

NEBRASKA BOARD OF Nursing NEWS

Volume 35 • Number 2 / Fall 2018

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Executive Director's Message

Ann Oertwich, RN, PhD



Change is a reoccurring theme for all of us in nursing, and this issue provides a number of thought-provoking articles to challenge our assumptions in nursing practice. From our feature article on Nursing and EMS Partnerships (p. 18) to part II of Nursing Delegation (p. 6) and finally Ask the Practice Consultant (p. 14), I believe there is great information here to stimulate thinking and discussion!

This issue has the full results of the LPN Renewal Survey data from 2017. Which brings us to thinking about RN renewal, open now, for all RNs and APRNs holding Nebraska licenses. See the reminder article on page 29. Don't forget to renew online and early!

I would like to also highlight the hard work of the Nebraska Center for Nursing, who recently released the supply and demand data for LPN, RN, and APRNs in

Nebraska through 2025. Currently in 2018, there is a total nursing shortage of 3,543 nurses (all licensees) in Nebraska. If nothing changes, that shortage will grow to 5,435 licensed nurses by 2025. The Center recently went on the road to six communities from Scottsbluff to Omaha to share the model's outcomes, learn about current strategies and offer partnership on problem solving initiatives. Numerous stakeholders came out to listen, share, and problem solve. Look for a full report of themes and plans in the next *Nursing News*.

Last, but not least, the Center for Nursing Foundation is showcasing the new nursing license plate, just previewed on p. 13 of this issue. What better way to show off your profession than through an awesome nursing license plate!!

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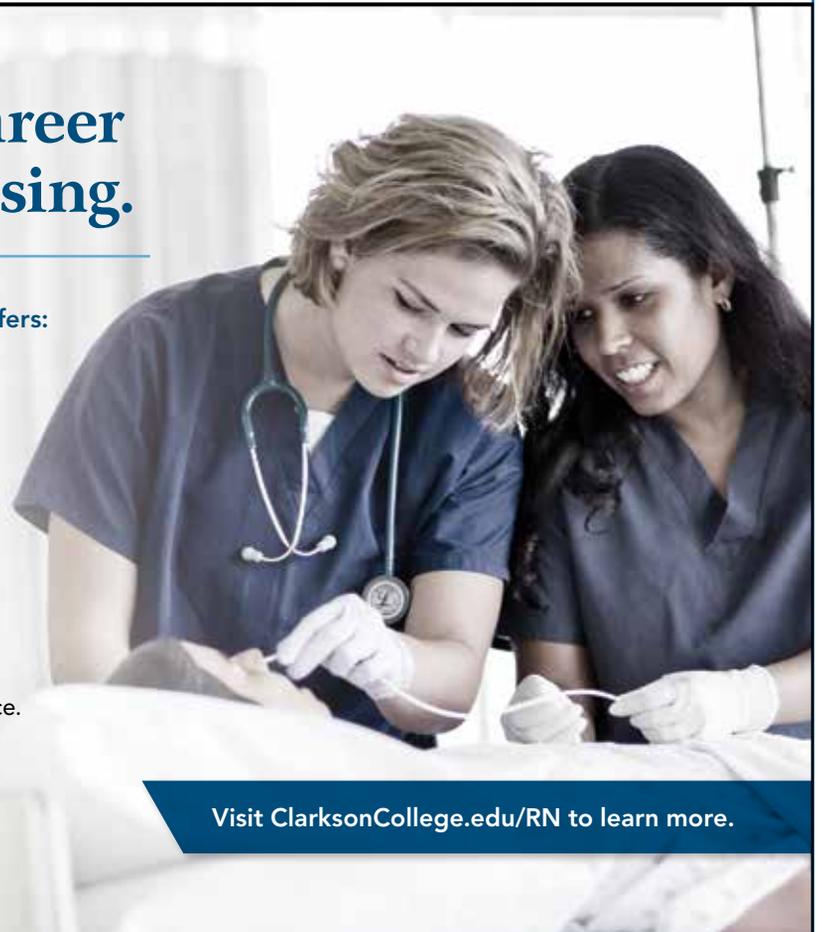
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Meeting Schedule 2019

Meetings of the Nebraska Board of Nursing are open to the public when the meeting is in open session. Meetings often go into closed session in the late morning or early afternoon in order to discuss confidential information. Estimated times for when the meeting will be in open and closed session can be found on each month's agenda. Agendas are posted at http://dhhs.ne.gov/publichealth/Pages/crl_brdmtgs.aspx. You can also request an agenda or obtain more information about attending a meeting by phoning (402) 471-0469 or emailing sherri.joyner@nebraska.gov.

2019 Board Meeting Dates

Jan 10	Feb 14
March 14	April 11
May 9	June 13
July 11	Aug 8
Sep 12	Oct 10
Nov 14	Dec 12

2019 Committee Meeting Dates

Jan 10	March 13
June 12	Sep 11
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Nursing Delegation 101

(Part II – the second of a 3-part series on Delegation in Nebraska)

In the last issue of *Nursing News*, the basics of Registered Nurse (RN) delegation were discussed. This included the five rights of delegation (right task, right circumstance, right person, right direction/communication, and right supervision and evaluation). This issue takes a deeper dive into nursing delegation – the 'how to.'

The Nebraska Nurse Practice Act (§38-2201 to 38-2238) defines delegation as “a means of transferring to another individual the authority, responsibility and accountability to perform nursing interventions.”

4) Evaluating the delegation plan.

Assessing Client/Patient Resources

The RN must assess a client/patient's individual health status (or those of a group of patients) to determine the patient or patients appropriate for delegation of care tasks. Questions to think about include: is the patient stable (chronic) or complex with rapidly changing needs? How much self-care can the patient provide vs. direct care needs? Which patient(s) should be managed only by a licensed nurse? The RN then analyzes the data and identifies



DELEGATION PROCESS

NAC 172 Chapter 99 outlines the delegation process as consisting of four broad steps:

- 1) Assessing client/patient(s) and resources;
- 2) Developing a delegation plan;
- 3) Implementing the delegation plan by providing direction and supervision; and

collective care needs, priorities and resources available to deliver care.

This also can be construed at a higher level, as nursing service administrators also must assess the health status of groups of client/patients and use this data to plan collective nursing care needs, priorities and staffing resources. Having the right staffing resources is key to planning effective delegation.

Developing a Plan

A solid delegation plan allows a Registered Nurse to provide care to a large group of patients, while retaining accountability for outcomes of the nursing plan of care. This can be done at the facility level, through a plan developed by nursing service administration or at the unit level by RNs delegating direct patient care.

Selecting the Right Task and Circumstance

Step one involves selecting and identifying *noncomplex* nursing interventions which may be delegated. Examples are those tasks that frequently reoccur in the daily care of a client/patient or group of patients; those which do not require nursing judgment to complete; those which do not require complex application of the nursing process; those that use a standard and unchanging process and the results are predictable and the risk is minimal. Non-complex interventions can be safely performed according to exact directions and do not require alteration of the procedure, or for which the results and patient response is predictable.

Complex interventions require nursing judgment to safely alter the procedure based on patient needs. Complex nursing interventions also may require nursing judgment to determine how to proceed from one step to the next.

Selecting the Right Person and Communication

The RN must evaluate the competency of the unlicensed individual to perform the task selected for delegation. Questions might include: have you ever done this task before, are you comfortable doing this task with this patient? If the answer is 'no' to either of these questions, the RN must either teach, re-teach or

accompany the person to perform the task.

The right communication involves the 'who, what, when, where and what to report' for the task. As noted above, it may also involve the 'how.' For example, I am asking you, Nurse Aide Smith to feed patient Brown in his room at lunchtime. Have you ever fed a stroke patient with swallowing difficulties before? Patient Brown has right sided weakness and has to take small bites, followed by sips of thickened liquids. Please watch for signs of choking (coughing or gagging), food pocketing, and allow extra time. Please report any feeding difficulties as well as amount of food consumed and fluids ingested.

Selecting the Right Supervision and Evaluation

The RN must determine the method and frequency of supervision. RNs may utilize both direct and indirect methods of supervision. *Direct supervision* means that the RN is physically present in the clinical area and available to assess, evaluate or respond immediately, if necessary. It does not mean looking over the shoulder of the delegate. *Indirect supervision* means that the RN is available for periodic inspection and evaluation, which may include tele-communication.

Determining the method of supervision is driven by the competence of the delegate, the nursing intervention delegated, as well as the stability or predictability of the client/patient condition. Supervision of the delegation plan can be conducted by other licensed nurses, including LPNs. In the latter case, the LPN must be available for direct supervision of the delegate.

continued on page 8

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Evaluation of the delegation plan includes obtaining feedback from the delegate, measuring the client/patient response and goal attainment related to the delegated task, and altering the delegation plan, based on the client/patient response. The RN is ultimately accountable for the outcome of nursing care, which includes evaluation of care provided by others, such as via nursing delegation.

