

Washington NURSING COMMISSION NEWS

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Nurses as Second Victims: Supporting Our Colleagues Following an Adverse Event

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The Process of Investigation: Fact v. Fiction

page 23

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The Washington State Nursing Care Quality Assurance Commission regulates the competency and quality of licensed practical nurses, registered nurses and advanced registered nurse practitioners by establishing, monitoring and enforcing qualifications for licensing, consistent standards of practice, continuing competency mechanisms, and discipline. The commission establishes standards for approval and evaluation of nursing education programs.

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The Washington Nursing Commission News circulation includes over 100,000 licensed nurses and student nurses in Washington.



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Message from the Chair

BY SUSAN WONG, MBA, MPA, RN

At last...summer has finally arrived! Congratulations to all the newly graduated nurses in Washington State.

As you embark on your career, you will encounter and touch many lives that will bring you joy and satisfaction. You will also feel compassion and sadness with difficult situations. Healthcare is hard work but definitely challenging and rewarding at the same time.

The nursing profession is full of challenging experiences. Nursing continues to change and evolve as research, science, and technology enhance nursing practice. At times, questions arise about new procedures and techniques, and you may wonder about your scope of practice. The Nursing Care Quality Assurance Commission Web site at <http://www.doh.wa.gov/hsqa/Professions/Nursing/default.htm> provides information on various resources such as the Scope of Practice Decision Tree, the Nurse Practice Act, and Commission Advisory Opinions. The Web site also contains information on licensing, continuing competency, and discipline.

I encourage all nurses to read the articles in the commission newsletters. They contain a wealth of information including updates and anticipated changes related to our profession. Publication of the newsletter occurs twice a year. You can find current and older issues of the newsletter on commission's Web site.

The commission holds business meetings six times a year to address issues related to our profession. Three meetings occur by videoconference at five different sites in the state. Commission members attend the other three meetings at the Department of Health in Tumwater. The public may attend all business meetings. I encourage you to attend.

As I look back on the years since first appointed to the commission, I have gained a wealth of knowledge in nursing regulation and a strong commitment for nursing excellence in the protection of public safety. I have enjoyed working with knowledgeable and expert commission members and staff from all walks of life. Serving as chair of the commission for the last three years has been a powerful experience of challenge and responsibility. I will treasure this experience as I embark on new challenges in the future.

Enjoy the Newsletter!

Susan Wong, Chair
Nursing Care Quality Assurance Commission

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As a nurse, you're one of the most important people in the health of your family, friends, and community. People trust your advice for their health decisions. With such an essential role, I often find myself asking for your help — and time after time, you come through.

Last June, I asked all healthcare providers in our state for help as we began implementing a new law we hoped would decrease exemptions for preschool and school immunizations. The law requires parents to talk to a licensed health care provider about the real benefits and potential risks of immunizations before they can file a vaccine exemption form with their child's school. Less than a year later, we've already seen a small, but important improvement in our statewide immunization exemption rate. This is great news and shows that when parents get accurate information from trusted health care professionals it helps them make vaccine decisions based on facts. Thank you for the important work you do to combat vaccine-preventable diseases.

Unfortunately, the news isn't all good and we still have a lot of work to do together. Although improving, our immunization coverage is spotty. Several school districts in the state have more than 10 percent of their students with immunization exemptions on file. Some individual schools have more than 20 percent of their children whose parents have exempted them from vaccination, for non-medical reasons. This leaves many children at risk of catching and spreading preventable illnesses. Some diseases, like measles, need less than a 5 percent susceptible population to take off, and clearly, in some areas we are at dangerous levels of vulnerability.

As you know, many diseases can spread quickly in schools and the current whoop-

We've been fortunate in the United States, where we've had the benefit of vaccine protection for many decades. Yet too many people are skeptical or complacent and are putting our families and communities at great risk.

ing cough epidemic is a sobering reminder about how serious these diseases can be. It also shows that immunization is key in protecting our community's health.

Across our state, we're seeing far too many infants and toddlers who are getting pertussis from adults and teens who weren't up-to-date with their pertussis vaccinations. Many adults — including health care staff and new parents — may mistakenly believe they're protected. In fact, most teens and adults need a booster shot. We already have more than 2,000 cases this year and the disease continues to spread. Sadly, we're on track to have the highest number of cases in more than six decades — since vaccine became widely used.

You can help slow this epidemic by using your influence as a trusted health partner:

- Make sure you, your family, and your patients are up-to-date on pertussis immunizations. Use a single dose of Tdap for all adolescents and adults as recommended.
- Give Tdap to all pregnant women after 20 weeks gestation, if they were not previously vaccinated. Vaccination during pregnancy is preferred, but post-partum vaccination is acceptable.
- Recommend vaccination to household members and other close contacts of infants. This disease is really hitting babies hard and the only way to protect them is to make sure that they're surrounded by people who are protected through vaccine.

- Consider the diagnosis of pertussis, even if the patient has been immunized if they meet any of these conditions;
 - Any respiratory symptoms in babies under 12 months.
 - Cough illness includes gagging, a whoop, or any cough that lasts more than two weeks (in patients of any age).
 - Respiratory illness of any duration in patients who've had contact with someone known to have pertussis.
- Report pertussis cases within 24 hours to your local health agency as required.

Information for health professionals and the public is on our 2012 Pertussis Epidemic website. Posters, parent fact sheets, and other materials about the disease are available in English and Spanish. You'll find county-by-county weekly updates on reported cases. Call your local health agency with questions or contact the Office of Immunization and Child Profile (OICP@doh.wa.gov), 360-236-3595.

We've been fortunate in the United States, where we've had the benefit of vaccine protection for many decades. Yet too many people are skeptical or complacent and are putting our families and communities at great risk. With your help, we can turn the tide on pertussis and improve our immunization rates. Thank you for your continued dedication to the health of your patients. They count on you — as I do — and you come through.

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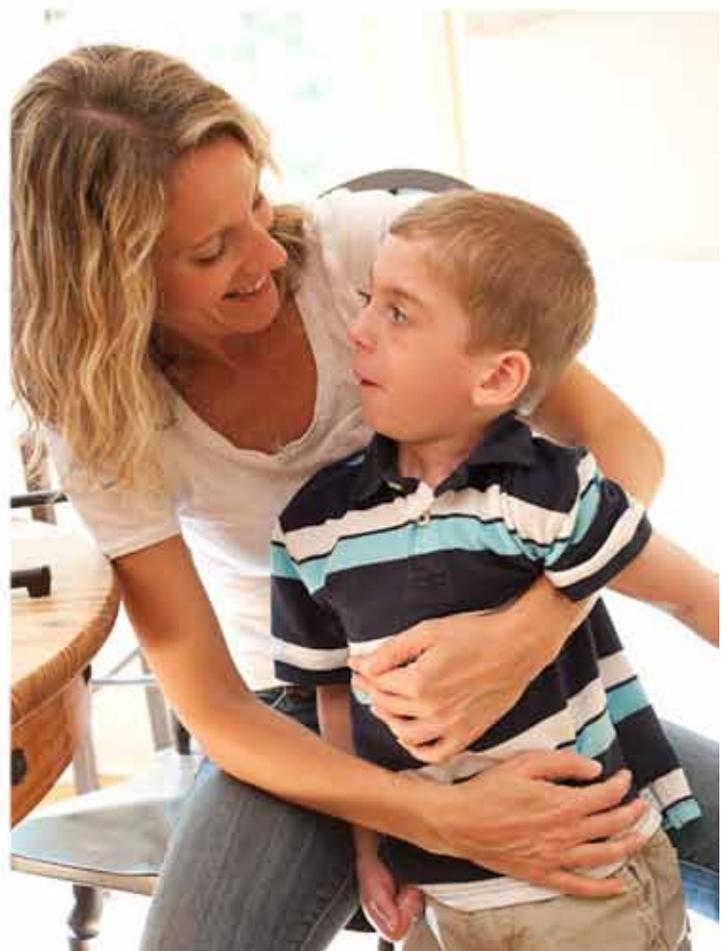
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Message from the Executive Director

BY PAULA R. MEYER, MSN, RN, NCQA-C

Executive Director Legislative Report

The 2012 legislature passed many bills related to nursing care in Washington. New laws affect the full spectrum of nursing care. This year's new laws address such issues as delegation of nursing care, working with licensed midwives, and Washington pharmacies accepting out-of-state Advanced Registered Nurse Practitioners' (ARNP) prescriptions. This article summarizes the new laws with links to the full laws.*

House Bill 1486 allows Washington pharmacies to fill prescriptions for controlled substances written by ARNPs licensed outside of Washington working up to their scope of practice. This law amended the Controlled Substances Act by adding ARNPs from any state to the list of practitioners with prescriptive authority for controlled substances. ARNPs with prescriptive authority for controlled substances from Idaho and Oregon write prescriptions for their patients who may reside in Washington or who may wish to have their prescriptions filled in Washington. The new law allows Washington pharmacies to fill these prescriptions for controlled substances. The law is effective on June 7, 2012.

House Bill 2186 added Licensed Midwives to the list of professionals working with nurses. The new law amends parts of the Nursing Practice Act to add licensed midwives. For example, RCW 18.79.040(1)(e) now states "The executing of medical regimen as prescribed by a licensed physician and surgeon, dentist, osteopathic physician and surgeon, podiatric physician and surgeon, physician assistant, osteopathic physician assistant, or advanced registered nurse practitioner, or as directed by a licensed midwife within his or her scope of practice." Hospital, Pharmacy, Birthing Center, and Licensed Midwife laws and rules must be followed.

House Bill 2366 addresses the prevention of suicide in Washington. The law recognizes the number of people in our nation and state affected by suicide and requires certain health professionals to receive education on prevention. Advanced registered nurse practitioners, registered nurses, and licensed practical nurses receive education in psychiatric care, including assessing for suicidal symp-

oms, referral to treatment, and immediate steps to take to protect people. Mental health education currently required in nursing education meets the new requirement.

The law requires the Secretary of Health to conduct a study and submit a report to the legislature by December 15, 2013. The report must include:

- (a) Available research and literature regarding the relationship between licensed health professionals completing training in suicide assessment, treatment, and management and patient suicide rates;
- (b) An assessment of which licensed health professionals are best situated to influence positively the mental health behavior of individuals with suicidal ideation;
- (c) An evaluation of the impact of suicide assessment, treatment, and management training on veterans with suicidal ideation; and
- (d) A review of the curriculum of health profession programs offered at Washington state educational institutions regarding suicide prevention.

