Nebraska Nursing NEWS

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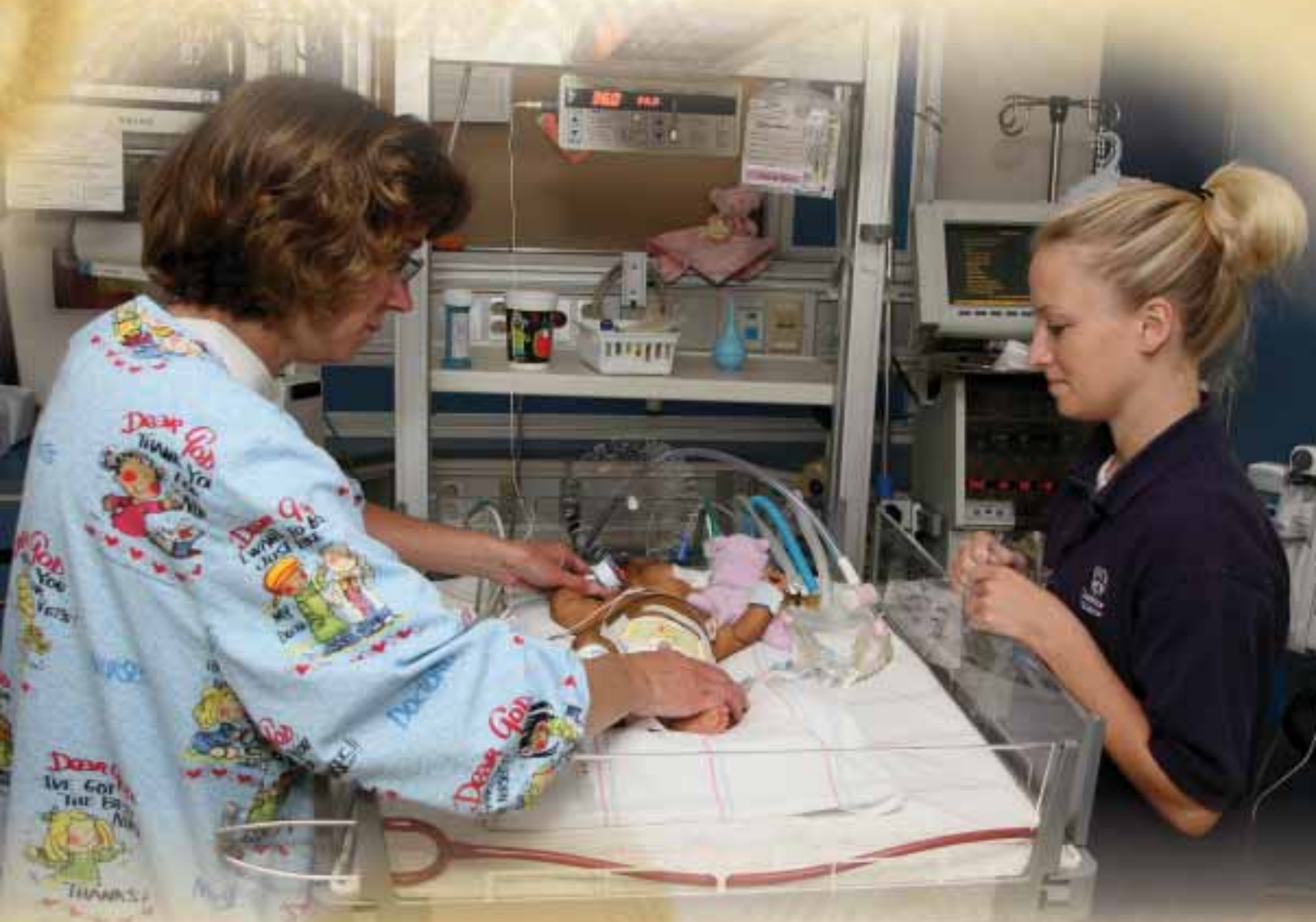

Changes in Uniform Licensing Law: Implications for Nursing

NURSING IN THE NEWBORN INTENSIVE CARE UNIT

Nursing Faculty Shortage: A View of Nebraska Nursing Faculty Demographics

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

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on the COVER

Alice Osborn, RN and Nicole Shoemaker, student from Clarkson College, with infant in the NICU at Creighton University Medical Center.

Executive Director's Message

Each year the Credentialing Division of the Department of Regulation and Licensure sponsors an All Board Members Meeting. This all-day event is an annual training session for members of boards from all of the health professions. This year's topic was Discipline: Past and Present. Much interesting information was presented throughout the day. One of the most enlightening presentations was by the keynote speaker, Donna Mooney. Ms. Mooney is a long-standing staff member of the North Carolina Board of Nursing. Her topic was generational issues. She focused on the effect generational issues have on the discipline process, but her comments are applicable to interaction between the generations at work, in the social setting and in the family.

We currently have members of four generations in the employment setting. Generations are defined by the individual's date of birth. Traits of the generations result from influences of world events that have occurred during the person's lifetime.

The current generations are:
Traditionalists – born between 1922 and 1943
Baby Boomers – born between 1943 and 1960
Generation X – born between 1960 and 1980
Millennium – born between 1980 and 2000

Tradtionalists are influenced by the Great Depression, the New Deal, World War II, the GI Bill and the birth of Social Security. Their traits include patriotism, loyalty, fiscal conservatism, faith in institutions, paternalistic and a strong family structure. Most traditionalists were raised with a stay-at-home mother.

Baby Boomers are influenced by the booming birthrate at the time they were born, economic prosperity, expansion to the suburbs, Vietnam, Watergate, Civil Rights Movement, the Kennedy Years, Woodstock and Haight-Ashbury. Their traits include being the "me" generation, flower children, lack of discipline, idealism, conspicuous consumption, questioning authority and women's lib.

Generation X is influenced by Sesame Street, MTV, TV, divorce, end of the Cold War, acceptance of drug use, advent of computers, birth of 401 K's, acceptance of women in the workplace, AIDS, crack cocaine and other street drugs, rap music and violence on TV and in the movies. This generation is techno savvy, culturally diverse, independent, entrepreneurial, likes unstructured living, wants their own space, sexual openness and defiance of authority.

Finally, the Millennium generation is influenced by the fall of the Berlin wall, expansion of technology, the roller coaster economy, latch key kids, Columbine and guns in schools, death keel to Social Security, multi-million dollar salaries, natural disasters, continued acceptance of drugs and violence, hip hop, women as leaders and 9/11. This group are independent thinkers, independent spenders, cyber literate, lack social graces and skills, are health conscious and globally concerned but locally apathetic.

This may all seem over simplified, but when you analyze behaviors and interaction between generations it all starts to make sense. Examples given included approaches to requesting time off, expectations for compensation, retention and recognition issues and assignments and work settings. In many work settings we have Baby Boomers as the decision makers for workers from Generation X and the Millennium generation. Learning to communicate between the generations and understand what is important to each of us is a difficult task, but one that must done.

From the regulatory perspective, public protection does not lend itself to creativity in fashioning outcomes/sanctions. Regulations are rules that all professionals are expected to live by. Applying those rules to generations of independent thinkers who defy authority is a real challenge. It is no wonder that the regulators who enforce the laws and the young workers who are not used to living with strict rules are frustrated. This is not an issue that will go away. New generations will continue to develop and be in conflict with the generations preceding them. This has always happened, but as the world moves and develops faster and faster the generations change more rapidly. Where historically a generation may have lasted 100 years or longer, the generations now change about every 20 years, resulting in the convergence of very different-thinking people living and working together.

As a Baby Boomer I welcome the fresh thinking and creativity of the Generation X'ers and the Millenniums. You keep us thinking and asking questions and you keep us young.

Charlene Kelly

Charlene Kelly

President's Message

Criminal background checks are required by federal law for childcare workers. These checks are also required in several states for employment as teachers, park and recreation service workers, bankers, weapon dealers, and burglar alarm company workers. Criminal background checks are commonly required for nursing students prior to beginning clinical experiences. However, in Nebraska, we do not require such checks for nursing licensure.

Do you think it is important to conduct criminal background checks for nursing licensure applicants? This controversial issue is under regulatory scrutiny at the present time. Momentum is growing toward requiring criminal background checks for nursing licensure applicants at both national and state levels.

On the national level, the 2005 Delegate Assembly of the National Council of State Boards of Nursing adopted Criminal Background Check (CBC) recommendations brought forward by the Discipline Resources Advisory Panel. Interested persons can go online and read the excellent paper presented to the Delegate Assembly found on pages 47-66 at the following site: http://www.ncsbn.org/pdfs/III_BB_2005_Section_II_Recommendation.pdf.

For those interested in a Cliff's Notes version, the recommendations for nursing regulators (found on pages 61-62 of the paper referenced above) can be summarized as follows:

1. Conduct state and federal criminal background checks on applicants for nursing licensure
2. Issue a permanent license upon receipt of criminal background check results and meeting all licensure requirements
3. Use conviction histories in decision-making regarding competence conduct and licensure
4. Establish guidelines to direct licensure decisions with consideration given to a continuum of criminal behavior, from lesser offenses—to serious offenses—to the most serious offenses. It is recommended that:
   a. There be a permanent licensure bar to the most serious felonies—murder, felonious assault, kidnapping, rape/sexual assault, aggravated robbery, sexual crimes involving children, criminal mistreatment of children or vulnerable adults, exploitation of vulnerable individuals
   b. There be a time-limited licensure bar for other serious crimes—drug trafficking, embezzlement, theft, arson
   c. There be a case-by-case licensure bar to lesser offenses
5. Consider mitigating and aggravating circumstances that may have a bearing on prior criminal conduct
6. Reserve the privilege to waive either the time-limited or permanent licensure bars if extraordinary circumstances warrant such action

At the recent 2006 Delegate Assembly, NCSBN Model Nursing Practice Act language was adopted consistent with these recommendations from 2005. Please keep in mind that the Model Nursing Practice Act exists simply as a model, and each state is free to adopt all, some parts or none of the model. State Nurse Practice Acts are laws enacted by state legislatures. Currently, 25 states require state and federal criminal background checks on their nursing licensure applicants. Nebraska is not one of these states.

