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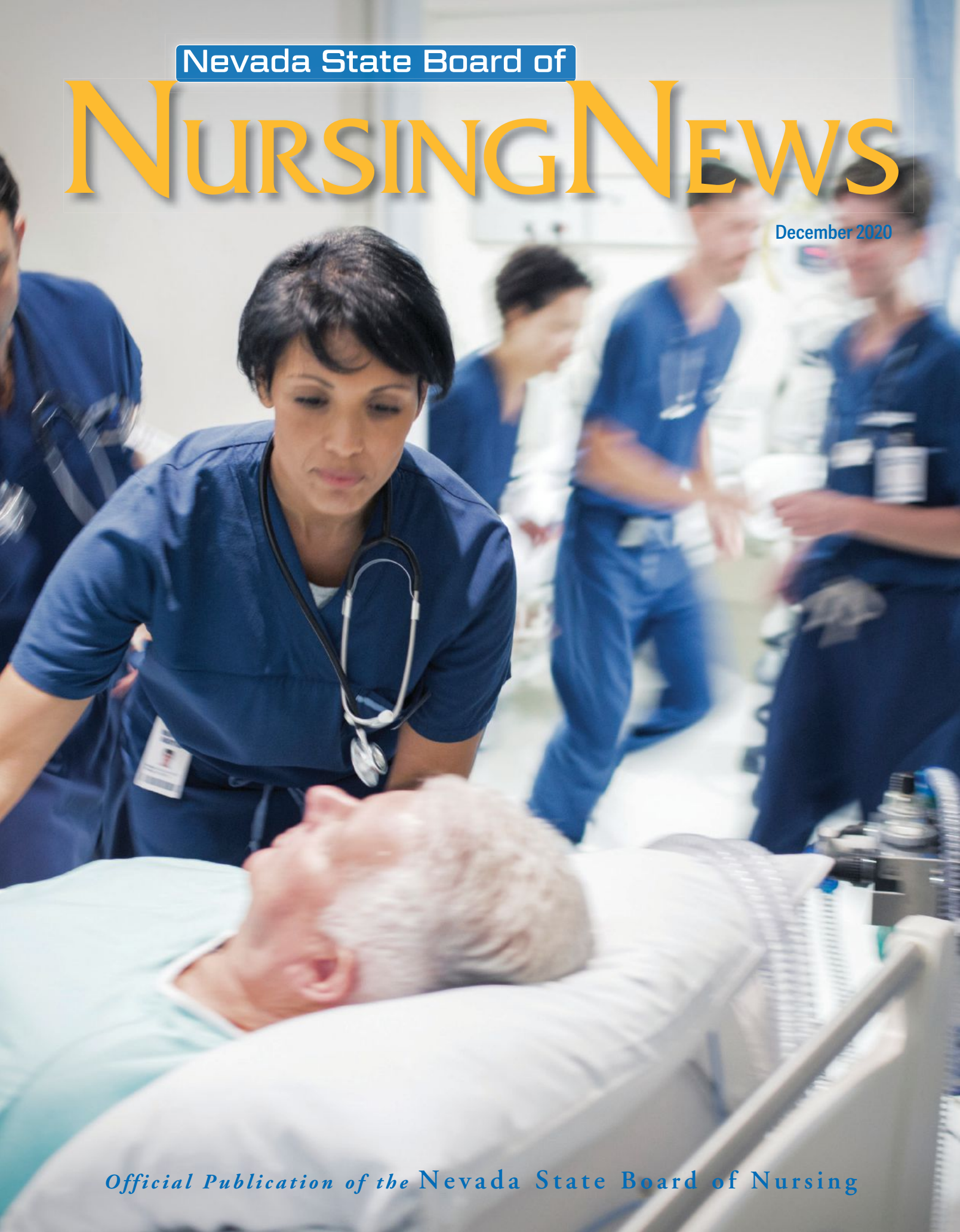
Nursing News

December 2020



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The Nevada State Board of Nursing News publishes news and information quarterly about Board actions, regulations, and activities. Articles may be reprinted without permission; attribution is appreciated.

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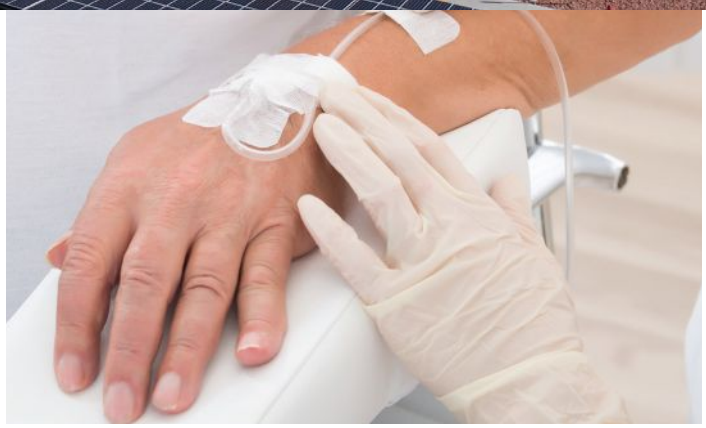

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WORDS

FROM THE EXECUTIVE DIRECTOR

Cathy Dinauer, MSN, RN, FRE

As we near the end of 2020, I am amazed at what a year it has been for nursing. The World Health Organization designated 2020 as the "International Year of the Nurse and the Midwife" to acknowledge nurses and midwives and the work they do. It was to correspond with the 200th anniversary of Florence Nightingale's birth. I am not sure what Florence Nightingale would have to say about the year 2020.