In conducting this report, the secretary from the Department of Health may collaborate with other health profession disciplinary boards and commissions, professional associations, and other interested parties. The secretary shall submit a report to the legislature no later than December 15, 2013. The Nursing Commission will assist in gathering information and drafting the report with the Secretary of Health.

House Bill 2247 expands the types of medications nurses in schools K-12 may delegate to unlicensed school personnel. Currently, school nurses may delegate oral medications. House Bill 2247 expands this practice to delegation of eye drops, eardrops, and topical medications. The Nursing Commission will work with the Office of the Superintendent of Public Instruction to provide guidelines on implementing this bill. The nurse retains the responsibility to determine if the delegation is safe and the person completing the task is competent. Competency includes being willing to complete the task, able to perform safely the task, and available to perform

the task as the student needs.

House Bill 2314 defines and describes the certification of home care aides. Home care aides are certified long-term care workers. Under the amended definition in RCW 74.39A.009(17(a)) “Long term care workers include all persons who provide paid, hands-on care services for the elderly or persons with disabilities including but not limited to individual providers of home care services, direct care workers employed by home care agencies, providers of home care services to persons with developmental disabilities under Title 71A RCW, all direct care workers in state-licensed boarding homes, assisted living facilities, and adult family homes, respite care providers, direct care workers employed by community residential service businesses, and any other direct care worker providing home or community-based services to the elderly or persons with functional disabilities or developmental disabilities.”

This law defines the training, examination, and certification requirements for home care aides. The law also allows nurses in community-based care settings to delegate nursing tasks to certified home care aides. The Nursing Commission will hold rules writing workshops to implement this law. Be on the lookout for the announcements of the workshop dates and locations on our nursing listserv.

House Bill 2473 allows certified nursing assistants in nursing homes to administer medications. The law requires the Nursing Commission to write rules on the education, examination, and supervision that certified nursing assistants must complete before they can receive this endorsement on their certification. The Nursing Commission will hold rules writing workshops to implement this law. The announcements will be posted on our listserv. Please join our nursing listserv to receive information on dates and locations of these very important workshops.

Senate Bill 5969 describes licensing services for spouses of military personnel. The law recognizes the contributions of our military personnel and their families. The Nursing Commission may grant a

Temporary Practice Permit until all licensing requirements are met when military personnel relocate to Washington and their spouse holds a professional license in another state. The Nursing Commission quickly issues temporary practice permits, usually within two days of receiving the application if the license is in good standing from another state. The temporary practice permit appears on our Provider Credential Search as soon as granted. The Provider Credential Search provides primary source validation of a license. Employers use the Provider Credential Search to verify the Temporary Practice Permit and licenses. Once the applicant meets all the requirements, the Nursing Commission issues a Washington nursing license.

Senate Bill 6237 creates a career pathway for Medical Assistants. The law moves all registered health care assistants into a new category of medical professional, Medical Assistant, Certified; Medical Assistant, Hemodialysis Technician; and, Medical Assistant, Phlebotomist. The law defines education, examination, registration, and certification requirements for medical assistants. The law also directs the Nursing Care Quality Assurance Commission to “review and identify other specialty assistive personnel not included in this chapter and the tasks they perform. The department of health shall compile the information from each disciplining authority listed in this subsection and submit the compiled information to the legislature no later than December 15, 2012.”

These new laws demonstrate the wide variety of professional relationships for nurses and the varied settings for nursing practice. Please join the nursing listserv to receive information on rules workshops. You can assist the Nursing Care Quality Assurance Commission in developing the regulations. Your input is very important.

*The on-line newsletter contains hyperlinks. If you wish to look up these bills on the Washington Legislature’s Web site go to www.leg.wa.gov, click on Bill Information at the left under Inside the Legislature and input the bill number where indicated under Search by Bill Number.



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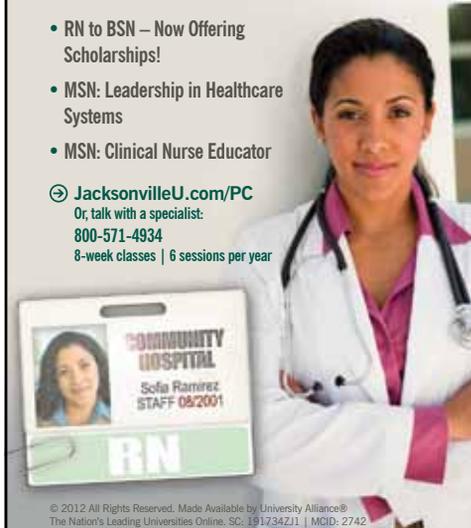
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“Bridging” from Home-Care Aide or Medical Assistant to Nursing Assistant Certified

Certified Home Care Aides (HCA) and Medical Assistants (MA) can now become Nursing Assistants Certified (NAC) without having to do the Nursing Assistant program in its entirety. The Alternative “Bridge” Training Program takes into account the skills that HCAs and MAs already possess and provides 24 hours of further training, to allow the transition to NAC.

The alternative training program consists of 24 hours of training that will equip HCAs and MAs with the additional skills necessary to pass the NAC competency exam. The program must meet the requirements of a state-approved nurse aide competency evaluation.

In order to be eligible for the alternative training program, the HCA must meet the minimum training requirements listed in WAC 246-841-545. The MA must meet the training requirements listed in WAC 246-841-550. If the HCA or MA meet these requirements, the next steps are as follows:

- enroll and complete an alternative “bridge” training program
- complete a CPR course
- complete seven hours of Acquired Immune Deficiency Syndrome (AIDS) training
- successfully pass the NA Competency Test
- apply through the Department of Health to become certified.

The increase in the elderly population and the high turnover of health care workers in long-term care settings support the need for alternative training programs. These numbers create a challenge in meeting the staffing needs in health care facilities.



In 2010, the Washington State Legislature recognized the need for a more stabilized workforce to assure the availability of trained personnel in health care facilities. ESSB 6582 was passed and signed by the governor on March 10, 2010. The bill provides a career advancement track by which the HCA and MA can obtain nursing assistant certification. This opportunity creates a potential resource to meet the rising basic care needs of Washington’s aging population.

In addition, this strategy provides a recruitment source of potential candidates to advance into licensed nursing practice, thereby increasing the number of available nurses to care for these more clinically complex patients in our health care facilities.

Effective January 2012, school sites can apply to become an alternative training program. Please see the Department of Health Nursing Care Quality Assurance Commission Web site for more information regarding alternative programs.



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Bullying in the Workplace: THE NURSE

Bullying in the workplace is a topic that comes up frequently when talking with nurses. We used to call it “eating our young” but the prominent problem has changed from hazing to bullying. This affects not only new nurses, but all nurses. Bullying may include unwarranted criticism, swearing, exclusion, humiliation, and blame without factual justification. Additionally, covert types of bullying, such as trivial criticism and isolated actions between the nurse and the bully can go unnoticed.

I processed a complaint filed against a nurse by her peers because she bullied them. It was the only way they felt they could get to her to stop the behaviors. I can empathize with the way they felt about bullying. In an already high-stress environment, victims feel higher stress when the bully works with

them. It undermines their work outcomes, which can result in ineffective patient care, make staff prone to mistakes, and make them feel on edge.

As a forty-year veteran of our profession, I remember the way I was treated as a novice nurse. You can outgrow being a novice but bullying continues like a virus. Having experienced bullying myself, I recognize how frustrated I felt. The criticism can come out of the blue and catch you unprepared leading you to an ineffective response or cause you to walk away. Even though the criticism is unfounded, it will continue to eat away at the victim. In part, this response stems from the fact that nurses provide care and do not take care of themselves. Sometimes, we work long hours under difficult conditions. We really do not need bullying. We should not

allow the bully to undermine our confidence in our own abilities.

The bully frequently feels insecure and actually feels threatened by the person being bullied. Realize you are not the source of the problem. Bullying is a control issue; not a performance one. Easy to say, but harder to deal with when the bully rallies others against you. The best defense is to learn effective direct communication skills. Assertiveness training can certainly help the situation. Bullying is not harassment. The state of Washington has laws against harassment (RCW49.60), but not against bullying. The work environment also needs to support you in making bullying off limits. The next article deals with ways the employer can approach bullying in the workplace.

	<h2 style="color: red; text-align: center;">Expect as much from us as we will from you.</h2>	
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<p style="color: red; text-align: center;">FAMILY PRACTICE</p> <p style="color: red; text-align: center;">ADULT-GERONTOLOGICAL</p> <p style="color: red; text-align: center;">MIDWIFERY</p> <p style="color: red; text-align: center;">PSYCHIATRIC-MENTAL HEALTH</p> <p style="color: red; text-align: center;"><i>Jesuit learning for social justice.</i></p>	 <p>Health care is more challenging than ever, so good leaders are needed to shape what the future holds. We know you expect a lot from us. That's why Seattle University graduate nursing will empower you, challenge you, and prepare you for what it takes.</p> <p>Be ready. Contact us today at nurse@seattleu.edu or (206) 296-5660.</p> <p> 901 12th Ave. Seattle, WA 98122 seattleu.edu/nursing</p>	

Bullying in the Workplace:

THE EMPLOYER

Victims of bullying may experience significant physical and mental health problems. These manifest as phobias, sleep disturbances, digestive problems, depression or self-blame and absence from work. Any or all of these affect performance. The bully undermines patient safety. Absenteeism increases. Transfer requests abound. Work life becomes more stressful. Morale drops. Nurses resign. Teamwork suffers. Once trust breaks down in a team, nurses may fail to contribute their best work or not offer ideas for improvement of work processes. This situation also leads to less reporting of failures or mistakes and less honesty about situations of questionable performance.

Employer costs increase as productivity dips, desire to meet organizational goals dwindles, and staff creativity is stifled. Healthcare organizations can support individuals who are bullied by recognizing that bullying does exist. Addressing bullying requires having a policy with consequences for bullying. Employee education on bullying, employee assistance programs, group classes on professional behavior, and communication and consistent enforcement of policies can reduce bullying in the workplace. I needed to confront my bully. I did so through my supervisor who got us together to talk about behaviors and perceptions.

Bullies lack insight about their behaviors. It is much easier to confront the behavior when it happens again if those blind

spots are on the table. Knowing that your supervisor supports you and will help or refer you to employee assistance takes some of the bite out of the bullying behavior. However, be aware that overt bullying may become covert bullying, which is often the phase after the bullying is acknowledged by management. A support system and communicating in a professional manner makes a big difference in both your environmental culture and day-to-day work.

Employer costs increase as productivity dips, desire to meet organizational goals dwindles, and staff creativity is stifled.