The Nebraska Legislature enacted LB 306 requiring criminal background checks for professionals authorized to prescribe controlled substances. This law went into effect September 4, 2005. The majority of nurses in Nebraska are not affected by this legislation. The Board of Nursing relies upon self-report by asking questions on licensure applications about prior criminal convictions. While the vast majority of nurses are honest, self-report is not always accurate.

The Board of Nursing has begun dialog on the issue of whether or not criminal background checks should be conducted for nursing licensure applicants. This topic was discussed at an Issues Forum on July 12, 2006 in Lincoln. Dr. Joann Schaefer, Director of the Nebraska Department of Health and Human Services Regulation and Licensure and the state's Chief Medical Officer, several nursing educators and other interested parties from the Department joined the Board of Nursing in a lively discussion of the CBC issue. Since the Board of Nursing is responsible for protecting public health and safety, is it time to change the question from "whether or not" to "how to" conduct criminal background checks? As a next step, the Board will review how other states are using the information obtained from CBC.

Marcy Echternacht

Marcy Echternacht

Nebraska Board of Nursing
Meeting Schedule 2006

Meetings of the Nebraska Board of Nursing convene at 8:30 a.m.; however, the board immediately goes into closed session to review investigative reports. Members of the public may not be present during closed session. The board typically returns to open session after 11:30 a.m. The agendas for the meetings are posted on our Web site at http://www.hhs.state.ne.us/crl/brdmtgs.htm#Nursing or you may obtain an agenda by phoning (402) 471-4376.

Day/Date	Time	Meetings	Location
Thursday, November 16	8:30 a.m.	Board of Nursing	Southeast Community College Continuing Education Center Room 304
Thursday, December 21	8:30 a.m. 2:00 p.m. 2:00 p.m.	Board of Nursing Education Committee Practice Committee	Staybridge Suites

**Staybridge Suites by Holiday Inn,* 2701 Fletcher Avenue, (27 Street & Fletcher Avenue), Interstate-80, Exit 403, Lincoln, Nebraska 68504, (402) 438-7829/(800) 238-8000, http://www.sbs-lincoln.com/

**Southeast Community College Continuing Education Center*
301 S. 68th St. Place, Lincoln, NE 68510

Deadline for RN License Renewal is October 31

All RNs are reminded that the deadline for license renewal is October 31, 2006. Each RN must renew his/her license regardless of when the license was issued. Renewal notice postcards were mailed to all currently licensed RNs on August 1, 2006. License renewal is available online using a credit/debit card or the forms can be downloaded and sent through the mail with a check for the renewal fee.

RNs are encouraged to use the online renewal option. It is convenient, faster and there is less chance of problems such as getting lost in the mail, forgetting to enclose the check and the forms being misplaced during processing.

If you have not yet renewed your license you should do so immediately. If you renewed your license over two weeks ago and still have not received your new license card in the mail you should contact our office.

RN licenses expire at midnight on October 31. Applications processed online or postmarked after that time will be assessed a $25 late fee. RNs who continue to practice nursing in Nebraska after the expiration will be assessed an administrative penalty fee.

Nurses Role with UNLICENSED PERSONNEL in the Physician's Office

by Karen Bowen and Nancy Holmgren

The department is frequently asked questions regarding unlicensed persons working in physician's offices. The questions include what they can and cannot do, who is responsible for delegating to the unlicensed person and what if any other credentials they need to have? Many of these individuals use the title Medical Assistant. In the state of Nebraska, Medical Assistants are not licensed, registered or certified. Some may hold a national certification from the American Association of Medical Assistants; however, these individuals are considered unlicensed persons, and therefore must have the proper authority to provide nursing tasks including giving medications.

"In the interest of public safety and consumer awareness, it is unlawful for any person to use the title nurse in reference to himself or herself in any capacity, except individuals who are or have been licensed as a registered nurse or a licensed practical nurse. . . " Neb. Rev. Stat. 71-1,132.17

An RN may delegate selected non-complex nursing interventions to unlicensed persons under the guidelines of 172 NAC 99-004, Standards for Delegation. When making a decision to delegate to an unlicensed person, the RN must determine which nursing interventions may be delegated, which unlicensed person(s) may provide the delegated interventions, how to communicate the delegation plan, the appropriate level of supervision and how to appropriately evaluate the delegation plan. Only RNs may delegate non-complex nursing interventions to be performed on behalf of the nurse.

The RN is accountable for the care of clients/patients and the outcomes of the delegation decision. In fact, 172 NAC 101-007.03 states a nurse may have disciplinary actions taken against their nursing license for "delegating and/or assigning nursing interventions contrary to the standards set forth in 172 NAC 99."

An example of appropriate delegation may include delegating routine vital signs to an unlicensed individual who has been trained and is competent to do the task. Inappropriate delegation would include

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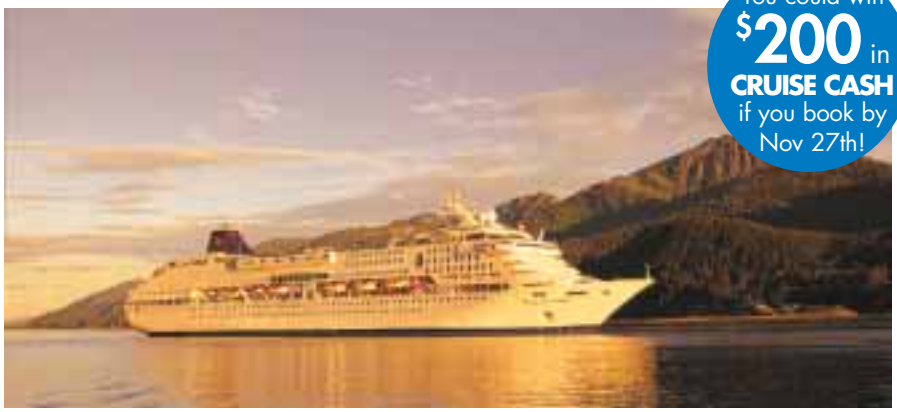

For more information about the cruise and the curriculum, please log on to our website at **www.thinkaboutitnursing.com** or call Teresa Grace at Poe Travel toll-free at **800.727.1960**.

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This eight-day cruise and nursing conference is slated to sail from **Houston** on **March 3, 2007**, and will visit the following ports:

- **Day One:** Houston
- **Day Two:** At sea (conferences)
- **Day Three:** Yucatan, Mexico
- **Day Four:** Cozumel, Mexico
- **Day Five:** Belize City, Belize
- **Day Six:** At sea (conferences)
- **Day Seven:** At sea (conferences)
- **Day Eight:** Houston

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Alcohol/Drug abuse assistance for health service professionals licensed, certified or registered by the State of Nebraska

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The Nebraska Licensee Assistance Program (NE LAP) provides alcohol/drug assessments, treatment referrals, case management/monitoring and education services for Nebraska health service professionals. Would you have estimated that only 51 percent of our cases are alcohol related? You likely would have thought this figure would be higher considering the predominant role of alcohol use in our society. You can now see that almost half our cases, 49 percent, are drug abuse and drug addiction problem situations.

Do you question why the number of drug problem cases are so high? It is important to know that the majority of these cases are not related to use of illegal drugs. They are cases involving prescription drug abuse and addiction. Our society places a high value on use of prescription medications to relieve emotional and physical pain. Health care professionals who work in environments where medications are an integral, sometimes essential, component to pain relief and healing, place an even higher value on medication than the overall general population.

Health care professionals who work in environments where medications are an integral, sometimes essential, component to pain relief and healing, place an even higher value on medication than the overall general population.

Health care professionals' values for medications can lead them to regularly turn to medications for pain relief rather than alternative solutions. If the medications are effective, it can cement their belief that the medications are their only pain relief solution. And as the medications provide physical and emotional relief, the concept that "more is better" can become a "must have" for pain.

However, most pain relief medications are controlled substances and carry risks. One need only review the instructions for the prescriptions in the PDR Drug Guide for Mental Health Professionals to find guidance, such as "may cause patients to become drowsy or less alert," or "avoid alcohol while taking this medication," or "taken with certain other drugs, the effects of either could be

increased, decreased or altered," or "medication should be taken exactly as prescribed," and "tolerance and dependence can develop with the use" of this medication. Generally, emotional and pain relief medications "should not be taken for a longer time or for any other purpose than prescribed."

As you have seen from the NE LAP statistics, health care professionals can become victims of the drugs that they believe are so helpful and necessary for them. Abuse of the drug takes over and the drug is not taken as prescribed. More of the drug is needed. Other prescription drugs may be added to the mix. The drugs are used over a long period of time. Eventually, temporary use of medications for pain relief becomes a long term addiction on the drugs. In the midst of a drug addiction, the health care professional's impairment or diversion of drugs at work leads to loss of practice privileges or his/her job and a referral to the Nebraska Licensee Assistance Program.

If you are a licensed health service professional wanting more information about alcohol/drug abuse or addiction or other related issues, please contact the Nebraska Licensee Assistance Program (NE LAP) at (800) 851-2336 or (402) 354-8055 or visit our website at www.lapne.org. If you know of or are concerned about a colleague's or employee's alcohol/drug abuse, contact the NE LAP for appropriate intervention and ongoing support. You may be saving a life, a family or a career.

open

MANDATORY REPORTING

- All nurses are required by law to self-report resignation or termination from a nursing position due to alleged incompetence, negligence, unethical or unprofessional conduct or physical, mental or chemical impairment.
- Patient abandonment is defined as withdrawal of nursing care services after acceptance of an assignment without making appropriate provisions for the patient to receive continued care.
- Failure to give notice of resignation as required by employment policy or failure to go to work as assigned are not considered patient abandonment, but are considered unprofessional conduct and may be grounds for discipline of a nurse's license.
- Employers cannot revoke a nurse's license. The state issued the license and only the state can revoke the license. The employer is required to report any termination for one of the reasons listed above and an investigation of the nurse's license may occur based on the report.
- A nurse terminated for one of the reasons listed above still has a license and the authority to practice nursing until that authority is removed or limited by the state. A nurse who has been terminated is required to report the termination to subsequent employers.

