OREGON BOARD OF NURSING

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[VO. 45 • NO. 2 • SPRING 2026]

Building a Culture of Disabled Belonging in Nursing Education

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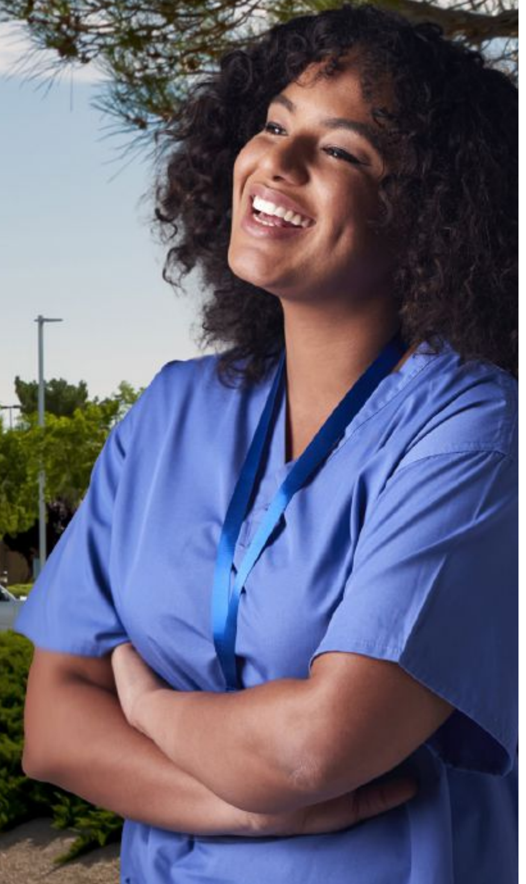

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EDITION 70

By OSBN Executive Director ***Rachel Prusak***, MSN, APRN, FNP-C, FAAN

WORKSITE MONITORING: ROLES, REQUIREMENTS, AND RESPONSIBILITIES

The Oregon State Board of Nursing recognizes that nurses experience substance use and mental health disorders at rates comparable to, or higher than, the general public. These conditions create risks to public health and safety, so monitoring programs play a critical role in overseeing nurses and nursing assistants in recovery and supporting their return to safe practice.

With Oregon's return to the alternative-to-discipline (ATD) model, more nurses will need a worksite monitor. To help clarify the process and the impact of this change, this article explains how monitoring programs protect public safety and support recovery. It specifically provides guidance for worksite monitors assisting nurses and nursing assistants being monitored for substance use disorder (SUD) and/or mental health diagnoses.

Monitored Practice Pathways

Licensees may return to work under monitored practice through two pathways: board probation or the Board's alternative-to-discipline program, the Health Professionals' Services Program (HPSP). Probation is a form of public discipline that requires a public Board Order and close collaboration with OSBN compliance specialists to meet the imposed conditions. The Health Professionals' Services Program (HPSP) is a confidential alternative-to-discipline program for nurses and other healthcare providers with SUD or mental health disorders.

Regardless of the pathway, licensees must have a worksite monitor. The HPSP or OSBN monitor reviews worksite monitor reports and oversees overall compliance.

Qualifications and Responsibilities of Worksite Monitors

A worksite monitor is a licensed healthcare professional who observes and reports on participants at work. The monitor acts as a link between the employer and the monitoring program, focusing on workplace behavior.

To serve as a worksite monitor, a licensed healthcare professional must complete the required training and post-test. In most cases, the participant's direct supervisor or manager serves in this role. There are instances when an alternative must be approved. Employers may also designate a backup monitor who can assume monitoring duties when the primary monitor is unavailable. The monitor must work in the same location as the participant. The monitor must be available to observe and assist for at least half of each shift. If off-site, the monitor must be reachable by phone or other systems. When unavailable, a secondary monitor must be designated.

As a worksite monitor, your key responsibilities include observing the participant at work, identifying and reporting signs of impairment, and assessing compliance with worksite restrictions. You must submit accurate and timely reports: for HPSP, monthly reports to the HPSP monitor; for probation, quarterly reports to the Oregon State Board of Nursing (OSBN). Document details of observed conduct, any issues, and actions taken in response. Ensure you are accessible and able to intervene if safety or compliance concerns arise.

Eligibility to Serve as a Worksite Monitor

In Oregon, any licensed healthcare professional can serve as a worksite monitor for nurses or CNAs returning after a substance use or mental health diagnosis. The monitored nurse or CNA continues to practice under their own license, not under the monitor's license. The monitor observes compliance with the return-to-work agreement and checks for signs of impairment.

Practice Restrictions and Work Hour Limitations

Worksite monitors must understand the return-to-work restrictions in Board orders or HPSP agreements. Common restrictions include prohibiting unsanctioned overtime, restricting unit floating, limiting access to controlled substances,

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and setting minimum-hour requirements. The Board limits participant work hours to support recovery. It allows full-time work but prohibits double shifts and limits overtime to two extra shifts per month. Worksite supervisors must understand and communicate practice restrictions. Participation in HPSP is confidential and should be disclosed only as necessary. Supervisors must ensure that the relevant staff are aware of any restrictions.

Supporting Recovery and Ensuring Safety

Monitoring programs for nurses with substance use or mental health diagnoses are essential for the safety and well-being of both the nurse or CNA and the public. Designed to support recovery and a safe return to competent practice, both probation and HPSP advance the Board's mission of safeguarding the public while promoting nurse wellness. For more information about monitored practice or becoming a worksite monitor, visit the Oregon State Board of Nursing: Monitored Practice.