Healthcare organizations can support individuals who are bullied by recognizing that bullying does exist.

Example of an Australian workplace anti-bully policy:

Company name considers workplace bullying unacceptable and will not tolerate it under any circumstances. Workplace bullying includes behavior that harms, intimidates, offends, degrades, or humiliates an employee, possibly in front of other employees, clients, or customers. Workplace bullying may cause the loss of trained and talented employees, reduce productivity and morale, and create legal risks.

Company name believes all employees should be able to work in an environment free of bullying. Managers and supervisors must ensure employees are not bullied.

Company name Unit has grievance and investigation procedures to deal with workplace bullying. Managers and supervisors must ensure employees are not bullied.

Company name Unit encourages all employees to report workplace bullying. Any reports of workplace bullying will be treated seriously and investigated promptly, confidentially, and impartially.

Company name encourages all employees to report workplace bullying. Managers and supervisors must ensure employees who make complaints or witnesses are not victimized. Disciplinary action will be taken against anyone who bullies a co-employee.

IDEAS OR SUGGESTIONS WELCOME!

Do you have any ideas or suggestions for the next Washington Nursing Commission newsletter? Would you like more information on a specific nursing regulation or law? Is there something you think we should address or include in future issues? Please submit suggestions to: Mindy.Schaffner@doh.wa.gov

NURSES AS SECOND VICTIMS: Supporting Our Colleagues Following an Adverse Event

John Nance's award-winning book, *Why Hospitals Should Fly: The Ultimate Flight Plan to Patient Safety and Quality Care*, describes health care as a complex system with potential for catastrophic consequences. Health care is a human enterprise—and as a result, it is imperfect. Any process involving humans will be prone to errors. We should recognize that it is not a matter of *if*, but *when*, because humans will always make mistakes regardless of our training. In fact, most preventable harm done to patients is caused by unintended human error and systems failures.

According to Donald Berwick, MD, outgoing administrator of Center for Medicare and Medicaid Services (CMS) and former president and Chief Executive Officer (CEO) of the Institute for Healthcare Improvement, few health care organizations use a systematic way of taking care of their clinicians who find themselves involved in adverse events that harm patients. Instinctively as clinicians our hearts naturally go out to the injured patient and family when something bad happens. They are the first and most important victim. However, clinicians are hurt too. Moreover, if we are really healers, then we collectively have a job of healing them too.

Nurses and other health care providers dealing with the emotional aftermath of a medical error have been described in literature as the “second victims.” Researcher Susan Scott, RN, MSN, at University of Missouri Health Care, developed this commonly used definition:

A second victim is a health care provider involved in an unanticipated adverse patient event, medical error and/or a

patient-related injury who becomes victimized in the sense that the provider is traumatized by the event. Frequently, second victims feel personally responsible for the unexpected patient outcomes and feel as though they have failed their patients, second-guessing their clinical skills and knowledge base.

When an error occurs, nurses report that they isolate themselves and withdraw in shame. Some will scrupulously review the moments of the event countless times, thinking “If only I would’ve...” They will condemn themselves as being not good enough, and second-guess other clinical decisions. They will struggle to concentrate and suffer a host of physical problems. Unfortunately, the risk of making a subsequent error also grows when a health care provider experiences the stress and symptoms of a second victim. Therefore, offering a warm hand of support to an affected nurse is not just the ethical thing to do, it is the safest thing to do.

In 2007, a University of Missouri Health Care system survey reported that one in seven caregivers (14 percent) had experienced a patient safety event within the past year that had caused personal problems such as anxiety, depression, or concerns about the ability to perform one's job. By 2010, a follow-up survey showed the number had climbed to one of every three caregivers (30 percent).

Nurses are part of this vulnerable group. A study of nurses, physicians, and pharmacists found that nurses were the group most likely to report negative emotions and fear of disciplinary action or punishment.

Common second victim symptoms include:

Physical symptoms

- sleep disturbances
- difficulty concentrating
- eating disturbance
- headache
- fatigue
- diarrhea
- nausea or vomiting
- rapid heart rate
- rapid breathing
- muscle tension

Psychological symptoms

- isolation
- frustration
- fear
- grief and remorse
- uncomfortable returning to work
- anger and irritability
- depression
- extreme sadness
- self-doubt
- flashbacks

Source: University of Missouri Health Care

Promoting a culture of caregiver support

Today too few nurses are supported adequately by their organizations following an adverse event. However, several promising support models are being developed and implemented by Scott and by others. These programs raise awareness through all-staff education, and provide support from peers and specially trained rapid-response team members.

Nurses and other health care providers dealing with the emotional aftermath of a medical error have been described in literature as the “second victims.”

One example is a program at University of Missouri Health Care, forYOU, which provides 24/7 free, confidential support to clinicians reacting to a stressful event or outcome. Trained peers from a range of disciplines support caregivers one-on-one, so the caregiver can explore normal reactions and feelings after adverse events. Additionally, forYOU educates co-workers and their families about the second victim phenomenon and prepares managers with tools to support second victims.

As nurses, you can begin to promote this culture shift by advocating for implementation of robust provider support programs in your organization. An excellent resource to help an organization get started is Medically Induced Trauma Support Services (MITSS), a nonprofit organization that helps support healing of patients, families, and clinicians affected by a medical trauma. Its Web site, at www.mitss.org, offers downloadable clinician-support toolkits and resources for organizations and individuals. Please feel free to contact the authors directly for additional resources, literature, and support.

As John Nance wrote, human mistakes are inevitable. Nevertheless, when they occur, we as healers can help alleviate our co-workers’ suffering, perhaps as well as our own.

Ron Hofeldt, MD, is Director of Physician Affairs at Physicians Insurance. Patricia I. McCotter, RN, JD, CPHRM, CPC, is the Director of Facility Risk Management and Provider Support at Physicians Insurance. She can be reached at patmc@phyins.com or (206) 343-6511. More information may be found at www.muhealth.org/secondvictim

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EASTERN STATE HOSPITAL ARNP

Eastern State Hospital, the 287 bed state psychiatric hospital in eastern WA, is recruiting for an advanced practice RN (ARNP) to provide medical care on the Adult Psychiatric, Forensic or Geropsychiatric Unit with a caseload of 30 patients. The ARNP would be part of the treatment team, which is comprised of the attending psychiatrist, medical provider, social worker, RN, and recreation therapist. The ARNP will treat common medical conditions and refer the patient for consultation to providers in the community for care that cannot be provided at ESH. ESH is twenty minutes southwest of Spokane. The ARNP is a member of the ESH Medical Staff comprised of 30 psychiatrists, physicians, ARNPs, and physician assistants. ARNPs are credentialed and privileged.

Contact Shirley Maike, **509.565.4352**
email: shirley.maike@dshs.wa.gov
Eastern State Hospital
PO Box 800
Medical Lake, WA 99022-0800.

RECOGNIZING AND HELPING THE NURSE “SECOND VICTIM”

Common Second Victim Physical Symptoms

- Uncontrolled crying/shaking
- Increased blood pressure
- Extreme fatigue/exhaustion
- Abdominal discomfort
- Sleep Disturbances
- Nausea, vomiting, diarrhea
- Muscle tension
- Headaches

Key Phrases that Indicate Coping Difficulty

- “...sickening realization of what has happened.”
- “This will alter the way I work from now on.”
- “I don’t deserve to be a nurse.”
- “This has been a career-changing event for me.”
- “This event shook me to the core. I’ll never be the same.”
- “This is a turning point in my career.”
- Other phrases post critical events.

Key Actions for Supporting Individual Peer/colleagues

- “Be there” – Practice active listening skills and allow the second victim to share his or her story. Offer support as you deem appropriate.
- If you have experience with an adverse event or bad patient outcome yourself, share it. “War stories” are powerful healing words.
- If you don’t have experience with an adverse event or bad patient outcome, be supportive and predict the victim’s needs.
- Avoid condemnation without knowing the story – it could have been you!
- Let your peer know that you still have faith in his or her abilities, and that he or she is a trusted member of your unit.
- Determine a way that you can make an individual difference.

Common Second Victim Psychosocial Symptoms

- Extreme guilt, grief
- Repetitive, intrusive memories
- Difficulty concentrating
- Loss of confidence, self doubt
- Return to work anxiety
- Frustration, anger, depression
- Second-guessing career



- Fear of damage to professional life
- Excessive excitability
- Avoidance of patient care areas

Key Words to Stimulate Conversation with Second Victims

- “Are you OK?”
- “I’ll help you work through this.”
- “You are a good nurse working in a very complex environment.”
- “I believe in you.”
- “I’m glad that we work together.”
- “Please call me if you would like to talk about it again.”
- “I can’t imagine what that must have been like for you. Can we talk about it?”
- “I’m here if you want to talk.”

Key Actions for Department Leaders

- Talk with the employee as soon as you become aware of the incident.
- Reaffirm your confidence in him or her as a staff member.
- Consider calling in flex staff to allow time to compose thoughts, prepare if an investigation is anticipated.
- Keep the second victim informed of likely next steps in the even of an investigation.
- Check on second victim regularly.
- Be visible to all staff; physical presence during post-even helps decrease anxiety and shows accessibility.

Permission for use of this document provided by Susan Scott, Patient Safety Coordinator, University of Missouri Health Care

Staging	Stage Characteristics	Common Questions	Proposed Institutional Actions
Stage 1 Chaos & Accident Response	Error realized/ event recognized. Tell someone ⇒ get help Stabilize/treat patient May not be able to continue care of patient Distracted Experience a wave of emotions	How did that happen? Why did that happen?	Identify second victims Assess staff member(s) ability to continue shift Activate” ForYOU Team” support as needed
Stage 2 Intrusive Reflections	Re-evaluate scenario Self isolate Haunted re-enactments of event Feelings of internal inadequacy	What did I miss? Could this have been prevented?	Ensure “ForYOU Team” Response Observe for presence of lingering physical and/or psychosocial symptoms
Stage 3 Restoring Personal Integrity	Acceptance among work/social structure Managing gossip/grapevine Fear is prevalent	What will others think? Will I ever be trusted again? How much trouble am I in? How come I can’t concentrate?	Provide management oversight of event. Ensure incident report completion. Manage unit/team’s overall response-“rumor control” esp. Evaluate if event debrief is indicated
(Stages 1-3 may occur individually or simultaneously)			
Stage 4 Enduring the Inquisition	Realization of level of seriousness Reiterate case scenario Respond to multiple “why’s” about the event Interact with many different ‘event’ responders Understanding event disclosure to patient/family Litigation concerns emerge	How do I document? What happens next? Who can I talk to? Will I lose my job/license? How much trouble am I in?	Identify key individuals involved in event Interview key individuals Develop understanding of what happened Begin answering ‘why’ did it happen
Stage 5 Obtaining Emotional First Aid	Seek personal/professional support Getting/receiving help/support	Why did I respond in this manner? What is wrong with me? Do I need help? Where can I turn for help?	Ensure emotional response plan in progress if needed. Ensure Patient Safety/Risk Management representatives are known to staff and available as needed.
Stage 6 Moving On (One of Three Trajectories Chosen)	Dropping Out Transfer to a different unit or facility Consider quitting Feelings of inadequacy	Is this the profession I should be in? Can I handle this kind of work?	Provide ongoing support of the second victim. Support second victim in search for alternative employment options within institution.
	Surviving Coping, but still have intrusive thoughts Persistent sadness, trying to learn from event	How could I have prevented this from happening? Why do I still feel so badly/guilty?	Provide ongoing support Maintain open dialogue
	Thriving Maintain life/work balance Gain insight/perspective Does not base practice/work on one event Advocates for patient safety initiatives	What can I do to improve our patient safety? What can I learn from this?	Provide ongoing support Support second victim in ‘making a difference’ for future. Encourage participation in case reviews involving event Encourage staff feedback on practice modifications.

