Nurses Join Race for the Cure

By Tracy L. Singh, RN, JD

The Nevada Nurses Association invites ALL Nevada nurses to join today. The structure of NNA continues to be a mystery and a few misconceptions may have dissuaded some nurses from joining in the past. As President, it is my goal to dispel the myths about NNA and increase our membership in 2010. We need every voice to be heard and the more members we have, the stronger our voice becomes.

First and foremost, NNA is an organization for ALL professional nurses, not just “American” or “Caucasian” nurses. As a Constituent Member Association (CMA) of the American Nurses Association, NNA refers to the Nevada chapter of the national association. “Nevada” and “American” refer to the region or location as opposed to the nationality or origin of the nurses who belong to the group.

Many nurses belong to various groups serving different needs (Continued on page 8)

Ethical Considerations of Nursing Competency

By John Malek, PhD, MSN, FNP-C

As nursing professionals it is our obligation to protect the safety and well-being of the public. The development of nursing standards and competency enhances professional development, providing a venue for high quality competent nursing care. Failure to maintain standards of care can be used to determine whether grounds exist for disciplinary action by a state licensing board or to assess civil liability against a nurse in a malpractice case. Within the structure of traditional ethical assumptions, beneficence requires providers “do good” to those under their care, mindful of their patients’ beliefs, values, and feelings, and respectful of their choices and decisions. (Continued on page 18)

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Visit us online at www.nvnurses.org

Join NNA today!
Membership application page 19
NNA Mission Statement

MISSION

The Nevada Nurses Association promotes professional nursing practice through continuing education, community service, nursing leadership, and legislative activities to advocate for improved health and high quality health care for citizens of Nevada.

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Are you interested in submitting an article for publication in RNFORMATION? Please send it in a Word document to us at nvnursesassn@mvqn.net. Our Editorial Board will review the article and notify you whether it has been accepted for publication. Articles for our next edition are due by March 1, 2010.

If you wish to contact the author of an article published in RNFORMATION, please email us and we will be happy to forward your comments.

In Memoriam

Sandra Olney, RN, WOCN
Mountain Careflight crew
Pilot Jim Bradshaw
Flight Nurse Clint Reger
Flight Paramedic Chris Ritz

Nurses and former nurse killed at Ft. Hood
Capt. John Gaffaney, RN
Capt. Russell Seager, RN
Lt. Col. Juanita Warman, RN
C.W.O. Michael Cahill (ret.), former RN

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Nurses in the Trenches

OSN Hosts Students from University of Hiroshima, Japan
Submitted by Patsy Ruchala

Robert Wood Johnson Foundation, Institute of Medicine Launch Initiative on the Future of Nursing in America

To identify solutions of nursing care that will not only address many of the issues facing the profession but also transform the way Americans receive health care, the Institute of Medicine (IOM) and the Robert Wood Johnson Foundation (RWJF) have launched a new Initiative on the Future of Nursing. As part of the initiative, IOM has convened a committee of experts to identify the potential for increasing access, improving quality and reducing costs through the involvement of nursing leaders and widespread use of nursing care solutions.

The study committee will review innovative models of nursing care and education; its goal is a transformational report on the future of nursing, with solutions that nursing can provide to improve the quality of patient care while controlling costs.

“We believe our nation cannot adequately address the challenges facing our health care system without also addressing the challenges facing the nursing profession,” said Risa Lavizzo-Mourey, M.D., M.B.A., President and CEO of RWJF. “For health reform to succeed, and for patients to receive better care at a cost we can afford, we must change the way health care is delivered. And nursing is at the heart of patient care.”

To learn more about the Initiative, visit www.thefutureofnursing.org or www.iom.edu/nursing.

Legislative Update
By Betty Razor, RN, BSN, CWOCN

Challenges to Legislating for the Nursing Profession

Nursing education teaches nurses to be proactive in the political and legislative arenas; yet most nurses lack a basic knowledge of the legislative process in their own community and state. Nurses need to develop their understanding of the legislative process and recognize that legislative change often requires compromise.

The first step is easy in Nevada for we have the best teaching tools on the Nevada Legislative website http://www.leg.state.nv.us/. All nurses should become well acquainted with what this website has to offer. You can be a true spokesperson as a nurse who values excellence, service, and competency. On the website, locate your assembly-person and Senator. Read their profiles and then contact them with a simple offer: “I am a constituent and a registered nurse, with extensive experience in... How can I be of help to you?” One simple reminder; when they call, you may not have the information they request and it is appropriate to state “I will obtain that information for you”. Then find the answer and return the call as quickly as possible. You may contact the NNA Legislative Chair or the NNA lobbyist for guidance if necessary.

NNA has made a commitment to employ a full time lobbyist who assists NNA’s Legislative Committee in the legislative process and in understanding the importance of personal contacts with legislators. Since my last RNFormation report the Nevada State Interim Health Care Committee had its first meeting and set up its extensive agenda for their monthly meetings between now and the next legislative session in 2011. You may check the legislative website for the schedule of meetings; those currently scheduled are Feb 17 and March 17. You may attend either in Las Vegas or Carson City or view via video conference from your computer (check the web site for the “How to”).

The NNA state Legislative Committee continues to meet monthly via teleconference and has set priorities for the next legislative session. These will be quite fluid as we progress through the year, and the committee will be working with our lobbyist, Cheryl Blomstrom, to monitor legislative activity affecting nursing and our patients. In addition, we will be monitoring medical boards for changes that affect health care policy.

Congratulations to Marenia Works who has been appointed as the only nurse on the Governor’s Health Information Technology Task Force. She is an excellent choice and will represent nurses and patients with compassion and expertise.

Following the primary elections, each candidate for legislative office in the general election will receive a questionnaire on issues affecting health care. The returns will be tabulated and printed in RNFormation. Look for it as guidance in making your vote count. As an additional reminder, EVERY NURSE SHOULD BE A REGISTERED VOTER.

I have tendered my resignation as legislative co-chair for the north and Teresa Serratt, an Orvis School of Nursing professor with a PhD in nursing policy will be filling this position. Welcome her at the next NNA Legislative committee meeting.


Register Now!
NNA District 1 Annual Conference
March 19, 2010

Nursing: Today and Tomorrow
Keynote Presentation: What Does Health Care Reform Mean For Nurses in Nevada?

Concurrent Sessions (Subject to revision)
Horizontal Violence
Obesity
Errors and Guilt
Healing Touch
Disruptive Behavior
National Nurse Response Team

Watch our website for details: www.nvnurses.org

We appreciate the assistance of Senator Harry Reid’s Office in requesting a keynote speaker from Washington, DC.
The Grab Bag

How would you answer this question?
Lab values suspicious of gastrointestinal bleeding include:

a. Increased BUN, increased creatinine
b. Decreased BUN, increased RBC count
c. Increased BUN, decreased HCT
d. Decreased HCT, decreased Hb

See answer and explanation on page 19.

Grab Bag will be a new feature in RNFormation. We welcome your submission of poetry, clinical questions, interesting stories, or anything you think might interest other nurses. Please send your submission as a word document to rnursesassn@mvqn.net.

Shelter of the Past

What structure this so all alone, abandoned, cast aside?
No longer shelter for a home; a weathered mask is all that’s shown.
Bones so brittle, hair so thin, there is no fire that burns within.
Wild grass grows deep and high beneath your frail feet,
A few surrounding trees give respite, protecting from defeat.
How long will you be standing, so proud to mark your days?
Enjoy my friend some comfort of cool green grass and trees that sway.
It is but a small reward, for a life that was well lived.

Submitted by John Malek, RN, PhD

The Pacific Coast Region of the Wound, Ostomy, and Continence Nurses Society invites you to their annual conference February 19-21, 2010, at the Claremont Resort and Spa in Berkeley, California. Conference topics may include Indwelling Catheters in the Acute Care Setting with a focus on Catheter-Associated UTI’s by Mikel Gray, PhD, OUNP, CCCN, FAAN; An Overview of PAD and Catheter Based Interventions for Critical Limb Salvage by Curtis Stjinis, MD; C diff - A Growing Concern by Salah Bibi, MD; Legal Aspects of Nursing Documentation by Pat Timm, RN, Esq.; and Geriatric Incontinence by Donna Thompson, MSN, FNP-BC, CCCN. REGISTER EARLY online at www.pcr.org.

Wound Ostomy & Continence Nurses Society

PACIFIC COAST REGION

The Northern Nevada Affiliate Race for the Cure is an annual event held in October, and 75% of proceeds stay right here! The remaining proceeds benefit the Komen national research foundation. Proceeds stay right here! The remaining proceeds benefit the Komen national research foundation. Please plan on joining other nurses in the Fall 2010 events and race.

Race for the Cure

(Cont’d from page 1)

University of Nevada, Las Vegas Nursing Professor Yu (Philip) Xu was recently elected President of the Asian American Pacific Islander Nurses Association (AAPINA), a national organization of nurses dedicated to supporting the health care needs of Asians and Pacific Islanders in the U.S. and around the world. Xu will assume the role of President-elect on January 1, 2010, and the role of President on January 1, 2012. Assistant Nursing Professor Patricia Alpert was elected to a two-year term as AAPINA Treasurer.

The AAPINA is a non-profit organization founded in 1992, with members employed in academic institutions, major medical centers, and community based health centers serving a diverse range of patients and families.