The year started like any other and quickly became like no other. In these extraordinary and unparalleled times, I find myself simply in awe of our profession. As nurses, we have risen to the occasion and demonstrated resiliency during the darkest of times. Nurses have been called heroes or superheroes for their work during this pandemic when many believe they are just doing their job. Nurses have demonstrated strong moral courage and resilience to work.

I am simply in awe of our profession and am so proud to be a nurse. While my role does not bring me to the bedside, it is my role to ensure that we do not create unnecessary barriers to practice, especially during these challenging times. To eliminate those barriers, we will introduce legislation to implement the nursing compact in Nevada. I cannot stress the importance of this legislation and its impact on access to care and the nursing workforce.

As we navigate our new normal, it will be important to focus on our new way of doing business. Video conferencing has exploded as the primary avenue to communicate with people. At the Nevada State Board of Nursing, we now use video conferencing for all our board meetings. We instituted a process to conduct hearings virtually while complying with open meeting laws, and this has proved to be a success and a format to be used in the future.

We will continue exploring new avenues to provide customer service to you while maintaining the protection of the public. Each day brings new challenges, and each day we will rise above the calamity of it all and do our best.

As nurses, we have learned to navigate this crisis and will come out the other side stronger than ever. Thank you all for the work you do. Let us be done with 2020 and move on to 2021.

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Paul Kapsar MSN, APRN, FNP-BC

MEDICATION-ASSISTED THERAPY FOR SUBSTANCE USE IN PRIMARY CARE

Why would you want to learn about medication-assisted therapy (MAT)? If no other reason, you can obtain twenty-four hours of continuing education credit, twenty-two of which count as pharmacology hours for board recertification. Currently, the MAT course does not meet the bi-annual continuing education requirement in Nevada. However, as caregivers, it is important to recognize that many of our patients have a level of substance use that significantly impacts their health. This impacts you and the effectiveness of the care you provide. Without this education, the goals you jointly set with your patient cannot be reached. As a provider, this blind spot will leave you confused, frustrated, and potentially ineffectual.

For APRNs to participate in MAT and obtain a buprenorphine waiver, the APRN must complete a twenty-four-hour, online program jointly sponsored by the American Academy of Nurse Practitioner and American Society of Addiction Medicine. This training is available free of charge. As an APRN who has been engaged in MAT for over eight years, I strongly recommend this course for all practicing APRNs regardless of their desire to obtain the waiver and prescribe buprenorphine/MAT therapy. It is important to recognize the challenges associated with substance abuse in these unprecedented times. This free education and training material may be the best education on substance use you will obtain, short of working in a substance recovery center.

Many APRNs may feel that substance abuse treatment is beyond their skillset or something they are not comfortable treating. All nurses are taught a standard patient care approach to the assessment of a new patient. This includes collecting history and physical data for each patient. If a nurse failed to ask a patient about a personal or family history of diabetes, kidney disease, or heart disease, it would be considered neglectful. Those questions are a standard part of the review of systems. As a nurse, would you neglect to ask the patient about the history of mental, physical, or sexual abuse/assault? Why then would nurses avoid asking about our patients' substance use histories? Many of us have been conditioned to avoid that conflict, but it is time to move beyond the confrontation and do what is best for the care of our patients.

I have heard other health care practitioners say that they do not see substance abuse patients in their practice. Upon further inquiry, I commonly learn the primary care practice in which they work does not routinely ask their patients questions about substance use. If a question is not asked, it is never answered! Sadly, many of our patients are dealing with substance use, whether we discuss it or not. 2017 data from the Substance Use and Mental Health Services Administration1 indicates approximately 19.7 million people age 12 and over have a substance use disorder related to alcohol or illicit drugs. This volume of potential users makes it difficult to imagine any practice without patients in need of substance use care.

Discussion of increased substance use has grown significantly since the start of the COVID 19 pandemic. A brief review of popular memes will provide many indicators of increased alcohol consumption. Many believe it is a funny joke when a parent is not able to teach because they are on their second bottle of wine for the day, but these memes are diminishing a rising problem. In late September 2020, a picture of a full stadium was captioned Alcoholics Anonymous 2021. Sadly, these are not jokes. In Nevada, liquor stores were allowed to open before almost any retail outlet in the state, and the consumption of alcohol worldwide has been increasing. [4,5,6]

Job insecurity, food insecurity, financial insecurity, depression, and hopelessness all have driven people to look for relief from this crisis. This relief presents to practices as increased alcohol consumption or subtly as opiate use in our patients. We have a responsibility to identify and manage the basics, develop a care plan with the patient, and, if necessary, refer out to another appropriate provider. Being educated on MAT allows YOU to be that appropriate provider for F10.20 Alcohol Use Disorder, uncomplicated, F11.20 Opiate Use Disorder, uncomplicated.

