commission has highlighted the need for civility in *Sentinel Alert #40: Behaviors that undermine a culture of safety* (2008). The Joint Commission reports that intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. This Joint Commission report was 5 years ago, yet we still face incidents of incivility and "bullying" type behaviors in the workforce.

What are these behaviors and how are they identified? Do we exhibit these behaviors ourselves and are unaware of the more subtle intimidating behaviors? Clark identified incivility as a continuum from eye rolling and other nonverbal behaviors and yelling or sarcastic comments to threatening behaviors, such as intimidation and physical violence (ANA, 2014). Seltzer states that overt and covert behaviors such as gossiping and sabotaging assignments need to be identified and addressed (ANA, 2014). This means that there needs to be "zero tolerance" in the workplace and that begins with organizational leadership. To be fair, the nursing profession is not the only profession that exhibits these types of behaviors. The Harvard Business Review (2013) found that 98% of all respondents (lawyers, architects, coaches and physicians) identified uncivil behavior in the workplace. But that does not let us off the hook; we too need to develop self-awareness of our behaviors and how these affect others in the workplace. We are all responsible and accountable for our own behavior! Following this message are several links *The American Nurse* (2014) listed as helpful in identifying and dealing with these behaviors.

American Nurses Association (2014). Toward civility. *The American Nurse* (January-February)

The Joint Commission (2008). Behaviors that undermine a culture of safety. *Sentinel Event Alert* (40) July. Available online at http://www.jointcommission.org/assets/1/18/SEA_40.PDF

www.nursingworld.org/Healthy-Work-Environment

www.nursingworld.org/Bullying-Workplace-Violence

www.osha.gov/Publications/OSHA3148/osha3148.html

OUR DUTY TO THE GREATEST GENERATION

How big of an event, really, is our death? In terms of its impact on us and those around us, it's up there. When I walk the halls of any assisted living or skilled nursing facility I wonder what each person was like in their "former life." I imagine that most of the people I'm looking at were truly magnificent in one way or another. What service did they offer? What kind of friend were they? How funny were they? How inspiring was the way they lead their life? What sacrifices did they make to serve someone else?

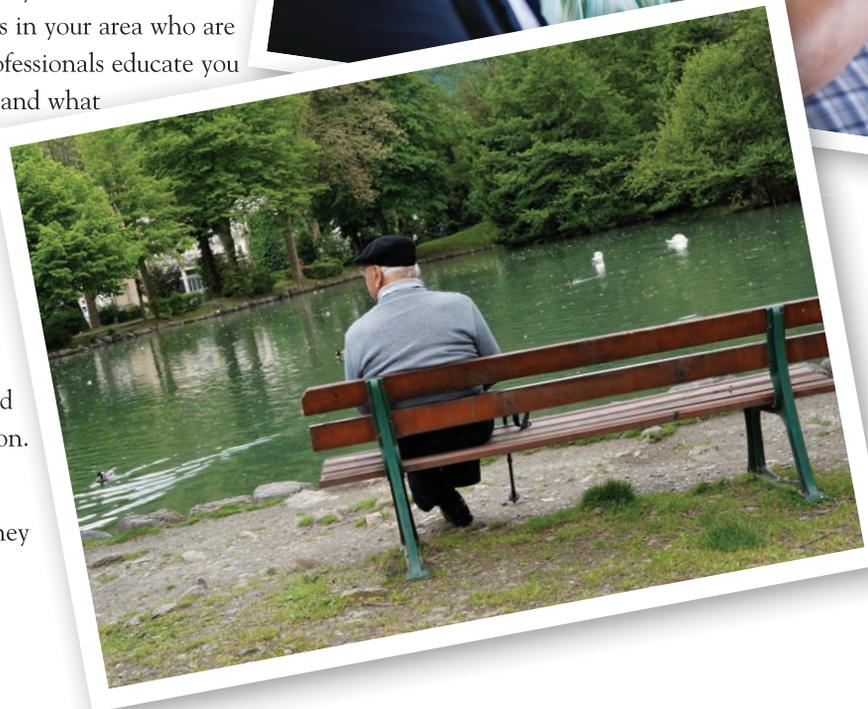
Most of us would probably agree we owe our forebears the utmost respect and dignity as they face their final, greatest challenges. Most of the effort expended to help those who gave us so much is focused on their physical well-being. While rehabilitating or caring for seniors physically is arguably our first duty, other kinds of attention are often ignored.

One area of a senior's life that is often ignored is their need for legal services. For example, many elderly people are concerned with how their children will get along when they are gone – both financially and in terms of their relationships with their siblings or a surviving parent or stepparent. Other people I have worked with are worried about whether they have "left their affairs in order." What they mean is, "have I signed the necessary paperwork or made the necessary arrangements so that my estate will not be a hassle or burden for my loved-one who has to take over when I'm gone?" In many cases, a simple one-page deed or beneficiary designation will save months of effort and headache for a survivor of a senior. Other needs prior to the end of life include planning for incapacity and looking at the availability of public benefits, such as VA Pension.

Why aren't these needs met? There are a variety of reasons, but some are: (1) the senior's own procrastination; (2) uncertainty or lack of agreement on the part of the family; and (3) senior care providers' concern over "getting involved."

