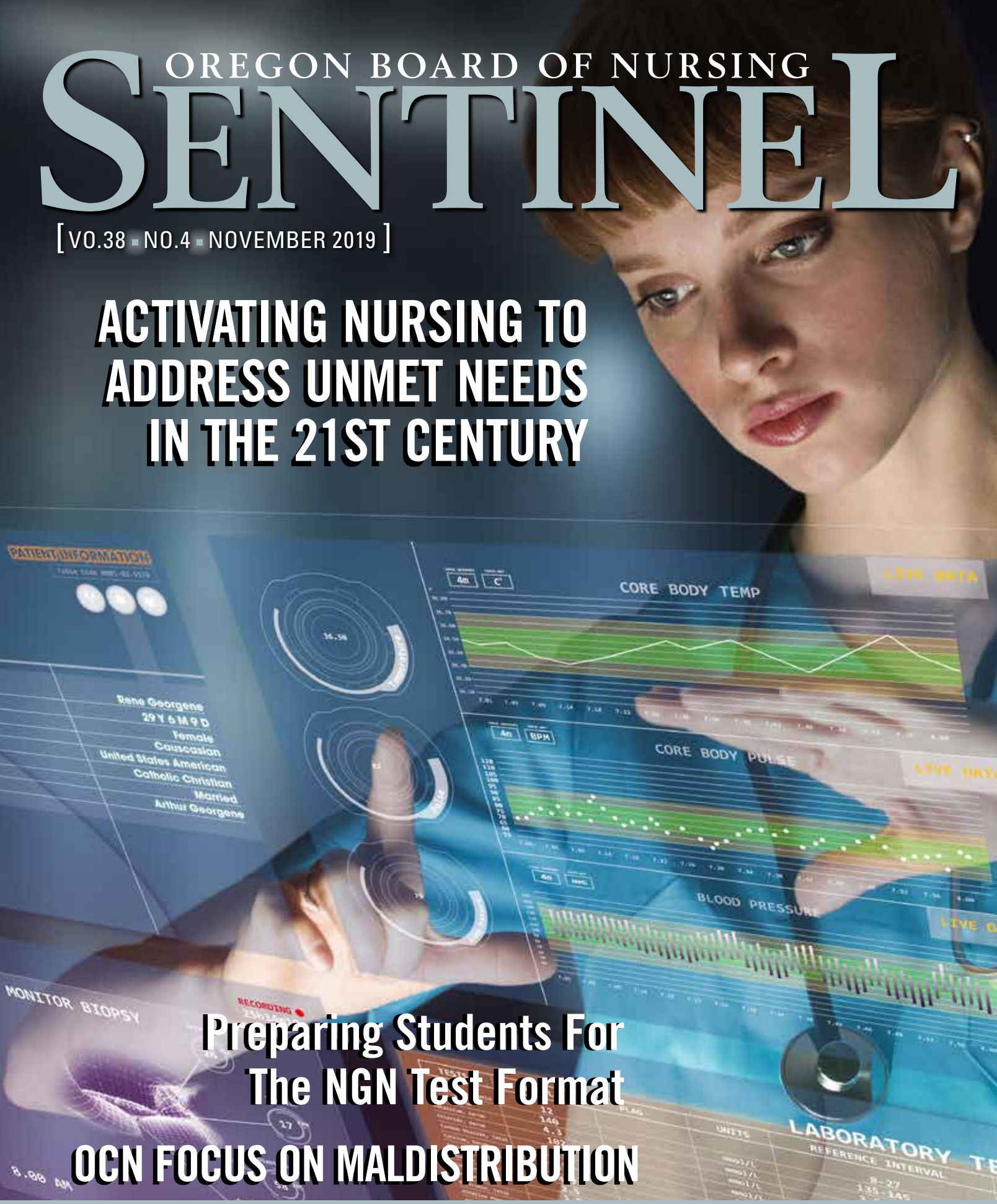
OREGON BOARD OF NURSING

SENTINEL

[VO.38 ▪ NO.4 ▪ NOVEMBER 2019]

ACTIVATING NURSING TO ADDRESS UNMET NEEDS IN THE 21ST CENTURY



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All Board Meetings, except Executive Sessions, are open to the public. All meetings are located at the OSBN Office 17938 SW Upper Boones Ferry Rd, Portland.

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

AN OVERVIEW OF THE ROBERT WOOD JOHNSON MARCH 2019 REPORT:

Activating Nursing To Address Unmet Needs In The 21st Century

This report was commissioned by the Robert Wood Johnson Foundation to serve as a background for the National Academy of Medicine committee on the Future of Nursing, 2020-2030. This article is intended as informational to the licensees and certificate holders of the Oregon State Board of Nursing (OSBN). This article does not imply any OSBN support or opposition of the contents of the report. It only examines the highlights of the report and should not be used to determine the context of the report in its entirety.

The report is divided into four parts:

Part 1: A History Of 21st Century Nursing

From its beginnings in the late 19th century, the practice of nursing has been grounded in the holistic approach recognizing the individual's experiences within their family, community relationships, and the environment where clients lived. Lillian Wald wrote in 1934 "the call to nursing is not only for the bedside care of the sick, but to help in seeking out the deep-lying basic causes of illness and misery." Nurses created their own care organizations and sent nurses into the community to care for the sick in their homes. Partnerships with community organizations that included donations of medicine, food, bedding, sources for loans and housing subsidies, community campaigns to clean roofs, disinfect houses and clean up trash. Nursing was the first profession who, even in its early years, understood the social determiners of health and acted. Immigrants and African American communities were particularly vulnerable and nurses trained individuals within the community to be nurses from the community and located within the community.

In 1909, Lillian Wald had convinced the Metropolitan Life Insurance Company that they should cover nursing services as a means of reducing death rates among its members. By 1911, these visiting nurse services were available to more than 90 percent of the 10.5 million policyholders in 2,000 cities across the country. These services were exclusively run by nursing.

In 1910, the publication of the Flexner report called for the professionalization of the practice of medicine. Using the theory that advancements can only be through the authority of knowledge into market power (increased compensation), physicians began to use their influence to obtain market control of health care and solidify their control of healthcare based primarily on the control of the market. By 1929, the medical profession, through the American Medical Association (AMA), mounted a campaign against the existing model of nursing run maternal-child care and were politically successful to divert all funds for these programs to the priorities of the AMA. Although medicine had until then restricted its activities to patients with diseases, physicians saw the growth of public clinics staffed by nurses and a few female doctors as a lost opportunity for expansion. Lillian Wald (1934) wrote, "the nurse question has become the women question."

The Hill Burton Act in 1946, authorizing the building of hospitals, caused the loss of public health funding. The structure of the hospitals along with the economic dominance of physicians relegated the work of nursing into support roles. Physicians required "competent and loyal assistants" to work in their absence. Women, who they hoped would not challenge the authority or economic position of the doctor would fill these roles.

The ultimate outcome has been that physicians see nurses as their support staff, and nurses may view physicians as the director of their practice through orders of care that were designed as a vehicle for reimbursement for services, not to place physician authority over the practice of nursing.

Further information on the widening gap between physicians and nurses can be read in the report.

Part 2: The Current Context

While unemployment in the United States is below 4% and economic expansion has called for an increase in the available workforce there is increasing concern about the number of adults unable to enter the workforce due to poor health. It is also well known that the United States (US) is outranked on the quality of healthcare by many developed countries. Despite outspending any other country on healthcare, the United States ranks 43rd in health outcomes. The Center for Disease Control has reported that for the second year in a row, US life expectancy has declined, driven in part by suicides, drug overdoses, obesity, and chronic diseases. The term "diseases of crippling despair" has been used as a term describing the crippling of the workforce.

A recent study by the Department of Defense reveals the magnitude of the challenge; among 17-24 year olds eligible for recruitment, 59% were not eligible because of health conditions such as obesity, substance abuse, mental health problems, and asthma. An additional 10% were disqualified due to criminal records or lack of high school graduation/GED (25%). Only 29% of the subjects in this study were found to be eligible for recruitment.

There is evidence that in the US, investment in the social determinants of health can arrest decline for specific at-risk groups.

The payment systems for health care services are undergoing change such as rewards for high quality and some penalties for poor outcomes. Innovative approaches to the current state of the health care system are being developed to address the issue of disparity of access and disparity of economic and social influences of care.

Part 3: Nursing Today

Studies are just beginning to emerge that attempt to describe how alternative payment models that recognize the expertise of the nurse in different ways. In studies showing the effectiveness of nurse practitioners, in areas where practice to the top of their licenses is allowed through state regulations, there is a shift from reliance on physicians in safety net and settings accredited as primary care medical homes. (Note: In Oregon, NPs and other advanced practice nurses have independent practice authority.) Care coordination and transactions of care have become essential functions for hospitals and affordable care organizations and these roles are filled by nurses at all practice levels.

Some systems have integrated nurse-led programs that target specific groups or problems. An analysis of "scientifically supported" interventions to improve health found that 35 out of 160 interventions are in the domain of the nurse and within the independent scope of practice of the nurse.

Part 4: Enhancing Nurses' Contribution in the 21st Century

Nurses have an historic opportunity to reclaim and expand their original vision of nursing practice. This practice is grounded in a holistic focus on patients in the context of their full psychosocial well-being as members of families, workplaces, and communities.

This return to the fundamentals of nursing practice is echoed in the American Nurse Association Code of Ethics where nursing is defined as, "the protection, promotion, and optimization of health and abilities, prevention of illness and injury, facilitation of healing, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, groups, communities, and populations." In practice, however, many of these elements are absent in many job settings where nursing interventions are directed by orders of other disciplines.

The nursing profession is currently facing a choice. Should nurses emulate other professions that have fought for and acquired dominance by establishing boundaries that exclude other professions and identify services over which nursing can claim a monopoly? Or should nurses take an alternative path, one that deepens their commitment to working at the intersection of disciplines, with far less concern about boundaries and exclusivity?