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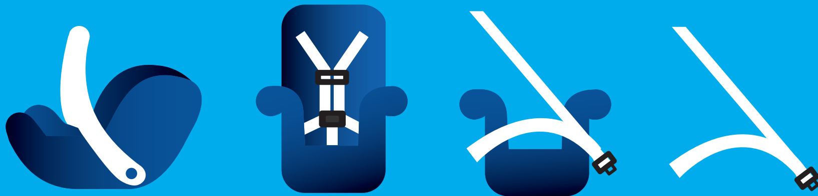

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By Linfield University School of Nursing guest authors: Associate Director/Learning Support Services ***Sari Platt, MFA***, Dean and Professor ***Paul Smith, PhD, RN, CNE***, and Associate Dean and Associate Professor ***Julie Fitzwater, PhD, RN, CNRN, CHSE, CNE***

BUILDING A CULTURE OF DISABLED BELONGING IN NURSING EDUCATION

More than 1 in 4 adults in the United States have a disability and are the world's largest minority group (CDC, 2024). Disability is a natural part of the human experience, one that nearly every individual will encounter in their lives whether it is through aging, injury, present from birth, or a change in health. Despite the prevalence of disability within the general population, individuals with disabilities remain significantly underrepresented within health professions education and the healthcare workforce. This underrepresentation reflects longstanding structural barriers within admissions processes, technical standards, and educational environments that have customarily limited access for disabled learners. Historically, disabled professionals have always been present in the healthcare fields but were limited to individuals capable of masking their disabling symptoms and forgoing workplace accommodations or whose condition was considered a socially acceptable norm. As the nursing profession continues to push recruitment and retainment of nurses to meet the demands of a growing field, more attention is needed to understand where nurses with disabilities are encountering barriers to access.

Two national organizations central to nursing education have articulated positions that support disability inclusion within academic nursing. The National League for Nursing hosts the resource *Inclusion of Disability in Nursing Education: Rationale and Guidelines*, developed by the Villanova University College of Nursing, which calls for the integration of disability content across curricula and the creation of inclusive learning environments (Villanova University College of Nursing, 2024). Similarly, the American Association of Colleges of Nursing affirms disability as a dimension of diversity within its position statement *Diversity, Equity, and Inclusion in Academic Nursing*, emphasizing the responsibility of schools of nursing to foster equitable access and inclusive excellence (American Association of Colleges of Nursing, 2021). Together, these documents signal a clear professional expectation that nursing education must actively advance disability inclusion in both curriculum and institutional culture. It's clear that the nursing field is readying for a change but embracing a culture of accessibility needs an informed and guided approach.

Diversity in the professional nursing workforce includes not just age, race, and ethnicity, but also physical, functional, and learning abilities (AACN Position Statement, 2024). Through a grant from the Josiah Macy Jr. Foundation, Linfield University School of Nursing turns toward its own student population to uncover how nursing educators are key facilitators in creating a more accessible and inclusive education and transition into practice. In Fall 2025, Linfield distributed a digital survey, the Campus Accessibility Measure (CAM), to students in its pre-licensure programs. Of 330 eligible students, Linfield received 81 responses with 67 completed surveys for a response rate of 20.3%.

CAM, developed by the National Disability Center for Student Success, focuses on both students with and without disabilities to address the ways that accessibility is experienced by and impacts all students and not just those who request formal academic accommodations (National Disability Center for Student Success, 2025). The CAM survey is designed to assess accessibility as a component of campus climate, capturing how institutional environments, classroom practices, and peer interactions influence students' experiences of inclusion and participation. Items within the instrument explore students' perceptions of accessibility in academic settings, the availability and effectiveness of institutional supports, and the degree to which students feel comfortable engaging in campus life. For students who identify as having a disability, additional questions examine experiences related to disclosure, use of accommodations, and perceived barriers within both classroom and clinical learning environments.

The questions in CAM address three facets of accessibility; classroom-level accessibility, campus-level accessibility, and social engagement and belonging. Some of the survey results were expected, such as reports of physical inaccessibility or classroom barriers that could be addressed with accommodations or the implementation of Universal Design for Learning (UDL). But other reports of "invisible" barriers gesture toward the need for a larger cultural change.

Recent research indicates that students with disabilities often experience diminished social belonging within nursing programs, shaped by ableist attitudes, stigma related to disclosure, and exclusionary interpretations of technical standards. Studies of undergraduate nursing students with disabilities describe feelings of being "othered," pressure to conceal disability status, and limited inclusion in peer and clinical learning environments—factors that directly undermine social connectedness and professional identity development (Garcia-Lee, Strnadová, & Dowse, 2023; Jamal-Eddine, 2025). These findings suggest that disability is not solely an access issue but also a belonging issue, with implications for retention and workforce diversity as it applies to nursing.

Importantly, ableism within nursing education is not only experienced by students with disabilities but is also witnessed by nondisabled peers. Classroom and clinical environments in which disability is subtly framed as incompatible with competence, independence, or patient safety, reinforcing exclusionary norms have been identified (Jamal-Eddine, 2025). When such attitudes are visible and unchallenged, they shape collective understandings of who "fits" within nursing, influencing both peer perceptions and disabled students' sense of social belonging.

In response, our research team turns its attention to the policy that directly shapes a future student's first interactions with a nursing program: the technical standards. For students with disabilities, this seemingly innocuous document is the first clear indicator of what kind of student a school believes has a place in the nursing profession. While a school may be willing to work closely with their disability services office to support a student with disabilities, the impression given by technical standards alerts students to real or perceived barriers present in a nursing education program.

While outdated technical standards may stop some students from applying, other students make the choice to hide their disability from both faculty and the disability services office. The technical standards can heighten a student's fear of disclosure as concerns about a perceived or real risk of discrimination have the potential to reshape their entire educational experience. The question then becomes; how can institutions update their technical standards to support the development of competent and knowledgeable nurses while also using them as an opportunity to indicate to disabled students that they have a place in the healthcare professions?

Technical standards implicitly direct what is considered an acceptable form of practice by faculty. A pertinent example is the requirement that students be able to perform care while standing. This version of a technical standard emphasizes the means of providing safe and accurate care rather than the outcome that must be reached. It implies that alternate modes of administering care, such as providing care while seated, are not an acceptable means for meeting learning outcomes. While this wording might seem harmless to a nurse without disabilities, a prospective student who is a wheelchair user may view this as a school's unwillingness to create an inclusive learning environment. Our research team's aim is to develop a framework for updating technical standards to empower other healthcare institutions to embrace policy change that reflects and meaningfully supports the changing student population and our diversifying workforce.

Through thoughtful reconstruction, technical standards can become a roadmap to belonging by creating pathways for both faculty and students to see disabled nurses as valued and proficient healthcare providers. When institutions intentionally reconsider how these policies are written and interpreted, they also create opportunities to challenge long-standing assumptions about who can practice nursing and

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how competence is demonstrated in clinical environments. Through these means, technical standards can evolve from static admission requirements into living documents that reflect the nursing profession's commitment to inclusion, safety, and excellence in patient care.

