OREGON BOARD OF NURSING
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WHY THE PRACTICE ACT DOES NOT CONTAIN A LIST OF EASY ANSWERS

Evidence-Based Practice: Are You Working at the Top of Your License?

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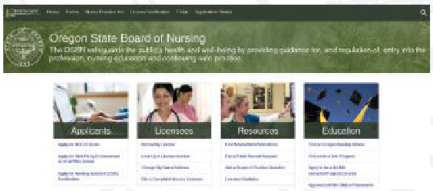

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EDITION 41

By OSBN Executive Director ***Ruby Jason, MSN, RN, NEA-BC***

WHY THE PRACTICE ACT DOES NOT CONTAIN A LIST OF EASY ANSWERS

The Board receives almost daily inquiries of, "Is it in my scope to do XYZ," or, "My employer expects me to do XYZ, and I don't think it is in my scope."

Nurses are often confused by the purpose of the Nurse Practice Act (NPA). If the act does not list items within the scope of a nurse, then what purpose does it serve? When does a nurse know when they have violated the practice act?

To understand the practice act fully, there must first be an understanding of the legal definitions regarding the practice of nursing, and how the language in the practice act reflects those definitions and describes the actions of nurses to implement legal practice. This understanding is based upon:

1. While nurses undergo education and testing to become a nurse, the actual ability for an individual to call themselves a "nurse" is a *legal* title authorized by the state in which the individual is licensed based on the legislatively authorized duties and authority of the state Board of Nursing. In Oregon, this authority is found in Oregon Revised Statute (ORS) 678.150.
2. Achieving nursing education and successful completion of the NCLEX examination do not guarantee that the legal title of "nurse" will be offered to an applicant for licensure. The Oregon State Board of Nursing (OSBN) has the authority to deny licensure to any candidate not meeting the standard of being a "duly qualified" candidate.
3. It is through this legal titling—and only through this titling—that an individual may practice nursing and call herself/himself a nurse. Removal of this titling by the OSBN, or failure to renew the license, prohibits an individual from the practice of nursing, seeking employment as a nurse, and using the title "nurse."

ORS 678.010 (8) states that the practice of nursing means *"diagnosing and treating human responses to actual or potential health problems through such services as identification thereof, health counseling, and providing care supportive to, or restorative of, life and well-being, and including the performance of additional services requiring education and training that are recognized by the nursing profession as proper to be performed by nurses licensed under ORS 678.010 to ORS 678.410 and that are recognized by rules of the Board."* The rules of the Board are identified in Oregon Administrative Rules (ORS) Chapter 851.

So, what does that mean? The practice of nursing is not associated with defined tasks. Nursing practice is the analysis of the response the individual has to their current state of health that brought them into contact with the nurse. This requires the nurse to have her/his own assessment and plan of care for the patient, which can include interventions authorized by a Licensed Independent Practitioner (LIP) whose practice focuses on ***diagnosis***. However, the LIP plan is separate from the nursing plan of care. The nurse is required, under the requirements of the practice act, to have their own plan for the patient's overall response.

To illustrate, consider the following example:

A 36-year-old woman with four children, all under the age of 10, has just been given a terminal diagnosis. While the woman is undergoing treatment authorized by the LIP, the nurse reviews the woman's human response and prioritizes her care, focusing on support of the woman's priorities regarding her current state of health. Is the woman able to focus on her own care needs when she is more concerned about what will happen to her children when she dies? Is her priority caring for her own needs or those of her children? It is the nurse who assesses these issues, and plans the care and the intervention.

Now let's look at how the NPA describes the legal practice of nursing in this situation by some examples of statements found in the practice act:

ORS 851-045-0060(2)(a): The RN shall base RN practice on current and evolving nursing science, other sciences, and the humanities.

ORS 851-045-0060(3)(c)(G): Evaluating the data

from the comprehensive assessment to identify problems or risks presented by the client. Develop reasoned conclusions that identify the client's problems or risks, develop a client-centered plan of care based on analysis of the client's problems of risks that establishes priorities in the plan of care, identifies measureable outcomes, and that includes nursing interventions prioritized reasoned conclusions.

ORS 851-045-0060(5): Advocate for the client's right to receive appropriate care, including client-centered care and end-of-life care that is respectful of the client's needs, choices, and dignity. Communicate the client's choices, concerns, and special needs to other members of the health care team.

As shown by these examples, the NPA describes how the nurse shall implement the legal definition of nursing. The practice act also has a statement describing the expectations of nurses with regard to co-workers, the use of social media, working with Certified Nursing Assistants and unregulated support staff, and the required communications with other members of the healthcare team.

The bottom line is that because nurses work in a wide variety of clinical settings and non-clinical settings, the practice act must be applicable to *all* nurses in *all* settings. This is known as the "context of care." The context of care refers to the environment in which the nurse works, the nurse's role within that environment, the regulations governing the practice setting, and the abilities of the client. The same statements in the practice act apply to every nurse, in every setting, in every role. No nurse with an Oregon license is exempt from the practice act, even if she/he never directly care for or encounter a patient in their practice. Note that the NPA is written with the term "client" rather than patient. For a staff nurse, the client is the patient. For a Chief Nursing Officer the client is the nursing delivery system in their facility. For a nurse working in informatics, the client is the nurse at the bedside who is using the informatics system to deliver care.

Let's review the same statements in our patient example above and relate those statements to a nurse working in informatics:

ORS 851-045-0060 (2) (a). The Nurse Informaticist must apply current knowledge of the practice of nursing and the technology of the system used by nurses to assure that the nurses are able to implement their practice.

ORS 851-045-0060(3)(c)(G): The Nurse Informaticist must gather information regarding the context of care in which nurses work in the facility to identify the problems and risks associated with the plan for informatics implementation, evaluate the plan and then modify the plan as the needs of the client change or if the system is not workable in the context of care.

ORS 851-045-0060(5): The Nurse Informaticist is accountable to communicate the needs of the client to those responsible for the overall system. The Nurse Informaticist is accountable to respect the practice of nursing and assure that the needs of the nurses with regard to their ability to care for their patients in developed within the implementation plan. There is not the need to address every concern, however, the Nurse Informaticist is accountable for knowing that the system works in each context of care in which it is used, including the appropriate education. Each individual nurse is accountable for being able to utilize the informatics technology within their own context of care, but it is the nurse informaticist who shall be held accountable under the practice act to provide the documentation that they abided by the practice act in the implementation of the system or the Board has the legal authority to take the same sanctions against the license of the Nurse Informaticist as the nurse providing direct patient care.

Clearly, if the practice act was a "laundry list" of tasks, these could not be applicable to all the contexts of care in which nursing has a role. Although many nurses do not provide direct care, all nursing practice is related in some way, directly or indirectly, to the safety of the public. In our examples, the nurse caring for the 36-year-old is accountable for her safe care, and the Nurse Informaticist is accountable to assure the nurse has informatics systems that aide in communicating the care provided through the practice of nursing.

So how does a nurse determine if a task, role, or intervention is within scope? Each nurse has a different scope-of-practice based upon their knowledge, skills, abilities, and competencies. To determine your scope please access our interactive Scope-of-Practice Decision Making Tree at https://osbn.oregon.gov/OSBNScopeTree/Choice1.aspx.

In the next edition of the *Sentinel*, we will review the statements in the Nurse Practice Act that provide the legal situations when a nurse is not practicing within the practice act.

By OSBN RN/LPN Education Policy Analyst ***Nancy Irland, DNP, NMNP, CNM***

EVIDENCE-BASED PRACTICE:
ARE YOU WORKING AT THE TOP OF YOUR LICENSE?

Do you remember your first impression of nursing? Perhaps it was placing a hand on a fevered brow, or a crisp, white uniform and black-ribboned cap. Maybe it was a doctor's "handmaiden." Has it ever been a professional whose trusted decisions are guided by research?

Previously, nurses didn't make decisions based on research (Polit & Beck, 2006). Very little nursing research was available. In addition, getting our hands on any research was often a futile effort that included a drive to the closest university to search the card catalog hoping to find something useful. Then, we would pay a fee to photocopy the article, take it back to the manager, and hope he or she would consider the change. Of course, it needed physician approval, too. As you can imagine, validation of good ideas did not seem worth the effort. The way we'd always done things worked just fine and was based on trusted, authoritative opinions.

Over time, everything changed. White uniforms, caps, and the handmaiden role were out; nursing research and accessibility to it on the internet were in. The public began demanding accountability for safety and quality in health care. With that came the phrase, "evidence-based medicine," which has been implemented in nursing as, "evidence-based practice." Evidence-based practice (EBP) has changed the field of nursing. It marks a shift among healthcare professionals from a traditional emphasis on authoritative opinions to an emphasis on data extracted from prior research and studies as well as patient preference. No more doing something because doctor X said so.

In spite of the benefits, the mention of EBP makes many nurses raise their eyebrows in disdain. This could be because of a misunderstanding that EBP requires bedside nurses to generate new research in addition to everything else they must do. It is important to recognize that EBP is not the generation of research. Instead, it is our *standardization of healthcare practices* by basing them on science, best evidence, and clinical expertise (Stevens, 2013). Today, nurses are valued members of interdisciplinary teams. Regulatory bodies expect nurses to go beyond being kind and caring. The opinion of the Oregon State Board of Nursing is that a nurse who works at the top of her or his license is a nurse whose trusted decisions are *guided and validated* by research and evidence.

In this article we'll take a look at the way things used to be before EBP. We'll review the history of this approach to patient care, define what we mean by EBP, and consider the benefits of EBP to us both professionally and personally. Finally, we'll look at ways to incorporate EBP into nursing practice in spite of limits on time and energy and perhaps see the concept with new eyes.