Implementing the Delegation Plan

Example 1

Mr. Brown is a 76-year-old male, 2 days post-stroke. He has left sided weakness, swallowing difficulties and some cognitive impairment.

Right person: Nurse Aide Smith is a 25-year-old who has worked on this sub-acute unit for 1 year, and is familiar with the stroke population.

Plan: assist in feeding stroke patient at meal times

Instruction: Mr. Brown has right sided weakness and has to take small bites, followed by sips of thickened liquids. Please watch for signs of choking (coughing or gagging), food pocketing, and allow extra time. Please report any feeding difficulties as well as amount of food consumed and fluids ingested.

Competency: Nurse Aide Smith voices competency in feeding a patient such as Mr. Brown and asks questions specific to Mr. Brown

Supervision: RN remains on unit over lunch time to be available to Nurse Aide Smith as needed (direct).

Evaluation: RN discusses task, post-feeding with Nurse Aide Smith. He indicates that Mr. Brown ate very slowly, with some pocketing of food, and needed much encouragement. His intake was 75% of his tray and 100% of thickened liquids provided. Provided oral cares after feeding complete. RN assessment of the patient indicates clear lung sounds, active bowel sounds, and patient resting comfortably.

Example 2

Mrs. Jones is a 77-year-old female, 5 days post AP resection for colon cancer with a permanent colostomy. She was moved to the sub-acute unit for pain control. She needs help with self-care of her ostomy as well.

Right person: Nurse Aide Peters is a 20-year-old, just off of her six week orientation.

Plan: develop patient's self-care of colostomy

Instruction: Mrs. Jones has a permanent colostomy from her surgery 5 days ago. Have you ever cared for a colostomy? (no) My goal is for her to become independent in her colostomy care, but she is still having some pain. Let's plan to work with her together, so I can show you how to empty the pouch, while evaluating how much Mrs. Jones knows and will do for herself.

Supervision: (direct) RN engages aide and patient in emptying pouch which as determined to be a

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noncomplex nursing intervention; teaching about when and how to empty. Patient is refusing to do self-care; so aide return demonstrates and encourages patient on next pouch emptying opportunity with patient.

Evaluation: teaching both patient and nurse aide together allows for each to encourage the other in a new skill, with the RN taking accountability for the learning/performance of both.

Evaluating the Delegation Plan

In the preceding example... Mrs. Jones reliance on the RN for assessment and management of postoperative pain was a complex nursing intervention. Nurse Aide Peters provided the patient with bath assistance, postoperative ambulation and was effectively directed to assist the patient with emptying the colostomy pouch—all noncomplex interventions. Noncomplex interventions can

become complex. Mrs. Jones refusal to participate in the emptying of the colostomy pouch required further evaluation and modification of the plan of care by the nurse.

ACTIVITIES WHICH CANNOT BE DELEGATED

The four things which can never be delegated are assessment, planning, evaluation and nursing judgment. Nursing service administrators must identify selected interventions through an organizational description of a nursing service delivery model or employer guidelines.

In summary, most delegation plans are not in print, but second nature to the RN in practice. This article is intended to provide clarity to the many misconceptions about appropriate RN delegation in Nebraska.

The four things which can never be delegated are assessment, planning, evaluation and nursing judgment.

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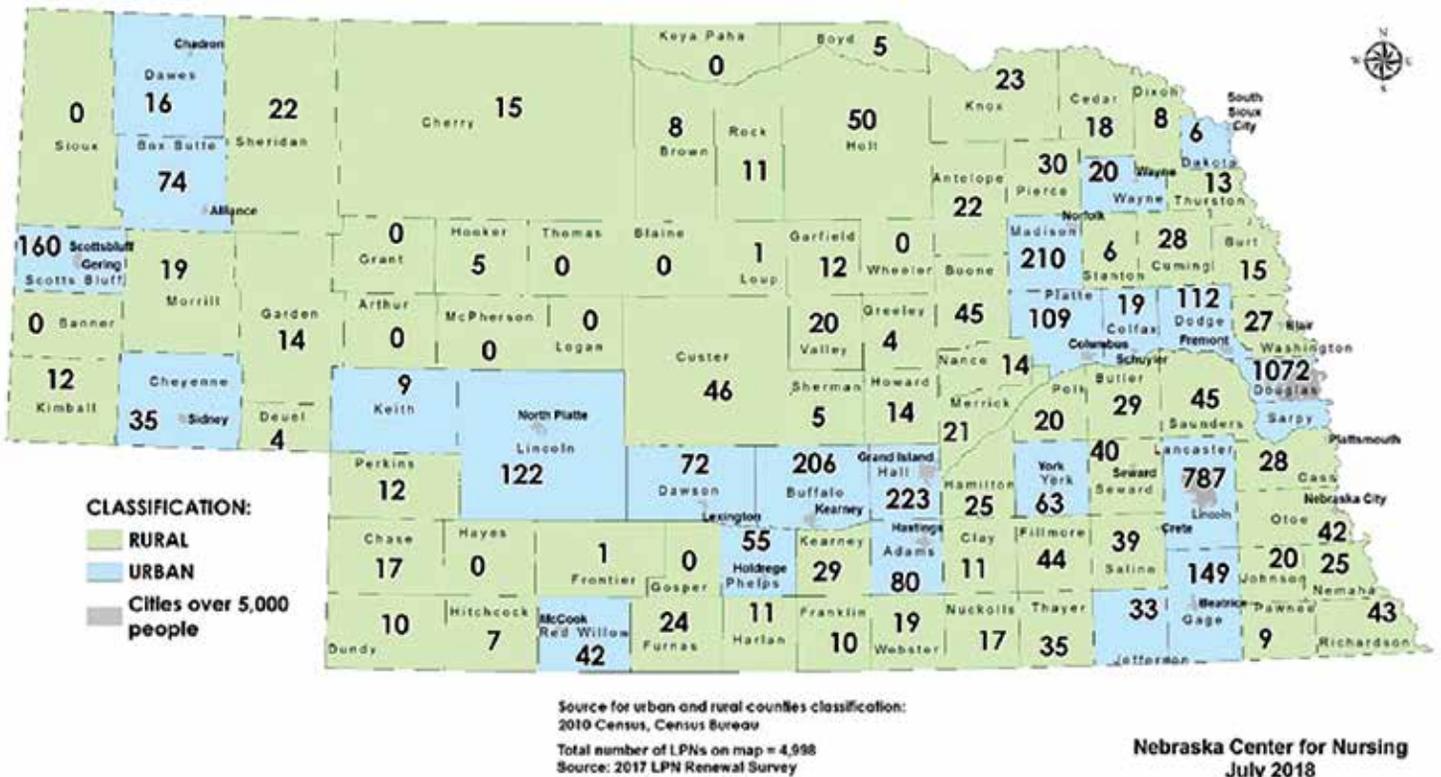
Results from the 2017 LPN Renewal Survey

By Juan-Paulo Ramirez, Ph.D.

Introduction

A total of 5,671 surveys were received by the Nebraska DHHS Licensure Unit during the 2017 LPN Renewal process (online surveys: 96%; paper surveys: 4%). The survey contains 28 questions that cover demographics, education level, work situation, work setting, geography, salary, nursing practice positions, and satisfaction levels with the profession. The set of questions is in accordance with the standardized minimum dataset developed by the National Forum of State Nursing Workforce Centers and the National Council of State Boards of Nursing (NCSBN). From the total number of surveys received, 5,004 LPNs (88%) indicated that their primary employer was located in Nebraska. The following are key findings of the survey.

Figure 1: Urban and Rural Counties where LPNs Work



Geographic distribution

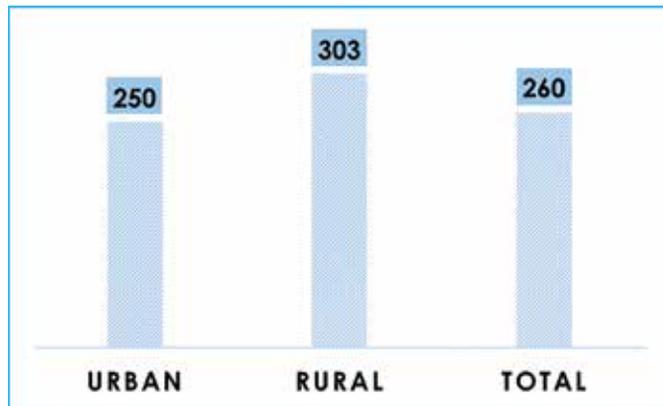
Three-fourths of LPNs work in urban areas (77.0%) and one-fourth work in rural areas (23.0%). Figure 1. Similar geographic distributions are found at the national level (U.S. DHHS, 2013).

Eight counties (Douglas, Lancaster, Hall, Madison, Buffalo, Sarpy, Scottsbluff, and Gage) concentrate 60% of all LPNs working in Nebraska. Three out of ten LPNs working in rural areas travel more than 20 miles (one-way) to their work places. In comparison, only two out of 10 LPNs travel the same distance in urban areas.