Although hesitancy or outright unwillingness to provide a venue for seniors to get good legal advice is sometimes thought of as "the safe way," it does not serve the folks we say we care so much about. We can't control a senior's procrastination or their family's tendency to fight, but we can and should do more to afford them the opportunity to get the help they need. Consider taking the time to really get to know two or three lawyers in your area who are experienced in serving the needs of seniors. Let those professionals educate you and your colleagues about their practices and procedures and what they can do to help in various situations. Consider allowing these professionals to give presentations to family groups on a regular basis. Then, when the need arises, you will be in a great position to recognize the situation and offer the patient or their family two or three names of people who can help. While others may distance themselves, refusing to help and figuratively walking on the other side of the road, you can be a "Good Samaritan" by helping a member of the greatest generation.

*John P. Michaelson is VA Accredited Elder Law Attorney Practicing in Nevada
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EOE

Nurses Helping WAR VETERANS

By Roseann Colosimo, PhD, MSN, RN



The other day on the news, a cheerful reunion was shown of military returning home. These soldiers are National Guards and some are returning from their fifth deployment to Afghanistan. Many soldiers today are citizen soldiers who receive much of their medical care outside of the military or Veterans Health Care System. It is important for all nurses to be aware of the developing evidence of health consequences related to blast injuries so appropriate treatment and referrals can be made for our wounded heroes who may not even know they have been wounded.

The wars in Iraq and Afghanistan are known for the enemy's reliance on improvised explosive devices (IEDs). It's estimated that explosive weaponry accounts for 75 percent of all US military casualties. Since 2001, 6,700 of US soldiers have been killed or 50,500 wounded in action because of IEDs. Concerned about the long-term health effects

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of exposure to blast, the Department of Veterans Affairs asked the IOM to assess the relevant scientific information and to draw conclusions regarding the strength of the evidence of an association between exposure to blast and health effects.

Stephen Hauser, MD Department Chair of Neurology at the University of California, San Francisco led the committee that wrote the IOM report “Gulf War and Health, Vol. 9: Long Term effects of Blast Exposures.”

The blast injuries can be categorized primary- blast wave itself, secondary- fragments of debris propelled, tertiary acceleration of a body part due to blast wind, fourth - burns and toxic exposure and fifth—caused illness resulting from chemical, radiologic and biologic exposure.

The IOM statement notes “when the energy from the blast shock wave is absorbed in the human body, it disrupts the natural state of the body at a molecular level, which can cause tissue damage not immediately apparent after the blast.”

The study in weighing evidence found sufficient evidence of causal relationship between eye injuries resulting from exposure to blast and permanent blindness or visual impairments, long term effects on genitourinary system, endocrine dysfunction in case of severe or moderate traumatic brain injury (TBI) and persistent headache with mild blast TBI and of course a causal relationship with Post traumatic stress syndrome (PTSD). The committee found that a fundamental feature of exposure to blast is that the consequences are complex, multisystem injuries. A lot of research still needs to be done looking at multisystem injury patterns.

Therefore, the next time you perform that assessment for a complaint of headache, or difficulty urinating make sure you ask enough questions about the combat history so your report to the MD or APRN is as helpful as possible.

Gulf War and Health Vol. 9 “Long Term Effects of Blast Injuries” IOM report 2014

“It is important for all nurses to be aware of the developing evidence of health consequences related to blast injuries so appropriate treatment and referrals can be made for our wounded heroes who may not even know they have been wounded.”

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INTERCONTINENTAL

My Intercontinental Journey in Nursing

By Anuradha Thirumalai (Anu), MSN, RN
Kaplan School of Nursing



Is there a human life that has not been touched by nursing? There is a nurse even in the most remote places of the world, a nurse by virtue of the actions of healing people not necessarily the degree possessed.

My love-hate relationship with nursing started back in 1994 with my enrollment in a Bachelor of Science in Nursing Program in the Southern Indian city of Chennai. I entered the profession in 1998 with a lot of trepidation with my conscience clock (CC) saying, "Do not kill anybody newbie." I was chewed into bits and pieces by my mentor to the point that I deserted nursing. "Eat the Young" is universal isn't it? I chose to do medical transcription. My principal at the college of nursing commented that my decision was a loss to nursing. It took two years for me to gather my courage to come back to nursing with Ms. CC's constant prodding - "What are you doing in medical transcription for heaven's sake, remember you were going to be a nurse!"

I found my niche in a smaller hospital where the medical director appreciated my level of education and the Director of Nursing was very supportive. Finally, I was able to overcome the fear that by being proactive, thinking ahead, and with expert guidance and support, I would be a fine nurse. In 2006, I came to the USA. The change in the arena, the types of patients, and the "protect your back-style" of nursing practice had my decision questioned again. Maybe, I should go back to medical transcription but Ms. CC was on board again discouraging my decision to back off from nursing. I got the greatest preceptor under the sun, good international orientation program, and very accepting coworkers, all is well. Thank God! I listened to Ms. CC.

I started on the medical-surgical floor. On the first day, my patient said that he needs to "pee" and "poop." He needs to do what and what? Ms. CC tells me to quickly look it up in the dictionary. Another day, I called the doctor to report on my patient's condition. The doctor said "Can you please give it to someone who can speak English?" I cannot question a doctor. How can I? I am just a nurse? Another fine day, my patient asks me if I am discriminating against her because she is black. My handshake, my headshake, my eye contact - all had a different connotation to my coworkers and patients.

The battle and the battlefield is different my international nurse says Ms. CC.