Caring for addiction should not have the stigma to be more difficult than caring for a diabetic patient with an HgbA1c of 12.2%, hypertension, renal failure, coronary artery disease, and hyperlipidemia. Basic Use Disorder treatment may be far easier than the complicated patient with multiple comorbidities. Yet, drug and alcohol use care frightens most of us far more.

Relapses are common, but this should not dissuade you from providing appropriate care. Substance use relapses are more obvious and have emotional and moral baggage attached. However, if you remove the stigma, substance use relapse is very similar to the diabetic patient who stops participating in their care plan and experiences a negative outcome. Both choices have significant consequences, except the diabetic patient does not usually end up at legal risk.

Consider a patient with an odd history of hypertension. A patient may be

in withdrawal from alcohol because they stopped consuming twenty-four hours before their scheduled appointment. They look fine. They smell fine, but their body is already responding to the withdrawal. You prescribe the patient with an anti-hypertensive. As soon as they get out of your office, they have a drink. The alcohol removes the physiologic stress of withdrawal and restores normal blood pressure. Then because you ordered a medication, the patient adds it to their system. Then becomes hypotensive. You decided to prescribe without a complete assessment of the patient because no one asked about substance use.

A patient with severe anxiety comes to the office and asks for benzodiazepines. Their PMP Aware does not show any opiate or benzodiazepine prescriptions. You prescribe without asking the patient if they are using non-prescribed medications. The incidence of overdose in situations of combined opiate/benzodiazepine overdose is significantly higher than opiates alone.[2]

The literature describes many tools in assessing a patient, including determining if they are using substances or drinking too much alcohol and if the patient is a victim of domestic violence, sexual abuse, or assault.[3] I have interviewed many patients about their substance use duration. I hear a variety of responses. Patients respond that they have never been asked. They tell me they want treatment but were afraid of judgment. Sometimes, they tell me that I am the first person to ask them about their substance use duration. Again, we see the potential of moral and emotional baggage interfering with good patient care and asking appropriate questions.

Screening tools are great, and some have reimbursement CPT codes. Since society is not comfortable with the topic, tool use may come across as stilted or insincere. In reality, these tools represent an ideal opportunity to reach out to a patient who may be in need. If the questions are asked in a non-judgmental, matter of fact manner, the patient will be more likely to share.

Over the years, I have had many male and female substance users reveal to me a distant unresolved history of sexual violence. When finally broached, a patient may tell me they have never told anyone about their trauma. That traumatic history is the core of the voice they are trying to drown out. If not resolved, the substance use will continue to control their life.

While buprenorphine (Subutex, Suboxone, Sublocade, Zubsolv) prescribing is a significant part of the push to utilize MAT, there are three medications considered MAT medications. As any prescriber understands fully, no medication is problem-free. A full description of the nuances of each medication is beyond the scope of this article and requires careful attention and a thorough medical history of the patient. While each of these drugs is intended to be used for Opiate Use Disorder management, except for naltrexone, they have been diverted and used illicitly.

Methadone (Dolophine), a DEA

continued on page 6

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schedule II long-acting opiate agonist, has been used as pain medication. It can be prescribed by those with proper DEA credentials, despite its contraindications and warnings. When used as a method to manage opiate use and withdrawal, there are many regulations and licensing elements that make Methadone difficult for the average clinician to provide this level of treatment.

Naltrexone, an opiate antagonist, was also created as a relapse prevention medication. It works by blocking the mu receptor from accepting the opiate. Before it can be started, the patient must be opiate free for 7-10 days to avoid precipitous withdrawal. This time delay is vexing for many patients. Naltrexone requires the user to take a daily pill, and patient compliance was often less than stellar. Naltrexone ER (Vivitrol) was developed as a monthly injection to ease daily decision-making considerations. Not everyone is happy with getting a monthly shot, and there are relatively few providers statewide who provide Naltrexone ER to patients. As naltrexone was offered in a clinical care setting, there were incidental findings that it modified the excess use of alcohol, and the generic was re-patented as Revia for alcohol use management.

Buprenorphine, a DEA schedule III long-acting opiate partial agonist, is the most recent entry to the illicit opiate use management process. Most patients do not realize that buprenorphine is an opiate. They consider themselves opiate free. Education is important. Buprenorphine is available as a schedule III pain patch, and anyone with the correct DEA credentials can prescribe it. However, the patch dosing is inadequate for opiate use disorder management. Buprenorphine sublingual was developed to manage Opiate Use Disorder by substituting a partial agonist for a full agonist. This makes it easier to manage withdrawal symptoms. Buprenorphine requires a washout period of prior opiate use, or a precipitated withdrawal will occur. This washout period varies between 12 and 24 hours. Regardless, this period is often more tolerable for the patient, and the buprenorphine will resolve withdrawal symptoms. This process is easily managed in the office, though it can take provider and staff time to manage.

As care providers, we must push through our discomfort to assist our patients even when MAT appears rather ominous. As outlined above, another patient with a different disease, such as diabetes and many comorbidities, may also feel ominous. Once you have the education and begin following the care process with the diabetic patient, it becomes easier. You will be truly amazed at the positive changes in the personality and wellbeing of your patients and their ability to meet jointly planned health goals. It is quite rewarding.