For a complete version of this report, please access through the Robert Wood Johnson Foundation:https://www.rwjf.org/en/our-focus-areas/topics/nurses-and-nursing.html

All references found in:

Patricia Pittman, *Activating Nursing to Address Unmet Needs in the 21st Century.* Robert Wood Johnson Foundation, Princeton, NJ, March 12, 2019.

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Foreword by OSBN RN/LPN Education Policy Analyst ***Nancy Irland***

PREPARING STUDENTS FOR THE NGN TEST FORMAT

The expected start date for the Next Generation NCLEX (NGN) test question format is 2023. This means that freshmen in a four-year nursing program who start this Fall will be among the first to be tested on clinical judgment. The National Council for State Boards of Nursing (NCSBN) has completed intensive research on the new question formats and the results are positive. To support students in becoming familiar with the testing format, the process can be incorporated into homework assignments and classroom discussions.

The Oregon State Board of Nursing is planning an October workshop for nursing faculty to discuss NGN formats; participants will divide into workgroups to write and share questions based on the NCSBN template. All nursing faculty are encouraged to attend. Watch the OSBN website for further details. To prepare, please review the NCSBN information below, begin testing it, and come ready to share what you've learned.

The Clinical Judgment Model

Clinical judgment is defined as the observed outcome of critical thinking and decision-making. It is an iterative process that uses nursing knowledge to observe and assess presenting situations, identify a prioritized client concern, and generate the best possible evidence-based solutions in order to deliver safe client care.

NCSBN research identified a list of contextual factors that play a role in the quality of nursing clinical judgment (Dickison et al, 2016). These factors may be divided into conditions that are internal (education, experience, knowledge, communication, consequences/risk, emotions/perceptions, professional orientation) or external (task complexity, time pressures, distractions, interruptions, professional autonomy) to the nurse.

Recognizing that it was necessary to ascertain whether clinical judgment is more than just possessing nursing knowledge, NCSBN conducted a pilot study in 2016 (Muntean et al. 2016 AERA presentation). Results from this study found that while knowledge is essential, it is not enough to substantiate the clinical judgment essential to safe nursing practice. The study also indicated that the average ability of a nurse to demonstrate the different steps in the clinical judgment process (cue recognition, hypothesis generation, hypothesis evaluation, taking actions, and evaluating outcomes) is progressive.

Thus, a nurse's ability to recognize cues, develop hypotheses, and take appropriate actions does not guarantee the ability to evaluate the outcomes of the action taken. Ultimately, no single element of clinical judgment adequately predicts a nurse's clinical judgment ability; it is the combination of all the elements that add validity and reliability to the measurement of a nurse's clinical judgment ability. In short, having content knowledge does not always translate to having clinical judgment skills.

The NCSBN Clinical Judgment Model (CJM) represents a fundamental shift from the current dichotomous measurement models in which something is either right or wrong. When context is removed and items are extremely sterile, a very precise and stable measurement can be obtained. But, the context in which we make decisions matters. Consequences, time constraints and risks cause someone to make decisions a certain way. The CJM can be broken down into four levels. Imagine that a nurse walks into a client room, cues exist that must be first be recognized and then analyzed in order to care for the client properly.

The nurse (1) forms hypotheses, (2) prioritizes them, generates solutions and then (4) takes actions. Research thus far has indicated that these actions can be measured. Layer 4 in the CJM is one that has not been introduced in any psychometric models before now – the context. The question is whether you can put context around items in a way that you actually make it more real.

NCSBN continues to develop item prototypes, collect data and do research on measuring clinical judgment and measuring the layers of the CJM.

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Dickison, P., Haerling, K. & Lasater, K. (in press). Integrating the National Council State Boards of Nursing-Clinical Judgment Model (NCSBN-CJM) into Nursing Educational Frameworks. Manuscript submitted for publication.

Dickison, P., Lou, X., Kim, D., Woo, A., Muntean, W., & Bergstrom, B. (2016). Assessing higher-order cognitive constructs by using an information-processing framework. Journal of Applied Testing Technology, Vol 17(1), 1-19.

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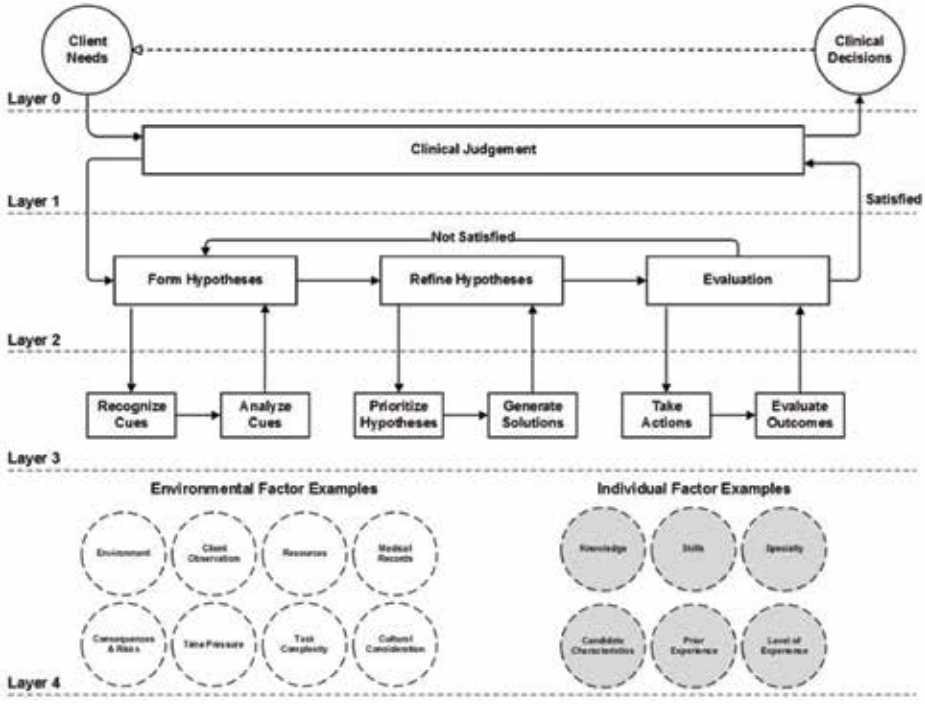
The NCSBN Clinical Judgment Model

The Layers of the Clinical Judgment Model



1. Recognize Cues – Identify relevant and important information from different sources (e.g., medical history, vital signs).

- What information is relevant/irrelevant?
- What information is most important?
- What is of immediate concern?

Do not connect cues with hypotheses just yet.

2. Analyze Cues – Organizing and linking the recognized cues to the client's clinical presentation.

- What client conditions are consistent with the cues?
- Are there cues that support or contraindicate a particular condition?
- Why is a particular cue or subset of cues of concern?
- What other information would help establish the significance of a cue or set of cues?

Consider multiple things that could be happening. Narrowing things down comes at the next step.

3. Prioritize Hypotheses – Evaluating and ranking hypotheses according to priority (urgency, likelihood, risk, difficulty, time, etc.).

- Which explanations are most/least likely?
- Which possible explanations are the most serious?

Item development should focus on ranking the potential issues and should use phrases such as "most likely."

4. Generate Solutions – Identifying expected outcomes and using hypotheses to define a set of interventions for the expected outcomes.

- What are the desirable outcomes?
- What interventions can achieve those outcomes?
- What should be avoided?

Focus on goals and multiple potential interventions—not just the best one—that connect to those goals. Potential solutions could include collecting additional information.

5. Take Action – Implementing the solution(s) that addresses the highest priorities.

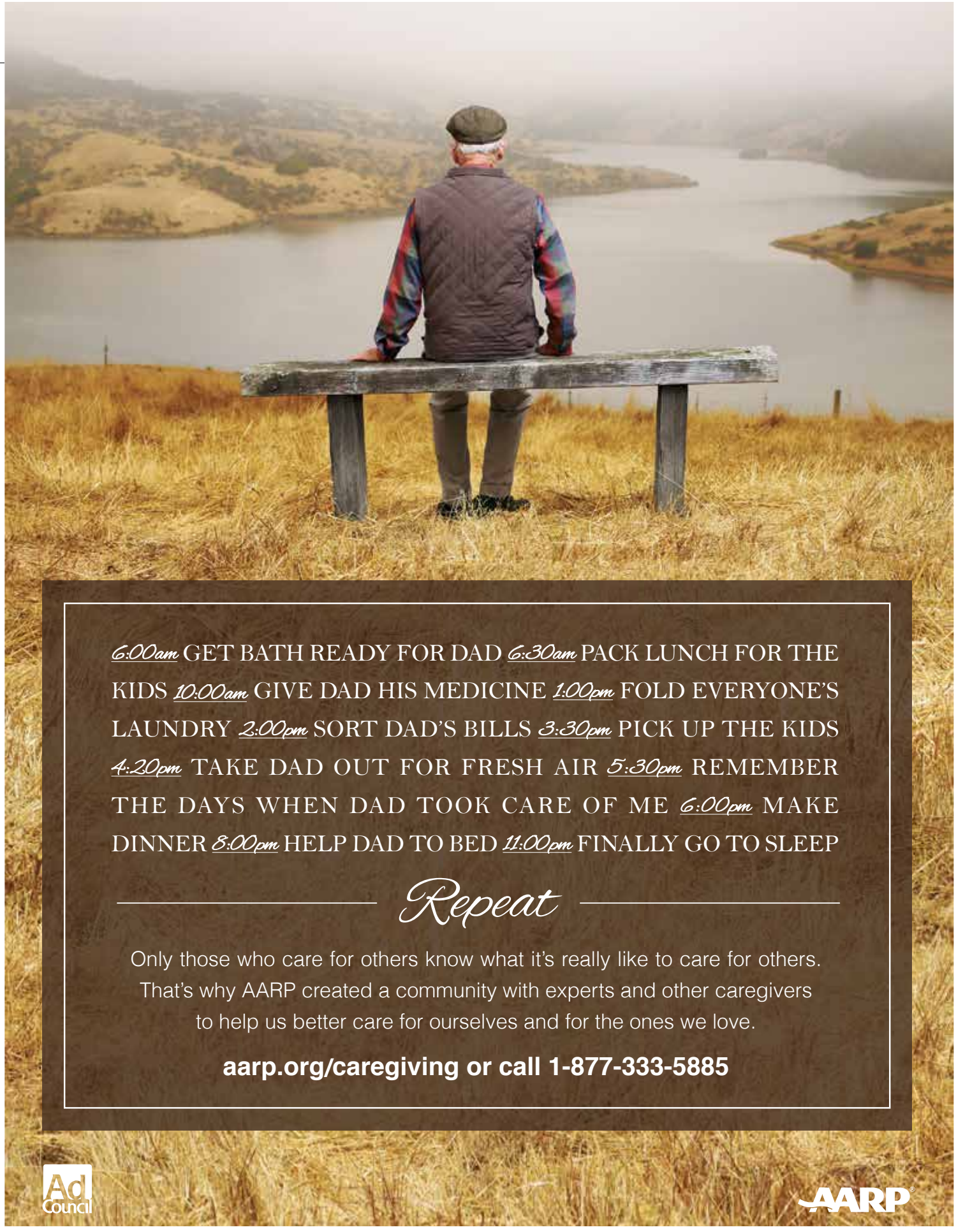
- Which intervention or combination of interventions is most appropriate?
- How should the intervention(s) be accomplished (performed, requested, administered, communicated, taught, documented, etc.)?

