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June 2016

Nursing Beyond the Walls of the Hospital

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• FROM THE EXECUTIVE DIRECTOR

Cathy Dinauer, MSN, RN

The Nevada State Board of Nursing (NSBN) has been very busy over the last few months. I would like to begin by announcing that Chris Sansom, Director of Operations, retired from the NSBN in March 2016. It was bittersweet and I will miss her very much. Ms. Sansom retired after 20 years with NSBN and was instrumental in the development of many of the agency's policies and procedures. I would like to thank her for all of her contributions to nursing regulation in Nevada. We wish her all the best in her retirement.

It is my pleasure to announce our executive team: Fred Olmstead, General Counsel; Dean Estes, Director of IT/HR/Finance; Catherine Prato-Lefkowitz, Director of Nursing Education; and Sam McCord, Director of Nursing Practice. In addition, Kimberly A. Arguello has joined our team as Deputy General Counsel for the NSBN. Ms. Arguello comes to us from the Attorney General's Office and is very familiar with the operations of the NSBN. Both Mr. Olmstead and Ms. Arguello will lead our legal department. Gail Trujillo has been promoted to Director of Licensure and Certification. Ms. Trujillo has been with the NSBN for several years and previously served as the Executive Assistant. Hillary Murphy is our new Executive Assistant. Ms. Murphy has been with us for two years and also manages our Facebook page. The changes within our organization were necessary in order to uphold the continuity of our agency while maintaining public protection. I welcome all of the new staff to the agency.

I would also like to welcome our newest Board member, Jacob Watts. Mr. Watts was appointed to the Board as our CNA Board Member in January. Mr. Watts resides in Carson City and currently works at Carson Tahoe Regional Healthcare. Mr. Watts has been a CNA for many years and his expertise will be invaluable on the Board.

In the last year NSBN has worked very hard to get three pieces of legislation passed. The first piece of legislation updated the regulations related to the practice of Licensed Practical Nurses (LPNs) in Nevada. The revisions to the regulations changed the LPN scope of practice to include LPNs conducting focused assessments, allowing for certain intravenous therapies to be delegated to certain LPNs and making changes to the subject requirements for a course in IV therapy. The second piece of legislation focused on APRN practice. This regulation established the training and experience required for an APRN to complete certain certificates concerning the mental condition of certain persons. The last piece of legislation changed part of the approval process for nursing programs in Nevada. Thank you to all who helped get these regulations passed. You can visit our website to view the regulations in their entirety.

We have begun preparing for the 2017 Legislative Session and expect to introduce legislation to enact the Enhanced Nurse Licensure Compact (ENLC). The ENLC allows a nurse, whom obtains a compact license in their primary state of residence, to practice in all other compact states on that license. The ENLC advances public protection and access to care through the mutual recognition of one state-based licensure, which is enforced locally and recognized nationally. We have begun providing education about the ENLC and will continue to do so.

As we move forward to the close of the fiscal year, we will begin creating our annual report. The annual report is a snapshot of all the work we have accomplished throughout the year and provides the public with statistics related to the regulation of nursing. This report will be available on our website sometime this summer.

We are also in the process of implementing a new Web-based licensing application called ORBS (Optimal Regulatory Board System). This is an electronic records management system, which will create a greater level of service to our applicants. Once implemented, applicants will be able to apply for licensure online through a secure cloud-based system creating a paperless application process. We have been preparing for the implementation of ORBS and anticipate full implementation in 2016.

Please do not hesitate to contact our agency, we are happy to answer questions relating to nursing practice, nursing regulation, the application process, or address any concerns you may have. We are also available to provide presentations to your organization about any of these topics. We understand the challenges facing nursing today in this ever-changing healthcare environment and are accessible to all interested parties throughout Nevada.

MESSAGE

FROM THE PRESIDENT

Dr. Rhigel 'Jay' Tan, DNP, RN, APRN

Greetings, from the Nevada State Board of Nursing!