Two years went by with issues such as a near-missed medication error that haunted me through sleep, patient fall, rapid response teams, the fall of a patient, accent issues, inability to stand up for myself with physicians, and confusion about patient advocacy. I added four years of intermediate care and intensive care experience to my medical-surgical nursing experience. After these, without sitting under a banyan tree like Buddha, enlightenment came; Nursing is a multifaceted profession with multiple responsibilities. With patient safety as the highest priority and critical thinking, there is no need for panic attacks and anxiety episodes. Nursing is not an island. There are plenty of resources such as committed nurses and nurse managers, great information technology, health care organizations and the board of nursing to look up for guidance. There is no nurse who has not experienced a testing situation such as a patient fall, a rapid response call, a code blue, a missed or near-missed medication error but strive for the best with every patient care situation. At the end of the day, the peace of mind that "I did everything that I could do" within my limits to help the patient is what matters the most. At this time, I have advanced my level of nursing with a Master's degree in nursing education enjoying teaching nursing students. I am able to stand up as a patient advocate questioning the judgment of the health care team without hesitation when there is an inkling of potential patient harm. I am dealing with families and patients with patience and empathy. I am often surprised that my coworkers and other new graduate nurses have started looking up to me for guidance now. When did this transformation happen, I do not know!

Like my Hindu god, nursing has multiple faces. I love nursing for its reach, for the dignity it brings, and the unshakable trust it enjoys from the served population. I cannot wait to see where nursing takes me in another ten years!

“Is there a human life that has not been touched by nursing? There is a nurse even in the most remote places of the world, a nurse by virtue of the actions of healing people not necessarily the degree possessed.”

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Transition from Military Medic to Nursing

Debra Scott, NSBN Executive Director was asked by Governor Sandoval to serve on the National Governor's Association's (NGA) Core State Team to address options for veterans' licensing and certification in Nevada. She attended the Veterans' Licensing and Certification Demonstration Policy Academy Meeting in Washington, DC, in November, 2013, where the six states (Iowa, Illinois, Minnesota, Nevada, Virginia, and Wisconsin) who received grants from the NGA to explore how to help veterans make the transition from military to civilian licensure/certification. The three occupations that Nevada is exploring are Licensed Practical Nurses (LPN), Emergency Medical Technicians (EMT), and Law Enforcement. Specific to healthcare, Ms. Scott has been tasked with assessing how military medics may find a path to licensure as LPNs in Nevada.

An important resource that allowed the NSBN to complete a gap analysis of its own nursing education requirements in comparison to military medical training in healthcare roles was the National Council of State Boards of Nursing's (NCSBN) report, NCSBN Analysis: A Comparison of Selected Military Health Care Occupations Curricula with a Standard Licensed Practical/Vocational Nurse Curriculum (2013). In preparing this report, the NCSBN conducted an in depth analysis of the healthcare specialist (medic), corpsman and airman curricula and compared it to the standard civilian curriculum for LPN/LVNs. The NCSBN is dedicated to assisting Boards of Nursing in licensing decisions that will allow veterans to enter nursing competently and safely. (NCSBN 2013)

Another resource was the White House report titled The Fast Track to Civilian Employment: Streamlining

Credentialing and Licensing for Service Members, Veterans, and Their Spouses, which encourages states to support legislation to ease the way for licensure/credentialing for this population.

Ms. Scott reviewed all the materials and determined this initiative may be beneficial for Nevada and could be supported by the NSBN under current regulation so that no legislative action would be required. At the biannual meeting of the Deans and Directors of Nevada schools of nursing, Board staff invited Margi J. Schultz, PhD, RN, CNE, PLNC, Director, GateWay Community College Nursing to speak about a program that is just beginning at her nursing program in Arizona. The Bridge Program is a 12 credit program which gives college credit in the practical nurse program to veterans who have been trained as military medics.

One of Nevada's nursing program directors, Deborah Ain, Interim Director of Nursing at the College of Southern Nevada (CSN), decided that this was a program that would fit with current CSN nursing programs since they already have an LPN program and an LPN to RN program providing an important career ladder. Ms. Ain and Barbara Kraus, the LPN Program Director, have begun developing the curriculum and have progressed to getting administrative and faculty approval to develop a transition program for veteran medics here in Nevada. Warren Pawlick, CSN nursing faculty, has agreed to take the lead on developing this program.

The nursing community is very proud of these actions and is welcoming the opportunity to infuse military experience and work values into the Nevada nursing community.

CONGRATULATIONS

Please join us in congratulating Rick Carrauthers and Sandy Halley on their reappointments to the Board of Nursing for the State of Nevada. Sandy was appointed to the Board for her first term in January, 2008 and serves as the Board's consumer member. Rick Carrauthers was appointed to the Board for his first term in October 2009; he serves as the Board's LPN member and is serving his first term as Board Vice-President. We truly appreciate your commitment to serve the citizens of Nevada as a member of the Nevada State Board of Nursing and supporting its mission of protecting the public's health, safety and welfare through the effective regulation of nursing.



Rick Carrauthers and Sandy Halley

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TRAINING

MEDICAL CORPSMAN TRAINING

By Linda Aure, BSN, RN-BC



When I was 18 years old I joined the Army. It may have been during Viet Nam war, but I do not want to give away my age. My decision was based on being part of a military family and wanting to serve my country in a tough time.

I was not aware of options for training, but was tested and selected to be trained as a Medical Corpsman. I was not sure what that meant but thought it was better than being chosen to cook or type.

After a fun and very educational basic training to learn about the military in general, I was sent to Fort Sam Houston in Texas for Medical Corpsman training.

- I learned what an emergency is, saw how fragile life can be, and how critical infection control and observations can be.