Demographics

Per capita LPN workforce: There are 260 LPNs per 100,000 residents in Nebraska, which is higher than the national rate (225 LPNs per capita). Geographic differences were found when comparing rural vs. urban LPNs per capita: Rural areas have a higher supply of LPNs than urban areas (303 vs. 250 LPNs per capita, respectively). See Figure 2. Counties with the highest LPN per 100,000 people in Nebraska are: Boone (841), Fillmore (788), Hooker (742), and Garden (735). Counties with the lowest number of LPN per 100,000 people are: Sarpy (96), Frontier (38), and Dakota (30). Twelve counties do not have a presence of LPNs.

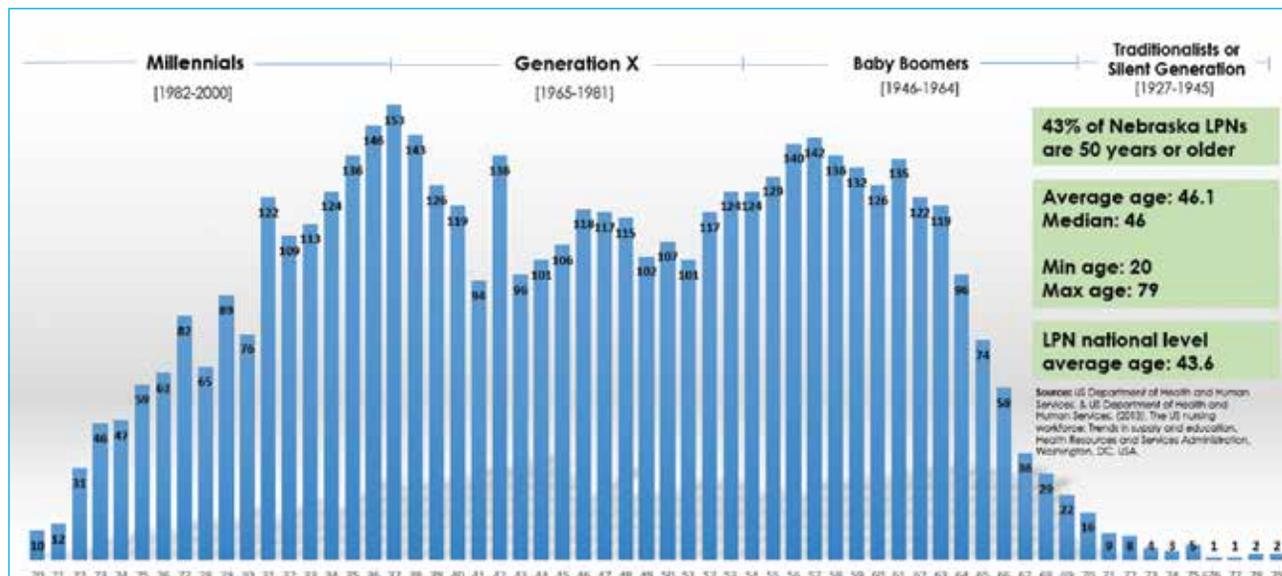
Figure 2: LPNs per 100,000 Residents in Urban and Rural Areas



Age: The average age of LPNs in Nebraska is 46.1 years old (median = 46), which is higher than the national average of 43.6 years of age. One-third of the LPN workforce are baby-boomers (currently 54 years and older). See Figure 3. LPNs working in rural areas are on average one and a half years older than LPNs working in urban areas. On average, LPNs are four years older than 10 years ago. A similar trend has occurred at the national level.

Gender: In Nebraska, 3.2% of LPNs identified themselves as male and 96.8% as female, which shows an increment of 0.1% in male nursing participation in comparison to the 2015 LPN nursing workforce. At the national level, 7.6% of LPNs are male.

Figure 3: Distribution of Nebraska Licensed Practical Nurses by Age



Race/ethnicity: Nearly 90% of LPNs are White, followed by African American/Black (5.2%), and Hispanics (3.9%). Overall, 11.7% of the Nebraska LPN workforce is a minority, which is 1.1% higher when compared to the 2015 LPN nursing workforce. See Figure 4. At the national level, race/ethnicity is more diverse, where over one-third of LPNs are a minority (36.8%).

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Settings, positions and specialties: Nursing Home/Extended Care is the major employer of LPNs with 33.9% of LPNs, followed by “Ambulatory Care Setting (Clinic)” (23.2%), “Hospital” (10.7%), “Other” (10.3%), “Home Health” (5.6%), and “Assisted Living Facility” (4.9%). See Figure 5. At the national level, nearly 30% of LPNs work in hospitals.

In Nebraska, a higher proportion of LPNs work in hospitals in rural areas than LPNs in urban areas (18.2% vs. 8.9%, respectively).

In terms of positions held, eight out of ten LPNs work as a “Staff Nurse,” followed by “Nurse Manager” (6.9%). In terms of specialties, over one-third of LPNs work in “Geriatric/ Gerontology” (32.1%), with noticeable differences by geographic location (46.4% of rural LPNs, vs. 27.9% of urban LPNs).

Satisfaction Levels: A high proportion of LPNs report that they are “Very Satisfied” or “Somewhat Satisfied” with their nursing career (97.6%), and only 2.4% indicated that they are not satisfied with their profession. See Figure 6.

Figure 4: Distribution of Nebraska LPNs by Racial/Ethnic Background

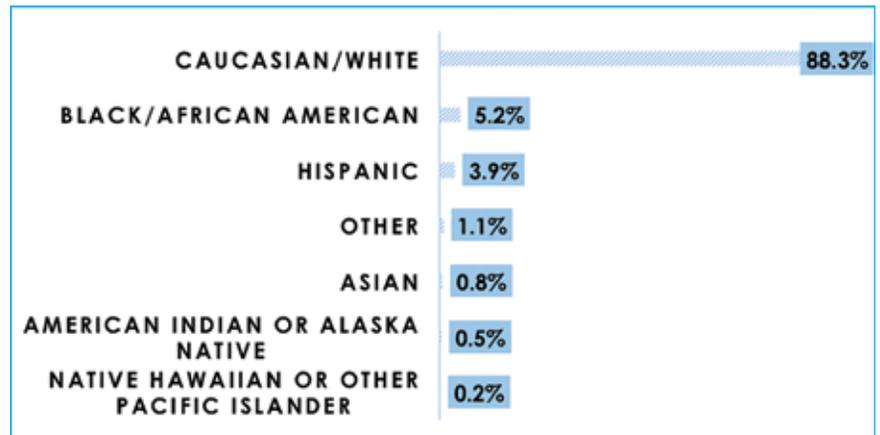


Figure 5: Nebraska LPN Work Settings

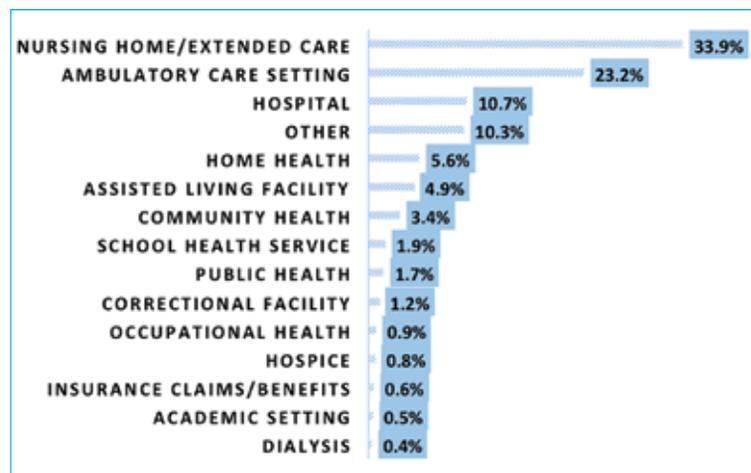
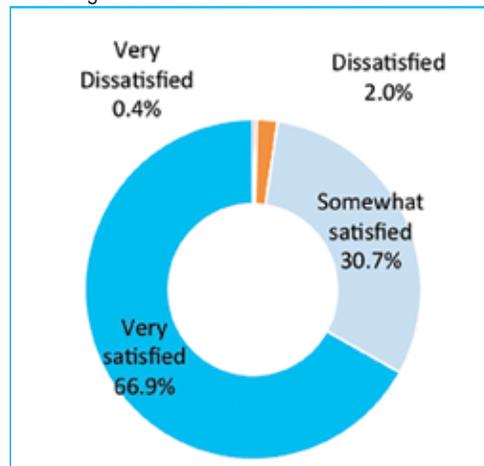


Figure 6: Satisfaction Levels with Nursing as a Career



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The Medical Assistant

Inquiry: *Medical Assistants do not have a scope of practice, therefore, they can perform any task that is delegated to them by another health care professional?*

Response:

Scope of practice. It is correct that Medical Assistants do not have a scope of practice. Only licensed health care professionals have a scope of practice. Scope of practice is defined in health care professionals' Practice Acts.

Delegated nursing interventions.