The Way Things Used to Be

Where do we get the courage to do what we do? As nurses, we're asked to do things to people that most others wouldn't think of doing: stick things into their bodies, push powerful drugs into their veins that could stop their hearts, and so forth. Why aren't we scared to do that? (Okay, sometimes we *are* a little scared). Those of you who have come into the profession in the last 20 years have had the benefit of grounding your practice on a growing body of evidence that didn't exist years ago. Before EBP, I was often scared; after EBP I felt more confident in what I was doing. I could carefully evaluate research to confirm that the practices I was asked to do had been validated as beneficial by research studies. Putting babies to sleep on their backs was one of those changes that seemed intuitively wrong (wouldn't they choke on mucus at the back of their throats?), but the research was powerfully in its favor.

Until the US Department of Health and Human Services established the National Institute of Nursing Research in 1993, standards of care were based

primarily on tradition or the established practices of a more renowned hospital down the road. Our main sources of evidence included whatever we learned in school, textbooks in the hospital library, recommendations from our more experienced colleagues, or providers' opinions. Without the internet, we weren't likely to validate the reliability of our practice if nothing "bad" was happening because of it. We had confidence in the status quo. As such, because many changes or innovations in practice came only by word of mouth, it was often terrifying to adopt them, though we did.

I still remember an event that happened before we obstetrical nurses were provided with formal neonatal resuscitation classes. I was the nurse assigned to assist a pediatrician with a planned resuscitation for a baby whose mother was having an emergency cesarean section for fetal distress (an old term). The pediatrician was new to our hospital and just out of residency. Because the cesarean was emergent, he had raced in from his office; there was no time to discuss our resuscitation ahead of time.

The surgeon placed the purple baby on the warmer. She was floppy like a fish, with glazed eyes. Between chest compressions performed by another nurse, the pediatrician quickly inserted an airway into the apparently lifeless baby. I had drawn up some epinephrine and was ready to inject it. The pediatrician said, "Pour it into the tube."

I was speechless. We traditionally gave epinephrine as an injection. But, the only time we were supposed to question a doctor's order was if an ordered medication was on a patient's allergy list. With my heart pounding, I did as he asked, hoping I was not killing this already-stressed newborn.

You know the rest of the story: the baby turned pink and cried loudly. I had just witnessed evidence that epinephrine in an ET tube worked without drowning the baby. When I asked the physician for a physiological explanation, he was kind enough to explain, and it all made sense. Still, I would have preferred to see the literature for myself before doing it. Later, when we began taking official neonatal resuscitation classes I saw the evidence.

History of Evidence-Based Practice

At about the same time, around 1971, a visionary epidemiologist in the United Kingdom named Archie Cochrane was becoming a vocal critic of the fact that most medical treatments were not based on a systematic review of clinical evidence. For the obvious reasons cited above, even physicians didn't have the time or the resources to review an adequate number of research articles to inform their practice. Mr. Cochrane made the decision that a collection of systematic reviews should be created—one-stop-shopping for research that would guide best practices. With that, the Cochrane Collaboration was born.

This is not to say that current medicine considers the evidence while traditional medicine did not. Providers have been using evidence for medical decision-making for many years What has changed is the *availability* of more evidence. This reduces the need for educated guesses and puts the responsibility on us to know about the evidence and to incorporate it into practice when indicated. Cochrane Reviews provide meta-analyses that do the time-consuming work of assessing and comparing a broad swath of studies around the world, to help determine the strength and reliability of the research and associated outcomes.

Defining Evidence Based Practice

So, let's get back to defining *evidence-based practice*. As we've said, it marks a shift from a traditional reliance on authoritative opinions to an emphasis on data from prior research and studies. We've noted that EBP is not the generation of new knowledge; it is the application of research. EBP blends research evidence with clinical expertise and encourages individualization of care by including patient preferences when indicated. Too often, allowing for individualization of care is overlooked, although that is one of the fundamental pillars of EBP.

Evidence-based practice has been traditionally conceptualized as a three-legged stool (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996) that depends on: 1) the best clinical evidence; 2) professional expertise and decision-making; and, 3) client preferences. Like all stools, however, the floor on which the stool is placed determines whether or not we feel safe sitting on it. Clearly, not everything we do in healthcare is quantifiable or researchable. Albert Einstein is credited as saying, "Not everything that counts can be counted, and not everything that can be

counted counts." This is where the *levels* of evidence come in. Research evidence is not binary; it isn't either "evidence-based" or "non-evidence-based." There's a continuum of "stronger" and "weaker" evidence that validates whether or not a treatment is effective.

Questions about the quality of the research, wording of the research question, and the outcomes of the research must all be evaluated with other research on the same topic before we decide to, "sit on the stool," and trust the evidence. Cochrane reviews do that for us. Our clinical reasoning includes individualizing the science with what this patient wants and what might be best in this situation, after the patient learns the pros and cons.

Benefits of Evidence-Based Practice

Our patients benefit best when we practice with the support of science and share the evidence with them. This also benefits us personally Evidence reduces fear and uncertainty in both the patient and in ourselves. It increases confidence. Evidence can confirm our intuition and give us the support to make needed changes. It helps us accept change and keep improving care. It helps develop a standard of care. Evidence gives us a defense for our actions if questioned. A nurse whose practice is validated with solid research develops a stellar reputation as someone to be trusted.

Incorporating Evidence on a Daily Basis

Why, then, do so many nurses resist the push to incorporate evidence-based practice in their work? Two of the top barriers cited are, "not having enough authority to change patient care procedures," and, "having insufficient time on the job to implement new ideas," (Griffiths, et al, 2001).

Evidence-based practice is a practice based on knowing. It's working intentionally, confirming that your beliefs and decisions about patient care are grounded in research. I would suggest that a nurse can incorporate EBP every day by bringing a questioning approach to her practice, validating her practice with applicable research, sharing those findings with patients and colleagues, and perhaps changing hospital policies when necessary. The Cochrane reviews can confirm the strength of the evidence to determine if one's standards of practice are scientifically supported by the three-legged stool of EBP. Imagine how powerful it would be if each nurse on your unit adopted one protocol or practice per year, to validate. A protocol without a good answer for *why* it was done could be either: 1) validated without needing change; 2) improved and tracked for better outcomes; or, 3) discarded as not helpful, and replaced with a new protocol, with the support of evidence. All of this, of course, requires the support of management. Sometimes the support of providers is also necessary.

Summary

The ancient phrase, "dare to know," was first used by the Roman poet Horace in 20 BCE. It is even more important now, with patients demanding that we know why we do what we do. The information and evidence is at our fingertips. If you don't know the evidence behind the treatments or standards you follow, look them up. Patients should be able to trust that the decisions we make are supported by the best research and scientific evidence available. More importantly, each nurse should take pride that he or she is working at the top of his or her license. Be that kind of nurse.

Dare to Know.
Suggested Research Data Bases
Cochrane Library:
http://www.update-software.com/publications/cochrane/

Pubmed:
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?DB=pubmed

UpToDate:
http://www.utdol.com

eMedicine:
http://www.emedicine.com

National Guideline Clearinghouse:
http://www.guidelines.gov

Clinical Evidence:
http://www.clinicalevidence.com/ceweb/index.jsp

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By OSBN RN/LPN Practice Policy Analyst ***Gretchen Koch, MSN, RN***

DIVISION 48:
RNS TEACHING A DESIGNATED CARE PROVIDER

The use of designated care providers was driven by the emerging human immunodeficiency virus (HIV) epidemic and related acquired immunodeficiency syndrome (AIDS) epidemic of the 1980s and 1990s. The resulting in-home care provided to persons diagnosed with HIV and/or AIDS was most often provided by a same-sex partner or by a close friend. It is important to note that during this time in Oregon, same-sex marriage was constitutionally banned. Same-sex domestic partnership status would not become legal until February 2008.

The changes made to Oregon law (Oregon Revised Statute 678) in 1997 created a legal means for the home health nurse and the hospice nurse to engage with a client's same-sex partner, significant other, or friend, in the exact manner as they would a member of the client's immediate family. This 1997 statutory change was the culmination of years of work done by the Oregon Association for Home Care.

Today, with acute health management occurring outside of traditional care settings, advancements in technologies bringing the delivery of procedures and treatments to the home setting, and shifting population demographics, Chapter 851 Division 48—the rules governing RNs who teach designated care providers—is as relevant as when it was first added to the Nurse Practice Act.

What It Does

Division 48 identifies levels of safe and acceptable practice for the registered nurse (RN) who teaches the person designated by, or on behalf of, the person requiring care, how to execute the medical order.

Division 48 rules are commonly used by the RN in the private home when an immediate family member, such as a parent, grandparent, spouse, partner, child, or sibling, may not be available to execute a medical order for another family member. In such a situation, a friend or neighbor who is chosen by the person requiring care may be taught by the RN to perform the ordered procedure as if they were a family member. The qualifying factor is that the RN must verify that the designated care provider does not receive or accept monetary or other compensation for executing the medical order.

New Rule Changes

Amendments to Division 48 of the Nurse Practice Act (Oregon Administrative Rules Chapter 851, Division 48) became effective on January 1, 2019. Those familiar with Division 48 will note that the rule language has been streamlined and shortened by removing redundant language. In addition, rules that contained standards for care providers and practice settings were removed as the Board holds no jurisdictional authority over either.

All RN practice-related standards were reworked to directly identify the RN's responsibility to:

- Adhere to Division 45 as the foundation for nursing practice when teaching a designated care provider;
- Ensure competency in one's own execution of the medical order prior to teaching its performance to the care provider;
- Verify that the person for whom the order is written has directly chosen their designated caregiver; or for the situation when the designation has been made by a third party on behalf of the person requiring the order, determine that the third party holds the legal authority to make the designation;
- Inform the care provider that they may not teach another person how to execute the order, may not transfer their authority to execute the order to another person, and may not receive or accept monetary or other compensation for executing the medical order;
- Generate and provide retrievable step-by-step instructions of how the medical order is to be performed on the person requiring care;
- Determine the need for future evaluation of the care situation based on nursing judgment; and
- Fulfill all mandatory reporting responsibilities.