The UNLV School of Nursing strives to meet the health care needs of Nevada by driving innovation in nursing education, research, and practice. The school offers undergraduate and master’s degree programs in nursing, post-master’s nurse practitioner certificate programs, and Nevada’s only doctoral program in nursing. For more information on the UNLV School of Nursing, please visit http://nursing.unlv.edu.

Elaborate on the text content here.
Meet Nevada’s Nurses: Jane Miller

(Cont’d from page 1)

Jane describes herself as a “flight nursing pioneer” and was often the nurse who, in her own words, was responsible for many “first ever” accomplishments. In 1975 she began working with the first hospital based emergency medical helicopter program formed in the United States at St Anthony’s Hospital in Denver. This was one of many “firsts” for Jane and for professional nursing as well. In 1978 Jane was the “first ever” Assistant Chief Flight Nurse with the Flight for Life program and while in this role, she developed a written flight nurse orientation program. Jane was co-editor for the trauma section of the first flight nurse text book (Flight Nursing–Principles and Practice) published in 1991. From the inception of flight nursing and air ambulance services, Jane has served in other interesting capacities. In the role of personal Trauma Nurse Specialist, Jane spent ten months with Senator Edward Kennedy as he campaigned for the Democratic presidential nomination from October 1979 to August of 1980. Jane quotes Senator Kennedy’s mother, Rose Kennedy, as dictating that her job was “to save his life if anything happened to him.” When Jane was working in Denver, she assisted with implementing rural education for Colorado, Montana, Utah, and Idaho via teleconference. This continuing education program in effect for flight nurses in Nevada and across the country.

In addition to her contributions to flight nursing and air ambulance services, Jane has served in other interesting capacities. In the role of personal Trauma Nurse Specialist, Jane spent ten months with Senator Edward Kennedy as he campaigned for the Democratic presidential nomination from October 1979 to August of 1980. Jane quotes Senator Kennedy’s mother, Rose Kennedy, as dictating that her job was “to save his life if anything happened to him.” When Jane was working in Denver, she assisted with implementing rural education for Colorado, Montana, Utah, and Idaho via teleconference. This continuing education program in effect for flight nurses in Nevada and across the country.

Jane’s enthusiastic encouragement coupled with sound training enabled other RNs to follow her path with confidence and competence. Jane’s own nursing career provides an outstanding illustration of the exciting achievements possible for the well prepared, professional RN pursuing a flight nursing career. While providing tremendous benefit to the community, flight nurses often realize personal satisfaction and reward.

The accomplishment Jane is most proud of is passing the torch of flight nursing to other RNs. Jane writes that she is “proud that I have been an instrumental force in preparing nurses to practice as an autonomous flight nurse; alone in the air with the patient, dealing with life and death situations. ...I was given this opportunity as a ‘pioneer’ in flight nursing and I am proud I was able to pass it on.” Jane played a key role in developing flight nursing as a nursing specialty and encouraged other nurses to practice flight nursing by communicating her excitement and satisfaction with its practice. Jane promoted flight nursing and expanded the number of RNs practicing as flight nurses by hiring critical care RNs and providing them with a well organized orientation utilizing written materials. Jane’s enthusiastic encouragement coupled with sound training enabled other RNs to follow her path with confidence and competence.

Jane advises prospective RNs to get an education. Jane explains that education is essential for the nursing profession “to keep it growing and expanding as we bring more science to the art of nursing. To stay vibrant in this profession, you must make a lifetime commitment to educate yourself, your patients and your community.” Jane’s own nursing career provides an outstanding illustration of the exciting achievements possible for the well prepared, professional RN pursuing a flight nursing career. While providing tremendous benefit to the community, flight nurses often realize personal satisfaction and reward.

Thank you, Jane, for your lifetime of work as a flight nurse pioneer and your efforts to encourage and prepare other RNs to practice as flight nurses. Congratulations on your well deserved receipt of the Lifetime Achievement Award.
Laborers Training Trust. The training will be free and at UNLV; and Doug Twilligear, Patient Advocate for construction management; David Shields, associate professor of Nursing and Howard R. Hughes College of Engineering Construction Management Program are teaming up to develop a fall prevention and safety training program for Southern Nevada's construction workforce.

The simulation-based program, funded through a $287,000 grant from the Occupational Safety and Health Administration (OSHA), will be open to all construction workers in Southern Nevada but will target Latino workers—a group that often receives little safety training yet suffers disproportionately from workplace injury and death.

UNLV’s team of occupational health and construction management experts will design, deliver, and evaluate the effectiveness of a fall prevention and safety program over a two-year period. The team will also produce safety awareness materials in both English and Spanish that reinforce the messages communicated during the training.

“There are requirements in place for construction managers to train employees exposed to fall hazards, but the incidence of deaths and injuries from falls indicate that not enough is being done,” said Nancy Menzel, project co-director and associate professor of nursing at UNLV. “This deficiency is especially true for immigrant construction workers, so health and safety professionals need to step in to provide the information and skills these workers need to protect themselves from falls.”

With assistance from the Laborers International Union of North America Local 872, more than 750 workers will participate in the training beginning next spring. Training will consist of two four-hour sessions, each held at UNLV. Topics to be covered range from assertiveness training and fall protection requirements to scaffold safety/ set-up and equipment inspections. The program will also use simulation as a training strategy for construction safety.

“Many factors can play into the improper use of safety equipment, such as feeling pressed for time, inability to ask questions in English or damaged and ill-fitting equipment,” said Pramen Shrestha, project co-director and associate professor of construction management. “Trainees need to have confidence in the messages communicated during the training. They need to know that if they recognize a poor safety situation, they have the right and ability to demand safety equipment prior to proceeding.”

The UNLV project is part of OSHA’s Susan Harwood Training Grant program, which supports workplace safety and health programs that educate workers and employers in industries with high hazard and fatality rates, workers with limited English proficiency and small business employers. Participating with Menzel and Shrestha on the project are Neil Opfer, UNLV associate professor of construction management; David Shields, associate professor and director of construction management at UNLV; and Doug Twilligear, Patient Advocate for Laborers Training Trust. The training will be free and open to all construction workers in Southern Nevada.

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Drs. Lamprecht and Brann

Touro University Nevada in Henderson currently offers the only DNP program in a Nevada higher education institution; a 39 semester unit online program with two-three day on-campus intensives scheduled two times a year providing a rich interchange among the doctoral students. Four from the first cohort of DNP students admitted in July 2004 completed the DNP program. Drs. Mary Brann, Donna Emanuele, Scott Lamprecht, and Diane McGinnis completed course work in biostatistics, epidemiology, health policy, practice-based research, informatics, genomics, organizational leadership, and ethical decision making. All used a practice area of choice and the practice-based dissertation. The dissertation process required each graduate to focus on making a change in the healthcare system using existing evidence from the literature. Dr. Brann, a faculty member at Touro University, developed a peer-review system that was integrated as part of a major medical center’s nursing shared governance initiative to enhance the autonomy of nursing staff and improving the perceived quality of care delivered as measured by the NDNQI scores. Dr. Emanuele, a FNP practicing in California, focused on the evidence that exists to achieve regulatory and legislative changes for APRNs. She used evidence-based research to introduce new legislation to expand the scope of practice for California NPs, which was signed by the Governor. Dr. Lamprecht, a faculty member at Touro University and an expert in military arts, compiled evidence from the literature to develop a screening tool to recognize the potential risk of sudden cardiac arrest in adolescent athletes. Pilot screening data showed the tool had positive predictive value in identifying potentially life-threatening outcomes if untreated. Dr. McGinnis, an APN in Nevada, was concerned that practicing nurses do not typically read peer-reviewed publications. She used a popular press online publication to deliver evidence-based information to practicing nurses and to measure the effectiveness of this “informational” method in delivering continuing education critical to quality nursing practice.

Research findings have linked patient morbidity and mortality to the educational level of the nurse. The DNP has been developed to offer the highest level of clinical practice preparation. The DNP recognizes the rigorous educational preparation for the NP, CNS, CRNA, and CNM by 2015, replacing Master’s level preparation with the DNP. However, with any proposed change there are opponents—particularly those who currently offer MS preparation for advanced practice roles and the PhD in Nursing. The PhD will continue to be the science. The DNP, as the clinician with doctoral preparation for advanced nursing practice, will drive the scientific inquiry needed in nursing—the DNP will pose questions to the PhD. The PhD will conduct the research needed to change practice, and the DNP will translate the science in the clinical practice setting.

AACN has proposed that the DNP will be the educational preparation for the NP, CNS, CRNA, and CNM by 2015, replacing Master’s level preparation (however, a request to delay this date has been made to AACN). The DNP recognizes the rigorous educational experience of programs that prepare advanced practice nurses. However, the DNP is also an appropriate educational degree for master’s-prepared nurses who are not APNs who wish a practice focus in a population based specialty, such as an adult critical care or administration role, where they will affect the environment of practice; using informatics to deliver clinical evidence, and in health policy where nursing scope of practice can be changed by the legislation.

Congratulations to our newest DNP’s—they are just beginning to change nursing practice!

