Alaska

Board of Nursing

Public Board Book

For

Meeting November 7, 8, 9, 2018

Location: 550 West Seventh Ave. Suite 1270
Anchorage AK 99501
Teleconference: 1-800-315-6338 Access: 34727

Board of Nursing

Agenda
November 7, 8, 9, 2018

Teleconference:800-315-6338
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Agenda Item	Time	Topic	Lead
Wednesday November 7			
1	9:00	Call to Order Roll Call Introductions Review Agenda Ethics Disclosure	
2	9:15	Regulations Project -Telehealth -Repeal 44.321	Jennifer Stukey LPN, Chair Gail Bernth MSN, APRN, EA Jun Maiquis, Regs Specialist
	10:30	BREAK	
3	10:45	Ketamine Clinics by CRNAs	April Erickson, CRNA
4	11:45	Cooperative Practice Agreements with Pharmacists	Wendy Thon MSN, APRN, Secretary
	12:30	LUNCH	
5	1:30	Public Testimony	Jennifer Stukey LPN, Chair
6	2:00	APU RN Program Application	Joe Lefleur MSN, Ed, Educator
	3:00	BREAK	
7	3:15	Administration of non-herbal nutritional supplements	Emily Palmer, Progrm Coordinator Clinton Lasley, Divison Director AK Pioneer Homes
8	3:35	Division Report FY 18 4th quarter and End of Year Division projects, future, military spouses	TBD
9	4:05	APRN request for Advisory Opinion related to administration of Botox and Dermal Fillers	Rachael Arnold MSN, APRN, FNP-C
	4:30	Recess	
Thursday November 8		Executive Session* No Public allowed	
	9:00	Call to Order Roll Call	Jennifer Stukey, Chair
10	9:15	Executive Session* No Public allowed	
	12:30	LUNCH	
	1:30	Recesss for the purpose to go off-site and review NCLEX test items	
11	2:00	NCLEX Item Review - not open to the public	Jennifer Stukey, LPN Chair Joe Lefleur MSN, Ed, Educator Gail Bernth MSN, APRN, EA

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Agenda Item	Time	Topic	Lead
Friday November 9			
	9:00	Call to Order Roll Call Introductions Review Agenda	Jennifer Stukey, Chair
12	9:10	Public Testimony	Jennifer Stukey, Chair
13	9:40	UAA Nurse Aide Program Application	Marianne Murray DNP, RN, CHSE Director UAA School of Nursing Lee Ann Carrothers Director of Allied Health
14	10:10	Certified Nurse Aide Program Reviews - self-evaluations	Joan Green, Nurse Consultant
	10:30	BREAK	
15	10:45	CNA Report & Licensing Statistics	Dave Worrell, CNA Licensing Examiner
	12:00	LUNCH	
16	1:00	Licensing Report	Lisa Maroney, Records & Licensing Supervisor
17	1:15	eNLC	Gail Bernth, Executive Administrator Jim Puente, NCSBN available for questions via teleconference
18	1:45	Governance Policies -Discipline Guidelines -Notification of APRN with loss of prescriptive authority -holding 2 licenses & level of practice	Jennifer Stukey LPN, Chair Joe Lefleur MSN, Ed, Educator Wendy Thon MSN, APRN, Secretary Sonia Lipker, Sr. Investigator
	3:00	BREAK	
	3:15	Tabled Agenda Items for Review	
19	3:30	PDMP Report	Submitted by Laura Carillo
20		Board Correspondence NCSBN Workforce Survey Data NCSBN 2018 Annual Meeting Minutes	
21	3:45	Elections	Jennifer Stukey LPN, Chair
	4:00	Adjourn	

Agenda Item

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Chapter 44. Board of Nursing.

(Words in **boldface and underlined** indicate language being added; words [CAPITALIZED AND BRACKETED] indicate language being deleted. Complete new sections are not in boldface or underlined.)

12 AAC 44 is amended by adding a new section to read:

12 AAC 44.925. Standards of practice for telehealth or telemedicine. (a) An advanced practice registered nurse (APRN) or registered nurse (RN) may practice telehealth if the following conditions are met:

(1) in order to provide care for a patient in this state, including diagnosis, treating, rendering an opinion, providing case management, the APRN or RN must be licensed to practice in this state under AS 08.68;

(2) an APRN may render a diagnosis, provide treatment, or prescribe, dispense, or administer a prescription drug provided

(A) the treating APRN, another APRN in the group practice, or a licensed physician in the state must be available to provide follow-up care;

(B) the treating APRN must request that the patient consent to sending a copy of the records to the patient's primary care provider if the treating APRN is not the primary care provider;

(C) a physically separated APRN may prescribe a controlled drug only if an appropriate licensed health care provider is physically present with the patient;

(D) an APRN may prescribe a prescription medication to a person without first conducting a physical examination, only if there is an established patient–APRN relationship, except

(i) for use in emergency treatment;

(ii) for expedited partner therapy for sexually transmitted diseases; or

(iii) in response to an infectious disease investigation, public health emergency, infectious disease outbreak, or act of bioterrorism;

(E) the treating APRN or RN must practice in accordance with all relevant laws and practice standards;

(F) an APRN may not prescribe, dispense, or administer

(i) a prescription drug in response to an Internet questionnaire or electronic mail message to a person with whom the APRN does not have a prior APRN-patient relationship;

(ii) an abortion-inducing drug;

(3) a record and documentation of telehealth encounters must be maintained to include:

(A) a clinical history to establish diagnoses and identify conditions and/or contra-indications to recommended treatment;

(B) a physical exam completed via telehealth technologies, or a previous in-person physical exam by the treating APRN, or a documented physical exam accessible by the treating APRN within the previous 365 days;

(C) treatment, recommendations, and issuing a prescription via electronic means; the treatment plan will be held to the same standards as those in traditional settings;

(D) patient informed consent for the use of telemedicine technologies;

(E) compliance with HIPAA and medical record retention rules;

(F) transmissions, including patient e-mail, prescriptions, and laboratory results must be secure within existing technology to include password protected, encrypted electronic prescriptions, or other reliable authentication techniques.

(b) In this section, "patient–APRN relationship" is establish when there is an in-person physical examination of the patient by the APRN, or another APRN or physician in the same group practice and the patient record is available to the treating APRN. (Eff. ___/___/____, Register ____)

Authority: AS 08.68.100

12 AAC 44.990 is amended by adding a new paragraph to read:

(33) "telehealth or telemedicine" means the practice and delivery of nursing or medicine encompassing preventative, health promotion, and curative aspects using electronic communications, information technology, or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider; this includes a wide array of clinical services using internet, wireless, video teleconferencing, satellite and telephone media. (Eff. 1/13/80, Register 73; am 10/8/81, Register 80; am 12/1/84, Register 91; am 4/2/86, Register 97; am 4/29/91, Register 118; am 7/28/95, Register 135; am 11/2/2001, Register 160; am 6/16/2002, Register 162; am 11/10/2002, Register 164; am 10/14/2004, Register 172; am 2/9/2007, Register 181; am 11/19/2008, Register 188; am 12/27/2012, Register 204; am 8/10/2016, Register 219; am 5/16/2018, Register 226; am ____/____/_____, Register _____)

Authority: AS 08.68.100 AS 08.68.275 AS 08.68.805

From:	The Brands
To:	Bernth, Gail A (CED); Dan Puig
Cc:	Tom Hepler; Erin McArthur; John Tappel; Laura Jones; mblenkush@latouchepediatrics.net
Subject:	Nurse Triage
Date:	Wednesday, October 3, 2018 9:17:43 PM

Dear Ms. Bernth: My group practice – LaTouche Pediatrics has a dedicated RN for nursing triage M-F and utilize Triage Logic after hours for our patients.

Speaking for myself, I would like to see the removal of the current limitation on our nurses triaging our patients that are not physically present in Alaska. In my opinion, this policy is outdated, and needs to be changed.

Our nurse is not practicing in a state they are not licensed in, but in fact, are in Alaska. The patient is out of state.

Our nurses use nationally recognized triage protocols and do not go outside the guidelines w/o consulting a physician. My license is in the State of Alaska and even we are "governed" by two contradictory statements by our board about the same issue. These guidelines never considered tele health and skype and should be updated. I really can't see any difference to our nurses triaging a patient who is in Nome versus Seattle. The protocols don't change when you cross a physical barrier. I am also aware that several other states have agreements to triage patients across state lines – and are not required to be licensed in each of those states.

With the expansion of tele-health and tele-doctors, there are multiple examples of advice and even therapy being given across state lines.

Tele-Stroke, Tele-Psych, and Tele-hospitalists providers currently provide medical advice across state lines without requiring a license in each state. Example an physician here in Alaska, exhibited stoke symptoms while in his office, he was taken to the ED, where he was examined and treated using a Tele-Health device by a physician in Oregon.

Insurance companies have 1-800 nurse and doctor telephone services to provide advice & at times, prescription medication across state lines.

Virtual office visits are now reimbursed by many insurance companies, and are often conducted across state lines.

Tele-Health has provided responsible, evidenced based care for many patients that have limited access, transportation issues, financial issues, or patients who do not have a primary provider. This outreach meets a great community need, and is a much valued service to our clinic patients.

I strongly encourage the Board of Nursing to change their opinion that nurses cannot conduct telephone triage across state lines.

Sincerely

Jeff Brand, MD
3340 Providence Dr. Suite 452
Anchorage, AK 99508
907-562-2120
jbrand@latouchepediatrics.net

From: Michelle Laufer
To: Bernth, Gail A (CED)
Subject: Nursing triage
Date: Tuesday, October 2, 2018 11:30:23 AM

Ms Bernth,

I am writing regarding the proposed codification of limitations on nurses providing triage advice to patients not physically present in the State of AK.

As a pediatric office we provide extensive triage services at no cost to our patients. This saves families unneeded worry, trips to the office, missed days of work, etc. When our families travel out of state we want to be able to provide ongoing commensurate care. As a medical home provider, we see patients from birth through teen years and we know our patients and families well. It is inappropriate and potentially unsafe for us to decline to speak with and advise them when they are out of state.

I hope common sense will prevail and nurses will continue to be able to triage our established patients when they travel.

Thank you,
Michelle Laufer, MD
AKpeds.

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Michelle Laufer, MD

From: Thad Woodard
To: Bernth, Gail A (CED)
Subject: nursing advice to patients not physically in Alaska
Date: Wednesday, October 3, 2018 7:28:01 AM

Ms. Bernth, I would like agree with Dr. Williow Monterrosa that the current opinion of the Alaska Board of Nursing that providing telephone advice to patients who have traveled out of Alaska is not within their scope of practice is not appropriate or patient friendly and can often lead to unnecessary expense.

Many health care experts support efforts to improve cost, patient access and quality of care to improve our current health care system but policies and regulations often stand in the way. A policy of not allowing nursing advice by telephone, especially when supervised by licensed medical providers (often using well validated protocols), to patients that have established medical home relationships just because they are not physically in Alaska is an example of a policy hampering efforts to improve cost, patient access, and quality. Policies need to support patients getting to the correct level of care efficiently not provide barriers.

Thad L Woodard, MD
Alaska Center for Pediatrics
Anchorage, Alaska

From: Schumacher, Amy
To: Bernth, Gail A (CED)
Subject: RN care for children located out of state
Date: Wednesday, October 3, 2018 6:28:23 PM

To Gail Bernth, MSN< ANP and team-

I'm very concerned about an limitations being considered to restrict our nurses from advising families when they travel out of state. Our families have direct access to their primary care team RNs who know them well. Maintaining this connection during travel is the ideal way to maintain continuity of care and assure that the team with knowledge about the child's medical issues, medications, allergies etc are the ones giving advice.

I'm also extremely concerned of any impact on advice our families receive from the subspecialty RNs out of state. Although this is less common, it could also have a huge negative impact on quality of care. Impacting a family with a child post bone marrow transplant being unable to reach out to the Seattle team could create significant risk.

I appreciate your support on this matter.

Sincerely,

Amy C. Schumacher, MD
Pediatrics
Southcentral Foundation

The Tri-Regulator Collaborative Position Statement on Practice Location for Consumer Protection

As the organizations representing the state and territorial licensing boards in the United States that regulate the practice of medicine, pharmacy and nursing, the Federation of State Medical Boards (FSMB), National Association of Boards of Pharmacy (NABP), and National Council of State Boards of Nursing (NCSBN) affirm that in a consumer protection model, health care practice occurs where the recipient of health care services is located.

The public protection mandate through state licensure is based on a patient-centered model. Patients come first and have a right to know that their health care provider is qualified and practicing safely. Patients also have a right to easily obtain information about a health care provider, including the provider's disciplinary record. Patients who have had perceived or actual harm should be able to contact the state licensing board where the health care practice occurred.

The increased use of telehealth modalities has highlighted the need to ensure consumer protection when care crosses geographic boundaries. Patients not residing in the location of the provider deserve the same quality of regulated practice regardless of where the provider is located. The Tri-Regulator Collaborative recognizes the importance of increased access to care and the efficient use of health resources. As practice occurs across geographic areas, licensing boards face the challenge of facilitating interstate practice while ensuring public protection. All three member organizations are actively involved in identifying and implementing licensure solutions to facilitate interstate access to quality health care while at the same time ensuring high standards of public protection.

Humayun J. Chaudhry, DO, MACP
President and
Chief Executive Officer
FSMB

Carmen Catizone, M.S., RPh, DPh
Executive Director
NABP

Kathy Apple, MS, RN, FAAN
Chief Executive Officer
NCSBN

From: Jennifer McKinnon
To: Bernth, Gail A (CED)
Subject: Limitations on nursing advise for out of state patients
Date: Tuesday, October 2, 2018 3:14:50 PM

Dear Ms. Bernth and the Alaska Board of Nursing,

I am a family nurse practitioner practicing at LaTouche Pediatrics in Anchorage. Due to Alaska's independent practice stance, I am able to have my own empaneled patients at the clinic. This means that I have "my" patients assigned to me and see me for all their care, both well visits and acute visits. Within my scope of practice, I diagnose, treat and prescribe multiple times during the course of my practice. Our goal at LaTouche is being a patient centered medical home. This coincides with my personal goal of being the primary provider for my patients.

As you know, many of us Alaskans travel out of state to see family or to escape the winter. When MY patients call or message me from out of state, I now cannot triage their symptoms or possibly renew a medication that I prescribed because they are out of Alaska. This make no sense to my patients or myself.

I respectfully request that you remove this barrier to my practice and the practice of fellow RNs and nurse practitioners. It is the right thing to do for our patients.

Jennifer McKinnon APRN, IBCLC and DNP candidate

From:	Theresa Dulski
To:	Bernth, Gail A (CED)
Subject:	Please let RNs provide phone triage to our patients traveling out of state
Date:	Monday, October 8, 2018 2:02:58 PM

Hello there,

I'm writing to share my support for maintaining AK nurses' ability to perform phone triage for our patients that are traveling out of state. Phone triage is an important component of the care that we provide in our clinic. It would seem strange/limit the care we provide if nurses were not able to have ongoing discussions with families about the health of their children we work with simply because they are traveling out of state.

Thank you for your consideration!
Theresa Dulski
Pediatrician

From: Clay, Patricia
To: Bernth, Gail A (CED)
Subject: Nurse triage concern
Date: Tuesday, October 2, 2018 11:59:12 AM

Good morning Ms. Bernth,

I received information from Dr. Willow Monterrosa regarding an upcoming vote to determine whether nurses in Alaska are allowed to provide telephone triage when a patient/family is out of state. I cannot overstate how this potential rule would be detrimental to the care of our patients. As pediatricians, we strive to provide a medical home for our families. This includes over the phone triage, for simple things such as Tylenol dosing to more complicated concerns involving how to help an acutely ill child. This relationship should not be severed simply because a family is out of state. In fact, I would argue that this is an essential service for families in transit, allowing them to avoid unnecessary ED or urgent care visits.

As a parent, I want to know I can continue to rely on my pediatrician's office for RN telephone triage, especially when out of state. And as a pediatrician, I want to ensure my families have the same service.

Please do not hesitate to contact me with additional questions or concerns, I am certainly more than willing to speak publicly about the issue if that would beneficial.

Thank you for your time,

Patti Clay, MD, MPH
Pediatrician, Outpatient Pediatrics
Southcentral Foundation
Ph (907) 729-8821
Fax (907) 729-3181

From: House Calls 4 Kids
To: Bernth, Gail A (CED)
Subject: Triaging Alaska patients out of State
Date: Tuesday, October 2, 2018 7:41:27 PM

Dear Gail,

I am a Pediatric Nurse Practitioner with my own business called House Calls 4 Kids LLC. Occasionally my patients do travel out of state. I also work at PAMC on the Nurse Advice Line. We used to be able to be able tell people we could talk to them wherever they were in the world. Years ago, I spoke with someone vacationing in Italy, someone in Africa. We have done calls from satellite phones to his brother who then called our line. All these people were from Alaska and knew about our advice line. Now, they have no one as this service just isn't offered everywhere.

Margaret A Kahler ARNP
Sent from my iPhone

From: Charles Ryan
To: Bernth, Gail A (CED)
Subject: Telephone triage to patients traveling out of state
Date: Wednesday, October 3, 2018 4:02:10 PM

When trying to make a difficult call, it is always best to consider the best interest and safety of the patient. In this instance, deciding if a nurse in Alaska can give advice over the phone to an established patient not in Alaska, the patient's interest demands that the nurse be allowed to do so. That is because the most compelling calls will involve patients with complex medical conditions, sometimes speaking with a nurse who not only knows the patient and the patient's history, but at times is an expert on that condition. He or she may be the only such expert the patient is able to contact. I would go so far as to say that it would occasionally constitute malpractice to withhold vital information from a patient simply based on the location of the patient. I know you will be able to craft language that allows a nurse to continue to give the same care over the phone to a patient with whom there is an established professional relationship, and still prohibit any potentially abusive practices
Thanks, Charles Ryan, MD

Agenda Item

3

Ketamine Infusion Therapy for Psychiatric Disorders and Chronic Pain Management

Practice Considerations

The following considerations are solely for general informational purposes. Certified registered nurse anesthetists (CRNAs) practice in accordance with professional ethics, scope and standards of practice, sound professional judgment, the best available evidence, the best interests of the patient, and applicable law. Consider legal and expert assistance regarding requirements for ketamine infusion therapy, including all federal, state, and local laws and regulations, specific to your practice.