Reporting forms can be obtained at http://www.hhss.ne.gov/reg/INVEST-P.HTM

By Sheila Exstrom, PhD, RN

An Overview of Enrollment and Graduation Trends in Nebraska Nursing Education Programs

The total number of students enrolled in nursing programs in Nebraska in 2005 was 4,462. The distribution was: Practical Nursing—829, Associate Degree—570, Diploma—194, Baccalaureate—2,170, BSN Completion—156, Masters' Programs—517, and PhD Programs—26.

After an all-time low in RN program enrollment in 1999, there has been a steady increase in enrollment since 2001. Enrollment in the undergraduate nursing programs has increased 42% in RN programs since 2001, resulting in all-time high enrollment in RN programs. This same upward trend has also been true for RN graduates, LPN enrollment (an 87% increase since 2001) and LPN graduates. There were 1,043 RN graduates in 2005, which is an all-time high as is the 501 PN graduates.

The number of students enrolled in BSN programs in 2005 was 2,170, which is still lower than the number enrolled in the early to mid 1990s. The number of students enrolled as well as the number of graduates from associate degree programs is at an all-time high, as is the number of students in the diploma program and the number of graduates of PN programs.

Between 2004 and 2005 enrollment in undergraduate RN programs increased 6% from 2,911 to 3,090. Enrollment in PN programs decreased nearly 7% (from 889 to 829) during this same time frame. This is still more than double the number of students enrolled in PN programs in the years leading up to 1999.

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complex nursing interventions such as starting an IV.

Unlicensed persons employed in physician's offices should not be referred to by other staff or refer to themselves as nurses. The use of the title "nurse" by unlicensed persons is misleading to the public and in violation of Neb. Rev. Stat. 71-1,132.17 which states, "In the interest of public safety and consumer awareness, it is unlawful for any person to use the title nurse in reference to himself or herself in any capacity, except individuals who are or have been licensed as a registered nurse or a licensed practical nurse. . . "

Medication Administration in the state of Nebraska is a regulated activity. Medication Administration is limited to:

1) individuals with capability and capacity to make an informed decision about medications;

2) caretakers; and

3) licensed health care professionals who have medication administration in their scope of practice.

Unlicensed persons may participate in the administration of medications by providing medications and documenting medications in accordance with the Medication Aide Act or RN delegation.

172 NAC 99-004.01C states that if RNs delegate medication provision, such delegation must be done in accordance with the Medication Aide Act, Neb.Rev.Stat. §71-6718 to 71-6742.

The Medication Aide Act states that if unlicensed persons are going to provide medications in any licensed health care facility, they must do so in accordance with the Medication Aide Act which requires them to be listed on the Medication Aide Registry.

In a physician's office (which is not a licensed health care facility), RN's may delegate medication administration to any unlicensed person, including someone using the title Medical Assistant. This may be done, though, only if in accordance with the delegation regulations found in Title 172 NAC 99-004. In this setting the unlicensed person including persons using the title Medical Assistant do not have to be listed on the Medication Aide Registry.

In any licensed health care facility, which includes but is not limited to entities licensed as health clinics, unlicensed persons including persons using the title Medical Assistant who are utilized to provide medications may only do so in accordance with the Medication Aide Act and therefore must be listed on the Medication Aide Registry.

All of the regulations, including the ones referred to above, can be accessed on our Web site, www.hhs.state.ne.us/crl/nursing/nursingindex.htm.

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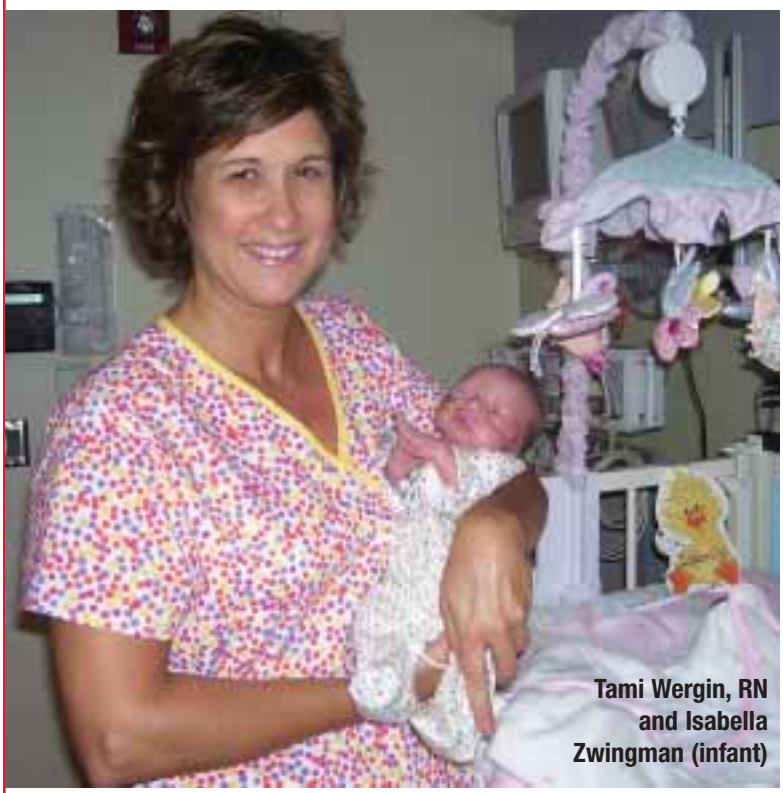
Premier Award for Quality

By Joyce Davis Bunger

Nursing in the Newborn Intensive Care Unit:

A CHALLENGING *and* REWARDING CAREER

As I walked out of my house, I grabbed a bottle of water. It weighed one pound and nine ounces. Two hours later I met a little girl that weighed only four ounces more than my bottle of water. It is not uncommon for babies to be born weighing less than 500 grams—a little more than one pound.



Tami Wergin, RN and Isabella Zwingman (infant)

These precious and fragile babies are Nebraska's smallest patients. And there is a good chance they will live their first three or four months in a Neonatal Intensive Care Unit. If there are additional complications, their stay could exceed 6 months.

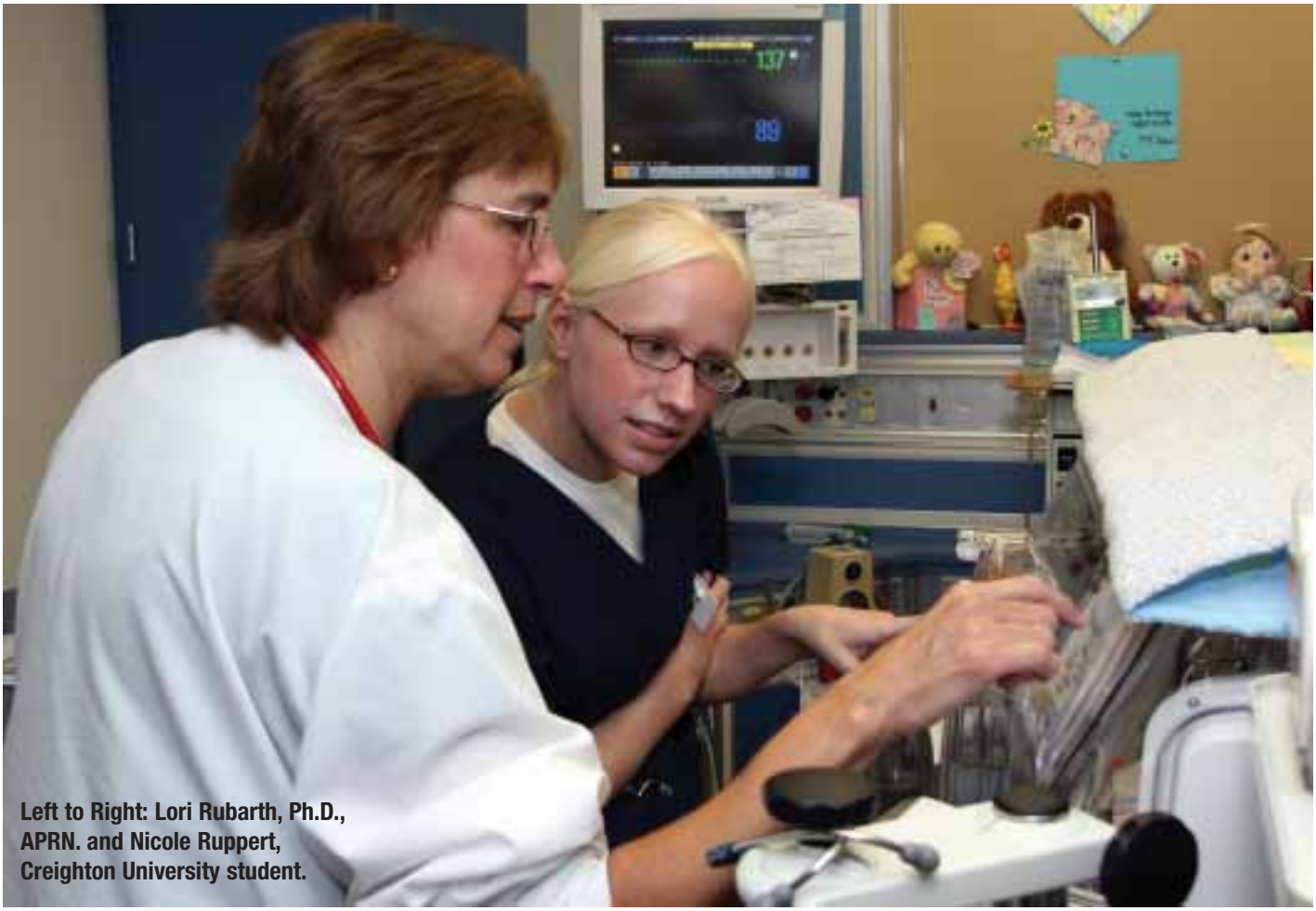
There are five Level 3 Neonatal Intensive Care Units (NICU) in the state—the Nebraska Medical Center, Alegent's Bergan Mercy Hospital, Creighton University Medical Center and Children's Hospital in Omaha and St. Elizabeth's Hospital in Lincoln. Level 3 NICUs mean that some surgeries and procedures can be performed within the unit and they care for the most acutely ill babies.