Medical Assistants may only perform delegated nursing interventions. Registered Nurse (RNs) or Advanced Practice Registered Nurse (APRNs) have licensure authority to delegate select, non-complex nursing interventions to Medical Assistants (see Delegation ... this issue of Nursing News...).

Inquiry: *If there is not a nurse in a particular practice setting, what can Medical Assistants do?*

Response:

Medical Assistants support the practice of licensed health care professionals. They may appropriately perform administrative duties like scheduling and computer entry—or clinical support tasks like rooming patients and collecting data and information from the patient that nursing and medical providers require to inform their plan of care (Nebraska Board of Nursing, July 2018a).

Inquiry: *Certified Medical Assistants can do more, i.e., have more skills than Medical Assistants who are not certified?*

Response:

Medical Assistant certification is not a recognized credential in Nebraska (Uniform Credentialing Act [UCA], Neb. Rev. Stat. §§ 38-101). Employers may require certification as a condition for employment, but being trained and certified to perform a particular task does not mean that task may be



performed under Nebraska law.

Inquiry: *What tasks may Medical Assistants perform under Nebraska law?*

Response: Medical Assistants as unlicensed persons may perform any task that is not limited to the practice of a credentialed health care professional. Credentialed means a license, certification or registration recognized by Nebraska law. A person with an active credential has the right to represent himself or herself as having the credential and the right to practice (UCA, Neb. Rev. Stat. §§ 38-113, 38-117, 38-121).

Inquiry: *What about phlebotomy, i.e., drawing blood?*

Response: Peripheral venous blood samples can be collected by any person, including a Medical Assistant, who has been trained and demonstrated the competency to do so. Phlebotomy does not require a credential.

Inquiry: *Can Medical Assistants draw blood from or flush central intravenous catheters or ports?*

Response: Access and care of central lines is intravenous (IV) therapy and can only be performed by qualified licensed nurses (Nurse Practice Act, 2017).

Inquiry: *Accept verbal orders?*

Response: Verbal orders are prescriptions from APRNs and medical providers responsible for the care of a particular patient with licensure authority to prescribe medications, diagnostic tests and therapeutic interventions. Medical Assistants, like other unlicensed persons, may not accept verbal orders from a licensed prescriber (Nebraska Board of Nursing, 2018b). They may, however, accept and complete a task that they are otherwise qualified and may lawfully perform in response to a written order from a provider, e.g., phlebotomy to obtain a laboratory specimen.

Inquiry: *Transcribe provider orders for electronic order entry?*

Response: Centers for Medicare & Medicaid Services (CMS) regulations permit licensed health care professionals and certified Medical Assistants to enter provider orders for medications, laboratory and radiology into computerized provider order entry systems (CPOE). These rules are specific for those health care entities participating in meaningful use calculation under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (CMS.gov, 2018). In Nebraska, as noted in the preceding section, since Medical Assistants may not accept verbal orders, they may only complete electronic order entry if they have exact written instructions from the prescriber. Changes or clarifications must also be made by the provider in writing, or the electronic entry amended by the provider themselves (Nebraska Board of Nursing, 2018b).

Inquiry: *Telephone triage?*

Response: Patient triage, either by telephone, or in-person and/or the giving of advice to patients can only be performed by licensed nurses. Triage means sorting or responding to patient requests for care. Triage requires assessment of the patient. Assessment is within the scope of practice of the RN. Licensed Practical Nurses contribute to patient assessment under the direction

of a RN or Licensed Practitioner (Nurse Practice Act, 38-2211-38-2212). Assessment cannot be delegated by the RN to an unlicensed person (172 NAC 99-004.01C).

Inquiry: *My provider's office told me that I could expect a phone call from 'the nurse.' The person who called and answered my questions was a Medical Assistant.*

Response:

Title protection. Health care professionals are obligated to correct anyone who incorrectly identifies them by a credential title that they do not have. 'Nurse' is a protected title. 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 an LPN or RN (Nurse Practice Act, Neb. Rev. Stat. §§ 38-2228).

Telephone contact. Medical Assistants may make phone calls to patients on behalf of licensed health care professionals, but the information provided to patients must be limited to general instructions such as the date, time and location for appointments and health care services, i.e., information generated as a result of the administrative support tasks performed by the Medical Assistant.

Inquiry: *Can the Medical Assistant provide patient teaching?*

Response: Only RNs can provide patient teaching and counseling. The unlicensed person may provide information related to promoting independence in personal care and activities of daily living. The unlicensed person may also be taught to recognize and report basic deviations in patients from healthy behavior and communication patterns (172 NAC 99-004.01C).

Provider instructions, such as those for medications or post-procedure care, may be reviewed with patients by Medical Assistants with patients in a pre-printed format. Medical Assistants may not respond to questions or offer patients information regarding a

particular diagnosis or medical plan of care, e.g., diabetes education.

Inquiry: *Can Medical Assistants supervise licensed health care professionals?*

Response:

Employers may create supervisory roles for unlicensed persons, but the unlicensed person has no authority related to a licensee's scope of practice. For example, a Medical Assistants may assume supervisory responsibilities for nurses that include clinic workflow, e.g., patient scheduling or preparing exam rooms. The Medical Assistant may not assume supervisory responsibilities that include training and monitoring the performance of activities that are limited to nursing scope of practice such medication administration and treatments.

Inquiry: *Can Medical Assistants administer medications?*

Response:

Medications may be *provided* to patients by a Medical Assistant if registered, i.e., credentialed as a Medication Aide in Nebraska (Medication Aide Act, 2013). Medication **provision** is a component of medication administration. Provision is limited to the act of giving or applying a dose of a medication (Medication Aide Act, Neb. Rev. Stat. §§ 71-6721).

Medication **provision is participation in medication administration.** Licensed health care professionals may **administer** medications if they have the statutory authority, i.e., it is within their scope of practice to do so (Medication Aide Act, Neb. Rev. Stat. §§ 71-6722). Medication **administration** is the act of providing a medication, and observing and taking appropriate action regarding desired effects, side effects, interactions and contraindications associated with a particular medication (Medication Aide Act, 71-6721).

The **provision** of medications by persons credentialed as Medication Aides is subject to specific regulatory

continued on page 16



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EEO/VEF

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requirements for training, competency assessment, direction and monitoring, and documentation. There are additional requirements for medication provision by alternate routes and prn dosing, which may include written instructions for the provision of a medication for each individual recipient (Medication Aid Act, 2013).

When unlicensed persons in any practice setting **provide** medications to patients, nurses have an ethical obligation to insist on risk assessment for patient safety and outcomes (American Nurses Association, 2015), as well as scrutiny by the health care team for compliance with all provisions of the law. In this context, an unlicensed person providing routine scheduled oral medications to a stable and cooperative resident in a long term care setting—is not the same as providing eye drops for a combative patient—is not the same as a supplemental dose of subcutaneous insulin for an acutely hyperglycemic patient—is not the same as a pediatric vaccination.

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Kathy Hoebelheinrich is the Nursing Practice Consultant with DHHS Licensure. She can be reached for inquiries related to scope of practice at kathy.hoebelheinrich@nebraska.gov 402-471-6443.

3 Steps

2 Minutes

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[Quitline services are available 24/7 in 170 languages.]

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 Pharmacotherapy can be prescribed if appropriate and is authorized after a patient registers with the Quitline and completes one counseling session with a Quit Coach.

Nebraska Medicaid allows one nicotine replacement medication (NRT) per patient's quit attempt with a maximum of two quit attempts annually. Patients must be 18 years or older and will be charged a co-pay (generally \$10 or less).

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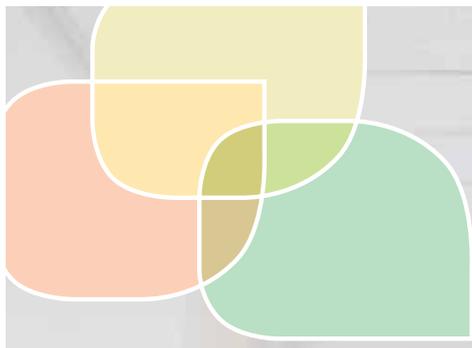
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LB1034

Nursing and EMS Partnerships

"If you always do what you've always done, you'll always get what you've always got."

Henry Ford

Notwithstanding the arguments for *how* or *why* it happened, or *when* the demand for health care services has ever not exceeded access to *who i.e.*, qualified health care professionals in the right place at the right time, *always doing what always has been done to get what has always been got* is simply no longer enough in our current healthcare system in Nebraska.

There are over 30,000 nurses in Nebraska. Nurses—LPNs, RNs and APRNs. Nurses are the largest group of health care licensees in the state providing direct patient care services. The shortage of nurses is projected to increase by 33.8%, or to 5,435, by the year 2025. By 2025, all economic regions in Nebraska

will be affected. Registered Nurses will have the largest portion of unmet demand, with the Panhandle and Sandhills regions being most severely impacted (Nebraska Center for Nursing, 2018).