Introduction

Over several decades, research has shown that ketamine has antidepressive properties.[1-3] Ketamine is approved by the U.S. Food and Drug Administration (FDA) for the induction and maintenance of anesthesia, although it is also being used for the management of psychiatric disorders and chronic pain management.[1,4,5] Ketamine has been incorporated into the treatment of psychiatric disorders, such as major depressive disorder (MDD), bipolar disorder, and post-traumatic stress disorder (PTSD), as well as post-operative and chronic pain management.[3,6] Intravenous (IV) ketamine therapy is not a first-line therapy for psychiatric disorders or chronic pain management and may be considered by the patient's interdisciplinary team after failure of standard treatment.

Interdisciplinary Patient-Centered Care

A patient-centered interdisciplinary team approach with consistent, clear communication to coordinate the management plan is necessary to optimize the patient's outcome. Continued screening, management, monitoring, and follow-up of patients with psychiatric issues or chronic pain is important throughout treatment and management.

Clinicians should engage the patient as part of the care team in shared decision making, as well as manage patient and caregiver expectations, with attention to the potential for nonresponse and treatment-emergent adverse events.[7] Through the informed consent process, the patient is made aware of the risks and benefits of proposed treatment and provided information that ketamine infusions for his or her condition is considered an off-label use of the product.[8] Alternative therapies, and their benefits and risks, should also be explained to the patient.[8]

The dose, frequency, and length of ketamine infusion treatment are individualized to each patient's condition, needs, and responsiveness to therapy with input from the interdisciplinary team. Serial infusions appear to be more effective than a single infusion for psychiatric and chronic pain conditions.[3,9,10] Ongoing patient evaluation and communication between the patient and clinicians will help direct the continued course of treatment.

Ketamine Infusion Clinics

Ketamine infusion clinics are becoming more available. These clinics should establish clear protocols and policy for best outcomes and patient safety.[1,11] Even when using low-dose ketamine, considerations include minimizing the potential for adverse events through

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premedication, individualized patient therapy, and monitoring of vital signs and general condition during the peri-infusion period.[10] When developing or joining a ketamine infusion service, clinicians should participate in the establishment of, or review, policies and procedures and check availability of routine and emergency supplies and equipment, as well as appropriately licensed and credentialed staff.

The American Association of Nurse Anesthetists (AANA) has developed a *Ketamine Infusion Therapy Considerations Checklist* for CRNAs who are interested in integrating ketamine infusion therapy into their practice. The checklist and information in this document provide an overview of practice and policy considerations for the use of ketamine infusions as an adjunct treatment for psychiatric disorders and chronic pain.

Safety Profile

Ketamine is a noncompetitive *N*-methyl-D-aspartate (NMDA) receptor antagonist. Ketamine's interaction with the NMDA receptor is important in anesthesia, because these receptors play a key role in central sensitization.[3] Ketamine has different binding sites such as opioid, monoaminergic, cholinergic, nicotinic and muscarinic receptors. The NMDA receptor, as a glutamate-dependent mechanism, is responsible for the pharmacologic properties.[6] Ketamine is eliminated through the kidneys and has an elimination half-life of 2-3 hours.[3] Following elimination, ketamine continues to have a prolonged effect.

Although low (sub-anesthetic) doses administered once or in a series of infusions has been shown as safe, the safety profile of prolonged ketamine use has not been established.[12] One of ketamine's positive features is the minimal effect on the central respiratory drive if given slowly, although rapid IV injection may cause transient apnea.[13] Ketamine is associated with very few drug-drug interactions and no contraindications are currently known to exist when combined with antidepressants, benzodiazepines, or other psychotropic medications.[14]

The most common side effects include psychotomimetic, dissociative psychiatric symptoms, confusion, inebriation, dizziness, euphoria, elevated blood pressure, and increased libido.[3,9,12,15,16] Ketamine can also have deleterious effects on liver and urinary tract function.[10] There may be a greater risk of ketamine-induced liver injury when infusions are prolonged or repeated over a short timeframe.[10] A clear monitoring plan should be in place to avoid or manage adverse events.[17]

Abuse/Addiction Properties

Ketamine abuse and diversion is a widely recognized problem in several countries in Europe and Asia, as well as in the United States.[18] Widespread use in the outpatient setting could produce physiological and psychological dependence on ketamine.[18] Appropriate patient screening should be conducted and caution taken when administering ketamine infusions due to the risk of abuse, addiction, or complications of long-term use.[4,12,19] Proper drug disposal measures are recommended to prevent the drug from being obtained illicitly.[3,20]

Use for Psychiatric Disorders

Because major psychiatric disorders, such as MDD, are among the most disabling mental, neurological, and substance use-related illnesses, new therapeutic approaches are being considered to treat or delay the onset of these disorders.[21]

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Ketamine infusions have been used as an adjunct to psychiatric treatment and can offer substantial short-term resolution of symptoms, although long-term resolution has not been noted.[11,22] IV low-dose ketamine can induce rapid and robust, although temporary, antidepressive effects, even in treatment-resistant patients who do not respond to electroconvulsive therapy.[2,6,11,16,18,19,23] Studies have shown that ketamine infusion reduces depressive symptoms and suicidal thoughts within a 30-40 minute period in approximately 60-75 percent of patients.[24]

Ketamine can effectively ameliorate symptoms of patients suffering from PTSD.[3,14] Feder et al. demonstrated that a single dose of ketamine, compared with a psychoactive placebo control medication, was associated with a rapid reduction in core PTSD symptoms and the benefit was often maintained beyond 24 hours, with some patients continuing to see reduced symptoms at two weeks.[14]

Use for Chronic Pain Treatment

Chronic pain is most effectively treated using a patient- centered, interdisciplinary, multimodal approach.[25,26] Ketamine may be used for chronic pain management for a range of disorders, including complex regional pain syndrome (CRPS), ischemic limb pain, phantom limb pain, fibromyalgia, and other neuropathic conditions.[3,10,15,22,25] Ketamine has also been shown to treat depression and anxiety in the context of chronic pain and other chronic illnesses.[6,27] As part of a multimodal approach, ketamine is not considered as the first or second choice in treatment for neuropathic pain, irrespective of the cause.[25] Since potential long-term effects on memory and cognition in chronic pain patients require further study, ketamine should be restricted to patients with therapy-resistant neuropathic pain, such as in refractory CRPS pain.[25]

Ketamine may have a role as an opiate adjunct for cancer pain, primarily of neuropathic origin, and may be a treatment option for patients who cannot tolerate opioids or those with problems with opioid responsiveness.[3] Ketamine can reduce the incidence and severity of opioid side effects, which is an important factor in patient compliance.[25] For example, an opioid-ketamine combination may be effective in non-neuropathic pain or in mixed nociceptive/neuropathic pain.[25]

Clinical Competency and Continuous Quality Improvement

CRNAs are educated and may be credentialed to manage acute and chronic pain, administer ketamine, assess the patient, and manage any associated side effects or complications.[28] CRNAs assess the addition of new activities to their practice and practice in accordance with their professional scope of practice, federal, state, and local law, and facility policy.[28,29] CRNAs participate with their practice team to develop policy and required competencies for the administration and monitoring of ketamine infusion therapy. The interdisciplinary team also engages in ongoing staff education, as well as continuous quality improvement and research to improve processes and patient outcomes.

Conclusion

The clinical use of ketamine infusion therapy for psychiatric disorders and chronic pain management continues to evolve. Clinicians, including CRNAs, should continue to contribute and monitor the development of related science, as well as engage in publication of new research on this topic.

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References

1. Sisti D, Segal AG, Thase ME. Proceed with caution: off-label ketamine treatment for major depressive disorder. *Curr Psychiatry Rep.* Dec 2014;16(12):527.
2. Williams NR, Schatzberg AF. NMDA antagonist treatment of depression. *Curr Opin Neurobiol.* Feb 2016;36:112-117.
3. Radvansky BM, Puri S, Sifonios AN, Eloy JD, Le V. Ketamine-A Narrative Review of Its Uses in Medicine. *Am J Ther.* Apr 24 2015.
4. Zhang MW, Harris KM, Ho RC. Is off-label repeat prescription of ketamine as a rapid antidepressant safe? Controversies, ethical concerns, and legal implications. *BMC Med Ethics.* 2016;17:4.
5. Ketamine Hydrochloride: Package Insert and Label Information. http://druginserts.com/lib/rx/meds/ketamine-hydrochloride-1/. Accessed July 15, 2016.
6. Parashchanka A, Schelfout S, Coppens M. Role of novel drugs in sedation outside the operating room: dexmedetomidine, ketamine and remifentanil. *Curr Opin Anaesthesiol.* Aug 2014;27(4):442-447.
7. Bobo WV, Voort JL, Croarkin PE, Leung JG, Tye SJ, Frye MA. Ketamine for Treatment-Resistant Unipolar and Bipolar Major Depression: Critical Review and Implications for Clinical Practice. *Depress Anxiety.* Apr 6 2016.
8. Informed Consent for Anesthesia Care. Park Ridge, IL: American Association of Nurse Anesthetists; 2016.
9. Rasmussen KG, Lineberry TW, Galardy CW, et al. Serial infusions of low-dose ketamine for major depression. *J Psychopharmacol.* May 2013;27(5):444-450.
10. O'Brien SL, Pangarkar S, Prager J. The Use of Ketamine in Neuropathic Pain. *Curr Phys Med Rehabil Rep.* 2014;2(2):128-145.
11. Howland RH. Ketamine for the treatment of depression. *J Psychosoc Nurs Ment Health Serv.* Jan 2013;51(1):11-14.
12. Rasmussen KG. Has psychiatry tamed the "ketamine tiger?" Considerations on its use for depression and anxiety. *Prog Neuropsychopharmacol Biol Psychiatry.* Jan 4 2016;64:218-224.
13. Gao M, Rejaei D, Liu H. Ketamine use in current clinical practice. *Acta Pharmacol Sin.* Mar 28 2016.
14. Feder A, Parides MK, Murrough JW, et al. Efficacy of intravenous ketamine for treatment of chronic posttraumatic stress disorder: a randomized clinical trial. *JAMA Psychiatry.* Jun 2014;71(6):681-688.
15. Schoevers RA, Chaves TV, Balukova SM, Rot MA, Kortekaas R. Oral ketamine for the treatment of pain and treatment-resistant depression. *Br J Psychiatry.* Feb 2016;208(2):108-113.
16. Singh JB, Fedgchin M, Daly EJ, et al. A Double-Blind, Randomized, Placebo-Controlled, Dose-Frequency Study of Intravenous Ketamine in Patients With Treatment-Resistant Depression. *Am J Psychiatry.* Apr 8 2016:appiajp201616010037.
17. Schak KM, Vande Voort JL, Johnson EK, et al. Potential Risks of Poorly Monitored Ketamine Use in Depression Treatment. *Am J Psychiatry.* Mar 1 2016;173(3):215-218.
18. Newport DJ, Carpenter LL, McDonald WM, et al. Ketamine and Other NMDA Antagonists: Early Clinical Trials and Possible Mechanisms in Depression. *Am J Psychiatry.* Oct 2015;172(10):950-966.
19. Montes JM, Lujan E, Pascual F, et al. Robust and sustained effect of ketamine infusions coadministered with conventional antidepressants in a patient with refractory major depression. *Case Rep Psychiatry.* 2015;2015:815673.

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20. Addressing Substance Use Disorder for Anesthesia Professionals. Park Ridge, IL: American Association of Nurse Anesthetists; 2016.
21. Fond G, Loundou A, Rabu C, et al. Ketamine administration in depressive disorders: a systematic review and meta-analysis. *Psychopharmacology (Berl).* Sep 2014;231(18):3663-3676.
22. Womble AL. Effects of ketamine on major depressive disorder in a patient with posttraumatic stress disorder. *AANA J.* Apr 2013;81(2):118-119.
23. Nguyen L, Marshalek PJ, Weaver CB, Cramer KJ, Pollard SE, Matsumoto RR. Off-label use of transmucosal ketamine as a rapid-acting antidepressant: a retrospective chart review. *Neuropsychiatr Dis Treat.* 2015;11:2667-2673.
24. Henderson TA. Practical application of the neuroregenerative properties of ketamine: real world treatment experience. *Neural Regen Res.* Feb 2016;11(2):195-200.
25. Niesters M, Martini C, Dahan A. Ketamine for chronic pain: risks and benefits. *Br J Clin Pharmacol.* Feb 2014;77(2):357-367.
26. Chronic Pain Management Guidelines. Park Ridge, IL: American Association of Nurse Anesthetists; 2014.
27. Moitra VK, Patel MK, Darrah D, Moitra A, Wunsch H. Low-Dose Ketamine in Chronic Critical Illness. *J Intensive Care Med.* Mar 2016;31(3):216-220.
28. Scope of Nurse Anesthesia Practice. Park Ridge, IL: American Association of Nurse Anesthetists; 2013.
29. Considerations for Adding New Activities to Individual CRNA Scope of Practice. Park Ridge, IL: American Association of Nurse Anesthetists; 2014.

Adopted by AANA Board of Directors September 2016.

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Questions:

- The AANA document states: “A clear monitoring plan should be in place to avoid or manage adverse events.” What is your monitoring plan?
    - Patients will be monitored continuously during the infusion
    - Our policy calls for blood pressure and continuous pulse oximetry throughout the infusion
- Do you have any policies and procedures in place?
    - Yes there are policies, procedures and protocols in place for each type of infusion
    - These are evidence-based and have been in practice for years at other clinics. They are updated as research continues to be produced
- What is your drug storage and disposal procedures?
    - Drug storage is according to DEA guidelines
    - The keys for the lock box will be stored in a separate safe when not in use
    - Disposal will be via sharps and medication waste bins that will be handled by a contracted company for removal from the facility
- Accepting referrals for mental health issues - who?
    - Referrals will be taken from patients and practitioners, however it is our policy that self-referring patients are being managed by a licensed mental health provider who it is within their scope to prescribe and manage psychiatric meds.
    - The patients we will be seeing are treatment resistant and therefore should have a primary psychiatrist or Mental Health Nurse Practitioner.
    - Patients who self-refer and are not under the care of either of these practitioners will be evaluated and referred to an appropriate provider for a thorough evaluation
- I would assume only those that can prescribe Ketamine and if it is within their scope of practice. Psychologist cannot prescribe, Mental Health Nurse Practitioners are able, whether FNPs could or not – debatable. Not sure if this is within an FNP scope of practice without additional education and certification.
    - If FNPs are managing these psychiatric patients meds and they are treatment resistant I would think they would have already sought the assistance of a mental health provider. If not, and they refer us a patient we would seek a referral from a mental health specialist
- What are we?
    - We are an infusion center. We are <u>NOT managing or diagnosing mental health</u> patients. We are anesthesia experts skilled in administration of ketamine, treatment of possible side effects, etc. We simply offer a safe place for patients to receive these infusions. We have continuous monitoring and ACLS capabilities with a full crash cart.

JAMA Psychiatry | Special Communication

A Consensus Statement on the Use of Ketamine in the Treatment of Mood Disorders

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IMPORTANCE Several studies now provide evidence of ketamine hydrochloride's ability to produce rapid and robust antidepressant effects in patients with mood and anxiety disorders that were previously resistant to treatment. Despite the relatively small sample sizes, lack of longer-term data on efficacy, and limited data on safety provided by these studies, they have led to increased use of ketamine as an off-label treatment for mood and other psychiatric disorders.

OBSERVATIONS This review and consensus statement provides a general overview of the data on the use of ketamine for the treatment of mood disorders and highlights the limitations of the existing knowledge. While ketamine may be beneficial to some patients with mood disorders, it is important to consider the limitations of the available data and the potential risk associated with the drug when considering the treatment option.

CONCLUSIONS AND RELEVANCE The suggestions provided are intended to facilitate clinical decision making and encourage an evidence-based approach to using ketamine in the treatment of psychiatric disorders considering the limited information that is currently available. This article provides information on potentially important issues related to the off-label treatment approach that should be considered to help ensure patient safety.

JAMA Psychiatry. 2017;74(4):399-405. doi:10.1001/jamapsychiatry.2017.0080
Published online March 1, 2017.

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The American Psychiatric Association Council of Research Task Force on Novel Biomarkers and Treatments found that the data from 7 published placebo-controlled, double-blind, randomized clinical studies on ketamine hydrochloride infusion therapy in the treatment of depression comprising 147 treated patients provide "compelling evidence that the antidepressant effects of ketamine infusion are both rapid and robust, albeit transient."[1(p958)] Reports of ketamine's unique antidepressant effects, combined with frequent media coverage promulgating the potential benefits of ketamine treatment, have generated substantial interest and optimism among patients, families, patient advocacy groups, and clinicians alike. This interest has led to a rapidly escalating demand for clinical access to ketamine treatment and an increasing number of clinicians willing to provide it. However, many in the field suggest that caution should be used with this approach, as the numbers of patients included in these published studies and case series remain relatively small (the eTable in the Supplement compares other recently developed treatments), and ketamine treatment for mood disorders has not been tested in larger-scale clinical trials to demonstrate its durability and safety over time.[2,3] Moreover, the treatment approach has not been subject to the scrutiny of a US Food and Drug Administration review or approval for an on-label psychiatric indication, and, despite more than 45 years of clinical experience with ketamine as an anesthetic agent, there are no postmarketing surveillance data on the use of ketamine for any psychiatric indication to provide information on its safety and effectiveness.