As a final note, if you have patients that are asking you for pain pills or anti-anxiety pills and you have not yet decided to provide MAT, please consider your referral carefully. Should the patient be referred to pain management? Do they need additional emotional or substance abuse evaluations? Referrals should reflect the individual's needs. We are all living through challenging times. Care providers are uniquely positioned to help patients. Consider what the patient is telling you and what they may not be telling you. Substance abuse is common, and our ability to affect this is not fully developed if we do not ask the questions.

Thanks to Tomas Walker, DNP APRN-BC for his review and suggestions.

Bio Summary

Paul Kapsar MSN, APRN has more than 49 years' experience in healthcare with an introduction as a hospital orderly, moving on to his RN in 1977 from Saint Vincent Health Center School of Nursing in Erie Pennsylvania, bachelor's degree in nursing from Slippery Rock University of Pennsylvania. Followed by a master's in nursing as a Family Nurse Practitioner in 1999 from the combined Clarion/Slippery Rock University of Pennsylvania Family Nurse Practitioner program. He is board-certified as a Family Nurse Practitioner.

His career includes experience as a staff nurse, nurse manager, emergency

preparedness and management, US Army Nurse Corps Officer - Retired, hospital information systems manager, university nursing instructor, professor of Western Medicine at a Traditional Chinese Medicine University, author, educator, jail health administration, full-time Family Practice Nurse Practitioner in a variety of settings including emergency department, family practice, internal medicine, hospice, inpatient and outpatient addiction care & pain recovery. He has participated in emergency management activities since 1985. He has added Reiki II, aquastretch, and meditation to his professional skill set, and for fun he holds an amateur radio - general license.

Paul's interests are varied and include looking at life with the eye of a two-year old and always asking "WHY? WHY do we do that! Why is that the best? Why should I do it that way?"

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

RESILIENCE IN THE TIME OF COVID-19

In the time of the COVID-19 pandemic, our roles as nurses have been challenged and changed during the last seven months. The unknown of this virus was evident in the beginning as many have worked to slow the spread, treat, and work with patients who recovered from the effects of the disease process. All eyes were on healthcare providers, first responders, and those essential workers to manage and heal the infected.

As time has progressed and the world continues with infection, and resilience of our healthcare workforce is one to consider. Nurses are on the front lines of this disease. Every nurse has a role. Over time, regardless of the role, the stress and anxiety of the constant threat and change has taken its toll.

Resilience is a term we learn in nursing education and apply to our community of care over the continuum of practice. Resilience is defined by Merriam-Webster (2020) as "an ability to recover from or adjust easily to misfortune or change; the capability of a strained body to recover its size and share after deformation caused especially by compressive stress."

In a study by Barzilay, et al. (2020), the researchers assessed stress, anxiety, and depression during the pandemic of more than 3000 healthcare providers. This convenience survey sought to assess resilience, levels of stress regarding COVID-19, anxiety, and depression. Participants completed the survey and were given feedback on their resilience survey, and then were provided personalized recommendations regarding stress management. They could also complete the Generalized Anxiety Disorder 7 questionnaire (GAD7) and depression Patient Health Questionnaire 2 (PHQ2).

The outcomes reported by participants were similar for most regarding financial burden and fears of contracting COVID-19. Younger participants were more concerned about getting the disease and passing it on to others, while older participants were worried about contracting it themselves. The worries expressed by all participants, in order of importance, include family getting COVID-19, unintentionally infecting others, financial burden after the pandemic, getting COVID-19, dying from COVID-19, and now having COVID-19. Women were found to be more worried about family getting COVID-19 and infecting others, while males were most concerned with the financial burden. When evaluating the resilience scores and the GAD7 and PHQ2, those with higher resilience scores are associated with lower generalized anxiety and depression (Barzilay, 2020).

The Centers for Disease Control and Prevention (2020) has information for healthcare personnel to cope with stress and ways to build resilience during the COVID-19 pandemic. One of the first steps is recognizing the symptoms of stress. These may include feeling irritated, angry, uncertain, anxious, helpless or powerless, overwhelmed, tired, sad or depressed, difficulty sleeping, lack of motivation, and difficulty concentrating.

Stress impacts each of us differently, and circumstances may trigger past experiences or traumatic events. For those working in busy emergency departments, the stress and the overwhelming number of sick patients may bring back memories of trauma from past mass casualties or exposure to traumatic events. These experiences increase stress for healthcare workers.

Tips offered for coping and enhancing resilience include keeping open communication with those around you. Talk openly with others about how you feel impacted and ask for help to access mental health resources in your organization. Recognize we all have control over some things and not others. The things we can control include our routine, sleep, and eating good food. Remember to take breaks, exercise, be outdoors when possible, and stay physically active (CDC, 2020). In a study of post 9/11 paramedics and emergency medical technicians, there are two key lessons: "on the ground" support for responders and the concept of "buddy care" (Smith, et al., 2019). On the ground support may include peers, chaplains, and other mental health professionals. These resources being available are important to work through issues now and when they are happening. Buddy care is a concept of helping each other and taking care of our own. Check-in on each other and stay tuned-in to each other's needs as we navigate the day-to-day stress of care during the pandemic.