From our team's CAM survey results, several themes emerged. Negative attitudes and social barriers were among the most reported challenges encountered by students with disabilities. These barriers significantly influenced students' willingness to disclose a disability. Many students described fear surrounding disclosure, including real or perceived concerns that doing so could change how they were perceived or treated and potentially reshape their educational experience.

Students also raised concerns about disclosure resulting in conscious or unconscious bias from faculty or clinical partners leading to a student's abilities being drawn into question or limiting their learning opportunities in clinical environments. For some students, this created a difficult balance between accessing needed support and protecting their identity and standing within the program. These findings suggest that while policies and accommodations may exist, the social climate within educational environments plays a critical role in whether students feel safe disclosing a disability. Addressing these barriers requires not only clear institutional processes but also ongoing efforts to foster inclusive learning environments where disability is understood as a dimension of diversity rather than a limitation to participation in nursing education. Expanding access for students with disabilities represents an opportunity not only to improve equity within nursing education but also to strengthen the future nursing workforce by welcoming individuals whose lived experiences and perspectives can enhance patient care.

As the nursing profession continues to address workforce shortages and strengthen pathways into the profession, disability inclusion must be part of the broader conversation about who belongs in nursing. Creating accessible educational environments and revisiting policies such as technical standards are not about lowering expectations, but rather about ensuring that expectations focus on meeting the essential outcomes of safe and competent nursing practice despite variability in means. When programs thoughtfully examine the ways in which policies, attitudes, and learning environments shape student experiences, more opportunities are created for qualified individuals to enter and thrive within the profession.

The work underway at Linfield University represents one step in a larger effort to better understand and remove barriers that have historically limited access to nursing education for students with disabilities. By engaging students, examining institutional practices, and partnering with organizations such as the Oregon State Board of Nursing, schools of nursing can help create pathways that support both excellence in nursing practice and a more inclusive workforce. As disability inclusion continues to gain attention within healthcare education, nurse educators have an opportunity to lead by ensuring that the future of the profession reflects the full diversity of the communities it serves.

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By OSBN Policy Analyst ***Gretchen Koch,*** MSN, RN

RN PRACTICE WITH AN UNREGULATED PRACTICE TEAM MEMBER

Increasingly, unregulated care providers are utilized by employers to carry out various health-related responsibilities. Registered nurses often reach out to Oregon State Board of Nursing (OSBN) staff to seek guidance on whether their unregulated assistive person (UAP) team member is permitted to perform a specific intervention or procedure.

Questions concerning what UAPs are permitted to do cannot be answered by OSBN staff for two reasons:

1. OSBN does not regulate unregulated people, and
2. OSBN does not regulate interventions or procedures.

OSBN staff can provide direction on standards in Chapter 851 Oregon Administrative Rules (OAR) that are pertinent to the practice of registered nursing with a UAP team member. These standards are identified in this article and establish RN permissions and responsibilities when practice occurs with a UAP team member. It is through the individual RN's application of these standards that the question of which specific activities and duties the RN may assign to their UAP practice team member is answered.

OAR Definitions

Before we dive into the standards, a wee exploration of terms and their definitions comes first. This is necessary because an RN's knowledge of the expressed meaning of a term used in a standard is vital for its proper application to practice. The following OAR Chapter 851 Division 6 defined terms are used in standards pertinent to RN practice with UAP team members:

- **Context of care**: This term means "…the environment where a licensee's practice of nursing occurs. Defining a specific context of care includes factors such as the location where the nurse's client receives nursing services, the licensee's practice role within the setting, regulations of the setting, policies and procedures of the setting, professional and specialty nursing practice standards applicable to the nurse's practice role, and the ability of the client to self-direct the nursing strategies or interventions to which they have given their consent."
- **Unregulated assistive person**: This term means "…the practice team member whose position description or job within an organization does not require licensure or certification by a state of Oregon health-related licensing agency. The UAP includes, but is not limited to, the person working as a: medical assistant, certified medical assistant, registered medical assistant, home care worker, emergency department technician, labor and delivery technician, direct care staff, direct support professional, traditional health worker, volunteer. The term applies to those who have state of Oregon issued health-related licensure or certification, but

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who hold a position where their license or certificate is not a requirement. The term does not apply to practice team members who are family members of the client."

- **Assign:** This term means "…the action of directing and distributing the work that each practice team member is already authorized by license or certification and organizational position description to perform."
- **Delegation process**: This team means "…the process used by an RN in a community-based setting to delegate the performance of a plan of care nursing procedure to an unregulated assistive person per OAR Chapter 851 Division 47."
- **Community-based setting**: This term means "…a setting that does not exist primarily for the purposes of providing nursing or medical services, but where nursing services could be required intermittently. These settings include adult foster homes, assisted living facilities, child foster homes, schools, and 24-hour residential care facilities."

With a refreshed knowledge of these definitions, we turn to the standards.

RN Standards

First up are RN scope in the practice of nursing standards located in OAR Chapter 851 Division 45. These standards identify the actions an RN must take in any Oregon setting and role to promote the safety of those receiving nursing services.

Division 45 standards pertinent to RN practice with a UAP team member are brief, direct, and located in OAR 851-045-0060(3). These standards give permission to the RN to assign plan of care interventions to practice team members per their context of care. Listed among the team members to whom an RN may assign is the UAP. The standards expressly identify: "The RN may assign to a UAP, work the UAP is authorized by organizational position description to perform in the setting."

The RN who is unsure what their UAP practice team member *is authorized by organizational position description to perform in the setting*, is directed to seek guidance from their nursing administration, management, or education department.

When an RN practices in a community-based setting (see definition above), a second Division of RN standards pertinent to practice with a UAP may also be applied. These standards are in OAR 851-047 Standards for RN Delegation Process. This means in addition to the Division 45 standards which permit an RN to assign work to a UAP, Division 47 permits the RN to use delegation process to authorize a UAP to perform a health-related procedure that would normally be performed by a nurse. To learn more about delegation process with a UAP, and the decisions an RN must make prior to delegating to a UAP, RNs are directed to access the OAR 851-047 standards directly.