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Note: The competencies for the practice doctorate are available on AACN’s website https://www.aacn.nche.edu/DNP/pdf/DNPEssentialsDraft_8-18-05.pdf
Suicide Prevention: Warning Signs and Interventions

Nevada's suicide rate is 4th in the nation, and the past year has seen a sharp increase in the numbers of suicides in some areas of Nevada. As trusted health care professionals, nurses may be the ones people in crisis (patients, friends, family members, colleagues, acquaintances) turn to for help. Misty Allen, Director of the Nevada Office of Suicide Prevention, offers advice about what to look for and what to do.

What are the warning signs that someone may be considering suicide?

- Threatening to hurt or kill oneself
- Looking for ways to kill oneself
- Talking or writing about death, dying, or suicide
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting reckless or engaging in risky activities—seemingly without thinking
- Feeling trapped
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated, or unable to sleep, or sleeping all the time
- Experiencing dramatic mood changes
- Seeing no reason for living, or having no sense of purpose in life

One useful tool to remember warning signs is the mnemonic IS PATH WARM?

- I – Ideation
- S – Substance Abuse
- P – Purposelessness
- A – Anxiety/Agitation
- T – Trapped
- H – Hopelessness
- W – Withdrawal
- M – Mood Change

Source: American Association of Suicidology, 2008

What should you do if you suspect someone—patient, friend, family member, colleague, acquaintance—is suicidal?

- The most important thing you can do for someone in distress is to listen to them. Our stories and our opinions are usually not helpful...let the other person do the talking.
- Express to your friend how you feel about them. This person needs to know they are important to you and you genuinely care about how they are feeling.
- Spend time with your friend. They may not have the energy to get out alone; you can help engage them in activities...laughter and exercise are extraordinarily helpful.

- It's always a good idea to ask how your friend is eating and sleeping. Nearly all of us will experience a change in our eating/sleeping habits when we are stressed or depressed. If we are able to keep these two things under control, we are usually much more capable of facing our problems.
- Remind your friend that they are not alone. You are going to help them get through this.
- Surprisingly, one of the best things you can do to help someone you suspect is suicidal is to ask them directly, "Are you feeling suicidal?"
- Asking the suicide question is no easy task, and it might be normal to have some fears and reservations. What are some of your fears? Why do you think it would be helpful to ask the question?
- Think for a moment about whether or not you would be able to tell someone if you were feeling suicidal. It is important for us to ask the question, because the person at risk may not be able to tell us.
- When asking the question, it is important to be caring but direct. Asking the question, "You're not going to do something crazy, are you?" might indicate to the person at risk that you are not comfortable with the issue of suicide and allows them to avoid giving you a straight answer.
- It is extremely important that someone feeling suicidal get help to cope with their crisis. Getting appropriate help can prevent them from becoming suicidal again.
- The best way to help is by physically going with the person to get help. Go with them to a counselor’s office, sit with them while they call the crisis line, or go with them to talk to their family. Providing emotional support in time of crisis may make a difference and save a life.
- If you are not able to physically be with that person, ask them to agree to seek help and then follow up to see how it went. The reassurance of a supportive friend is priceless.

Community Resources:

Supportive Family and Friends
- Medical Doctor
- Mental Health Professional

Community Resource Line (dial) 2-1-1
- No. NV Adult Mental Health Services (775) 688-2001
- Senior Mental Health Outreach Program (775) 688-2001
- Children’s Cabinet (775) 686-6200

Suicide Prevention Lifeline 1-800-273-TALK (8255)

For more information, contact the Office of Suicide Prevention, Nevada Department of Health and Human Services, www.suicideprevention.nv.gov, Reno (775) 688-2964 Ext. 249, Las Vegas (702) 486-8255.

Reprinted from “Suicide Prevention Information” by permission of the Office of Suicide Prevention, Department of Health and Human Services.
In October, the Nevada Nurses Association held its annual general membership meeting by video conference between Las Vegas and Carson City. With assistance from Rose Yuhos, RN, Executive Director and her staff at AHEC in Southern Nevada, we were able to communicate directly with members from both districts without the need for travel. AHEC provided the facilities and arranged for technical support in both locations. NNA is eternally grateful for AHEC's generosity. During the meeting we discussed NNA's structure, upcoming events, goals and objectives; we created a Membership Code of Honor; and we presented election results and held an installation ceremony for our new board members.

Our educational presentation, “Endless Possibilities in an Uncertain Economic Environment”, was very interactive and enlightening. We discovered the incredible amount of experience our members had to share with each other as we presented numerous interesting and creative career paths in nursing; and at the same time we got to know each other a little bit better.

This year’s President's award went to Betty Razor, RN, for her years of dedicated service as our “North Star” serving as President for District I and most recently as co-chair for the Legislative Committee. Betty has been a tremendous asset to the organization.

The annual state meeting for all NNA members was held in October via video broadcast between Las Vegas and Carson City. Participants from both locations.

Betty Razor & Pam Johnson

Celebrating Nurse’s Appreciation Night With the Reno Bighorns

The Bighorn Basketball team invites all nurses to their “Nurse’s Appreciation Night” on April 2, 2010 at the Reno Events Center, 400 N. Center St. Reno, NV 89501. Tip off is at 7pm.

Reno Bighorns vs. Albuquerque Thunderbirds Nurse’s Appreciation Night will feature:
- Recognition of Nurses of Achievement honoree and NNA scholarship recipients
- Basketball game between 2 competing nursing organizations prior to the Bighorns game
- A halftime medical emergency demonstration
- A $6 discounted ticket will be offered to all nurses, as well as their friends and families. Please fill out the registration form below and return it to 250 Evans Ave., Reno, NV 89501; or contact Aaron Hubbard or Mark Drake at (775) 284-2622 or aaron@renobighorns.com or mark@renobighorns.com to get your tickets.

Deadline for tickets is March 31, 2010.

Employer ____________________________
Name ________________________________
Phone ________________________________
Address ______________________________
City, State, Zip _________________________
E-mail ________________________________

Number of tickets ______ x $6 = $ ____________
Credit Card # __________________________
Exp. ________________________________

(ALL) (Cont’d from page 1)

and interests. I believe it is important for ALL nurses to support and belong to multiple nursing organizations, and there are many groups and sub-groups to choose from. For example, as a Nurse Attorney, I currently belong to eleven different professional organizations with varying purposes and missions. While some associations may have common or overlapping goals and objectives, they all have differing perspectives and approaches to achieving those goals. This is why it is important to belong to multiple organizations, and even more important for those groups to work together whenever possible.

Second, it is important to note that NNA is a professional organization with no union or collective bargaining affiliations. In some states, the CMAs are union organizations or have formal workplace advocacy functions for individual nurses. Others, including NNA, do not have any union affiliations whatsoever and are strictly professional organizations.

Regardless of union affiliation, all CMAs are active in the legislative process in their respective states and at the national level, ANA has been THE nursing organization at the forefront in healthcare reform discussions advocating for nurses and our patients. While we don’t all agree with certain aspects of HCR, we all agree that change is necessary.

The Constituent Member Associations (or state chapters) of the American Nurses Association meet at least annually to discuss important issues and challenges faced by nurses in other states across the country. Over the years, changes have been proposed at the national level to allow and/or disallow union affiliations. Most recently, recognizing that nurses are more powerful when they work together than when they are in opposition to one another, the constituent members of ANA have taken a stand to come together in support of all state structures, regardless of union or non-union activity. We also recognized the importance of working together with other nursing organizations to reach our common goals while respecting the individual goals and objectives of all nursing groups.

In Nevada, we basically have two main regions, North and South. The State Board for NNA deals with activities and goals at the state level. The Northern District (District I) has its own Board and has been very active for many years. The Southern District (District III) was inactive for quite some time and has recently been working to restructure, electing board members and planning for local activities in the South. NNA also has a special practice group for Nevada’s Advanced Practice Nurses. This group has Northern and Southern chapters with each Co-Chair serving on the NNA State Board. It is my goal in 2010 to strengthen all groups within NNA and bring our nurses closer together.

The annual state meeting for all NNA members was held in October via video broadcast between the North and South, which allowed us to bring our members together without the need for travel. Special thanks go out to Rose Yuhos, RN and her staff at AHEC in Southern Nevada for providing their facility and support in coordinating the meeting between locations.

To join NNA today, please go to www.nrnurses.org/members/NNAapplication.pdf to download and submit your application. To avoid delays and expedite your membership benefits, fax your application to (778) 201-9002. Thank you and I look forward to meeting and working with you all.

By Tracy Singh, RN, JD

Las Vegas participants

Carson City participants by video

New officers in northern and southern Nevada were sworn in by President, Tracy Singh.
President
Beatrice “Betty” Razon RN, BSN, CWOCN

I moved to Carson City in 1999 from So. California where I’d started CWOCN programs at community hospitals, a research program at St. Hope, and my own private practice in 1993. When retiring to Nevada I restarted my private practice to provide services in the community. I currently act as a mentor to other WOC Nurses in the area and co-chair the support group. I’m also active in health ministry at church, which I find to be very rewarding, such as helping the community in a disaster as a CERT member. I have served in various positions in NNA at both the district and state levels and currently co-chair the state Legislative Committee. Serving as President of District One has been an honor and a privilege; there are many challenges, but what an incredible journey working with the dedicated nurses who contribute their time and talents to strengthen the status of NNA as a valued and viable force in nursing.