Life in the NICU changed dramatically with the introduction of Surfactant in 1988. Many recall the tragic death of President John F. Kennedy's small son, Patrick in 1963. He died of Hyaline Membrane Disease. His lungs collapsed. Other babies died because of the ventilators they were forced to use. Surfactant is a synthetic solution that keeps the sacs in the lungs open so babies are able to breathe on their own sooner.

There have been other incredible new developments in the NICUs, such as ventilators tailor-made for neonates and tiny tubing. However, more and more babies are being born before their due dates due to younger mothers, drug-addicted mothers and multiple births.

"Being a nurse in the NICU is something I love to do—and have since 1986," shared Julie Sundermeier, APRN, lead neonatal nurse practitioner at the Nebraska Medical Center. "It is always a thrill to be there to watch a new baby come into the world. Being involved in helping these little ones grow and thrive is so rewarding."

Sundermeier and Jenny Solano, currently working as a



Left to Right: Lori Rubarth, Ph.D., APRN. and Nicole Ruppert, Creighton University student.

NNP at Bergan Mercy, were the first Neonatal Nurse Practitioners in Nebraska. They graduated from Creighton's neonatal nurse practitioner program in 1998. At that time, there was a growing need for nurse practitioners due to the decrease in the numbers of physicians in pediatric residencies.

Nurse practitioners attend many caesarian section and all high-risk births. (It should be noted that nearly one-third of all deliveries are caesarian section deliveries.) They are also called upon to resuscitate babies, perform procedures, interpret lab and diagnostic studies and problem solve situations in the delivery room and while the infants are being cared for in the NICU. They manage the care of the babies in collaboration with the neonatatologists.

To become a neonatal nurse practitioner, a bachelor's-prepared nurse, with a minimum of 2 years NICU experience, completes a graduate program and passes a special certification examination. For most, graduate school is a 2 to 3 year commitment, depending on whether the student attends full time or part time.

NICUs have changed in recent years. They used to be brightly-lit, rather loud nurseries, with many isolettes in a row. Families could only visit sporadically and there was never a private time for a mother and her baby to bond. Today's modern NICU is dimly-lit and very quiet. Babies have private rooms equipped with rocking chairs and bulletin boards where siblings can post their drawings.

Shelley Brannen, BSN, has been a neonatal nurse for 29 years. She is currently on staff at the Nebraska Medical Center.

"I recall babies going home from the NICU and the moms would call to say the baby wouldn't stop crying," recalled Brannen. "It took years for us to figure out that the babies were over stimulated—lots of light and commotion. When they got home, it was too quiet and they cried."

Lori Rubarth has been a NICU nurse for close to 30 years. Over the years she has become certified as a neonatal nurse practitioner and went back to get her Ph.D. Today she directs the neonatal nurse practitioner program at the Creighton University School of Nursing and also maintains a practice at the Creighton University Medical Center and Bergen Mercy.

The survival rate for neonates has improved over the years.

"When I first became a neonatal nurse,

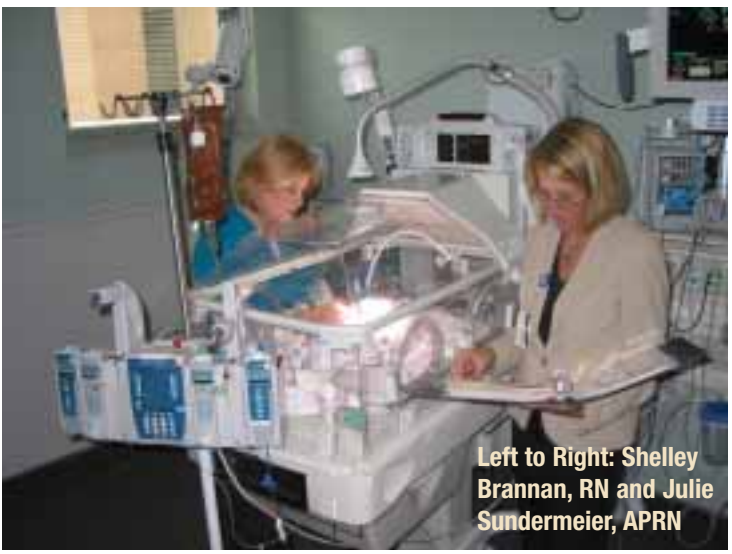
"It is always a thrill to be there to watch a new baby come into the world. Being involved in helping these little ones grow and thrive is so rewarding."

– Julie Sundermeier, APRN, Nebraska Medical Center

babies born before 24 weeks didn't survive—and there was little effort on the part of the medical staff to "save" the baby. Today almost 50% of the babies born at 24 weeks survive," said Rubarth.

Most babies stay in the NICU until their "due date." In addition to breathing on their own, they need to develop to a full-term baby. Ninety-nine percent of the babies go home and stay home after leaving the NICU. All agreed it is because of the tender loving care the babies receive—not just from the nurses, but from the families that are encouraged to come and hold even the tiniest of babies (a big change from years ago when no one held the babies for a long time).

"Kangaroo care" means skin to skin. Because of the private rooms, Moms can hold their babies—skin to skin—frequently. Babies and moms bond quickly. Moms learn to recognize the special nuances about their babies—making them more comfortable and confident in caring for their babies. Moms are given private areas for breast pumping so the infants can be fed mother's breast milk.



Left to Right: Shelley Brannan, RN and Julie Sundermeier, APRN

Years ago, neonates were sedated. Today non-pharmacological approaches are used and they are more successful.

"Babies are swaddled. We place them in positions that feel very much like they felt in utero," said Brannen. "We pay attention to their 'cues' to let them tell us what they need."

Tami Wergin has been a nurse in the NICU at St. Elizabeth's Regional Medical Center in Lincoln for over 20 years. She graduated from the University of Nebraska with an Associate Degree in Nursing and later completed her BSN at Wesleyan University. She is certified in high-risk neonatal nursing. She started working in pediatrics as a new graduate and then moved to the NICU.

Wergin believes the biggest challenge for the NICU nurse is balancing the needs of the infant with the needs of the family while maintaining family-centered care. Time management is also a challenge in the NICU as it is in other areas of nursing.

Wergin's greatest rewards are seeing most of her tiny patients do well and leave the nursery healthy. She enjoys hearing from the families of the infants she has cared for. She says, "The families never forget us. They tell us about the fond memories they have of the nurses who cared for their infant in the NICU."

Wergin likes working in this area due to the wide range of experiences it offers. She works with deliveries and is on the transport team. She has opportunities to work in the newborn nursery as well as with low birth weight infants and high risk infants. Wergin stated that new graduates often start in the newborn nursery and move to other areas as they gain new skills.

High-risk babies born outside of Omaha and Lincoln are transported to the NICUs by carefully trained transport teams. The Nebraska Medical Center first had a transport team in 1972. Ambulances and helicopters were equipped with isolettes. Most moms experiencing high-risk pregnancies are followed closely, many times in tertiary centers where the NICU is close by. However, most premature births are unpredicted.

Modern NICUs have "family rooms" adjacent to the unit, enabling families to come and visit and to have a place of their own to relax and play while visiting the baby. In Omaha many of the moms stay at the Ronald McDonald House while their baby is in the NICU; however if they must return home, volunteer "baby holders" come to hold the babies often.

What makes a good NICU nurse? All the nurses interviewed said similar things—they like the pace, they like the intensive care and acuity of their patients, and they like the littlest of patients because of the unique challenges that they and their families face. Older babies and young children in the Pediatric Intensive Care Units are often very afraid and resistant to medical interventions, Rubarth noted.

Being a NICU nurse is very stressful—its pace is not unlike the adult intensive care unit. Patients are very, very sick and need constant monitoring. When infants get ill—it can happen incredibly fast.

"My biggest challenge is leaving the job at the bedside," said Sundermeier. "A few of our babies don't get better. We see parents with their 'dreams broken'—what they thought would be a perfect little child is born with many problems, when (and if) it goes home special care may be required for the rest of its life."

Brannen added that once the babies leave the NICU, they may never see the babies again. Should the baby return to the hospital, they go into the Pediatric Intensive Care Unit or the pediatric department.

"Sometimes parents stop back for a visit or send us pictures—and we love that!" said Brannen. Many hospitals have NICU reunions for the NICU graduates and their families.

Rubarth agreed sending the baby home is bittersweet. You have gotten to know the baby and their family; you see the joy in their eyes that their family is going home. However, many babies emerge from the NICU with special needs that could mean a lifetime of peril for the family. Even the slightest infection can be disastrous for the baby.

"We save babies lives every day. As nurses, we are able to do the interventions that really make a difference. Our little patients stay with us a long time—it is the nurses that support the baby and their families, enabling the baby to go home sooner and healthier."

Joyce Davis Bunger *is Assistant Dean, Creighton University School of Nursing and public member on the Board of Nursing.*

Changes in Uniform Licensing Law: *Implications for Nursing*

by Charlene Kelly

The Uniform Licensing Law (ULL) has been in existence in Nebraska since 1927. The purpose of the Uniform Licensing Law is to have one location in the statutes where everything that is common to all professions is located. Over the years the ULL has been amended and changed and things that are not common to all professions have crept into this section of the statutes. The ULL applies to many of the professions regulated by the department. For the most part nursing has not been under ULL. The exceptions are the section of ULL that deal with such things as fees, discipline, and the Licensee Assistance Program. The ULL is in serious need of a total rewrite to update provisions, to bring all of the professions under ULL and to change the name of this section of the law to Uniform Credentialing Act (UCA). Committees and task forces coordinated by the department have been working for several years to revise the provisions of the UCA and to draft the proposed legislation that will accomplish the goals including comprehensiveness, currency and uniformity. It is anticipated that this proposed legislation will be introduced in the 2007 legislation session. If the legislation passes, nursing will be subject to the provisions of UCA.