The Big Picture

While it may go without saying, it is important to remember that regardless of setting, a prudent RN does not dole out the performance of their plan of care interventions to UAPs in a vacuum. Prior to arriving at the decision that such action is safe for their client, the prudent RN has adhered to multiple other Division 45 standards - standards in place to protect persons who receive nursing services. RNs are encouraged to access OAR 861-045 directly to review the standards applicable to their practice of nursing.

In Closing

Per Division 45 of the NPA, an RN in any Oregon setting and role may assign plan of care interventions to their UAP practice team member per their context of care. The question of which interventions or procedures an RN is permitted to assign to their UAP practice team member can only be answered through the individual RN's application of OAR 851-045-0060(3) standards. When RN practice occurs in a community-based setting, OAR 851-047 establishes additional standards which permit an RN to authorize a UAP to perform a health-related procedure that would normally be performed by a nurse.

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By OSBN Policy Analyst ***Sarah Wickenhagen***, DNP, APRN, FNP-C

EMERGING COMPLAINTS: IV HYDRATION AND AESTHETIC PRACTICES IN APRN REGULATION

Intravenous hydration lounges and cosmetic/aesthetic businesses have become more visible in Oregon and across the United States. While these services are marketed as convenient, consumer-friendly, and often cash-pay, they carry significant regulatory and professional risks for APRNs. Complaints to boards of nursing are increasing, echoing national concerns highlighted by the North Carolina Board of Nursing and Board of Pharmacy. This article explores the nature of these complaints, the regulatory lens in Oregon, and the lessons APRNs must take to safeguard their licenses and the public.

Scope & National Context

APRNs are independent practitioners in Oregon but must practice within the requirements of Divisions 45 and 55 of the Nurse Practice Act. Nationally, boards warn against menu-driven care, inadequate documentation, improper delegation, and poor emergency preparedness. OSBN has received complaints in the past 18 months that reflect these same themes: unsafe prescribing, scope creep, and boundary violations. These risks are amplified in IV hydration and aesthetic settings where services are often marketed directly to consumers.

IV Hydration Risks

Provider judgment, not patient choice, must drive clinical decision-making. APRNs cannot rely on clients to select treatments from a menu of IV 'cocktails' without an individualized provider assessment. IV fluids and additives are regulated by the Oregon Board of Pharmacy and federal law, and APRNs must follow those regulations. Additives such as vitamins and minerals must be evidence-based and clinically appropriate. Practices that involve experimental or unsupported substances place both patients and providers at risk.

In addition, APRNs must coordinate care responsibly. Administering B12 injections or similar interventions without notifying a patient's primary care provider may mask underlying health conditions and interfere with continuity of care. Proper assessment, follow-up, and communication with other providers remain essential standards of safe practice.

CASE STUDY 1: MENU-DRIVEN IV THERAPY

A client presents to an IV hydration clinic requesting a "hydration and immunity cocktail" selected from a posted menu. The APRN reviews a brief intake form but does not perform a comprehensive assessment. The infusion is administered with added vitamins and electrolytes without a clearly documented clinical indication.

Considerations:

APRNs are responsible for clinical decision making, regardless of the business model. Allowing patients to select treatments from a menu with an individualized assessment shifts care away

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from provider judgment and into consumer-driven practice. This approach raises concerns related to medical necessity, appropriate use of additives, and compliance with pharmacy regulations. The APRN scope and standards of practice in Division 55 of the Nurse Practice Act requires the APRN— to determine the treatment plan.

Aesthetic and Cosmetic Practice Concerns

APRNs receive no formal preparation in cosmetic injections, fillers, or surgical aesthetics as part of their graduate education. These services fall under the purview of other regulatory bodies, and APRNs must carefully evaluate whether their practice in these areas is consistent with their education, certification, and scope of practice.

Delegation and supervision also present risks. RNs may be delegated tasks only with proper orders and oversight, while delegation to unlicensed personnel is generally unsafe and may constitute a violation of the Nurse Practice Act. APRNs must ensure they are present or provide appropriate supervision in any setting where these services occur. Documentation of assessment, rationale, informed consent, and follow-up must be consistent and thorough.

CASE STUDY 2: ASSIGNMENT TO TEAM MEMBERS IN AESTHETIC PRACTICE

An APRN owns a medical spa offering IV hydration and cosmetic injections. Due to high demand, the APRN is not consistently onsite and relies on both licensed and unlicensed employees to carry out treatment interventions ordered for clients.

Considerations:

Assigning work to practice team members in these settings must be carefully considered. The APRN is responsible for knowing the duties, functions, and activities the recipient of their assignment is authorized by license or certification and organizational position description to perform.

Additionally, the absence of oversight of team members in the performance of assigned activities, or unclear supervisory structures, may place patients at risk and expose the APRN to regulatory action. This issue is especially significant in procedures requiring assessment, clinical judgment, or those associated with potential complications. These concerns may also intersect with requirements from other regulatory bodies depending on the services provided and the structure of the practice.

Business and Legal Issues

Beyond clinical risks, APRNs entering IV hydration and cosmetic practice face business and legal considerations. Malpractice insurance may exclude coverage for aesthetic or IV services, leaving providers personally liable. APRNs must secure coverage that specifically includes these services.

Business operations must also comply with state law. Practices should be properly licensed with the Oregon Secretary of State and meet any applicable public health or local regulations. APRNs must also represent themselves accurately; titles matter, and misrepresentation in advertising or promotion can itself constitute a violation of the Nurse Practice Act. Cash-pay practices create additional ethical challenges, particularly around transparency, affordability, and promises of results.

Tips for APRNs

1. Perform individualized assessments and avoid menu-driven care.
2. Comply with all Board of Pharmacy and federal regulations on IV fluids and additives.
3. Coordinate with primary care providers when administering interventions such as B12.
4. Secure malpractice insurance that specifically covers IV hydration and aesthetic services.
5. Ensure your business is properly licensed with the Secretary of State and compliant with public health regulations.
6. Use accurate professional titles in all advertising and public representation.
7. Only delegate within scope and to licensed personnel; avoid delegation to unlicensed staff.
8. Document all aspects of care: assessment, orders, informed consent, procedure, and follow up.
9. Maintain ethical standards in cash-pay services, ensuring transparency, informed consent, and realistic expectations.