I think the main role of a corpsman was to provide care for wounded soldiers, but I was never sent out of the USA or out of an acute hospital.

I worked under doctors and nurses who were either military and had to be saluted or civilians who had the same status, but did not need to be saluted.

Although I had basic nursing/medical training in a classroom setting the most comprehensive training was on the job. The training in Fort Sam Houston that I remember included lots of information of being in war zones and treating injured soldiers, and basic information about diseases, infection control, and nursing procedures. There were multiple levels of training and I am pretty sure I took the very basic training.

I remember doing clinics where a physician would train me about a procedure, i.e. EKGs, show me how it was done, watch me do some, and then let me do them for days or weeks as needed. I remember the EKG clinic well as an 18 year old woman who learned how to give directions to the military

men to take only their shirts off for the EKG.

I remember spending weeks in a shot clinic where all I gave were injections, using both metal and glass syringes, drawing up medications, administering medication, charting medications, and then sterilizing the syringes and needles.

Each clinic would address infection control and safety issues and also military rules for treatment of soldiers and sick call etc. I spent months in the hospital emergency room and worked side by side with a physician who was a Major and one of my most memorable mentors. She was a career soldier and loved her work, but was quite stern, serious, concise and quick to assess and treat soldiers. She was not hesitant to lecture soldiers on bad habits or to report soldiers who had infections they should not have had??? Her bedside manner would probably not be appreciated in a civilian hospital but was functional in the military hospital.

After months of training in various sections of the acute hospital and being trained as a soldier, i.e. marching, weapon training, bioterrorism training, I was assigned my permanent duty at the hospital.

No one asked me for my opinion or preference and I was told to report to the OB department for the night shift. Apparently not all corpsmen treat soldiers, but do treat their families. Again I was trained on the job.

I started in the nursery which was the last place I ever wanted to be. I learned how to bathe, feed and assess newborns. I learned how to teach mothers how to breast feed and care for their babies. Did I mention I was an 18 year old woman who had never been near a baby? I learned how parents think their child is beautiful no matter what I thought. I learned if a newborn had no chin to look at the father, who also had no chin, before calling the pediatrician.

The warm temperature in the nursery and me trying to stay awake while maintaining an active social life may have prompted my leaving the nursery to work in post partum.

In post partum I was trained to care for mothers after

delivery and the importance of ambulation, bowels, bladder, etc. That was much more interesting than the newborns but training was different as the mothers talked and needed to learn so much in a short time. I think women stayed in the hospital about 3 days in those days. After a few months, again I was told I would rotate to labor and delivery. By this time I had an idea of what happened in that unit.

I was again in training to do assessments of the women in labor or who thought they were in labor, and how to prepare for delivery. I learned very quickly what needs to be reported to the nurse and how quick something can go very wrong. I learned what an emergency is, saw how fragile life can be, and how critical infection control and observations can be. I learned how hand held masks with anesthesia could make a delivery so much better and so much quieter. I saw the miracle of birth and the miracle of bonding right before my eyes. I also learned body mechanics and how to protect myself. Labor and delivery was my final duty station, and I learned



how to deal with patients, families, and physicians in stressful and challenging times and in good times.

When I got out of the military I went to work as a nursing assistant, but my military corpsman training was not related to elderly or chronic conditions. I was not familiar with that patient population. The transition was hard. I actually had to start training all over.

I did go on to take more practical nursing training that filled in lots of areas that I had no knowledge of. Many procedures that I had done then made more

sense and I understood why the procedure was being done. I also realized that anatomy, physiology and systems training were lacking in my military training. Although I appreciated my military training, I did realize there was more to learn. After a few years as a practical nurse I went on to get my RN and then my BSN and really learned how much I was not aware of. The medical corpsman training helped me decide on a nursing career and was a stepping stone to further education to become a well rounded nurse.

The military corpsman training was adequate for what I did in the military mainly because I learned on the job. I had very specific jobs and was supervised very closely. My scope of practice was different for each unit I worked on and determined by what I was trained and competent to do. The military did allow me to qualify for the GI bill which I used to help pay the educational costs for my initial practical nursing license. I will always be grateful for that assistance.

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NCSBN's NCLEX® Examinations GO "Green"



In an effort to improve both effectiveness and efficiency the National Council of State Boards of Nursing's (NCSBN) NCLEX® program will go "green" and transition to a completely paperless program. Internet access has largely replaced print-based materials for information gathering and transactions; because of this NCSBN can now deliver the same information more expeditiously and reliably through electronic means.

The list of current paper-based materials that have been identified as going paperless include:

- Authorization to Test (ATT) letter
- NCLEX® Examination Candidate Bulletin and Candidate Bulletin At-A-Glance
- "Eights Steps of the NCLEX®" handout
- Scan form registrations
- Money order, certified check and cashier check payments
- "You've Completed the NCLEX® but Still Have Questions" brochure

To begin the process of transitioning to paperless, an email address for all candidates that register on the phone or online will be required immediately. Candidates who do not have an email address will be instructed to obtain a free email account through providers such as Gmail or Yahoo. Once the email account has been created the candidate may register for the NCLEX online at www.pearsonvue.com/nclex or by phone.

Implementation for the paperless initiative will take place in the first quarter of 2014. NCSBN ensures a smooth transition and that the same information will be delivered through electronic means. Visit www.nclex.org for more detailed information or join the NCLEX electronic mailing list.