For "how" questions, ensure that specific elements from the scenario are what determines approach. Avoid memorized or "textbook" procedures. The item stem and/or the responses should include action verbs.

6. Evaluate Outcomes – Comparing observed outcomes against expected outcomes.

- What signs point to improving/declining/ unchanged status?
- Were the interventions effective?
- Would other interventions have been more effective?

Item development should focus on the efficacy of the intervention(s) from the previous items.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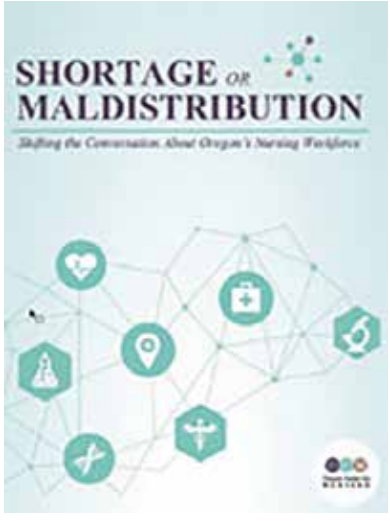
CONVERSATION AROUND OREGON'S NURSE WORKFORCE FOCUSES ON MALDISTRIBUTION

The Oregon Center for Nursing (OCN) recently released a new report on the nursing workforce, *"Shortage or Maldistribution: Shifting the Conversation Around Oregon's Nursing Workforce."* The report provides updated, detailed information on nursing professionals in Oregon, and looks at how those numbers have changed in recent years.

"For years, nursing communities across the nation have discussed an impending nursing shortage and discussed global strategies to address the crisis," says Jana R. Bitton, OCN's Executive Director. "Our recent report suggests Oregon needs to have a much more nuanced conversation that discusses the maldistribution of nurses, or shortages that are occurring in certain regions of the state or in specific work settings."



Oregon Center for NURSING

There are more than 42,500 registered nurses, 3,750 advanced practice nurses, and 4,300 licensed practical nurses estimated to be working in Oregon. The report discusses the increase in the number of professionals from other states seeking licensure in Oregon, the geographic distribution of the registered nurse workforce, and vacancy and turnover rates by employers.

"As we start looking at community or regional maldistribution of the nursing workforce, there are many implications," Bitton says. "Local employers and educators need to look at their partnerships to see how community needs are being met. The presence or absence of other healthcare professionals and how their role intersects with nursing is also a big interest."

The report, Shortage or Maldistribution: Shifting the Conversation Around Oregon's Nursing Workforce is available to download on the Publications page of the OCN website. In addition, interactive data charts, and a recorded webinar with report author, Dr. Rick Allgeyer are available for public use.

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

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

PRECEPTING ADVANCED PRACTICE REGISTERED NURSING (APRN) STUDENTS: FAQs for Preceptors and APRN Students

The national need for APRNs has resulted in many public and for-profit education programs to offer distance (online) didactic content to students who do not live in the state where the program is officially located. While didactic content can be delivered through various platforms of distance learning, required clinical practicums must be done in a live patient environment. The Oregon State Board of Nursing (OSBN) has no jurisdictional authority to approve out-of-state education for undergraduate or graduate programs. The OSBN does have authority, however, when the student is utilizing Oregon-based clinics and facilities for their practicum experience. The safety of the patient while being cared for by the preceptor and the student falls within the mission of the OSBN.

The following FAQs are intended for:

- current licensed APRNs who are currently precepting advanced practice students or are considering the preceptor role, and
- students attending out-of-state APRN education programs who intend to take (or are currently taking) clinical practicums in an Oregon clinic or facility.

Please access OAR 851-050-0009 for Nurse Practice Act requirements for in-state clinical practicums when a student is attending an out-of-state program.

These FAQ's are also applicable to preceptors for in-state APRN programs. At present the only programs offering in-state APRN education is the Oregon Health & Science University and University of Portland. At present, the Board has approved out-of-state APRN clinical placements for 40 separate and distinct education programs. As of November 1, 2019, there were 201 students in 459 different clinical placements representing 23 different programs. The other 17 programs did not place students in Oregon during the current term.

Preceptor FAQs:

Why are these rules in place?

The nature of the independent scope of practice of an APRN places accountability with the nurse to provide safe care at the level of advanced nursing practice. During a clinical practicum, the APRN student applies clinical knowledge and decision-making that could impact the health and safety of an Oregonian. Any application of nursing care in Oregon falls under the jurisdiction of the OSBN. Because the APRN student is already a registered nurse (RN) in Oregon, any patient care issue associated with their practicum falls under their nursing license whereas an undergraduate nursing student does not yet possess a license and technically does not fall under OSBN jurisdiction.

Since the APRN student is already a licensed RN, what is accountability of the preceptor?

The preceptor is accountable to assure that the clinical experiences provided in the practicum allow the APRN student to achieve the established outcomes of their clinical course. At the APRN education level, faculty presence may be limited to once a term, which is not enough to assure that the student has met course objectives. Faculty rely heavily on the feedback from preceptors to determine the student's success in the course. Preceptors must be oriented to the requirements of the program, the course objectives, and the expected clinical outcomes. It is the preceptor who determines that, for that term, the RN is successfully transitioning into advanced nursing practice through observation and documentation review for each clinical intervention performed by the student.

Can I be paid to be a preceptor?

The Nurse Practice Act is silent on reimbursement for precepting. This would be an arrangement between

the preceptor and the program. Since all APRNs also possess an RN license, all the requirements of OAR 851-045, "Standards and Scope of Practice for Licensed Practical Nursing and Registered Nurses," are applicable to APRN practice. OAR 851-045-0060 (8) (e) states that the RN's responsibility for leadership and quality of care means, "Participating in the development and mentoring of new licensees, nursing colleagues, students, and members of the healthcare team." So, while the Practice Act expects that the practice of nursing includes precepting students, there is no statement precluding nor including reimbursement, nor is precepting an absolute requirement of the practice act.

Can I sign off and bill on a chart when I have not been in the room with the student?

Licensees of the OSBN are expected to bill according to state and federal billing laws and regulations. Rules for billing are not part of the Nurse Practice Act. Per the Centers for Medicare and Medicaid, in order for the preceptor to bill for the patient encounter performed by the student, the preceptor must either personally perform or re-perform the physical examination and decision-making, but does not need to re-document the actual encounter if the preceptor verifies that the student's documentation would match their own. The preceptor should make a note of what was done to verify the student's assessment and decision-making.

The OSBN has authority to discipline licenses of preceptors who have been sending students into care encounters and then simply co-signing and billing for the visit under the name of the preceptor without any re-examination of the client for the purposes of validation. This activity would be considered billing fraud and violates state and federal billing laws. There have been instances where a preceptor has taken on several students in order to increase the ability to bill. The idea was not to educate, but to increase billing.

Can I refuse to be a preceptor?

Yes, this is an independent decision to be made by the APRN. There are employers who contract with education programs and it may be an employment requirement, but not, as stated previously, a requirement of the Nurse Practice Act.

Is a faculty visit required and what happens if the program never sends someone to visit the clinical site?

Per OAR 851-050-0009 (h), the program must provide the OSBN with the name of the faculty providing direct clinical evaluation of the student. The faculty must be licensed in Oregon in order to provide this direct clinical evaluation. Many programs contract with Oregon licensed APRNs who go from clinical site to clinical site providing direct clinical evaluation. These evaluators, for the purposes of OSBN rule, are considered to be adjunct to the faculty and can fulfill the direct clinical evaluation function for the program. If the preceptor determines that there is not enough clinical evaluation or that the program is not meeting the needs of the program, feedback should be given to the program and to the OSBN. The preceptor can always discontinue their relationship with the program.

Student FAQs:

What if my program does not obtain OSBN approval for me to take a clinical in Oregon?

Programs should actively assist the student in obtaining clinical placement. However, it is ultimately up to the student to ensure that their clinical placement has been approved by the OSBN. Failure to verify such approval falls under the requirements of the student's RN license and is subject to possible discipline or rejection of the application to be a licensed Oregon APRN.

My program has told me that the OSBN prohibits Oregon clinical placements for students of my program. Why?

The petition process is based upon the school's desire to place students in Oregon for their clinical practicum. The OSBN has approved many programs and has not barred any program from participation provided all the information regarding clinical placements are submitted to the Board and no student starts their practicum prior to Board approval. If your program states Oregon does not allow placements, it is because the program has not petitioned the OSBN for approval.

I have heard that the Board is changing their rules to require a majority of my clinical practicums with an APRN to be in the same population focus as my educational track. I have been with the same

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Medical Physician for my practicums, and I really like the experience, so why this proposed change?