The relatively unique nature of this situation presents an urgent need for some guidance on the issues surrounding the use of ketamine treatment in mood disorders. This review by the American Psychiatric Association Council of Research Task Force on Novel Biomarkers and Treatments Subgroup on Treatment Recommendations for Clinical Use of Ketamine is intended to complement the recent American Psychiatric Association meta-analysis[1] and other recent reviews[4-10] and aims to provide an overview and expert clinical opinion of the critical issues and considerations associated with the off-label use of ketamine treatment for mood disorders. Because relatively limited high-quality, published information on this topic exists, to our knowledge, this report is not intended to serve as a standard, guideline, clinical policy, or absolute requirement. The main intent of the report is to highlight the current state of the field and the critical issues to be considered when contemplating the use of ketamine for treatment-resistant depression. Use of this report cannot guarantee any specific outcome and is not endorsed or promulgated as policy of the American Psychiatric Association.

Patient Selection

There are no clearly established indications for the use of ketamine in the treatment of psychiatric disorders. However, the selection of appropriate patients for ketamine treatment requires consideration of the risks and benefits of the treatment in the context of the patient's severity of depression, duration of current episode, previous treatment history, and urgency for treatment. To date, the strongest data supporting ketamine's clinical benefit in psychiatric disorders are in the treatment of major depressive episodes without psychotic features associated with major depressive disorder.[1,11] Even these data are limited by the fact that most of those studies evaluated efficacy only during the first week following a single infusion of ketamine. However, emerging studies suggest that repeated dosing can extend the duration of effect for at least several weeks.[12,13] Although some limited data on the use of ketamine in treating other psychiatric diagnoses exist (eBox 1 in the Supplement), we do not believe there are sufficient data to provide a meaningful review of the assessment of risks and benefits of ketamine use in these other disorders at present.

In addition to diagnostic considerations, appropriate patient selection requires an assessment of other medical, psychological, or social factors that may alter the risk to benefit ratio of the treatment and affect the patient's capacity to provide informed consent. For these reasons, we recommend that each patient undergo a thorough pretreatment evaluation process (**Table**)[14-17] that assesses several relevant features of the patient's past and current medical and psychiatric condition before initiating ketamine treatment. We also recommend that an informed consent process be completed during this evaluation. Rationale for the suggestions listed in the Table are provided in eBox 1 in the Supplement.

Table. Recommended Components of Preprocedural Evaluation for Appropriateness of Ketamine Hydrochloride Treatment

Component	Recommendation
1	A comprehensive diagnostic assessment should be completed to establish current diagnosis and evaluate history of substance use and psychotic disorders
2	Assessment of baseline symptom severity should be completed to allow later assessments of clinical change with treatment[a]
3	A thorough history of antidepressant treatment should be collected and documented to confirm previous adequate trials of antidepressant treatments
4	A thorough review of systems should be performed to evaluate potential risk factors associated with ketamine treatment[b]
5	Decisions on the specific physical examination and laboratory screening assessments should be made according to established guidelines and advisories issued by the American College of Cardiology Foundation/American Heart Association and the American Society of Anesthesiologists and should be based on a patient's individual clinical characteristics[c]
6	A careful review of past medical and psychiatric records and/or corroboration of the past history by family members are strongly encouraged; all current medications and allergies should be reviewed, including histories of opiate and benzodiazepine use; the use of a baseline urine toxicology screen is strongly encouraged to ensure the accuracy of the reported substance use and medication record
7	An informed consent process, including discussion of the risks associated with the treatment,[d] the limits of the available information pertaining to the potential benefits of the treatment, the fact that this is an off-label use of ketamine, and a discussion of alternative treatment options should be completed; this discussion should be complemented with written materials, and the patient should provide written informed consent before initiating treatment

[a] Self-report versions of the Inventory of Depressive Symptomatology and Quick Inventory of Depressive Symptomatology (http://counsellingresource.com/quizzes/depression-testing/qids-depression/) are examples of scales that are available at no cost to clinicians and researchers.

[b] This review should also include questions pertaining to functional exercise capacity, which has been demonstrated to provide a good screening tool for patients that are at increased risk for adverse events associated with anesthesia exposure and surgical procedures.[14,15]

[c] American College of Cardiology Foundation and the American Heart Association guidelines for perioperative cardiovascular evaluation and management of patients undergoing noncardiac surgery[16] and practice advisory from the American Society of Anesthesiologists.[17]

[d] The Ketalar package insert (http://www.accessdata.fda.gov/drugsatfda_docs/label/2012/016812s039lbl.pdf) provides essential information related to risk of ketamine administration.

Clinician Experience and Training

There are considerable differences in the experience and clinical expertise of the clinicians currently administering ketamine to patients for the treatment of mood disorders. At present, there are no published guidelines or recommendations outlining the specific training requirements that clinicians should complete before administering doses of ketamine that are lower than those used in anesthesia. In attempting to balance the needs for treatment availability and patient safety, one must consider the information available regarding the use of ketamine at the relevant dose range in similar patient populations to formulate an advisory on clinical credentialing for ketamine administration for the treatment of mood disorders.

The peak plasma ketamine hydrochloride concentrations of 70 to 200 ng/mL seen with the typical antidepressant dose of 0.5 mg/kg delivered intravenously (IV) during 40 minutes (0.5 mg/kg per 40 minutes IV) do not produce general anesthetic effects. The concentrations are well below the peak plasma ketamine hydrochloride concentrations generally used for surgical anesthesia (2000-3000 ng/mL) and below the concentrations associated with awakening from ketamine hydrochloride anesthesia (500-1000 ng/mL).[18-20] Reporting on 833 ketamine infusions in healthy individuals resulting in peak plasma ketamine concentrations in the same general range as those achieved with a dose of 0.5 mg/kg per 40 minutes IV, Perry et al[21] found 3 individuals who became nonresponsive to verbal stimuli, but all remained medically stable during the infusion and none required any form of respiratory assistance. A second, more recent study reported no persistent medical complications or significant changes in oxygen saturation among 84 otherwise healthy patients with depression who received a total of 205 infusions of ketamine hydrochloride, 0.5 mg/kg per 40 minutes IV.[9] However, transient mean (SD) peak increases in systolic (19.6 [12.8] mm Hg) and diastolic (13.4 [9.8] mm Hg) blood pressure were reported during the infusions, with blood pressure levels exceeding 180/100 mm Hg or heart rates exceeding 110 beats per minute in approximately 30% of the patients treated. A single serious adverse cardiovascular-related event was reported in this study (0.49% of infusions), but it was considered to be attributable to a vasovagal episode following venipuncture for a blood draw, and it resolved without complications.

The data available from these studies and other case reports in the literature suggest that the dose of ketamine hydrochloride typically used in the treatment of mood disorders (0.5 mg/kg per 40 minutes IV) does not appear to have significant effects on the respiratory status of healthy individuals or patients with depression who are otherwise generally medically healthy. However, ketamine treatment could have meaningful effects on blood pressure and heart rate for some patients. Considering the potential risks associated with ketamine hydrochloride administration at the dose of 0.5 mg/kg per 40 minutes IV, it is recommended that clinicians delivering the treatment be prepared to manage potential cardiovascular events should they occur. Based on this information, we suggest that a licensed clinician who can administer a Drug Enforcement Administration Schedule III medication (in most states this is an MD or DO with appropriate licensing) with Advanced Cardiac Life Support certification should provide the treatments.

Because it is also possible for patients to experience prominent transient dissociative or even psychotomimetic effects while being treated with ketamine,[22] clinicians should also be familiar with behavioral management of patients with marked mental status changes and be prepared to treat any emergency behavioral situations. Furthermore, it is suggested that an on-site clinician be available and able to evaluate the patient for potential behavioral risks, including suicidal ideation, before discharge to home. Finally, treating clinicians should be able to ensure that rapid follow-up evaluations of patients' psychiatric symptoms can be provided as needed.

In addition to the minimal general training requirements, it is also recommended that clinicians develop some level of experience with the specific method of ketamine administration before performing the procedure independently. Precise delineation of required experience and documentation of this experience should be based on local community standards of practice and/or clinical practice committees. Reports such as the *Statement on Granting Privileges for Administration of Moderate Sedation to Practitioners Who Are Not Anesthesia Professionals*, published by the American Society of Anesthesiologists,[23] can be used to inform the development of these standards.

Treatment Setting

Although the administration of ketamine at peak plasma concentrations similar to those produced by a dose of 0.5 mg/kg per 40 minutes IV has proven to be relatively safe to date, the potentially concerning acute effects on cardiovascular function and behavior suggest that the clinical setting should provide sufficient means of monitoring the patients and providing immediate care if necessary. Although there are relatively low levels of evidence to support the use of any specific monitoring methods in reducing the risks of ketamine treatment with doses that are lower than those used in anesthesia, it should be expected that such a facility have a means of monitoring basic cardiovascular (electrocardiogram, blood pressure) and respiratory (oxygen saturation or end-tidal CO_2) function. It should also be expected that there would be measures in place to rapidly address and stabilize a patient if an event should arise. These measures would include a means of delivering oxygen to patients with reduced respiratory function, medication, and, if indicated, restraints to manage potentially dangerous behavioral symptoms. Moreover, there should be an established plan to rapidly address any sustained alterations in cardiovascular function, such as providing advanced cardiac life support or transfer to a hospital setting capable of caring for acute cardiovascular events. Patients deemed at higher risk for complications based on pretreatment evaluation should be treated at a facility that is appropriately equipped and staffed to manage any cardiovascular or respiratory events that may occur.

Medication Delivery

Dose

Most clinical trials and case reports available in the literature have used the ketamine hydrochloride dose of 0.5 mg/kg per 40 minutes IV that was cited in the original report by Berman et al.[24] Limited information is available regarding the use of different routes of delivery and doses of ketamine. A meta-analysis of 6 trials assessing the effects of the standard dose of 0.5 mg/kg per 40 minutes IV and 3 trials assessing very low doses of ketamine hydrochloride (50-mg intranasal spray, 0.1-0.4 mg/kg IV, and 0.1-0.5 mg/kg IV intramuscularly or subcutaneously) reported that the dose of 0.5 mg/kg per 40 minutes IV appears to be more effective than very low doses in reducing the severity of depression.[4] However, there is substantial heterogeneity in the design of the clinical trials, and the total number of participants included in that analysis is very few, markedly limiting the ability to draw any firm conclusions from this report.

Although there is now a growing number of reports examining the effects of various doses and rates of ketamine infusion, including studies showing lower doses and reduced infusion rates[25-27] to be effective and studies showing higher doses and extended infusion rates[28,29] to have clinical benefit, at present we believe that insufficient information was provided in those studies to allow any meaningful analysis of any specific dose or route of treatment compared with the standard dose of 0.5 mg/kg per 40 minutes IV. Considering the lower-level evidence for doses and routes of administration other than 0.5 mg/kg per 40 minutes IV, if alternative doses are being used, that information should be presented to the patient during the informed consent process, and appropriate precautions should be made in managing any increased risk associated with the changes in ketamine administration. However, the use of alternative doses and routes of administration could be appropriate for individual patients under specific conditions.

One example of a rationale for dose adjustment is related to the dosing of ketamine for patients with a high body mass index (calculated as weight in kilograms divided by height in meters squared). The fact that greater hemodynamic changes were observed in patients with a body mass index of 30 or higher who were receiving a dose of 0.5 mg/kg per 40 minutes[9] suggests that adjusting the ketamine dosing to ideal body weight (using the person's calculated ideal body weight and not actual body weight to determine dosing) may be an appropriate step to help ensure safety for patients with a body mass index of 30 or higher. However, there is currently very limited information supporting this approach.

Delivery Procedure

To help best ensure patient safety and to minimize risks, it is strongly advised that site-specific standard operating procedures be devel-

oped and followed for the delivery of ketamine treatments for major depressive episodes. The standard operating procedure should contain predosing considerations covering the following: (1) confirmation of preprocedural evaluation and informed consent; (2) assessment of baseline vital signs, including blood pressure, heart rate, and oxygen saturation or end-tidal CO_2; (3) criteria for acceptable baseline vital signs before initiation of medication delivery (eBox 2 in the Supplement); and (4) incorporation of a "time-out" procedure in which the name of the patient and correct dosing parameters are confirmed.

Standard operating procedures should also include specifically defined ongoing assessments of patients' physiological and mental status during the infusion process, including the following: (1) assessment of respiratory status (ie, oxygen saturation or end-tidal CO_2); (2) assessment of cardiovascular function (blood pressure and heart rate, reported on a regular basis); (3) assessment of the level of consciousness (ie, Modified Observer's Assessment of Alertness/Sedation Scale[30]) or other documented assessment of responsiveness; and (4) delineation of criteria for stopping the infusion (eBox 3 in the Supplement) and a clear plan for managing cardiovascular or behavioral events during treatment.

Immediate posttreatment evaluations, assessments, and management should ensure that the patient has returned to a level of function that will allow for safe return to his or her current living environment. This assessment should include documentation of return to both baseline physiological measures and mental status. It is also critical to ensure that a responsible adult is available to transport the patient home if the treatment is being administered on an outpatient basis. Recommendations regarding driving and use of heavy machinery, as well as use of concomitant medications, drugs, or alcohol, should also be reviewed before discharge. It is also important to review follow-up procedures and ensure that the patient has a means of rapidly contacting an appropriately trained clinician if necessary.

Follow-up and Assessments

Efficacy Measures of Short-term Repeated Administration

The existing data surrounding the benefits of repeated infusions of ketamine remain limited.[1,11] Although an increasing number of small case series evaluate the efficacy of repeated ketamine administration for the treatment of major depressive episodes, there is a very small number of randomized clinical trials in the literature.[1] The lack of clinical trials in this area makes it difficult to provide suggestions on the frequency and duration of treatment with even moderate levels of confidence. Most studies and case reports published to date on this topic have examined the effects of less than 1 month of treatment.[12,26,31-34]

A recent randomized, placebo-controlled clinical trial (using saline as the placebo) of 68 patients with treatment-resistant major depressive disorder examined the efficacy of ketamine, 0.5 mg/kg per 40 minutes IV, both 2 and 3 times weekly for up to 2 weeks and found both dosing regimens to be nearly equally efficacious (change in mean [SD] Montgomery-Åsberg Depression Rating Scale total score for ketamine 2 times weekly, −18.4 [12.0] vs placebo, −5.7 [10.2]; and ketamine 3 times weekly, −17.7 [7.3] vs placebo, −3.1 [5.7]).[13] After 2 weeks of treatment, patients treated with ketamine 2 times weekly showed a 69% rate of response and 37.5% rate of remission vs placebo, at 15% and 7.7%, respectively, and those treated with ketamine 3 times weekly had a 53.8% rate of response and 23.1% rate of remission vs placebo, at 6% and 0%, respectively. In the ensuing open-label phase of the study, patients were allowed to continue with active medication at the dose frequency they were originally assigned for an additional 2-week period. At the end of 4 weeks of treatment, the 13 patients who received ketamine 2 times weekly and continued to receive the additional 2 weeks of treatment had a mean 27-point reduction in the Montgomery-Åsberg Depression Rating Scale score compared with a 23-point decrease for the 13 patients who received ketamine 3 times weekly. Although this was clearly not a definitive study, it is the best evidence currently available, to our knowledge, to suggest that twice-weekly dosing is as efficacious as more frequent dosing for a period of up to 4 weeks. In general, most of the available reports describing the effects of repeated treatments showed the largest benefits occurring early in the course of treatment, but some reports did show some cumulative benefit of continued treatment.[31]

Very limited data exist to suggest a clear point of determining the futility of treatment, but there are a few reports of patients responding after more than 3 infusions. Based on the limited data available, patients should be monitored closely using a rating instrument to assess clinical change to better reevaluate the risk to benefit ratio of continued treatment. In addition, only 1 report suggests that an increased dose of ketamine (beyond 0.5 mg/kg per 40 minutes) may lead to a response to treatment in patients who had previously not responded.[28] Equally few data are available to suggest a standard number of treatments that should be administered to optimize longer-term benefit of the treatment.

Efficacy of Longer-term Repeated Administration

To our knowledge, there are extremely limited published data on the longer-term effectiveness and safety of ketamine treatment in mood disorders. This literature is confined to a few case series that do not allow us to make a meaningful statement about the longer-term use of ketamine.[35,36] Several clinics providing such treatments are currently using a 2- or 3-week course of ketamine delivered 2 or 3 times per week, followed by a taper period and/or continued treatments based on empirically determined duration of responses for each patient. However, there remain no published data that clearly support this practice, and it is strongly recommended that the relative benefit of each ketamine infusion be considered in light of the potential risks associated with longer-term exposure to ketamine and the lack of published evidence for prolonged efficacy with ongoing administration. The scarcity of this information is one of the major drawbacks to be considered before initiating ketamine therapy for patients with mood disorders and should be discussed with the patient before beginning treatment.

Safety Measures and Continuation of Treatment

Based on the known or suspected risks of cognitive impairment[37] and cystitis[38] associated with chronic high-frequency use of ketamine and the known substance abuse liability of the drug,

assessments of cognitive function, urinary discomfort, and substance use[39] should be considered if repeated administrations are provided (eBox 4 in the Supplement).