Throughout all stages individuals may experience physical and/or psychosocial symptoms. Triggering of symptoms and repetitive thoughts regarding the event can occur anytime during stages 2-6.

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Licensure Actions

“Many nurses are not aware that it is the NCQC’s job to protect the public, not to provide support to the respondent (one against whom a complaint has been filed).” The Nursing Commission’s orders emphasize return to safe nursing practice. The following is a list of licensure actions taken between January 1, 2011, and December 31, 2011.

LICENSEE	DATE OF ACTION	ACTION	VIOLATION
Bigley, Karla A., RN	01/05/11	Suspension	Failure to comply with previous order
Taylor, Christian F., LPN	01/07/11	Suspension	Failure to comply with previous order
Taylor, Christian F., RN	01/07/11	Suspension	Failure to comply with previous order
Stanley, Sharon J., RN	01/07/11	Suspension	Failure to comply with previous order
McClain, Angela L., RN	01/14/11	Suspension	Sexual misconduct
Kearns, Sylvia L., RN	01/18/11	Probation	Alcohol and other substance abuse; Violation of federal or state statutes, regulations or rules
Patton, Craig R., RN	01/31/11	Suspension	Alcohol and other substance abuse; Violation of federal or state statutes, regulations or rules
Guse, Debi D., LPN	02/01/11	Probation	Violation of federal or state statutes, regulations or rules
Ratcliff, Bob L., RN	02/01/11	Monitor	License disciplinary action by a federal, state, or local licensing authority
Barrett, Rosemary, LPN	02/01/11	Suspension	Alcohol and other substance abuse; Criminal conviction; Violation of federal or state statutes, regulations or rules
Reed, Gayle A., RN	02/01/11	Voluntary Surrender	Misrepresentation of credentials
Conahan, Megan A, RN	02/01/11	Suspension	License disciplinary action by a federal, state, or local licensing authority; Violation of or failure to comply with licensing board order
Kelly, David W., LPN	02/02/11	Suspension	Incompetence; Practicing beyond the scope of practice; Violation of federal or state statutes, regulations or rules
McClain, Deborah S., RN	02/02/11	Suspension	Incompetence; Violation of federal or state statutes, regulations or rules
Chandler, Tracy L., RN	02/03/11	Suspension	License revocation by a federal, state, or local licensing authority
Whittaker, Elizabeth A., RN	02/10/11	Monitor	Violation of or failure to comply with licensing board order
Howell, Penni H., RN	02/14/11	Suspension	Failure to comply with previous order
Eisenbeis, Debi R., LPN	02/15/11	Suspension	Failure to comply with previous order
Miller, Michael E., LPN	02/15/11	Suspension	Failure to comply with previous order
Barr, Margaret M., RN	02/17/11	Suspension	Violation of or failure to comply with licensing board order
Brown, Kelly L., RN	02/28/11	Suspension	Criminal conviction; License disciplinary action by a federal, state, or local licensing authority
Scheerens, Thomas P., RN	03/01/11	Monitor	Violation of or failure to comply with licensing board order
Werner, Donna E., RN	03/07/11	Suspension	Failure to comply with previous order
Muhammad, Yahya A.	03/07/11	LPN Licensure Denied	Failure to meet initial requirements of a license; License disciplinary action by a federal, state, or local licensing authority
Soliven, Rosalina C.	03/07/11	LPN Licensure Denied	Failure to meet initial requirements of a license
Bain, Sarah M., RN	03/08/11	Suspension	Violation of or failure to comply with licensing board order
Drury, Sasha, RN	03/08/11	Suspension	License disciplinary action by a federal, state, or local licensing authority
Robertson, Sean T., RN	03/09/11	Suspension	Alcohol and other substance abuse; Violation of federal or state statutes, regulations or rules
Christie, Sandra L., RN	03/10/11	Suspension	Alcohol and other substance abuse
Bethea, Vivian D., LPN	03/16/11	Suspension	Incompetence; Violation of federal or state statutes, regulations or rules
Marshall, Karen A., RN	03/21/11	Suspension	Violation of or failure to comply with licensing board order
Harding, Ann M., RN	03/22/11	Suspension	License disciplinary action by a federal, state, or local licensing authority
Scharf, Jessica A., RN	03/29/11	Suspension	License disciplinary action by a federal, state, or local licensing authority
Schiller, Sharon K., RN	04/04/11	Suspension	License disciplinary action by a federal, state, or local licensing authority
Leonce, Alain S.	04/06/11	LPN Licensure Denied	Failure to meet initial requirements of a license
Bodamer, Michael J., RN	04/06/11	Probation	License disciplinary action by a federal, state, or local licensing authority
Linville, Patrick I., RN	04/08/11	Suspension	Diversion of controlled substance
Edge, Brenda J., RN	04/13/11	Suspension	License disciplinary action by a federal, state, or local licensing authority
Taffer, Rhonda L., RN	04/13/11	Suspension	License disciplinary action by a federal, state, or local licensing authority
Hendershot, Joshua L., LPN	04/13/11	Licensure Denied	License disciplinary action by a federal, state, or local licensing authority; Misrepresentation of credentials
Kaluzny, Micah W., RN	04/14/11	Suspension	Alcohol and other substance abuse; Failure to cooperate with the disciplining authority; Violation of federal or state statutes, regulations or rules
Dyer, Gretchen G., LPN	04/15/11	Suspension	Failure to comply with previous order
Yost, Michelle A., LPN	04/18/11	Suspension	Failure to comply with previous order
Fuentes, Juan de Dios, RN	04/25/11	Suspension	Sexual misconduct
Westcott, Crystal A., RN	04/26/11	Suspension	License disciplinary action by a federal, state, or local licensing authority
Buechler, Hillary A., RN	04/26/11	Probation	Alcohol and other substance abuse; Failure to meet initial requirements of a license; License disciplinary action by a federal, state, or local licensing authority; Practicing beyond the scope of practice
Omohundro, Janice M., RN	04/27/11	Suspension	Violation of or failure to comply with licensing board order
Nolasco, Elsa J. P., RN	05/06/11	Probation	License disciplinary action by a federal, state, or local licensing authority
Snider, Amie M., RN	05/06/11	Monitor	Alcohol and other substance abuse; Criminal conviction; License disciplinary action by a federal, state, or local licensing authority
Boardman, Barbara A., ARNP	05/06/11	Suspension	Alcohol and other substance abuse; Violation of federal or state statutes, regulations or rules
Boardman, Barbara A., RN	05/06/11	Suspension	Alcohol and other substance abuse; Violation of federal or state statutes, regulations or rules