APRN education consists of a minimum of 500 hours of practicum over 15 months to 2 years to develop assessment skills, diagnostic decision-making, and planning for the care of the client. Each program of APRN education is focused upon a specific population i.e.: Family Practice, Adult Gerontology, Pediatrics, etc. The national certification exam, required for licensure, is also focused upon the same population as your educational degree. APRNs have been shown to function at the same level of clinical safety as their medical physician counterparts because of that very narrow focus of practice development. In order for APRNs to be independent practitioners from the moment their license is issued, being precepted by a licensee with your same patient population focus, is essential to the transition from RN level practice to advanced nursing practice. While physicians can be excellent preceptors, they practice medicine, not nursing at the advanced level and should not be the preceptor of the student for a majority of practicum experience. The practice of nursing at the advanced level is legally separate from that of the practice of medicine and a physician is not qualified to educate the student regarding the practice of nursing.

What programs does the OSBN recommend for APRN education?

The OSBN does not recommend programs. The decision regarding any program is up to the student based upon their needs and career development options.

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

DISCIPLINARY CASE STUDIES

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

CASE STUDY #1

Certified Nursing Assistant (CNA) 1 was employed as a CNA in a care facility. The Board received a complaint from management of the care facility that CNA 1 was recently terminated for violating resident privacy and failing to respect the dignity of a resident. It was reported that CNA 1 was observed with his cell phone on a video call while performing care, including peri-care on a resident. The incident was also reported to Adult Protective Services (APS) and law enforcement.

According to evidence gathered during the investigation, CNA 1 was asked to prepare a resident for the dining room. When CNA 1 went to the resident's room, he had his cell phone in his hand and set it down on the resident's nightstand. CNA 1 performed incontinence care for the resident when it was noticed by a witness that the cell phone was placed at a 45 degree angle and on a live video call. When reported to supervisors, CNA 1 was suspended pending further investigation. According to witnesses, following notification of the suspension, CNA 1 went to the staff breakroom and made a statement to staff that CNA 1 wished people would not go over his head regarding issues they had with him and that he was being suspended for changing a resident while on FaceTime.

When CNA 1 was interviewed by an OSBN investigator, he adamantly denied being on a video call while performing care to the resident. CNA 1 stated that he had the phone in his hand when he came in resident's room and set it on the table. CNA 1 said that the statement he made to staff in the breakroom must have been misunderstood, as he was asked why he was leaving and he just relayed the allegation. CNA 1 does not know why allegations were made regarding his statement and the fact that he admitted to being on FaceTime.

When interviewed, the patient was not aware of the incident. Oregon Adult Protective Services conducted an investigation and determined that the incident occurred, but did not substantiate abuse against the CNA. Law enforcement elected not to move forward with criminal charges related to the incident.

The Board determined that CNA's conduct was in violation of the Nurse Practice Act, specifically conduct derogatory to the standards of a nursing assistant, failing to respect the dignity and rights of the resident, and violating the privacy and confidentiality of the resident. CNA 1 elected to stipulate to a voluntary surrender of his certified nursing assistant certificate for a period of at least three years, which the Board accepted.

CASE STUDY #2

Certified Nursing Assistant (CNA) 2 was reported to the Board for an allegation of patient abuse. CNA 2 worked in a memory care facility and was observed on video surveillance physically abusing a resident with dementia. The Oregon Department of Human Services (DHS) and law enforcement were notified and began investigating.

During the OSBN investigation, the video surveillance was reviewed. The video showed CNA 2 pushing a resident in a wheelchair into a large room. The CNA 2 is then seen covering the resident's face with her hand, and then she quickly pulled the resident's head back while continuing to push the wheelchair. When CNA 2 is done pushing the resident, she leans over resident's shoulder, and the view is obstructed in the video. A co-worker came over to assist CNA 2 and discovered that the resident's finger was stuck in the wheelchair. CNA 2 and her co-worker helped free the resident's finger. When CNA 2 was confronted by her manager about the incident, she stated that the resident had gotten her finger stuck in the wheelchair and that CNA 2 and co-worker helped free her finger. CNA 2 did not mention covering the resident's face or pulling her head back. When the manager asked if anything else happened, CNA

2 said no. CNA 2 was then shown the video and was shocked at what she saw. CNA 2 immediately apologized and admitted that she lost her cool with the resident, as the resident had been difficult and combative that day. CNA 2 told her manager that she was resigning and that she would no longer be a CNA to ensure that nothing like this ever happened again. After leaving the facility, CNA 2 sent a message to her manager again apologizing for her behavior and stating that she would be "turning in her license."

During CNA 2's interview with Board staff, she reiterated that she just "snapped," and covered the resident's mouth and pulled her head back after resident had been hitting and slapping her, and acting out the whole shift. CNA 2 said she was very sorry and didn't mean to be so rough with the resident.

DHS placed CNA 2 on the Nursing Assistant Abuse Registry. Law enforcement cited CNA for harassment, but elected not to pursue criminal charges.

The Board found that CNA 2 violated the Nurse Practice Act (NPA) by engaging in conduct derogatory by abusing a resident and failing to respect the dignity and rights of the resident. The Board voted to issue a Notice of Proposed Revocation of CNA certificate. CNA 2 did not request a hearing within the allotted timeframe, and the Board issued a Final Order of Revocation of Nursing Assistant Certificate by Default.

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

YOU ASK, WE ANSWER

Q: My current RN practice role does not include traditional hands-on nursing care. Will I be able to count the hours I work as nursing practice hours for the purposes of relicensure?

A: Most likely. It is important to know that it is not the work setting, job title, or reimbursement for services that makes one's role nursing practice; it is the individual licensee's application of the body of nursing knowledge in the engagement of actions and behaviors that demonstrate the practice of nursing as defined by Oregon's Nurse Practice Act (NPA). The NPA defines the practice of nursing as diagnosing and treating human responses to actual or potential health problems.

The NPA also identifies that the RN's scope includes practice in a variety of roles. These roles include the provision of client care; clinical direction and supervision of others in the provision of care; the development and implementation of health care; nursing administration and management; nursing research; nursing case management; nursing informatics; consultation in the practice of nursing; and others.

The common denominator of all these different practice roles is the practice of nursing as defined above.

This means that when your role encompasses nursing assessment, identification of client needs or risks, identification of expected outcomes, planning how nursing services will be implemented, implementation of your plan for services, with evaluation of the plan for continuation or revision based on ongoing assessment – you are engaging in the practice of nursing.

It is also helpful to remember that the client for whom the RN is diagnosing and treating human responses to actual or potential health problems includes the family unit; employees within an organization or business; a faith-based congregation; a geographic population, and the individual person.

For additional information on this topic, please access and read the Board's interpretive statement Practice Requirements for the Licensed Practice Nurse, Registered Nurse & Advanced Practice Registered Nurse on the OSBN website. The statement assists the licensee to recognize the types of practice roles that meet NPA practice hour requirements and provides a list of key elements to consider when determining actual hours spent in the practice of nursing.

Q: Can an LPN administer medication through a peripherally inserted central catheter (PICC)?

A: It depends. It depends because Oregon's Nurse Practice Act does not provide a list of procedures or interventions "authorized" for performance at the LPN level of licensure. Each individual LPN must determine how to proceed (or not to proceed) with any specific activity based upon several factors.

In short, these factors include the individual LPN's educational preparation; competencies with the performance of the specific activity; the environment of care where the LPN would perform the activity; the client's treatment plan or plan of care; the safety and appropriateness of the intravenous medication ordered for administration to the client, and more.

The Board has developed a useful tool to guide the individual nurse in their decision to accept or decline an assignment involving infusion therapies and interventions. The tool is accessible on the Board's Practice Statements and Guidance webpage and titled: Vascular and Non-Vascular Access and Infusion Therapy.

Q: Is it within the CNA scope of practice to place, reposition, or discontinue an external urine collection device like a condom catheter?

A: This question is answered by 851-063-0030 Authorized Duties and Standards for Certified Nursing Assistants. This division of the NPA contains all duties for which the CNA I has been authorized to perform and additional duties authorized for performance by the CNA II.

Spoiler Alert: Division 63 authorized duties for the CNA 1 include …providing catheter care including the application of and removal of external urinary catheters.

An employer can narrow the list of duties that may be performed by the CNA in the work place. However, an employer may never expand the CNA's duties beyond what is authorized in Division 63. Additionally, the RN's plan of care will further identify which duties are to be implementing for a specific client.

Division 63 may be accessed directly via the Nurse Practice Act link on the OSBN website.

Q: This week I took an RN position with an assisted living facility (ALF). My first day on the job, I was provided with a stack of RN Delegation Transfer forms. Each form had the name of a

client, a care provider, and the name and signature of the facility's previous RN. My name had been printed on the bottom of each form next to a signature line for me to sign and date.

When I asked about the forms, I was told by the facility administrator to just sign and date the paperwork because they have a survey coming up. The administrator and other staff assured me that the forms met all of the requirements for a transfer of delegation, and that I would be fine. This doesn't seem right because I haven't even met most of the clients or care providers whose names are on the forms. What should I do?

A: A red flag went up for good cause! As a licensee of the Board, you—and you alone—are responsible for your practice and accountable for your decisions and actions. Your description of the situation communicates that the administrator wants you to put the cart before the horse; the cart being the form, the horse being your nursing practice. Before you exit the barn, let's review the legal requirements of RN practice.

Each individual RN is responsible for their own nursing practice; a practice that is grounded in nursing process. Nursing process always begins with a nursing assessment of the client. Nursing assessment provides for the RN to identify the client's response to actual or potential health problems/risks, identify expected outcomes for the problems, and to plan nursing services designed to address, mitigate, or prevent the client's identified problems. This is not an option; it's the law.

Sans engagement in these legally required components of RN practice, there is no practice or authority for an RN to provide nursing services for a client…and we haven't even addressed the RN's responsibilities for engagement in delegation process.

When RN practice occurs in a community setting, the RN may consider and utilize delegation process as one option for implementation of a nursing care plan intervention that involves the performance of a nursing procedure for the client. All decisions made by the RN when considering delegation as a means to deliver a care plan intervention must be grounded in the safety and well-being of the client.