This is the new normal for the foreseeable future, so the tools we put in place to manage the daily stress and anxiety of our practice environments today will help us navigate the ups and downs of the pandemic in the months to come. By utilizing tools to self-evaluate while watching out for each other will help improve well-being for ourselves and our communities. All healthcare workers must recognize stress, take action to build resilience and coping skills, and, most importantly, know where to go if you need help.

Resources for help include the National Suicide Prevention Lifeline (1-800-273-TALK), Disaster Distress Helpline (1-800-989-5990), and the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/hcp/mental-health-healthcare.html

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NSBN WELCOMES NEW BOARD MEMBERS

Tracey McCollum, BSN, MSN, PHN, RN, CENP, NEA-BC,

Tracey joined Carson Tahoe in 2014, with over 16 years of nursing leadership experience. She earned her Master of Science in Nursing/Nursing Administration degree from the University of Texas at Arlington after completing her Bachelor of Science in Nursing/ Public Health Nurse degree. She has a strong clinical background in Critical Care, Obstetrics and Med-Surg, as well as focusing seven years of her career in Quality & Risk Management. Tracey started her nursing career in Northern California, where she worked as a Director of Nursing for 10 years. She is a strong servant leader with director experience in outpatient services; has led a multidisciplinary team to design, build, and run a new Urgent Care/Occupational Health Center; and develop this new service-line. Tracey has also been a Director of Employee Health, Occupational Health, and Safety.

Additionally, Tracey holds a green belt certificate in Lean Six Sigma, is a Certified Executive in Nursing Practice (CENP), Nurse Executive-Advanced/Board Certified (NEA-BC), and a proud member of the Northern Nevada Nurse of Achievement Committee. She has worked with the community as a graduate of Carson City Leadership Institute. She is a member of the Human Rights Review Committee through Eagle Valley Children's Home in Carson City. Tracey is a Board member with Friends-In-Service-Helping (FISH) in Carson City and serves on the Board of Directors for Sierra Donor Services.

Most recently Tracey was appointed by the Governor to the Board of Nursing for the State of Nevada. She was appointed specifically to advocate for the Nevada indigent patient population.

Tracey was voted as People's Choice Director of Nursing for 2020 at the Shining Stars of Nursing annual event. Tracey's passion is building strong teams at the nursing leadership level. Tracey is married with two sons. She enjoys golf, concerts, and traveling.

Cheryl A. Maes, PhD, APRN, FNP-BC

Hi, my name is Cheryl Maes. I am a graduate of the BSN and MSN programs at the University of Nevada, Las Vegas, and the PhD in nursing program at the University of Arizona. I have been a registered nurse since 1993 and continued with my journey to become an advanced practice registered nurse (APRN) in 2000. I am a board-certified family nurse practitioner and have and continue to provide primary care in a family practice setting. I am also an assistant professor at the University of Nevada, Las Vegas School of Nursing, and currently teach in the undergraduate and the family nurse practitioner program. I am also a member of several professional organizations, including the American Association of Nurse Practitioners, Gerontological Advanced Practice Nurses Association, Western Regional Advanced Practice Nurses Network, and Sigma Theta Tau International Honor Society of Nursing.

It has been a joy for me to teach nursing students in the same place that sparked my love of learning. My passion for teaching strives on my belief of how crucial it is to keep the health and safety of our citizens in mind while providing care. I take my job seriously, and when assigned a task, I will see it through to completion. I thrive through challenges and constantly set goals for myself, so I have something to strive toward. I am not comfortable with settling, and I am always looking for an opportunity to do better and achieve greatness. I am a person who is positive about every aspect of life. There are many things I like to do, to see, and to experience. I like to think; I like to dream; I like to talk; I like to listen. I spend my non-work time with my family, going to the gym, shopping, listening to music, and watching sports. Beyond any doubt, I am honored to be a member of the Nevada State Board of Nursing and trust that I will serve the citizens of our state well.

2020:
A TOUGH YEAR FOR NURSES

By Craig K. Perry, J.D., Attorney at Law
www.lvnurseattorney.com

In retrospect, 2020 was a difficult year for nurses. Work was plentiful, but that caused some of the problems, as the demand for nurses outstripped supply. The strain on nurses affected the quality of care.

My sister-in-law recently retired, after working for 37 years as a RN. She retired in July, at the height of the COVID breakout—stressed and worn out. Her daughter is a RN in Texas; her husband lost his job due to COVID-related business shut downs; weeks ago, she gave birth to their second child. They, too are stressed and worried as she returns to work full-time. Like many, she carries a heavy load.

Amidst all of this, the high standards of care upheld by the nursing profession continue unabated. How do administrators and employers cope with the influx of COVID-19 cases, and the growing backlog of routine, necessary or elective medical care, in the face of these shortages? Some simply place greater demands on their nurses: more time, more patients, and heavier workloads than ever before.