To access a copy of Division 48, visit the OSBN's website at www.oregon.gov/OSBN and click on "Nurse Practice Act."

By OSBN Investigations Manager ***Jacy Gamble,*** *Investigator* ***Karen Russell,*** *and Nurse Investigator* ***Heather Johnson, BSN, RN***

DISCIPLINARY CASE STUDIES

Although disciplinary action taken by the Board is a matter of public record, the identity of the nurses referenced in this article will remain confidential.

CASE STUDY #1

Certified Medication Aide (CMA) was employed as a medication aide in a care facility. The Board received a report that CMA failed to apply a resident's Fentanyl patch as ordered, but documented that the patch had been applied. CMA stated she was withdrawing the patch from the medication cart when she was asked to give another resident his pain medication and forgot to follow up on the Fentanyl patch. CMA reported she had told one of two charge nurses that she may have documented a medication not administered, however, neither could corroborate her statement.

According to her personnel records, CMA had been previously counseled and disciplined by her employer several times over the last few years for issues related to documenting a task not completed and failure to follow care plans. During the investigative interview, CMA acknowledged the Board's concerns that there appeared to be a pattern of poor practice habits.

The Board determined that CMA's actions violated the Nurse Practice Act and that public discipline was warranted. CMA agreed that she had engaged in conduct unbecoming a nursing assistant related to dishonesty, failure to follow care plans, jeopardizing client safety, documenting care not provided, entering inaccurate data, and failing to communicate information to the supervising nurse. The Board accepted CMA's Stipulated Order for Probation with Conditions, which included the requirement to take education courses relevant to the violations.

CASE STUDY #2

Nurse A was employed as a Licensed Practical Nurse at a nursing home in a temporary charge nurse position. It was alleged that Nurse A had failed to assess a resident who was experiencing shortness of breath during the night shift. According to Nurse A's documentation, the resident was assessed for shortness of breath at approximately 0400. At the time of assessment, the resident's oxygen saturation was 84 percent and the resident was placed on two liters of oxygen. According to the chart notes, the resident's oxygen saturation increased to 93 percent with the oxygen.

Board staff asked Nurse A to compose a written statement detailing the allegation. When Board staff reviewed the statement there were discrepancies between the statement and the chart notes. Board staff requested Nurse A attend a personal interview to review the discrepancies.

When Board staff discussed the details with Nurse A, it became clear that the nurse did not complete the proper documentation surrounding the event. Nurse A stated that a full respiratory assessment was done; however, there was no documentation to substantiate the nurse auscultated the resident's lungs before or after oxygen was initiated. In addition, there were no chart notes stating the physician was contacted regarding a change in condition, or that the nurse obtained valid orders to start the resident on oxygen. Nurse A discussed with the patient whether she would like to be transferred to the Emergency Room to be assessed; the resident declined, but this also was not charted. In addition, Nurse A failed to put the resident on alert charting, per facility policy, for a change in condition.

Nurse A admitted the shift was very busy, and he had minimally charted in order to finish his shift on time and continue to care for the other residents he was assigned to. Nurse A was educated by Board staff that if you do not document all of the interventions you have completed, the Board considers that said interventions were not completed.

Nurse A agreed that he had violated the Nurse Practice Act by failing to document the assessment of the resident, failing to notify the resident's provider, failing to obtain an order for interventions prior to implementing them, and for misrepresenting the facts of the event in a written statement to Board staff. The Board accepted a signed Stipulated Order for Reprimand from Nurse A, who took accountability for his Nurse Practice Act violations.

By OSBN Investigations Manager ***Jacy Gamble***

I RECEIVED A SUBPOENA FROM THE OSBN: WHAT DOES THAT MEAN?

When the Oregon State Board of Nursing (OSBN) conducts an investigation, Board staff use many tools during the investigative process. One of the most common resources at the Board's disposal is the authority to issue subpoenas for various records.

When a Board investigator determines that records are needed to conduct the investigation, they can issue a subpoena. The subpoena is directing you (either the custodian of records, a supervisor, or Human Resources staff) to provide specific records, which can be personnel records, patient records, internal investigative documents, or many other types of information. Please read the subpoena closely to ensure that you provide all of the requested information. Each subpoena contains the legal citation granting the Board the authority to issue a subpoena. The subpoenas are legally enforceable, which means that failure to produce the requested records or to request an extension by the deadline can result in the Oregon Department of Justice taking action to compel the recipient to produce the requested documents.

The OSBN is a HIPAA-exempt entity, so there is no need to redact any information in the documents. It is important to remember that the subpoenas are for documents only. You do not need to appear personally. Please pay attention to the due date for the requested records.

All investigations conducted by the OSBN are confidential. With every subpoena issued, the Board

includes a cover letter that describes the methods available to submit the documents. The cover letter also requests the recipient to keep the subpoena confidential—do not discuss them with other members of your staff. There are several reasons that the receipt of a subpoena should be kept confidential:

- The issuance of a subpoena does not mean thatthe licensee or certificate-holder identified on the subpoena has done anything wrong, or has or will receive discipline from the Board.
- Unless there is a restriction on the license or certificate listed on the OSBN website, the receipt of a subpoena itself does not mean that they are restricted from practicing nursing or are a danger to the public.
- The integrity of the investigation can be compromised if the recipient of the subpoena shares that information with other staff.
- Revealing the existence of a subpoena can also cause worry and stress to the licensee or certificate-holder in question, or promote the spread of rumors amongst other staff if they find out that the Board is asking for records related to them or their co-workers.

If you receive a subpoena and have any questions about it, the name and contact information of the assigned investigator is located on the subpoena and cover letter.

Chemeketa Community College in Salem, Oregon seeks energetic and teaching-focused candidates for full-time, 180-day Nursing faculty positions. An Equal Opportunity Employer, Chemeketa Community College encourages and actively seeks applications from women, veterans, people with disabilities and racially/ethnically diverse candidates. This faculty position will be committed to student success and is responsible for providing didactic and clinical instruction to students. Participation in departmental and college activities, effective communication with students and staff, and use of technology are essential components.
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Requirements

- Bachelor's degree from an accredited institution in Nursing and current enrollment in an MS in Nursing (MS must be complete within 3 years)
- Current unencumbered Oregon RN license ***or*** eligible for Oregon Licensure (no investigation pending by any State Board of Nursing)
- Nursing experience in medical/surgical or equivalent within the past five years

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By OSBN RN/LPN Practice Policy Analyst ***Gretchen Koch, MSN, RN***

YOU ASK, WE ANSWER

QUESTION: *I am an RN who practices at an assisted living facility. Is changing a colostomy bag a taught task or a delegation?*

ANSWER: The answer may be *neither* – and before we have that discussion, know that the NPA does not regulate procedures. The NPA regulates the licensed nurse's engagement in *nursing practice* in *all* settings where nursing practice may happen.

It is also important to know that the concept of "delegated task or a taught task" is flawed. The manner in which a RN incorporates any given intervention into a client's nursing plan of care, and who the RN chooses to perform said intervention, depends on *far more* than the intervention itself.

The RN's clinical decision regarding who will perform an intervention within the nursing plan of care will occur with the safety and well-being of the client being front and center. The decision will be grounded in the RN's comprehensive assessment of the client and will be shaped by the context of care of the setting.

As a refresher, the RN-level comprehensive assessment is the collection and in-depth analysis and synthesis of client data from which the RN: 1) identifies and prioritizes client problems/risks, and 2) identifies expected outcomes related to the respective identified problems/risks. The RN's prioritized client problems/risks and their respective outcomes are then presented in the RN's a plan of care where specific interventions designed to address, mitigate, or prevent the identified problems/risks are communicated.

The RN has several options for implementation of nursing care plan interventions based on the assessed needs of the client and what is allowed in the practice setting. Options include:

- The RN Implements the intervention directly for the client. This would occur for the client with a fresh post-op or new colostomy as nursing assessment of the client and their surgical wound/stoma is indicated. This would also occur for the client who presents with an injury or trauma to an established stoma (or related bowel area). The RN ensures that the engagement in the activity/intervention is supported by facility policy.
- The RN assigns the intervention to an LPN who possesses competencies to safely perform the intervention. Again, this could occur for the client with a fresh post-op colostomy where a focused nursing assessment of the surgical wound/stoma is indicated. This could also occur for the client who presents with an injury or trauma to an established stoma.
- The RN teaches the client how to perform their own maintenance colostomy care, how to recognize problems with the stoma and bowel activity, and what to do if problems arise. The RN ensures that clear instructions were accessible and available for reference.
- The RN teaches a family member how to perform maintenance colostomy care, how to recognize problems with the stoma and bowel activity and actions to take when problems arise (if allowed in the setting). The RN ensures that clear instructions were accessible and available for reference.
- The RN teaches the client's designated care provider (per Division 48 of the NPA) to perform maintenance colostomy care, how to recognize problems with the stoma and the client's bowel activity and actions to take when problems arise (if allowed in the setting). The RN ensures that clear instructions were accessible and available for reference.
- The RN teaches an unlicensed assistive person how to provide maintenance colostomy care (i.e., emptying the colostomy bag, cleaning of the ostomy site, and changing the bag that does not adhere to the skin). When RN determines the UAP to be safe in their performance of the intervention(s), the RN may then assign performance of the maintenance colostomy care to the UAP. The RN ensures that clear instructions were accessible and available for reference.

The RN's plan of care would indicate who is responsible for performance of the intervention.

While *delegation process* is an RN practice privilege that can occur in community based setting (such as

assisted living facility), it doesn't fit with maintenance colostomy care. Delegation is a care delivery option for the performance of a *nursing procedure*. Colostomy care is considered a regular function of personal grooming, hygiene, toileting, and elimination (i.e., an activity of daily living).

With the above discussion, you can see why the answer to the question "Is changing a colostomy bag a taught task or a delegation?" could be *neither*.