So what will these changes in UCA mean to nursing? Many of the provisions that are currently in the Nurse Practice Act will now be found in the UCA. For example:

- Definition of terms that are not specific to nursing
- Process for Board of Health appointments to the Board of Nursing
- Purposes of the Board
- Authority to promulgate rules and regulations including continued competency requirements
- Authority to make recommendations about licensure and disciplinary actions
- Board member per diem payments
- General licensure/examination requirements (requirements specific to nursing will be retained in the Nurse Practice Act)
- Renewal requirements and procedures
- Administrative penalty fee for practicing without an active license. Additionally, the following changes will be made to the ? Act. Only one license renewal notice will be sent to licensees. There will no longer be a 30-day extension of the renewal period. After the expiration date the licensee's license status will be "expired." The licensee will have to apply for reinstatement and meet the renewal requirement to regain active status. The licensee will still have the option to request that his/her license be placed on inactive status.

- The requirement for the nursing administrators, staff nurses and LPNs on the board to be evenly distributed between acute care, long term care and community will be replaced with "The Board of Health shall attempt to ensure that the board is representative of acute care, long-term care, and community-based care."
- The current requirement for the board to be evenly representative of each congressional district in the state will change to requiring a minimum of three and a maximum of five from each congressional district.
- The LPN educator on the board will be required to have a graduate degree in nursing (current requirement is baccalaureate requirement) and five years of experience in education (current requirement is three years).

If the bill passes it will not go into effect for nearly a year.

More information and education materials on the changes will be made available if the proposed legislation is introduced and passes.

Licensure Actions

The following is a list of licensure actions taken between May 1, 2006 and August 31, 2006 additional information on any of these actions is available by calling (402) 471-4923.

LICENSEE	DATE OF ACTION	ACTION	VIOLATION
Angela Koehler RN	5/9/06	Non-Disciplinary Assurance of Compliance	Unprofessional Conduct-Practice of the professional beyond authorized scope.
Mark Calligaro LPN	5/9/06	Voluntary Surrender in Lieu of Discipline	
Rose Roebuck LPN	5/15/06	Censure	Unprofessional Conduct-Failure to maintain an accurate patient record; Committing any act which endangers patient safety and welfare.
Beverly McIntosh RN	5/15/06	Limitation	Unprofessional Conduct-Failure to utilize appropriate judgment in administering safe nursing practice based upon level of nursing for which licensed; Failure to exercise technical competence; Failure to maintain an accurate patient record.
Andrea Sattlefield RN	5/16/06	Non-Disciplinary Assurance of Compliance	Unprofessional Conduct-Leaving a patient care nursing assignment without notifying personnel so that reasonable arrangements for continuation of care can be made.
Tammy Overton LPN	5/16/06	Non-Disciplinary Assurance of Compliance	Failure to comply with the state mandatory reporting law by failing to report misdemeanor conviction in accordance with the state mandatory reporting law.
Linda Branchaud-Knapp RN	5/17/06	Non-Disciplinary Assurance of Compliance	Failure to comply with the state mandatory reporting law by failing to report loss of employment due to alleged unprofessional conduct.
Diana Davis LPN	5/18/06	Non-Disciplinary Assurance of Compliance	Failure to comply with the state mandatory reporting law by failing to report loss of employment due to alleged unprofessional conduct.
Collette Echols LPN	5/18/06	Non-Disciplinary Assurance of Compliance	Unprofessional Conduct-Failure to furnish the Board or its investigator with requested information or requested documents on license renewal.
Sally Wentworth LPN	5/19/06	Non-Disciplinary Assurance of Compliance	Failure to utilize appropriate judgment in administering safe nursing practice based upon level of nursing for which licensed. Failure to comply with the state mandatory reporting law by failing to report loss of employment due to alleged unprofessional conduct.
Felicia Worlds LPN	5/19/06	Non-Disciplinary Assurance of Compliance	Violation of the Uniform Controlled Substances Act
Cindy Goff LPN	5/23/06	License Reinstated on Probation	Previous Discipline
Sabra Trueman LPN	5/23/06	30 day Suspension	Unprofessional Conduct-Failure to maintain an accurate patient record; committing any act which endangers patient safety and welfare. Dishonorable Conduct
Cheryl Lange LPN	5/23/06	Probation	Practice of the profession while ability to practice is impaired by controlled substances. Violation of the Uniform Controlled Substances Act. Habitual Dependence
Lavonna Morris LPN, LPN-C	5/23/06	Suspension for 30 days, Probation	Unprofessional Conduct-Failure to utilize appropriate judgment in administering safe nursing practice based upon level of nursing for which licensed; Failure to follow policies and procedures implemented in the practice situation to safeguard patient care; Failure to maintain an accurate patient record. Failure to comply with the state mandatory reporting law by failing to report loss of employment due to alleged unprofessional conduct.
Brian Craven LPN	5/25/06	30 day Suspension followed by Probation	Disciplinary Action in Another State. Failure to comply with the state mandatory reporting law by failing to report disciplinary action taken by another state.
Terri Incontro LPN	5/25/06	Non-Disciplinary Assurance of Compliance	Unprofessional Conduct-Failure to seek consultation, collaboration or direction from another licensed healthcare provider when warranted by patient condition.
Rochelle Helmick LPN	6/2/06	Suspension	Unprofessional Conduct-Misappropriating medications of a patient or agency.
Deborah Brittenham RN	6/2/06	Suspension for 30 days	Unprofessional Conduct-Falsification of patient records.
Theresa Wiese RN	6/2/06	Suspension for 30 days	Unprofessional Conduct-Misappropriating medication of a patient or agency.
Joquana Walker LPN	6/5/06	Initial License Issued on Probation	Conviction of misdemeanors that have a rational connection with fitness or capacity to practice the profession.
Karmen Goerks LPN	6/6/06	Suspension	Unprofessional Conduct-Failure to maintain an accurate patient record; Committing any act which endangers patient safety or welfare; Practice of the profession beyond authorized scope. Failure to report employment termination in accordance with the state mandatory reporting law.

LICENSEE	DATE OF ACTION	ACTION	VIOLATION
Amy Mills LPN	6/6/06	Non-Disciplinary Assurance of Compliance	Unprofessional Conduct-Failure to utilize appropriate judgment in administering safe nursing practice based upon level of nursing for which licensed.
Paul Gordier RN	6/7/06	License Reinstated on Probation	Previous Discipline
Kayla McBride LPN	6/8/06	Revocation	Violation of previously imposed terms and conditions of licensure probation.
Dale Brock RN	6/8/06	Censure Civil Penalty	Unprofessional Conduct-Practice of the profession without a current active license or temporary permit.
Stephen Larison LPN	6/8/06	Voluntary Surrender in Lieu of Discipline	
Karen Codr LPN	6/12/06	Non-Disciplinary Assurance of Compliance	Unprofessional Conduct-Failure to utilize appropriate judgment in administering safe nursing practice based upon level of nursing for which licensed.
Jessica Emery LPN	6/12/06	Non-Disciplinary Assurance of Compliance	Violation of the Uniformed Controlled Substances Act
Susan Wulf RN	6/13/06	Non-Disciplinary Assurance of Compliance	Unprofessional Conduct-Practice of the professional beyond authorized scope.
Constance Buresh LPN	6/18/06	Revocation	Conviction of misdemeanors which have a rational connection with fitness or capacity to practice the profession. Violation of the Uniformed Controlled Substances Act Unprofessional Conduct-Failure to provide the Department with requested information during a disciplinary investigation.
Catherine Trump RN	6/18/06	Suspension for 30 days followed by Probation	Habitual Dependence. Unprofessional Conduct-Misappropriating patient medications for personal use. Violation of the Uniform Controlled Substances Act
Christopher Wanamaker RN	6/18/06	Limitation	Unprofessional Conduct-Failure to utilize appropriate judgment in administering safe nursing practice based upon level of nursing for which licensed; Failure to maintain an accurate patient record; Committing any act which endangers patient safety and welfare. Failure to comply with the state mandatory reporting law by failing to report misdemeanor convictions in accordance with the state mandatory reporting law.
Bryce Miller RN, CRNA	6/24/06	RN-Retroactive Suspension followed by Probation CRNA-Suspension	Unprofessional Conduct-Falsification of patient records; Failure to maintain an accurate patient record; Misappropriation of medication. Violation of the Uniform Controlled Substances Act
Carol Erhardt RN	6/28/06	License Reinstated on Probation	Previous Discipline
Tonya Whittington-Langle LPN	6/29/06	Non-Disciplinary Assurance of Compliance	Failure to comply with the state mandatory reporting law by failing to report misdemeanor conviction in accordance with the state mandatory reporting law.
Carissa Rickard LPN	7/5/06	Voluntary Surrender in Lieu of Discipline	
Vicki Stuhr LPN	7/5/06	Voluntary Surrender in Lieu of Discipline	
Arlene Goergen LPN	7/7/06	Non-Disciplinary Assurance of Compliance	Unprofessional Conduct-Failure to utilize appropriate judgment in administering safe nursing practice based upon level of nursing for which licensed.
Carolyn Griger LPN	7/16/06	Suspension for 30 days	Unprofessional Conduct-Practice of the profession beyond authorized scope.
Karen Harris RN	7/17/06	Non-Disciplinary Assurance of Compliance	Unprofessional Conduct-Practice of the professional beyond authorized scope.
Jayna Conley LPN	7/25/06	Civil Penalty. Probation Extended	Violation of previously imposed terms and conditions of licensure probation.
Tina Foerster LPN	7/25/06	Probation	Conviction of a misdemeanor which has a rational connection with fitness or capacity to practice the profession.
John Fahrnbruch II RN	7/25/06	Probation	Habitual Dependence. Conviction of a misdemeanor which has a rational connection with fitness or capacity to practice the profession.
Linda Carsten RN	7/25/06	Retroactive 30 day Suspension	Unprofessional Conduct-Falsification of patient records.
Kenneth Hirschfeld RN	7/25/06	Suspension	Dishonorable Conduct-Diversion of controlled substances from place of employment. Habitual Dependence. Violation of the Uniform Controlled Substances Act
Gayleen Kuehn RN	7/25/06	Voluntary Surrender in Lieu of Discipline	
Judy Moeller RN	7/25/06	Voluntary Surrender in Lieu of Discipline	
Tammy Davis LPN	7/25/06	Non-Disciplinary Assurance of Compliance	Unprofessional Conduct-Failure to utilize appropriate judgment in administering safe nursing practice based upon level of nursing for which licensed.
Tara Erb LPN	7/28/06	Initial License issued on Probation	Conviction of misdemeanors which have a rational connection with fitness or capacity to practice the profession.
Michael O'Connell LPN	7/28/06	Probation	Disciplinary action in another state.
Randall Somer RN	7/28/06	Non-Disciplinary Assurance of Compliance	Failure to comply with the state mandatory reporting law by failing to report loss of employment due to alleged unprofessional conduct.