Welcome to this edition of the Nevada State Board of Nursing Magazine! I am excited to report that the Board of Nursing has had a successful 2016 so far! I would like to acknowledge Cathy Dinauer for her exceptional work as the new Executive Director. Her leadership has shined through and she has a great team working with her to ensure the Nevada State Board of Nursing continues to meet its mission of protecting the public's health, safety, and welfare through effective regulation of nursing. This edition has some pertinent information for nurses in a variety of disciplines. I am pleased to report that three new nursing regulations have been passed by legislation. Make sure to visit the Nevada State Board of Nursing website to read about the three new regulations concerning APRN practice, nursing education, and LPN scope of practice. As a friendly reminder, sign up for E-Notify for updates on your Nevada nursing license status. The E-Notify resource is available in all jurisdictions that are participants of the National Council of State Board of Nursing database. If you have further questions, or would like board staff to come present to you and your organization, please feel free the Board at 888-590-6726.

APRN COMPACT

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

A colleague recently commented to me that everything these days seems to be about advanced practice registered nurses (APRN) and he wished something else would be the topic of choice at meetings. With reflection, it does seem there's a lot of buzz regarding the APRN role in health care today. In the past six years, we have seen the Affordable Care Act (ACA)(2010)[1] signed into law and the Institute of Medicine Report Future of Nursing: Leading Change, Advancing Health (2010)[2] impact the nursing profession in significant ways. Nurse practitioners have a big responsibility and impact in playing a vital role in helping realize the goals and objectives set forth in the 2010 ACA legislation.

Most licensed nurses are familiar with the registered nurse compact. In 2000, The National Council State of State Boards of Nursing (NCSBN)[3] set forth an initiative to expand the mobility of nurses with the Nurse Licensure Compact (NLC). Currently, there are 25 states who enacted the NLC legislation. Nevada is currently not part of the NLC.

> ***"The benefits of an APRN licensure compact could include allowing access to care while maintaining the highest public protection and safety at the state level where nurses practice."***

The APRN Compact was approved May 4, 2015 by The National Council of State Boards of Nursing. If the model legislation is adopted and approved by individual states, it would allow APRNs to hold one multistate license with privilege to practice in other compact states. To date, Wyoming and Idaho have adopted the APRN Compact Model Legislation.

The model legislation of the APRN compact is outlined in 11 articles approved by the special delegate assembly. These articles include: 1) findings and declaration of purpose; 2) definitions; 3) general provisions and jurisdiction; 4) applications for APRN licensure in a Party State; 5) additional authorities invested in party state licensing boards; 6) coordinated licensure information system and exchange of information; 7) establishment of the interstate commission of APRN compact administrators; 8) rulemaking; 9) oversight, dispute resolution and enforcement; 10) effective date, withdrawal and amendment; and 11) construction and severability. A complete copy of the articles may be accessed at the NCSBN (https://www.ncsbn.org/aprn-compact.htm)[4].

So what would enactment of the APRN compact mean to the Nevada nurse practitioner? If licensed in a state part of the compact, the APRN would be able to hold a multistate license with privilege to practice in other states part of the compact. All of the same laws and regulations are still in place, but ability to practice without having to undergo multiple licenses in individual states. It is important to

underscore the APRN Uniform Licensure Requirements outlined in the document "APRN Compact Rules" clearly outlines the rules in fine detail (https://www.ncsbn.org/APRN_Compact_Rules.pdf)[5]. This document outlines the definition of terms, licensure requirements by resident and party state, recognized APRN roles and population foci, eligibility for APRN single state licensure, and the coordinated licensure information system.

The benefits of an APRN licensure compact could include allowing access to care while maintaining the highest public protection and safety at the state level where nurses practice. Other benefits include allowing travel across state borders to provide vital services during disasters, telehealth nursing services, online nursing education, and removing burdensome expenses for the APRN and organizations who may employ them as they bear the cost of multiple licenses.

Take a few minutes to read about the APRN Compact and see how you might want to get involved in the future of practice in Nevada and the United States. Our advocacy for patient's access to care is vital to the well-being of the citizens of Nevada and all citizens of the United States.