LICENSEE	DATE OF ACTION	ACTION	VIOLATION
Spradling, Cindy D., RN	05/06/11	Suspension	Alcohol and other substance abuse; Violation of federal or state statutes, regulations or rules
Chesky, Jennifer M., RN	05/06/11	Suspension	Alcohol and other substance abuse; License disciplinary action by a federal, state, or local licensing authority
Long-Anderson, Ember R., LPN	05/06/11	Suspension	Criminal conviction
Zoleta, Carlito A., LPN	05/13/11	Suspension	Failure to cooperate with the disciplining authority
Dunthorn, Dottie L., LPN	05/18/11	Suspension	Failure to comply with previous order
Evans, Kathleen J., LPN	05/20/11	Suspension	Violation of or failure to comply with licensing board order
Vasquez, Rose M., ARNP	05/27/11	Suspension	Violation of or failure to comply with licensing board order
Vasquez, Rose M., RN	05/27/11	Suspension	Violation of or failure to comply with licensing board order
Olsen, Andrea M., RN	05/27/11	Suspension	Failure to cooperate with the disciplining authority
Palmer, Susanna T., RN	05/27/11	Suspension	Alcohol and other substance abuse; Diversion of controlled substances, Violation of federal or state statutes, regulations or rules
Albert, Allan J., LPN	05/31/11	Monitor	Alcohol and other substance abuse; Criminal conviction
King, Sara B., LPN	05/31/11	Monitor	Narcotics violation; Violation of federal or state statutes, regulations or rules
Stokke, Michele M., RN	05/31/11	Suspension	Narcotics violation; Violation of federal or state statutes, regulations or rules
Ryle, Tracie L., RN	05/31/11	Suspension	Incompetence; License suspension by a federal, state, or local licensing authority; Narcotics violation; Violation of federal or state statutes, regulations or rules
Jones, Jessica S., RN	05/31/11	Suspension	Violation of or failure to comply with licensing board order
Anderson, Sharon G., RN	05/31/11	Suspension	Incompetence; Narcotics violation; Violation of federal or state statutes, regulations or rules
Carroll, Michele, LPN	06/02/11	Suspension	Alcohol and other substance abuse; Failure to cooperate with the disciplining authority
Blansett, Monica D., LPN	06/06/11	Suspension	Failure to comply with previous order
Weiss, Beth M., RN	06/10/11	Probation	License disciplinary action by a federal, state, or local licensing authority
Jones, Belinda F., RN	06/15/11	Suspension	License disciplinary action by a federal, state, or local licensing authority
Givens, John J., RN	06/15/11	Suspension	Violation of or failure to comply with licensing board order
Barr, Larry D., LPN	06/23/11	Suspension	License disciplinary action by a federal, state, or local licensing authority; Narcotics violation; Unable to practice safely by reason of alcohol or other substance abuse
Bourbonnais, Travis A., LPN	06/23/11	Suspension	License disciplinary action by a federal, state, or local licensing authority
Stone, Betty M.	06/23/11	RN Licensure Denied	Immediate threat to health or safety; License disciplinary action by a federal, state, or local licensing authority
Hunter, Carmen L., RN	06/24/11	Suspension	Failure to comply with previous order
Huebner, Russell J., RN	07/12/11	Probation	License disciplinary action by a federal, state, or local licensing authority
Fischer, Andreas, RN	07/12/11	Probation	License disciplinary action by a federal, state, or local licensing authority
Paine, Jacqueline K, RN	07/13/11	Suspension	Criminal conviction
Gannaway, Kimberly R., RN	07/13/11	Suspension	Violation of or failure to comply with licensing board order
Daddio, Susan J., LPN	07/15/11	Suspension	License disciplinary action by a federal, state, or local licensing authority
Green, Jennifer A., RN	07/19/11	Probation	Criminal conviction; Diversion of controlled substance; Narcotics violation or other violation of drug statutes; Unable to practice safely by reason of alcohol or other substance abuse; Violation of federal or state statutes, regulations or rules
Dowty, Ruth D., RN	07/25/11	Suspension	Alcohol and other substance abuse; Failure to cooperate with the disciplining authority
Raymond, Carlyle, RN	07/25/11	Suspension	Violation of or failure to comply with licensing board order
Magwood, Bridget T., RN	07/29/11	Suspension	Failure to comply with previous order
Erickson, Eric T., RN	08/05/11	Suspension	Alcohol and other substance abuse
Jordan, Amber R., RN	08/10/11	Suspension	License suspension by a federal, state, or local licensing authority
Walgamott, Anne M., RN	08/11/11	Suspension	Violation of or failure to comply with licensing board order
Louissaint, Margaret	08/11/11	LPN Licensure Denied	Failure to meet initial requirements of a license
Thomas, Aleyamma, RN	08/11/11	Suspension	License disciplinary action by a federal, state, or local licensing authority
Martin, Colleen R., RN	08/12/11	Probation	Negligence; Violation of federal or state statutes, regulations or rules
Nekola, Kelly., RN	08/18/11	Suspension	Violation of or failure to comply with licensing board order
Reyes, Cielito A.	08/19/11	LPN Licensure Denied	Failure to meet initial requirements of a license
Baird, Jennifer L., RN	08/22/11	Suspension	Violation of or failure to comply with licensing board order
Smith, Anna C., RN	08/22/11	Suspension	License disciplinary action by a federal, state, or local licensing authority; Violation of or failure to comply with licensing board order
Winiewicz, Wendy L., RN	08/26/11	Probation	Error in prescribing, dispensing or administering medication; Incompetence; Violation of federal or state statutes, regulations or rules
Milstead, Julie A., LPN	08/26/11	Suspension	Sexual misconduct; Violation of federal or state statutes, regulations or rules
Brown, Dawn M., RN	08/26/11	Suspension	Alcohol and other substance abuse
Olsen, Jacqueline K., RN	08/26/11	Suspension	Violation of or failure to comply with licensing board order
Blake, Nancy D., RN	08/26/11	Suspension	Diversion of controlled substance; Narcotics violation; Violation of federal or state statutes, regulations or rules
Harris, Marcy C., RN	08/30/11	Probation	Alcohol and other substance abuse; Violation of federal or state statutes, regulations or rules
Rydberg, Jay W., RN	08/30/11	Probation	Mental disorder
Kertland, Warren B., RN	09/02/11	Suspension	Alcohol and other substance abuse; Failure to cooperate with the disciplining authority; Narcotics violation or other violation of drug statutes
Fournier, Perri E., RN	09/14/11	Suspension	Violation of or failure to comply with licensing board order
Weber, Mary C., ARNP	09/15/11	Monitor	Alcohol and other substance abuse; Criminal conviction; License disciplinary action by a federal, state, or local licensing authority
Weber, Mary C., RN	09/15/11	Monitor	Alcohol and other substance abuse; Criminal conviction; License disciplinary action by a federal, state, or local licensing authority
Pudil, Tanya S., RN	09/22/11	Suspension	License disciplinary action by a federal, state, or local licensing authority
Calliccoat, Nicholas W., RN	09/23/11	Probation	Violation of federal or state statutes, regulations or rules
Smith, Angelica K, LPN	09/23/11	Suspension	Narcotics violation; Violation of federal or state statutes, regulations or rules

LICENSEE	DATE OF ACTION	ACTION	VIOLATION
Cusick, Tia, M., LPN	09/26/11	Suspension	Violation of or failure to comply with licensing board order
Sheldon, Melissa J., RN	09/28/11	Suspension	License disciplinary action by a federal, state, or local licensing authority
Anderson, Robin M., RN	09/30/11	Suspension	Failure to comply with previous order
Wrinkle, Amber M., LPN	10/03/11	Suspension	Violation of or failure to comply with licensing board order
Simmons, Jean A., RN	10/03/11	Suspension	License disciplinary action by a federal, state, or local licensing authority
McCaslin, Laura F., RN	10/04/11	Suspension	License disciplinary action by a federal, state, or local licensing authority
Chen, Fang	10/06/11	LPN Licensure Denied	Failure to meet initial requirements of a license
Pomerinke, Jerriann, RN	10/14/11	Suspension	Alcohol and other substance abuse; Criminal conviction; Narcotics violation
Radacina, Jenelia I., LPN	10/14/11	Suspension	Unable to practice safely by reason of psychological impairment or mental disorder
Wee, Li-Phing C.	10/14/11	RN Licensure Denied	Failure to meet initial requirements of a license
Ackerbauer, Kristen M., RN	10/20/11	Suspension	License disciplinary action by a federal, state, or local licensing authority
Yang, Liuqing	10/25/11	RN Licensure Denied	Failure to meet initial requirements of a license
Asrari, Deborah M., RN	10/27/11	Monitor	Alcohol and other substance abuse; Violation of federal or state statutes, regulations or rules
Breunig, Roxanne B., RN	10/27/11	Probation	Error in prescribing, dispensing, or administering medication
Weathers, Gina M., LPN	10/27/11	Suspension	Narcotics violation; Violation of or failure to comply with licensing board order
Swaffield, Gina R., RN	10/27/11	Suspension	License disciplinary action by a federal, state, or local licensing authority
Scheerens, Thomas P., RN	10/28/11	Suspension	Failure to comply with previous order
Ngurimu, Anthony K., LPN	10/31/11	Suspension	License disciplinary action by a federal, state, or local licensing authority
Holl, Melissa F., RN	11/01/11	Suspension	License disciplinary action by a federal, state, or local licensing authority
Patrick, Sherry A., RN	11/02/11	Suspension	Failure to cooperate with the disciplining authority; Unauthorized dispensing of medication; Violation of federal or state statutes, regulations or rules
Bliss, Julie A., RN	11/15/11	Monitor	Diversion of controlled substance; Narcotics violation; Violation of federal or state statutes, regulations or rules
Kemp, Kevan D., ARNP	11/15/11	Suspension	Violation of or failure to comply with licensing board order
Kemp, Kevan D., RN	11/15/11	Suspension	Violation of or failure to comply with licensing board order
Pithan, Gregory G., RN	11/15/11	Suspension	License disciplinary action by a federal, state, or local licensing authority
King, Sara B., LPN	11/16/11	Suspension	Failure to comply with previous order
Johnson, Ashley M., RN	11/16/11	Monitor	License disciplinary action by a federal, state, or local licensing authority
McSherry, Gordon E., RN	11/16/11	Suspension	Alcohol and other substance abuse; Incompetence; Violation of federal or state statutes, regulations or rules
Ratcliff, Bob L., RN	11/17/11	Suspension	Failure to comply with previous order
Anderson, Elizabeth M., RN	11/22/11	Suspension	Unable to practice safely by reason of psychological impairment or mental disorder
Petering, Laura A., RN	11/29/11	Suspension	License disciplinary action by a federal, state, or local licensing authority
Dhaliwal, Balwinder K.	11/29/11	LPN Licensure Denied	Failure to meet initial requirements of a license
Westby, Linda L., RN	11/30/11	Suspension	Failure to comply with previous order
Middleton, Judith K., LPN	11/30/11	Suspension	Failure to comply with previous order
Ayat, Janice C.	11/30/11	LPN Licensure Denied	Failure to meet initial requirements of a license
Haverty, Joseph D.	11/30/11	LPN Licensure Denied	Failure to meet initial requirements of a license
Freeman, Clarice C., LPN	12/21/11	Probation	Alcohol and other substance abuse; Criminal conviction
Gregory, Michael A., ARNP	12/22/11	Monitor	Patient abuse; Sexual misconduct; Violation of federal or state statutes, regulations or rules
Gregory, Michael A., RN	12/22/11	Monitor	Patient abuse; Sexual misconduct; Violation of federal or state statutes, regulations or rules
Thamert, Carol J., ARNP	12/22/11	Probation	Mental disorder
Thamert, Carol J., RN	12/22/11	Probation	Mental disorder
Gotelli, Christine A., RN	12/22/11	Probation	License revocation by a federal, state, or local licensing authority
Schreck, Carol A., RN	12/22/11	Probation	Incompetence; Violation of federal or state statutes, regulations or rules
Waters, David B., RN	12/22/11	Monitor	License disciplinary action by a federal, state, or local licensing authority
Bailey, Brandon L., RN	12/22/11	Monitor	Alcohol and other substance abuse; Criminal conviction; Violation of federal or state statutes, regulations or rules
Ketcham, Donna J., RN	12/22/11	Suspension	Narcotic violation; Violation of federal or state statutes, regulations or rules
Harris, Sharon K., RN	12/22/11	Suspension	Criminal conviction; License disciplinary action by a federal, state, or local licensing authority
Stewart, Kenya M., LPN	12/27/11	Suspension	Criminal conviction
Picou, Nancy L., LPN	12/29/11	Probation	Narcotics violation or other violation of drug statutes
Doering, Deborah L., RN	12/29/11	Suspension	License disciplinary action by a federal, state, or local licensing authority

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My Personal Experience with a Complaint Against My License

I cannot imagine what it would be like to commit a serious clinical error, but I know what it is like to have a complaint filed against my nursing license.