This means that the new RN who is considering the acceptance of another RN's existing delegation (i.e., a transfer of delegation) remains personally responsible for, and answerable to, the requirements of nursing process as described above. The new RN is responsible to complete a nursing assessment of the client, identify the client's response to actual or potential health problems/risks, identify expected outcomes for the problems, and to plan nursing services designed to address, mitigate, or prevent the client's identified problems. Without these foundational components of nursing practice having been completed by the new RN, there is no authority for the new RN to accept a delegation transfer.

The new RN who is considering the acceptance of another RN's existing delegation must actively adhere to Chapter 851 Division 45 (rule number 851-0040(5)) standards on accepting and implementing orders. If these standards cannot be met by the new RN, there is no authority to accept the transfer.

The new RN must also have evidence that the ordered procedure is within their own individual scope of practice; does not require interpretation or independent decision-making; and that the results of performing the procedure for the client are reasonably predictable. If these conditions cannot be met by the new RN, there is no authority to accept the transfer.

The new RN who is considering the acceptance of another RN's existing delegation must directly observe the assistive person perform the procedure on the client and render a decision regarding the assistive person's competency in its performance. If the assistive person is unable to demonstrate safe and accurate performance of the procedure on the client, there is no authority for the new RN to accept the transfer.

There are additional requirements of the new RN who is considering the acceptance of another RN's existing delegation but this response is getting lengthy. Just know that placing the cart (the form) before the horse (nursing process) is juxtaposed to client safety and is conduct derogatory to the practice of nursing.

Q: My employer is now requiring all nurses to work overtime and take on extra shifts. Can they do that?

A: This question is not answered by Oregon's Nurse Practice Act, since the Board of Nursing has no authority in that area. The Oregon Health Authority holds jurisdiction over the laws and regulations on hospital nurse staffing. The Oregon Department of Human Services holds jurisdiction over the laws and regulations for nurse staffing in nursing facilities. For general labor laws, the regulatory agency is the Oregon Bureau of Labor and Industries. If you are represented by a labor union, you may also find provisions for working conditions within the bargaining agreement or labor contract.

Q: Can I use my Oregon nursing license to practice in Arizona this winter?

A: This question can only be answered by the Arizona State Board of Nursing. The Oregon Board of Nursing's jurisdiction is limited to the practice of nursing that occurs with persons who physically reside within the borders of our state. This means that you must inquire directly with the Arizona nursing board regarding licensure requirements for their state.

By OSBN Executive Assistant ***Peggy Lightfoot***

RULES ROUNDUP

ADMINISTRATIVE RULES ADOPTED AND PROPOSED BY THE OREGON BOARD OF NURSING

The Oregon Board of Nursing (OSBN) operates in an environment of ever-changing laws, public concerns, and legislative mandates that requires ongoing rulemaking. As a state agency, the OSBN has statutory authority to amend Oregon administrative rules (OAR) to ensure public safety and consistency in procedures.

The OSBN has adopted several rules this year, with additional proposed amendments scheduled for Administrative Rule hearings during the November Board meeting; the proposed rule language is the result of bills that passed during the 2019 Legislative Session, and will become effective on January 1, 2020.

Adopted Rules (Effective August 1, 2019)

OAR 851-006: Standard Definitions

During a recent review of the Nurse Practice Act, it was noted that most divisions contained a definition section, that there were duplicate definitions, or that the same terms had separate definitions based upon the division where the term was used. Board staff proposed to adopt a new division specifically for definitions used throughout the Nurse Practice Act, and an Administrative Hearing was held during the June Board meeting, at which time the Board voted to adopt Division 6 – Standard Definitions. The new division clarifies terms used throughout the NPA, and streamlines the entire document. The definitions sections in several divisions of OAR 851 were repealed through the same rule hearing process, also during the June Board Meeting.

OAR 851-031: Standards for Licensure of Registered Nurses and Licensed Practical Nurses

The rule amendments to several sections of OAR 851-031 eliminates the requirement for a transcript from an Oregon based nursing program, with added language for graduation verification. Graduates from non-Oregon nursing programs will continue to be required to submit a transcript as evidence of program completion. The rule revisions also eliminated the requirement for a passport photo; advances in biometric identification at the test site assures that the candidate applying for the initial license is the same individual taking the test.

OAR 851-062: Standards for Certification of the Nursing Assistant and Medication Aide

The purpose of the rule amendments were to clarify when nursing assistant certification is required; change to allow unlimited testing up to one year of the date of completion of the nursing assistant training program; added aeronautical medic as an option for obtaining CNA 1 certification; changed military service requirement from within five years of application to within two years of application; clarified expectation for primary source verification; additional requirement for student nurses to test for CNA certification; and added explanation of CNA employment. Adoption of rules included addition of 75 clinical hours requirement of nursing assistant level one training or a combination of clinical hours and CNA employment hours equal to 75 hours for eligibility to take CNA 2 training, and provide provision for student nurses who have graduated from an approved nursing program as an avenue for obtaining a CNA 2. Adopted rules included the addition of a section that makes a provision for individuals who previously held

an Oregon CNA certification to reactivate their certification if they worked 400 hours in the previous two years, under a nurse, in another state where they held current CNA certification. Additional revisions were to clarify language and to align rules for simplicity and consistency. Sections were repealed due to redundancy, and language already currently addressed in Oregon Revised Statues and other sections of OAR 851.

The following proposed rules will be considered by the Board during administrative rule hearings on November 14, 2019:

Proposed Rules (To be effective January 1, 2020)

OAR 851-001: Rules of Practice and Procedure

The proposed revisions to OAR 851--001-0030 are a result of Senate Bill 854, adding the option for occupational licensing Boards to accept a Taxpayer Identification Number (TIN) in lieu of a Social Security number. The proposed revisions to this section includes adding language to clarify the Social Security number options. Proposed amendments to other sections of OAR 851-001 includes clarification that written requests for contested case hearings also allow for electronic submission of requests; deletes reference to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV) and clarifies that all evaluations for fitness to practice must align with the DSM V criteria; and clarifies the term "SI" (Subject Individual) by referencing statute and rule that defines SI. Additional proposed amendments include minor revisions for clarification, and reference updates.

OAR 851-002: Agency Fees

As a result of House Bill 3030 and Senate Bill 688, occupational licensing boards are required to accept the out-of-state license of the spouse of an active duty member of the armed forces as the only requirement for a temporary Oregon license or certification. Language regarding the issuance of these temporary licenses is noted in additional rule change descriptions. The proposed revisions to several sections of OAR 851-002 adds and defines the $50 fee for the temporary license or certificate. Additional proposed revisions to OAR 851-002 aligns Department of Defense directives to all active duty service members by adding language that, as required by statute, fee waivers will be granted to active duty military personnel holding a license or certificate with the Board if allowed by the Department of Defense policy; brings fee language in alignment with the rules in OAR 851-062; and removes outdated language related to fees for public record requests that is now included in DAS Policy 107-001-030.

OAR 851-031: Standards for Licensure of Registered Nurses and Licensed Practical Nurses
OAR 851-050: Nurse Practitioners
OAR 851-052: Certified Registered Nurse Anesthetists
OAR 851-054: Clinical Nurse Specialists
OAR 851-056: Advanced Practice Registered Nurse Authority to Prescribe and Dispense
OAR 851-062: Standards for Certification of the Nursing Assistant and Medication Aide

House Bill 3030 and Senate Bill 688, which direct all professional licensing Boards to offer temporary, non-renewable licenses to spouses or partners of military members stationed in Oregon who hold current licensure in another U.S. state or jurisdiction, also affect these sections of rule. Additional proposed revisions replaces the term "Certified" with "Licensed" for certain advanced practice nurse types, to comply with Senate Bill 64, and to make minor editing and language revisions. As a result of HB 2698, proposed revisions to OAR 851-056-0010 delete the ten-day prescription restriction for Certified Registered Nurse Anesthetists. And, SB 127 changes the license type "Nurse Midwife Nurse Practitioner" listed in OAR 851-050 to "Certified Nurse Midwife."

Official notices of rulemaking are printed in the Secretary of State Bulletin. To access recent editions of the Bulletin, visit the Secretary of State website at https://secure.sos.state.or.us/oard/displayBulletins.action .

To receive OSBN Rule Hearing notifications, access Rule Hearing Notices under Subscription Lists on the OSBN website home page, www.oregon.gov/osbn.