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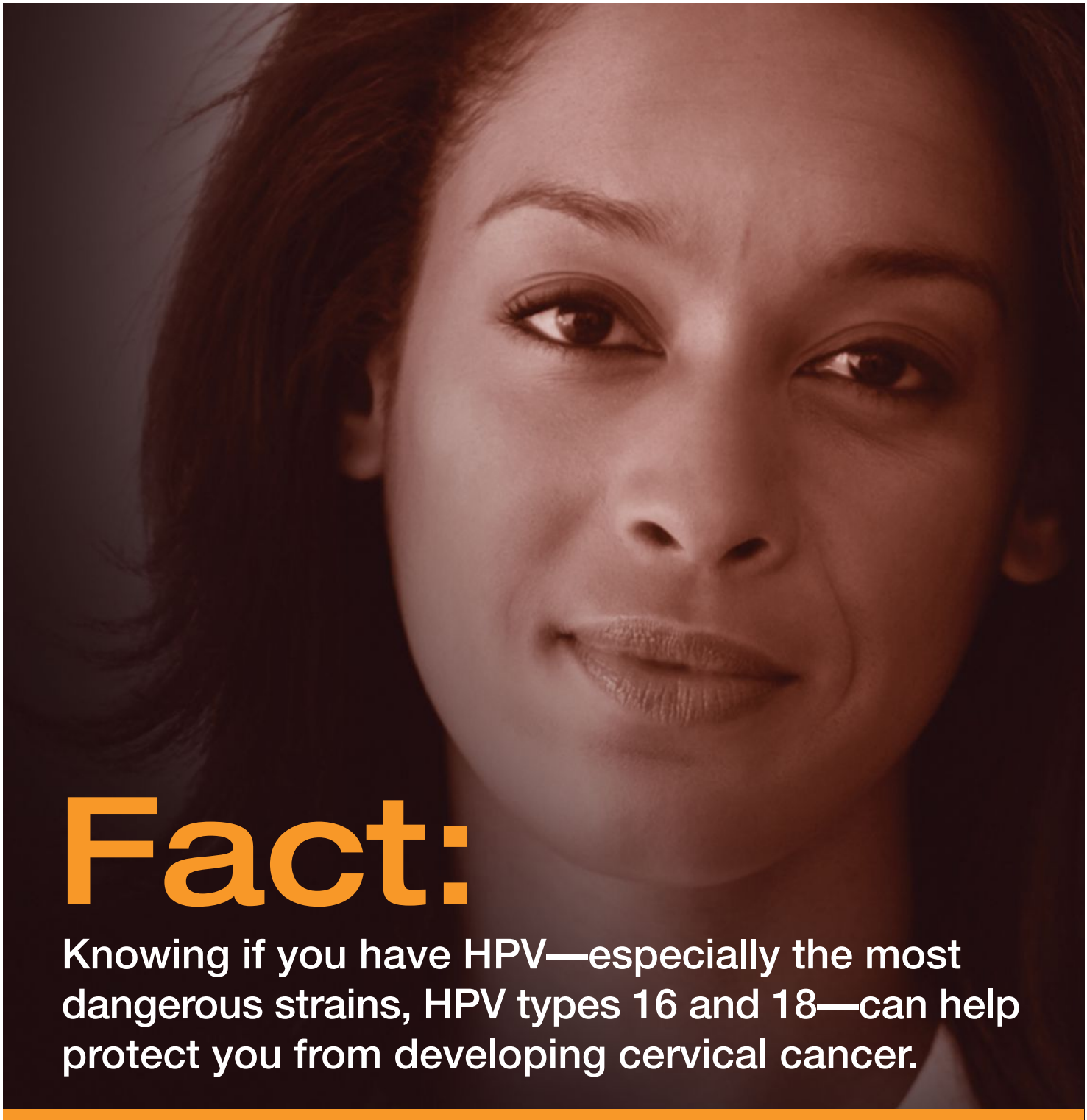

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MEET THE STAFF

Kimberly A. Arguello

Thank you for allowing me to introduce myself to the Nevada health care professionals. My name is Kimberly A. Arguello and I have joined the Nevada State Board of Nursing as Deputy General Counsel. I obtained my law degree from Santa Clara University and have had a variety of opportunities in my career. I have been in Nevada since 1993. My early career was spent practicing general litigation. For the past ten years I was with the Office of the Attorney General. As a Senior Deputy Attorney General, my duties included representation of Divisions in ongoing litigation, day to day legal counsel, and prosecution of cases before the Real Estate Commission, Common-Interest Communities and Condominium Hotels Commission and the Appraisal Commission. I have also represented other State agencies such as the Taxicab Authority, Nevada Transportation Authority, Office of the Labor Commissioner and Apprenticeship Council. Part of my duties entailed representing various Boards and Commissions as board counsel such as Veterinary Medicine and Architecture. In that role, I had the pleasure of working with the Nevada State Board of Nursing for many years as Board Counsel. I am familiar with the workings of the Board and feel that my experience will be an asset to the Board. I am excited to work with the Nevada State Board of Nursing and the staff in my new role. I believe nursing and CNA regulation is of the utmost importance and I am proud to be a part of the team.