CASE STUDY 3: BUSINESS AND LIABILITY EXPOSURE

An APRN launches an IV hydration and aesthetic business as a cash-pay service, which is marketed as wellness-focused and low-risk. After several months, a patient experiences an adverse reaction following an infusion. Subsequently, the APRN determines that their malpractice insurance policy does not provide coverage for aesthetic procedures or IV hydration services.

Considerations: Operating without appropriate coverage places the provider at significant financial and legal risk. When considering your options, think about your business needs and what may be required by regulatory and licensing bodies, depending on the structure and operation of the practice.

CASE STUDY 4: A STRUCTURED AND DEFENSIBLE PRACTICE

An APRN offers IV hydration services with a structured clinical framework. Each patient receives a comprehensive assessment, including a medical history, medication review, and evaluation for contraindications. Treatments are based on clinical findings rather than menu selection. Documentation includes clinical rationale, informed consent, and a follow-up plan. The APRN maintains appropriate malpractice coverage and communicates with other providers when indicated.

Considerations:

This approach reflects alignment with regulatory requirements and professional standards. Emerging areas of practice can be incorporated safely when grounded in clinical judgement, appropriate documentation, and in line with your scope of practice. This focus remains on individualized care and defensible decision making.

APRNs must document IV hydration and aesthetic services with the same rigor as any other clinical encounter. The nursing process—assessment, diagnosis, planning, intervention, and evaluation—should be evident in every note. At a minimum, providers should maintain a structured SOAP (Subjective, Objective, Assessment, Plan) note that captures the presenting concern, provider assessment, clinical rationale, orders, informed consent, treatment provided, patient response, and follow-up plan. Recording only the product given, without documenting assessment or rationale, is inadequate. Documentation is essential.

Conclusion

IV hydration and aesthetic/cosmetic clinics are rapidly growing, but they bring heightened regulatory, legal, and ethical risks. For APRNs in Oregon, the lessons are clear: the provider, not the patient, makes the treatment decision; regulatory and scope of practice standards always apply; and business, malpractice, and representation details matter as much as clinical care. By practicing with vigilance, APRNs can protect their patients, their licenses, and the integrity of the profession while navigating these emerging areas.

Top 5 Red Flags for APRNs in IV Hydration & Aesthetic Practice

1. Menu-Driven Services – Patients selecting IV 'cocktails' without an individualized provider assessment.
2. Unverified Additives – Using substances without FDA approval, Board of Pharmacy compliance, or clinical evidence.
3. Delegation to the Wrong Person – Assigning tasks to unlicensed staff, or RNs without clear orders and supervision.
4. Lack of Business & Coverage Preparation – Operating without malpractice coverage for aesthetics/IV practice or without proper business licensing.
5. Documentation Gaps – Missing assessments, informed consent, follow-up, or coordination with a primary care provider.

References

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By OSBN Policy Analyst, ***Michelle Bell, MSN, RN, CIC, NEA-BC***

WHY SHOULD NURSING STUDENTS CONSIDER NURSING ASSISTANT CERTIFICATION?

Nursing Assistant certification is an investment in professional readiness and provides a smooth transition into the nursing role as it gives student nurses a practical, structured pathway to begin their journey with confidence. RN or LPN education and licensure requires a significant investment of financial resources and time and for those students who desire or need to continue employment during their educational journey, working as a Certified Nursing Assistant offers an opportunity to earn an income while strengthening foundational nursing skills prior to a full launch into nursing practice. Building a solid hands-on foundation early in their education can boost confidence, strengthen communication skills, and increase exposure to direct patient care.

CNA duties include taking vital signs, infection prevention practices, therapeutic communication, and ADL support such as personal care, feeding, mobility support and other nursing care tasks. Working as a CNA places nursing students within real healthcare teams employed across care settings, including long term care, acute care, assisted living, behavioral health, and community settings; this type of experience may be beneficial when applying for positions after graduation.

As a result of the OSBN's efforts to modernize the Nurse Practice Act, it is now easier for nursing students to pursue nursing assistant (NA) certification alongside their nursing studies. Nursing students who are currently enrolled in an RN or LPN program are eligible to sit for the OSBN-approved two-part NA exam. Nursing schools must verify their students' enrollment but are no longer required to attest to delivering the state NA curriculum.

To start the four-step process:

1. The nursing student must first create an account in the OSBN Licensing Portal (https://osbn.boardsofnursing.org/orbn) and submit a NA exam application.
2. Next, ask your program director or dean to complete and submit the Nursing Student Verification of Enrollment for NA/MA Certification form found on the OSBN website.
3. Student should follow the directions in the NA Exam application to get their fingerprints taken.
4. Student should watch their email for a message from the exam vendor TMU with further directions to schedule their exam. Please read the TMU instructions and details regarding the exam.

The exam consists of two parts, a **knowledge test** which may be remotely proctored as well as an in-person **skills demonstration** test. Once both exam components are successfully completed and OSBN CNA certification is issued, students are listed on the Oregon NA Registry and are eligible to work as CNAs in any care setting across the state.

For more information, please review:

- **OAR 851-062-0050 Initial Nursing Assistant (NA) Certification Eligibility:** (D) Proof of current enrollment in a nursing education program approved by the Board or, for non-Oregon programs, by the appropriate agency in that state or U.S. territory.
- **OAR 851-062-0020 (5) Oregon CNA Certification**: An RN, LPN or student nurse must have active CNA certification before being identified as a CNA and performing CNA authorized duties.
- **Oregon Nursing Assistant Candidate Handbook**: https://www.hdmaster.com/testing/cnatesting/oregon/orformpages/OR%20NA%20Candidate%20Handbook.pdf

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DASH DIET

DIETARY APPROACHES TO STOP HYPERTENSION

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DASH DIET SERVINGS BY FOOD GROUP

Include multiple servings of these food groups in your diet every day.