Access to Emergency Medical Service (EMS) providers in Nebraska presents different opportunities. With approximately 7,200 licensees, EMS providers are a comparatively smaller group. Nurses can and do fulfill roles within emergency response teams, but the episodic and typically rapid response required relies on a highly organized network of both volunteer and licensed professionals ready and poised to respond. Emergency medical service provider shortages

occur in all locations across the state, affecting both volunteer and paid services. Volunteer services are particularly impacted, seeing a decrease in staff due to work and family obligations, education requirements and an aging workforce.

Earlier this past year, LB1034 was passed by the Legislature to amend the Emergency Medical Services Practice Act. LB1034 became effective on July 19, 2018.

The new law leads the way for streamlining scope of practice regulation for EMS providers. It also includes provisions for hospital and health clinic employers to more fully integrate EMS providers into nursing staffing patterns for direct patient care and



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support roles. LB1034 also fulfills a long-held objective by the Emergency Medical Services Board to recruit and retain EMS providers and their families in rural communities. The expectation is that more individuals will be incentivized to obtain EMS licensure if they can be employed in hospitals and health clinics, and continue to serve in a volunteer capacity for their local services (see Great Plains inset pg. 20).

Practice Definitions

Emergency Medical Responder

(EMR) (also known as First Responder) has completed a course and received certification in providing non-invasive, pre-hospital care for medical emergencies such as CPR, basic first aid, and AED use.

Emergency Medical Technician (EMT) has completed a longer course and certification in providing pre-hospital care including the competencies of the first responder as well as management of medical emergencies such as trauma, childbirth, and triage – a limited scope of practice with supervision of a medical director. This care can be further defined as simple invasive interventions, management and transportation of individuals and non-visualized intubation.

Emergency Medical Technician

Intermediate (EMT-I) includes education and certification as above, with the addition of intermediate life support which includes visualized intubation, EKG interpretation skills, and limited pharmacological interventions.

Advanced Emergency Medical

Technician (AEMT) includes education and certification as above, with the addition of advanced life support, complex interventions, treatments and pharmacological interventions.

Paramedic includes education and certification as above, with the addition of advanced life support, complex interventions, treatments, pharmacological interventions and surgical cricothyrotomy.

The Nurse-Paramedic model at Children's Hospital & Medical Center in Omaha has two components. Some Nurse-Nurse critical care flight teams have been transitioned to Nurse-Paramedic teams, explains Megan Sorensen, MHA, RN, CEN, NEA-BC, clinical manager of Children's Critical Care Transport. "This is not unusual for adult flight teams, but it is certainly a new idea for pediatric and neonatal transport.

Nursing process and critical care skills like managing intravenous infusions are coupled with the crisis management skills of the Paramedic in the more austere out-of-hospital environment. The teams are not hierarchal. Lead roles are frequently unspoken and interchangeable between nurses and paramedics depending upon the needs of the patient."

Sorensen was also part of the team that developed and implemented inpatient paramedic positions. Scope of practice, orientation checklists and policies and procedures were compared side by side to build the roles. The program started with four full-time staff equivalents and more paramedic positions are currently posted. Sorensen stressed that the addition of paramedics has not and will not replace nursing positions. Paramedics by nature are highly self-directed and, by design are expected to be readily accessible to nursing staff. They participate in incoming change of shift report to anticipate needs related to acuity, or provide monitoring support and transport for scheduled procedures. Nursing staff rely on paramedics to employ priority skills within their scope of practice like airway management and resuscitation. Sorensen says orderly deployment of the latter has been reassuring to those intimidated by the EMS provider orientation to rapid response.

"We talked about this for a long time...what could we do to better leverage staff nurses' time, or in other words, allow nurses to be nurses. Once we became serious about it, implementation required six to eight months. Considering the too small sample size for outcome monitoring, quality metrics for now will be largely oriented to the commodity of nursing time, e.g., did the nurse get a meal break, was she able to leave at the end of a scheduled shift."



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continued on page 20

ChildrensOmaha.org/JoinOurTeam EOE



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The amendments to the Emergency Medical Services Practice Act adds scope of practice descriptions for each of the following provider roles:

Over time, the intent of this provision is to enable DHHS to eliminate the lists of tasks that have been identified as within scope of practice for EMS providers in current regulations for each level of licensure. As the practice of all health care professionals evolves and changes over time, rote lists of tasks are easily dated and can become unnecessarily restrictive. Nursing made a comparable change with the retirement of the LPN-C credential by the Legislature in 2017. Intravenous (IV) therapy skills were added to LPN scope of practice. The LPN-C regulations did not include Peripherally Inserted Center Catheters (PICC) which are

now in common usage for IV therapy, particularly in patient care settings that rely on LPN staffing.

Expansion of EMS Practice in Hospitals and Health Clinics

Practice for EMS providers now includes the addition of the EMT to the EMT-I, AEMT and Paramedic as permitted to practice in hospitals and health clinics. LB1034 qualifies provider practice as occurring under the *supervision* of a licensed health care practitioner, or the *direction* of a Registered Nurse (RN) while employed by or serving as member of an emergency medical service, hospital or health clinic licensed by DHHS. Licensed health care practitioners include a physician medical director or physician surrogate for an emergency medical service; a physician, physician

assistant (PA) or advanced practice registered nurse (APRN) for a hospital or health clinic.

The Board of Nursing fully supported *direction* by the RN as the optimal way to define the relationship between RN and EMS providers. Precedent exists in nursing regulations (172 NAC 99-002) which defines the LPN as directed by the RN. Direction means the provision of guidance and supervision by the registered nurse responsible for managing the nursing care of the patient. Directed activities are those that the person being directed has the education and training, certification and/or credentials to provide.

What does LB1034 mean for employers?

New models of care. Employers are encouraged to develop new and

According to Tammy Brockmoller, MSN, RN, Director of Emergency Services, Great Plains Medical Center, North Platte is somewhere in the middle—not small enough to be rural and not a city either. “There is a limited pool of qualified health care professionals in the community. With an emergency department expansion underway, we know that we have to think outside of the box for staffing if we are to safely and appropriately care for the patients that come to us.”

Great Plains Health in North Platte is expanding its emergency department from 13 to 27 beds. Great Plains serves 34 counties in three states. “We are not only treating more patients, but they are sicker and we are holding them longer. We are a Level 3 trauma center. The next closest hospital trauma center is 96 miles away.”

As Great Plains started exploring better utilization of existing EMT and paramedic staff currently employed as ED technicians, it became clear that they first needed to start using those staff to the top of their licensed skill sets. Changes in CMS rules that permit licensed staff to complete computer entry for provider orders was a start. Following consultation with both the EMS and Nursing Boards, Great Plains is on its way to developing hybrid roles. “Within the next 3 months, we anticipate onboarding and transitioning existing EMS staff into stronger patient care support roles. The goal is not to replace nurses, but rather provide a higher level of assistance. It is more than making do with the staff we have. Emergency Medical Service staff are highly qualified individuals.”

As more staff positions are added to accommodate the emergency department expansion, the next step will be looking to EMS Services outside of Great Plains. The health system currently employs an individual who is a squad volunteer in a nearby rural community. “We know that there are others like that who can be employed in our system and continue to serve their own communities. We also anticipate being able to offer employment opportunities for EMS trained individuals in our North Platte Fire Department.”



creative models of care that blend the best of Nursing and EMS providers' skill sets to meet the needs of the patient populations that they serve.

New roles. Employers can explore *hybridization* of roles or functions of EMS staff (see Great Plains inset pg. 20). A hybrid role is one that a health care professional has acquired competencies and/or credentials for practice beyond a primary, or more traditional skill set in the workplace. For example, EMS providers might meet Registry requirements as a Medication Aide or be trained in new skills for hospital bedside care.

Role hybridization is not the delegation of complex nursing interventions (see Delegation, this issue) or the delegation by a licensed health care professional of tasks that can only be performed by that or other licensed health care professionals, e.g., radiographic procedures.

Scope of practice integrity. Nursing process is the anchor for RN scope of practice. Registered nurses plan, implement and coordinate patient care. LB 1034 preserves statutory scope of practice for both Nursing and EMS professionals by allowing them to contribute what they do best from their licensed scope of practice skill sets in a particular practice setting (see Children's inset pg. 19). EMS providers can be relied upon to provide pre-hospitalization or emergency field skills that they excel in like IV access or emergency airway management, including intubation.

Onboarding. The exploration of new models of care and blended roles will require that employers undertake a review of scope of practice; job descriptions and roles; policies and procedures, and onboarding/training/practice protocols in their particular setting. Role planning and integration should be a thoughtful

and deliberate process (see Children's inset).

LB1034 challenges both Nursing and EMS providers to investigate new and better ways to develop and integrate team-oriented models into

staffing patterns. As the father of the assembly line and mass production, Henry Ford would surely be impressed by what the *always been done to get what has the always been got* is necessarily not.



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Licensure Actions

The following is a list of licensure actions taken between April 1, 2018, to June 30, 2018.

Additional information regarding the actions identified below is available on our website at www.nebraska.gov/LISSearch/search.cgi by searching for the licensee. To view a copy of the action, click on "View Scanned Documents" once in the License Details Section of the search. The information may also be requested by e-mailing sherri.joyner@nebraska.gov.