For the most part, nurses are responding to the call of duty and delivering admirably, but over time, the burden is straining them. As I write this, a new wave of COVID-19 cases are dramatically increasing. Nevada's Governor Sisolak recently contracted the virus. The new influx of COVID patients is straining hospital resources, which translates into more work for the beleaguered nurses of Nevada.

I wish you all could listen to the stories I hear, every week, from nurses who are worried about losing their licenses because of mistakes they made or are accused of making under this pressure. The Nevada State Board of Nursing has no direct, regulatory control over how hospital administrators and other medical providers run their practices. Too few states have enacted laws to regulate nurse-to-patient ratios. As a result, nurses are at the mercy of their supervisors and employers who assign them work, and the number of patients they care for.

Have you ever seen the I Love Lucy episode of Lucille Ball and her friend Ethel working at a candy factory? "If one piece of candy gets past you unwrapped, you're fired!" shouts the supervisor. As the conveyor belt speeds up, they try to wrap each chocolate, but it's impossible. Fearing for their jobs, they start eating the ones they can't wrap, and then resort to hiding them in their hats and dresses. It's a disaster, and it's a great metaphor to what I see happening to nurses today; from where I sit, I listen to nurses who struggle mightily to perform all required tasks, but the mounting pressures and workload of their jobs cause them to slip up, and even cover up mistakes once in a while. How they must deal with these pressures is anything but comical.

When nurses make mistakes, The Board can impose many forms of discipline: impose probation or a public reprimand; suspend, revoke, or accept a voluntary surrender of a license, etc. (see NAC 632.296). It's a sobering list.

Here are the most common problems I saw in 2020 that led to errors, with some recommended solutions:

Problem: Lack of help. I've heard of CNs, DONs, and other Admins refusing to help nurses for fear of COVID exposure, even though not enough RNs or CNAs are on the floor.
Solution: Raise objections within the organization through nurse and management meetings. Make sure those notices are given in writing. If all else fails, call Sam McCord at the NSBN and report your concerns.

Problem: Lack of training. Administrators don't always train their staff on their protocols, including forms and software; this year, I saw an uptick in cases where meds were not properly wasted, for example.
Solution: Always waste meds in front of another nurse, without exception. Obtain documentation for any training you receive. Ask for training if any practices or protocols are different than what you did at other locations or from what you learned in school.

Problem: Following the Crowd. Many nurses get in the habit of copying what everyone else is doing, even if it falls below proper nursing practices.
Solution: Ask questions, and document your concerns. Suggest changes. Point out deficiencies. All too often, co-workers are all doing the same wrong thing, but my client is the only person who is investigated. Why? It doesn't matter why—and the Board may not care, because they only address what is reported. "Everyone else is doing it" is not a good reason, it's only an excuse. Report substandard practices—and be proactive!

Problem: Limited time to complete tasks. You can't finish everything you're expected to do during your shift.
Solution: If other nurses can consistently finish the same amount of work as you—in less time—unless you're new, find a job that matches your abilities. If you're struggling, ask for hep and document it. Confirm in writing what you were told. Call Sam McCord at the Board if you have problems that are not being addressed.

Summary. Many of the mistakes I saw committed in 2020 were made by devoted nurses who, due to a massive increase in work load, hours worked, and lack of help or training, made mistakes. Be assertive and put things in writing. Poor practices are never an acceptable option. Those who do eventually end up facing possible, disciplinary action.

Craig Perry has been practicing law in Nevada for 31 years, and has represented hundreds of nurses before the Nevada State Board of Nursing. Consultations are confidential and free. Call (702) 893-4777 for more info, or visit our website at lvnurseattorney.com.

By Vicki L. Schmidt MSN, APRN, FNP-C

ALIENE CARRINGTON EWELL: INNOVATIVE NURSING LEADER

Innovation is the process of creating something different and new. Innovative leaders are creative and forward-thinking. They strive to create an environment with others who are creative and generate new ideas (Asurakkody & Shin, 2018). When I think about innovative nursing leaders, I think of Aliene Carrington Ewell. Many people will not recognize this name, but members of Chi Eta Phi Sorority Incorporated will. Ewell founded Chi Eta Phi with the support and assistance of 11 other nurses, collectively known as "The Twelve Jewels." Chi Eta Phi is a professional nursing organization founded on October 16, 1932, at Freedman's Hospital in Washington, D.C. (Miller, 1968).

Founding members of Chi Eta Phi Sorority.

During my journey of pledging the Eta Eta Eta chapter of Chi Eta Phi here in Las Vegas, I wanted to know more about its foundation. I learned Ewell graduated from Freedman's Hospital School of Nursing (Miller, 1968). Freedman Hospital was purchased by Howard University in 1967. The College of Nursing and Allied Health Sciences is housed in the original building. Freedman's was a pioneering hospital, which treated freed slaves, disabled, and elderly Black patients. Later the hospital would treat the general African American population in Washington DC. Unfortunately, the hospital faced many scandals, including embezzlement, misconduct, malpractice, and neglect before Howard University's purchase in 1967. Yet, during these challenging times, the medical staff was able to provide the underprivileged D.C. community with much needed medical care (Stolp-Smith, 2018). I personally cannot imagine what it was like to be a nurse trying to provide the best care for my patients and advance my career during this time, given the scandalous situations they must have faced.