ADVANCING PRACTICE
at the Orvis School of Nursing

Jackie Ferdowsali MSN, APRN, AGACNP-BC
University of Nevada, Reno Orvis School of Nursing

The adult-gerontology acute care nurse practitioner (AGACNP) exemplifies the evolutionary journey of the advance practice nurse. In the 1980's, a physician work force shortage in the intensive care unit led to the recognition of a need for advance practice nurses with the knowledge, skill, and ability to care for increasingly complex, and critically ill patients; thus creating the acute care nurse practitioner (ACNP) (Kleinpell, Hravnak, Magdic, & Guttendorf, 2014). A national recognition of wide variation from state to state in how advance practice nurses were licensed and their scope of practice approved further influenced the role of the ACNP. The National Council of State Boards of Nursing (2008) developed *The Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education (LACE)* to address these inconsistencies. The Consensus Model identified a certified nurse practitioner (CNP) as one of four clinically based advance practice roles that is prepared in one of six population foci. Furthermore, the CNP is prepared based on either the acute and/or primary care national competencies. Thus, the adult-gerontology *(population)* acute care *(competencies)* nurse practitioner *(role)* was realized.

The American Association of Critical-Care Nurses (AACN) (2012) describes the AGACNP focus as "patients with acute, critical, and/or complex chronic illnesses who may be physiologically unstable, technologically dependent, and highly vulnerable for complications" (p. 13). Within this patient population the AGACNP is responsible for providing "restorative, curative, rehabilitative, palliative, and/or supportive end-of-life care" (p. 13). The rapidly evolving healthcare system has resulted in a patient population with increasingly chronic and complex conditions living outside the traditional acute care hospital. This recognition supports not defining the AGACNP practice site by physical boundaries, but rather underscores the concept that the AGACNP's practice is not setting specific but population specific. AACN specifically states that for the AGACNP "care is continuous and comprehensive and may be provided in any setting where the patient may be found" (p. 13).

The positive impact of the AGACNP on patient care has been documented by an evidence-based review (Kleinpell, Ely, & Grabenkort, 2008). Other research studies have found that AGACNPs care is equal to that provided by physicians and is associated with decreased length of stays and overall cost savings (Collins et al, 2014; Hoffman, Taota, Zullo, Scharfenberg, & Donahoe, 2005; Meyer & Miers, 2005; Morris et al., 2012).

Continued on page 12 >>>

The Orvis School of Nursing at the University of Nevada, Reno is proud to be the first and only nursing school in the state of Nevada to offer this advance practice degree. The School of Nursing is actively developing community partnerships in Reno, Las Vegas and rural practice sites across the state, in order to provide graduate students with strong clinical practicum experiences that best prepare them for their future practice as AGACNPs.

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CNO CORNER

As many of you are aware, the licensed practical nurse (LPN) regulations were recently passed and put into law. It is important for LPNs, those who employ LPNs and those who educate LPNs to understand what this piece of legislation means. The regulation now permits an LPN to conduct a focused assessment. As stated in the regulation, a focused nursing assessment means an appraisal of a patient's current health status conducted by an LPN for the purpose of inclusion in the management of the patient's care which includes: identifying normal and abnormal findings related to a patient's physical and mental condition, anticipation and recognition of changes in a patient's condition, and evaluating whether or not information must be communicated to other members of the patient's health care team. In addition, the LPN contributes to the patient's plan of care by conducting a focused assessment.