President Elect
John J. Malek PhD, MSN, FNP-C

My career in nursing is as diverse as the profession itself. I have worked as a staff nurse in med-surg and ICU, and in patient education, home health, behavioral health and management. Upon completion of my education as a family nurse practitioner, I was the first advanced practitioner employed by Carson Tahoe Hospital. The desire to work with those less fortunate led me to pursue practice in acute and primary care in rural Nevada for many years. Graceland University bestowed upon me the university’s highest achievement in community leadership, academics, research, and clinical expertise. I began to volunteer with the NSBN disability advisory committee in 1994 and continue as a consensual member today. My interests in the needs of communities and those less fortunate was the driving force for obtaining my BSN in 1982 from UNR, and my MSN in 2003 from UNLV. I have devoted most of my career to caring for the pediatric population. I was a school nurse in Elko for 9 years and currently work at the Juvenile Detention facility in Reno.

Treasurer
Kathy Ryan RN, MSN

Hello—It’s my pleasure to continue to serve the nurses and residents of Nevada as an active member of the Nevada Nurses Association. As District One’s new Treasurer, I look forward to promoting events that increase our revenues so that we can continue to support nursing education in Northern Nevada.

I hope one day to become a Clinical Nurse Specialist in cardiac and vascular care, but in the meantime I enjoy my involvement with investigating, research, teaching, and writing. In addition, I would like to volunteer in medically underserved areas, and as a parish nurse and advocate.

I am thankful for God’s blessings in my life, I believe that serving others serves Him, and I treasure the opportunities He has provided me.

Co-Secretary & Director
Linda Lesperance MSN, APN

I am a native Nevadan, and love this state for the great wide open spaces. I received my BSN in 1982 from UNR, and my MSN in 2003 from UNLV. I have devoted most of my career to caring for the pediatric population. I was a school nurse in Elko for 9 years and currently work at the Juvenile Detention facility in Reno.

Co-Secretary and Director
Linda Saunders BSN, MSN, Med

My name is Linda Saunders, but you can call me “Linda S” or “the other Linda.” I am joining the NNA District 1 Board as Director and Co-Secretary. As a nurse for 40+ years, I hold a BSN, MSN & Masters in Education (Special Ed/Learning Disabilities). In the past, I was also an ANCC certified Adult NP. Over the years I’ve worn many caps, from camp nurse and school nurse to acute care staff nurse, cardiac step-down, ortho and float pool. For the past 22 years I’ve taught nursing at TMCC, with a focus on the Med-Surg areas. Currently, I am phasing-in to retirement from TMCC and working per diem in Extended Care. That’s nursing; never boring! I’m looking forward to working with all Nevada nurses, and facing the new challenges ahead!

Directors
Debi Ingraffia-Strong MSN, RN

Nursing is a wonderful profession, and after 28 years, I still love it! I graduated from Orvis School of Nursing at UNR in 1982, and have worked in Critical Care and Urgent Care ever since. I attended my Masters in Nursing from University of Phoenix, and in 2001, started my work in Critical Care. As the MRSA Prevention Coordinator (MPC) my responsibilities include the supervision of the VA’s national initiative to reduce the spread of MRSA and other Multidrug-resistant Organisms (MDROs) through education, identification of barriers, implementation of staff solutions, and culture change; with the ultimate goal of reducing healthcare associated infections (HAIs) to ZERO. My areas of expertise include Critical Care, Cardiac Care, and MRSA, and my areas of interest include Infection Prevention, Education, and Healthcare Reform.

Nominating Committee
Chair, Beth Bomberger RN, MSN, FNP-C, APN

Marla Johnson, RN, BSHA

My history is a long time (30 year) resident of Carson City and I was involved in the re-activation of NNA in Carson City in the mid 80’s. I originally moved from Iowa and obtained my LPN in ’85, my AD in nursing at WNC in ’85, and my BSHC at Juliet, IL in ’02. My experience includes acute care, community health, home health, parish nursing, hospice, and long term care. I recently retired to enjoy my retirement in my home in Fallon. Activities include reading, hiking and cooking. Gary and I have been married for 30 years.
Lisa Black, PhD, RN
President-Elect

I am honored to have been selected as the President-elect of the Nevada Nurses Association.

The coming years will be exciting times for nursing in Nevada, and I look forward to working with you as we meet the challenges ahead and continue to move nursing forward in Nevada.

I would like to take this opportunity to introduce myself and share a little bit of my nursing background with you. I am a native Nevadan, having grown up in the Minden/Gardnerville area. After completing my BSN in 1993 at the Orvis School of Nursing at the University of Nevada, Reno, I worked in a variety of acute care roles, ultimately settling in Oncology and Hospice nursing.

I initially became active with the Nevada Nurses Association in 1999 after a life-altering occupational injury, and fell in love with the legislative/health policy process. Through my years of activity with the NNA I have had the opportunity to serve the Association in several capacities. I served in elected positions on the NNA Board of Directors and was subsequently employed as the Association’s Executive Director, Health Policy Administrator, and Lobbyist from 2002 to 2005.

Through my political activity, I also found that I have a passion for teaching nurses and those who wish to become nurses. I returned to school to complete a MS in Nursing Education at the Orvis School of Nursing, and then a PhD in Nursing/Health Policy at the University of California, San Francisco. I am currently employed as a full-time Assistant Professor at the Orvis School of Nursing, and am the Assistant Chief Nursing Officer/Clinical Nurse Specialist at Sierra Surgery Hospital in Carson City. I am certified in Operative Room Nursing (CNOR). I am the Assistant Chief Nursing Officer/Clinical Nurse Specialist at Sierra Surgery Hospital in Carson City. My nursing career has included the operating room, pre-op, education coordinator, infection control, employee health, quality control, school nursing, public health, and nursing leadership. One of my goals for the Nevada Nurses Association is to increase membership and encourage nurses to get involved. My passion in nursing includes providing a supportive environment for our nurses so they provide excellent patient care, researching literature for evidence-based practices and incorporating those practices into the work environment, improving the quality of nursing care, infection control, and employee health. My goals in nursing are to support and to provide leadership to nurses, get nurses involved in professional organizations, and promote nursing as a profession.

NNA President Tracy Singh announced the winners of the state elections and two post-election appointments at the NNA State Annual meeting, October 24, 2009.

The NNA State Officers for October, 2009-October, 2010 will be:

- President: Tracy L. Singh, RN, JD
- President-Elect: Lisa Black, PhD, RN
- Vice-President: Amy Ragnone, MSN, MA, RN
- Secretary: Lara L. Carver, PhD, RN
- Treasurer: Pam Johnson, RN, BSN
- Director Nicola Aaker, MSN, MPH, RN
- Director Denise Olgretree-Mcguinn, RN, MS, Med., APN, PNP
- Director Mary Bordmass, PhD, RN
- APN North Co-Chair David Burgio, MS, PMHCNS-BC
- APN South Co-Chair Tomas Walker, RSNA, APN, CDE
- District 1 President Beatrice Razor, RN, BSN, CWOCN
- District 3 President Martha Drohobytscher, MSN, CNS, CNP

Nominating Committee: Laura Martin, Lisa Melaerts, Theresa Tarrant, RN, PhD, RN

Welcome to the Nevada Nurses Association!

We are pleased and proud to warmly welcome our new members.
Perhaps the simplest way to protect your license is to keep your address with the nursing board current in all states where you are licensed at all times. Failing to do so may actually be the single most damaging mistake you can make should there ever be a complaint filed against you and anyone can submit a complaint at any time for any reason.

As a Nurse Attorney, my practice is dedicated to helping nurses learn how to avoid malpractice and protect their professional licenses. For the past several years, I have attended and observed the majority of nursing board hearings held in Reno and Las Vegas, even when I am not representing a particular client before the board. As President of the Nevada Nurses Association and independently as a Nurse Attorney for nurses, I often testify before the Nevada State Board of Nursing on various issues involving nurses in our state. As I observe the hearings year after year, by far the most disturbing thing for me to watch is when nurses lose their licenses for failing to respond to a Notice of Complaint and Hearing.

The Nevada Nurse Practice Act allows the Nursing Board to proceed with a hearing with or without you. If a disgruntled patient, co-worker or even significant other submits a complaint against you to the Nursing Board, an investigation will be conducted regardless of your response. If it is determined that the evidence supports the allegations made and if such conduct would be in violation of the Nevada Practice Act in any way, a formal Notice of Complaint and Hearing will be issued. If you do not respond and/or do not attend the hearing, Board Counsel will present the undisputed facts as though they are true. If you’re found guilty of violating the Nurse Practice Act, the Board will have no choice but to order disciplinary action against your license, up to and including revocation for up to ten years.

Sometimes nurses simply choose to ignore a complaint or requests for additional information. However, the most difficult cases are those involving nurses who simply failed to submit their change of address as required by law. It is clearly not easy for the Board to impose disciplinary action against a nurse who may not even be aware of the allegations presented. The Board members are always sure to ask about what attempts have been made to contact the nurse in question. The bottom line is, licensed nurses and certified nursing assistants in Nevada are required to update their address with the Board and failure to do so will not protect nurses from disciplinary action. I cannot remember a hearing where there was not at least one nurse who lost his or her license after failing to submit a change of address form.

In some cases, the facts alleged may have been true and some form of disciplinary action would have been imposed even if the nurse had responded and appeared for the hearing. However, in my experience, when nurses respond to a complaint, cooperate with the investigation, take personal responsibility for their actions, and are willing to participate in the negotiation or hearing process, their chances of avoiding a revocation and/or reducing the level of disciplinary action taken are much greater. This is true with or without the assistance of counsel. Although, having an attorney who understands nursing board matters can make the process far less stressful than going it alone and may be worth the expense in the long run.