Considering the known potential for abuse of ketamine[40] and recent reports of abuse of prescribed ketamine for the treatment of depression,[41] clinicians should be vigilant about assessing the potential for patients to develop ketamine use disorder. Close clinical follow-up with intermittent urine toxicology screening for drugs of abuse and inquiries about attempts to receive additional ketamine treatments at other treatment centers should be implemented when clinical suspicion of ketamine abuse is present. Moreover, the number and frequency of treatments should be limited to the minimum necessary to achieve clinical response. Considering the evidence suggesting that the mechanism of action requires some delayed physiological effect to the treatment and does not appear to require sustained blood concentrations of the drug to be present, there is no evidence to support the practice of frequent ketamine administration. The previously mentioned report showing twice-weekly dosing to be at least as effective as dosing 3 times a week[13] for up to 4 weeks appears to support this idea instead of more frequent dosing schedules.

At this point of early clinical development, we strongly advise against the prescription of at-home self-administration of ketamine; it remains prudent to have all doses administered with medical supervision until more safety information obtained under controlled situations can be collected. Discontinuation of ketamine treatment is recommended if the dosing cannot be spaced out to a minimum administration of 1 dose per week by the second month of treatment. The goal remains to eventually taper and discontinue treatment until more long-term safety data can be collected.

Future Directions

The rapid onset of robust, transient antidepressant effects associated with ketamine infusions has generated much excitement and hope for patients with refractory mood disorders and the clinicians who treat them. However, it is necessary to recognize the major gaps that remain in our knowledge about the longer-term efficacy and safety of ketamine infusions. Future research is needed to address these unanswered questions and concerns. Although economic factors make it unlikely that large-scale, pivotal phase 3 clinical trials of racemic ketamine will ever be completed, there are several studies with federal and private foundation funding aiming to address some of these issues. It is imperative that clinicians and patients continue to consider enrollment in these studies when contemplating ketamine treatment of a mood disorder. It is only through these standardized clinical trials that we will be able to collect the data necessary to answer some of the crucial questions pertaining to the efficacy and safety of the drug. A second means of adding to the knowledge base is to develop a coordinated system of data collection on all patients receiving ketamine for the treatment of mood disorders. After such a registry is created, all clinicians providing ketamine treatment should consider participation.

ARTICLE INFORMATION

Accepted for Publication: January 11, 2017.

Published Online: March 1, 2017. doi:10.1001/jamapsychiatry.2017.0080

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Conflict of Interest Disclosures: Dr Sanacora reported receiving consulting fees from Allergan, Alkermes, AstraZeneca, BioHaven Pharmaceuticals, Hoffman La-Roche, Johnson & Johnson (Janssen), Merck, Naurex, Servier Pharmaceuticals, Taisho Pharmaceuticals, Teva, and Vistagen Therapeutics in the past 24 months and receiving research contracts from AstraZeneca, Bristol-Myers Squibb, Eli Lilly & Co, Johnson & Johnson (Janssen), Hoffman La-Roche, Merck & Co, Naurex, and Servier in the last 24 months. Free medication was provided to Dr Sanacora for a National Institutes of Health–sponsored study by Sanofi. Dr Sanacora reported holding shares in BioHaven Pharmaceuticals Holding Company and being a co-inventor on patent No. 8778979 ("Glutamate agents in the treatment of mental disorders"). Dr Frye reported receiving grant support in 2016 from AssureRx, Janssen Research & Development, Mayo Foundation, Myriad Genetics, and Pfizer; serving as a paid consultant for Mayo, Janssen Research & Development LLC, Mitsubishi Tanabe Pharma Corporation, Myriad Genetics, Neuralstem Inc, Sunovion, Supernus Pharmaceuticals, and Teva Pharmaceuticals; and receiving continuing medical education and travel support from the American Physician Institute and CME Outfitters. Dr McDonald reported receiving research support from the National Institute of Mental Health, National Institute of Neurological Disease and Stroke, Stanley Foundation, Soterix, Neuronetics, and Cervel Neurotherapeutics; receiving reimbursement for travel and an honorarium for serving as a consultant on the Neurological Devices Panel of the Medical Devices Advisory Committee, Center for Devices and Radiological Health, Food and Drug Administration, and serving as an ad hoc member of several National Institute of Mental Health and National Institute of Neurological Disease and Stroke study sections; and receiving royalties or a stipend for a contract with Oxford University Press to co-edit a book on the clinical guide to transcranial magnetic stimulation in the treatment of depression and for serving as a section editor for *Current Psychiatry Reports*. Dr Mathew reported receiving research funding from the Department of Veterans Affairs, National Institute of Mental Health, Janssen Research & Development, and Otsuka; receiving consulting fees from or serving on advisory boards for Acadia, Alkermes, Cerecor, Genentech, Naurex, Otsuka, Teva, Valeant, and Vistagen Therapeutics; and receiving support from the Johnson Family Chair for Research in Psychiatry at Baylor College of Medicine and resources and use of facilities at the Michael E Debakey Veterans Affairs Medical Center in Houston, Texas. Dr Schatzberg reported receiving consulting fees from Forum, Gilead, Takeda, Xhale, Clintara, Pfizer, Myriad Genetics, Alkermes, and Neuronetics in the past 3 years; holding equity in Seattle Genetics, Incyte Genetics, Corcept (co-founder), Merck, Gilead, Xhale, Amnestix, Synosia, Neuronetics, and Intersect ENT; receiving grant funding from Janssen; and receiving royalties from American Psychiatric Publishing and Stanford University for use patents. Dr Summergrad reported receiving honoraria from CME Outfitters, Pharmasquire, and universities and associations for nonpromotional speaking; royalties from Harvard University Press, Springer, and American Psychiatric Press; and consulting fees and stock options from Mental Health Data Services Inc and Quartet Health Inc, in which he also has stock. Dr Nemeroff reported receiving consulting fees from Xhale, Takeda, Mitsubishi Tanabe Pharma Development America, Taisho Pharmaceutical Inc, Lundbeck, Prismic Pharmaceuticals, Bracket (Clintara), Total Pain Solutions (TPS), Gerson Lehrman Group (GLG) Healthcare & Biomedical Council, Fortress Biotech, Sunovion Pharmaceuticals Inc, and Sumitomo Dainippon Pharma; being a share holder in Xhale, Celgene, Seattle Genetics, Abbvie, OPKO Health Inc, and Bracket Intermediate Holding Corp; receiving income or equity from American Psychiatric Publishing, Xhale, Bracket (Clintara), CME

Outfitters, and Takeda; and holding patent No. 6,375,990B1 related to the method of and devices for transdermal delivery of lithium and patent No. 7,148,027B2 related to the method of assessing antidepressant drug therapy via transport inhibition of monoamine neurotransmitters by ex vivo assay.

Group Information: The American Psychiatric Association (APA) Task Force on Novel Biomarkers and Treatments members include: Charles B. Nemeroff, MD, PhD (University of Miami Miller School of Medicine); William McDonald, MD (Emory University School of Medicine); Linda Carpenter, MD (Butler Hospital, Brown University); Ned Kalin, MD (University of Wisconsin School of Medicine and Public Health); Carolyn Rodriquez, MD, PhD (Stanford University); Maurico Tohen, MD, DrPh, MBA (University of New Mexico); and Alik Widge, MD, PhD (Massachusetts General Hospital, Harvard University).

Additional Contributions: Shaun Gruenbaum, MD, Department of Anesthesiology, Yale University School of Medicine, assisted with and reviewed this manuscript. He was not compensated for his contribution.

REFERENCES

1. Newport DJ, Carpenter LL, McDonald WM, Potash JB, Tohen M, Nemeroff CB; APA Council of Research Task Force on Novel Biomarkers and Treatments. Ketamine and other NMDA antagonists: early clinical trials and possible mechanisms in depression. *Am J Psychiatry*. 2015;172(10):950-966.

2. Sisti D, Segal AG, Thase ME. Proceed with caution: off-label ketamine treatment for major depressive disorder. *Curr Psychiatry Rep*. 2014;16(12):527.

3. Zhang MW, Harris KM, Ho RC. Is off-label repeat prescription of ketamine as a rapid antidepressant safe? controversies, ethical concerns, and legal implications. *BMC Med Ethics*. 2016;17(1):4.

4. Xu Y, Hackett M, Carter G, et al. Effects of low-dose and very low-dose ketamine among patients with major depression: a systematic review and meta-analysis. *Int J Neuropsychopharmacol*. 2016;19(4):pyv124. doi:10.1093/ijnp/pyv124

5. Coyle CM, Laws KR. The use of ketamine as an antidepressant: a systematic review and meta-analysis. *Hum Psychopharmacol*. 2015;30(3):152-163.

6. Lee EE, Della Selva MP, Liu A, Himelhoch S. Ketamine as a novel treatment for major depressive disorder and bipolar depression: a systematic review and quantitative meta-analysis. *Gen Hosp Psychiatry*. 2015;37(2):178-184.

7. McGirr A, Berlim MT, Bond DJ, Fleck MP, Yatham LN, Lam RW. A systematic review and meta-analysis of randomized, double-blind, placebo-controlled trials of ketamine in the rapid treatment of major depressive episodes. *Psychol Med*. 2015;45(4):693-704.

8. Fond G, Loundou A, Rabu C, et al. Ketamine administration in depressive disorders: a systematic review and meta-analysis. *Psychopharmacology (Berl)*. 2014;231(18):3663-3676.

9. Wan LB, Levitch CF, Perez AM, et al. Ketamine safety and tolerability in clinical trials for treatment-resistant depression. *J Clin Psychiatry*. 2015;76(3):247-252.

10. McCloud TL, Caddy C, Jochim J, et al. Ketamine and other glutamate receptor modulators for depression in bipolar disorder in adults. *Cochrane Database Syst Rev*. 2015;9(9):CD011611.

11. Caddy C, Amit BH, McCloud TL, et al. Ketamine and other glutamate receptor modulators for depression in adults. *Cochrane Database Syst Rev*. 2015;9(9):CD011612.

12. Murrough JW, Perez AM, Pillemer S, et al. Rapid and longer-term antidepressant effects of repeated ketamine infusions in treatment-resistant major depression. *Biol Psychiatry*. 2013;74(4):250-256.

13. Singh JB, Fedgchin M, Daly EJ, et al. A double-blind, randomized, placebo-controlled, dose-frequency study of intravenous ketamine in patients with treatment-resistant depression. *Am J Psychiatry*. 2016;173(8):816-826.

14. Kristensen SD, Knuuti J, Saraste A, et al; Authors/Task Force Members. 2014 ESC/ESA guidelines on non-cardiac surgery: cardiovascular assessment and management: the Joint Task Force on non-cardiac surgery: cardiovascular assessment and management of the European Society of Cardiology (ESC) and the European Society of Anaesthesiology (ESA). *Eur J Anaesthesiol*. 2014;31(10):517-573.

15. Eagle KA, Berger PB, Calkins H, et al; American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Update the 1996 Guidelines on Perioperative Cardiovascular Evaluation for Noncardiac Surgery). ACC/AHA guideline update for perioperative cardiovascular evaluation for noncardiac surgery—executive summary: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Update the 1996 Guidelines on Perioperative Cardiovascular Evaluation for Noncardiac Surgery). *Circulation*. 2002;105(10):1257-1267.

16. Fleisher LA, Fleischmann KE, Auerbach AD, et al; American College of Cardiology; American Heart Association. 2014 ACC/AHA guideline on perioperative cardiovascular evaluation and management of patients undergoing noncardiac surgery: a report of the American College of Cardiology/American Heart Association Task Force on practice guidelines. *J Am Coll Cardiol*. 2014;64(22):e77-e137.

17. Apfelbaum JL, Connis RT, Nickinovich DG, et al; Committee on Standards and Practice Parameters; American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology*. 2012;116(3):522-538.

18. Miller RD. *Miller's Anesthesia*. 7th ed. Philadelphia, PA: Churchill Livingstone; 2010.

19. Grant IS, Nimmo WS, McNicol LR, Clements JA. Ketamine disposition in children and adults. *Br J Anaesth*. 1983;55(11):1107-1111.

20. Bowdle TA, Horita A, Kharasch ED. *The Pharmacological Basis of Anesthesiology*. New York, NY: Churchill Livingstone; 1994.

21. Perry EB Jr, Cramer JA, Cho HS, et al; Yale Ketamine Study Group. Psychiatric safety of ketamine in psychopharmacology research. *Psychopharmacology (Berl)*. 2007;192(2):253-260.

22. Krystal JH, Karper LP, Seibyl JP, et al. Subanesthetic effects of the noncompetitive NMDA antagonist, ketamine, in humans: psychotomimetic, perceptual, cognitive, and neuroendocrine responses. *Arch Gen Psychiatry*. 1994;51(3):199-214.

23. American Society of Anesthesiologists. Statement on granting privileges for administration of moderate sedation to practitioners who are not anesthesia professionals (approved by the ASA House of Delegates on October 25, 2005, and reaffirmed on October 26, 2016). http://www.asahq.org/~/media/Sites/ASAHQ/Files/Public/Resources/standards-guidelines/statement-on-granting-privileges-to-nonanesthesiologist-administering-physicians-deep-sedation.pdf. Accessed December 19, 2016.

24. Berman RM, Cappiello A, Anand A, et al. Antidepressant effects of ketamine in depressed patients. *Biol Psychiatry*. 2000;47(4):351-354.

25. Singh JB, Fedgchin M, Daly E, et al. Intravenous esketamine in adult treatment-resistant depression: a double-blind, double-randomization, placebo-controlled study. *Biol Psychiatry*. 2016;80(6):424-431.

26. Rasmussen KG, Lineberry TW, Galardy CW, et al. Serial infusions of low-dose ketamine for major depression. *J Psychopharmacol*. 2013;27(5):444-450.

27. Vande Voort JL, Morgan RJ, Kung S, et al. Continuation phase intravenous ketamine in adults with treatment-resistant depression. *J Affect Disord*. 2016;206:300-304.

28. Cusin C, Ionescu DF, Pavone KJ, et al. Ketamine augmentation for outpatients with treatment-resistant depression: preliminary evidence for two-step intravenous dose escalation. *Aust N Z J Psychiatry*. 2017;51(1):55-64.

29. Lenze EJ, Farber NB, Kharasch E, et al. Ninety-six hour ketamine infusion with co-administered clonidine for treatment-resistant depression: a pilot randomised controlled trial. *World J Biol Psychiatry*. 2016;17(3):230-238.

30. Drake LM, Chen SC, Rex DK. Efficacy of bispectral monitoring as an adjunct to nurse-administered propofol sedation for colonoscopy: a randomized controlled trial. *Am J Gastroenterol*. 2006;101(9):2003-2007.

31. Shiroma PR, Johns B, Kuskowski M, et al. Augmentation of response and remission to serial intravenous subanesthetic ketamine in treatment resistant depression. *J Affect Disord*. 2014;155:123-129.

32. Diamond PR, Farmery AD, Atkinson S, et al. Ketamine infusions for treatment resistant depression: a series of 28 patients treated weekly or twice weekly in an ECT clinic. *J Psychopharmacol*. 2014;28(6):536-544.

33. Ghasemi M, Kazemi MH, Yoosefi A, et al. Rapid antidepressant effects of repeated doses of ketamine compared with electroconvulsive therapy in hospitalized patients with major depressive disorder. *Psychiatry Res*. 2014;215(2):355-361.

34. Segmiller F, Rüther T, Linhardt A, et al. Repeated S-ketamine infusions in therapy resistant depression: a case series. *J Clin Pharmacol*. 2013;53(9):996-998.

35. Blier P, Zigman D, Blier J. On the safety and benefits of repeated intravenous injections of ketamine for depression. *Biol Psychiatry*. 2012;72(4):e11-e12.

36. Szymkowicz SM, Finnegan N, Dale RM. A 12-month naturalistic observation of three patients receiving repeat intravenous ketamine infusions for their treatment-resistant depression. *J Affect Disord*. 2013;147(1-3):416-420.

37. Morgan CJ, Riccelli M, Maitland CH, Curran HV. Long-term effects of ketamine: evidence for a persisting impairment of source memory in recreational users. *Drug Alcohol Depend*. 2004;75(3):301-308.

38. Wood D. Ketamine and damage to the urinary tract. *Addiction*. 2013;108(8):1515-1516.

39. Morgan CJ, Curran HV; Independent Scientific Committee on Drugs. Ketamine use: a review. *Addiction*. 2012;107(1):27-38.

40. Kalsi SS, Wood DM, Dargan PI. The epidemiology and patterns of acute and chronic toxicity associated with recreational ketamine use. *Emerg Health Threats J*. 2011;4:7107.

41. Schak KM, Vande Voort JL, Johnson EK, et al. Potential risks of poorly monitored ketamine use in depression treatment. *Am J Psychiatry*. 2016;173(3):215-218.

Invited Commentary

Use of Ketamine in Clinical Practice
A Time for Optimism and Caution

Charles F. Zorumski, MD; Charles R. Conway, MD

Increasing evidence, primarily from small studies, supports the idea that the dissociative anesthetic ketamine has rapid antidepressant effects in patients with treatment-refractory major depression.[1] The beneficial effects of ketamine are observed within hours of administration and can last approximately 1 week. Given that up to one-third of patients with major depression fail current treatments,[2] there is a clear need for novel and more effective treatments. Results to date have led to increasing off-label use of ketamine in clinical practices, with little guidance about clinical administration. In this issue of the *JAMA Psychiatry*, Sanacora and colleagues[3] provide a much-needed consensus statement to help guide clinical use of ketamine.

Related article page 399

Sanacora et al[3] provide a thoughtful overview of ketamine use, including commentary about patient selection, risks, clinician experience, treatment setting, drug administration, and follow-up. The authors acknowledge the major limitations in the available data: limitations that should give pause to clinicians considering the use of ketamine in their practices. Sanacora and colleagues[3] state that data on ketamine in psychiatric practice, especially longer-term use of ketamine, are limited or nonexistent. Thus, their recommendations are purposefully vague in places.