LICENSEE	DATE OF ACTION	ACTION	VIOLATION
Jacqueline Spoor LPN	7/28/06	Non-Disciplinary Assurance of Compliance	Failure to comply with the state mandatory reporting law by failing to report loss of employment due to alleged unprofessional conduct.
Brooke Bynum LPN	7/31/06	Non-Disciplinary Assurance of Compliance	Unprofessional Conduct-Leaving a patient care nursing assignment without giving adequate notice to personnel so that reasonable arrangements for continuation of care can be made.
Betty Werner LPN	7/31/06	Non-Disciplinary Assurance of Compliance	Failure to utilize appropriate judgment in administering safe nursing practice based upon level of nursing for which licensed. Failure to comply with the state mandatory reporting law by failing to report loss of employment due to alleged unprofessional conduct.
April Ndango LPN	8/2/06	Non-Disciplinary Assurance of Compliance	Unprofessional Conduct-Committing any act which endangers patient safety or welfare.
Romunda Baker LPN	8/4/06	Suspension for 30 days	Unprofessional Conduct-Failure to utilize appropriate judgment in administering safe nursing practice based upon level of nursing for which licensed; Leaving a patient care nursing assignment without notifying personnel so that reasonable arrangements for continuation of care can be made. Failure to comply with the state mandatory reporting law by failing to report loss of employment due to alleged unprofessional conduct.
Tiffani Cullum LPN	8/4/06	Probation	Habitual Dependence. Violation of the Uniform Controlled Substances Act
Janice Echolt LPN	8/4/06	Censure	Unprofessional Conduct-Practice of the profession beyond authorized scope.
Victor McDonald LPN	8/4/06	Revocation	Conviction of a misdemeanor which has a rational connection with fitness or capacity to practice the profession. Violation of the Uniform Controlled Substances Act
Denie Nesvan LPN	8/4/06	Censure. Civil Penalty. Probation	Unprofessional Conduct-Failure to utilize appropriate judgment in administering safe nursing practice; Failure to exercise technical competence based upon level of nursing for which licensed; Assigning nursing interventions contrary to standards.
Elizabeth Sobotka LPN	8/4/06	Revocation	Violation of previously imposed terms and conditions of licensure probation.
Bridget Fox RN	08/04/06	Suspension for 30 days followed by Probation	Unprofessional Conduct-Failure to exercise technical competence based upon level of nursing for which licensed; Failure to maintain an accurate patient record; Committing any act which endangers patient safety. Practicing the profession in a pattern of negligent conduct. Failure to comply with the state mandatory reporting law by failing to report misdemeanor convictions in accordance with the state mandatory reporting law.
Shannon Roudebush RN	8/4/06	Censure. Civil Penalty	Unprofessional Conduct-Failure to utilize appropriate judgment in administering safe nursing practice; Failure to exercise technical competence; Failure to maintain an accurate patient record; Failure to comply with the state mandatory reporting law by failing to report misdemeanor convictions in accordance with the state mandatory reporting law.
David Snell RN	8/4/06	Revocation	Violation of previously imposed terms and conditions of licensure limitation.
Christine Daily LPN	8/4/06	Suspension for 30 days	Unprofessional Conduct-Intentional falsification of material facts in a material document connected with the practice of nursing.
Michael Ament RN	8/8/06	License Reinstated on Probation	Previous Discipline
Angela Werner RN	8/8/06	License Reinstated on Probation	Previous Discipline
Patricia Marsh RN	8/14/06	Revocation	Habitual Dependence. Violation of the Uniformed Controlled Substances Act
Emily Leader LPN	8/21/06	Initial License issued on Probation	Conviction of misdemeanors that have a rational connection with fitness or capacity to practice the profession. Habitual Dependence
Michael Foster RN	8/21/06	License Reinstated on Probation	Previous Discipline
Heather Kilpatrick RN	8/21/06	Probation	Unprofessional Conduct-Committing any act which endangers patient safety and welfare; Failure to maintain an accurate patient record. Violation of an Assurance of Compliance Practicing the profession in a pattern of negligent conduct.
Laura Kenyon LPN	8/22/06	Non-Disciplinary Assurance of Compliance	Unprofessional Conduct-Giving a controlled substance which had been personally prescribed for her to another individual. Failure to comply with the state mandatory reporting law by failing to report loss of employment due to alleged unprofessional conduct.
Christy Umberger LPN	8/22/06	Initial License Issued on Probation	Conviction of misdemeanors that have a rational connection with fitness or capacity to practice the profession.
Dezeree Brown RN	8/28/06	Voluntary Surrender in Lieu of Discipline	
Michael Warner RN	8/28/06	Voluntary Surrender in Lieu of Discipline	
Amy Krannawitter LPN	8/28/06	Probation	Habitual Dependence. Conviction of a misdemeanor which has a rational connection with fitness or capacity to practice the profession.

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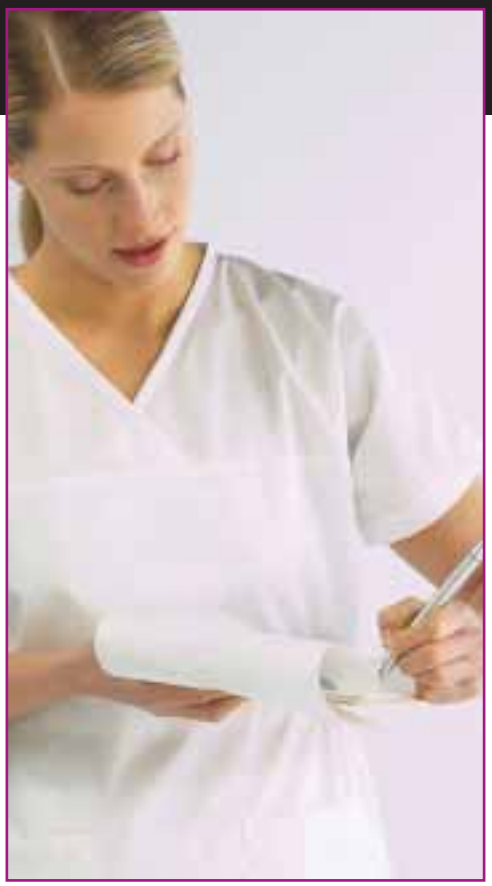

As you have read and heard, the "Umbrella Bill" or LB 256 passed in 2005. It will go into effect July 1, 2007. This bill will bring all the advanced practice nurses under the APRN title, including the Clinical Nurse Specialists (CNS). Currently CNSs in Nebraska are not licensed. After July 1, 2007, all CNSs will be required to have a license to practice as a CNS.

The process of writing all the regulations to implement LB 256 is underway, including new CNS regulations. These CNS regulations will provide specifics for such things as the process of licensing, continuing competency and so forth, based on the new Clinical Nurse Specialist Statutes (Practice Act).

Some CNSs have expressed concern that they do not meet some of the requirements to take a certifying examination, such as the number of clinical hours they had in their education program. The statutes do contain a provision whereby the CNS currently practicing can apply for a license between July 1, 2007 and September 1, 2007 without having to meet the requirement of having a certification from an approved certifying body. They will be "grandfathered" in if they apply for licensure during that timeframe.

Watch the Nursing News for further updates on the implementation LB 256. You may also contact Karen Bowen, MS, RN, Nursing Practice Consultant at 402-471-6443 with questions.

REVISED ADVISORY OPINION

At the September Board of Nursing meeting, the board approved revisions to the advisory opinion, Analgesia and Moderate Sedation. Below is the new opinion. This and all the advisory opinions can be found on our Web site, www.hhs.ne.gov/crl/nursing/nursingindex.htm.

Analgesia/ Moderate Sedation

Moderate/Conscious Sedation

Definitions

Minimal Sedation is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

Moderate Sedation/Analgesia (formerly referred to as "Conscious Sedation") is a drug-induced depression of consciousness during which patients respond purposefully* to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Deep Sedation/Analgesia is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

General Anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.
*Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.

Management and Monitoring

It is within the scope of practice of a registered nurse who is not a qualified anesthesia provider to manage and monitor the care of patients receiving IV moderate/conscious sedation during therapeutic, diagnostic, or surgical procedures provided the following criteria are met:

1. Administration of IV conscious sedation medications by non-anesthetist RNs is allowed by institutional policy, procedures, and protocol. Written protocols which address specific drugs to be used for moderate/conscious sedation, the purpose, goals, techniques, desired outcomes of administration, and the recommended dose per kilogram of body weight that may be safely administered by an RN, taking into account the patient's age and co-morbidities.

2. A qualified anesthesia provider or attending physician orders the medications to achieve IV conscious sedation.

3. Guidelines for patient monitoring, drug administration, and protocols for dealing with potential complications or emergency situations are available and have been developed in accordance with accepted standards of anesthesia practice.

4. The registered nurse managing and monitoring the care of the patient receiving IV conscious sedation shall have no other responsibilities that would leave the patient unattended or compromise continuous patient monitoring.