Several years ago at a professional organization retreat we discovered that over half of us in attendance had experienced complaints against our nursing licenses. Our group was made up of leaders, officers or former officers, and award winners. If half of this group had weathered a complaint, we speculated that a significant number of our general members had also suffered this humiliation. When one receives a complaint, the response is feeling alone, disgraced, and guilty, whether a violation has been committed or not.

As a pro tem member of the Nursing Care Quality Assurance Commission (NCQAC) my primary responsibility is for the disciplinary process. I review investigator reports and make recommendations to a review panel based upon the standards of practice. However, nothing in my work on the NCQAC prepared me for being the subject of a complaint.

Every nurse's nightmare is committing a serious error. Most of us go into nursing with the intent of providing comfort and

care, so when we cause pain or distress by accident, we suffer as well. The idea of second victim is somewhat new:

Second victims are health care providers who are involved in an unanticipated adverse patient event, in a medical error and/or a patient related injury and become victimized in the sense that the provider is traumatized by the event. Frequently, these individuals feel personally responsible for the patient outcome. Many feel as though they have failed the patient, second-guessing their clinical skills and knowledge base.¹

Whether a serious error has occurred or not, I would argue that any nurse who experiences a complaint feels failure and wonders what could have been done differently to satisfy the complainant.

My experience has led me to reflect on how and who should provide support to nurses. Agencies that employ nurses certainly play a big role in providing support. My agency provided an attorney to help me respond to the complaint, which provided me relief and guidance. Professional organizations are in an ideal position to reach out to members. Individuals must feel that they have the resources needed to ask for and receive support. If you know

you have somewhere to turn, you will come out of the shadows. To cut down on the secrecy and shame, I have personally resolved to tell my story whenever appropriate.

Many nurses are not aware that it is the NCQAC's job to protect the public, not to provide support to the respondent (one against whom a complaint has been filed). However, the NCQAC can provide links and connections so the respondent knows where to turn for help. The NCQAC can partner with agencies and professional associations to publicize supports and resources. I would even propose that the NCQAC create a "Bill of Rights for Respondents."

We might wish there was no need for the disciplinary process, but as long as it exists it should be understandable and transparent. There is no shortage of shame, guilt and humiliation when something goes wrong. All agencies and organizations must work together to avoid the proliferation of second victims.

Reference:

¹SD Scott, LE Hirschinger, KR Cox, M McCoig, J Brandt, and LW Hall. The natural history of recovery for the healthcare provider "second victim" after adverse patient events. Qual Saf Health Care 2009;18 p. 326

Nursing Care Quality Assurance Commission **MEETING DATES**

DATES

July 13, 2012

September 14, 2012

November 9, 2012

We invite you to attend! All business meetings and workshops are open to the public. We strongly encourage nurses and students to attend meetings to learn about issues addressed by the commission.

Two weeks prior to each meeting, we place an agenda and location sites on the Web site at <http://www.doh.wa.gov/hsqa/Professions/Nursing/minutes.htm>. Topics range from rules, advisory opinions and school approvals to subcommittee reports. Business meeting agendas include an opportunity for you to comment. Workshops include training opportunities for commission members. We hope to see you at a future meeting.

The Process of Investigation: FACT V. FICTION

So you come home from a long, demanding shift one day and there is a letter in your mailbox from the Department of Health, informing you that you are the subject of an investigation. Your heart sinks as you read the words; you slump in your favorite chair and think, “What’s next?”

RCW 18.130 defines the process and authority of the Nursing Care Quality Assurance Commission (NCQAC), and you can find the details of the 25 sections of conduct, acts, and conditions that constitute unprofessional conduct in RCW 18.130.180. This includes the requirement for a licensee to cooperate with the disciplining authority.

Investigators refer to the nurse under investigation as *the respondent*. The

assigned health care investigator (of which there are nine in the NCQAC unit, including the chief investigator) begins the investigation by gathering documents and records related to the allegation(s) the complainant made against the respondent. Depending on the allegation, the investigator may also contact witnesses, asking for written statements that address specific issues. The investigator does this by writing a letter of cooperation to the witnesses, asking very specific questions. Witnesses and facilities must submit the requested information within 14 days.

Depending on the nature of the investigation, investigators may wait to contact the respondent until after they have spoken

with witnesses and gathered documents, or may speak with the respondent early in the investigation. At some point, usually after a careful records review, the investigator will contact the respondent with a detailed letter of allegation and give the respondent an opportunity to address the allegations and tell their side of the story. This is most often done by mail and written response, but could also be an in-person interview. The respondent also has 14 days to return a statement.

Investigators encourage respondents to be thorough in their responses, as this is the respondent’s first opportunity to inform the commission about the situation.
continued on page 24

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tion. It is also appropriate to submit other documentation you have that supports your statement.

At any time during the course of the investigation, the respondent has the right to retain legal counsel at their expense. The investigation is confidential and the law prohibits investigators from discussing the facts of the case with anyone not directly involved. Attorneys representing respon-

dents must submit a letter of representation to the investigator as soon as possible so investigators may speak with the attorney about the case.

Finally, the investigator's role is to gather all the appropriate evidence and statements in an investigative file and describe the evidence in a report. The investigator is not a decision maker and cannot draw conclusions or make recommendations about

the case. The investigator is always willing to answer questions about the process to concerned respondents, but cannot discuss the details of the investigation.

Once the case file leaves the investigations unit, a staff attorney and reviewing commission member review the file to determine next steps. Look for a sequel article about the rest of the process in a future newsletter issue.

BY TOM BOLENDER, LICENSING UNIT

Should I Place My License Into Inactive Status or Let It Expire?

Washington Nursing Care Quality Assurance Commission licensing staff members receive many calls every day with this question: So which is the best option? Should I place my license into Inactive status or let it expire? That is a question to ask yourself and be sure you understand the consequences of each choice.

Oftentimes a nurse feels she has worked hard to achieve her status as a nurse and has a hard time with the thought of letting it expire. Many nurses moving out of state believe they should never let their original license expire. Some are only planning to be gone a short time, while others are taking a break from the profession. The travel nurses who work in our state, but also may have an assignment out of state, frequently do not want to pay for a license they are not going to use. Each of these situations is understandable. So what do you do?

For the nurse who does not want to let her license go, this is a very hard question. If you place your license into inactive status you will be required to renew your license each year at a reduced rate. The RN inactive status renewal is \$65 compared to the regular license renewal amount of \$101. The LPN inactive status renewal fee is \$45 annually compared to the regular license renewal amount of \$96. Note: it is

So which is the best option? Should I place my license into Inactive status or let it expire? That is a question to ask yourself and be sure you understand the consequences of each choice.

not legal to work as a nurse in the state of Washington while in inactive status.

You have up to three years to renew your license by simply paying the full renewal fee. If your license is in inactive status, you must fill out a Reactivation application. If you wish to return to active practice from inactive status, you may do so for up to three years by simply paying the full renewal fee. You must also take a refresher course if your license is in inactive status for more than three years, or has expired for more than one year. You can reactivate your license in your original state of licensure at some point in the future. You must follow the reactivation requirements by the laws of that state. You are not required to retake the National Council Licensing Examination (NCLEX).

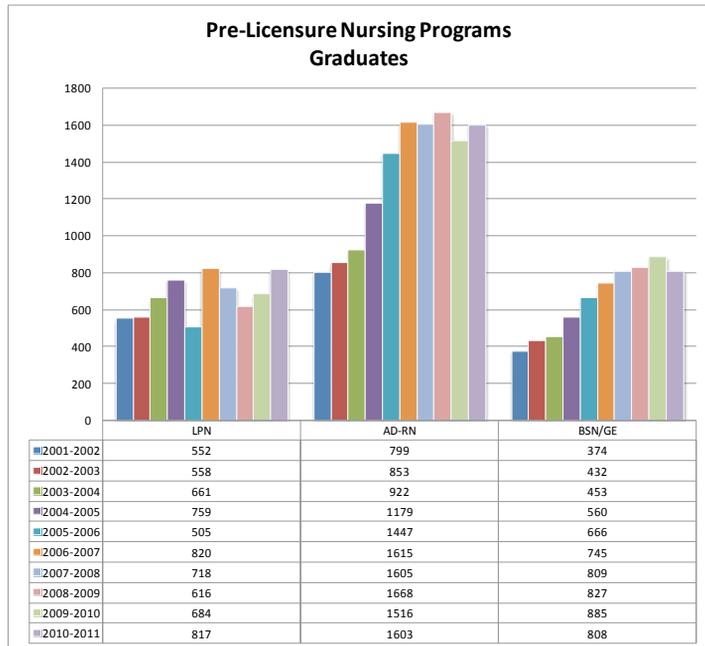
The nurse who takes a break from working in Washington for less than three years will find the inactive status a great option. The same is true for a travel nurse who wants to come back to Washington within three years. Remember: the nurse completes a Reactivation application when a license expires for more than one year, or is in inactive status for more than three years.

Starting in 2014, the requirements for reactivating a license from either the inactive or expired status will change. At that time, any nurse in inactive status for any period of time, or in expired license status for more than one year must complete a continuing competency agreement with the commission. This agreement requires the nurse to sign a contract agreeing to accumulate 177 practice hours and 15 hours of continuing education within the first year of renewal. If the nurse fails to accumulate the specified hours, a refresher course is then required. Once those requirements have been met, the nurse can resume the regular three year continuing competency cycle of 531 practice hours and 45 continuing education hours every three years.

In the end, the decision is yours. I hope the information you have received will help you make an informed decision. If not, please feel free to call Tom Bolender at 360-236-4700 for more information.

NURSING EDUCATION IN WASHINGTON STATE

Thirty-nine colleges and universities in the state of Washington offer nursing programs. Thirty of the nursing programs are nationally accredited; all are approved by the Nursing Care Quality Assurance Commission (NCQAC). Even with budget reduction, public and private academic institutions have maintained their commitment to nursing education. Over the last ten academic years, the number of practical nursing graduates has increased 48 percent. In the same ten academic years, associate degree registered nursing graduates increased 101 percent. Bachelor of Science and Graduate Entry registered nursing graduates increased 116 percent over these ten years. (See Figure 1).