There is little doubt that ketamine is having a major effect on psychiatry. If clinical studies continue to support the antidepressant efficacy of ketamine, psychiatry could enter an era in which drug infusions and deliveries with more rapid responses become common. Basic science studies examining the mechanisms underlying ketamine are advancing rapidly, providing hope for even better treatments in the future.[4] Although ketamine is an uncompetitive antagonist of *N*-methyl-D-aspartate glutamate receptors (NMDARs), rodent studies indicate that ketamine produces its antidepressant-like effects by enhancing transmission mediated by the α-amino-3-hydroxy-5-methyl-4-isoxazolepropionic acid class of glutamate receptors through modulation of intracellular signaling.[4] Studies are under way to understand how ketamine alters human brain networks, as well as efforts to develop other NMDAR antagonists for use in psychiatry.[4] Recent data question whether ketamine itself, and NMDAR antagonism specifically, are key mediators of antidepressant actions.[5] Ketamine metabolites that are not active at NMDARs show antidepressant-like effects in rodents,[5] suggesting that alternative mechanisms could be important. Determining the role of NMDARs and alternative mechanisms could perhaps lead to antidepressants that are better tolerated by patients.

Despite great enthusiasm, the limitations highlighted by Sanacora et al[3] are noteworthy and should be emphasized. Because of limited data to guide clinical practice, these limitations extend to almost every recommendation in the consensus statement, including, perhaps most importantly, patient selection. The bulk of the literature describes the effects of ketamine in patients with treatment-refractory major depression. The definition of treatment-refractory major depression and where treatments such as ketamine fall in the algorithm for managing treatment-refractory major depression remain poorly understood.[2] Even within the literature on ketamine treatment, there is considerable variability in defining treatment-refractory major depression (some studies required only 1 antidepressant failure, and others studied patients who failed electroconvulsive therapy). It is unclear whether patients with depression that is not treatment-refractory or patients with other psychiatric illnesses are appropriate candidates for ketamine treatment, and extreme caution must be exercised in patients with psychotic or substance use disorders.

There are also major limitations in what is understood about the dose, duration of infusion, and route of administration for ketamine. Most studies examining ketamine for depression use intravenous infusions of 0.5 mg/kg for 40 minutes. This dosing derives directly from a study by Krystal and colleagues[6] in the early 1990s in which they used this same dosage to induce psychotic and cognitive symptoms in healthy adults. Fortunately, psychotic symptoms last only a few hours and have not been a major problem in studies of ketamine in depression. What is unknown is whether other ketamine dosing regimens would have more or fewer beneficial and adverse effects.

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An advisory opinion adopted by AZBN is an interpretation of what the law requires. While an advisory opinion is not law, it is more than a recommendation. In other words, an advisory opinion is an official opinion of AZBN regarding the practice of nursing as it relates to the functions of nursing. Facility policies may restrict practice further in their setting and/or require additional expectations related to competency, validation, training, and supervision to assure the safety of their patient population and or decrease risk.

OPINION: LOW-DOSE CONTINUOUS IV KETAMINE ADMINISTRATION FOR TREATMENT OF INTRACTABLE OR CHRONIC PAIN, OR DEPRESSION
APPROVED: 11/15
REVISED DATE:
ORIGINATING COMMITTEE:
SCOPE OF PRACTICE COMMITTEE

Within the Scope of Practice of __X__ RN ____ LPN

ADVISORY OPINION

LOW-DOSE CONTINUOUS IV KETAMINE ADMINISTRATION FOR TREATMENT OF INTRACTABLE OR CHRONIC PAIN, OR DEPRESSION

STATEMENT OF SCOPE

It is NOT within the Scope of Practice of a Registered Nurse (non-CRNA) to administer IV Ketamine for the purposes of anesthesia.

It is NOT within the Scope of Practice of a Registered Nurse (non-CRNA) to administer an IV Ketamine via bolus dose.

It is within the Scope of Practice of a Registered Nurse (RN) to administer low-dose (sub-anesthetic) continuous IV Ketamine for the purposes of pain control (analgesia) and antidepressive effects when the following requirements are met:

I. GENERAL REQUIREMENTS

a. The employer maintains a written policy and procedures
b. A Licensed Independent Practitioner (LIP)
    i. Evaluates the patient
    ii. Places an order for Low-dose IV Ketamine
    iii. Is readily available in facility from the time the medication is initiated until completion of the infusion
c. A validated sedation scale is used (e.g. Richmond Agitation Sedation Scale, Sedation Agitation Scale) to monitor level of sedation
d. Low dose IV Ketamine infusion is prepared by pharmacy.
e. Low-Dose IV ketamine is infused via an IV infusion pump preferably with smart pump technology
f. Ketamine is infused via a dedicated IV line
g. RNs may adjust the rate of infusion per a patient specific order.
    i. Standing orders or protocols are not used.
h. ACLS/PALS provide readily available in facility.

i. The dose ordered is within a sub-anesthetic dose range as defined by the organization's policy
j. RNs have the right and obligation to refuse to administer Ketamine in amounts that may induce moderate or deep sedation or anesthesia.
k. Patient monitoring includes electrocardiogram, oxygenation, blood pressure, respiratory rate, temperature (when appropriate) and level of sedation is maintained during and following the infusion.

II. COURSE OF INSTRUCTION

1. The RN administering low-dose continuous IV Ketamine for chronic pain or depression must complete an annual instructional program including supervised clinical practice. The instructional program includes but is not limited to:
    i. Anatomy and physiology, oxygen delivery, airway management and devices, frequency of vital sign, necessary emergency equipment
    ii. Use of specialized monitoring equipment, sedation scale, pain scale, and smart pump functionality
    iii. Ketamine
        - Drug classification (general anesthetic, controlled substance), preparation, onset, duration, desired effect, sub-anesthetic dose range, indications, contraindications, medication interactions, side effects, adverse reactions.
    iv. Recognition of potential clinical complications and appropriate nursing interventions
    v. Levels of sedation (minimal, moderate, deep, and anesthesia) with an emphasis on minimal sedation.
    vi. Nursing care responsibilities including but not limited to assessment, monitoring and documentation.
2. Completion of education and competency is available on file with the employer
3. Current certification in BLS is on file with the employer

III. RATIONALE

Clinical studies have shown that Low-dose continuous IV Ketamine may provide analgesia among opioid tolerant patients experiencing refractory post-operative pain, neuropathic pain, and chronic pain. In addition clinical evidence exist that administration of low-dose IV Ketamine have resulted in improvement in mood and suicidal thinking. A Registered Nurse may acquire the knowledge and skill required to safely administer Ketamine (an anesthetic agent) at sub-anesthetic doses.

This advisory opinion CANNOT be construed as approval for the RN to administer an anesthetic as described in A.R.S. § 32-1634.04.

IV. REFERENCES

Arizona State Board of Nursing Advisory Opinion
Palliative Sedation at End of Life
https://www.azbn.gov/Documents/advisory_opinion/AO%20PALLIATIVE%20SEDATION%20AT%20END%20OF%20LIFE.pdf

Caddy C., Giaroli G., White T. P., Shergill S. S., Tracy D. K., (2014) *Ketamine as the Prototype Glutamatergic Antidepressant: Pharmacodynamic Actions, and Systematic Review and Meta-analysis of Efficacy.* Therapeutic Advances in Psychopharmacology. 4(2) 75-99 DOI: 10.1177/2045125313507739

Campbell-Fleming, J. M., Williams A., (2008) *The Use of ketamine as Adjuvant Therapy to Control Severe Pain.* Clinical Journal of Oncology Nursing. 12(1) 102-107. http://www.ncbi.nlm.nih.gov/pubmed/18258579

Correll, G. E., Maleki J., Gracely, E. J., Muir, J. J., Harbut, R. E., (2004) *Subanesthetic ketamine Infusion Therapy: A Retrospective Analysis of a Novel Therapeutic Approach to Complex Regional Pain Syndrome.* Pain Medicine. 5(3) 263-275. http://www.ncbi.nlm.nih.gov/pubmed/15367304

Finkel, J., Pestieau, S., & Quezado, ZNM. (2007) Ketamine as an adjuvant for treatment of cancer pain in children and adolescents. *Journal of Pain,* 8(6), 515-421

Himmelseher, S., Durieux, M. E., (2005) *Ketamine for perioperative Pain management.* Anesthesiology 102(1). http://www.rsds.org/pdfsall/ketaminefor-perioperative-pain-mgt.pdf

Hocking, G., Cousins, M. J., (2003) *Ketamine in Chronic Pain Management: An Evidence Based Review*. Anesthesia & Analgesia 97; 1730-9. http://journals.lww.com/anesthesia-analgesia/Fulltext/2003/12000/Ketamine_in_Chronic_Pain_Management__An.37.aspx

Minnesota Board of Nursing. Statement of Accountability for Administration of Medications Classified as Anesthetics by the Registered Nurse. December 2009. http://mn.gov/health-licensing-boards/nursing/practice/topics/rn-admin-anesthetics.jsp

Nebraska Board of Nursing. Low-Dose Ketamine. June 2014. http://dhhs.ne.gov/publichealth/Licensure/Documents/LowDoseKetamine.pdf

New York State Office of the Professions-Nursing. IV Drug Administration of ketamine for the Treatment of Intractable Pain. June 2011 http://www.op.nysed.gov/prof/nurse/nurse-iv-ketamine.htm

O'Connell, N. E., Wand, B. M., McAuley J., Marston L., Moseley G. L., (2013) *Interventions for Treating Pain and Disability in Adults with Complex Regional pain Syndrome- An Overview of Systematic Reviews* (Review) The Cochrane Library 2013 Issue 4. http://www.ncbi.nlm.nih.gov/pubmed/23633371

Pasero, C., McCaffery, M., (2005) *Ketamine low doses may provide relief for some painful conditions.* America Journal of Nursing. 105(4), 60-64. http://www.jstor.org/stable/29745702

Subramaniam, K., Subramaniam, B., Steinbrook, R. A. (2004) *Ketamine as Adjuvant Analgesic to opioids: A Quantitative and Qualitative Systematic Review.* Anesthesia and Analgesia 99: 482-95. http://www.ncbi.nlm.nih.gov/pubmed/15271729

Texas Board of Nursing Off-Label Administration of Ketamine for Pain Management by a Nurse. October 2012. https://www.bon.texas.gov/faq_nursing_practice.asp#t21

Wyoming State Board of Nursing. IV Administration of ketamine for Intractable Pain for Adults. October 2013. https://nursing-online.state.wy.us/Resources/ketamine%20advisory%20opinion.pdf

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SUMMARY REPORT OF KENTUCKY BOARD OF NURSING ADVISORY OPINIONS ON NURSING PRACTICE ISSUES

July 1, 2017 – June 30, 2018

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- AOS #36 Resuscitation Orders, Pronouncement of Death and Death Certificate – 10/2017

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Advisory Opinion Statements – Withdrawn

- AOS #05 The Performance of Advanced Life Support Procedures by Nurses – 04/2018

Task Forces/Work Groups Established

None

Task Forces/Work Groups

LPN IV Therapy Workgroup

Statutes/Regulations – Revised

- 201 KAR 20:057 Scope and Standards of Practice of Advanced Practice Registered Nurses – Effective 11/2017 and Approved Additional Revision 06/2018
- 201 KAR 20:400 Delegation of Nursing Tasks – Effective 02/2018
- 201 KAR 20:490 Licensed Practical Nurse Infusion Therapy Scope of Practice – Approved Revision 6/2018

Statutes/Regulations – New

- 201 KAR 20:065 Professional Standards for Prescribing Buprenorphine-Mono-Product or Buprenorphine-Combined-with-Naloxone by APRNs for Medication Assisted Treatment for Opioid Use Disorder – Effective 01/2018

The Kentucky Board of Nursing is authorized by Kentucky Revised Statutes (KRS) Chapter 314 to regulate nurses, nursing education and practice, promulgate regulations and to issue advisory opinions on nursing practice, in order to assure that safe and effective nursing care is provided by nurses to the citizens of the Commonwealth.

The Kentucky Board of Nursing issues advisory opinions as to what constitutes safe nursing practice. As such, an opinion is not a regulation of the Board and does not have the force and effect of law. It is issued as a guideline to licensees who wish to engage in safe nursing practice, and to facilitate the delivery of safe, effective nursing care to the public.

Mission of the Kentucky Board of Nursing

The primary mission and purpose of the Board is to enforce public policy related to the safe and effective practice of nursing in the interest of public welfare. As a regulatory agency of state government, the Board of Nursing accomplishes this mission as authorized by Kentucky Revised Statutes (KRS) Chapter 314—The *KENTUCKY NURSING LAWS* and attendant administrative regulations. In accomplishing one aspect of the mission, the Board of Nursing issues advisory opinions on what constitutes the legal scope of nursing practice.

An opinion is not a regulation of the Board; it does not have the force and effect of law. Rather, an opinion is issued as a guidepost to licensees who wish to engage in safe nursing

practice.

To date, the Board has published forty (41) (38 are currently active) advisory opinion statements, as listed on the "Kentucky Board of Nursing Publications" form and on the Board's website at http://kbn.ky.gov.

Advisory opinion statements are developed and published when:

1. Multiple inquiries are received regarding a specific nursing procedure or act;
2. The Practice Committee or APRN Council determines that a specific nursing procedure or act has general applicability to nursing practice and warrants the development of an opinion statement; or
3. The Board directs that an opinion statement be developed.

When studying issues, the Board reviews and considers applicable standards of practice statements published by professional nursing organizations; the educational preparation of both registered and licensed practical nurses as provided in the prelicensure nursing education programs in the Commonwealth; and, when applicable, the organized post-basic educational programs for advanced registered nurse practitioners. The Board also gathers information regarding practice issues from nurses in relevant practice settings (including staff nurses, supervisors, nurse faculty members, etc.) and/or representatives from state nursing associations in the Commonwealth, among others. Further, the Board reviews applicable opinions issued by the Office of the Attorney General.

Accountability and Responsibility of Nurses

In accordance with KRS 314.021(2), nurses are responsible and accountable for making decisions that are based upon the individuals' educational preparation and current clinical competence in nursing, and requires licensees to practice nursing with reasonable skill and safety.

Acts that are within the permissible scope of practice for a given licensure level may be performed only by those licensees who personally possess the education and experience to perform those acts safely and competently. A nurse/licensee who doubts his/her personal competency to perform a requested act has an affirmative obligation to refuse to perform the act, and to inform his/her supervisor and the physician prescribing the act, if applicable, of his/her decision not to perform the act.

If a licensee accepts an assignment that the licensee believes is unsafe or for which the licensee is not educationally prepared, then the licensee also assumes the potential liability, which may occur as a result of the assignment. Others may equally or concurrently be responsible, accountable, and liable for a licensee's actions.

Practice should be consistent with the *Kentucky Nursing Laws*, established standards of practice, and be evidenced based.

Practice Opinions

In addition to the 38 active advisory opinions published as of June 30, 2018, the Board has issued from July 1, 2017 to June 30, 2018, individual practice opinions in response to inquiries on specific nursing practice situations, summarized as follows:

1. **Scope of Practice for Registered Nurses in the Delegation of Medication Administration of Klonopin® (Clonazepam) Wafers for Seizure Management to Unlicensed Assistive Personnel**

   December 2017 – it was the advisory opinion of the Board that:

   The delegation of the medication administration of Klonopin® (Clonazepam) wafers for seizure management to unlicensed assistive personnel is within the scope of practice for a Registered Nurse.

2. **APRNs (CRNAs & CNMs) Role Designation/Population Focus Performing Sports Physicals**

   April 2018 – it was the advisory opinion of the Board that:

   The performance of a sports physical is within the scope of practice for the APRN who within the APRN role designation and population focus, is currently educationally prepared and clinically competent in the performance of sports physicals.

   APRNs should utilize the KBN Guidelines for Determination of APRN Scope of Practice and KBN Scope of Practice Decision-Making Model for APRNs, to determine if the performance of a task or procedure is within their individual scope of practice.

3. **Scope of Practice of the APRN CRNA in the Independent Practice of Cosmetic and Dermatologic Procedures**

   April 2018 – it was the advisory opinion of the Board that:

   The independent practice of ordering medications and performing cosmetic and dermatologic procedures is not within the scope of practice of an APRN CRNA. The performance of cosmetic and dermatologic procedures may be within the scope of practice of the APRN who utilizes the registered nurse license and is educationally prepared and clinically competent to perform cosmetic and dermatologic procedures under the orders of an authorized prescriber.

   APRNs should utilize the KBN Guidelines for Determination of APRN Scope of Practice and KBN Scope of Practice Decision-Making Model for APRNs, when determining if a particular procedure is within the APRN's individual scope of practice.

4. **Scope of Practice of the Ketamine Clinics for Chronic Pain/PTSD**

   April 2018 – it was the advisory opinion of the Board that:

   It is within the scope of practice for a CRNA to prescribe Ketamine for chronic pain. The CRNA should be educationally prepared and clinically competent and hold the necessary collaborative agreements for prescriptive authority (CAPA-NS and CAPA-CS). It is not within the scope of practice for a CRNA to diagnose or prescribe Ketamine for mental health conditions. However, a CRNA may administer Ketamine for mental health conditions on the prescription of an appropriate provider.

   APRNs should utilize the KBN Guidelines for Determination of APRN Scope of Practice and KBN Scope of Practice Decision-Making Model for APRNs, when determining if a particular procedure is within the APRN's individual scope of practice.

All advisory opinion statements may be downloaded from the KBN website http://kbn.ky.gov.