QUESTION: *Who regulates certified medical assistants in Oregon? Are they under the Oregon Medical Board?*

ANSWER: In Oregon, there is no state agency or health-related licensing Board that regulates medical assistants (MA). This means that the MA is an unregulated health worker and there are no legally regulated training requirements or competencies for the person who uses the title of medical assistant, certified medical assistant or registered medical assistant. The Medical Practice act does not cover certified medical assistants; this is a common misconception.

Most MAs have received formal medical assistant training and have graduated from a training program that meets nationally accepted standards. Some MAs pursue national certification and/or registration through private certification and registration organizations. Those who do so successfully carry the title of certified medical assistant or registered medical assistant. As you know, attaining certification in one's area of focus communicates to peers and the public that one has pursued additional education and has met nationally accepted standards.

MAs functions under their own job description and carry out the work that is assigned to them by the physician, the nurse practitioner, and possibly the RN. The scope of the RN's practice when working with an MA, and the standards of care the RN must adhere to when working with the MA, are those identified for working with the unlicensed assistive person. This means when assigning and supervising MA work, the RN must adhere to those specific standards contained within Division 45 of the Nurse Practice Act.

By OSBN Communications Manager ***Barbara Holtry***

2019 LEGISLATIVE SESSION UPDATE

Since the 2019 Legislative Session began January 22, several bills have been introduced that could affect nurses or other health care practitioners. The following is a brief description of several other bills (either House Bills or Senate Bills) that affect licensees, the Board itself, or healthcare in general:

- HB 2188 & SB 128—Allows the Board of Medical Imaging to issue a permit to supervise fluoroscopy to qualified advanced practice registered nurses.
- HB 2230—Limits the amount of overtime nursing staff who work in correctional facilities may be required to work.
- HB 2303—Deletes the requirement that pseudoephedrine be classified as a Schedule III controlled substance.
- HB 2698 and SB 136—Removes the 10-day supply limitation on prescriptions for certain controlled substances issued by CRNAs.
- HB 2722—Includes nurse practitioners, physician assistants, and naturopathic physicians in the definition of "attending provider" who has primary responsibility for treatment of person diagnosed with a debilitating medical condition.
- SB 64—Changes several sections of the Nurse Practice Act (found in ORS chapter 678) to reflect that the Oregon State Board of Nursing (OSBN) licenses nurse practitioners and clinical nurse specialists, rather than certifies them. The change will help differentiate between state licensure and national certification for advanced practice nurses. The bill also changes several sections of ORS 678 to reflect that the Board approves nursing education programs, rather than accredits them. The term "accredited" is reserved for those organizations approved by the state to accredit institutions of higher education. The Board is authorized only to measure a school's nursing education program's ability to meet the standards developed in Board rule, not to certify the quality of the school itself.
- SB 65—Based on requests from nurse midwives, the OSBN submitted this bill to create a standalone advanced practice license type entitled certified nurse midwife (CNM). All currently licensed nurse midwife nurse practitioners will be relicensed as CNMs. The new CNMs will be able to hold prescriptive privileges; they will practice nursing as they do now as NPs, just under a different license type. The change will bring Oregon into alignment with the rest of the country. Oregon is currently the only state that doesn't license CNMs.
- SB 66—Removes barriers to LPN licensure by allowing applicants who have graduated from the US Air Force Licensed Vocational Nurse program (and are so designated on the DD214 form) to take the NCLEX-PN exam. The change will also apply to endorsement applicants who were licensed in other states based on recognition of military education.
- SB 67—Since ambulatory surgical centers are defined elsewhere in statute, the bill removes it as a definition from the Nurse Practice Act. It also changes the term 'conscious sedation' to 'moderate sedation' and 'anesthesia' to 'general anesthesia.' The language changes were developed in collaboration with the Oregon Health Authority, the OSBN, and various stakeholders.
- SB 130—Authorizes school nurses associated with school-based health center to engage in the practice of telehealth.
- SB 5523—This bill appropriates the Board of Nursing's budget for the 2019-21 biennium. Although the Board is an Other Funded agency (funded through licensing fees and not the state's General Fund), it needs Legislative approval on how to spend its funds.

The session is scheduled to end by June 21, 2019, although that date could be extended. To learn more about the above bills or bills that have been introduced since press time, visit the Legislature's website (www.leg.state.or.us/bills_laws) or contact your district legislators.

By OSBN Communications Manager ***Barbara Holtry***

OREGON.GOV/OSBN

Redesigned OSBN Website Debuts

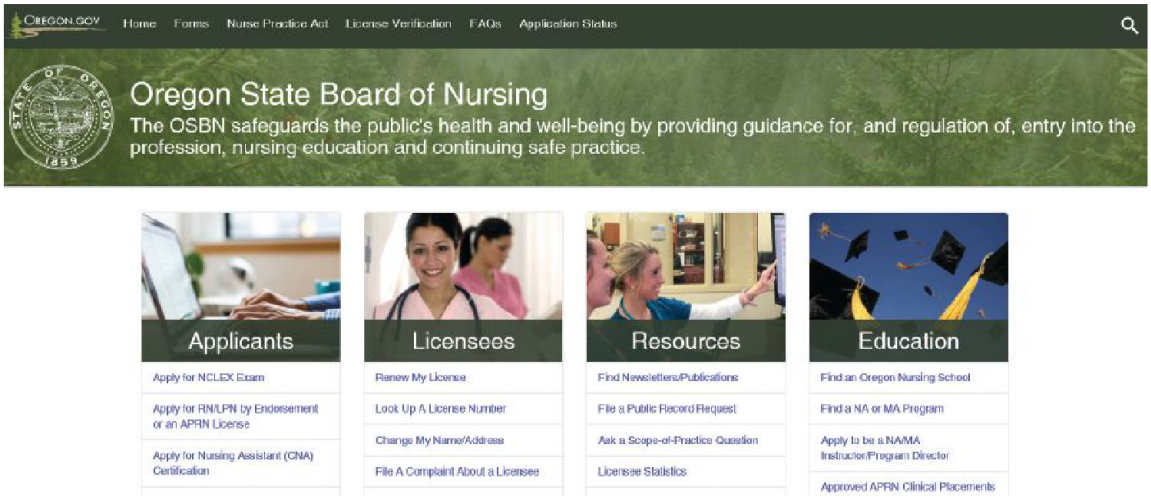
After months of hard work and testing with hundreds of licensees and students, the Oregon State Board of Nursing (OSBN) is pleased to announce the launch of its newly designed website: www.oregon.gov/OSBN.

As of February 12, users will notice the site is more intuitive and accessible, as well as being easier to navigate and find the information they need. The new site design also includes a site-specific search engine, so users have more information at their fingertips. In addition, the site design is in accordance with the latest State of Oregon website standards, using plain language and mobile-device friendly templates.

Although the website address remains the same, the look is entirely new. The new homepage is divided into four "buckets" of information: Applicants, Licensees, Resources, and Education. Links within those buckets have been placed according to user preference.

The redesign of the OSBN website is the first step: a new online licensing system interface is planned this summer that will incorporate almost all applications for licensure or certification and make the application process easier for everyone.

Watch future issues of *Sentinel* for more information.



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By OSBN Executive Director ***Ruby Jason, MSN, RN, NEA-BC***

APRNS: INFORMATION YOU CAN USE

Practice Act Revisions for Advanced Practice Nurses: Work continues on revising the three existing rule divisions pertaining to each advanced practice nursing (APRN) license type and prescriptive authority (OAR 851, Divisions 50, 52, 54, and 56). The goal is to prevent redundancy and/or discrepancies in language and practice standards. An advisory task force has met five times since the Board authorized this change to the NPA in June 2018. While only the members of the task force may consider the content of the rules, the meeting is open to the public, and there is time on the agenda for comments from non-task force members. The major recommendations of the task force thus far are:

- Create new divisions based on subject instead of license type. The three new divisions would address the approval of education programs, licensing, and scope-of-Practice/ Standards-of-Practice.
- Eliminate Division 56, since all APRN license types now have the ability for prescriptive authority, and incorporate those requirements and standards into the new licensing and scope-of-practice/standards-of-practice divisions.
- Providing timeline for the attainment of the DNP as the entry-level education for licensure as a Nurse Practitioner.

There is no timeline for completion of the complex work.

Material Risk Form: Per OAR 851-056-0026 (6)(b)(B), a Material Risk Notice is to be provided to and signed by patients before treatment of intractable pain commences. During the review process of the APRN divisions, it was noted that this is not required by Oregon Statute based upon the passage of SB 800A by the legislature in 2007. The statute does require that the clinician should discuss with the

patient the known risks and realistic benefits of opioid therapy, and the patient and clinician responsibilities for managing therapy. Although the specific form is not required, the content of the discussion and documentation of such remains the same. The form that is currently available on the Oregon Medical Board website addresses all the issues to be covered between the patient and the clinician providing the clinician with assurance that all the required discussion parameters have been covered. While it is advisable to continue using this form, it is not required by Oregon statute, and even though Div 56 remains unchanged for now, statutes supersede the rules of the Board. The APRN Advisory Task Force will review this language with an eye toward accurately reflecting current Oregon law.

Advanced Nurse Practitioners Working as Registered Nurse First Assists (RNFA): Oregon Revised Statute 678.366 required the Board of Nursing to adopt rules establishing procedures for the recognition of registered nurses to become RNFAs by receiving additional certification through nationally recognized professional organizations. The rules for obtaining an RFNA certification recognized by the Board are listed in OAR 851-045-0060(12) under the Scope and Standards for Registered Nurses and Licensed Practical Nurses. The Board has provided further information on the OSBN website with the Interpretive Statement entitled, "APRNs in the Role of Registered Nurse First Assists." In both statute and rule, the level of practice for RNFAs is linked to the license as the Registered Nurse, not the Advanced Practice license as an NP, CNS, or CRNA. The role of the RNFA is not covered in advanced practice education to the extent required by the Board. Although historically Nurse Practitioner Nurse Midwives have scrubbed in to assist in surgical procedures and this is covered in the basic Midwifery education, this educational exposure is not the equivalent of the education as an RNFA. If the APRN or the RN wishes to bill or be identified in the patient's chart as an RNFA, the rules of division 45 apply and the Board must receive the appropriate forms and education attestation as required in OAR 851-031-0088. While the APRN may manage the patient at the advanced practice level pre- and post-surgical procedure, the role of the RNFA may only be practiced by adherence to the rules of the Board.