Licensee	Date of Action	Action	Violation
Castonguay, Amber D. LPN 24909	04-06-18	Probation Coursework	Abuse of, dependence on, or active addiction to alcohol, any controlled substance, or any mind-altering drug. Unprofessional conduct - Failure to follow policies or procedures implemented in the practice situation to safeguard patient care.
Costello, Nancy L. LPN 14949	04-06-18	Voluntary Surrender	Dishonorable conduct. Unprofessional conduct - Failure to follow policies or procedures implemented in the practice situation to safeguard patient care. Unprofessional conduct – Intentional falsification of material facts in a material document connected with the practice of nursing.
Donovan, Patricia A. RN 45272	04-06-18	Censure Coursework	Practice of the profession beyond its authorized scope. Unprofessional conduct - Failure to follow policies or procedures implemented in the practice situation to safeguard patient care
Hobbs, Shawn E. RN 56633	04-06-18	Probation Suspension (30 days)	Misdemeanor conviction that has a rational connection with fitness to practice the profession. Failure to report misdemeanor conviction in accordance with state mandatory reporting law. Misrepresentation of material facts in procuring or attempting to procure a credential. Abuse of, dependence on, or active addiction to alcohol, any controlled substance, or any mind-altering drug.
Lang, Jolene A. LPN 13954	04-06-18	Probation	Misdemeanor conviction that has a rational connection with fitness to practice the profession. Abuse of, dependence on, or active addiction to alcohol, any controlled substance, or any mind-altering drug.
Marks, Jessica J. RN 77611	04-06-18	Limitation	Practice of the profession while ability is impaired by alcohol, controlled substances, drugs, mind-altering substances, physical disability, or emotional disability. Failure to report loss of nursing employment in accordance with state mandatory reporting law.
Shcherbiy, Bogdana RN 53862	04-06-18	Suspension (90 Days))	Misdemeanor conviction that has a rational connection with fitness to practice the profession. Failure to report misdemeanor conviction in accordance with state mandatory reporting law. Misrepresentation of material facts in procuring or attempting to procure a credential. Abuse of, dependence on, or active addiction to alcohol, any controlled substance, or any mind-altering drug.
Snyder, Benjamin L. RN 79359	04-06-18	Probation	Misdemeanor conviction that has a rational connection with fitness to practice the profession. Abuse of, dependence on, or active addiction to alcohol, any controlled substance, or any mind-altering drug.
Swanda, Kathy L. RN 56679	04-06-18	Probation	Misdemeanor conviction that has a rational connection with fitness to practice the profession. Abuse of, dependence on, or active addiction to alcohol, any controlled substance, or any mind-altering drug.
Zywiec, Jennifer J. RN 80261	04-06-18	Censure Coursework	Unprofessional conduct - Failure to follow policies or procedures implemented in the practice situation to safeguard patient care. Unprofessional conduct – Failure to maintain an accurate patient record.
Donker, Karen D. LPN 14067	04-11-18	Assurance of Compliance	[Nondisciplinary Action]
Allison, Kelly K. RN 51384	04-19-18	Assurance of Compliance	[Nondisciplinary Action]
Heinrich, Sandra L. RN 65126	04-20-18	Assurance of Compliance	[Nondisciplinary Action]
Lawton, Cherie A. RN 80357	04-20-18	Assurance of Compliance	[Nondisciplinary Action]

Morgan, Krista L. RN 72846	04-23-18	Suspension 12 Months	Dishonorable conduct. Abuse of, dependence on, or active addiction to alcohol, any controlled substance, or any mind-altering drug. Violation of Uniform Controlled Substances Act. Unprofessional conduct - Misappropriating medications, supplies or personal items of a patient or agency. Unprofessional conduct - Committing any act which endangers patient safety or welfare.
Sandin, Sandra B. RN 75853	04-23-18	Censure Coursework	Unprofessional conduct - Failure to follow policies or procedures implemented in the practice situation to safeguard patient care. Unprofessional conduct - Committing any act which endangers patient safety or welfare.
Waltke, Amanda L. RN 75011	04-23-18	Censure Civil Penalty (\$1,000) Coursework	Unprofessional conduct - Intentional falsification of material facts in a material document connected with the practice of nursing.
Hall, Rebecca J. RN 82211	04-25-18	Assurance of Compliance	[Nondisciplinary Action]
Higer, Sandra K. RN 47514	04-25-18	Assurance of Compliance	[Nondisciplinary Action]
Rose, Cindy L. RN 67004	04-25-18	Assurance of Compliance	[Nondisciplinary Action]
Tucker, Amanda A. RN 67571	04-25-18	Assurance of Compliance	[Nondisciplinary Action]
Tucker, Juanita J. RN 52122	04-30-18	Assurance of Compliance	[Nondisciplinary Action]
DeWitt, Ellen K. RN 79535	05-02-18	Probation	Dishonorable conduct. Abuse of, dependence on, or active addiction to alcohol, any controlled substance, or any mind-altering drug. Violation of Uniform Controlled Substances Act. Unprofessional conduct - Misappropriating medications, supplies or personal items of a patient or agency
Erb, Crystal R. LPN 24791	05-02-18	Censure Civil Penalty (\$1000) Coursework	Unprofessional conduct - Failure to safeguard patient's dignity or right to privacy. Unprofessional conduct - Misappropriating medications, supplies or personal items of a patient or agency. Failure to report loss of nursing employment in accordance with state mandatory reporting law.
Fraka, Tara L. LPN 23484	05-02-18	Voluntary Surrender	Misdemeanor conviction that has a rational connection with fitness to practice the profession. Practice of the profession while ability is impaired by alcohol, controlled substances, drugs, mind-altering substances, physical disability, or emotional disability. Abuse of, dependence on, or active addiction to alcohol, any controlled substance, or any mind-altering drug. Violation of Uniform Controlled Substances Act.
Jackman, Maureen K. RN 54341	05-02-18	Probation	Misdemeanor conviction that has a rational connection with fitness to practice the profession. Felony conviction that has a rational connection with fitness to practice the profession. Failure to report convictions in accordance with state mandatory reporting law.
O'Keefe, Katie M. LPN 18620	05-02-18	Voluntary Surrender	Dishonorable Conduct. Violation of Uniform Controlled Substances Act. Unprofessional conduct - Misappropriating medications, supplies or personal items of a patient or agency. Unprofessional conduct - Failure of a licensee, who is the subject of a disciplinary investigation, to furnish the Board or its investigator with requested information or requested documents. Misdemeanor conviction that has a rational connection with fitness to practice the profession.
Boardman, Lori. C. RN 68538	05-03-18	Assurance of Compliance	[Nondisciplinary Action]
Bateman, Stephanie J. (aka Stephanie Pochop) LPN 15132	05-08-18	Probation	Illness, deterioration, or disability which impairs the ability to practice nursing.
Durand, Sheri L. RN 38962	05-16-18	Assurance of Compliance	[Nondisciplinary Action]
Paslawski, Adriann M. RN 77596	05-17-18	Censure Coursework	Unprofessional conduct - Failure to utilize appropriate judgment in administering safe nursing practice based upon the level of nursing for which the individual is licensed. Unprofessional conduct - Failure to follow policies or procedures implemented in the practice situation to safeguard patient care. Unprofessional conduct - Failure to maintain an accurate patient record.

Ramsdell, Kelli J. LPN 15529	05-17-18	Censure Civil Penalty (\$1,0000) Coursework	Unprofessional conduct - Failure to safeguard patient's dignity or right to privacy. Failure to report loss of nursing employment in accordance with state mandatory reporting law.
Taylor, Patricia A. LPN 22417	05-17-18	Suspension (30 Days) Coursework	Unprofessional conduct - Failure to follow policies or procedures implemented in the practice situation to safeguard patient care. Unprofessional conduct - Committing any act which endangers patient safety or welfare.
West, Jenna B. RN 76607	05-17-18	Probation	Dishonorable conduct. Abuse of, dependence on, or active addiction to alcohol, any controlled substance, or any mind-altering drug. Violation of Uniform Controlled Substances Act. Unprofessional conduct - Misappropriating medications, supplies or personal items of a patient or agency. Violations of the Uniform Credentialing Act and regulations relating to the Nurse Licensure Compact.
Borman, Melissa R. RN 51861	05-31-18	Censure Coursework	Unprofessional conduct - Failure to utilize appropriate judgment in administering safe nursing practice based upon the level of nursing for which the individual is licensed. Unprofessional conduct - Failure to follow policies or procedures implemented in the practice situation to safeguard patient care.
Schneider, Matthew P. RN 76123	05-31-18	Censure Civil Penalty (\$1000) Coursework	Unprofessional conduct - Failure to maintain an accurate patient record. Unprofessional conduct - Falsification or intentional unauthorized destruction of patient records.
Brewer, Brent D. RN 82865	06-05-18	Censure Coursework	Unprofessional conduct - Failure to follow policies or procedures implemented in the practice situation to safeguard patient care.