Ewell wrote that she recognized the need to organize nurses in various areas and at all levels of education, to uplift one another, promote higher education for the nursing profession, and participate in other areas of society. She created an organization, which encompassed these criteria, and also promoted dedication and friendship among nurses. Founding Chi Eta Phi during the Great Depression is another testament to Ewell's determination (Miller, 1968). By 1939, the organization grew to four graduate chapters of nurses and one undergraduate chapter of nursing students. Under the guidance of Ewell's leadership and determination to serve humanity, these chapters served the underprivileged community by giving out food, toys, and clothes during the holidays. They also held summer picnics for the children of these same communities. There were community projects organized, such as childhood diphtheria immunizations, adolescent girls and mothers' clubs, and multiple donation projects. The members began a trend of furthering their education by earning bachelors' of science degrees. In 1936, Chi Eta Phi gained membership to the Council of Sororities and Fraternities (Miller, 1968).

For 17 years, Ewell served as National President. During her years as president, the chapters grew with both undergraduate and graduate nurses, the organization was awarded multiple prestigious awards, and began funding multiple nursing scholarships (Miller, 1968). In the first publication of Chi Eta Phi's "The Glowing Lamp" in 1950, Ewell wrote:

"The members of Chi Eta Phi must not fail to meet the responsibility and the challenge that is a part of our heritage. Our sorority has always led the way and its organ must continue to uphold the spirit and tradition of a Greek letter organization. Such can only be accomplished if we all work together for one common purpose – to be second to none in whatever task we undertake." (Miller, 1968, p. 158)

Today, Chi Eta Phi is a prestigious international nursing organization with many members, including the 36th president of the American Nurses Association, Dr. Ernest Grant (ANA President, n.d.). The current National President is Priscilla J. Murphy (Leadership 2, 2017). Chi Eta Phi continues standing strong with more than 101 graduate chapters and

Las Vegas- Eta Eta Eta Chapter of Chi Eta Phi.

41 undergraduate chapters located all over the United States and St. Thomas. There are well over 8,000 student nurse and registered nurse members and counting. Membership is extended by invitation only and open to both men and women (Membership, 2019). Members continue to work together, uplifting one another and focusing on the same mission and vision as the original chapter members. The Chi Eta Phi values include education, leadership development, scholarships, disease prevention/health promotion, improving the health of communities, and others (About, 2017). Chi Eta Phi continues to be guided by the motto "Service for Humanity" (Chi Eta Phi Sorority, Incorporated, 2020). I believe our jewel, Aliene Carrington Ewell, would be so very proud of the organization her innovative leadership created.

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DRUG USE AND ACCIDENT RISK AMONG PILOTS

In 2014, the National Transportation Safety Board (NTSB) published a report examining the impairment trends in the prevalence of controlled substances, over-the-counter medications and illicit drugs used by pilots who died in aviation accidents between 1990 and 2012. The goal of the study was to describe the prevalence of OTC and prescription medications among those pilots who died and to examine the needs and recommendations for safety improvements.

The study reviewed a population of 6,677 pilots who died in aviation accidents between 1990 and 2012. The percent of pilots with positive toxicology results for all drugs increased over time (NTSB, 2014). Patterns of increased drug use were consistent with overall drug use trends in the U.S. at the time. Benadryl and Unisom products were found to be the most common drugs used.

The study concluded that the overall risk of pilot impairment increased over the time of the study. Recommendations to improve safety included:

1. increased education for pilots regarding the effects of medications that cause impairment;
2. ensure that pilots have approved medical certificates prior to flying; and
3. provide education and awareness to providers regarding transportation safety risks associated with certain medications. Patient education is paramount regarding the effects of impairment.

Please remember the importance of routinely discussing with patients the effect their diagnosed medical conditions or recommended drugs may have on their ability to safely operate a vehicle in any mode of transportation.

A link to the original study can be found at: https://www.ntsb.gov/safety/safety-studies/Documents/ss1401.pdf

NTSB (2014). Drug Use Trends in Aviation: Assessing the Risk of Pilot Impairment. National Transportation Safety Board. https://www.ntsb.gov/safety/safety-studies/Documents/ss1401.pdf


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Nevada State Board of Nursing News

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- Spanish-Speaking Services for Consumers

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Term expires 10/31/2023

BOARD TALK

BOARD MEETINGS

The Nevada State Board of Nursing has a seven-member Board, appointed by the Governor, consisting 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

Dates and locations are subject to change

January 20-22, 2021
DoubleTree by Hilton
Las Vegas Airport
7250 Pollock Dr,
Las Vegas, NV 89119

March 17-19, 2021
Hyatt Place,
Reno-Tahoe Airport
1790 E. Plumb Lane,
Reno, NV 89502

May 11-14, 2021
DoubleTree by Hilton
Las Vegas Airport
7250 Pollock Dr,
Las Vegas, NV 89119

July 13-15, 2021
TBA

September 22-24, 2020
DoubleTree by Hilton
Las Vegas Airport
7250 Pollock Dr,
Las Vegas, NV 89119

November 18-20, 2020
Hyatt Place,
Reno-Tahoe Airport
1790 E. Plumb Lane,
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ADVISORY COMMITTEES

The Nevada State Board of Nursing is advised by and appoints members to six standing advisory committees. Committee meetings are open to the public; agendas are posted on the Board's website and at community sites. We have 1 RN member open on Education Advisory Committee (1). We have 1 CNA advisory, 1 RN home health, and 1 RN acute care. There are no other openings 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 video-conference in Reno and Las Vegas.