Oregon Acute Opioid Prescribing Guidelines: These guidelines were published in October 2018 and endorsed by the Board of Nursing. These guidelines can be accessed on the OSBN website at https://www.oregon.gov/OSBN/pages/advanced_practice.aspx. This link also provides information for advanced practice nurse regarding the DEA, Buprenorphine FAQs, and various other topics of interest to the APRNs.

By OSBN Communications Manager ***Barbara Holtry***

MEET THE TEAM

The Oregon State Board of Nursing is much more than just, "that place where you get your license renewed every two years." To achieve our mission of public protection, our team is hard at work approving educational and training programs, providing outreach presentations to employers and licensees, answering scope-of-practice questions, investigating possible violations of the Nurse Practice Act, maintaining our online systems, and, yes, issuing licenses. In each issue of the *Sentinel*, we'll introduce you to two of the team members who make everything work

DEENA WHITEHURST

OSBN Licensing Technician Deena Whitehurst has worked in healthcare-related occupations almost her whole adult life. "I can't seem to stay away from it!"

An Oregonian since age five, Whitehurst grew up in Turner the oldest of five kids. "They called me 'Miss Mature' in my family," she says with a laugh. "But, I was voted the Class Flirt in high school, so go figure!"

After working at Salem Hospital as a nutrition specialist for a few years, she became the Events and Demonstration Coordinator at Waremart (now called WinCo). She coordinated charity and holiday events with music and costumed employees for eight years, and worked extensively with the public and her coworkers. "It was probably my most enjoyable job ever. The staff was happy all the time. It was a great experience."

Whitehurst returned to Salem Hospital as a Pharmacy Tech for seven years, and managed to attain her Associate's Degree in business from the University of Phoenix while working 50 hours a week. Wanting to try something a little different, she moved to Performance Health Technology, as a medical claims processor. She quickly became a software trainer for medical providers' office staff and spent several years on the IT side of healthcare. Whitehurst did desktop support and provider relations while based in Salem, and then helped Bend Memorial Clinic implement their EPIC medical charting system.

Her four granddaughters brought her back to the west side of the state, and she joined the OSBN in April of 2018. "It's been a huge culture shock to work for the state instead of private industry, but I like it. I have a very supportive manager and co-workers," she says. As a licensing tech, she focuses on advanced practice nurse and prescriptive authority applications—new applications and renewals. She is also a backup for reactivation application processing. "There are a lot of requirements for advanced practice nurses, and I like to help them navigate the process."

She says she enjoys the team approach in her department and the collaborative focus on the agency's mission of public safety. "It's all about the people we're serving, which includes the public."

Whitehurst is an avid hiker and takes four to six hikes a year throughout the state. "Jefferson Park is my favorite—absolutely beautiful. South Sisters is my next goal." She also loves gardening and spending time with her family, which includes attending her granddaughters' sporting events. "They always try to wear me out, but I wear them out! I'm lucky to have everyone so close by."

NAKEITA WEST

"When I saw the job listing, I thought, 'Let's try it!' Why not, right?" says Delaware native Nakeita West about her cross-country move to join the Oregon State Board of Nursing as an Investigator in 2016.

While growing up in Laurel, Del., West always wanted to become a doctor. But when she attended Delaware State University for pre-med and nursing, she decided that

wasn't the right path for her. "When I re-considered how long I'd have to be in school and the debts I'd have to incur, I decided it just wasn't practical. But I was still interested in healthcare." She enrolled instead with Delaware Technical Community College and studied to become a paramedic.

"I loved riding along in ambulances on calls," she recalls. "I liked the fast pace, but ultimately decided that wasn't for me, either."

She worked for a few years as a technician in a doctor's office and as a CNA in Milford Memorial Hospital's Labor and Delivery department. At that point, pregnant with her first child, she decided to take a very different turn—she joined the Delaware Capitol Police, went to the police academy, and served as an officer for almost 11 years.

"It's separate from the state patrol. We were stationed in state buildings, the capitol, and the governor's mansion," she explains. For a time, she was assigned to the Court Division, and toured courthouses across the state. She also did a lot of motivational speaking. "I loved it. I never had to fight anyone; I was always able to talk people down. Everybody makes bad choices sometimes. You just have to learn from them."

After West was injured on the job in 2011, she was on light duty until she retired a year later and switched to the Delaware Bank Commissioner's office as an investigator. Shortly thereafter, she decided it was time to take another leap, this time to Oregon with her husband and four children.

"I like this because there's always something different, and I learn something new every day. It combines my original love of healthcare with investigations. Best of both worlds. And we have a great group of people here."

As an investigator, West receives cases regarding potential violations of the Nurse Practice Act, and gathers information to determine what happened. "It's about keeping the public safe and increasing their trust in us, but also about helping licensees become better practitioners," she explains. "We're not here to get people in trouble. The more important part of my job is preserving trust between the licensees and the public."

Until last year, her daughters used to be involved in competitive cheerleading, which meant not a lot of free time. "We were always traveling from one competition to the next," she says. "Now, we have more time to explore Oregon a bit. We need to see Crater Lake this summer."

DISCIPLINARY ACTIONS

Actions taken in October, November, and December 2018. Public documents for all disciplinary actions listed below are available on the OSBN website at www.oregon.gov/OSBN (click on 'Look Up a Nurse or Nursing Assistant').

Name	License Number	Discipline	Effective Date	Violations
Heather A. Agee	200541538RN	Revocation	11-14-18	Using intoxicants to the extent injurious to herself or others,and failing to answer questions truthfully.
Sara A. Arnholtz	200242813RN	Voluntary Surrender	12-12-18	Violating a person's rights to privacy and confidentiality,and failing to answer questions truthfully.
Zoey D. Berggren	201041669RN	Probation	12-12-18	12-month probation. Failing to accurately document nursing interventions in a timely manner, entering inaccurate documentation into a health record, and failing to conform to the essential standards of acceptable nursing practice.
Donald L. Bons	200742846RN/ 201391732NP-PP	Probation	12-12-18	Six-month probation. Violating a person's rights to privacy and confidentiality, failing to maintain professional boundaries, and failing to conform to the essential standards of acceptable nursing practice.
Debora N. Bowden	093006290RN	Probation	11-14-18	12-month probation. Obtaining unauthorized medications
Allen R. Brewer-Nielsen	000034579CNA	Revocation	12-12-18	Using intoxicants to the extent injurious to himself or others, and failing to cooperate with the Board during the course of an investigation.
Natalie N. Brizuela	201407784RN	Probation	11-14-18	12-month probation. Inaccurate recordkeeping, entering late information into the record, and failing to conform to the essential standards of acceptable nursing practice.
Danitra R. Brown	200942023RN	Probation	10-10-18	24-month probation. Failing to conform to the essential standards of acceptable nursing practice and using intoxicants to the extent or in a manner injurious to herself or others.
Heather T. Brown	200842210RN	Probation	11-14-18	24-month probation. Practicing nursing while impaired, and using intoxicants to the extent or in a manner injurious to herself or others.
Kristen K. Buckner	Nurse Imposter	Civil Penalty	11-14-18	$5,000 civil penalty. Practicing nursing without a license.
Kelly S. Carey	201602397LPN	Suspension	10-10-18	Minimum of 14-day suspension. Failing to cooperate with the Board during the course of an investigation.
Mary J. Carlsen	094006957RN	Probation	11-14-18	24-month probation. Failing to conform to the essential standards of acceptable nursing practice, and failing to document nursing interventions accurately and in a timely manner.
Niamh Charles	083040591RN/ 200850151NP	Voluntary Surrender	12-12-18	Failing to take action to preserve client safety based on nursing assessment and judgment, and failing to answer questions truthfully.
Shawn C. Clark	200930226LPN	Reprimand	11-14-18	Incomplete recordkeeping, performing acts beyond his authorized scope, and failing to conform to the essential standards of acceptable nursing practice.
Sueann M. Coe	201505653CNA	Revocation	10-10-18	Violating the terms and conditions of a Board Order.
Kristina A. Crellin	201210150CNA/ 201220109CMA	Revocation	10-10-18	Entering inaccurate documentation into a health record, falsifying data, and failing to document medications as administered.
Cody L. Crow	201408709RN	Revocation	12-12-18	Using intoxicants to the extent injurious to himself or others, unauthorized removal of drugs from the workplace, using his role as a nurse to defraud a person of their personal property, and failing to answer questions truthfully.
Molly C. Dahlen	201242555RN	Probation	11-14-18	24-month probation. Failing to document client care information, falsifying data, obtaining unauthorized medications, and failing to conform to the essential standards of acceptable nursing practice.
Betty L. Dahnke	089006165RN	Reprimand	11-14-18	Failing to maintain professional boundaries, and failing to conform to the essential standards of acceptable nursing practice.
Victoria D. Deeks	079011396RN/ 079011396N3	Suspension/ Probation	11-14-18	One-year suspension, followed by 36-month probation Using intoxicants to the extent injurious to herself or others.
Gretchen L. Dennison	090005158LPN	Voluntary Surrender	10-10-18	Performing acts beyond her authorized scope and beyond the level of nursing for which she is licensed.
Martha M. Desantis	000012280CNA	Voluntary Surrender	10-10-18	Engaging in abusive behavior toward coworkers, entering inaccurate information into a health record, and failing to implement the plan of care developed by the RN.
Melissa A. Dixon	201391083CNA	Voluntary Surrender	11-14-18	Impairment.
Margaret L. Doyle	201601074LPN	Suspension	12-12-18	Minimum of 14-day suspension. Failing to cooperate with the Board during the course of an investigation.