Qualifications

1. The registered nurse managing the care of patients receiving IV conscious sedation is accountable to:

   a. Demonstrate the acquired knowledge of anatomy, physiology, pharmacology, cardiac arrhythmias and complications related to IV conscious sedation and medications.

   b. Understand the principles of oxygen delivery, respiratory physiology, oxygen transport and uptake, as well as demonstrate the ability to use oxygen delivery devices.

   c. Anticipate and recognize potential complications of IV conscious sedation in relation to the type of medication being administered.

   d. Possess the requisite knowledge and skills to assess, diagnose and intervene in the event of complications or undesired outcomes. The nurse must be able to institute nursing interventions in compliance with orders (including standing orders) or institutional protocols or guidelines.

   e. Demonstrate competency in airway management and resuscitation appropriate to the age of the patient. This may be completed by ACLS/PALS certification or appropriate competency assessment.

   f. Demonstrate knowledge of the legal ramifications of administering IV conscious sedation and/or monitoring patients receiving IV conscious sedation, including the RN's responsibility and liability in the event of an untoward reaction or life-threatening complication.

Additional Guidelines

1. The institution or practice setting has in place an educational/competency validation mechanism that includes a process for evaluating and documenting the individuals' demonstration of the knowledge, skills, and abilities related to the management of patients receiving IV conscious sedation. Evaluation and documentation of competence occurs on a periodic basis according to institutional policy.

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2. Intravenous access will be continuously maintained for the patient receiving IV conscious sedation and analgesia.

3. All patients receiving IV conscious sedation will be continuously monitored throughout the procedure as well as the recovery phase by physiologic measurements including, but not limited to, respiratory rate, oxygen saturation, blood pressure, cardiac rate and rhythm, and patient's level of consciousness.

4. Supplemental oxygen will be immediately available to all patients receiving IV conscious sedation and administered per order (including standing orders).

5. An emergency cart with a defibrillator must be immediately accessible to every location where IV conscious sedation is administered. Suction and a positive pressure breathing device, oxygen, and appropriate airways must be in each room where IV conscious sedation is administered.

6. Provisions must be in place for back-up personnel who are experts in airway management, emergency intubation, and advanced cardiopulmonary resuscitation if complications arise during IV conscious sedation.

7. It is not considered appropriate for an RN to administer propofol, etomidate, pentothal and Ketamine for the use of IV conscious sedation.

Analgesia

It is the opinion of the Nebraska Board of Nursing that it is within the scope of practice for a Registered Nurse to manage the care of non-pregnant patients receiving analgesic medication via epidural catheter for acute or chronic pain.

Management and Monitoring

The RN will assume responsibility for patient care only after the anesthesia provider has placed the catheter, verified placement of the epidural catheter, and administered an initial test dose of pain medication with the patient's vital signs remaining stable.

The RN may:

1. Monitor the patient's vital signs, mobility, level of consciousness, and perception of pain.

2. Replace empty infusion syringes or infusion bags with new, pre-prepared solutions containing the same medication and concentration, according to standing orders provided by the anesthesia care provider.

3. Remove the catheter, if educational criteria and institutional policy allow. Removal of the catheter by a RN is contingent upon receipt of a specific order from a qualified anesthesia or provider.

4. Decrease or stop the continuous infusion if there is a safety concern

5. Initiate emergency therapeutic measures according to institutional policy and/or protocol if complications arise.

The following are not considered within the scope of practice for an RN:

1. The RN may not administer anesthetic medications via an epidural catheter for the purposes of pain control or anesthesia. The RN may not bolus, rebolus, give an initial test dose or increase the rate.

2. The RN may not place the catheter or check placement.

Qualifications

1. Only RNs with the appropriate education, knowledge, skills and supervised clinical practice are allowed to administer and manage the medications for epidural analgesia.

2. Education: The RN must receive instructions in and demonstrate competence in the following;

a. Epidural anatomy and physiology.

b. Indications and contraindications to epidural analgesia.

c. Potential adverse reactions.

d. Maintenance of the catheter and or infusion device and related equipment.

e. Pharmacology and pharmacokinetics of commonly used analgesia medications.

f. Nursing care responsibilities as defined and approved by institutional policy.

Additional Guidelines

1. Written policy and procedures are maintained by the employer/agency. Guidelines for the patient monitoring, drug administration, management, and protocols for dealing with potential complications or emergency situations are available and have been developed in conjunction with the physician or CRNA.

A licensed nurse is accountable to be competent for all nursing care that he/she provides. Competence means the ability of the nurse to apply interpersonal, technical and decision-making skills at the level of knowledge consistent with the prevailing standard for the nursing activity being applied. Accountability also includes acknowledgment of personal limitations in knowledge and skills, and communicating the need for specialized instruction prior to providing any nursing activity.

REFERENCES

Endorsement of Position Statement on the Role of the Registered Nurse (RN) in the Management of Patients Receiving IV Conscious Sedation for Short-Term Therapeutic, Diagnostic, or Surgical Procedures. ANA Board of Directors Policy/Position. 1997

Endorsement of Position Statement on the Role of the Registered Nurse (RN) in the Management of Analgesia by Catheter Techniques (Epidural, Intrathecal, Intrapleural, or Peripheral Nerve Catheters). ANA Board of Directors Policy/Position. 1997

Considerations for Policy Guidelines for Registered Nurses Engaged in the Administration of Conscious Sedation. American Association of Nurse Anesthetists. 2003.

Role of the Registered Nurse (RN) in the Management of Patients Receiving Conscious Sedation for Short-Term Therapeutic, Diagnostic or Surgical Procedures. American Association of Critical-Care Nurses. 1996.

Position Statements: Sedation and Analgesia. Society of Gastroenterology Nurses and Associates, Inc. Revised 1998.

Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. American Society of Anesthesiologists. 1999.

Recommended Practices for Managing the Patient Receiving Conscious Sedation/Analgesia. American Association of Operating Room Nurses. 2000

Adopted 1989; Updated 1991; Reaffirmed January 1996; Revised December 1998; Revised April 2004; Revised September 2006

Nebraska Center for Nursing Overview of Current Activities

Online Clinical Scheduling Program • The Center for Nurisng (CFN) board viewed a demonstration of the online clinical scheduling program developed and marketed by the Oregon Center for Nursing. The online programs supports maximum utilization of clinical facilities. A similar demonstration is scheduled in October for the Deans and Directors. California has developed a similar software program which will also be explored.

Enrollment Data • The 2005 annual reports from nursing education programs revealed 1,177 students enrolled. 397 of the enrolled students are minorities – 55 of which are international students. This is up from 1,043 a year ago.

Student Passport • The Nursing Deans and Directors are working on a student passport project that will eliminate the need for students to repeat CPR, immunization records, HIPAA training and criminal background checks as they move from facility to facility. This will reduce duplicative paper work and increase the amount of student and faculty time that can be devoted to educational activities.

Employer Vacancy Survey • Vacancy rates for RNs have decreased from 10% in 2000 to 6.5% in 2002 to 5.9% in 2006. At the same time LPN vacancy rates have fluctuated from 10.2% in 2000 to 3.8% in 2002 to 6.7% in 2006. Unlicensed Assistive Personnel (UAP) vacancies were 7.9% in 2000, 4.8% in 2002 and 5.4% in 2006.

Regionally, RN vacancy rates were highest in the Omaha metropolitan area (7.6%). LPN vacancy rates were highest in the central part of the state (12.7%) and UAP vacancy rates were highest in the western end of the state. Vacancy rates for RNs in rural and urban areas were nearly the same, while rural areas are experiencing a higher vacancy rate for LPNs and a slightly higher rate for UAPs.

Survey of Inactive and Lapsed Nurses • A survey of RNs who went inactive or lapsed during the 2006 license renewal period is being conducted to determine the reason why the nurse is not keeping his/her license on active status. One goal of this study is to assess the degree to which the workplace environment influences nurse's decisions to go inactive or lapsed.

Electronic Newsletter • The first issue of the CFN electronic newsletter *Nursing . . .Briefly* was developed and distributed. The CFN Web site is currently out of operation. As soon as it is restored the second issue of the newsletter will be distributed.

Faculty Loan Update • Ten loans have been allocated for academic year 2006-2007 to graduate nursing education programs in Nebraska based on enrollment. UNMC will receive 3 loans, Creighton and Wesleyan will each receive 2 loans and Methodist, Clarkson and College of St. Mary will each receive 1 loan.

Registry Action on Nurse Aides & Medication Aides

From 06/01/06 to 07/31/06, the following nurse aides have become ineligible for employment in long-term care facilities and/or intermediate care facilities for persons with mental retardation:

Name	Nurse Aide Registry #	Action	Date Entered
Brandt, Danelle	54843	Finding of Conviction	07/28/06
Ely, Dannel	72902	Finding of Conviction	07/12/06
Gonzalez-Castro, Jennifer	68651	Finding of Abuse	06/26/06
Hill, Antoinette	48971	Finding of Neglect	07/06/06
Hutson, Jessica	69138	Finding of Neglect	06/16/06
Johnson, Versie	42948	Finding of Abuse	07/28/06
Johnson, Yvonne	62657	Finding of Neglect	07/31/06
LaDeaux, Gena	13737	Finding of Conviction	06/26/06
McDaniel, James	67018	Finding of Abuse	06/26/06
		Finding of Neglect	06/26/06
Ogden, Kimberly	42390	Finding of Conviction	06/15/06
Omo-Noyan, Ben	58798	Finding of Abuse	07/28/06
		Finding of Neglect	07/28/06
Roberts, Marianne	21589	Finding of Conviction	07/28/06
Snider, Rick	28049	Finding of Neglect	07/28/06
Swartz, Angie	28704	Finding of Conviction	07/28/06
Welch, Jean	32256	Failure to Pay Fees/ Delinquent Child Support Payment	06/16/06
Wink, Patricia	49649	Finding of Abuse	07/28/06

From 06/01/06 to 07/31/06, the following medication aides have been removed from the Medication Aide Registry:

Name	Medication Aide Reg #	Action	Date Entered
Brandt, Jean	48175	Moral Character	07/28/06
Brown, Michael	56595	Competency Violation	07/17/06
Gannaway, Lana	10630	Competency Violation	07/03/06
Goff, Lisa	51819	Competency Violation	07/17/06
King, Saddie	52044	Competency Violation	07/12/06
Klasna, Kendra	55506	Failure to Pay Fees	06/15/06
Kreis, Constance	52063	Competency Violation	07/12/06
Lorenz, Sydnie	50360	Competency Violation	07/31/06
Ogden, Kimberly	48667	Moral Character	06/15/06
Swartz, Angie	28704	Moral Character	07/28/06
Wieck, Billie	52376	Competency Violation	07/12/06

By Kay Maize, RN, MS, MSN, Ed.D,. Dean of Nursing, BryanLGH College of Health Sciences

NURSING FACULTY SHORTAGE

A VIEW OF NEBRASKA NURSING FACULTY DEMOGRAPHICS

Nursing education is an advanced and valued role in the nursing field. If you have the skills, interest, and inclination to be an educator, now is the prime time to explore the role and determine your educational and experiential needs for transitioning into an educator role.