Over the past couple of years, Nevada was hit hard with the highest foreclosure rates in the country. Nurses were not immune to this massive unwelcomed loss of homes which was no doubt one of the most stressful events most of them had been through. Others have been taking advantage of low home prices. It is conceivable to think that there may be hundreds, if not thousands of nurses who do not have current and accurate information on file with the Nevada State Board of Nursing.

If you know a nurse who has moved recently, or claims not to have received this newsletter issued by the Nevada Nurses Association, or the newsletters issued by the Nevada State Board of Nursing, even if that nurse is no longer living in Nevada, please remind him or her to submit a change of address form to the Board as soon as possible. Updating your address is imperative not only to protect your license, but to receive important information concerning changes and current issues in nursing.

For additional comments or questions about this article, feel free to contact the author directly at tsingh@tlsinghlaw.com.

AVOID MALPRACTICE & PROTECT YOUR LICENSE: Working with Medical Assistants

by Tracy L. Singh, RN, JD

Recently, questions have been presented concerning the regulation of medical assistants in Nevada. Medical assistants are unlicensed workers employed by physicians and physician assistants. They are regulated by the Medical Board. There is currently no regulation mandating a minimum amount of training or education necessary to work as a medical assistant in Nevada, and criminal background checks are not required. Legislators are likely to address these issues in the upcoming Legislative Session and the Nevada Nurses Association has already been asked to provide guidance and proposed language for such regulation. While NNA recognizes that medical assistants are not nurses and will not be regulated by the Nursing Board, nurses are most concerned with patient safety and NNA will be advising legislators accordingly.

One thing nurses should be aware of is that nurses, former nurses and certified nursing assistants may not work as medical assistants in order to perform duties outside their scope of practice. For example, medical practices will often hire CNAs to work as MAs in their offices and train them to perform skills that would not otherwise be allowed by the Nurse Practice Act. In this case, any hours worked as an MA would not count toward the renewal of the CNAs Certificate.

Additionally, nurses who have been previously licensed in Nevada or in other jurisdictions and who have either allowed their licenses to expire or have lost their licenses for one reason or another may be at risk for “practicing without a license” if they are hired as medical assistants and continue to perform “nursing” functions without a license.

The most common question presented by nurses in the face of pending changes in regulation relates to Registered Nurses and Advance Practice Nurses who currently practice in facilities with medical assistants and other unlicensed personnel. There is no regulation preventing nurses from working with medical assistants in the healthcare setting. However, it is important for nurses to be aware of any limitations placed on the medical assistant’s scope of practice, as well as level of training and competency needed to perform certain functions.

The Nurse Practice Act prohibits nurses from delegating nursing functions which require the knowledge and skill of a nurse to unlicensed/non-nursing personnel. Furthermore, nurses should be careful when asked to supervise medical assistants who are directed to perform nursing-related functions by physicians when the physician is not present.

If you are currently working with a medical assistant, and you are asked to supervise or delegate nursing functions to a medical assistant, you may be putting your license at risk. For clarification, you may refer to the Nevada Nurse Practice Act, anonymously contact the Nursing Board for guidance, or seek the advice of legal counsel from an attorney who is familiar with nursing matters to ensure compliance and protect your license.

For additional comments or questions about this article, feel free to contact the author directly at tsingh@tlsinghlaw.com.

AVOID MALPRACTICE & PROTECT YOUR LICENSE: Update Your Address!

by Tracy L. Singh, RN, JD

The Nevada Nurse Practice Act allows the Nursing Board to impose disciplinary action against a nurse who may not even be aware of the allegations presented. The Board members are always sure to ask about what attempts have been made to contact the nurse in question. The bottom line is, licensed nurses and certified nursing assistants in Nevada are required to update their address with the Board and failure to do so will not protect nurses from disciplinary action.

I cannot remember a hearing where there was not at least one nurse who lost his or her license after failing to submit a change of address form.

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Over the past couple of years, Nevada was hit hard with the highest foreclosure rates in the country. Nurses were not immune to this massive unwelcomed loss of homes which was no doubt one of the most stressful events most of them had been through. Others have been taking advantage of low home prices. It is conceivable to think that there may be hundreds, if not thousands of nurses who do not have current and accurate information on file with the Nevada State Board of Nursing.

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For additional comments or questions about this article, feel free to contact the author directly at tsingh@tlsinghlaw.com.
The American Association of Neuroscience Nurses–Northern Nevada Chapter (AANN-NNC)  
by Narendra Ballard, APN, MSN

The American Association of Neuroscience Nurses–Northern Nevada Chapter (AANN-NNC) was founded in 2004 by Jennifer Richards, PhD, RN and Christine Canner-Peterson, APN, MSN. Both remain active in the chapter today. AANN-NNC has approximately 40 members from the Northern Nevada area. The majority of our members are registered nurses, however non-RN members including physical therapists and nursing students are invited to join. Discounted membership dues are offered, as non-RN members enjoy the benefits, but per the by-laws, are unable to vote or hold leadership positions within the group. Membership in the national AANN is encouraged but currently not required. I am the current President of the chapter and an APN with Sierra Neurosurgery Group in Reno. Peggy Reutzel is our Secretary; she is a staff RN on the neuroscience unit at Renown Regional Medical Center. Our Treasurer is Cara Fenn, who is an RN supervisor on the same unit.

AANN-NNC’s mission is to promote the advancement of neuroscience nursing as a specialty through the development and support of nurses to promote excellence in patient care. Any medical personnel interested in the care of the neuroscience patient may join. The neuroscience specialty includes the entire spectrum of neurosurgery and neurology patient populations. The patients may have a diagnosis of subdural hematoma, spinal cord injury, seizure disorder, multiple sclerosis, or brain tumor. The patient may be in the hospital after an elective spine surgery or because they have had a stroke. Many of our members work on a neuroscience nursing unit as a bedside RN, however others work in rehabilitation, critical care, the peri-operative setting, case management, orthopedics, private practice, and advanced practice. This wide range of experience brings together a diverse group that can share their differing experiences to further their knowledge and understanding of the care of the patients within this setting.

The goal of AANN-NNC is to provide educational meetings quarterly to further the knowledge base of our members and to allow for social networking. The educational dinners are open to all who are interested. Generally there is no cost, unless membership fees are due. The education is provided by physicians, RN’s, and medical/pharmaceutical representatives, and covers a wide range of topics including seizure management, spinal cord stimulators, and placement of artificial lumbar disks. AANN-NNC is striving to fulfill the goal of charitable giving each year. In December we had our 2nd annual winter social where all members were asked to donate monies that will be matched by the chapter and donated to a local charity.

We are constantly looking towards the future and what would benefit the members by promoting an on-going learning environment that is both cost-effective and interesting. We look to our members for ideas and energy to continue toward meeting our overall mission. For further information please go to our website www.aann-nncc.org
The misuse of prescription drugs for non-medical purposes is a risk to public health and safety. The rates of misuse and diversion of prescription drugs to non-medical uses have nearly doubled since the 1990s. According to Columbia University’s National Center on Addiction and Substance Abuse near 15.1 million Americans visit emergency room doctors each year for drugs and a surge in the number of prescription narcotics overdose than from illicit drugs or automobile accidents. The Nevada Substance Abuse Prevention and Treatment Agency (SAPTA) 2009 Prescription Drug Fact Sheet indicates that Nevada ranks ninth in the nation in the illegal use of prescription pain relievers in people aged 12-17 and fourth in the nation in this category in people aged 18-25.

In addition, Dr. Pinson reports that Nevada ranks #1 nationally in the consumption of hydrocodone, #4 in oxycodone use, #7 for codeine, and #17 for meperidine. He notes that Nevada pharmacies filled 26,000,000 prescriptions for alprazolam in 2008 for a population of only 3-4 million.

Methods of Diversion

The U.S. Drug Enforcement Agency (DEA) reports that there are several methods of diversion in Nevada, including illegal sale and distribution by health care professionals and others employed in health care and “doctor shopping,” going to a number of doctors to obtain prescriptions for a controlled pharmaceutical (a drug with abuse potential brought under legal control). The DEA reports that the primary method of diversion in Nevada is the illegal purchase of controlled substances via Internet pharmacies, with prescription fraud on the rise in both the Las Vegas and Reno areas.

Senator Harry Reid (personal communication, November, 2009) states that prescription drug abuse is a serious problem that must not go ignored, which is why we passed the Ryan Haight Online Pharmacy Consumer Protection Act, making it illegal to sell controlled substances over the Internet without a prescription. Dr. Pinson adds that statutes require doctors prescribing drugs on the Internet to have a face-to-face contact with the patient every six months, and the Nevada Board of Pharmacy certifies legitimate Internet pharmacies. However, the problem of illegal Internet sales continues. Pinson recently visited Canada to inspect Canadian Internet pharmacies, which are legal by Nevada law. He found that only about 100 of the approximately 1000 Internet pharmacies claiming to be Canadian were actually located in Canada.