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BOARD TALK

BOARD MEETINGS

A seven-member board appointed by the governor, the Nevada State Board of Nursing consists of four registered nurses, one practical nurse, one certified nursing assistant and one consumer member. Its meetings are open to the public, agendas are posted on the Board's website and at community sites.

BOARD MEETING DATES

March 26-28, 2014	Reno
May 21-23, 2014	Las Vegas
July 16-18, 2014	Zephyr Cove
September 17-19, 2014	Las Vegas
November 5-7, 2014	Reno

ADVISORY COMMITTEES

The Nevada State Board of Nursing is advised by and appoints members to five standing advisory committees. Committee meetings are open to the public; agendas are posted on the Board's website and at community sites. If you are interested in applying for a committee appointment to fill an upcoming opening, please visit the Board's website or call the Board office for an application.

MEETINGS AND OPENINGS

The openings (listed in parentheses) will occur in the next six months. All meetings will be held via videoconference in Reno and Las Vegas.

Advanced Practice Registered Nurse Advisory Committee (none)

May 6, 2014, August 5, 2014,
November 4, 2014

Certified Nursing Assistant Advisory/ Medication Aide-Certified Committee (four)*

April 3, 2014, July 8, 2014
October 2, 2014

Disability Advisory Committee (none)

April 18, 2014, October 17, 2014

Education Advisory Committee (one)

April 17, 2014, August 21, 2014,
October 16, 2014

Nursing Practice Advisory Committee (none)

April 8, 2014, June 10, 2014, August 5, 2014,
October 7, 2014, December 9, 2014

*One MA-C, one AARP member, two RN members: one must be in Long Term Care

• COME TALK TO THE BOARD

During each regularly scheduled meeting of the Nevada State Board of Nursing, Board members hold a Public Comment period for people to talk to them on nursing-related issues.

If you want to speak during the Public Comment period, just check the meeting agenda for the date and time it will be held. Usually, the Board president opens and closes each day of each meeting by inviting Public Comment. Time is divided equally among those who wish to speak.

For more detailed information regarding the Public Comment period, please call the Board.

• WE'LL COME TALK TO YOU

Board staff will come speak to your organization on a range of nursing-related topics, including nursing education, continuing education, delegation, the impaired nurse, licensure and discipline processes, and the Nurse Practice Act.

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Nurses: the Board is also auditing for compliance with the one-time renewal requirement for a four-hour bioterrorism course. You must keep a copy of your bioterrorism certificate of completion indefinitely.

MOVING?

Now you can change your address online!

The law requires you to inform the Board when you change addresses

You're required by law to inform the Board, in writing, of any address change, including a zip code change. The easiest and fastest way for you to make your address change is to go to the Board's website and click on the Address Change link. You may also send an email to nursingboard@nsbn.state.nv.us, call the Board and request an address change form, or mail a signed letter to the Las Vegas office. Remember to include your name, license or certificate type and number, former address, current address, social security number, date of birth, and email address.

CERTIFICATION

National Certification

By Susan S. VanBeuge, DNP, APRN, FNP-BC, CNE, FAANP



As of June 1, 2014 Nurse Practitioners (NP) in Nevada are required to submit proof of national certification in their area of practice to obtain licensure (NRS 632.237). Specifically, advanced practice registered nurses (APRNs) must “submit proof of certification by the American Board of Nurse Specialties, the National Commission for Certifying Agencies of the Institute for Credentialing Excellence, or their successor organizations, or any other nationally recognized certification agency approved by the Board” (Section 1. NRS 632.237).

The process to make this statute started long before the 2011 legislative session when it was approved by the Nevada Legislature and signed by the Governor. Leaders in the NP community came together as one voice to make this a reality for Nevada in early 2007. At the time, Nevada was one of four states who did not require certification as a requirement for licensure. Given these statistics, the call to action was made.

Why require certification? The American Association of Nurse Practitioners (AANP) reports the purpose of their certification program is “to provide a valid and reliable program for entry-level nurse practitioners to recognize their education, knowledge, and professional expertise....and to provide a process for validation of an APRN’s qualifications and knowledge for practice as a primary care nurse practitioner” (AANP, 2014).

Nurse practitioners apply to their respective organizations to take examinations in the area they have received education and training. There are a variety of roles as an APRN, so the specific exam will be based on the formal education and degree program. Eligibility to take exams requires the candidate to have basic comprehensive graduate-level course work in advanced physiology/pathophysiology, advanced health assessment, and advanced pharmacology. Formal education must also have content in health promotion and/or maintenance, differential diagnosis, disease management, and the use of pharmacologic and non-pharmacologic interventions in caring for patients. Depending on the certification, applicants are required to have a minimum of faculty-supervised and validated clinical hours within their formal education.

The Consensus Model for APRN Regulation or APRN Consensus Model outlines how licensure is delineated from

the role to the population of foci. The APRN roles described are nurse anesthetist, nurse-midwife, clinical nurse specialist, and nurse practitioner. Each of these roles further defines the population foci for individual practice. For NPs, this role and population foci is the cornerstone of practice licensure and certification. The population foci areas are: family/individual across lifespan, adult-gerontology, neonatal, pediatrics, women’s health/gender-related, and psychiatric-mental health. APRNs may have more than one population foci depending on their documented formal education. Education programs must contain both didactic and clinical education experiences necessary to prepare for the populations served (American Nurses Credentialing Center, 2013).