Advanced Practice Advisory Committee:
February 11, 2020
~~May 5, 2020~~ Cancelled
June 5, 2020
August 18, 2020
November 3, 2020

CNA advisory
January 9, 2020
~~April 9, 2020~~ Cancelled
August 6, 2020
October 8, 2020

Disability Advisory Committee
December 19, 2019
February 13, 2020
~~April 23, 2020~~ Cancelled
June 18, 2020
August 13, 2020
October 15, 2020
December 10, 2020

Education Advisory Committee
January 10, 2020
~~April 17, 2020~~ Cancelled
August 21, 2020
October 23, 2020

LPN Advisory
February 18, 2020
~~April 21, 2020~~ Cancelled
June 16, 2020
August 18, 2020
October 20, 2020
December 15, 2020

Practice Advisory
February 4, 2020
~~April 7, 2020~~ Cancelled
June 2, 2020
August 4, 2020
October 6, 2020
December 1, 2020

Education Advisory Committee (1)
CNA advisory (1 CNA, 1 RN home health, 1 RN acute care, 1 LPN Member, 1 RN- AARP)

MOVING?

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You are required, by law, to inform the Board of any address change, including a zip code change within 30 days from the date of the change. To change your address please login to your Nevada Nurse Portal account and click on "manage profile". You can also update your email address, phone number or request a name change through your Nevada Nurse Portal account.

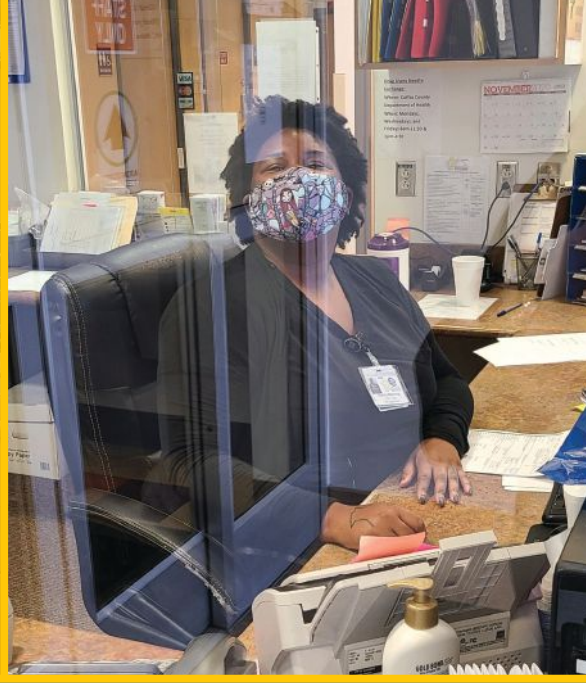
WHAT A CNA NEEDS TO KNOW ABOUT CONTINUING EDUCATION AND EMPLOYMENT AUDITS

When Certified Nursing Assistants (CNAs) are selected for a random continuing education and employment audit, they are required to submit certificates of completion for 24 hours of continuing education or in-service training and proof of 40 hours of employment as a CNA. During an audit, there are two requirements to be mindful of with these submissions. First, the CNA should verify all of the continuing education or in-service training hours being submitted are approved by the Board. Second, the CNA will need documentation that they practiced in the capacity of a CNA. The CNA is responsible for submitting their own continuing education certificates or proof of in-service training from their facility and complying with the continuing education and employment audit. Additionally, pursuant to NAC 632.193 (6), the CNA must:

- Submit to the Board a letter written by the employer of the nursing assistant on the stationary of the employer with the name of the nursing assistant.
- The name of the employer; and a statement that the nursing assistant has provided at least 40 hours of nursing services or services related to the scope of practice of a nursing assistant for monetary compensation under the direct supervision of a registered nurse or licensed practical nurse.

All audit requests are sent at the first of every month through the CNA's Nevada Nurse Portal Message Center and to the email address of record. Audit requests are due 30 days from the date of the original notice.

In 2015, the CNA Advisory Committee issued an advisory opinion regarding CNA practice. This advisory opinion specifically states, "The Board may consider that a CNA has met the forty hours of employment requirement if documentation is received from the employer verifying the CNA has practiced for 40 hours as, and within the scope of practice of a CNA, but at times also performs other duties under a different title at the same facility." The advisory opinion can be found by clicking on the following link CNA Hours of Employment for Renewal of Certificates. What does this mean exactly? If the CNA is employed solely as a Cardiology Tech, Mental Health Tech, or other position, then the CNA is not working as a CNA even though they may do some of the same duties as a CNA, and they hold a CNA certificate in Nevada. CNAs and facilities must understand this requirement.



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