The regulation also makes changes to the intravenous therapy scope for LPNs. An LPN, who has completed a course in intravenous therapy pursuant to NAC 632.242 may start peripheral intravenous therapy excluding midline or midclavicular catheters, may administer, by adding a solution, the following medications: antimicrobials, blood and blood products (under the supervision of a registered nurse), Histamine H2 receptor antagonists, proton pump inhibitors and steroids. LPNs may administer IV fluid and medications from a container which is commercially prepared or premixed and properly labeled by a pharmacist or registered nurse designated by the pharmacist. The LPN may maintain patency of a peripheral intermittent vascular access device, including a peripherally inserted central catheter (PICC) using a nontherapeutic dose of flush solutions, withdraw blood from a PICC line (but must follow institutional policies and must have demonstrated competence). The LPN may not administer any medication used for purposes of sedation.

The regulations in their entirety may be located on our website.

Melodie Osborn, RN, BSN, MBA and Derrick Glum MBA, FACHE

Nursing Beyond the WALLS OF THE HOSPITAL

Transitional Care in Practice Today

"This is how I envisioned nursing when I graduated over 20 years ago – true holistic care of patients and their families," beams Kim Brenay, MSN, Renown Manager of Hospice, as she speaks about her career path from a Critical Care to a Hospice RN. Transitional Care encompasses the post-acute community and focuses on coordination of care provided as patients move from one healthcare setting to another. This care transition can involve a move between facilities from an acute hospital to a Skilled Nursing Facility; or between a general practitioner to a specialist; or from one goal of care focus to another such as from curative to palliative or hospice care.

This new emphasis on Transitional Care affords nurses a myriad of challenging opportunities in unique care settings, where both clinical experience and emotional intelligence are the key skills for success. "Nurses working in Transitional Care must be able to see the big picture for their patients in terms of their health status and needs on the continuum of care, but also have the ability to deliver very individualized care to patients and their families through a highly personal connection," Samantha Moore, BSN, Renown Director of Nursing.

With the introduction of the Affordable Care Act, hospitals and healthcare delivery systems have struggled with how to succeed in shifting from fee-for-service to value-based care. With its focus on patient-centered goals that improve the overall quality of care and decrease cost, Transitional Care has become an integral component for achieving pay-for-performance models that benefit both patients and healthcare providers.

Renown Health in Reno, NV has met this challenge by creating an entirely new system for delivering patient care outside of the acute setting. In June 2015, Renown Health introduced a new Transitional Care Division, one of four operating divisions within the system, to complement their extensive portfolio of services. The Transitional Care Division is comprised of the full continuum of post-acute services; including acute inpatient rehabilitation, skilled nursing, home health care, hospice and palliative care, wound care and hyperbaric oxygen, rehabilitation therapies and assisted living. One of the many values of the Transitional Care Division is the coordination of care at the right time, at the right level of care, and at the right cost.

Having a dedicated Transitional Care Division and leadership team allows Renown Health to inspire better health and well-being in our communities. Nurses are the frontline in developing the relationships with every patient so that their needs are met in the short-term and their goals are met long-term. "Acute care can save your life, but in Transitional Care we help patients live their life," says Kim Butler, RN, MPSL, Renown Director of Clinical Excellence. "That's why it's so exciting to work in Transitional Care – it's nursing on patient-centered terms; whether we are your home, we're in your home, or we're preparing you to be at home."

If you are interested in a career in Transitional Care where you are at the forefront of care that puts patients and families first, please contact Brittany Brown at bbrown@renown.org.

BE IN THE KNOW…

Three regulations have just passed. They are now effective and in law. The regulations are in Education, LPN practice, and APRN scope.

Please refer to the full regulations on the Nevada State Board of Nursing website to read them in their entirety!

LPN Regulation: Changes related to recording, reporting, competencies, delegable and non-delegable procedures, and intravenous therapy.

Education Regulation: Changes related to innovative educational approaches, fulfill educational requirements before closing a program, program approval, qualifications of an administrator of a program, licensing members of a faculty, and requirements for an instruction program for practical and registered nurses.

APRN Regulation: Changes related to training, certificates, and expertise related to mental health.