Name	License Number	Discipline	Effective Date	Violations
Warren E. Duncan	201810340CNA	Probation	11-14-18	12-month probation. Misrepresentation during the certification process, using intoxicants to the extent injurious to himself or others, and failing to conform to the essential standards of acceptable CNA performance.
Donna Emley-Blackmore	079011393RN	Civil Penalty	10-12-18	$2,500 civil penalty. Practicing nursing without a current license.
Carmen M. Engelhardt	201810339CNA	Probation	11-14-18	24-month probation. Using intoxicants to the extent or in a manner injurious to herself or others.
Natasha A. Fletcher	201503042CMA	Probation	11-14-18	12-month probation. Failing to administer medications as ordered by a LIP, falsifying medication administration records, and documenting the provision of services that were not provided.
Jennifer J. Gill	201408596CNA	Suspension	10-10-18	Minimum of 14-day suspension. Failing to cooperate with the Board during the course of an investigation.
Christopher J. Gillespie	201408406CNA	Voluntary Surrender	11-14-18	Using intoxicants to the extent injurious to himself or others.
Wendi S. Gonzales	201394807RN	Voluntary Surrender	12-12-18	Resorting to fraud during the application process for licensure.
Elizabeth L. Graham	201701535CNA	Reprimand	10-10-18	Engaging in abusive or threatening behavior toward a co-worker and engaging in unacceptable behavior towards clients.
Destony M. Hammond	CNA Applicant	Application Denied	11-14-18	Failing to cooperate with the Board during an investigation.
Mindy R. Hanna	201402014LPN	Revocation	10-10-18	Entering inaccurate information into a health record, the unauthorized removal of medications from the workplace, demonstrated incidents of dishonesty, and failing to cooperate with the Board during the course of an investigation.
Mindy R. Hanna	201402014LPN/ RN Applicant	Application Denied RN Applicant	12-12-18	Unauthorized removal of medications from the workplace, and failing to answer questions truthfully.
Patricia S. Hanna	RN Applicant	Voluntary Withdrawal	11-14-18	Using intoxicants to the extent injurious to herself or others.
Dustin J. Harris	201130039LPN	Reprimand	11-14-18	Demonstrated incidents of dishonesty and failing to conform to the essential standards of acceptable nursing practice.
Jennifer N. Hilley	201607646LPN	Probation	12-12-18	24-month probation. Practicing while impaired, and using intoxicants to the extent or in a manner injurious to herself or others.
Claudia D. Hudson	201402509CNA	Revocation	12-12-18	Violating the terms and conditions of a Board Order, using intoxicants to the extent injurious to the CNA or others, and failing to answer questions truthfully.
Danielle T. Jones	201243365RN	Probation	11-14-18	12-month probation. Failing to dispense medications, failing to document, and failing to conform to the essential standards of acceptable nursing practice.
Rowena R. Jones	201130001LPN	Reprimand	11-14-18	Performing acts beyond her authorized scope, failing to take action to preserve client safety, and failing to conform to the essential standards of acceptable nursing practice.
Lucille D. Judish	085075395RN	Probation	11-14-18	24-month probation. Falsifying data, failing to clinically supervise person to whom an assignment has been made, and failing to conform to the essential standards of acceptable nursing practice.
Dee A. Karl	200511846CNA	Reprimand	11-14-18	Failing to respect a client's dignity and rights, and failing to conform to the essential standards of acceptable CNA duties.
Johannan E. Kelly	200943299RN	Voluntary Surrender	12-12-18	Practicing when unable due to a mental impairment.
Kevina L. Kemp	000044666CNA/ 201020107CMA	Revocation	11-14-18	Willful misrepresentation during the certification process, and abusing a person.
Tiffany S. King	Nurse Imposter	Civil Penalty	11-14-18	$5,000 civil penalty. Practicing nursing without a license.
Jaimi L. Labonte	201402009LPN	Probation	12-12-18	24-month probation. Abusing a client, and engaging in other unacceptable behavior towards clients.
Matthew A. Langley	201600505CNA	Probation	12-12-18	12-month probation. Demonstrated incidents of reckless behavior, and using intoxicants to the extent or in a manner injurious to himself or others.
Kathrine C. Larsen	Nurse Imposter	Civil Penalty	11-14-18	$2,500 civil penalty. Practicing nursing without a license.
Sarah A. Little	200212724CNA	Revocation	10-10-18	Violating a person's rights of privacy and confidentiality, abusing a person, and failing to provide documents requested by the Board.
Franki L. Lewis	201130115LPN	Revocation	10-10-18	Inaccurate recordkeeping, and obtaining unauthorized controlled drugs.
Nicole L. Lillie	200930353LPN	Reprimand	11-14-18	Failing to take action to preserve client safety, and failing to conform to the essential standards of acceptable nursing practice.
Richard C. Lucero	200642185RN	Voluntary Surrender	10-10-18	Failing to take action to preserve client safety and failing to implement the plan of care.

Name	License Number	Discipline	Effective Date	Violations
Janet A. Matthews	077038880RN/ 200150137NP/ 200680014DP	Revocation	10-10-18	Inaccurate recordkeeping, developing standards of nursing care that jeopardize patient safety, practicing nursing while impaired, and failing to conform to the essential standards of acceptable nursing practice.
Kristy M. McCarter	201130509LPN	Voluntary Surrender	11-14-18	Unauthorized removal of drugs from the workplace, and using intoxicants to the extent injurious to herself or others.
Sara M. McDermott	201603883LPN	Voluntary Surrender	11-14-18	Physical condition that prevents her from safely practicing nursing.
Gina V. Merritt	201811159LPN	Civil Penalty	12-12-18	$1,750 civil penalty. Practicing nursing prior to obtaining an active Oregon license.
Jelene S. Minnick	081001471RN	Voluntary Surrender	12-12-18	Violating the terms and conditions of a Board Order.
Brigitte A. Montgomery	200242798RN	Reprimand	10-10-18	Failing to conform to the essential standards of acceptable nursing practice.
Molly L. Morrison	200830011LPN	Voluntary Surrender	10-10-18	Obtaining unauthorized controlled medications.
Michael S. Murphy	201390480RN	Revocation	10-10-18	Inaccurate recordkeeping, practicing nursing while impaired, and failing to cooperate with the Board during the course of an investigation.
Kristin Olson	RN Applicant	Application Denied	11-14-18	Misrepresentation during the licensure process, and failing to cooperate with the Board during an investigation.
Robert J. Parrish	200410455CNA	Application Denied	10-10-18	Conviction of a crime that bears demonstrable relationship to CNA duties and using intoxicants to the extent injurious to himself or others.
Kerry L. Patterson	201042207RN	Probation	11-14-18	24-month probation. Practicing while impaired, and using intoxicants to the extent or in a manner injurious to herself or others.
Emunah G. Pearl	201211534CNA CMA Applicant	Voluntary Surrender Voluntary Withdrawal	12-12-18 12-12-18	Conviction of crimes that bear demonstrable relationship to the duties of a CNA.
Wendy Pepper	201702017RN	Suspension	12-12-18	Minimum of 14-day suspension. Failing to cooperate with the Board during the course of an investigation.
Brenda C. Price	099007611RN	Probation	11-14-18	12-month probation. Obtaining unauthorized medications, entering inaccurate documentation into a health record, and failing to conform to the essential standards of acceptable nursing practice.
Amal Rabadi	201608964RN	Suspension	10-10-18	Minimum of 14-day suspension. Failing to cooperate with the Board during the course of an investigation.
Nicole K. Rempel	200112300CNA	Revocation	12-12-18	Failing to maintain professional boundaries, unauthorized removal of money from a person, and using her role as a CNA to solicit money for personal gain.
James M. Rohde	200942282RN	Revocation	10-10-18	Engaging in sexual contact with a client and failing to maintain professional boundaries with a client.
Megan A. Ross	201707008LPN	Probation	11-14-18	24-month probation. Unauthorized removal of supplies from the workplace, and using intoxicants to the extent or in a manner injurious to herself or others.
Michael S. Russo	201508321CNA/ 201607855CMA	Voluntary Surrender	11-14-18	Obtaining unauthorized drugs, and failing to cooperate with the Board during an investigation.
Theresa M. Saunders	200441115RN	Voluntary Surrender	11-14-18	Violating the terms and conditions of a Board Order.
Dorinda L. Schaper	095003006RN	Suspension/ Probation	11-14-18	30-day suspension, followed by 24-month probation. Documenting the provision of services that were not provided, the unauthorized removal of medications from the workplace, and using intoxicants to the extent or in a manner injurious to herself or others.
Joseph N. Schneider	201404489LPN	Revocation	10-10-18	Violating the terms and conditions of a Board Order.
Cynthia V. Sewell	200941908RN	Probation	11-14-18	24-month probation. Practicing while impaired, and failing to comply with the terms and conditions of the Health Professionals' Services Program.
Jennifer L. Sizer	200640155RN	Suspension/ Probation	10-10-18	30-day suspension, followed by 24-month probation. Violating client's rights to privacy and confidentiality and implementing standards of nursing care that jeopardize patient safety.
Marian K. Smith	RN Applicant	Voluntary Withdrawal	11-14-18	Misrepresentation during the licensure process and failing to answer questions truthfully.
Rion J. Smith	RN Applicant	Voluntary Withdrawal	10-10-18	Misrepresentation during the licensure process.
Joy S. Squires-Jensen	095003074RN	Application Denied	12-12-18	Violating the terms and conditions of a Board Order, and failing to provide documents requested by the Board.