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Please be aware that your new expiration date will not appear on the Licensure Lookup system immediately after you renew. It may take up to a week to process and approve your online renewal.

New licensees. If you received your initial Nebraska RN license after October 31, 2016, you do not need to meet the continuing competency requirements. You do need to pay the full renewal fee, however.

Audits. When you renew, you need to attest that you have met the continuing competency requirements or that you qualify for a waiver. You do not need to send in your practice records or continuing education certificates unless you are randomly selected for an audit. If you are selected for an audit, you will be notified by mail after you renew your license. You will then have 30 days to submit documentation verifying that you met the continuing competency requirements. If you do not submit the requested documentation, your license will be placed on expired status.

Nurse Licensure Compact. Twenty-nine states, including Nebraska, belong to the Nurse Licensure Compact. The Nurse Licensure Compact covers RN and LPN licenses. It does not apply to APRN licenses.

States that belong to the Compact issue two types of RN licenses: single-state and multistate. A single-state Nebraska license authorizes you to practice nursing in Nebraska. A multistate Nebraska license authorizes you to practice in Nebraska and in other states that belong to the Compact.

- Your license will be renewed as a multistate license if you are a Nebraska resident and your license is currently multistate. If you miss the renewal deadline, you risk losing your multistate eligibility.

- Your license will be renewed as single-state if you currently have a single-state license or if you are not a resident of Nebraska.

If you have moved from Nebraska to another Compact state, you need to apply for a license in your new home state. Even if you have a multistate Nebraska license, once you change residence to another Compact state, your multistate privilege is no longer valid unless you have a licensure application pending in your new home state.

How do I know if I have a multistate license? Go to www.nursys.com and do a Nursys Quick Confirm verification.

APRNs Only. The requirements for the mandatory 3 hours of opioid continuing education (CE) for APRNs following the passage of LB931 will be not be in effect until the 2020 RN/APRN license renewal year. Continuing education courses that meet the requirements will be offered beginning 10/1/18. APRNs are advised that eligible courses between 10/1/18 and 10/31/18 are applied to the 2018 CE renewal requirements, they cannot be applied again to the 2020 renewal requirements. More information will be forthcoming in a future issue of *Nursing News*.

Inactive status. Perhaps you have retired from nursing or have moved to another state and do not plan on working in Nebraska in the future. You can request inactive status using the renewal postcard that is being mailed to you. Check the box for "inactive status," sign the card, and mail it back to the Licensure Unit. You can also request inactive status by using the online renewal site or by using a paper renewal form. There is no fee to place your license on inactive status.

Sometimes people let their licenses expire instead of placing them on inactive status. If your license expires, you cannot practice nursing in Nebraska and you cannot represent yourself as a nurse in Nebraska. With inactive status, although you cannot practice nursing in Nebraska, you may represent yourself as an inactive nurse. Both inactive and expired nurses can apply for reactivation of their licenses by submitting a reinstatement application.

Paper renewals. If you are unable to renew online, the option of submitting a paper renewal form is still available. You can print a paper renewal application from our website. Type dhhs.ne.gov/renew into your browser, and then click on your license type under "Paper Renewal." You can also call (402) 471-4376 and ask that a paper form be mailed to you. If you use a paper renewal form, you need to pay the renewal fee with a check or money order. Credit card payments are not accepted for paper renewals.

Renewing in person. A drop-off box for renewal applications is located in the DHHS Licensure Unit office on

the first floor of the Nebraska State Office Building. The office is open from 8 am to 5 pm Monday-Friday, and is located at 14th and M Streets in Lincoln. Bringing your application to our office might save a day or two in processing time, but it will not otherwise significantly expedite the renewal process.

Don't wait until the last minute! Renewing online before midnight on October 31st or getting your paper renewal postmarked by October 31st does not guarantee that you can work as a nurse on November 1st. You will need to wait until staff have actually processed your application. Paper renewals can take several weeks to process. Online renewals are processed more quickly, but there is still a waiting period. If you wait until late October to renew, you risk having an expired license on November 1st.

Sometimes, licensees who try to renew online at the last minute are blocked due to technical problems with their computers or internet access. These people then have to apply for reinstatement of their licenses, which takes more time and costs more money.

What happens if you miss the deadline? The online renewal system for RN and APRN licenses will close at midnight on October 31st. Paper renewal forms postmarked after October 31, 2018, will not be accepted. If you miss the deadline:

- Your license will be placed on expired status. You cannot work as a nurse on an expired license. Licensees who do practice after the expiration of their licenses are assessed an administrative penalty of \$10 per day, up to \$1,000. They might also face disciplinary action.
- You will need to apply for reinstatement in order to get your license on active status again. You can find the reinstatement application by going to dhhs.ne.gov and entering "RN reinstatement" in the search box near the top right of the homepage. The application must be mailed back to our office with a check or money order to cover the renewal fee plus an additional \$35 reinstatement fee.
- You might jeopardize your ability to maintain a multistate license. In order to reinstate your license as a multistate license, you may be required to submit fingerprints to the Nebraska State Patrol and meet other requirements established by the Nurse Licensure Compact.

Need Assistance? If you have questions about renewal, you can contact the Nursing Office at (402) 471- 4376 or by e-mail at dhhs.nursingrenewals@nebraska.gov.



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For More Information... Visit our website at: <http://dhhs.ne.gov/publichealth/pages/cr1NursingHome.aspx>

If you do not have access to the Internet, please contact the Licensure Unit for information or questions concerning:

Nursing

General Issues

Ann Oertwich PhD, RN, Program Manager
(402) 471-0317
ann.oertwich@nebraska.gov
or
Sherri Joyner, Licensing Coordinator
(402) 471-0469
sherri.joyner@nebraska.gov

Probation and Compliance Monitoring

Anna Harrison, RN, BSN
(402) 471-0313
anna.harrison@nebraska.gov

Complaint Filing/Mandatory Reporting Investigations Division

(402) 471-0175

RN and LPN Name and Address Changes

(402) 471-4376
dhhs.nursingoffice@nebraska.gov

Nursing Practice Consultant

Kathy Hoebelheinrich, MSN, APRN
kathy.hoebelheinrich@nebraska.gov
402-471-6443

Nursing Education Consultant

Jacci Reznicek MSN, RN
Jacci.reznicek@nebraska.gov
(402) 471-4917

Advanced Practice Nursing Licensing (APRN-NP, APRN-CRNA, APRN-CNM, APRN-CNS)

Kathy Hoebelheinrich
(402) 471-6443
kathy.hoebelheinrich@nebraska.gov

Registered Nurse Licensing

RN Licensure Based on Exam (NCLEX)
Mary Guthrie
(402) 471-4375
mary.guthrie@nebraska.gov

RN Licensure Based on Endorsement

JeanAnn Vidaurri
402-471-0136
JeanAnn.Vidaurri@nebraska.gov

Licensed Practical Nurse

Licensing (LPN)
Kimberley Lewis
(402) 471-4925
kimberley.lewis@nebraska.gov

Nursing Support

Medication Aide Statutes/Regulations and Practice Standards

Connie Wagner, RN, BSN, Nurse Consultant/
Supervisor
(402) 471-4969
connie.wagner@nebraska.gov

Medication Aide Renewals, Applications, and Name or Address Changes

Phone: (402) 471-4322
Email: DHHS.nursingsupport@nebraska.gov
Fax: (402) 742-1151

Dialysis Patient Care Technician

Dialysis Patient Care Technician Statutes/Regulations

Connie Wagner, RN, BSN, Nurse Consultant/
Supervisor
(402) 471-4969
connie.wagner@nebraska.gov

Dialysis Patient Care Technician, Applications, and Name or Address Changes

Phone: (402) 471-4908
Email: DHHS.nursingsupport@nebraska.gov
Fax: (402) 742-1151

Nurse Aide

Nurse Aide Statutes/Regulations and Practice Standards

Connie Wagner, RN, BSN, Nurse Consultant/
Supervisor
(402) 471-4969
connie.wagner@nebraska.gov

Nurse Aide employment registration and termination, Transferring Nurse Aide to another state, Transferring Nurse Aide to Nebraska (Interstate Endorsement), New Nurse Aides on Registry, Nursing Students, Foreign Trained Nurses, and

Lapsed or Inactive RNs/LPNs, Nurse Aides-Intermediate Care Facility - Developmentally Disabled, and Nurse Aide Name and/or Address Changes

Phone: (402) 471-4322
Email: DHHS.nursingsupport@nebraska.gov
Fax: (402) 742-1151

Paid Dining Assistant

Paid Dining Assistant Statutes/Regulations and Practice Standards

Connie Wagner, RN, BSN, Nurse Consultant/
Supervisor
(402) 471-4969
connie.wagner@nebraska.gov

Course Applications, Paid Dining Assistant Applications, and Name and Address Changes

Phone: (402) 471-4322
Email: DHHS.nursingsupport@nebraska.gov
Fax: (402) 742-1151