Whole Grains — 6–8 servings
examples
- 1 slice of bread
- ⅓ cup cooked rice/pasta
- ½ cup oatmeal/cereal
- 5–6 crackers
- 6" tortilla

Vegetables — 4–5 servings
examples
- 1 cup raw vegetables
- ½ cooked vegetables

Fats & Oils — 2–3 servings
examples
- 1 tsp oil/butter
- 1 Tbsp mayonnaise
- 2 Tbsp salad dressing

Fruit — 4–5 servings
examples
- 1 small fresh fruit
- 2 Tbsp dried fruit
- ½ cup fruit juice

Low-fat/Fat-free Dairy — 2–3 servings
examples
- 1 cup milk/yogurt
- 1 oz cheese

Lean Protein — ≤6 servings
examples
- 1 egg 1 oz lean meat, fish, or poultry
- 1 Tbsp peanut butter

Count these groups by the week rather than the day.

Nuts & Seeds, Beans & Peas — 4–5 servings per week
examples
- ½ cup cooked legumes
- ⅓ cup nuts
- 2 Tbsp nut butter
- 2 Tbsp seeds

Sweets & Added Sugars — ≤5 servings per week
examples
- 1 Tbsp sugar
- 1 Tbsp jelly/jam

These recommendations are based on a 2000-calorie diet.
The illustrations provide examples of serving sizes.

Following the DASH diet can help lower your blood pressure and reduce your risk for heart disease and stroke. Healthy blood pressure is 120/80

TIPS FOR SUCCESS

- If you are lactose intolerant, try yogurt, hard cheese such as cheddar or swiss, and lactose-free milk.
- Buy fresh fruits and vegetables in season when possible. Frozen fruits are a nutritious, cost- effective option all year round as well as canned vegetables with no added salt.
- Experiment with herbs and spices to enhance flavor without adding excess salt.
- How you eat and how you move go hand in hand when it comes to health. Look for fun new physical activities to enjoy.
- Don't let yourself get overwhelmed! Make gradual, manageable changes to your routine.
- Celebrate successes and forgive slip-ups. Habits take 3-4 weeks to create, so keep moving forward!

Reproducible Handout: For more information on dairy and the DASH Diet, scan the QR code or visit: WinnersDrinkMilk.com

By OSBN Policy Analysts ***Gretchen Koch***, MSN, RN,
and ***Sarah Wickenhagen***, DNP, APRN, FNP-C

YOU ASK, WE ANSWER

Q: I provide RN services for my elderly neighbors. The husband can no longer perform his wife's daily insulin injections. The wife has found a friend of theirs who is willing to give her the insulin shots if I teach him how. In addition to Division 45, are there any other Nurse Practice Act standards I should be aware of?

A: Yes. In addition to adhering to RN scope and standards of nursing practice in Chapter 851 Division 045, you should also follow Division 48 *Standards for the Registered Nurse Who Teaches a Designated Caregiver How to Execute a Medical Order*. The Division 048 standards identify RN responsibilities when teaching a friend or neighbor, chosen by the person requiring care, how to execute a medical order for that person. The best to you in your practice.

Q: What does the Nurse Practice Act (NPA) say about cardiopulmonary resuscitation (CPR) training and training on the use of an automated external defibrillator (AED)?

A: The NPA is silent on both. This means that neither CPR training nor AED training is a requirement to obtain a nursing license, renew a nursing license, or engage in the practice of nursing.

Requirements for CPR and/or AED training are typically a function of the following:

- The laws and rules governing one's practice setting or practice unit,
- credentialling standards applicable to a setting,
- practice setting policies,
- the requirements of one's position description, and
- individual professional competency attainment and maintenance of competencies.

Q: I live in Kansas, have a Kansas-issued multi-state (nurse licensure compact - NLC) license, just started a new RN care management position with a national health insurance company, and I have been assigned Oregon clients. Does my multi-state license cover my nursing practice with clients located in Oregon?

A: No. An Oregon RN license issued by the Oregon Board of Nursing is required to engage in the practice of nursing with any client physically located in the state of Oregon.

Q: Where do I find a list of health procedures approved for performance by nurses?

A: There is no list published by the Oregon State Board of Nursing (OSBN) that specifies activities, interventions, or roles universally approved for all nurses. Each nurse is responsible for determining whether a particular activity, intervention, or role falls within their individual scope of practice. To make this determination, nurses must apply the standards outlined in Oregon Administrative Rules (OAR) 8510450065(2)(a) and (b). These standards include eight criteria that, when all are met, establish that the activity, intervention, or role is within the nurse's individual scope of practice. Nurses are required to accept only those assignments that fall within their individual scope and to decline those that do not.

Nurses who need help applying the criteria should consult their employer's education department, nursing administration, or management.

Q: I need clarification regarding your state's regulations on the administration of propofol for procedural sedation in dental office settings. Specifically, could you please advise whether RNs or NPs are permitted to function as sedation providers administering propofol in a dental office, and if so, is this permitted under standing orders, physician supervision, or independent practice? Are there any required certifications, permits, or training requirements? Are there practice setting restrictions (e.g., hospital vs. office-based dental setting)?

A: From a nursing regulatory perspective, the OSBN provides guidance on the **scope of nursing practice as it relates to administering sedating and anesthetic agents,** including procedural sedation. OSBN rules and interpretive statements related to nursing scope and APRN practice are available on our website at the following links:

- OAR Chapter 851 Division 45- Standards and Scope of Practice for RNs and LPNs https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=3929

- OAR Chapter 851 Division 55- APRN scope of practice https://secure.sos.state.or.us/board/displayDivisionRules.action?selectedDivision=5986
- OSBN guidance on sedating and anesthetic agents https://www.oregon.gov/osbn/Documents/Resource_SedationGuidelines_September2024.pdf
- Healthcare facilities, including hospitals and office-based settings, typically determine provider privileges, supervision requirements, and sedation policies through their credentialing processes and bylaws.

OSBN regulates **nursing practice;** questions regarding **the requirements for dental offices, anesthesia permits, or provider supervision**, should be directed to the **Oregon Board of Dentistry**, which regulates dental practice and anesthesia standards in those facilities.

Q: I am certified as an Adult Nurse Practitioner and currently practice in an ambulatory care setting. Under Oregon regulations, am I permitted to provide an inpatient cardiology consult when I am not assuming responsibility for the patient's ongoing inpatient management? Specifically, I am seeking guidance on whether an acute care certification is required to provide a consultative opinion in the inpatient setting when the primary management remains with the inpatient team.