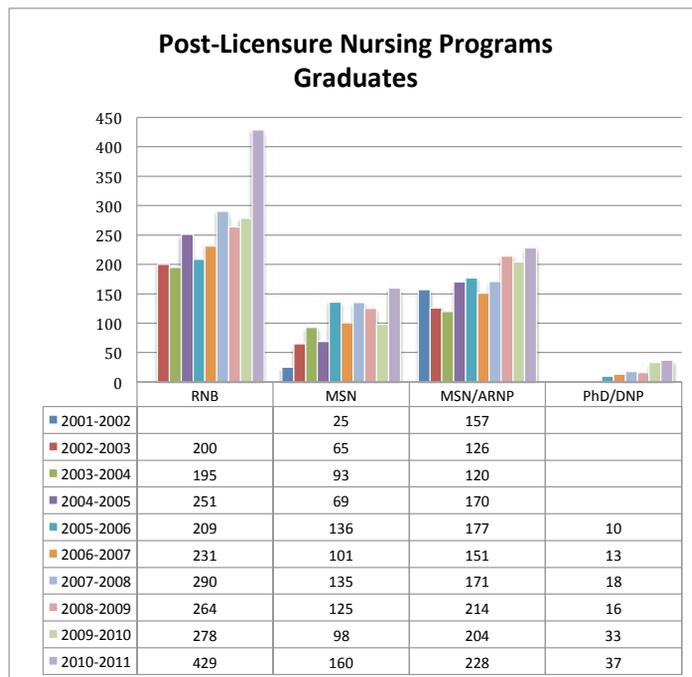


One indicator of nursing education quality is pass rates on the national licensing exam. Average pass rates for Washington's practical and registered nursing candidates consistently exceed the national average.

Demographics among pre-licensure programs show that practical nursing programs have more diversity. Less than half of practical nursing students identify as white/Caucasian. Approximately 70 percent of registered nurse students identify as white/Caucasian. Bachelor degree programs report an average student age of 25 years. Associate degree programs report an average student age of 32 years. All programs report 79-87 percent of the students are women.

The increasing complexity of health care demands continuing

education for care providers. The number of associate degree registered nurses completing a bachelors degree in nursing increased 115 percent over the last nine academic years. The number of Advanced Registered Nurse Practitioner (ARNP) graduates increased 41 percent over ten academic years. Non-ARNP master's degree in nursing graduates over the same ten years increased 540 percent. The number of doctoral degrees awarded over the last six academic years increased 270 percent. (See Figure 2)



Nursing programs do not have space for the number of qualified applicants requesting entry. For the last two academic years, programs report admitting 40-60 percent of qualified applicants. Two factors continue to limit the size of nursing programs. Programs have difficulty hiring nursing faculty, primarily because academic salaries are lower than health care facilities. Nursing faculty is leaving nursing education, either retiring or seeking higher salary elsewhere. The other limiting factor is availability of clinical learning sites for students. Over half of nursing programs report difficulty identifying adequate clinical sites.

NCQAC publishes an annual summary of data from Washington State nursing programs. These reports are available on our Web site: <http://www.doh.wa.gov/hsqa/Professions/Nursing/NursingPrograms.htm>

For more information regarding this article contact Mindy Schaffner at mindy.schaffner@doh.wa.gov.

Washington Health Professional Services

"I shall always be grateful that there was a program for me to be part of. Without this program I would have lost my nursing license, my livelihood and my future... I walk tall and hold my head high as a nurse and a woman in recovery." Quote from a WHPS program participant.

I am excited to write this article as the Washington Health Professional Services (WHPS) executive director. With more than 30 years of state service working in behavioral health, chemical dependency, and occupational health, WHPS provides the greatest opportunity for me to support public health and health care professions.

Nurses are valuable professionals, community members, and individuals. The WHPS program provides an avenue for nurses who misused substances to re-enter the work force as productive professionals. My goal is to apply my experience as a nurse and manager to continue the WHPS program's history of excellence while at the same time being responsive to the always changing health care landscape.

Washington Health Professional Services

WHPS is an abstinence-based monitoring program designed for nurses impacted by substance use disorders. The program focuses on early detection, referral to treatment, and recovery monitoring. The American Nurses Association estimates that six to eight percent of nurses use alcohol or drugs to the extent that is sufficient to impair professional performance.

The mission of WHPS is to ensure entry into recovery for the impaired practitioner while providing protection of the public's safety. It does this by:

- Protecting the public's health and safety from impaired practitioners;
- Retaining skilled, highly trained practitioners;
- Encouraging and promoting recovery; and
- Bringing the health care professional safely back to practice.

WHPS uses diagnosis, treatment, and compliance monitoring to ensure structure and accountability of nurses with substance use disorders. Once the nurse completes a chemical dependency evaluation, the case consultant team develops a customized monitoring plan to ensure the best opportunity to return safely to practice. In addition, we work closely with employers to support continued employment and ensure patient safety.

Program Participation

WHPS currently monitors more than 400 nurses. Nurses may enter the WHPS program several different ways:

- Voluntary: We encourage self-referral. It speeds treatment and recovery. Vol-

untary participation in the WHPS program is fully confidential.

- Alternative to Discipline: A licensing authority or the department may refer a health care professional to the WHPS Program as an alternative to license discipline.
- License Discipline: A licensing authority may refer a health care professional through an order for monitoring.

Confidentiality is a key component of the WHPS program. Confidentiality of WHPS participants and records is protected by state and federal law. It is much more likely that nurses will seek and engage in treatment when they feel secure.

Contact WHPS

We provide education and consultation services free of charge to employers, schools and universities, and professional associations. WHPS staff is available to assist in planning and consultation for interventions with nurses who may be diverting drugs from the workplace or coming to work impaired. You can find more information about WHPS at <http://www.doh.wa.gov/hsqa/professionals/WHPS/default.htm> or you may send questions to WHPS@doh.wa.gov

BY CHRIS BAUMBARTNER, DIRECTOR
WASHINGTON STATE PRESCRIPTION MONITORING PROGRAM

Washington's Prescription Monitoring Program

A new tool in patient care is now fully operational and available for prescribers, pharmacists, and other licensed health professionals to use. Prescription Review (the state Prescription Monitoring Program)

went live to providers on January 4, 2011.

The Washington State Department of Health is very pleased to bring this new resource online. It provides important information on controlled substances that

have been dispensed to patients. Data collection began in October 2011 and as of March 12, 2012 the system has more than 5.5 million records and more than 6,000 providers have registered for and received

access. Over 700 Advanced Registered Nurse Practitioners (ARNP) have already registered for and received access.

Of the 3,540,188 records collected in 2011 more than 900,000 of them were for Hydrocodone Acetaminophen. This one drug accounted for a quantity of more than 49 million pills.

Between October 1, 2011 and February 29, 2012 more than 477,000 individuals in Washington State received at least one prescription for a Schedule II drug. During that same time period more than 713,000 individuals received at least one prescription for a schedule III drug.

Practitioners may request prescription history reports for their patients from the program. The information is online 24 hours a day, seven days a week anywhere that a user has Internet access.

To register to access the information...

1. On or after December 12, 2011, visit the following site (<http://www.wapmp.org/practitioner/pharmacist/>) to register by following the steps in the *Training Guide for Practitioners and Pharmacists* posted there.
2. If you have a Washington State health care provider license, fill out the online form and submit it. If you are an out-of-state practitioner or are unable to successfully submit the form online, complete the form online, submit the information, print the form, have it notarized, and send it by mail to: Washington PMP | P.O. Box 47852 | Olympia, WA 98504-7852.
3. If we approve your account online, the system will send you an e-mail containing your logon information. If you mail a notarized form, we will send your logon information once we review and verify your information.

The department encourages providers to use this new system to provide improved patient care and help us prevent prescription drug misuse.

The program Web site (www.doh.wa.gov/hsqa/PMP/default.htm) provides more information and an option to receive updates through a listserv. You can also contact PMP Director Chris Baumgartner at 360-236-4806 (prescriptionmonitoring@doh.wa.gov).

It Can't Be That Easy, Can It?

What is the secret to a quick and painless licensing process in Washington State, you ask? Drum-roll please. The secret is reading the License Requirements in the Endorsement Application packet. Yup, it's really that easy. Endorsement Application instructions and requirements provide step-by-step guidelines to help nurses be proactive. I must say, about 60 percent of these questions I receive wouldn't be asked if the applicant read the instructions and requirements; which leads me to assume instructions/requirements are oftentimes skimmed through (or thrown out accidentally on purpose! Gasp!). This lack of attention to detail poses an even bigger problem when using recruiting agencies.

Many travel nurses hold multiple state licenses making use of recruiting agencies beneficial. However, nurses at times put 100 percent of the responsibility of licensing on recruiters, causing communication wires to criss-cross. Recruiting agencies and nurses should review license requirements together; keeping in mind that the Washington State Nursing Commission cannot provide information to third parties. Nurses are solely responsible for the progress of their applications.

All endorsement applicants must provide verification of their original license regardless of status. Certain states do not participate in the national licensing and discipline database called Nursys. In these situations, the nurse's original board of nursing must verify your nursing license in that state. Please contact your respective board of nursing for verification fees and processing timeframe.

This lack of attention to detail poses an even bigger problem when using recruiting agencies.

The fingerprint-based background check may complicate the endorsement process. Non-resident applicants must complete this requirement (no, it doesn't matter if a nurse has been fingerprinted by the other 49 States). The Nursing Care Quality Assurance Commission (NCQAC) mails a fingerprint packet to the nurse once an out-of-state application comes into our office. Upon review of a complete application, the Commission issues a temporary practice permit to the nurse who completes fingerprints. Temporary practice permits are active for six months only.

Let me do a quick summary of the highlights:

- Application:
 - Pay correct application fee
 - Answer all personal data questions
 - Send in original application, not a photocopy
- Verification:
 - Original State regardless of status
 - Nursys.com if your original state participates
 - Verification form if your state does not participate in Nursys.com
- Fingerprints:
 - Required for all non-residents
 - Temporary license issued if the previous two bullet points are met

Please read the application instructions and requirements. For more information on this topic contact amanda.whipple@doh.wa.gov

ADDRESSING DIVERSITY AND EDUCATION IN WASHINGTON STATE:

How WCN is Implementing the IOM Recommendations.

For the past eight years, the Washington Center for Nursing (WCN) has worked to facilitate streamlining of nursing education, enhance nursing workforce diversity, and promote nursing to K-12 students and second-career populations. We are changing the landscape of nursing to increase the number of nurses and to reach the Institute of Medicine (IOM) national goal of a nursing workforce with 80% baccalaureate degree or higher by 2020. We are also helping to implement transition-to-practice programs to provide full support of new graduates. These are steps for the health of Washington.

Increasing Diversity: Creating an Inclusive Nursing Environment

The National Research Council's report, *In the Nation's Compelling Interest: Ensuring Diversity in the Health-Care Workforce*, shows health care disparities are reduced when the health care workforce reflects the composition of the general population. WCN has reported on Washington's nursing workforce diversity and the nursing faculty. The data indicate we must bolster the diversity of our nursing workforce to ensure our increasingly diverse population receives the quality care it needs and wants.