By OSBN Fiscal Manager ***John Etherington***

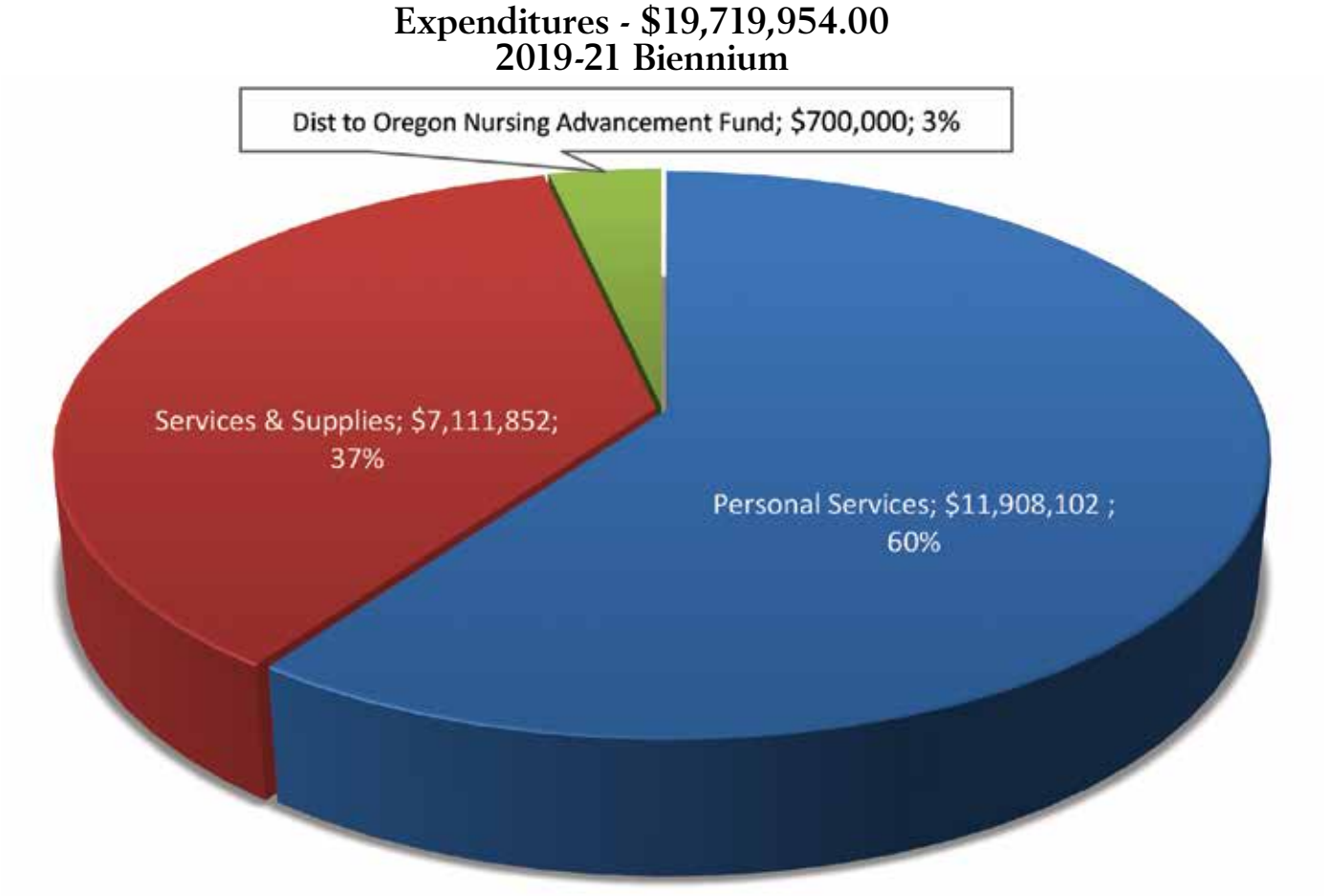
OSBN BUDGET APPROVED BY LEGISLATURE

The Oregon State Board of Nursing 2019-2021 budget was passed by the Oregon Legislature, signed by Governor Kate Brown on April 15, 2019, and went into effect July 1. The Nursing Board is an "Other Funded" agency, which means it is supported primarily by licensing fees and receives no General Fund money. Although the Board receives no Oregon General Fund money, it does receive federal funds specifically for the regulation of nursing assistants; nine percent of the Board's budget comes from federal funds channeled through the Department of Human Services. The remainder (91%) of the $19 million budget comes from licensing fees.

Expenditures for the Board are comprised of 60 percent for salaries, wages, and benefits, 37 percent spent on services, supplies, and the Health Professionals' Services Program (HPSP), and 3% is directed by law to the Oregon Nursing Advancement Fund. Expenditure and Revenue reports are presented to the Board quarterly at public Board meetings.

The mission of the Board of Nursing is to safeguard the public's health and wellbeing by providing guidance for, and regulation of, entry into the nursing profession, nursing education, and continuing of safe practice. The OSBN strategic plan for 2019-2021 biennium has three main objectives: 1) Focus on customer service, 2) Effective, high quality leadership and governance, and 3) Provide guidance for, and regulation of, the nursing profession of Oregon. The Board and its staff regulate the practice of more than 80,000 nurses and nursing assistants. The agency is comprised of five sections: Licensing and Fiscal Services, Investigations, Administration, Communications, and Nursing Policy.

To learn more about the various bills filed for this year's legislative session, visit the Legislature's website at www.oregonlegislature.gov.



DISCIPLINARY **ACTIONS**

Actions taken in July, August, and September 2019. Public documents for all disciplinary actions listed below are available on the OSBN website at www.oregon.gov/OSBN (click on 'Look Up a Nurse or Nursing Assistant').

Name	License Number	Discipline	Effective Date	Violations
Meredith J. Abdi	201905587RN	Probation	7-10-19	24-month probation. Failing to conform to the essential standards of acceptable nursing practice.
Monica L. Adams	RN Applicant	Application Denied	9-11-19	Failing to answer questions truthfully and failing to report incidents of child abuse to the appropriate state agencies.
Manuel E. Aguilar	201012148CNA	Revocation	7-10-19	Demonstrated incidents of dishonesty, stealing property from a client's family, and failing to conform to the essential standards of acceptable CNA performance.
Brandon L. Aune	201700165CNA	Voluntary Surrender	8-14-19	Failing to take action to preserve client safety, falsifying data, and jeopardizing the safety of a client.
Leslie M. Ayhens	200740627RN	Civil Penalty	7-10-19	$5,000 civil penalty. Practicing nursing without a current Oregon license.
Bethany J. Barna	095006519RN	Voluntary Surrender	9-11-19	Suspension of her Wyoming license and the unauthorized removal of medications from the workplace.
Jose L. Betanzos	CNA Applicant	Application Denied	7-10-19	Willful misrepresentation during the certificate application process.
Vadra M. Bezner	201904616CNA	Voluntary Surrender	8-14-19	Violating the terms and conditions of a Board Order.
Todd A. Boone	201393498CNA	Voluntary Surrender	9-11-19	Violating the terms and conditions of a Board Order.
Michael Bulkin	201230276LPN	Suspension	9-11-19	90-day suspension. Failing to take action to preserve client safety, falsifying data, and failing to conform to the essential standards of acceptable nursing practice.
Michelle D. Butcher	200741419RN	Probation	7-10-19	24-month probation. Falsifying data and using intoxicants to the extent injurious to herself or others.
Candace M. Cain	200710684CNA	Probation	9-11-19	12-month probation. Client neglect, leaving a CNA assignment without notifying supervisory personnel, and failing to accurately document.
Debra C. Casey	091003032LPN	Voluntary Surrender	8-14-19	Entering inaccurate documentation into a client record, failing to document information for client care, and failing to conform to the essential standards of acceptable nursing practice.
Katherine A. Chidester	RN Applicant	Voluntary Withdrawal	9-11-19	Misrepresentation in procuring a license, and failing to answer questions truthfully.
Pepito J. Decena	201901069RN	Revocation	7-10-19	Willful fraud in applying for a license.
Devon L. Devecka	200530400LPN	Probation	7-10-19	24-month probation. Performing acts beyond her authorized scope, failing to maintain professional boundaries with a client, and failing to conform to the essential standards of acceptable nursing practice.
Debra L. DeWeese	000039422CNA	Voluntary Withdrawal	8-14-19	Failing to answer questions truthfully and using intoxicants to the extent injurious to herself or others.
Cheryl L. Douglas	200310725CNA	Revocation	7-10-19	Unauthorized removal of drugs from a client, and using intoxicants to the extent injurious to herself or others.
Dawn M. Enderle	200842375RN	Denied Application	8-14-19	Failing to answer questions truthfully, failing to report to the Board her felony arrest and conviction within 10 days, and failing to cooperate with the Board during the course of an investigation.
Carmen M. Engelhardt	201810339CNA	Voluntary Surrender	8-14-19	Violating the terms and conditions of a Board Order.
Jennifer M. Espinoza	201505992CMA	Reprimand	7-10-19	Failing to conform to the standards and authorized duties of CMAs.
Lisa Farmer	201700723LPN	Voluntary Surrender	7-10-19	Using intoxicants to the extent injurious to herself or others, and failing to report to the Board her misdemeanor conviction within 10 days.
Laura R. Finney	082011822RN	Voluntary Surrender	7-10-19	Violating the terms and conditions of a Board order.
Marion E. Gamundoy	201801644RN	Voluntary Surrender	9-11-19	Attempting to obtain unauthorized controlled medications, performing acts beyond her authorized scope, and failing to answer questions truthfully.
Nicole E. Garcia	201042084RN	Probation	9-11-19	12-month probation. Failing to conform to the essential standards of acceptable nursing practice.
Talia P. Giardini	201404788RN	Probation	7-10-19	12-month probation. Demonstrated incidents of reckless behavior, and using intoxicants to the extent injurious to herself or others.
David H. Gizara	094006393RN	Suspension/Probation	7-10-19	12-month suspension, followed by 24 month probation. Neglecting a client, incomplete recordkeeping, and failing to conform to the essential standards of acceptable nursing practice.
Felicia Z. Goetsch	098000214RN	Voluntary Surrender	9-11-19	Violating the terms and conditions of the Health Professionals' Services Program.
Elizabeth L. Graham	201701535CNA	Voluntary Surrender	8-14-19	Failing to implement the plan of care developed by the RN, and failing to respect the client's dignity and rights.
Derek A. Greenwood	201905656RN	Probation	7-10-19	24-month probation. Demonstrated incidents of dishonesty, and using intoxicants to the extent injurious to himself or others.
David W. Hamrin	201230307LPN	Voluntary Surrender	9-11-19	Unauthorized removal of drugs from the workplace, using intoxicants to the extent injurious to himself or others, and falsifying data.
Vanessa C. Hancock	RN Imposter	Civil Penalty	7-10-19	$5,000 civil penalty. Practicing nursing without a current Oregon license.
Christina M. Heil	200730414LPN	Revocation	8-14-19	Using her position as a CNA to exploit a client for personal gain, abusing a client, and failing to maintain professional boundaries with a client.
Tana M. Hillsman	201010820CNA	Reprimand	8-14-19	Failing to conform to the standards and authorized duties of CNAs, and jeopardizing the safety of a client.
Theresa M. Hines	095006299RN	Revocation	7-10-19	Failing to comply with the terms and conditions of the Health Professionals' Services Program.