A: The Oregon Nurse Practice Act (NPA) does not specify whether a particular national certification is required to provide a consultative opinion in a specific clinical setting. In Oregon, APRNs must practice **within the scope of their education, training, national certification, and demonstrated competency.**

Many facilities establish their own **credentialing and privileging requirements** that may determine whether a provider may participate in inpatient care activities or provide consultative services. Those requirements may include specific certifications or experience depending on the nature of the clinical role.

If questions arise regarding an APRN's practice, the nurse must be able to demonstrate that their actions were **consistent with their education, certification, clinical experience, and current evidence-based practice**. Providers may wish to consult their facility's credentialing office or medical staff by-laws to determine whether additional privileges or certification are required for consultative activities in an inpatient setting.

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We look forward to hearing from you! Submit your questions for future editions to: osbn.practicequestion@osbn.oregon.gov.

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Getting support and supporting yourself to "leave work at work" is important to help create a work-life balance. Mentally preparing to leave work can make a big difference. Here are some ideas to consider as you end your day.

TAKE A MOMENT
Look around you and reflect on the day.

IDENTIFY ONE THING
Recall one thing that was difficult today. Let the feelings be present for a moment...then allow them to pass by you and be released.

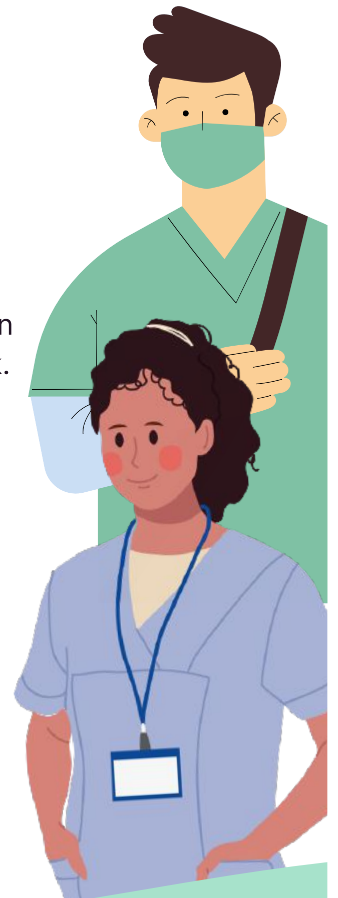
FIND THREE THINGS
Think of three things to be grateful for about your work day. It can be a patient's smile, a colleague's help, or a deep breath you took.

ACKNOWLEDGE
Today may have been hard, but it's not forever. Breathe.

ARE YOU OK?
Really ok? Don't struggle in silence. Connect with someone.

LOOK AT YOUR COLLEAGUES
Are they ok? Don't let them struggle either. Be their support.

BREATHE
With a renewed breath, head home to reset and recharge.



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DISCIPLINARY ACTIONS

Actions taken in February 2026. Public documents for all disciplinary actions listed below are available on the OSBN website at www.oregon.gov/OSBN (click on 'License Verification').

Name	License Number	Discipline	Board Vote	Violations
Jacqueline D. Burton	202214367RN	Reprimand	2-18-26	Failing to document nursing practice implementation in a timely manner and failing to conform to the essential standards of acceptable nursing practice.
Robert J. Driscoll	200540603RN	Voluntary Surrender	2-18-26	Failing to fully cooperate with the Board during an investigation.
Stacie L. Duell	200641553RN	Probation	2-18-26	24-month probation. Violating the terms and conditions of a Board Order.
Tracy L. Harper	202210199RN	Probation	2-18-26	24-month probation. Demonstrated incidents of fraud and failing to conform to the essential standards of acceptable nursing practice.
Timothy Hobizal	202007800RN	Civil Penalty	2-18-26	$250 civil penalty. Violating a person's rights of privacy and confidentiality by accessing their information without proper authorization or a demonstrated need to know.
Maryanne Karina-Kimani	10011914	Reprimand	2-18-26	Failing to accurately document nursing interventions and failing to communicate information about the patient's status to members of the healthcare team in a timely manner.
Daud B. Koleosho	10023091	Voluntary Surrender	2-18-26	Demonstrated incidents of fraud.
Amy M. Lamb	200141824RN/ 201150010NP	Reprimand		Abuse of prescriptive authority, failing to document nursing interventions and practice implementation, and failing to communicate information regarding a client's status to other individuals who are authorized to receive information.
Andrea R. Mora	200942221RN	Civil Penalty	2-18-26	$1,325 civil penalty. Practicing nursing without a current Oregon license.
Genevieve Randall	201802454LPN	Voluntary Surrender	2-18-26	Violating the terms and conditions of a Board Order.
Jill M. Riffe	086003095RN	Reprimand	2-18-26	Performing acts beyond her authorized scope and failing to document nursing interventions.
Teresa N. Tran	201406788RN	Probation	2-18-26	24-month probation. Violating the terms and conditions of a Board Order.
Vincent G. Valera	202208686RN	Suspension	2-18-26	15-day suspension. Demonstrated incidents of reckless behavior and failing to conform to the essential standards of acceptable nursing practice.
David J. Wareham	201810691RN	Voluntary Surrender	2-18-26	Due to disciplines of his RN licenses in other jurisdictions.

Eli D. Stutsman
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Licensing Tip:

Use a Personal Email Address

When adding or changing your email in the OSBN License Portal, remember to use a personal email address, such as Gmail or Comcast. If you use a school, company, or hospital email address, you may miss important notifications from the board. Companies or schools may not recognize OSBN as an approved sender. You could miss the online account validation email or courtesy renewal reminders

2026 OSBN BOARD MEMBERS

OLANIKE TOWOBOLA, RN, DNP
BOARD PRESIDENT

TERM: 2/8/24 – 12/31/26

Ms. Towobola is a registered nurse at the Veterans Affairs Hospital and has 10 years of nursing experience. She received her Bachelor of Science in Nursing degree from Morgan State University in Baltimore, Md., and her Doctor of Nursing Practice degree from Capella University in Minneapolis, Minn. Ms. Towobola serves in one of the two direct-care RN positions on the Board. She resides in Corvallis, Ore.