The shortage of nurses has been in the forefront of health care for quite some time. Through analysis of the nursing shortage and implementation of strategies to reduce the shortage, an additional emerging issue has been recognized – that of a shortage of nursing faculty. The aging trajectory indicates that the faculty shortage is expected to grow, directly hindering educational programs in the ability to increase the number of individuals educated to enter into the profession.

The American Association of Colleges of Nursing (AACN) conducts annual surveys of baccalaureate and graduate programs in nursing. Based on the 2004-2005 enrollment and graduation information, the AACN reported that 32,797 qualified applicants were not accepted into baccalaureate and graduate nursing programs in 2004. One of the main factors was insufficient faculty as reported by 76.1% of the programs (Berline, Wilsey, and Bednash, 2005). Ruth Corcoran of the National League for Nursing (NLN) reported that 125,000 qualified nursing school applicants were not able to enroll in 2004 because of faculty shortage (Corcoran, 2005). The number reported from the NLN takes into account all levels of nursing education, therefore a significantly higher number than that reported from AACN.

AACN projected in a March 4, 2004, press release, "….that between 200-300 doctorally-prepared faculty will be eligible for retirement each year from 2003 through 2012, and between 220-280 master's-prepared nurse faculty will be eligible for retirement between 2012 and 2018." (AACN, 2004). Data concurring with the growing concern for a faculty shortage has also been published from the National League for Nursing. "By 2017, two-thirds of nurse faculty teaching today will have reached retirement age…" (Corcoran, 2005).

A survey to determine the faculty status in Nebraska was developed and all Nebraska nursing programs were requested to participate. The survey was presented to the Nebraska Assembly of Nursing Deans and Directors for input and request for participation. To provide confidentiality of individual faculty information, the request from Deans and Directors was honored to revise the survey for programs to submit data in aggregate form rather than by individual. This limited the ability to analyze data based on the various categories of data collected. The survey was distributed to the18 colleges and universities in Nebraska that currently offer nursing education, with 17 responding.

Nebraska data from the survey represented all levels of nursing education. The number of Nebraska nurses in education represented in the 17 responding nursing education programs was 422. Nebraska findings indicated Nebraska will be faced with a major loss of nurse educators in the next ten to 15 years.

The following bar graph illustrates the age distribution of Nebraska nurse educators. The average age of the Nebraska nursing educator was 49. Based on a retirement age of 65, 55% percent, or 228 Nebraska nurse educators will be eligible to retire in ten to 15 years. In ten years alone, 108 or 26% will be eligible for retirement.

Retirement will also highly impact the overall teaching experience of educators. Currently, 51% of Nebraska nurse educators have over ten years of experience in academia. In contrast, 37% have less than five years experience in education.

The shortage of nurses has been in the forefront of health care for quite some time... an additional emerging issue has been recognized – that of a shortage of nursing faculty.

Opportunity in nursing education awaits you. As you give consideration to the nurse educator role, an excellent resource for linking to all Nebraska Nursing education programs is the Nebraska Center for Nursing. The Center can be accessed at http://www.center4nursing.org.

If you would like to observe a nurse educator and experience the role directly, I would welcome the opportunity to arrange for such as experience with the nursing faculty at BryanLGH College of Health Sciences. There is a reason that 51% of the Nebraska nurse educators have over ten years experience in academia. It is a rewarding career option within the practice of nursing.

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American Association of Colleges of Nursing (March 4, 2004). AACN strengthens online resource to address the nation's shortage of nurse educators. Washington, D.C.: American Association of Colleges of Nursing. www.nche.edu/Media/NewsReleases/2004/2004FacultyCareerLink.htm

Corcoran, R. D. (2005) Newsletter. NLN Update, 8(24). www.nln.org/newsletter/dec52005.htm

Nursing History

by Charlene Kelly, Ph.D., R.N.

As I prepare these articles on the history of nursing in Nebraska I continue to be indebted to Wendell Oderkirk for his 1990 dissertation on The Transformation of Nebraska Nursing Education, 1888-1941. His writing gives fascinating glimpses into nursing's past. I have been focusing on the very early years of the organization of nursing education and nursing regulation in Nebraska, circa 1910. This issue we fast forward to the 1920s for a glimpse of what nursing education was like in that era.

In the 1920's each school was required to submit a form to the Department of Public Welfare addressing a number of criteria. In 1926, Charlotte Burgess, Director of the University of Nebraska School of Nursing, reported that its nurses' home had five single rooms and thirty-seven double rooms. The home's matron and the school faculty lived at the home. It is presumed that the students also were housed there. The 130-bed University Hospital treated an average daily patient load of 105 patients. The school's students did not affiliate with another institution. Ms. Burgess earned $2,500 per year and her three assistants, who served as hospital supervisors and training school instructors, earned from $100 to $150 per month. Students in their third year served as special duty nurses for inpatients for as long as two months, at 10 hours per day. Patients did not pay for this service. Burgess reported that a new 125-bed wing was under construction and that several courses in theory have been added. The program enrolled 26 first year students, 22 second year students, and 17 third year students. Twelve students were dismissed in 1926 and five others "left training." The hospital provided uniforms, textbooks and laundry, but paid students no allowance, characteristic of better schools of the day. Students received one-half day off during the week and on Sunday. Otherwise they worked 48 hours per week, not including 10 hours of night duty when it was their turn. Students administered anesthetics under the direction of physician and each nurse cared for about 20 obstetrics cases. The hospital supplied thermometers and glass hypodermics, and did not hold students liable for breakage as many hospitals did. University students lost only 214 days to illness in 1925, 40 days of which were for recovery by two students from appendectomies and 40 more days to diphtheria recovery by four students. This illness rate was low in comparison to previous years and in comparison to other schools.

Each training program was inspected annually by an inspector appointed by the Department of Public Welfare. For example, an inspection report letter sent to Lucy Austin the training school superintendent at Bryan Memorial Hospital in the fall of 1926 praised the hospital's physical plant, but thought the laboratory was too small and poorly located. The dietary kitchen dumb waiter on the first floor opened in the clinical laboratory, "not a satisfactory arrangement." It was observed that Ms. Austin was not registered in Nebraska. Austin's use of "R.N." in her signature on the Bryan report made her "liable to criminal prosecution." The school's library consisted of 11 out-of-date books donated by a doctor. Students lacking previous instruction worked in the operating room, obstetrics, and on night duty, an "irregular" practice. The nurses' home needed more dressers, and the home's one toilet and bath was "not adequate" for the number of students. The department withheld accreditation until Bryan took organizational steps to remove the deficiencies. Bryan's problems paralleled those found at most schools during the 1920's and 1930's.

Twenty 1986 Years Ago in *Nursing News*

- There were 17,071 RNs and 6,459 LPNs licensed in Nebraska.
- RN licenses were scheduled to expire on December 31, 1986. License renewals were still being done annually and the annual renewal fee was $30, a $10 increase over the previous fee of $20. This was the first fee increase in six years.
- Leota Rolls, board member from Hastings, had been elected to the board of directors at the National Council of State Boards of Nursing at their annual meeting in Williamsburg, Virginia. She will serve as Area II Director on the board of directors.
- Vicky Burbach joined the staff of the Bureau of Examining Boards as the nursing practice consultant. Jan Cepure moved from nursing practice consultant to full-time nursing investigator.
- Sheila Ciciulla recounted her experiences as a member of the board of nursing. Many changes had occurred during her eight-year tenure on the board.
  - Reorganization of the Health Department and Bureau of Examining Boards to subsume the board of nursing.
  - Preparation for Sunset Review
  - Revision of the Nurse Practice Act. The board worked collaboratively with organized nursing groups to reconcile differences and create compromise in order to present a unified voice in support of the proposed practice act. This was acclaimed as a "first" among senators expecting lengthy disagreement from the nursing community.
  - Nurse anesthetists were legally established as the first nurse practitioners in Nebraska.
  - Other nurse practitioners and the nurse midwives followed the same course and legalized their status and scope of practice.
  - Board committees were established to better utilize the time of board members.
  - Nursing News, the newsletter of the board of nursing, was initiated.

Practice FAQs

Q: I am a unit supervisor and have student nurses working as techs on my unit. Most of them are seniors and will be graduating soon. They are anxious to get some "hands on" experience while working as techs. Since they are student nurses and have done a lot of procedures in their clinical experience, can I have them do things such as starting IV's?

A: No. They are working in the capacity of a tech and can only do things a tech can do. There is no exception for student nurses working in an unlicensed capacity. Until they have completed their program, passed NCLEX, and are licensed, they can only provide care that an unlicensed assistive person can provide. No one may practice nursing without a nursing license. In fact, the statutes state that it is unlawful for a person to practice as a nurse or call themselves a nurse unless they hold a nursing license.

A student can perform nursing services during clinical experience without a nursing license because of a provision in the statutes. The statutes state that a student nurse enrolled in an approved nursing program may provide nursing services "when the services are a part of the student's course of study". So, they are limited to only performing nursing services as part of their nursing courses.

For More Information... Visit our Web site at: http://www.hhs.state.ne.us

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