In Nevada, APRNs will be required to show certification in their role and population of foci. The APRN shall engage in diagnosis, treatment and conduct related to their area of licensure and certification. It is the responsibility of individual APRNs to know their scope of practice and work within this scope in all aspects of care provided. For APRNs licensed before June 1, 2014 in Nevada, the new regulations do not apply. All new licensees’ after June 1, 2014 will be required to provide evidence of certification in the area they have been trained and educated from a nationally recognized agency approved by the board. If you have a question about an approved Board, call the Nevada Board of Nursing and clarify before you take the examination.

National certification is a good thing for Nevada APRNs. It demonstrates professional practice, entry-level competence, and education.

References:

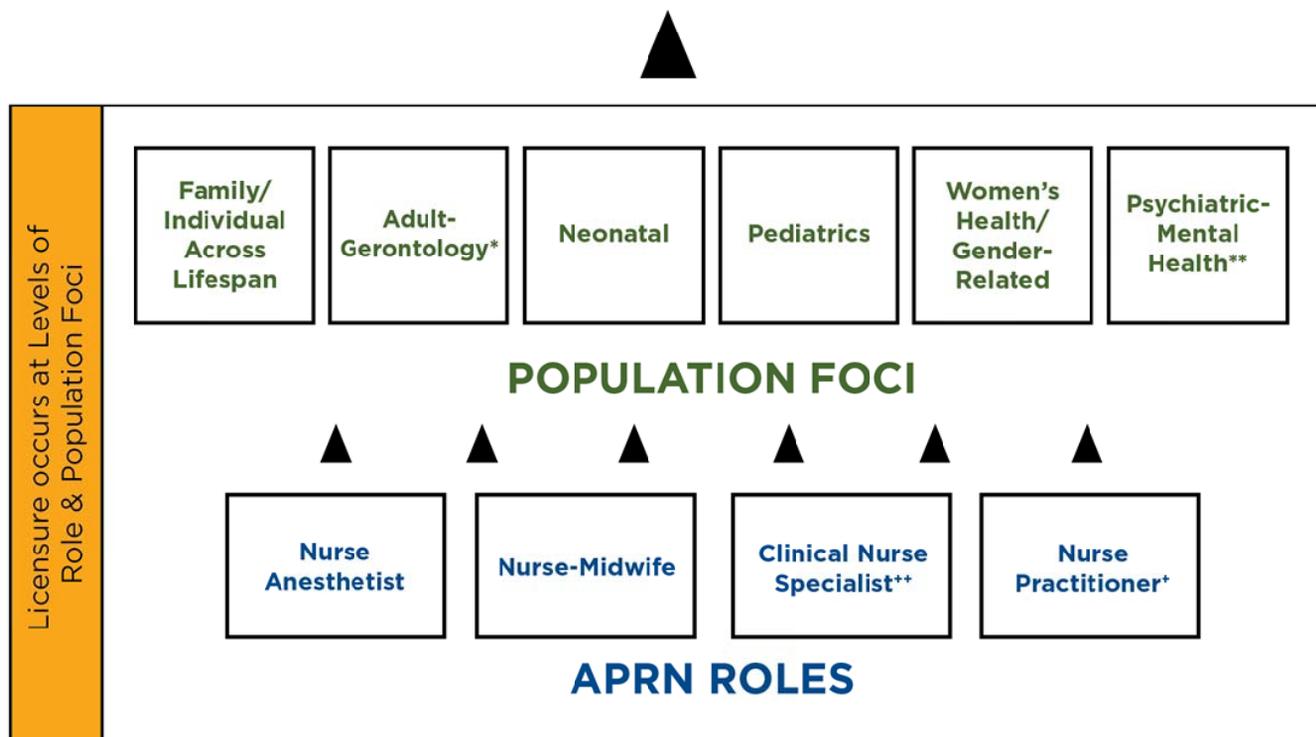
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American Nurses Credentialing Center, (2013). Consensus Model for APRN Regulation. Downloaded February 10, 2014 from <http://www.nursecredentialing.org/APRN-FAQ.aspx>

Nevada Revised Statute (2014). NRS 632.237. Downloaded February 10, 2014 from <http://www.leg.state.nv.us/NRS/NRS-632.html#NRS632Sec237>

APRN Specialties

Focus of practice beyond role and population focus linked to health care needs
Examples include but are not limited to: Oncology, Older Adults, Orthopedics, Nephrology, Palliative Care