MARGARET HILL
PRESIDENT-ELECT
PUBLIC MEMBER

TERM: : 7/15/23 - 12/31/25, 1/1/26 - 12/31/28

Ms. Hill has almost 30 years of experience in commercial real estate and securities compliance for financial institutions. She has also volunteered for more than 10 years at the Oregon Museum of Science and Industry. She received her Bachelor of Arts degree in economics from California State University in Sacramento, Calif. Ms. Hill serves as one of two public members on the Board and resides in Portland, Ore.

MATTHEW CALZIA, RN

TERM: 1/1/26 – 12/31/28

Mr. Calzia is a registered nurse at PeaceHealth Sacred Heart Medical Center with 14 years of nursing experience. He received his Associate Degree in Applied Science Nursing from Lane Community College in Eugene, Ore., and his Bachelor of Science in Nursing degree from Boise State University, Boise, Idaho. Mr. Calzia serves in one of the two direct-care RN positions on the Board. He resides in Eugene, Oregon.

RACHEL DENNIS, CNA

TERM: 3/1/25-12/31/27

Ms. Dennis is a CNA and monitor technician at PeaceHealth Sacred Heart Medical Center Riverbend in Springfield, Ore., and has more than 10 years of experience as a CNA. She received her CNA training and Associate of Science degree from Lane Community College in Eugene, Ore., and her CNA2 training from EMT Associates in Springfield. Ms. Dennis serves in the CNA position on the Board and resides in Springfield, Ore.

JONI KALIS, MPT, MS, PT
PUBLIC MEMBER

TERM: 2/8/24 – 12/31/26

Ms. Kalis has more than 30 years of experience in physical therapy and more than 20 years of experience on regulatory bodies; she most recently served on the board of directors for the Federation of State Boards of Physical Therapy. She received her Bachelor of Science degree from Mankato State University in Mankato, Minn., her Master of Science degree from the University of Arizona in Tucson, Ariz., and her Master of Physical Therapy degree from Northern Arizona University in Flagstaff, Ariz. Ms. Kalis serves as one of two public members on the Board and resides in Lincoln City, Ore.

FELIPA NESTA, LPN

TERM: 3/1/25-12/31/27

Ms. Nesta is a licensed practical nurse at Kaiser Permanente Sunnyside Medical Center in Clackamas, Ore., and has more than 17 years of healthcare experience. She received her practical nursing diploma from Concorde Career College in Portland, Ore. Ms. Nesta serves in the LPN position on the Board and resides in Happy Valley, Ore.

RACHEL MITZEL, RN, APRN-CRNA, APRN-NP

TERM: 3/1/25-12/31/27

Ms. Mitzel is a certified registered nurse anesthetist at Cascade Anesthesia Services in Powell Butte, Ore., and has more than 20 years of nursing experience. She received her Bachelor of Science degree in Zoology from Oregon State University in Corvallis, Ore., her Bachelor of Science in Nursing from the University of Colorado in Colorado Springs, Colo., her Master of Science in Nursing Anesthesia from the University of Cincinnati in Cincinnati, Ohio, and her Master of Science in Nursing in mental health from the University of Pueblo, in Pueblo, Colo. Ms. Mitzel serves in one of the two direct-care RN positions on the Board. She resides in Powell Butte, Ore.

LINDA STANICH, RN

TERM: 2/8/24 – 12/31/26

Ms. Stanich is the director of Health Services at Hearthstone at Murrayhill in Beaverton, Ore., and has more than 30 years of nursing experience. She received her Bachelor of Science in Nursing degree from Purdue University in West Lafayette, Ind. Ms. Stanich serves in the Nurse Administrator position on the Board. She resides in Forest Grove, Ore.

CLAIRE MCKINLEY YODER, PHD, RN, CNE
BOARD SECRETARY

TERM: 2/8/24 – 12/31/26

Ms. McKinley Yoder is director and assistant professor at the University of Portland School of Nursing in Portland, Ore., and has more than 25 years of nursing experience. She received her Bachelor of Science degree from Oregon State University, Corvallis, Ore, her Bachelor of Science in Nursing and her Master of Nursing degrees from the University of Pennsylvania in Philadelphia, Pa., and her PhD in Nursing from Villanova University in Villanova, Pa. Ms. McKinley Yoder serves in the Nurse Educator position on the Board. She resides in Portland, Ore.

YOUR BOARD IN ACTION

HIGHLIGHTS FROM THE FEBRUARY 2026 BOARD MEETING

Rulemaking

During the February 2026 board meeting, the Board agreed that proposed rule changes to Division 21 (Standards for Nursing Education Programs) should move forward to a public rule hearing on March 18. The changes mean that Oregon-based educational institutions would be permitted to explore the development of master's degree, post-master's certificate, or post-doctoral certificate awarding APRN education programs.

Nursing Education

The Board granted continuing approval through February 2030 to Umpqua Community College's practical nursing education program and Tillamook Bay Community College's registered nursing education program. In addition, the Board approved curriculum changes at Walla Walla University and Lane Community College nursing education programs and approved Western University of Health Sciences' preliminary application for a pre-licensure registered nurse education program.

For a copy of meeting materials, complete meeting minutes, or a list of scheduled events, please visit the OSBN website at www.oregon.gov/OSBN/meetings.

2026 OSBN BOARD MEETING DATES

Date	Time	Meeting
June 24, 2026	9 a.m.	Board Meeting (Primarily Executive Session)
June 25, 2026	9 a.m.	Board Meeting
August 19, 2026	9 a.m.	Board Meeting (Primarily Executive Session)
August 20, 2026	9 a.m.	Board Meeting
October 14, 2026	9 a.m.	Board Meeting (Primarily Executive Session)
October 15, 2026	9 a.m.	Board Meeting
December 16, 2026	9 a.m.	Board Meeting (Primarily Executive Session)
December 17, 2026	9 a.m.	Board Meeting

Please visit the OSBN website at www.oregon.gov/osbn/Pages/board-meetings for agendas, materials, time changes, and logistical details. To view all board meetings, visit https://www.youtube.com/@OregonStateBoardOfNursing/

Nurses!

Licensing Tip: National Certifications

All nurse practitioners and CRNAs must have proof of current national certification on file in the OSBN office to renew their Oregon nursing license. When you renew your national certification, remember to send a copy to OSBN.

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