CNA SKILLS GUIDELINES

The Nevada State Board of Nursing would like to thank Chris Sansom for her leadership and guidance in revising the CNA Skills Guidelines. Chris and the CNA Committee worked very diligently to revise the guidelines. This tool will continue to be an asset to the CNA students as well as the CNA training programs. These guidelines will help streamline the skills the CNA students need to master to be safe and competent CNAs. To view the approved revised CNA Skills Guidelines, please visit the NSBN website at www.nevadanursingboard.org . We wish Chris Sansom a happy, healthy, and fun retirement!

PROMOTING SAFETY

in pre-licensure education

Catie Chung, PhD, RN, CNE, CCM, CCP &
Julie Siemers, DNP, RN

We all know that healthcare has become increasingly complex. And that, despite clinicians best efforts, healthcare errors continue to plague us. Death toll from medical errors in U. S. hospitals compares to "three jumbo jets falling out of the sky and killing all passengers on board every 48 hours" (Allen, 2009). National standardized indicators of patient safety have improved only 2.3% annually over the period (AHRQ, 2010), and several papers published in high-impact medical journals in the past 12 months alone have exposed the enduring hazards of hospitals (Macphail, 2011). James (2013) reports that the 98,000 deaths reported by the Institute of Medicine (IOM) in 1999 didn't include errors of omission in their data.

Nursing education has been tasked with developing pre-licensure students into RNs who can practice safely. While that sounds obvious, the gaps between RN clinical practice and the student experience in the clinical setting are extensive. Practicing as a new RN while being exclusively responsible for multiple patients is a steep learning curve from the security of the student nurse role. Carrying out all of those responsibilities safely should occur due to habitual practice in nursing school.

One way that nurse educators are preparing beginning nurses with the appropriate skills to meet these complex patient care challenges is to use a framework for education that is focused on safety and quality of beginning registered nursing practice. The QSEN-based (Quality and Safety Education for Nurses) framework for pre-licensure education can guide curriculum and instruction so that new graduates have a foundation of quality and safety to hang their practice hat on (www.qsen.org).

The six QSEN competencies are:

- Safety
- Quality improvement
- Evidence-based practice
- Teamwork & collaboration
- Patient-centered care
- Informatics

Each of the competencies have corresponding knowledge, skills, and attitudes (KSAs) that formulate the framework of safe, quality beginning nursing practice. These competencies are supposed to be threaded throughout each nursing course, both didactic and clinical, to assist students' development of their nursing practice. The QSEN framework

> ***"As nursing education continues to improve methods of teaching safe practice to nursing students, developing a foundation of knowledge and safe practice skills will continue to be the priority."***

is further detailed with proficiencies that pre-licensure nursing students need to achieve within each competency to deliver safe quality patient care.

The ultimate goal of QSEN, and of nursing education, is to develop the best quality entry-level RNs. In reflecting upon the many healthcare errors that continue to occur in the U.S., a high quality entry-level RN is a nurse who understands and practices safely.

Another way that QSEN assists nursing education is by helping develop new clinical adjunct faculty. While these nurses are certainly experts in their area of practice, they often do not have a background in nursing education. QSEN gives faculty specific examples of ways students might demonstrate the KSAs. This is a very useful tool for new faculty or faculty without a foundation in education.

These examples can also serve nurses at the clinical sites who help coach nursing students when on the clinical unit. So often nurses work with students from multiple programs and haven't been given information about how this specific program curriculum works. Or what specific objectives the student is trying to achieve. The QSEN competencies assist by giving examples of behaviors that every pre-licensure nursing student should display.

Here is an example:
Safety competency.

Knowledge: Delineate general categories of errors and hazards in care.

Skills: Communicate observations of concerns related to hazards and errors to patients, families and the health care team.

Attitudes: Value own role in preventing errors.

So while the student asking you about why the patient never wears their "fall risk" non-slip hospital socks may seem to you to be missing the big picture that might not be so. The student actually might be communicating a safety hazard concern to you!

As nursing education continues to improve methods of teaching safe practice to nursing students, developing a foundation of knowledge and safe practice skills will continue to be the priority.