Last April, WCN welcomed Christine Espina DNP, MSN, RN as our Diversity Network Director. Christine is helping create a virtual online mentoring program that supports minority/underrepresented students by pairing them with experienced nurses from like groups. The network will provide a safe space where experienced nurses can help nursing students and new graduates through their nursing programs and during their first jobs.



More Nurses Means More Education

Under health care reform by 2014, approximately 300,000 new individuals will be eligible for health care coverage in the state of Washington. With the expected retirement of many in our nursing workforce, we are looking at a drastic nursing shortage of registered nurses as soon as 2015. It is a lack of capacity for applicants rather than a lack of applicants that is our problem. In order to teach more nursing students, we need more nurse educators.

IOM Recommendations:

The Washington Nursing Action Coalition (WNAC) is charged with ensuring all IOM recommendations are implemented in our state. The four workgroups, education, practice, leadership and collaboration, are beginning their work. To join a group or follow a group, email info@wcnursing.org.

WCN has been educating current nurses and nursing students about the IOM recommendations and the impact of these recommendations. Ms. Tieman, Executive Director of WCN, recently spoke at the Nursing Students of Washington State

annual conference to clarify the need for action. Students asked me how the IOM recommendations are affecting the industry, their careers and educational choices, and what steps they might take.

The Promise of Nursing

If you attended the Johnson and Johnson Promise of Nursing for Washington gala in 2006 or 2009, to raise money to fund scholarships for nurses and nurse educators, mark your calendar for October 20, 2012 for gala number three! More information can be found at the WCN site. www.WACenterforNursing.org

WCN and Washington's Future

WCN recognizes that in order to create change, you have to start at the roots. One of our next projects focuses on introducing middle and high school students to nursing via new media. We are excited about reaching a younger generation through multimedia such as our blog. Watch for more information at <http://www.WACneterforNursing.org>. We love hearing from you! Feedback, ideas, questions? Please contact Maddiem@wcnursing.org. We look forward to working with you.

Washington State Advanced Registered Nurse Practitioner Survey Results

Background & Purpose:

The Nursing Care Quality Assurance Commission (NCQAC) recognizes three designations of Advanced Registered Nurse Practitioner (ARNP) in Washington State. WAC 246-840-302(1). These designations and numbers of licensees are:

- (1) Nurse practitioners (NP)-- 3,811;
- (2) Certified nurse midwives (CNM)--- 787; and
- (3) Certified registered nurse anesthetists (CRNA)-- 359.

These three groups comprise the 4,957 licensed ARNPs in Washington. (Licensing statistics DOH, 2011).

ARNP titles, scope of practice, degree of independent practice, and state boards of nursing rules differ from state to state. This variation often makes it difficult to move from state to state or for advanced practice nurses to practice to the full extent of their educational preparation.

The National Council of State Boards of Nursing (NCSBN) sought to address this issue by working with 48 professional nursing groups to develop the Advanced Practice Registered Nurse (APRN) Consensus Model. Published in 2008, the goal of the APRN Consensus Model is to lower barriers to practice across state lines by providing a model for consistent titles, education, scope of practice, and legislation. Many states are now using the model to guide education and legislation toward conformity with the model, promoting consistency among states. In furtherance of this goal, a survey was launched by NCQAC to determine how well Washington State ARNPs understand the model and its origins, and to what extent they support selected elements of the model.

Survey Method and Description

The survey was launched at the October 27 to 29 Pacific Northwest 34th Annual National Conference: Advanced Practice in Primary and Acute Care Conference (880 attended). NCQAC made the survey available on-line on its Web site from October through December 2011.

The survey included ten multiple-choice questions and one open-ended question.

form advanced practice title in all states; knowledge of the role and functions of our state nursing commission; and the prescriptive authority of advanced practice nurses under federal and state law. The last question was open-ended giving respondents the opportunity to identify what they considered the most pressing issues for advanced practice nurses in Washington.

Figure 1: Question: The APRN Consensus Model was:

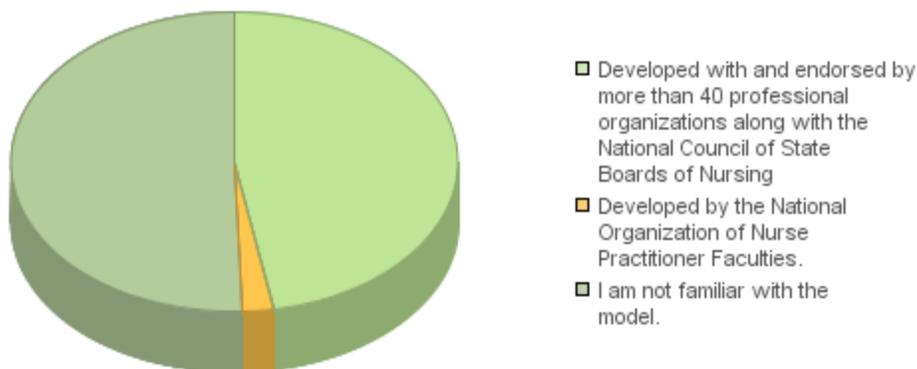
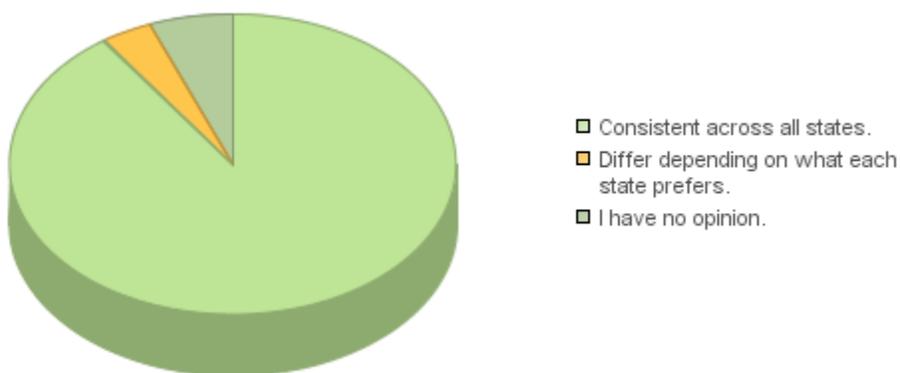


Figure 2: Question: In my opinion, the title for nurse practitioners should be:



The survey asked respondents how long they had been licensed in Washington State and then surveyed their awareness of the APRN Consensus Model. The survey also included questions on a uni-

Results of the Survey

A total of 579 nurse practitioners responded to the survey. Incomplete surveys were set aside. This left 360 surveys
continued on page 30

We look forward to collaborating with ARNPs, advanced nursing practice associations, and other stakeholders to work toward accomplishing the goals set forth in the APRN Consensus Model.

to use in the analysis. Statistics have been rounded to the nearest whole number. The results follow:

Respondents' Licensure History in Washington State:

- 11 percent had been licensed <1 year
- 25 percent had been licensed 1-5 years
- 17 percent had been licensed 6-10 years
- 47 percent had been licensed over 10 years.

The APRN Consensus Model (see Figure 1):

- 50 percent reported some knowledge of the APRN Consensus Model
- 50 percent reported they were not familiar with the model.

Preference Title Uniformity (see Figure 2)

- 91 percent reported preferring a uniform title throughout the United States
- 7 percent reported no opinion
- 4 percent opined the title should vary by state.

The questions asked:

Awareness of Role and Function of Washington State Nursing Commission

- 94 percent – To oversee licensure, discipline, scope of practice, and education regulations (Correct)
- 73 percent – To respond to inquiries that related to laws and rules governing ARNP practice in Washington State (Correct)
- 22 percent – To initiate all laws and rules that govern and regulate ARNP practice (Incorrect)

Knowledge of Number of States in which Advanced Practice Nurses Have Independent Prescriptive Authority

- 18 percent reported 1-10 states
- 29 percent reported 11-20 states (the correct answer)

28 percent reported 20-30 states

24 percent reported more than 31 states.

“The most pressing issues for ARNPs in Washington State are . . .”

223 of the 360 completing the surveys made comments.

The most frequent comments by number who commented on the item were:

- 48 – The need for equal pay for equal work.
- 40 – The importance of maintaining their scope of practice and independence.
- 38 – Education issues including: (a) access to further education; (b) clarity about the doctoral of nursing practice; (c) pain management information; (d) understanding regulations; and (e) continuing education reporting for renewal related to the new RN requirements.
- 20 – Barriers to practice: (a) restriction of full scope of practice in home health and nursing home practice settings due to federal regulations; (b) limitations in practice across state lines; and (c) limitations on scope of practice by agencies where they were employed.
- 16 – Better education of the public and other disciplines about their role.
- 15 – The need for a consistent title, several mentioned “not too many initials.”
- 13 – Better access to care for those who cannot afford it.
- 9 – The need for respect and recognition compared to other professions.
- 7 – ARNPs need to get together and communicate with one another.

Strengths and Limitations of the Survey:

- The strength of the study was that the online method brought a significant response. Advertising at the largest ARNP continu-

ing education conference of the year was helpful in launching the survey.

- The main limitation of the study was that it was designed to discard partially completed surveys. Although 579 started the survey, only 360 were available for analysis, thus 219 surveys could not be included in the analysis.

Implications of the Findings and Recommendations for Action:

The responses to the multiple-choice questions highlighted the need to disseminate more information about both NCSBN and NCQAC: Only 50% of those responding were familiar with the APRN Consensus Model. The preference for a uniform title for advanced practice nurses throughout the United States (91%) was strong. This finding may support efforts to seek title congruence with the APRN Consensus Model.

The open-ended questions shed light on key concerns of ARNPs in our state. While the percentage supporting title uniformity was high, this will require legislation. The degree of concern about protection of the current scope of practice and independence in Washington is also strong.

Other prominent concerns reported included: (a) equal pay for equal work; (b) education issues; (c) informing other professionals about the advanced practice role; and (d) barriers to practice imposed by federal legislation. The survey results can assist the NCSBN and NCQAC as they prioritize their goals and help devise successful strategies for working on issues of concern to advanced practice nurses.

In conclusion, the Web site was found to be effective in gathering data about ARNP viewpoints and can be a useful tool in further education and communication about issues both within the state and across state lines. NCQAC extends a special thanks to all the ARNPs who took the time to respond to the survey. We look forward to collaborating with ARNPs, advanced nursing practice associations, and other stakeholders to work toward accomplishing the goals set forth in the APRN Consensus Model.



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