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Determining Scope of Practice

KRS 314.021(2) holds all nurses individually responsible and accountable for the individual's acts based upon the nurse's education and experience. Each nurse must exercise professional and prudent judgment in determining whether the performance of a given act is within the scope of practice for which the nurse is both licensed and clinically competent to perform. In addition to this advisory opinion statement, the Kentucky Board of Nursing has issued Advisory Opinion Statement #41 RN/LPN Scope of Practice Determination Guidelines which contains the KBN Decision-Making Model for Determining Scope of Practice for RNs/LPNs and published the APRN Scope of Practice Decision Making Model providing guidance to nurses in determining whether a selected act is within an individual nurse's scope of practice now or in the future. Copies of Advisory Opinion Statement #41 RN/LPN Scope of Practice Determination Guidelines and the APRN Scope of Practice Decision Making Model may be downloaded from the Board's website http://kbn.ky.gov.

KRS 314.011(6) defines "registered nursing practice" as:

…The performance of acts requiring substantial specialized knowledge, judgment, and nursing skill based upon the principles of psychological, biological, physical, and social sciences in the application of the nursing process in:

a) The care, counsel, and health teaching of the ill, injured or infirm;
b) The maintenance of health or prevention of illness of others;
c) The administration of medication and treatment as prescribed by a physician, physician assistant, dentist, or advanced practice registered nurse and as further authorized or limited by the board, and which are consistent either with American Nurses' Association Scope and Standards of Practice or with standards of practice established by nationally accepted organizations of registered nurses. Components of medication administration include, but are not limited to:
    1. Preparing and giving medication in the prescribed dosage, route, and frequency, including dispensing medications only as defined in subsection (17)(b) of this section;
    2. Observing, recording, and reporting desired effects, untoward reactions, and side effects of drug therapy;
    3. Intervening when emergency care is required as a result of drug therapy;
    4. Recognizing accepted prescribing limits and reporting deviations to the prescribing individual;
    5. Recognizing drug incompatibilities and reporting interactions or potential interactions to the prescribing individual; and
    6. Instructing an individual regarding medications;
d) The supervision, teaching of, and delegation to other personnel in the performance of activities relating to nursing care; and
e) The performance of other nursing acts which are authorized or limited by the board, and which are consistent either with American Nurses' Association Standards of

Practice or with Standards of Practice established by nationally accepted organizations of registered nurses.

KRS 314.011(10) defines "licensed practical nursing practice" as:

> …The performance of acts requiring knowledge and skill such as are taught or acquired in approved schools for practical nursing in:
> a) The observing and caring for the ill, injured, or infirm under the direction of a registered nurse, advanced practice registered nurse, physician assistant, licensed physician, or dentist;
> b) The giving of counsel and applying procedures to safeguard life and health, as defined and authorized by the board;
> c) The administration of medication or treatment as authorized by a physician, physician assistant, dentist, or advanced practice registered nurse and as further authorized or limited by the board which is consistent with the National Federation of Licensed Practical Nurses or with Standards of Practice established by nationally accepted organizations of licensed practical nurses;
> d) Teaching, supervising, and delegating except as limited by the board; and
> e) The performance of other nursing acts which are authorized or limited by the board and which are consistent with the National Federation of Licensed Practical Nurses' Standards of Practice or with Standards of Practice established by nationally accepted organizations of licensed practical nurses.

KRS 314.011(8) defines "advanced practice registered nursing practice" as:

> "Advanced practice registered nursing" means the performance of additional acts by registered nurses who have gained advanced clinical knowledge and skills through an accredited education program that prepares the registered nurse for one (1) of the four (4) APRN roles; who are certified by the American Nurses' Association or other nationally established organizations or agencies recognized by the board to certify registered nurses for advanced practice registered nursing as a certified nurse practitioner, certified registered nurse anesthetist, certified nurse midwife, or clinical nurse specialist; and who certified in at least one (1) population focus. The additional acts shall, subject to approval of the board, include but not be limited to prescribing treatment, drugs, devices, and ordering diagnostic tests. Advanced practice registered nurses who engage in these additional acts shall be authorized to issue prescriptions for and dispense nonscheduled legend drugs as defined in KRS 217.905 and to issue prescriptions for but not to dispense Schedules II through V controlled substances as classified in KRS 218A.020, 218A.060, 218A.080, 218A.100, and 218A.120, and under the conditions set forth in KRS 314.042 and regulations promulgated by the Kentucky Board of Nursing on or before August 15, 2006. …The performance of these additional acts shall be consistent with the certifying organization or agencies' scopes and standards of practice recognized by the board by administrative regulation.

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OPINION: IV ADMINISTRATION OF KETAMINE FOR INTRACTABLE PAIN
APPROVED DATE: October 10, 2013
REVIEWED DATE:
REVISED DATE:
ORIGINATING COMMITTEE:
Practice & Education Committee

An advisory opinion adopted by WSBN is an interpretation of what the law requires. While an advisory opinion is not law, it is more than a recommendation. In other words, an advisory opinion is an official opinion of WSBN regarding the practice of nursing as it relates to the functions of nursing. Facility policies may restrict practice further in their setting and/or require additional expectations related to competency, validation, training and supervision to assure the safety of their patient population and/or decrease risk.

Within the Scope of Practice/Role of ____APRN __X__RN ____LPN ____CNA

ADVISORY OPINION
IV ADMINISTRATION OF KETAMINE FOR INTRACTABLE PAIN FOR ADULTS

A number of inquiries have recently been received by the Board for Nursing questioning the intravenous administration, by Registered Professional Nurses (RNs), of drugs classified as anesthetic agents (most specifically ketamine), to patients experiencing pain. The Board's advisory opinions indicated that it is not within the scope of practice for RNs to use these medications for conscious sedation. However, meeting certain conditions, an RN could administer such drugs to patients in an intensive care unit or emergency room department. Recent inquiries have requested that a re-examination of this position consider the use of low-dose ketamine infusion for pain control.

As background information, ketamine is identified by the Federal Drug Administration as an intravenous anesthetic agent. It has been used for this purpose since the 1960s. However, because of its psychomimetic reactions which include: feeling light-headed, floating, having "out of body" experiences, visual hallucinations, "tripping", delusions, and delirium, ketamine's use as an anesthetic agent has had limitations.[3,8,9] In contrast, these central nervous effects have made ketamine attractive as a drug of abuse.[2,8]

Within the last ten years, although not licensed for this purpose, low-dose ketamine has found utility as an aid in providing analgesia for the treatment of post-operative pain, neuropathic pain, and chronic pain especially related to patients with opioid tolerance. Clinical studies suggest that in the majority of patients, the use of low-dose ketamine is a useful adjunct to standard practice opioid analgesia resulting in: a decrease in opioid requirements in both surgical and non-surgical patients,[1,3,4,6,7,10,12,13] fewer physician interventions to manage severe pain[12], a positive impact on knee mobilization after total knee arthroplasty[1], a decrease in post-operative nausea and vomiting[3], and reduced pain scores for as long as one-year after surgery. The literature also cautions that prescribers must be vigilant, and that further study is warranted to determine optimal dosages of low-dose ketamine administration[2,3,11].

Because ketamine is licensed as an anesthetic agent that must be administered by anesthesia providers, because of the "complexity of patient assessment, treatment decision-making and initial monitoring,[2]" because of a legitimate concern for the potential for abuse, and because of the possibility of distressing side effects, the Board is cautious in considering the administration of low-dose ketamine infusion by RNs in general patient care areas. Thus, the Board continues to affirm its position but, based on current research evidence, adds the following modification:

Within the first twenty-four (24) hours of initiation of low-dose ketamine administration, RNs, with demonstrated competence, can administer and monitor patients on this regimen only to patients in recovery rooms, critical care, hospice, step-down or palliative care areas, that is, in patient care units with low patient to nurse

ratios. **Following this time period, and with no evidence of untoward side effects, such patients can be cared for by RNs, with demonstrated competence, on general patient units.**

I. RATIONALE

The intent of administering low-dose ketamine is to provide analgesia for the treatment of pain. This procedure is performed by RNs with additional education, skills, and demonstrated competency. **This advisory opinion CAN NOT be construed as approval for the RN (non-CRNA) to administer an anesthetic agent for the purposes of anesthesia**.

II. GENERAL REQUIREMENTS

A. Candidates for low-dose ketamine administration must be 18 years of age or older.
B. Candidates for low-dose ketamine administration must be evaluated by Anesthesiology or Licensed Independent Provider and assessed for appropriateness before initiation of therapy.
C. A patient-specific order for a low-dose ketamine infusion must be provided by and is *restricted* to Anesthesiology or a Licensed Independent Provider.
D. Low-dose ketamine infusions must be prepared ***only*** by the pharmacy.
E. Low-dose ketamine should be infused through its own dedicated IV line (when possible) or via the most proximal port of a carrier solution.
F. Low-dose ketamine should be infused through portless IV tubing to avoid inadvertent bolusing.
G. Low-dose ketamine should NOT be bolused as a treatment for pain except by an anesthesia provider.
H. Low-dose ketamine should be infused using an IV infusion control device with a locked control panel.
I. Vital signs should be monitored as well as alertness, orientation, evidence of nystagmus, bad dreams and unpleasant hallucinations.
J. The prescriber should be notified of a heart rate greater than 100 beats per minute, a systolic B/P less that 90 mmHg, a respiratory rate less than 10 breaths per minute, oxygen saturation of less than 93% and symptoms of emergence reactions such as bad dreams, hallucinations and nystagmus.
K. The facility must provide a written policy and procedure that documents the role of the RN in the administration of low-dose ketamine, frequency of assessment and availability of qualified prescriber.
L. Policies, procedures, and protocols (order sets) have been approved by the facility prior to implementation.
M. Policy and procedure will specify the required emergency equipment and medications which must be immediately available to the patient receiving low-dose ketamine. This includes all emergency equipment and medication required to regain and/or maintain the patient's cardiac and respiratory state.
N. Only RNs who have documented initial and ongoing clinical competency on file with the employer may administer low-dose ketamine.
O. Current certification in Advanced Cardiac Life Support (ACLS) on file with the employer.
P. Continuous pulse oximetry will be monitored on all patients during low-dose ketamine administration.
Q. The RN responsible for administering low-dose ketamine may not leave the patient unattended or engage in other tasks that could compromise continuous monitoring of patient, airway and/or level of consciousness.
R. The RN has the right and responsibility to refuse to administer any medication that may induce procedural sedation when in the professional judgment of the RN, the medication or combination of medications, the dosages prescribed, or frequency of administration may produce a state of moderate or deep sedation or place the patient at risk for complications.

III. REFERENCES

1. Adam F, et al. [2005] Small-Dose Ketamine Infusion Improves Postoperative Analgesia and Rehabilitation After Total Knee Arthroplasty. Anesth Analg: 100:475–80.
2. Akporehwe, N. A, et al.[2006] Ketamine: a misunderstood analgesic? BMJ: 332:1466.

3. Bell RF, Dahl JB, Moore RA, Kalso E. [2005] Peri-operative ketamine for acute post-operative pain: a quantitative and qualitative systematic review (Cochrane review). Acta Anaesthesiol Scand: 49:1405—1428.
4. Elia N, & Tramer MR. [2005] Ketamine and postoperative pain – a quantitative systematic review of randomised trials. Pain: 113: 61–70.
5. Grande LA, et al. [2008] Ultra-Low Dose Ketamine and Memantine Treatment for Pain in an Opioid-Tolerant Oncology Patient. Anesth Analg: 107:1380 –3.
6. Guillou N, et al. [2003] The Effects of Small-Dose Ketamine on Morphine Consumption in Surgical Intensive Care Unit Patients After Major Abdominal Surgery. Anesth Analg: 97:843–7.
7. Lahtinen, P, et al. [2004] S(+) Ketamine as an Analgesic Adjunct Reduces Opioid Consumtpion After Cardiac Surgery. Anesth Analg: 99:1295-1301.
8. Rakie, A. & Golumbiewski, J. [2009] Low-Dose Ketamine Infusion for Postoperatice Pain Management. J. of PeriAnesthesia Nursing: 24, 4:254-257.
9. Slatkin, N & Rhiner, M. [2003] Ketamine in the Treatment of Refractory Caner Pain: Case Report, Rationale , and Methodology. Journal of Supportive Oncology: 1.4:287-293.
10. Subramaniam K, Subramaniam B, Steinbrook RA. [2004] Ketamine as Adjuvant Analgesic to Opioids: A Quantitative and Qualitative Systematic Review. Anesth Analg: 99:482–95.
11. Suzuki M, et al. [2006] Low-dose Intravenous Ketamine Potentiates Epidural Analgesia after Thoracotomy.Anesthesiology: 105:111–9.
12. Webb AR, et al. [2007] The Addition of a Small-Dose Ketamine Infusion to Tramadol for Postoperative Analgesia: A Double-Blinded, Placebo-Controlled, Randomized Trial After Abdominal Surgery. Anesth Analg: 104:912–7.
13. Yamauchi M, et al. [2008] Continuous Low-Dose Ketamine Improves the Analgesic Effects of Fentanyl Patient-Controlled Analgesia After Cervical Spine Surgery. Anesth Analg: 107:1041–4.
14. New York State Board of Nursing. Advisory Opinion: IV Administration of Ketamine for Intractable Pain in Adults.

Pain Medicine

Pain Medicine 2012; 13: 263–269
Wiley Periodicals, Inc.

Efficacy of Outpatient Ketamine Infusions in Refractory Chronic Pain Syndromes: A 5-Year Retrospective Analysis

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Disclosure: This research was not funded by external research grants.

Abstract

Objective. We evaluated whether outpatient intravenous ketamine infusions were satisfactory for pain relief in patients suffering from various chronic intractable pain syndromes.

Design. Retrospective chart review.

Setting and Patients. Following Institutional Review Board approval, we retrospectively analyzed our database for all ketamine infusions administered over 5 years from 2004 to 2009.

Outcome Measures. Data reviewed included doses of intravenous ketamine, infusion duration, pain scores on visual analog scale (VAS) pre- and post-procedure, long-term pain relief, previous interventions, and side effects. All patients were pretreated with midazolam and ondansetron.

Results. We identified 49 patients undergoing 369 outpatient ketamine infusions through retrospective analysis. We excluded 36 infusions because of missing data. Among our patients, 18 (37%) had a diagnosis of complex regional pain syndrome (CRPS). Of the remaining 31 (63%) patients, eight had refractory headaches and seven had severe back pain. All patients reported significant reduction in VAS score of 5.9 (standard error [SE] 0.35). For patients with CRPS, reduction in VAS score was 7.2 (SE 0.51, $P < 0.001$); for the others, the reduction was 5.1 (SE 0.40, $P < 0.001$). The difference of 2.1 between groups was statistically significant (SE 0.64, $P = 0.002$). In 29 patients, we recorded the duration of pain relief. Using the Bernoulli model, we found (90% confidence interval) that the probability of lasting pain relief in patients with refractory pain states was 59–85% (23–51% relief over 3 weeks).

Conclusions. We conclude that in patients with severe refractory pain of multiple etiologies, subanesthetic ketamine infusions may improve VAS scores. In half of our patients, relief lasted for up to 3 weeks with minimal side effects.

Key Words. Ketamine; CRPS; Chronic Pain; Pain Management

Introduction

Chronic pain affects over 76 million people in the United States. Long-standing intractable pain can be particularly challenging to treat and resistant to multiple treatment modalities. Ketamine, an *N*-methyl-D-aspartate (NMDA) receptor antagonist, has been shown to be effective in patients with complex regional pain syndrome (CRPS) and has also been studied for its effectiveness with pain syndromes in an intraoperative setting [1,2]. There is still some reluctance, however, to use ketamine in the management of chronic pain. As an anesthetic, ketamine has been associated with drowsiness, dizziness, disorientation, and hallucinations. These psychotomimetic side effects have likely limited the use of ketamine for management of pain in outpatients.

NMDA receptors are activated by the excitatory neurotransmitter glutamate and have a known involvement in various forms of neural plasticity, both short and long term. By this mechanism, the NMDA receptors and their antagonist, ketamine, may be crucially involved in chronic pain pathways.

The first evidence of clinical relief of neuropathic pain by ketamine was found in clinical case reports from patients with cancer pain from nerve injury [3]. Since then, several controlled studies have been performed with intravenous ketamine for post-herpetic neuralgia, diabetic neuropathy, and CRPS [1,4,5]. Ketamine has also been used in low doses to relieve fibromyalgia-related pain symptoms [6,7].

Because of the analgesic efficacy of intravenous subanesthetic doses of ketamine, we routinely administer it to outpatients with severe intractable pain syndromes, for whom conventional treatments are unsuccessful. We hypothesized that intravenous infusions of ketamine in outpatients would offer satisfactory pain relief from chronic intractable pain syndromes of many etiologies.

Materials and Methods

Following IRB approval, a database from a university pain clinic was retrospectively analyzed for the period from 2004 to 2009. All patients had refractory pain for at least 6 months and received low-dose outpatient ketamine infusion treatments after being informed of its risks and giving consent. Patient records were reviewed for demographics, doses of intravenous ketamine, infusion duration, pain scores on a visual analog scale (VAS) pre- and post-treatment, previous pain clinic interventions, and side effects. Infusions were administered by a physician. Standard monitors were applied throughout treatment, including electrocardiography, pulse oximetry, blood pressure every 5 minutes, and oxygen therapy as needed. Patients were monitored for 30–60 minutes after infusions and before discharge home. No changes were made in their medications on the day of infusion, and no changes had been made to their medications in the previous month.

All patients were pretreated with midazolam and ondansetron. The initial dose of ketamine was 0.5 mg/kg given over 30–45 minutes. If this dose was effective, it was continued in subsequent infusions. If tolerated, the dose was increased at subsequent infusion to the highest tolerated dose producing analgesia without unacceptable side effects. Ketamine infusions were discontinued when pain relief was not adequate.