Name	License Number	Discipline	Effective Date	Violations
Lynn E. Jacobs	099007601RN	Probation	8-14-19	24-month probation. Failing to accurately document, failing to communicate information regarding the client's status, and failing to dispense or administer medications in a manner consistent with state and federal law.
Courtney N. Jarvis	201601067RN	Reprimand	8-14-19	Failing to document nursing interventions accurately, and failing to conform to the essential standards of acceptable nursing practice.
Jessica T. Jennings	201507077RN	Probation	9-11-19	48-month probation. Identify Theft conviction, using intoxicants to the extent injurious to herself or others, and practicing while impaired.
Amber L. Judson	201401065CNA	Reprimand	9-11-19	Abusing a person, and failing to respect the dignity and rights of a person receiving nursing services.
Steven W. Kennimer	200241434RN	Voluntary Withdrawal	8-14-19	Using intoxicants to the extent injurious to himself or others.
Anna J. Kidd	201609111CNA	Suspension	9-11-19	Minimum 14-day suspension. Failing to cooperate with the Board during an investigation.
Cheryl L. Knutson	L201709369RN	Voluntary Surrender	9-11-19	Violating the terms and conditions of a Board Order.
Kathleen M. Kretz	097006340RN	Voluntary Surrender	7-10-19	Failing to comply with the terms and conditions of the Health Professionals' Services Program.
Kristopher C. Kruse	201501090RN	Reprimand	8-14-19	Failing to entering inaccurate documentation into a health record, and failing to conform to the essential standards of acceptable nursing practice.
Carol J. Lambert	201600939RN	Revocation	7-10-19	Obtaining unauthorized drugs, and using intoxicants to an extent injurious to herself or others.
Marny L. Lawson	200342022RN/	Voluntary Surrender	9-11-19	Physical condition that prevents her from practicing safely, and practicing while impaired.
Tiffiny B. Lee	201702655RN	Voluntary Surrender	7-10-19	Mental impairment as evidenced by documented deterioration of nursing practice.
Tiffany Leflore	201801961LPN	Suspension	9-11-19	Minimum 14-day suspension. Failing to cooperate with the Board during an investigation.
Wade E. Little	200840597RN	Voluntary Surrender	9-11-19	Conviction of a crime that bears demonstrable relationship to nursing, and demonstrated incidents of abusive behavior.
Kent A. Madruga	201041994RN	Reprimand	7-10-19	Failing to maintain professional boundaries with a client.
Lorelei B. Mahr	098003008RN	Voluntary Withdrawal	9-11-19	Failing to provide documents requested by the Board.
Ramiro D. Marquez	201113199CNA	Revocation	7-10-19	Demonstrated incidents of dishonesty, and convictions for Theft.
Valerie K. Martinez	000024372CNA	Revocation	9-11-19	Violating the terms and conditions of a Board Order.
Kathleen M. McLean	200741034RN	Probation	7-10-19	24-month probation. Conduct derogatory to the standards of nursing.
Mackenzie L. Mejia	201210698CNA	Reprimand	7-10-19	Abusing a person and failing to respect the dignity and rights of a client.
Dane Mentzer	201802723RN	Voluntary Surrender	8-14-19	Falsifying data, practicing nursing while impaired, and failing to cooperate with the Board during an investigation.
Random Mitchell	201602432RN	Probation	7-10-19	24-month probation. Obtaining unauthorized drugs from a client, and using intoxicants to the extent injurious to himself or others.
Melissa M. Nel	201501723RN	Voluntary Surrender	8-14-19	Failing to comply with the terms and conditions of the Health Professionals' Services Program.
Tierney E. Nunes	201900158RN	Reprimand	8-14-19	Demonstrated incidents of dishonesty.
Margo L. Ott	087003275RN	Reprimand	8-14-19	Failing to using social media to communicate protected client data, and failing to respect the dignity and rights of clients.
Della D. Parrish	201502167CNA	Revocation	7-10-19	Demonstrated incidents of violent behavior, abusing a person, and engaging in threatening behavior towards a coworker.
Hanako B. Paul	098003038LPN	Probation	9-11-19	24-month probation. Failing to take action to preserve client safety, falsifying data, and failing to communicate information regarding client status to the healthcare team.
Matthew Plummer	201908392RN	Probation	9-11-19	24-month probation. Using intoxicants to the extent injurious to himself or others.
Amal Rabadi	201608964RN	Voluntary Surrender	7-10-19	Demonstrated incidents of dishonesty, and failing to report her misdemeanor conviction within 10 days.
Christian B.W. Rupe	201403085RN	Voluntary Surrender	8-14-19	Violating the terms and conditions of a Board Order, and failing to answer questions truthfully.
Amir H. Sabzalian	201805009CNA	Reprimand	9-11-19	Demonstrated incidents of reckless behavior, and jeopardizing the safety of a person under his care.
Debra L. Shafer	200950057NP	Reprimand	9-11-19	Failing to conform to the essential standards of acceptable nursing practice.
Angela G. Shuck	200241838RN	Application Denied	8-14-19	Violating the terms and conditions of a Board Order.
Erin M. Sloan	098007135RN	Suspension	8-14-19	Minimum 14-day suspension. Failing to cooperate with the Board during an investigation.
Brian D. Smith	089000350RN	Revocation	7-10-19	Using intoxicants to an extent injurious to himself or others, and failing to report felony and misdemeanor convictions to the Board within 10 days.
Jasmine I. J. Smith	201390649RN	Revocation	9-11-19	Failing to comply with the terms and conditions of the Health Professional's Services Program.
Kathleen D. Smith	200643028RN	Reprimand	9-11-19	Failing to conform to the essential standards of acceptable nursing practice.
Mary Jane G. Supnet	094000195RN	Voluntary Surrender	9-11-19	Violating the terms and conditions of a Board Order.
Alan D. Swartz	200041355RN	Voluntary Surrender	7-10-19	Obtaining unauthorized drugs, and using intoxicants to the extent injurious to himself or others.
Yvonne M. Taylor	200830311LPN	Application Denied	7-10-19	Convictions for crimes that bear a demonstrable relationship to the practice of nursing.
Debra M. Torres	090000397RN/090000397N6	Voluntary Surrender	7-10-19	Violating the terms and conditions of a Board order.
Ericka M. Waminal	201802434CNA	Voluntary Surrender	9-11-19	Leaving a CNA assignment without properly notifying supervisory personnel.
Sarah M. Webber	201701655RN	Voluntary Surrender	9-11-19	Using intoxicants to the extent injurious to herself or others.

Name	License Number	Discipline	Effective Date	Violations
Thomas L. Weeks	200710645CNA	Revocation	7-10-19	Demonstrated incidents of reckless behavior, using intoxicants to the extent injurious to himself or others, and failing to cooperate with the Board during an investigation.
Kira L. Whiteley	200610910CNA	Voluntary Surrender	9-11-19	Abusing a person, and failing to report to the Board her Battery conviction within 10 days.
Patti J. Winklebleck	076036011RN	Civil Penalty	7-10-19	$5,000 civil penalty. Practicing nursing without a current Oregon license.
Natalia E. Yazzie	201704726CNA	Revocation	8-14-19	Performing authorized duties while impaired, using intoxicants to the extent injurious to herself or others, and failing to answer questions truthfully.
Timothy A. Yett	200542542RN	Probation	9-11-19	24-month probation. Using intoxicants to an extent injurious to himself or others.

2019-20 OSBN BOARD MEETING DATES

November 12, 2019 6:30 p.m.
Board Meeting

November 13, 2019 8:30 a.m.
Board Meeting (Primarily Executive Session)

December 18, 2019 4:30 p.m.
Board Meeting via Teleconference
(Primarily Executive Session)

January 8, 2020 4:30 p.m.
Board Meeting (Primarily Executive Session)

February 11, 2020 6:30 p.m.
Board Meeting

February 12, 2020 8:30 a.m.
Board Meeting (Primarily Executive Session)

February 13, 2020 8:30 a.m.
Board Meeting

March 11, 2020 4:30 p.m.
Board Meeting (Primarily Executive Session)

April 7, 2020 6:30 p.m.
Board Meeting

April 8, 2020 8:30 a.m
Board Meeting (Primarily Executive Session)

April 9, 2020 8:30 a.m.
Board Meeting

May 6, 2020 4:30 p.m.
Board Meeting (Primarily Executive Session)

June 9, 2020 6:30 p.m.
Board Meeting

June 10, 2020 8:30 a.m.
Board Meeting (Primarily Executive Session)

June 11, 2020 8:30 a.m.
Board Meeting

July 8, 2020 4:30 p.m.
Board Meeting (Primarily Executive Session)

August 5, 2020 4:30 p.m.
Board Meeting (Primarily Executive Session)

September 8, 2020 6:30 p.m.
Board Meeting

September 9, 2020 8:30 a.m.
Board Meeting (Primarily Executive Session)

September 10, 2020 8:30 a.m.
Board Meeting

September 11, 2020 8:30 a.m.
Board Work Session

October 7, 2020 4:30 p.m.
Board Meeting (Primarily Executive Session)

November 17, 2020 6:30 p.m.
Board Meeting

November 18, 2020 8:30 a.m.
Board Meeting (Primarily Executive Session)

November 19, 2020 8:30 a.m.
Board Meeting

December 9, 2020 4:30 p.m.
Board Meeting (Primarily Executive Session)

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

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

2019 OSBN BOARD MEMBERS

MICHELLE CHAU, LPN

Term: 1/1/19 – 12/31/21

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

KATHLEEN CHINN, RN, FNP

PRESIDENT-ELECT

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

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

ANNETTE COLE, RN

Term: 1/1/18 – 12/31/20

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

ADRIENNE ENGHOUSE, RN

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

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

SHERYL OAKES CADDY, JD, MSN, RN, CNE

Term: 1/1/18 – 12/31/20

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

BOBBIE TURNIPSEED, RN

BOARD PRESIDENT

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

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

WILLIAM YOUNGREN, CNA

BOARD SECRETARY

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

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

Public Members Needed: The Oregon State Board of Nursing is seeking one public board member for a term that begins January 1. Public members cannot hold a current or former nursing license or nursing assistant certificate, or have a relationship to nursing. To apply, visit the Governor's Boards and Commissions webpage (https://www.oregon.gov/gov/ admin/Pages/How_To_Apply.aspx). For more information on the specific duties of an OSBN board member, visit the board's About Us webpage, or contact OSBN Communications Manager Barbara Holtry at barbara.holtry@state.or.us.