Name	License Number	Discipline	Effective Date	Violations
Caroleanne Stalcup	085069868LPN	Voluntary Surrender	12-12-18	Abusing and neglecting a client, and implementing policies that jeopardize client safety.
Christopher J. Stamulis	201703758RN	Reprimand	11-14-18	Failing to maintain professional boundaries, and violating a person's rights of privacy and confidentiality.
Andrea Sun	201243463RN	Voluntary Surrender	10-10-18	Violating the terms and conditions of a Board Order.
Brianna L. Sutton	201502089CNA	Reprimand	12-12-18	Violating a person's rights of privacy and confidentiality.
Breanna M. Swars	200912475CNA	Voluntary Surrender	11-14-18	Demonstrated incidents of dishonesty, failing to maintain professional boundaries, the unauthorized attempted removal of drugs from any setting, and using intoxicants to the extent injurious to herself or others.
Virginia L. Tan	200942916RN	Application Denied	12-12-18	Using intoxicants to the extent injurious to herself or others, and willful misrepresentation during the licensure process.
Amber M. Thompson	201806868CNA	Voluntary Surrender	10-10-18	Violating the terms and conditions of a Board Order.
Debra L. Thompson	200830365LPN	Voluntary Surrender	12-12-18	Gross incompetence.
Victoria W. Thompson	201111561CNA/ 201111561CMA	Application Denied	12-12-18	Conviction of a crime that bears demonstrable relationship to the duties of a CNA, and failing to cooperate with the Board during an investigation.
Erica Trent	201806869CNA	Voluntary Surrender	11-14-18	Violating the terms and conditions of a Board Order.
Trudy E. Urban	091007006RN	Probation	10-10-18	24-month probation. Using intoxicants to the extent injurious to herself or others, and practicing nursing while impaired.
Kathy P. Vuong	201142153RN	Reprimand	12-12-18	Performing acts beyond her authorized scope, unauthorized removal of supplies from the workplace, and failing to conform to the essential standards of acceptable CNA duties.
Serena L. Watson	200940087RN	Suspension	11-14-18	Minimum of 14-day suspension. Failing to cooperate with the Board during the course of an investigation.
Mallory H. Wright	201042567RN	Voluntary Surrender	11-14-18	Failing to document nursing interventions in a timely and accurate manner, and failing to dispense medications in a lawful manner.
Carmen R. Woodell	201407484CNA	Revocation	10-10-18	Demonstrated incidents of violent behavior and using intoxicants to the extent injurious to herself or others.


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NA/MA CERTIFICATION RULE CHANGES DELAYED UNTIL AUGUST 1

Clearer, better-organized parameters for how to obtain a nursing assistant or medication aide certificate is the goal of the OSBN's current work on Division 62 of the Oregon Nurse Practice Act. Although the Board of Nursing approved some revisions during the November 2018 board meeting, subsequent efforts to implement the rules revealed more opportunities to improve the division.

To that end, implementation of the November changes has been paused, and a new draft will be presented to the Board during the April 2019 board meeting for review and potential approval to proceed with rulemaking in June.

Future changes to Division 62 include:

- Clarification on when an individual can be hired to perform nursing assistant duties in a licensed nursing facility.
- Unlimited attempts on the CNA or CMA state competency exam within one year of completion of the training program.
- Reduction from two years to one year from training program completion for CNA state competency exam eligibility.
- Addition of testing requirement for student nurses and graduates of nursing programs to obtain a CNA 1.
- Establishment of CNA 2 as a separate certification.
- Explanation of CNA and CMA nurse supervision and monitoring to meet the paid employment requirement.
- Provision for an individual whose prior unencumbered Oregon CNA 1 has been expired for over two years, to reactivate their Oregon CNA 1 if they have worked in another US state or jurisdiction with active certification at least 400 hours in the last two years doing CNA authorized duties under nurse supervision or monitoring.
- Similar process for a student nurse in the US to obtain an Oregon CNA and CMA.

For more information, visit the OSBN online meeting calendar at www.oregon.gov/meetings.aspx.

2019 OSBN BOARD MEETING DATES

February 12, 2019 **6:30 p.m.** OSBN Board Meeting	June 11, 2019 **6:30 p.m.** Board Meeting	September 13, 2019 **8:30 a.m.** Board Work Session
February 13, 2019 **8:30 a.m.** OSBN Board Meeting *(Primarily Executive Session)*	June 12, 2019 **8:30 a.m.** Board Meeting *(Primarily Executive Session)*	October 9, 2019 **4:30 p.m.** Board Meeting via Teleconference *(Primarily Executive Session)*
February 14, 2019 **8:30 a.m.** OSBN Board Meeting	June 13, 2019 **8:30 a.m.** Board Meeting	November 12, 2019 **6:30 p.m.** Board Meeting
Mach 13, 2019 **4:30 p.m.** OSBN Board Meeting via Teleconference *(Primarily Executive Session)*	July 10, 2019 **4:30 p.m.** Board Meeting via Teleconference *(Primarily Executive Session)*	November 13, 2019 **8:30 a.m.** Board Meeting *(Primarily Executive Session)*
April 9, 2019 **6:30 p.m.** OSBN Board Meeting	August 14, 2019 **4:30 p.m.** Board Meeting via Teleconference *(Primarily Executive Session)*	December 18, 2019 **4:30 p.m.** Board Meeting via Teleconference *(Primarily Executive Session)*
April 10, 2019 **8:30 a.m.** OSBN Board Meeting *(Primarily Executive Session)*	September 10, 2019 **6:30 p.m.** Board Meeting	
April 11, 2019 **8:30 a.m.** OSBN Board Meeting	September 11, 2019 **8:30 a.m.** Board Meeting *(Primarily Executive Session)*	
May 8, 2019 **4:30 p.m.** OSBN Board Meeting via Teleconference *(Primarily Executive Session)*	September 12, 2019 **8:30 a.m.** Board Meeting	

All Board Meetings, except Executive Sessions, are open to the public.

All meetings are located at the OSBN Office 17938 SW Upper Boones Ferry Rd, Portland.

2019 OSBN BOARD MEMBERS

MICHELLE CHAU, LPN

Term: 1/1/19 – 12/31/21

Ms. Chau is a Panel Manager for the Multnomah County Health Department in Portland, Ore. She completed her practical nursing program at Mt. Hood Community College in Gresham, Ore., and has a BS degree in Advanced Chemistry, Biology, and General Science from Oregon State University in Corvallis, Ore. She has 10 years of nursing experience, and serves in the Licensed Practical Nurse position on the Board.

KATHLEEN CHINN, RN, FNP

PRESIDENT-ELECT

Terms: 1/1/16 – 12/31/18, 1/1/19 – 12/31/21

Ms. Chinn is a Family Nurse Practitioner with the PeaceHealth Senior Health and Wellness Center in Eugene, Ore. She received her Associate Degree in Nursing from Lane Community College in Eugene, Ore., and her Bachelor of Science in Nursing and Master's degrees from Oregon Health Sciences University in Portland, Ore. She resides in Eugene, Ore.

ANNETTE COLE, RN

Term: 1/1/18 – 12/31/20

Ms. Cole is the Vice President of Patient Care Services and Chief Nursing Officer at Sky Lakes Medical Center in Klamath Falls and has 30 years of nursing experience. She received her Bachelors of Science in Nursing degree from the Oregon Institute of Technology in Klamath Falls, Ore., and her Masters of Science in Nursing and Health Care Administration degree from the University of Phoenix. Ms. Cole serves in the Nurse Administrator position on the Board. She resides in Klamath Falls.

ADRIENNE ENGHOUSE, RN

Terms: 1/1/16 – 12/31/17, 1/1/18 – 12/31/20

Ms. Enghouse is a Staff Nurse at Kaiser Sunnyside Medical Center in Clackamas, Ore. She serves in one of two direct-care RN positions on the Board. She received her Associate Degree in Nursing from Mount Hood Community College in Gresham, Ore., and resides in Portland, Ore.

COLIN HUNTER, JD

PUBLIC MEMBER

Terms: 10/1/15 – 12/31/15, 1/1/16 – 12/31/18

Mr. Hunter is an attorney with the Angeli Law Group in Portland, Ore. He received his Bachelor's degree from Claremont McKenna College in Claremont, Calif., and his juris doctorate from the University of California, Berkeley, School of Law. Mr. Hunter resides in Portland, Ore

SHERYL OAKES CADDY, JD, MSN, RN, CNE

Term: 1/1/18 – 12/31/20

Ms. Oakes Caddy is Director of the Nursing Department at Linn-Benton Community College in Albany and has more than 30 years of nursing experience. She received her Associate of Science in Nursing from Linn-Benton Community College in Albany, Ore., her Bachelor of Science in Nursing from Oregon Health Sciences University in Portland, Ore., her Master of Science in Nursing from Walden University, Baltimore, Md., and her Doctor of Jurisprudence from Willamette University School of Law in Salem, Ore. Ms. Oakes Caddy serves in the Nurse Educator position on the Board and resides in Lebanon, Ore.

BOBBIE TURNIPSEED, RN

BOARD PRESIDENT

Terms: 1/1/16 – 12/31/17, 1/1/18 – 12/31/20

Ms. Turnipseed is a staff nurse at St. Alphonsus Medical Center in Ontario and has more than 30 years of nursing experience. She received her Associate Degree in Nursing from Boise State University in Boise, Idaho. Ms. Turnipseed is one of two direct-patient care RNs on the Board. She resides in Ontario, Ore.

RYAN WAYMAN

PUBLIC MEMBER

Terms: 4/1/13 – 12/31/15, 1/1/16 – 12/31/18

Mr. Wayman is one of two public members on the Board. He is the West Region Vice President at AXA Advisors and resides in Portland.

WILLIAM YOUNGREN, CNA

BOARD SECRETARY

Terms: 6/1/16 – 12/31/18, 1/1/19 – 12/31/21

Mr. Youngren is a Unit Clerk at Legacy Emanuel Medical Center in Portland and has been a nursing assistant since 2012. He received his Bachelor's Degree in English from Portland State University and his nursing assistant training from Portland Community College.

Mr. Youngren resides in Portland, Ore.