The efficacy of the treatment was measured with pain scores recorded pre- and post-infusion on a VAS of 0–10. A score of 0 indicated no pain, and 10 corresponded to the worst pain imaginable. The reduction in pain score was tabulated, and adverse effects were recorded at each infusion.

The change in VAS (data given as mean with standard deviation [SD] or median with ranges) was computed using a mixed effects model with autoregressive (AR) correlation for the repeated measures. Incidence was defined as the number of events and the number of patients experiencing at least one treatment-related adverse event during the treatment period. Data on safety were tabulated separately for the patients with and without CRPS. All of the analyses were conducted using Statistical Productive analytic software (PASW Statistics 18.0, Chicago, IL, USA). The level of significance was set at $P < 0.05$.

The ketamine infusions were scheduled routinely every 3–4 weeks per pain clinic protocol. For evaluating the long-term pain relief with the intravenous ketamine infusion, we contacted the patients on the roster and asked directly about the duration of pain relief following treatment. We asked the patients about their pain score at the conclusion of the ketamine infusion. We then asked how long this score was maintained. A few patients responding to the infusions were also prescribed memantine. They were followed up for the efficacy of the treatment.

Results

We identified 49 patients who had a total number of 369 outpatient ketamine infusions. Three infusions were excluded from analysis because of missing data. Based on our review of patient's charts, outpatient ketamine infusion was considered as a potential, last-line adjuvant therapy in cases with refractory pain, only partially responsive to conventional treatments. As a consequence, only approximately 10 patients per year were offered and underwent outpatient ketamine infusions. Demographics and patient characteristics are described in Table 1. Overall, the median patient age was 45 (range, 18–68 years). The majority (63.3%) of the patients were female. The average weight was 83.8 kg (±23.9 kg). The median number of infusions per patient was 4 (range 1–36).

Figure 1 shows that CRPS was diagnosed in 18 patients (37%). Of the remaining 31 patients (63%) with intractable pain syndromes, eight had refractory headaches and seven had severe back pain. Figure 1 illustrates the distribution of diagnoses. All patients had chronic unrelenting pain for at least 6 months, with a mean duration of pain symptoms of 5.62 years. They underwent extensive diagnostic and treatment modalities including, but not limited to, somatic (neuraxial or peripheral) and/or sympathetic

Table 1 Demographics and patient characteristics

	Patient Subgroup		
	CRPS (N = 18)	Non-CRPS (N = 31)	Total (N = 49)
Age (years)			
Median	46	42	45
Range	21–55	18–68	18–68
Gender, n (%)			
Female	11 (61.1)	20 (64.5)	31 (63.3)
Male	7 (38.9)	11 (35.5)	18 (36.7)
Weight (kg)			
Mean	79.9	86.1	83.8
SD	21.3	25.3	23.9
Number of infusions			
Median	5.5	3	4
Range	1–36	1–34	1–36
Total	153	210	363
VAS at baseline			
Mean (SD)	8.2 (1.7)	6.7 (1.9)	7.2 (2.0)
95% CI	7.4, 9.1	6.0, 7.4	6.7, 7.8

CRPS = complex regional pain syndrome; VAS = visual analog scale; SD = standard deviation; CI = confidence interval.

Diagnosis	Number of patients
CRPS	18
Intractable headache	8
Chronic back pain	7
Somatic pain	5
Fibromyalgia/myalgias	4
Central neuropathic pain	4
Postherpetic neuralgia	2
Cervical radiculopathy	1

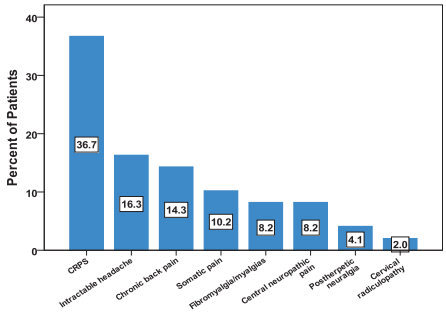


Figure 1 Patient subgroups by diagnosis. CRPS = complex regional pain syndrome.

nerve blocks, spinal cord or peripheral nerve stimulation, various surgical decompressions or interventions, various injections (trigger points, scar infiltrations, field blocks, joint injections) physical therapy, psychotherapy, and medical management. Upon offering the outpatient ketamine infusion as a treatment option, all the treatments mentioned above failed to provide satisfactory pain relief. In addition, all patients exhibited signs of central sensitization as evidenced by presence of an increased area of perceived pain in the absence of a specific, identifiable nociceptor as well as worsening pain with minimal stimuli.

The infusion data are described in Table 2. Ketamine infusions were administered for a median of 38.3 minutes (range, 30 minutes to 8 hours). Mean (SD) total ketamine dose per infusion was 0.9 (±0.4) mg/kg. Median duration between infusions was 233.7 days (range 12–680 days). Before infusion, mean VAS was 7.6 (±1.9) for all patients. For patients with CRPS, mean score was 8.5 (±1.1), and for the others it was 7.0 (±2.0). After infusion, the median VAS overall was reduced to 0.9. The change in VAS was computed using a mixed effects model that took into account the repeated measures per patient. All patients reported a significant reduction in VAS score of 5.9 (standard error [SE] 0.35) or 77% pain relief. For patients with CRPS, reduction in VAS score was 7.2 (SE 0.51, $P < 0.001$); for the others, the reduction was 5.1 (SE 0.40, $P < 0.001$). The difference of 2.1 between the two groups was statistically significant (SE 0.64, $P = 0.002$).

A total of 35 nonserious adverse events were reported by 23 (46.9%) patients (Table 3), 9 (50.0%) patients with CRPS, and 14 (45.2%) others. Hypertension and sedation were among the most common adverse events in both groups. Comparatively, there was a higher incidence of hallucination and confusion in patients without CRPS. In all cases, the side effects were minimal.

Unfortunately, we did not have data for long-term relief for all the patients. However, we attempted telephone interviews for all the patients on the roster. We were able to contact only the patients for whom current contact information was available. We identified 29 (59%) patients from our 49 patients included in the study. When contacted, the patients were asked about pre- and post-infusion pain scores as well as how long the post-infusion scores were maintained. Duration of pain relief after ketamine infusions was defined as time period until the low pain score

Table 2 Infusion data by patient subgroup

	Patient Subgroup		
	CRPS (N = 18)	Non-CRPS (N = 31)	Total (N = 49)
Infusion dose (mg/kg)			
Mean	1.0	0.9	0.9
SD	0.5	0.4	0.4
Infusion duration (minute)			
Median	43.8	34.7	38.3
Range	30–60	30–165	30–165
Days between infusion			
Median	30.8	34	33.7
Range	18–680	12–95	12–680
VAS before infusion			
Mean	8.5	7.0	7.6
SD	1.1	2.0	1.9
VAS after infusion			
Median	0.8	1.0	0.9
Range	0–6	0–9	0–9

CRPS = complex regional pain syndrome; SD = standard deviation; VAS = visual analog scale.

Table 3 Adverse events

	Patient Group: N (%) of Patients		
	CRPS (N = 18)	Non-CRPS (N = 31)	Total (N = 49)
Any event	9 (50.0%)	14 (45.2%)	23 (46.9)
Agitation	1 (5.7%)	1 (3.2%)	2 (4.1%)
Confused state	1 (5.7%)	2 (6.5%)	3 (6.1%)
Disorientation	0 (0.0%)	1 (3.2%)	1 (2.0%)
Dissociation	0 (0.0%)	1 (3.2%)	1 (2.0%)
Feeling cold	0 (0.0%)	1 (3.2%)	1 (2.0%)
Hallucination	1 (5.7%)	4 (13.2%)	5 (10.2%)
Hypertension	4 (22.2%)	2 (6.5%)	6 (12.2%)
Nausea	1 (5.7%)	1 (3.2%)	2 (4.1%)
Nystagmus	0 (0.0%)	1 (3.2%)	1 (2.0%)
Paresthesia	0 (0.0%)	1 (3.2%)	1 (2.0%)
Pharyngolaryngeal pain	0 (0.0%)	1 (3.2%)	1 (2.0%)
Restlessness	1 (5.7%)	0 (0.0%)	1 (2.0%)
Sedation	2 (11.1%)	2 (6.5%)	4 (8.0%)
Somnolence	0 (0.0%)	1 (3.2%)	1 (2.0%)
Tachycardia	1 (5.7%)	0 (0.0%)	1 (2.0%)
Vertigo	0 (0.0%)	1 (3.2%)	1 (2.0%)
Vomiting	2 (11.1)%	1 (3.2%)	3 (6.1%)

CRPS = complex regional pain syndrome.
One patient may have experienced more than one adverse event.

obtained at the conclusion of their treatment started to increase. In all the cases, the analgesic regimen was not altered. When asked about functional status, patients reported subjective improvements in quality of life after ketamine infusion such as improved exercise tolerance and increased energy.

Eight (27%) of the 29 patients contacted reported pain relief lasting several hours after the ketamine infusion. Twenty-one patients (73%), considered responders to the treatment, reported pain relief for more than 1–2 days; for 11 (38%) of them, relief lasted more than 3 weeks.

Using a Bernoulli statistical model, we stated the hypothesis that ketamine infusion is effective in intractable pain states and calculated the probability that a random patient suffering from severe chronic pain would respond to this treatment. This probability is the p parameter of the Bernoulli trial. To carry out the confidence interval calculations, we used the standard approximation of the outcomes in a repeated Bernoulli trial to a normal distribution. The second assumption we made was that the patients were statistically independent. This was considered appropriate as upon review of all patients' demographic data, there were no obvious common patterns. We proceeded on calculating the 90% confidence interval using the mathematical formulae associated with the chosen statistical model.

The main statistical estimator was the outcome mean, $M = \frac{1}{N}\sum_{i=1}^{N} R_i$, where R_i denotes the random variable for the outcome of the treatment on a given patient, and assumes a value of 1 in case of success and 0 otherwise, and N is the number of trials. Based on the normal approximation, the $1 - \alpha$ two-sided confidence interval for the unknown parameter p can be computed as

$$\left[M - z\left(1-\frac{\alpha}{2}\right)\sqrt{\frac{M(1-M)}{N}}, M + z\left(1-\frac{\alpha}{2}\right)\sqrt{\frac{M(1-M)}{N}} \right]$$

Here, $z(r)$ is the r-quantile of the standard normal distribution. In particular, for $\alpha = 0.1$, we obtain that $z(0.95) \approx 1.65$.

For 90% confidence interval, when taking into consideration only the patients contacted regarding the duration of pain relief (29), our calculations showed 59–85% probability that a patient with severe pain would respond favorably (either short or long term) to the ketamine infusion with 23–51% probability that this pain relief in this random patient would last more than 3 weeks. If assumed that all the patients not contacted did not have long-standing pain relief, for the total number of patients (49), the calculations showed 31–53% chance that a random patient would respond to the ketamine infusion with lasting pain relief, but only 13–31% probability that this relief will last more than 3 weeks. The results of this analysis (Table 4) were statistically significant showing a favorable effect when compared with the alternative.

Nine (18%) of the 49 patients evaluated were given memantine, an oral NMDA-receptor antagonist at the current Food and Drug Administration approved dose of 10 mg po bid, after they had at least one successful outpatient ketamine infusion. The oral regimen with memantine was started with the purpose of gradually transitioning patients from intravenous therapy to an oral

Table 4 Results of the mathematical calculations based on the statistical Bernoulli model showing favorable outcome (long-term pain relief) after ketamine infusion (90% confidence interval)

	Nt	Nc	Rt	Rl
Numbers of patients	49	29	21	11
p (Nc)	N/A	100%	59–85%	23–51%
p (Nt)	100%	N/A	31–53%	13–31%

Nt = total number of patients (N total); Nc = number of patients contacted (N contacted); Rt = number of patients reporting more than 1–2 days pain relief in response to ketamine infusion (responders total); Rl = number of patients reporting more than 3 weeks pain relief in response to ketamine infusion (responders long); p (Nc) = chance of a random patient to respond to ketamine infusion based on the number of patients contacted; p (Nt) = chance of a random patient to respond to ketamine infusion based on the total number of patients; N/A = not applicable.

regimen. Table 5 summarizes those results. The mean dose of ketamine per infusion for these patients was 0.65 mg/kg (range 0.3–1.2 mg/kg). Mean reduction of pain from ketamine infusions was 65% (range 0–100%), and mean pain reduction after starting memantine was 22% (range 0–60). Three of the patients had CRPS, and the other six patients had chemo-induced neuropathy, neurofibromatosis, Brown–Sequard syndrome, visceral pain, headache, or spinal stenosis. Three patients experienced side effects from memantine. Six (66%) patients reported improved quality of life with memantine (either improved sleep quality or enhanced pain relief from subsequent ketamine infusions).

Discussion

Ketamine acts both centrally and peripherally. Its action is mediated by multiple receptor subtypes including opioid, NMDA, alpha-amino-3-hydroxy-5-methyl-4-isoxazole propionate, kainite, and gamma-amino butyric acid A receptors [8]. In chronic pain, ketamine appears to interact with the NMDA receptor. When stimulated, primarily by the excitatory neurotransmitter glutamate, the NMDA receptor leads to central sensitization via an upregulating feedback mechanism, a potential pathway for chronic pain. Reversal of central sensitization by NMDA-receptor antagonists such as ketamine is believed to reduce pain and may reduce the amount of opioid analgesics patients need as well [9,10]. Ketamine also has been shown to decrease opioid tolerance through an interaction between NMDA receptors, the nitric oxide pathway, and μ-opioid receptors [11].

Psychomimetic actions of ketamine and its perceived unfavorable clinical risk–benefit ratio preclude its wide use as a pain management agent. However, a growing body of literature supports the use of ketamine in low doses as an analgesic [8]. It has been used in the treatment of various neuropathic pain syndromes and CRPS in subanesthetic intravenous doses [4,12–15].

Early evidence suggestive of clinical relief of neuropathic pain in patients with cancer pain involving nerve injury was followed by several controlled studies using low-dose ketamine for a few other conditions (post-herpetic neuralgia, diabetic neuropathy, CRPS, and fibromyalgia) [1,3–7]. Much of the research has been focused on neuropathic pain and far less studies investigates effects of intravenous ketamine on other chronic pain states. Twenty-five milligrams of intranasal ketamine was demonstrated to be an effective treatment for severe disabling aura in patients with severe familial hemiplegic migraine [16]. However, only two of the 11 patients studied demonstrated reduction in their headache quality.

Our results are supported by those of several other studies. Krusz [17] had a high success rate with ketamine for patients with multiple refractory pain syndromes.

This retrospective review found good efficacy for ketamine infusions in a variety of clinical situations with a safe

Table 5 Patients transitioned to oral memantine

		Ketamine Infusions		Memantine Treatment			
Diagnosis	Age/ Gender	Pain Reduction (%)	Duration of Pain Reduction	Pain Reduction (%)	Side Effects	Subjective Improvement in Quality of Life	Continued Ketamine Infusions After Memantine
CRPS	40/F	8	2 weeks	60	Sedation	Yes	No
CRPS	45/F	40	1.5 weeks	40	Headache	Yes	Yes*
CRPS	39/F	95	4 weeks	0	No	Yes	Yes
Chemo-induced neuropathy	49/M	65	5 weeks	0	No	Yes	Yes*
Neurofibromatosis	58/F	100	4 days	60	No	Yes	No
Brown–Sequard syndrome	26/F	50	3.5 weeks	10	Sedation	Yes	No
Visceral pain	41/M	100	3 weeks	10	No	No	No
Headache	50/M	70	2 weeks	20	No	No	No
Spinal stenosis	58/F	60	1 week	0	No	No	No

* Enhanced pain relief with infusions after memantine.
CRPS = complex regional pain syndrome.

margin of tolerability evidenced by the low degree of severity for the documented side effects.

One of the limitations of our study is the lack of data on long-term pain relief. However, our results from documented records, phone calls, and statistical analysis suggest that there is a significant chance (more than 30%) that a patient with refractory pain will have lasting pain relief after a 30-minute infusion with subanesthetic doses of ketamine. Our study design was retrospective, which is another limitation. To date, there have been no large randomized controlled trials with ketamine. Whether patients responding to ketamine infusions can be transitioned to an oral medication regimen remains to be seen. Thus far, no oral medication has proven to elicit a great analgesic response. Recently approved in the United States as a neuroprotective drug for Alzheimer patients, memantine, an oral NMDA-receptor antagonist, has shown some results in the treatment of phantom limb and neuropathic pain conditions [18]. Ketamine provides a more potent decrease in pain than memantine, possibly related to a lower equipotent dose of memantine po when compared with intravenous ketamine. Despite this difference, memantine improved quality of life in two-thirds of patients with minimal side effects. While limited by possible risks involved with higher doses of memantine (such as apoptosis, controlled neuronal cell death reported in animal models), additional studies are needed to investigate the optimal dose of memantine when used as an oral adjunct in refractory chronic pain patients responding to ketamine infusions [19].

For patients suffering from intractable chronic pain syndromes, alternative pain regimens may prove valuable. Our retrospective study demonstrates that for some patients with severe refractory pain of multiple etiologies, outpatient intravenous infusions of ketamine for 30 minutes at subanesthetic doses may significantly improve VAS scores with minimal side effects. These infusions are particularly useful when other interventions have failed.

Acknowledgments

We would like to thank Elizabeth Kadisak for preparation of the manuscript and Sally Kozlik for editing it. We thank Mihai Anitescu and Chuanhong Liao for the feedback on statistical analysis.