Actions Underway in Nevada to Control Diversion of Prescription Drugs

The growing concern about the diversion of controlled substances for non-medical use led Nevada to form the Controlled Substance Prescription Abuse Prevention Task Force, including representatives of SAPTA, Nevada Division of Investigation, health licensing boards, Medicaid, professional associations, pain management doctors, impaired professional help groups, and industry. The Task Force developed a database with a goal of identifying potential “doctor shoppers” (which is a felony) and referring them for treatment. This system requires dispensing practitioners and pharmacists to report their controlled substance prescription records weekly to the Task Force. This data is analyzed for warning signs of abuse, such as a single patient’s use of multiple doctors and multiple pharmacies. If a patient sets off enough “red flags,” the Task Force sends a letter to every practitioner and pharmacy the patient has visited. It is then up to each of these professionals to determine how to handle this patient. This is a screening tool rather than a law enforcement tool and attempts are made to bring assistance to people found to be misusing prescription drugs. The Task Force has one intervention officer whose role is to arrange treatment when appropriate. The system receives over 200,000 hits per year—and its working! For those who receive treatment (Pinson, personal communication, 2009):

1. The average number of doctor visits drops approximately 37%
2. The average number of prescriptions drops from 150 to 46 per year

This Nevada effort has become a model for the nation, and is especially valuable for urgent care and emergency room doctors, who can run a check on a patient 24/7 while the patient is still in the facility. Dr. Pinson encourages APNs who prescribe controlled substances to use the system. For more information, call (775) 687-5694.

Nursing’s Role in Prescription Drug Misuse/Diversion

Nurses are in an excellent position to recognize and assist with the problem of misuse or diversion of prescription drugs. Recommended actions include:

• patient education regarding the dangers of sharing drugs—patients may not understand that sharing prescription drugs with family or friends is illegal and potentially harmful—they may harm the person they are trying to help.
• patient education regarding the hazards of controlled substances—patients need information about every drug prescribed for them, and the need to secure controlled substances if children or adolescents may have access to the medicine cabinet.
• patient education regarding unused prescriptions. The current recommendation

(Continued on page 16)
Your spouse, your child, your family, your pets...
If you’re like most adults, you would rather have a root canal or face a tax audit than write a will. This article will address the basic steps you need to take to ensure your estate will take care of your loved ones after you’ve gone or if you become incapacitated.

You say “I don’t have an estate.” Look around your residence—what will happen to all your “things” if you have an accident on the way home from work today? Who needs to be contacted? Who will take care of your children, your pets, your most precious possession, your priced collections, and even your bills? Even a single person needs to prepare for any eventuality.

Don’t procrastinate! Do follow the nine steps below to ensure you have taken care of all aspects of estate planning. You’ll find that doing so will provide you an unbelievable peace of mind.

Getting started is the hardest part! Gather all the basic information you’ll need in a notebook (even a box will do). For every item include the location of further information.

• Make a list, in order of preference, who you want contacted if you die or are incapacitated; start with family, friends, work contacts, church and organizations (NVSBN). Include names, addresses, and phone numbers. For beneficiaries, include birthdays and social security numbers.

• Locate your birth certificate, baptismal record, social security card, driver’s license, passport, divorce papers, military and retirement papers, and RN license number.

• List assets: home, furniture, computer/electronic items, professional items, storage sites (location), auto, (make, model, license #), checking/saving accounts, annuities, and long term and/or life insurance (account numbers, and institution including address and phone number).

• List debts: mortgage, home/fire/auto insurance, property taxes, credit cards.

• List monthly and annual expenditures (bills).

• List which possessions you want to give to a specific beneficiary.

Once you have all the above information you can begin estate planning. Many forms are available online; be sure they are applicable to Nevada.

Number One: Durable Power of Attorney for Health Care
This is a critical first step. Who do you want making health decisions for you when you are incapacitated?
Select a representative and an alternate. Discuss your decisions with them and other family members. Be sure everyone in the family understands your wishes. Forms are available from hospitals, and they provide assistance in completing them. Forms should be signed and notarized, and copies given to all your physicians and local hospitals. Often elderly place a copy on their refrigerator door.

Number Two: Make a Will
The goal of a will is to set in writing your wishes for your estate upon your death, and who will manage the process. Include in your will who will care for your children, your pets, and your property, and the specifics of inheritance (who, what, how much, and when). This should be carefully considered.

Number Three: Power of Attorney for Financial Matters
Assign this responsibility cautiously, for this designee will have the authority to make money and property decisions for you (if you are unable) and your underage children. Again, select an alternate. This form must be signed and notarized.

Number Four: Special Provisions for Minor Children
If you have minor children you should assign a physical legal guardian and a financial custodian to manage property and finances until your children reach legal maturity. Always have an alternate. You must discuss this thoroughly with the chosen representatives. Should the physical legal guardian and the financial custodian be the same person(s), or two different people? The answer is unclear. There is agreement however, that the physical legal guardian(s) should be a couple whenever possible.

Number Five: Is a Trust Advisable?
Trusts may allow survivors to avoid probate court. Although forms are available online, this is a complex and lengthy legal process; legal consultation may be your wisest course of action.

Number Six: Beneficiary Status
One of the biggest challenges in estate management is maintaining current records, especially beneficiary records. If a beneficiary dies, or is incarcerated, and no alternate is named, managing your estate becomes complex and difficult. Every five years, check your assigned beneficiary and update as necessary.

Number Seven: Long Term or Life Insurance
This decision is very personal based on the amount required to care for and protect your children and your home, and pay debts, taxes, and other anticipated expenses immediately after one’s death. Look over your bills for two—three months to assess the approximate amount required for very basic needs. Long term care insurance has many pros and cons and is a topic for individual consideration.

Number Eight: Plans for Final Arrangements
You can provide a true blessing to your loved ones when this is planned well in advance—even when you’re young. Decision-making is difficult when people are grieving—you can reduce their stress with well thought out planning. So at least write down your wishes. Do you want a service? If so, where and what kind? Do you want cremation or burial? Can you pay for a major portion of the cost now prior to your death?

Number Nine: Storage of Paperwork
Store your will and other important papers in a safe and secure place, like a safety deposit box in a bank. Be sure your executor knows the location of— and has access to—your information when the time comes. Most banks have very strict rules on access to safety deposit boxes and the executor may need a court order to access this prior to your death.

There is a misperception that only rich people need an estate plan; but the truth is we all need plans, if only to reduce the anxiety, stress, and disagreements of our loved ones. A plan is critical for those with young children. You can complete most of these forms on your own, but consider legal assistance if you have questions about your specific situations or have challenging estate planning issues. This is advisable for those with complex family arrangements, those with a business, or those who believe someone will contest the will. The goal of estate planning is to clearly outline your wishes and intentions in the event of your death with the hope that your heirs can meet your goals without stress or unnecessary worries.
Hospice in America: Comfort Care at End of Life
by Paula Schneider, MPH, RN, CHPN

When I was asked to write this article on hospice nursing so that nurses in all areas of health care can understand hospice and promote its ideals, philosophy, and services, I felt a mix of apprehension and joy. I was apprehensive because for the past eight years, I’ve simply received patients. I’m not really on the front line of professionals that refer patients to hospice. Patients arrive and depart in various stages of acceptance of their situation. On the other hand, I felt grateful to be given the opportunity to share what I see as the power of hospice services; providing good physical symptom management, spiritual care, pain management, and fear of the spiritual aspects of dying and death, through the use of a knowledgeable team of experienced professionals.

So, with that introduction, I will proceed to share my sense of awe and wonder and love of the hospice care we currently have in our country. Some of you may know that prior to 1983, hospice services were available only for a few wealthy patients. These services were not reimbursed by private insurance companies, Medicare, Medicaid, or managed care. During the 1980’s, dying patients were placed in hospitals, at the end of the hallway, to spend their last hours alone. Adequate symptom relief was not something many hospice professionals thought about. Dying patients were frequently ignored and allowed to pass away without the benefit of the wonderful medications we possess today.

In fact, it must be noted that America is probably the only country on earth that offers its citizens an interdisciplinary model of end-of-life care that can be rendered in homes, assisted living facilities, skilled nursing facilities or hospice houses. We are very fortunate that this wonderful benefit is currently covered by Medicare and almost all other insurances in America. Sadly, only about 30% of Americans will die with hospice. That means that 60% will die without the benefit of effective medications that relieve end-of-life symptoms such as pain, shortness of breath, nausea and vomiting, and constipation. They will also not receive the other benefits offered by the Medicare model: services of a physician, registered nurse case manager, social worker, chaplain, hospice aide, and volunteer. They will not have the benefit of a hospital bed and other durable medical equipment that may serve to make their last days more comfortable. They will not pay for their own medications—medications that may have been covered by hospice. In addition, they will not have access to a registered nurse who is part of a professional team ready and willing to ensure safe, competent, discrete, and peaceful care 24 hours a day, 7 days a week. These comfort-focused services are powerful perks for patients who do not feel well while being cared for by an inexperienced or uneducated caregiver.

Hospice nurses and other team members interact with families and patients at what might possibly be the most stressful time of their lives. They are among the first to confront patients with a life-threatening disease such as the United States, they most likely have not prepared for their demise very well. They may not have considered a living will to be very important, and the term “Durable Power of Attorney for Health Care” (DPOAHC) may be meaningless to them. In many cases, patients have not discussed with another their wishes regarding how they want to live their last days on earth. When hospice is not committed to hospice, they are forced by the situation to make choices and to contemplate topics that are distasteful to them. Frequently our team must help patients and families understand that they can even begin teaching them about symptoms to expect, the use of medications for symptom relief, and the dying process in general. Sometimes we must move quickly as we are seeing more and more patients with cancer in their last days who have only hours to live. Many caregivers and patients alike are totally unprepared for what to expect over the days, weeks, or months that follow.