By OSBN Licensing and Fiscal Manager ***John Etherington***

TIPS TO HELP YOUR APPLICATION PROCESS

As we move into a new year, the Oregon Board of Nursing (OSBN) licensing department would like to share some tips about Oregon state licensing processes. Every year we experience application delays because of required items to complete an application were not given to OSBN. In our ongoing education outreach, OSBN would like to share some top licensing procedures and tips to help you with the licensing process.

- All new users and renewal licensees will be required to "register" in order to access the online application system. Registration is a two-step process; the first step is creating an online account with a valid email address. After an account is created, our system will send you a verification email to the email address you provided on your account. You will then need to go into your email account, open the verification email, and click on the link in that email to finish setting up your verified account (don't forget to check your email spam and junk folders for the verification email). Once an account is set up and verified, then you can start your online application.
- Apply early: There are many factors to application and the processing time is not predictable. Waiting until a few days before your license expires or accepting a job offer without being licensed are not recommended. OSBN does not expedite applications (except for active military spouses or partners).
- Use OSBN application tutorials: OSBN has online tutorials to help explain the licensing process. Tutorials are available for CNA1 exam applications, as well as RN/LPN Exam, RN/LPN Endorsement, and RN/LPN Reactivation applications. Please check out our forms page https://www.oregon.gov/OSBN/Pages/forms.aspx to see if your application type has a tutorial.
- Incomplete applications will not be accepted by the system. If all required documents are not provided, then the application is incomplete. An incomplete application will not be processed until proper information is received.
- Fees must be paid in order for the application to be started. If the fee is not paid when you submit your application, the application will be incomplete and will not be processed until proper fee amounts are received and processed.
- Disclosure Questions and Background Check: It is required that you truthfully answer all of the disclosure questions on your application. Even if you have been advised by an attorney that you do not have to disclose, or if your offense was as a juvenile, you should disclose the information on your application. If information is found during your national and state fingerprint background check that was not disclosed on the application, your application will be placed in a background review process. The background review process will add additional time in order for us to approve your application.
- If you are required to provide documentation of citizenship, court documents, or other information required by the application, then please provide those with the application.
- OSBN cannot use fingerprints taken for other state agencies or educational institutions. You will need to have fingerprints taken based on OSBN directions and policies.
- Check the Status of Your Application: You may go to the OSBN application status wizard https://app2.osbn.oregon.gov/OSBNAppStatus/Search.aspx to check your application status. Once a licensing technician is able to review and approve the application documents, the various process steps will be checked off on the wizard. Just because the OSBN has received a document does not mean it has been approved, so make sure to allow some time for review of documents.
- Applicants may use a computer in the Board office if needed, on business weekdays between 7:30 am and 4 pm. We recommend a local library or other computer source if you are outside the Portland metro area and cannot travel to our Board office.

Please check out the OSBN website at www.oregon.gov/OSBN to find additional resources and information. If you are unable to find the answer to your questions, then you may call our licensing department at 971-673-0652, ext. 2, from 9 am–3:00 pm.

Changes to Oregon Health Plan (OHP) Prescriber Enrollment Implementation – ACTION REQUIRED

The Oregon Health Authority (OHA) has postponed implementation of the prescriber enrollment requirement for fee-for-service Oregon Health Plan prescription claims from November 13, 2018 to March 1, 2019.

- Too many prescribers have not enrolled at this time, which would disrupt the care of OHP members. OHA is expanding its provider outreach strategies to get more prescribers enrolled to avoid interruptions to members' prescription therapy.
- To help us with this plan, please share this requirement with your colleagues and encourage prescribing providers and pharmacies to verify that OHA's system recognizes them as an Oregon Medicaid provider (https://www.or-medicaid.gov/ProdPortal/Validate%20NPI/tabid/125/Default.aspx).
- If they aren't recognized as Oregon Medicaid providers, they need to enroll with OHA or their local coordinated care organization (CCO) as soon as possible.

Providing services is voluntary; enrollment does not require a provider to serve all Oregon Health Plan (OHP) members. It does ensure your prescriptions to OHP members will be covered.

HOW TO ENROLL

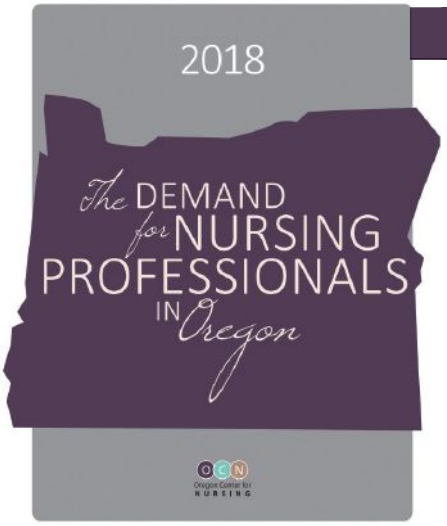
To enroll with OHA, prescribing providers can enroll using the OHP 3113 form. Pharmacies and other providers seeking direct reimbursement from OHA will need to complete a packet of four enrollment forms.

To learn which forms to complete and submit, visit OHA's Provider Enrollment page: https://www.oregon.gov/oha/HSD/OHP/Pages/Provider-Enroll.aspx.

To enroll with a CCO, contact the CCO: https://www.oregon.gov/oha/HSD/OHP/Pages/Coordinated-Care-Organizations.aspx.

QUESTIONS?

- About prescriber enrollment: Contact Provider Enrollment at 800-336-6016 (Option 6) or provider.enrollment@dhsoha.state.or.us.
- About fee-for-service prescription claims: Contact the Pharmacy Call Center at 888-202-2126. This number is for providers only.
- About coordinated care organization (CCO) claims: Contact the CCO (https://www.oregon.gov/oha/HSD/OHP/Pages/Coordinated-Care-Organizations.aspx).



STRONG DEMAND FOR NURSES CONTINUES IN OREGON

Employers in Oregon continue to report a strong demand, or need, for nurses according to The Demand for Nursing Professionals in Oregon - 2018, a new report released by the Oregon Center for Nursing (OCN).

"Employers report difficulties in recruiting, hiring, and retaining nurses across the spectrum of health care," said Jana R. Bitton, OCN's Executive Director. "While hospitals seem to be using contract labor to help reduce the number of open positions, vacancy rates for long term care, home health/hospice and public health have continued to climb."

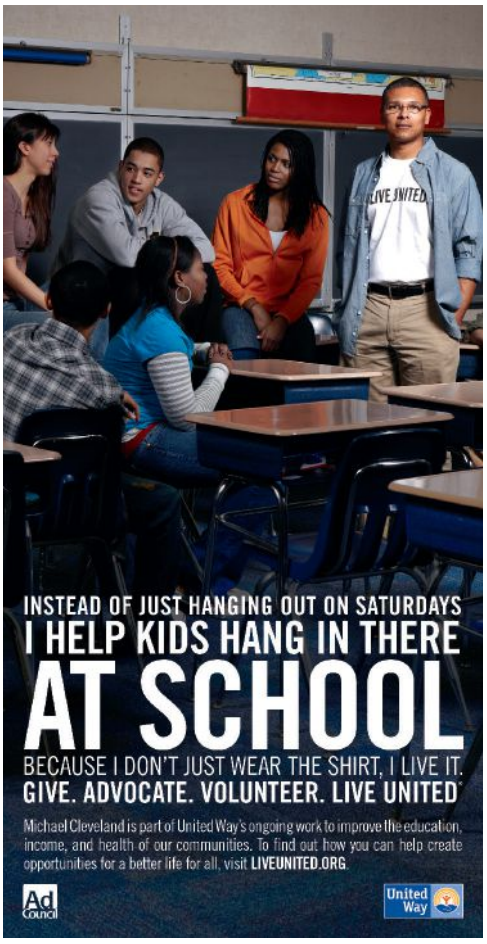
OCN conducted its research by contacting hospitals and health systems, skilled nursing facilities, home health and hospice agencies, and public health departments across Oregon to ask about current and projected hiring needs for nurses.

"The demand for nurses in Oregon isn't lessening," Bitton said. "Our hope is this updated information will help inform employers, policymakers, and schools as they work to ensure Oregonians have access to health care and quality nursing professionals."

The full study, T*he Demand for Nursing Professionals in Oregon*, is available to download on the Publications page of the OCN website. Interactive data charts are also available on the site, as well as a recorded webinar with report author, Dr. Rick Allgeyer.

OCN is a nonprofit organization created by nursing leaders in 2002. OCN facilitates research and collaboration for Oregon's nursing workforce to support informed, well-prepared, diverse, and exceptional nursing professionals. Recognized by the Oregon state legislature as a state advisory for nursing workforce issues, OCN fulfills its mission through nurse workforce research, building partnerships, and promoting nursing and healthcare. For more information about OCN, please visit www.oregoncenterfornursing.org.

OCN
Oregon Center for NURSING



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Sonequa Martin-Green, SU2C Ambassador

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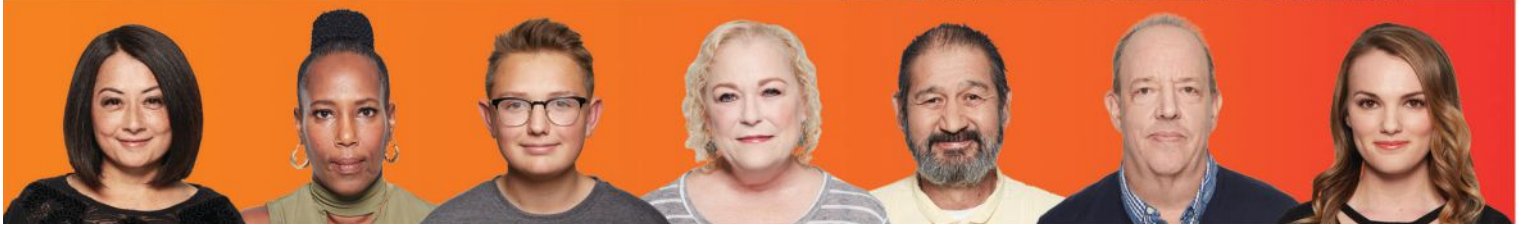

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