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FORMING THERAPEUTIC RELATIONSHIPS
in Intercultural Nursing

Cynthia Karl, RN
Nevada State College RN-BSN Student

Imagine yourself traveling in China when suddenly you experience shortness of breath and chest pain. It is evident that you must find a hospital and seek care. You finally find yourself in the emergency room; you are overwhelmed and scared. You are rushed from one diagnostic room to the next all while the healthcare team attempts to explain the care they are providing. Minority patients find themselves in this situation far too often. When caring for a patient of a different culture, it is often difficult to overcome barriers in order to establish a therapeutic relationship. Therapeutic relationships serve as the foundation for providing excellent nursing care. Literature will be used in this paper to provide support from peer-reviewed experts in their fields. Welch (2005) conducted interviews that found that therapeutic relationships developed under trust, shared power, mutuality, self-revelation, congruence, and authenticity. Within cross-cultural nursing, these steps may be challenging to accomplish. This paper will outline the steps nurses must take in order to overcome the obstacles to develop therapeutic relationship with their diverse patients. Therapeutic relationships are difficult to form in intercultural nursing; clear communication, language translation, and a desire to provide care without bias will bond the bridge between the nurse and the patient.

Firstly, clear communication is needed to form a therapeutic relationship in intercultural nursing. Meddings and Haith-Cooper (2008) state a shocking statistic about minority childbirth care in the UK; those who are from the minority are twice as likely to die than patients who were native English speakers. This example clearly shows the disservice we are doing to our intercultural patients when we don't facilitate clear communication. A myriad of obstacles appear when there are two different languages spoken. One obstacle is that it becomes difficult to create a line of open communication between the nurse and the patient. Meddings and Haith-Cooper (2008) proposed that when there is a language barrier nurses will unconsciously focus on the physical care rather then also providing psychological support. A lack of support will hinder the formation of a therapeutic relationship. Another obstacle is that often times it becomes difficult to verify that the patient understands and agrees with the plan of care. The nurse may also find it difficult to recognize the patient's healthcare knowledge deficits and determine the need for education. Without clear communication, the patient is unable to become a self-advocate, and what is worse is that the nurse in unable to be the advocate for that patient. As stated earlier, trust is vital in the formation of therapeutic relationships. Without clear communication, the nurse is unable to gain the patient's trust. Without trust, there is no therapeutic relationship.

Furthermore, language translation should be used to help form a therapeutic relationship in intercultural nursing. Pergert, Ekblad, Enskar, and Bjor (2007) affirm, "Linguistic diversity is the primary obstacle in the process of developing a transcultural caring relationship" (p. 319). Ultimately what is best is when nurses can speak directly to their own patients in their own language. However when language translation is needed, there are multiple avenues that a nurse can take to help. In the past, family members have been used as a means of language translation. However, this should no longer be done because it creates bias. There is no way to assure that the

patient is receiving all of the information or the correct information. As well as vice versa, there is no way to assure that the nurse is being told everything the patient is trying to communicate. Another form of language translation is via telephone language line. This is a fine substitute for a translator but quickly becomes cumbersome. A live translator would be a great option. It allows for real time translation and there is no subjectivity on part of the translator. However, there are complications that can arise with both language line and a translator. Pergert et al. (2007) points out that a when there is language diversity, a nurse may fail to have a caring conversation and develop an interpreter reliance. Each method has its pros and cons, so nurses must use their judgment when deciding on which form of language translation they would use. Whatever technique is used, the nurse must take care to recognize that language translation is a vital part of nursing care that is needed to form a therapeutic relationship.

Finally, a desire to provide care without bias is needed to form a therapeutic relationship in intercultural nursing. The nursing theorist; Leininger, is quoted by Donnelly (2000) as saying; "Nurses without preparation in transcultural nursing would be handicapped when working with people from diverse culture" (p. 110). Modern health disparities can be attributed to this handicap that nurses perpetuate in the healthcare system. Prejudice and racism are seen far to often between interactions of nurses and their patients. This prejudice is seen on both sides, from nurse to patient and from patient to nurse. Prejudice is intolerance to people from other cultures due to thoughts of one's own supremacy (Pergert et al., 2007). It is this negative bias that doesn't allow a therapeutic relationship to form. Communication is in part nonverbal. Frustration may be felt when nurses cannot communicate with their patients this can become visible in their nonverbal cues (Meddings & Haith-Cooper, 2008). It is through these nonverbal cues that a person may be able to pick up the sense that their nurse carries negative feelings towards them. Intercultural therapeutic relationships face more obstacles; as such, patients feel they receive less quality in care (Pergert et al., 2007). Pergert et al. (2007) conducted interviews in which one interviewee states; "But it won't be on equal terms when they can't, when they can't understand us" (p.324). This is a sad truth that patients should never have to experience. Patients should feel that caring relationship from their nurse whether they speak the same language or not. The nurse should have that inner desire to care without prejudice, only then can a strong therapeutic relationship form.