Clinic and other RNs are in a good position to (Continued on page 18)

Hospice (Continued)
begin dialog with patients and families about the need to create living wills, DPOAHCs, and do not resuscitate (DNR) orders. It behooves us all to be familiar with these documents that families can share the benefits of having these forms signed with our patients and families. This discussion may also open the door to information-sharing about the benefits of hospice addition. Hospice nurses in hospitals, clinics, and doctor’s offices can act as patient advocates when they see patients who are declining despite treatments, surgeries, chemotherapy, and radiation. Nurses familiar with what hospice is, how helpful it can be, and how comfort is the main focus of all hospice care, can talk to families about the various services options offered by Medicare, such as home health and hospice. Home health services are once a patient is admitted to hospice, the patient is discharged from hospice. In hospice care, the family can be safe and secure in their home environment. I’ve seen patients who lie in bed and move only their eyelids deny pain. I know then that the patient is having pain that is manifesting itself as fatigue and weakness. Often when the patient begins to achieve good pain control through the use of state-of-the-art narcotics and anti-anxiety medications, he or she will decide to get out of bed and join in life again. This is very rewarding to see!

Many times I have heard of patients who would like to discontinue aggressive therapy for their condition, especially cancer, but because of one or more family members’ associations of “giving up,” the patient will continue with what can be extremely stressful and uncomfortable treatments long beyond their

We went through the grief of letting our nana die when she decided that it was her preference to discontinue aggressive therapy for her condition, especially cancer, but because of one or more family members’ associations of “giving up.” We rallied against it and yet, in the end, she was right; we accepted her decision and spent the next four months just enjoying her time with us. On the day before she died (she lived near San Francisco in Marin County, with Hospice caring for Nana, my mom and I went out for lunch to a place in Tiberon Nana loved, bought used paperback books (another favorite), fresh seafood and nugs, and a bouquet of purple iris, her favorite flower. We had dinner that night, laughed, cried and were with her when she passed early in the morning. I had the privilege of bathing her for her last journey as she had chosen the Neptune Society for cremation and ashes spread at sea. We pinned a corsage to her nightgown made from the iris.

It was such a blessing for both my mom and me.

Cheryl Blomstrom

Advance Directives

by Wallace J. Henkelman, MSN, RN

In 1990, the federal government enacted the Patient Self-Determination Act that, among other things, directed the states to provide the availability of advance directives for their citizens. An advance directive is a statement made by competent adults describing their wishes for health care in circumstances in which they are unable to express their desires. There are two types of advance directives in general use, Living Wills and Durable Powers of Attorney for Health Care.

The Living Will, sometimes called a directive or directive to physicians, is the simpler of the two advance directives. It states that the person, upon being declared terminally ill, wants to be provided with comfort measures only, and no measures to prolong life. Note that this document only goes into effect if the person is declared terminally ill.

The Durable Power of Attorney for Health Care, also called a healthcare proxy, allows an adult, while competent, to appoint persons to make health care decisions on their behalf in circumstances in which they become unable to make decisions for themselves. Note that the person need not be terminally ill at the time. It is important for health care personnel to be aware that the legislation on Durable Powers of Attorney for Health Care restricts the appointment of certain categories of persons as decision makers. The most important restriction is that no one can be appointed if they are “an employee of a provider of health care.” That restriction means that most nurses cannot be appointed as decision-makers except by their legal next of kin.

Legally, neither family members nor physicians can act against the wishes stated in the advance directives. Health care providers are required by law to turn the care of the patient over to another provider if they do not wish to comply with the expressed wishes.

There is nothing in the proposed health care reform legislation that makes changes in the use of Advance Directives. There are no “death panels”, nor is there any government involvement in the decision-making process. The only provision relating to Advance Directives is that physicians would be allowed to charge a consultation fee for discussing Advance Directives with patients.

An important point to make in discussing Advance Directives involves what to do with the documents. Persons executing these documents should be advised to make copies and distribute them to anyone who might be asked for them. Personal physicians or other health care provider as well as any clinics or other institutions they should have copies in the medical records. They should take copies with them if they are hospitalized. The documents can also be kept on file in the office of the Nevada Secretary of State using the website at http://www.livingwilllockbox.com. Access to those documents is at the discretion of the person filing them.

Advance Directives are an important aspect of ensuring personal autonomy in making health care decisions. For more information on Advance Directives please visit http://dhcpc.state.nv.us/advancedirectives.htm.
is that any unused prescription, especially controlled substances, be destroyed—place the drug in a tight plastic bag mixed with kitty litter or coffee grounds, seal tightly, then throw away in the trash. Another option is to advise patients of upcoming prescription take back programs. Kevin Quint of Join Together Northern Nevada reports that the first ever take back event in Reno in October brought in 39,000 pills (80 pounds!). A statewide event is being planned in 2010. For information, contact Join Together Northern Nevada at (775) 324-7557, or kquint@jtnn.org.

- adding prescription drug abuse information to school health courses. The National Council on Patient Information and Education, along with the Substance Abuse and Mental Health Services Administration (SAMHSA) and representatives from other organizations have launched a new campaign, “Maximizing Your Role as a Teen Influencer: What You Can Do to Help Prevent Teen Prescription Drug Abuse.” A turn-key presentation for use by healthcare professionals working in school-based settings can be downloaded and used free of charge at http://www.talkaboutrx.org/maximizing_role.jsp. This is a one hour presentation on prescription drug abuse reviewed and approved by Layne Wilhelm of SAPTA.

- pursuing professional continuing education. The Center for the Application of Substance Abuse Technology (CASAT), UNR, is offering courses for health care providers working in specialties other than mental health to assist them in providing help to patients with substance abuse issues. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is supported by SAHMSA as a valuable tool in early intervention. SBIRT is particularly recommended for people working in ER, urgent care, or outpatient clinics. To participate in this training, contact CASAT at (775) 784-6265 or (888) 734-7476.

The problem of prescription drug abuse presents a dilemma for nurses and other health care professionals, who have a legal and ethical responsibility to uphold the law and help protect society from drug abuse. However, we also have a responsibility to ensure that pain is relieved and patients receive medication when they need it. Scott stresses the importance of nurses assessing and evaluating the patient, not just treating symptoms, such as pain. Ask yourself, “Does what they are asking for make sense?” Scott describes the experience of her mother, who developed back pain. She saw an orthopedist who prescribed Norco. The pain increased, and she was given increasing doses of pain medication without evaluation of the cause of the pain. Eventually, she was admitted to ICU with an epidural abscess and spent four months in the hospital. Scott encourages nurses to evaluate and consider a whole person, not just a pain level. If you suspect the patient may be drug seeking, encourage the doctor to do a check through the task force system.

There are many excellent resources to guide practitioners in opioid pain management, such as the Opioid Prescribing Tool Kit by Nathaniel Katz, MD, MS, of Tufts University School of Medicine and The Pain Care Resource Manual by Berkshire Health Systems, Inc.

If you suspect that a patient has a drug problem, there are several recommendations for intervention:

- talk to the patient.
- encourage the patient to seek treatment if he/ she has a problem with substance abuse. If you are unsure where to refer the patient, call SAPTA at (775) 684-9434 Monday through Friday, 8-5. Quint and Join Together Northern Nevada are also willing to help find available treatment for patients with substance abuse issues. Patients can also call the Substance Abuse Help Line at 1-800-450-9530.
- obtain necessary HIPPA release forms and access multidisciplinary resources (other professionals and entities you can readily turn to for information, assistance, and referral such as local pain specialists, substance abuse professionals and treatment organizations, psychologists, pharmacists, SAPTA, and the Nevada State Board of Pharmacy). Consider multidisciplinary treatment for chronic pain.
- SAPTA acknowledges that the system is already overwhelmed, and Wilhelm indicates the patient may be placed in a pre-treatment group until space is available for treatment. He cautions against placement in short-term treatment (e.g. a two-week program), noting that treatment (combined outpatient and inpatient) of less than 90 days is not supported by current research. He recommends a model based on Recovery Supported Systems of Care, which involves community groups with a variety of resources in the treatment process.
- stay involved with the patient and monitor his/ her progress in treatment.

Fedor reminds us that a person who has become drug or alcohol dependent is someone’s family member and our community member. “Dependence and addiction to these medications is a disease like cancer and heart disease and treatment needs to be implemented for these people. They may not be cured overnight but you just keep working toward a cure…by helping them you help the community and promote community wellness.”

**References**


In response to the article “Violence against Nurses Working in US Emergency Departments” (Gacki-Smith, et al., 2009), I want to inform other nurses of the impact this article has had on my practice as a staff nurse. As a result of this information, I pay more attention to my surroundings, including patients’ levels of frustration and body language. I will advocate for more stringent guidelines and protective measures for nurses. Increased emphasis must be placed on safety in the workplace. My goal is to create a safe and report any incidents that may pose a threat to staff and the appropriate persons. The violence is real and I will no longer walk to my car alone after dark or assume that “it can never happen to me.”