General

Mailing Labels

Available online at http://dhhs.ne.gov/publichealth/Pages/cr1_orders.aspx

Information on Disciplinary Actions

Diane Pearson
(402) 471-4923
diane.pearson@nebraska.gov

Become a Safe Injection Champion

Since 2001, there have been more than 50 outbreaks associated with unsafe injection practices in U.S. health care facilities (Centers for Disease Control and Prevention [CDC], unpublished data, 2016). During the same time period, more than 150,000 patients in the United States have been notified of potential exposure to hepatitis B virus, hepatitis C virus, and HIV due to breaches, including reuse of needles and syringes for more than one patient or because of shared medications.^{1,2}

In response to the growing number of outbreaks and patient notifications related to unsafe injection practices, the One & Only Campaign was developed by the Safe Injection Practices Coalition (SIPC), a group of health care-related organizations convened by the National Foundation for the CDC and led by the CDC.³ This public health education campaign works to raise awareness among patients and health care providers about safe injection practices. The campaign's key messages are based on CDC's evidence-based guidelines and addresses proper use of injection equipment and injectable medications. Nebraska was one of 10 states chosen to be a partner with the One and Only Campaign. Nebraska had one of the largest outbreaks of outpatient clinic-spread disease due to unsafe injection practice. A hematology/oncology clinic worker routinely used the same syringe to draw blood from patients' central venous catheters and to draw saline from bags that were used for multiple patients. In 2002, ninety-nine patients with clinic-acquired HCV infection were identified.

Even though the One and Only Campaign has delivered the Safe Injection message to many health care workers, a study by Kossover-Smith, et al, found that an educational campaign alone is not sufficient to ensure understanding and adherence to safe injection practices; a multifaceted approach is likely needed.⁴ To add to the approaches to decrease breaches with safe injection practices, a grant was written and approved to develop a Safe Injection Champion Program. The purpose of the program is to train and assign an individual who would advocate for injection safety at every healthcare facility that administers injections. Deploying an injection safety champion at every healthcare facility will increase surveillance of unsafe practices and allow for immediate mediation of poor practices, before they reach the patient.

The injection safety champion program consists of an hour-long video program that is viewed through the CDC TRAIN web-based system. The educational portion includes an impassioned speech by Evelyn McKnight, one of the Nebraska oncology patients who contracted Hepatitis C. After viewing the program, the participant must log onto the CDC Training and Continuing Education (TCEO) site, complete a competency assessment and evaluation. Upon completion

staff who can monitor safe practice

- Intentional routine auditing of practice by an employee for patient safety
- Receiving new information as practice changes and "best practices" are shared
- Free information and resources as the program is funded with ELC grant

To become a Safe Injection Champion, log on to the Nebraska DHHS website and go to the Safe Injection Champion



of the 3 requirements – video, competency assessment and evaluation – the participant is eligible to receive continuing education credit. The course is approved for continuing education credit for physicians, pharmacists, nurses, certified public health professionals and more. The credit will be available for the next two years and is cost free. Following completion of the program, the new champion will be sent a welcome letter plus a tool to audit practices at their facility. The tool calculates an adherence percentage, so it can be used to ongoingly monitor compliance with approved practices. Periodically, additional information to keep the safe injection updated will be sent as practices change or areas of concern are identified.

“What we’re trying to do now is develop a program that would instantiate a prevention tool,” says Dr. Thomas Safranek, Nebraska State Epidemiologist. “It will promote the training and assignment of an individual who would advocate for injection safety at a given location. Training larger numbers of people is part of the goal.”

Benefits of having a Safe Injection Champion at your facility:

- Recognition to your customers of using a critical patient safety practice
- Having a knowledgeable employee on

page. The step by step instructions to take the course are listed. The direct link to the Safe Injection page is: <http://dhhs.ne.gov/publichealth/HAI/Pages/SafeInjection.aspx>

Interventions in the past have not stopped this avoidable patient harm. Join the over 200 healthcare professionals in over 30 states who have committed to becoming a Safe Injection Champion for their facility.

1. Centers for Disease Control and Prevention. CDC grand rounds: preventing unsafe injection practices in the U.S. health-care system. (2013). *MMWR Morb Mortal Wkly Rep* 62: 423-5.
2. Guh AY, Thompson ND, Schaefer MK, Patel PR, & Perz JF. (2012). Patient notification for bloodborne pathogen testing due to unsafe injection practices in the US health care settings, 2001-2011. *Med Care*, 50: 785-91.
3. Safe Injection Practices Coalition. One & Only campaign website. Available from: <http://www.oneandonlycampaign.org>. Accessed June 11, 2018.
4. Kossover-Smith, et al. (2017). *American Journal of Infection Control* 45: 1018-23.

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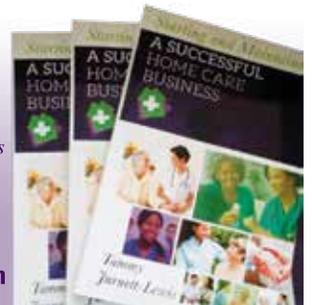
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This activity has been submitted to the Midwest Multistate Division for approval to award nursing contact hours. The Midwest Multistate Division is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

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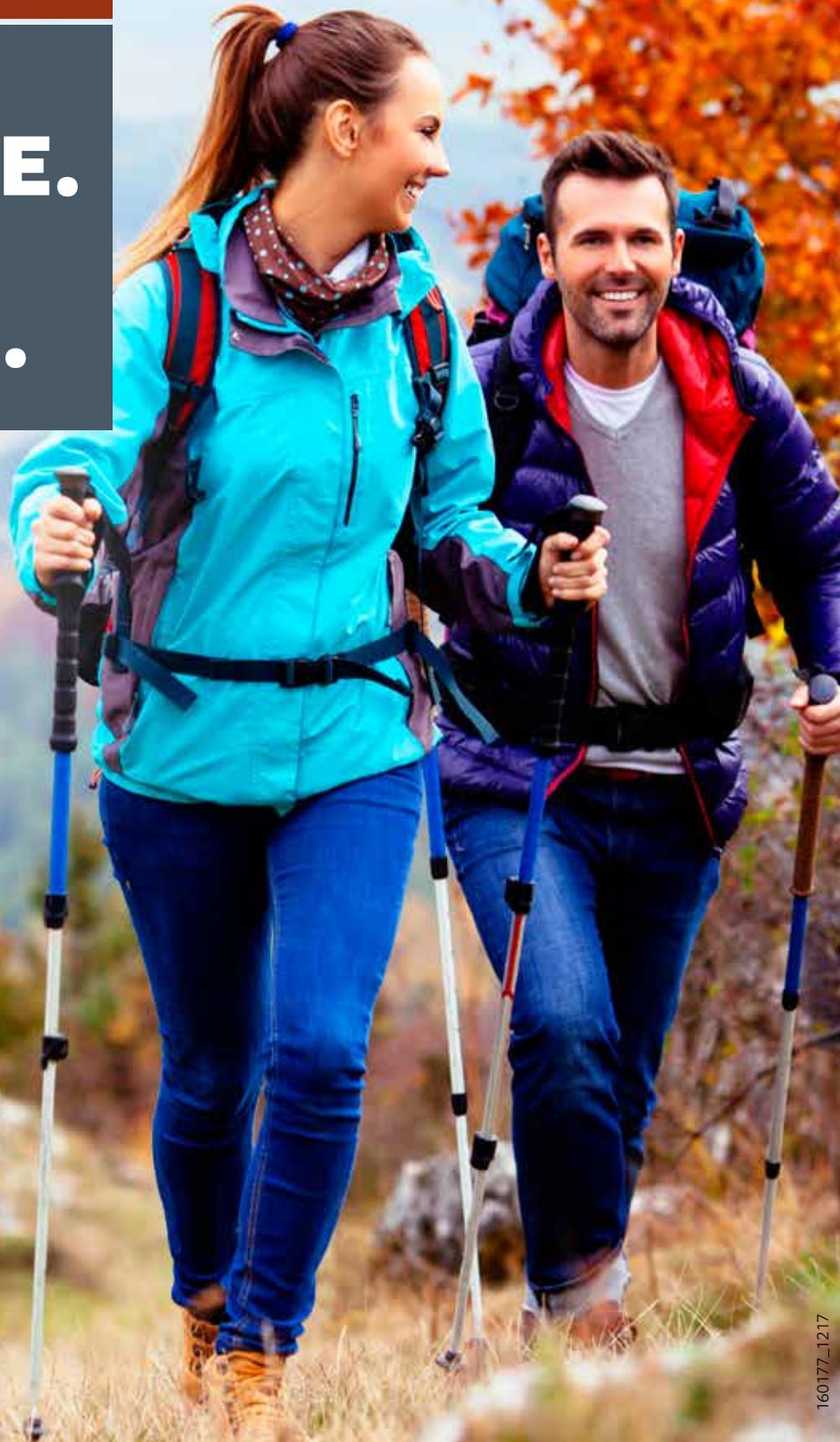
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