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

MEET THE TEAM

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

HEATHER JOHNSON, RN

After moving every few years due to her husband's job in the U.S. Coast Guard, OSBN Nurse Investigator Heather Johnson, RN, is happy now to call Portland home—for good.

Born and raised on the California coast, Johnson met and married her husband while he was stationed at Morro Bay, Calif. She decided she needed a portable career that would allow her to get a job anywhere he was assigned. "My mom was a nurse, so I had an idea of what it was like," she says. "It seemed like a good fit." While they were stationed in Massachusetts, she received her practical nurse education from Upper Cape Cod Regional Technical School and was licensed as an LPN. She then obtained an associate's degree from Cape Cod Community College and became an RN in 2009. "Cape Cod was amazing in the summer, but it shuts down in the winter and is fairly miserable!"

After six years in the East Coast, they spent a few years each in Newport, Ore., back to Morro Bay, and then Depoe Bay, Ore., where her husband retired after 21 years. "We liked Oregon so much, we decided to stay," she explains. She obtained her Bachelor of Science in Nursing from Linfield College in 2012.

Her desire for a portable, flexible career was fulfilled: over the years, she's worked in an in-patient detox unit, traumatic brain injury rehabilitation, acute care, home health, and diabetes education. However, with two young boys at home, she wanted a job with a more predictable schedule; she joined the Oregon Board of Nursing as a Nurse Investigator in August 2018.

As an investigator, she uses her wealth of experience to review complaints of possible Nurse Practice Act violations and interview witnesses. "I consider myself a 'fact finder'," Johnson says. "I don't judge people and try to make the process as painless as possible. I sort through evidence—documents, records, etc.—to find the facts of a case and present them to the Board. Public safety is the bottom line."

Johnson says she enjoys the work/life balance she has at the Board. "It's great to be able to spend evenings with my family." In addition to her husband and sons, her niece is living with them while she goes to college nearby. She spends most of her free time taking her kids to Taekwondo, soccer, and baseball. "But when we can, we like to road trip to the snow or a beach," she says. "Just hop in the car and go!"

JODIE RICHARDSON

OSBN Licensing Technician Jodie Richardson can't sit still. Constantly in motion, she came out of retirement to join the Board of Nursing staff in July 2018. "I was bored!" she says with a laugh. "I had to get back in the workforce."

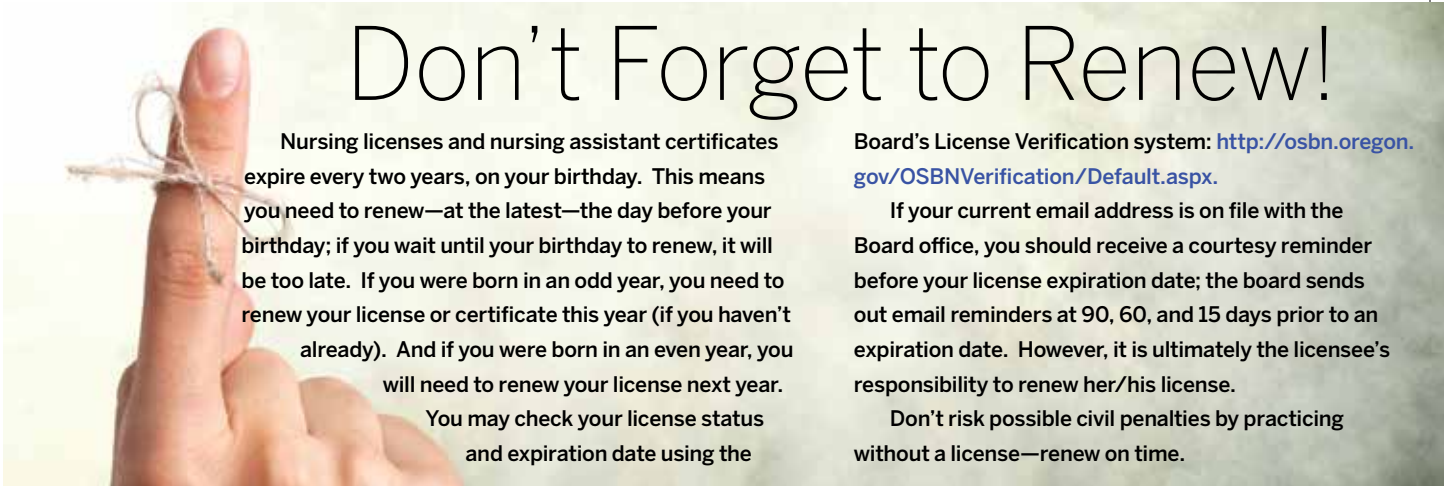
The daughter of an Army Master Sergeant, Richardson was born in Portland, but raised in the U.S. and Germany. "We lived all over here in the states, and in Munich, Frankfurt, Heidelberg, and Stuttgart in Germany. By the time I was 10, I'd had vaccinations the other kids hadn't even heard of!"

During her two marriages (both of her husbands were Army sergeants), she traveled to additional posts throughout Germany, Pennsylvania, California, Florida, Georgia, Alaska, Louisiana, and Washington. She worked as a civilian employee during this time in a range of departments, including US Army Material Command, Transportation, the European Command Audio-Visual Club, the Ranger camp in Georgia, and the Equal Employment Opportunity Officer's office at Ft. Lewis (now Joint Base Lewis-McChord) in Washington. She also worked a few years behind the ticket counters for Mark Air in Anchorage and Alaska Airlines at SeaTac.

Along the way, Richardson finished her Associate Degree in Secretarial Sciences and Accounting at Pierce College in Tacoma, Wash. When her second husband retired, she finally settled down in one spot and worked for Regence Blue Shield in Tacoma for 19 years. "I was mostly in customer service, but moved to quality assurance for the last five years. It was interesting," she says. In 2014, after a lifetime of almost perpetual movement, Richardson decided to retire and moved to Kansas to live with one of her daughter's family. But after a few years, she discovered retirement wasn't for her. "I needed some action, so I moved back to the place I started—Portland."

In the OSBN Licensing department, she processes license applications for endorsement, which involves reviewing transcripts and license verifications. "I love my job and the people here. The work is challenging and it keeps me young," she explains. "The staff here is the friendliest I've ever encountered. Everyone helps each other. It's inspiring."

In her free time, she enjoys making jewelry, reading, and spending time with her three daughters, four grandchildren, and three great-grandchildren. "They all keep me busy—just the way I like it!"



Don't Forget to Renew!

Nursing licenses and nursing assistant certificates expire every two years, on your birthday. This means you need to renew—at the latest—the day before your birthday; if you wait until your birthday to renew, it will be too late. If you were born in an odd year, you need to renew your license or certificate this year (if you haven't already). And if you were born in an even year, you will need to renew your license next year.

You may check your license status and expiration date using the Board's License Verification system: http://osbn.oregon.gov/OSBNVerification/Default.aspx.

If your current email address is on file with the Board office, you should receive a courtesy reminder before your license expiration date; the board sends out email reminders at 90, 60, and 15 days prior to an expiration date. However, it is ultimately the licensee's responsibility to renew her/his license.

Don't risk possible civil penalties by practicing without a license—renew on time.

By OSBN Licensing Manager ***Tracy Gerhardt***

OSBN FREQUENTLY ASKED QUESTIONS

The Customer Support team at the Oregon State Board of Nursing receives more than 3,000 phone calls and emails every month. Below are some of the most frequently asked questions and answers about the licensing process.

Q: How long will it take for my new license/certificate to be issued?
A: There is no way for Board staff to estimate how long it will take to issue a new license or certificate.
Processing timelines for submitted applications depend on how quickly we receive all required information. All requirements must be met, including the national background check, before a license or certificate will be issued to an applicant.

Q: I want to check the status of my application.
A: You can follow your application status online using the Application Wizard on our website at: https://osbn.oregon.gov/OSBNAppStatus/Search.aspx. This tool reflects the most up to the minute information regarding the processing of your application.

Q: Can you expedite my application? I have a job starting soon.
A: Unless you are the spouse or domestic partner of a military member who is on active duty and stationed in Oregon, the Board does not expedite applications. Oregon Revised Statute requires that all applications be processed in order of receipt.

Q: How many times can I take my exam (NCLEX or CNA) until I pass?
A: There is no limit to the number of times a person can take the exam before their application expires. If you are an RN or LPN applicant, you may take the NCLEX again after a 46-day period has passed from the date you last took the exam. There is no waiting period for CNA applicants.

Q: How long does it take to renew a license?
A: If a person qualifies for renewal, the renewal is usually completed within three to five days of submission.

Q: I just got my license eight months ago. Why do I have to renew it already?
A: License expiration is determined based upon your birthdate and numerical sequence of the year you were born. If you were born in an odd year, your license will expire at 12:01 a.m. on your birthday in an odd numbered year. If you were born in an even numbered year, your license will expire at 12:01 a.m. on your birthday in an even numbered year. Because of this process of determining expiration dates, your initial license may expire in as little as six months or in as many as 30 months, depending on the date you were licensed and your next qualifying birthday. The license expiration process is set by the Oregon Legislature and is not under the control of the Board or Board staff.

Q: I want an Oregon NP license. Do I also have to apply for an RN license in Oregon?
A: Yes. Nurse practitioners are required to hold current Oregon licensure as an RN in order to be licensed as an NP.

Q: I was arrested for a crime, but was never charged or convicted. When I apply for licensure do I need to disclose that to the Board?
A: Yes, even arrests that did not result in formal charges or a conviction must be disclosed.

Q: I was arrested as a juvenile for an MIP, do I really need to disclose that arrest on my application?
A: Yes. Applicants must disclose all arrests, charges, or citations, no matter how old the applicant was at the time.

Q: I was charged with a crime, but went to court and the case was dismissed, or I was found not guilty. Do I need to disclose that?
A: Yes. Even arrests or charges that ended with dismissal or a not guilty finding may appear on a LEDS report, and therefore, need to be disclosed on your application.

Oregon State Board of Nursing
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