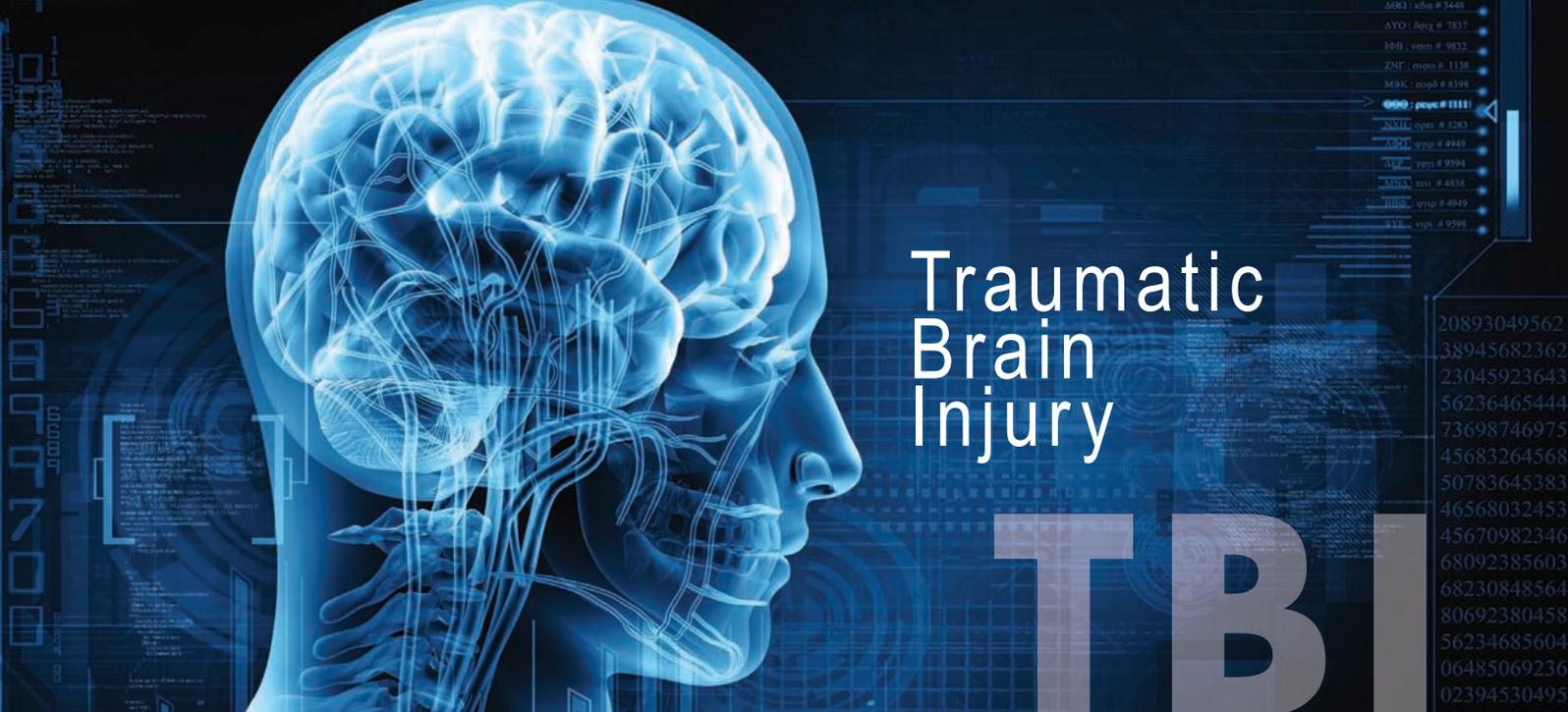
+The certified nurse practitioner (CNP) is prepared with the acute care CNP competencies and/or the primary care CNP competencies. At this point in time the acute care and primary care CNP delineation applies only to the pediatric and adult-gerontology CNP population foci. Scope of practice of the primary care or acute care CNP is not setting specific but is based on patient care needs. Programs may prepare individuals across both the primary care and acute care CNP competencies. If programs prepare graduates across both sets of roles, the graduate must be prepared with the consensus-based competencies for both roles and must successfully obtain certification in both the acute and the primary care CNP roles. CNP certification in the acute care or primary care roles must match the educational preparation for CNPs in these roles.

Under this APRN Regulatory Model, there are four roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), and certified nurse practitioner (CNP). These four roles are given the title of advanced practice registered nurse (APRN). APRNs are educated in one of the four roles and in at least one of six population foci: family/individual across the lifespan, adult-gerontology, neonatal, pediatrics, women's health/gender-related or psych/mental health. Individuals will be licensed as independent practitioners for practice at the level of one of the four APRN roles within at least one of the six identified population foci. Education, certification, and licensure of an individual must be congruent in terms of role and population foci. APRNs may specialize but they can not be licensed solely within a specialty area. Specialties can provide depth in one's practice within the established population foci.

* The population focus, adult-gerontology, encompasses the young adult to the older adult, including the frail elderly. APRNs educated and certified in the adult-gerontology population are educated and certified across both areas of practice and will be titled Adult-Gerontology CNP or CNS. In addition, all APRNs in any of the four roles providing care to the adult population, e.g., family or gender specific, must be prepared to meet the growing needs of the older adult population. Therefore, the education program should include didactic and clinical education experiences necessary to prepare APRNs with these enhanced skills and knowledge.

** The population focus, psychiatric/mental health, encompasses education and practice across the lifespan.

++ The Clinical Nurse Specialist (CNS) is educated and assessed through national certification processes across the continuum from wellness through acute care.



Traumatic Brain Injury

TBI

By Roseann Colosimo, PhD, MSN, RN

Watching the Olympics the other night, I heard the announcer say that one of the cross snow boarders was in an induced coma for a brain injury on January 12, 2014. It is very amazing that as our knowledge of Traumatic brain injury increases our actions to curb our behaviors have not changed.

The Brain Trauma website lists fast facts:

1. Traumatic Brain injury is the leading cause of death and disability in children and adults ages 1 to 44
2. 52,000 deaths a year
3. 1.5 million head injuries seen in United States Emergency Rooms
4. 2% of US population currently live with disabilities resulting from TBI
5. Exposure blasts leading cause of TBI in military
6. 30% of soldiers admitted to Walter Reed Army Medical Center have TBI

Kathryn Roethal reports that 42% of all High School athletes are female. Girls' soccer is second only to boys' football with most concussions. Concussion is another word for mild traumatic brain Injury. 8% of all concussions come from girls' soccer. Symptoms reported are different by gender. Girls report being sensitive to noise and drowsiness after a concussion; whereas, boys report amnesia and confusion.