Transcultural nursing poses its own impediments into the development of a caring rapport. Stickley and Freshwater (2002) state that a vital part of the healing process is the therapeutic

When caring for a patient of a different culture, it is often difficult to overcome barriers in order to establish a therapeutic relationship.

relationship. Therapeutic relationships are difficult to form in intercultural nursing; clear communication, language translation, and a desire to provide care without bias will bond the bridge between the nurse and the patient. Clear communication allows the patient and nurse to openly discuss plan of care, knowing that each party is receiving and understanding the message. Language translation should always be used. A nurse must use their judgment in choosing the right form of language translation. A desire to provide care is at the core of a therapeutic relationship. I have experienced the frustrations of caring for patients that do not speak the same language as I. These situations have left me feeling like I could have done more to form a therapeutic relationship. In writing this piece, I have learned that there are multiple ways a nurse can assist in the formation of a caring relationship. In this paper I have outlined many ways nurses should alter their ways or thinking. Most importantly, the nurse must understand that it is their job to provide healing for the patient no matter their cultural background.

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BOARD MEMBERS

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.

• 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.

BOARD MEETING DATES

July 20-22, 2016	Zephyr Cove
September 21-23, 2016	Las Vegas
November 16-18, 2016	Reno

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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 (five)
August 2, 2016
November 8, 2016

Certified Nursing Assistant Advisory/ Medication Aide-Certified Committee (two)*
July 12, 2016
October 4, 2016
*One MA-C

Disability Advisory Committee (none)
October 21, 2016

Education Advisory Committee (none)*
August 25, 2016
October 20, 2016

Nursing Practice Advisory Committee (four)
August 23, 2016
October 11, 2016
December 6, 2016

MOVING?

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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.

COSMETIC PROCEDURES

What You Need to Know

By Teresa Cartmill BSN, RN
Board Lead Nurse Investigator

The Nevada State Board of Nursing (Board) receives numerous phone calls and emails throughout the year from nurses inquiring about regulations which may allow them to administer cosmetic medications such as Botox, Restylane ®, Radisse®, and Juvederm®.

In 2015, an article written by Connie Brennan, RN, CPSN, CANS, states that almost 9.2 million cosmetic procedures were conducted in 2014, which was a 273% increase in the number of procedures performed compared to 1997. Brennan explains how important it is for practitioners administering cosmetic injections to understand human facial and muscle anatomy, the "Danger Zones" associated with neurotoxin complications, how skin ages, and what to do in the event of an adverse event associated with a neurotoxin. The Board's role is to ensure that nurses injecting these dangerous drugs to the public are both competent and working within state regulations.

For a Licensed Professional Nurse (RN) in Nevada to be able to perform cosmetic procedures using these dangerous drugs competently and safely they must:

- Have documented competencies of training/education that are outside of a normal nursing education program; and
- Have a licensed practitioner (MD, DO, PA, APRN) who actually examines the patient; and
- Have a licensed practitioner's order (Standing orders must be dated, and will expire after 6 months, or if there is change in the patient's medical history); and
- The licensed practitioner must also be present on-site at all times when the nurse administers the cosmetic medication to the patient; and
- A patient chart must be maintained for each patient with the medication lot numbers documented; and
- The licensed practitioner must maintain control of the cosmetic medications and monitor access by the Licensed Professional Nurse (After the cabinet has been unlocked by the licensed practitioner, the RN may retrieve the medication).

All nurses have an obligation to understand the laws and rules in the states where they practice and how they may impact their professional scope. Nurses must practice with prudency and efficacy, and maintain the standard of care in Nevada.

Reference: Brennan, C. (2015). Update on Neurotoxins for Facial Rejuvenation. Plastic Surgical Nursing, 35(2), 69-75. doi:10.1097/psn.0000000000000091

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