The article explained a study that was performed to investigate emergency nurses’ experiences and perceptions of violence from patients and visitors in US emergency departments (Beck et al., 2004). The study revealed that violence against ED nurses is highly prevalent. It showed that precipitating factors to these violent incidents were consistent with research literature and the potential to mitigate these factors is present. These factors include low staffing levels, inadequate security, lack of violence prevention programs, the perception that hospitals, clinics, and pharmacies are sources of drugs and money, lack of staff training on recognizing and dealing with potentially dangerous patients, and the possession of weapons by violent patients and visitors to the hospitals. To prevent violence, hospitals must have trained, armed and visible security personnel and staff must have knowledge of how to recognize and handle potential dangerous situations. Above all, staff must feel free to report these actions to the hospital administrators for proper handling. To alleviate violent actions, hospital administrators, ED managers, and hospital security must be committed to facilitate improvement and ensure a safe workplace for ED nurses.

Workplace violence is serious, and a real occupational risk. Statistics will never tell the whole story because staff members do not come forward to inform management of most incidents. Many patients are verbally abusive and physically aggressive regardless of the situation, and this occurs in the ED and throughout hospitals and health care settings. During my short nursing career, I noticed that some abusive behavior by patients is accepted as the norm. This was not part of my expectation as a nurse. At some health care facilities, some nurses do not take notice of abuse and have accepted this type of treatment as “part of the job.” When asked about the derogatory statements and threats from patients, the response is typically: that’s how the patient normally acts. I’m positive this has an effect on the nurse-patient relationship. I know that I would not be comfortable going into a patient’s room to provide care if something might happen to me. When I asked if management was informed of these abusive behaviors, the answer was usually “no” because that was the way the patients chose to act, and patients’ rights came first. Nurses need to inform management about any situation that may affect their safety, staff safety, or the safety of another patient.

Nurses owe it to themselves to get involved in legal and legislative to stay informed and be part of what happens to them. On March 19, 2003, the executive director of the Nevada Nurses Association sent a letter to the Nevada State Legislature Senate Judiciary Committee soliciting support regarding Assembly Bill 53 to enhance the criminal penalty for assault on a health care worker. On April 25, 2003, Assembly Bill 53 (AB 53) was passed by the Nevada Legislature and signed into law by Governor Guinn. AB 53 “enhances criminal penalty for committing assault or battery upon certain providers of health care”. The legislation adds health care workers to the list of occupations where the enhanced penalty applies, so that the assault on a health care worker in the course of performing his or her job is now punishable as a class D felony (NV RNFormation, 2003).

I am confident that the information in this article will be helpful to nurses and bring awareness to the prevalence and seriousness of violence against nurses working in US health care facilities. My goal is to highlight the ongoing need to recognize workplace violence and report it to the proper officials, protecting nurses. I would like to thank The Journal of Nursing Administration, the authors and all other staff involved in this article for recognizing the importance of keeping nurses safe in the environment of care.

References


desires. If the office or hospital nurse has formed good rapport and trust with this patient, they may frankly discuss the patient’s true wishes. The nurse may then, with the patient’s permission, act as liaison between the patient and the family and actually facilitate a move toward a more humane way of spending the last days. Ultimately the decision to continue treatment may be made, but at least this difficult topic has been broached. And the next time it comes up, it may not be as shocking and difficult.

When the patient or family has decided hospice may be an option, the nurse asks the physician for an order for a hospice evaluation. Medicare requires a doctor’s order for an evaluation, but once again, the nurse can take the lead and guide the physician through this process to make it easier. As we all know, physicians are busy and can become overwhelmed themselves, but the nurse can assist in securing the evaluation. The family can then obtain information about the Medicare hospice benefit and make their decisions about hospice with more knowledge. Also, after the evaluation appointment, the family will be more comfortable because they have already met a hospice team member, usually an RN.

Having worked in hospice for almost nine years and served in various areas of health care as an RN for 33 years, I have observed many situations in life that cause pain and fear. I fully believe that education and some exposure to end-of-life scenarios help alleviate the overwhelming fear that many people feel when they discover that they are living their last days or weeks. Nurses are in excellent positions to feel when they discover that they are living their last days. Ultimately the decision to spend the last days. Ultimately the decision to

Nonmaleficence, an additional assumption, counsels providers to “do no harm” to patients and to protect those who cannot protect themselves.

The public image of nursing conveys trust, caring, safety, knowledge, and is a highly regarded ethical force in healthcare. Under the theory of corporate liability, a health care facility can be held liable for damages caused by its employees or staff when it has reason to know that a nurse rendering care is incompetent to do so. It is imperative that nurses understand the meaning of standards, what determines competency, and how to provide for safe practice.

Standards of Care

Webster (1995) defines standard as “something set up and established by authority as a rule for the measure of quantity, weight, extent, value, or quality.” A standard of care is a measuring scale that defines the average degree of skill, care, and diligence exercised by a nurse under the same or similar circumstances. Standards may be specific or general. A specific standard would be the observation, documentation, and care of post anesthesia patients. A general standard would be the implementation of monitoring the frequency and duration of vital signs across the continuum of care. Although the frequency and duration of monitoring vital signs vary within specialties, the skill, care, and diligence exercised by a nurse remains constant.

Competency

Knowledge does not imply competency. Although nursing’s patterns of knowing are interrelated and arise from the whole of experience, nurses continue to build on their acquired knowledge as they practice. Empirics addresses the critical questions “What is this?” and “How does it work?” Personal knowing addresses the critical questions “Do I know what I do?” and “Do I do what I know?” Ethics addresses the critical questions “Is this right?” and “Is this responsible?”

These critical questions and others like them are implicit in practice. The process of posing a question and seeking answers or solutions improves practice and advances the knowledge upon which practice is founded. According to Webster (1995), competency means “having requisite or adequate ability or qualities.” Patients we care for assume to varying degrees that when a procedure is performed, medications are explained, or health promotion techniques are provided that we are competent in what we do and say.

Standards and competency in clinical practice continually evolve as health care research identifies better treatments and techniques. National and state accrediting organizations and specialty groups revise their guidelines based on that research. As thinking in health care changes, facilities that employ nurses update their policies accordingly. Court cases and legislation continue to clarify the duties nurses owe patients. Maintaining standards and competency of care is your key to safe practice. Information disseminated from a variety of sources forms a framework of expectations for nursing care. That includes adjusting your care to each patient based on many factors such as acuity, age, and mental status. For these reasons, you need to keep pace with current standards and guidelines. Standards of care and standards of performance are both described in terms of competency. Being competent is the level of acceptable practice, and professional growth is necessary to competence. Professional growth moves the nurse beyond mere competence as a minimum standard of practice and toward excellence as an ideal of practice.

Keys to Success

Competence assessment involves skills testing and written assessment. Competency assessment focuses on your performance in caring for a patient with a certain device and includes education and ongoing review as well as demonstrated performance capability. Assessment means demonstrating, documenting, and integrating knowledge and skills through the application of standards of care and established policies and procedures. Additional assessments include certification and continuing education requirements. Achieving, maintaining, and improving competence may be time consuming and expensive, but ignorance is far more so. Get a copy of your nurse practice act and read it carefully. Use the Internet to track nursing trends and rely on sites maintained by reputable groups such as professional societies, universities, government agencies, and health care news publishers. Subscribe to at least one professional journal focusing on material that’s most relevant to your current practice. Join a professional nursing organization such as the American Nurses Association. When reviewing policies and procedures, look for references that indicate the policy is far more so. Get a copy of your nurse practice act and read it carefully. Use the Internet to track nursing trends and rely on sites maintained by reputable groups such as professional societies, universities, government agencies, and health care news publishers. Subscribe to at least one professional journal focusing on material that’s most relevant to your current practice. Join a professional nursing organization such as the American Nurses Association. When reviewing policies and procedures, look for references that indicate the policy was based on recently published professional nursing resources.

Remaining current on professional standards and competency is a career-long effort with many rewards. Besides protecting yourself from liability, you’ll contribute to better outcomes for your patients, gain colleagues’ respect, and open the door to leadership opportunities.

Resources: www.nursesbooks.org/ and www.nursingworld.org

References available upon request.
How would you answer this question?

Lab values suspicious of gastrointestinal bleeding include:

a. Increased BUN, increased creatinine
b. Decreased BUN, increased RBC count
c. Increased BUN, decreased HCT
d. Decreased HCT, decreased Hb

The correct answer is “c,” increased BUN, decreased HCT.

A decrease in the hematocrit associated with an increase with BUN signals gastrointestinal bleeding. Look for concomitant non-steroidal anti-inflammatory (NSAID) use. Anemia is a common problem in our hospitalized patients. However, one way to help differentiate the etiology of anemia is to take a look at the patient’s BUN. The blood urea nitrogen (BUN) will increase and hematocrit will decrease if your patient has gastrointestinal bleeding. Dehydration can also increase the BUN; but with dehydration you will see an increase in hematocrit, not a decrease.

What happens is when the patient has GI bleeding the blood is digested and proteins from the blood get back into the bloodstream in the form of urea nitrogen. By assessing the BUN together and independent of creatinine you will be able to differentiate between renal problems, dehydration and gastrointestinal bleeding.

Here is how to use it in your practice. A drop in hematocrit with no change in BUN indicates that the patient is bleeding elsewhere, maybe from a wound site. A drop in hematocrit associated with an increase in BUN indicates gastrointestinal bleeding. An increase in BUN and an increase in hematocrit indicates dehydration.

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