Common symptoms of Mild TBI are:

Physical	Cognitive
Headache	Slowed thinking
Sleep disturbance	Poor concentration
Dizziness	Memory problems
Balance problems	Difficulty Finding Words
Fatigue	Visual disturbances
Emotional	Light sensitivity
Anxiety -Irritability	Ringing in ears
Depression – Mood swings	

The Defense and Veterans Brain Injury Center (DVBIC) suggests these ways to improve your memory:

1. Avoid distractions
2. Get plenty of sleep
3. Write it down
4. Avoid alcohol and tobacco and caffeinated drinks
5. Prioritize
6. Maintain a routine
7. Stay mentally active learn something new every day
8. Lower your stress level
9. Stay physically active
10. Eat healthy
11. Allow extra time for tasks

DVBIC also recommends tracking memory problems with a journal:

What happened? Why do you think it happened?

What strategy can you use in the future? Did your new strategy work?

Nurses in all areas of nursing deal with patients who have memory and traumatic brain injuries. These are simple but important hallmarks of helping the patient to be self empowered to have less problems and function better. Of course since I am a senior I can use some of the tips myself for senior moments.

www.DVBIC.org

www.braintrauma.org

Have a question?
Give us a call.

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SOCIAL MEDIA



By Jennifer Snidow, MPH, MBA, CNA

Recently, I developed and presented to my fellow board members a social media outreach strategy for the Nevada State Board of Nursing. I am an active social media user, and believe it is a wonderful resource for individuals and organizations alike. You can easily communicate with friends and family, and receive important updates on issues and causes you care about. However; those of us in the nursing profession, including CNAs, must be aware that we are held to a higher standard when it comes to our conduct online. It is important to remember that we represent our profession, our workplaces and most importantly, our patients, whether we are online or not.

While most of us recognize that we have a legal and ethical obligation to maintain patient privacy and confidentiality at all times, and work very hard to protect it, there are times when we may not think our conduct online has any impact on the care we provide to our patients. That is not always true.

Many online users fail to realize that once something is posted online it can be sent or shared to others, way beyond the user's circle of friends or followers. Think of all those pictures on Facebook where a child is holding a sign that says if "If I get 1000 likes my mom says she will buy me a puppy." That post is originally intended for that user's friends, but as his friends each click like on the post, it is shared with each of their friends. As friends of friends click like, that post moves even further away from the poster's original circle. Very soon, people who have no idea who this child is will have this post show up on their Facebook page.

Now, imagine if that was a post you wrote about having a challenging patient on your shift, a co-worker you didn't like, or a management decision at your job you didn't agree with. That information has the capacity to spread, very fast and very far and you wouldn't have any control over it. But, you are still responsible for it, and it can be traced back to you.

The National Council of State Boards of Nursing have released guidelines for using social media responsibly. According to the NCSBN, some nurses and nursing assistants have lost their jobs, been disciplined by state boards and have been criminally charged due to poor judgment when using social media. I encourage each of you to take a moment and read the guidelines and case studies presented by the National Council. They can be found at www.ncsbn.org/social_media_guidelines.pdf



“While most of us recognize that we have a legal and ethical obligation to maintain patient privacy and confidentiality at all times, and work very hard to protect it, there are times when we may not think our conduct online has any impact on the care we provide to our patients. That is not always true.”

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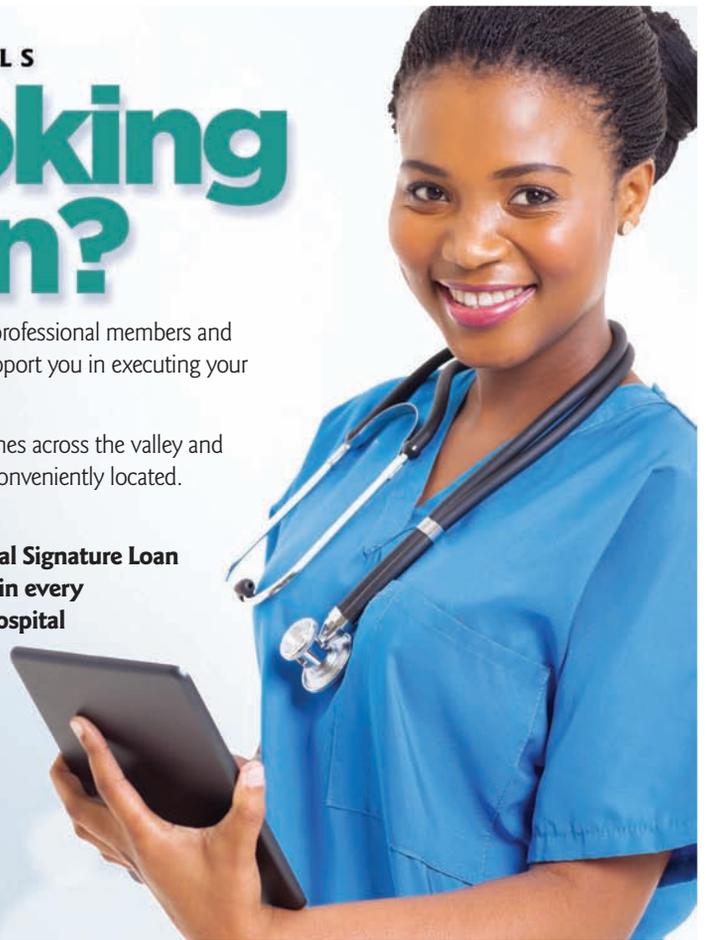
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