References

1 Correll GE, Maleki J, Gracely EJ, Muir JJ, Harbut RE. Subanesthetic ketamine infusion therapy: A retrospective analysis of a novel therapeutic approach to complex regional pain syndrome. Pain Med 2004;5: 263–75.

2 Visser E, Schug SA. The role of ketamine in pain management. Biomed Pharmacother 2006;60:341–8.

3 Kronenberg RH. Ketamine as an analgesic: Parenteral, oral, rectal, subcutaneous, transdermal and intranasal administration. J Pain Palliat Care Pharmacother 2002;16:27–35.

4 Sang CN. NMDA-receptor antagonists in neuropathic pain: Experimental methods to clinical trials. J Pain Symptom Manage 2000;19:S21–5.

5 Chizh BA, Headley PM. NMDA antagonists and neuropathic pain—Multiple drug targets and multiple uses. Curr Pharm Des 2005;11:2977–94.

6 Sörenson J, Bengtsson A, Bäckman E, Henriksson KG. Pain analysis in patients with fibromyalgia. Effects of intravenous morphine, lidocaine, and ketamine. Scand J Rheumatol 1995;24:360–5.

7 Graven-Nielsen T, Aspergren KS, Henriksson KG, et al. Ketamine reduces muscle pain, temporal summation, and referred pain in fibromyalgia patients. Pain 2000;85:483–91.

8 Hocking G, Cousins M. Ketamine in chronic pain management: An evidence-based review. Anesth Analg 2003;97:1730–9.

9 Bennett GJ. Update on the neurophysiology of pain transmission and modulation: Focus on the NMDA receptor. J Pain Symptom Manage 2000;19(suppl 1):S2–6.

10 Price DD, Mayer DJ, Jianren M. NMDA-receptor antagonists and opioid receptor interactions as related to analgesia and tolerance. J Pain Symptom Manage 2000;19:S7–11.

11 Mao J, Price DD, Mayer DJ. Mechanisms of hyperalgesia and morphine tolerance: A current view of their possible interactions. Pain 1995;62:259–74.

12 Bell RF, Eccleston C, Kalso EA. Ketamine as an adjuvant to opioids for cancer pain. Cochrane Database Syst Rev 2003;(1):Art. No: CD003351. DOI: 10.1002/14651858.

13 Cohen SP, DeJesus M. Ketamine patient-controlled analgesia for dysesthetic central pain. Spinal Cord 2004;42:425–8.

14 Harbut RE, Correll GE. Successful treatment of a nine year case of complex regional pain syndrome type-I (reflex sympathetic dystrophy) with intravenous ketamine-infusion therapy in a warfarin-anticoagulated adult female patient. Pain Med 2002;3:147–55.

15 Schwartzman RJ, Goldberg ME, Dotson J. Multiday low dose ketamine infusion for the treatment of complex regional pain syndrome (CRPS). Pain Physician 2005;8:175–9.

16 Kaubh H, Herzog J, Kaufer T, Dichgans M, Diener HC. Aura in some patients with familial hemiplegic migraine can be stopped by intranasal ketamine. Neurology 2000;55:139–41.

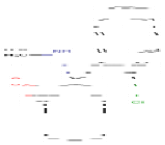
17 Krusz JC. Intravenous treatment of chronic daily headaches in the outpatient headache clinic. Curr Pain Headache Rep 2006;10:47–53.

18 Buvanendran A, Kroin JS. Early use of memantine for neuropathic pain. Anesth Analg 2008;107:1093–4.

19 Ju WK, Kim KY, Angert M, et al. Memantine blocks mitochondrial OPA1 and cytochrome c release and subsequent apoptotic cell death in glaucomatous retina. Invest Ophthalmol Vis Sci 2009;50:707–16.

Drugs

Targets (14) Enzymes (5) Biointeractions (20)

Name	Ketamine
Accession Number	DB01221 (APRD00493)
Type	Small Molecule
Groups	Approved, Vet approved
Description	Ketamine is an NMDA receptor antagonist with a potent anesthetic effect.[6] It was developed in 1963 as a replacement for phencyclidine (PCP) by Calvin Stevens at Parke Davis Laboratories. It started being used for veterinary purposes in Belgium and in 1964 was proven that compared to PCP, it produced minor hallucinogenic effects and shorter psychotomimetic effects. It was FDA approved in 1970, and from there, it has been used as an anesthetic for children or patients undergoing minor surgeries but mainly for veterinary purposes.[14]
Structure	 3D Download Similar Structures
Synonyms	(+-)-Ketamine (±)-ketamine 2-(2-Chloro-phenyl)-2-methylamino-cyclohexanone 2-(methylamino)-2-(2-chlorophenyl)cyclohexanone 2-(o-chlorophenyl)-2-(methylamino)-cyclohexanone DL-ketamine Ketamina Kétamine Ketaminum NMDA Special K
External IDs	100477-72-3 / NSC-70151

Product Ingredients

INGREDIENT	UNII	CAS	INCHI KEY
Ketamine hydrochloride	O18YUO0I83	1867-66-9	VCMGMSHEPQENPE-UHFFFAOYSA-N

Prescription Products

Show 10 entries Search

		MARKETING	MARKETING

Indication

Ketamine is indicated as an anesthetic agent for recommended diagnostic and surgical procedures. If skeletal muscle relaxation is needed, it should be combined with a muscle relaxant. If the surgical procedure involves visceral pain, it should be supplemented with an agent that obtunds visceral pain. Ketamine can be used for induction of anesthesia prior other general anesthetic agents and as a supplement of low potency agents.[15]

Reports have indicated a potential use of ketamine as a therapeutic tool for the management of depression when administered in lower doses.[7] These reports have increased the interest for ketamine in this area and several clinical trials are launched for this indication.[16, 8]

Associated Therapies

Adjunct to general anesthesia therapy

Anesthesia induction and maintenance therapy

Pharmacodynamics

Ketamine is a rapid-acting general anesthetic producing an anesthetic state characterized by profound analgesia, normal pharyngeal-laryngeal reflexes, normal or slightly enhanced skeletal muscle tone, cardiovascular and respiratory stimulation, and occasionally a transient and minimal respiratory depression. The anesthetic state produced by Ketamine has been termed as "dissociative anesthesia" in that it appears to selectively interrupt association pathways of the brain before producing somesthetic sensory blockade. It may selectively depress the thalamoneocortical system before significantly obtunding the more ancient cerebral centers and pathways (reticular-activating and limbic systems).[2]

Ketamine enhances descending inhibiting serotoninergic pathways and can exert antidepressive effects. These effects are seen in concentrations ten times lower than the needed concentration for anesthetic proposes. The effect of ketamine can be described as analgesic by the prevention of central sensitization in dorsal horn neurons as well as by the inhibition on the synthesis of nitric oxide. Ketamine can present cardiovascular changes and bronchodilatation.[9]

Mechanism of action

Ketamine interacts with N-methyl-D-aspartate (NMDA) receptors, opioid receptors, monoaminergic receptors, muscarinic receptors and voltage sensitive Ca ion channels. Unlike other general anaesthetic agents, ketamine does not interact with GABA receptors.[5]

TARGET	ACTIONS	ORGANISM
Glutamate receptor ionotropic, NMDA 3A	antagonist	Human
Substance-P receptor	antagonist	Human
D(2) dopamine receptor	agonist partial agonist	Human
Delta-type opioid receptor	binder	Human
Sodium-dependent noradrenaline transporter	inhibitor	Human
Kappa-type opioid receptor	agonist	Human
Mu-type opioid receptor	binder	Human
Muscarinic acetylcholine receptor	binder	Human
5-hydroxytryptamine receptor 2	antagonist	Human
5-hydroxytryptamine receptor 1	antagonist	Human
5-hydroxytryptamine receptor 3A	potentiator	Human
Alpha-7 nicotinic cholinergic receptor subunit	antagonist	Human
Cholinesterase	inhibitor	Human
Nitric oxide synthase, brain	inhibitor	Human

Absorption

Ketamine absorption is very rapid and the bioavailability is around 93%. After the first pass

Drugs

Drug Interactions

Show 10 entries Search

DRUG	INTERACTION	DRUG GROUP
Alfentanil	The risk or severity of adverse effects can be increased when Alfentanil is combined with Ketamine.	Approved, Illicit
Allopregnanolone	The risk or severity of adverse effects can be increased when Ketamine is combined with Allopregnanolone.	Investigational
Alphacetylmethadol	The risk or severity of adverse effects can be increased when Ketamine is combined with Alphacetylmethadol.	Experimental, Illicit
Alphaprodine	The risk or severity of adverse effects can be increased when Ketamine is combined with Alphaprodine.	Illicit
Alprazolam	The risk or severity of adverse effects can be increased when Alprazolam is combined with Ketamine.	Approved, Illicit, Investigational
Amikacin	The risk or severity of adverse effects can be increased when Ketamine is combined with Amikacin.	Approved, Investigational, Vet Approved
Amiodarone	The metabolism of Ketamine can be decreased when combined with Amiodarone.	Approved, Investigational
Amisulpride	The risk or severity of adverse effects can be increased when Ketamine is combined with Amisulpride.	Approved, Investigational
Amitriptyline	The risk or severity of adverse effects can be increased when Ketamine is combined with Amitriptyline.	Approved
Amobarbital	The risk or severity of adverse effects can be increased when Ketamine is combined with Amobarbital.	Approved, Illicit

Showing 11 to 20 of 508 entries ‹ 1 3 4 5 ... 51 ›

Food Interactions Not Available

Synthesis Reference John A. Flores, Kenton L. Crowley, "Process for the preparation of ketamine ointment." U.S. Patent US5817699, issued June, 1995.
US5817699

General References

1. Harrison NL, Simmonds MA: Quantitative studies on some antagonists of N-methyl D-aspartate in slices of rat cerebral cortex. Br J Pharmacol. 1985 Feb;84(2):381-91. [PubMed:2858237]
2. Bergman SA: Ketamine: review of its pharmacology and its use in pediatric anesthesia. Anesth Prog. 1999 Winter;46 (1):10-20. [PubMed:10551055]
3. Bonanno FG: Ketamine in war/tropical surgery (a final tribute to the racemic mixture). Injury. 2002 May;33(4):323-7. [PubMed:12091028]
4. Lankenau SE, Sanders B, Bloom JJ, Hathazi D, Alarcon E, Tortu S, Clatts MC: First injection of ketamine among young injection drug users (IDUs) in three U.S. cities. Drug Alcohol Depend. 2007 Mar 16;87(2-3):183-93. Epub 2006 Sep 18. [PubMed:16979848]
5. Reboso Morales JA, Gonzalez Miranda F: [Ketamine]. Rev Esp Anestesiol Reanim. 1999 Mar;46(3):111-22. [PubMed:10228376]
6. Ivani G, Vercellino C, Tonetti F: Ketamine: a new look to an old drug. Minerva Anestesiol. 2003 May;69(5):468-71. [PubMed:12768186]
7. Yang Y, Cui Y, Sang K, Dong Y, Ni Z, Ma S, Hu H: Ketamine blocks bursting in the lateral habenula to rapidly relieve depression. Nature. 2018 Feb 14;554(7692):317-322. doi: 10.1038/nature25509. [PubMed:29446381]
8. Kirby T: Ketamine for depression: the highs and lows. Lancet Psychiatry. 2015 Sep;2(9):783-4. doi: 10.1016/S2215-0366 (15)00392-2. [PubMed:26360893]
9. Xu J, Lei H: Ketamine-an update on its clinical uses and abuses. CNS Neurosci Ther. 2014 Dec;20(12):1015-20. doi: 10.1111/cns.12363. [PubMed:25417928]
10. Clements JA, Nimmo WS, Grant IS: Bioavailability, pharmacokinetics, and analgesic activity of ketamine in humans. J

12. Kaka JS, Hayton WL: Pharmacokinetics of ketamine and two metabolites in the dog. J Pharmacokinet Biopharm. 1980 Apr;8(2):193-202. [PubMed:7431222]
13. Pypendop BH, Ilkiw JE: Pharmacokinetics of ketamine and its metabolite, norketamine, after intravenous administration of a bolus of ketamine to isoflurane-anesthetized dogs. Am J Vet Res. 2005 Dec;66(12):2034-8. doi: 10.2460/ajvr.2005.66.2034. [PubMed:16379643]
14. Ketamine [Link]
15. Ketamine monograph [Link]
16. Time magazine [Link]

Clinical Trials

Show 10 entries Search

PHASE	STATUS	PURPOSE	CONDITIONS	COUNT
0	Active Not Recruiting	Basic Science	Depression	1
0	Active Not Recruiting	Basic Science	Major Depressive Disorder (MDD)	1
0	Active Not Recruiting	Supportive Care	Hemorrhoids / Perianal Fistulas	1
0	Active Not Recruiting	Treatment	Cancers / Depression / Head and Neck Carcinoma	1
0	Active Not Recruiting	Treatment	Social Anxiety Disorder (SAD)	1
0	Completed	Prevention	Depression	1
0	Completed	Treatment	Bipolar I Disorder / Bipolar II Disorder / Depression, Bipolar / Major Depressive Disorder (MDD) / Suicidal Ideation	1
0	Not Yet Recruiting	Prevention	Post-Mastectomy Chronic Pain Syndrome / Postoperative pain	1
0	Not Yet Recruiting	Treatment	Distal Radius Fractures / Sedation, Conscious	1
0	Not Yet Recruiting	Treatment	Major Depressive Disorder (MDD) / Treatment Resistant Depression (TRD)	1

Showing 1 to 10 of 473 entries ‹ 2 3 4 5 ... 48 ›

Manufacturers

Not Available

Packagers

Bedford Labs
Ben Venue Laboratories Inc.
Bioniche Pharma
Hospira Inc.
JHP Pharmaceuticals LLC
Medisca Inc.
Monarch Pharmacy
Pharmedium
Physicians Total Care Inc.

Dosage forms

Show 10 entries Search

FORM	ROUTE	STRENGTH
Solution	Intramuscular; Intravenous	50 mg
Injection	Intramuscular; Intravenous	10 mg/mL
Injection	Intramuscular; Intravenous	100 mg/mL
Injection	Intramuscular; Intravenous	50 mg/mL
Injection, solution	Intramuscular; Intravenous	10 mg/mL
Injection, solution	Intramuscular; Intravenous	100 mg/mL

Showing 1 to 10 of 13 entries

Showing 1 to 10 of 10 entries

Drugs

DrugBank does not sell nor buy drugs. Pricing information is supplied for informational purposes only.

State Solid

Experimental Properties

PROPERTY	VALUE	SOURCE
melting point (°C)	92.5ºC	Medical toxicology of drug abuse. (2012)
water solubility	Soluble	'MSDS'
logP	3.120	Medical toxicology of drug abuse. (2012)
pKa	7.5	Ketamine monograph

Predicted Properties

PROPERTY	VALUE	SOURCE
Water Solubility	0.0464 mg/mL	ALOGPS
logP	2.69	ALOGPS
logP	3.35	ChemAxon
logS	-3.7	ALOGPS
pKa (Strongest Acidic)	18.78	ChemAxon
pKa (Strongest Basic)	7.45	ChemAxon
Physiological Charge	1	ChemAxon
Hydrogen Acceptor Count	2	ChemAxon
Hydrogen Donor Count	1	ChemAxon
Polar Surface Area	29.1 $Å^2$	ChemAxon
Rotatable Bond Count	2	ChemAxon
Refractivity	65.55 $m^3 \cdot mol^{-1}$	ChemAxon
Polarizability	24.97 $Å^3$	ChemAxon
Number of Rings	2	ChemAxon
Bioavailability	1	ChemAxon
Rule of Five	Yes	ChemAxon
Ghose Filter	Yes	ChemAxon
Veber's Rule	Yes	ChemAxon
MDDR-like Rule	No	ChemAxon

Predicted ADMET features

PROPERTY	VALUE	PROBABILITY
Human Intestinal Absorption	+	0.9974
Blood Brain Barrier	+	0.9826
Caco-2 permeable	+	0.6326
P-glycoprotein substrate	Substrate	0.5753
P-glycoprotein inhibitor I	Non-inhibitor	0.5948
P-glycoprotein inhibitor II	Non-inhibitor	0.8383
Renal organic cation transporter	Non-inhibitor	0.6737
CYP450 2C9 substrate	Non-substrate	0.6363

Drugs

Mass Spec (NIST) Not Available

Spectra

SPECTRUM	SPECTRUM TYPE	SPLASH KEY
Predicted GC-MS Spectrum - GC-MS	Predicted GC-MS	Not Available
Predicted MS/MS Spectrum - 10V, Positive (Annotated)	Predicted LC-MS/MS	Not Available
Predicted MS/MS Spectrum - 20V, Positive (Annotated)	Predicted LC-MS/MS	Not Available
Predicted MS/MS Spectrum - 40V, Positive (Annotated)	Predicted LC-MS/MS	Not Available
Predicted MS/MS Spectrum - 10V, Negative (Annotated)	Predicted LC-MS/MS	Not Available
Predicted MS/MS Spectrum - 20V, Negative (Annotated)	Predicted LC-MS/MS	Not Available
Predicted MS/MS Spectrum - 40V, Negative (Annotated)	Predicted LC-MS/MS	Not Available
LC-MS/MS Spectrum - LC-ESI-QTOF , positive	LC-MS/MS	splash10-004i-0930000000-8216e02922628a5070cf
LC-MS/MS Spectrum - LC-ESI-ITFT , positive	LC-MS/MS	splash10-00di-0090000000-7704dbbfa717abc4bab2
LC-MS/MS Spectrum - LC-ESI-ITFT , positive	LC-MS/MS	splash10-000i-0090000000-aff2b684d97275321043
LC-MS/MS Spectrum - LC-ESI-ITFT , positive	LC-MS/MS	splash10-000i-0290000000-1707dec51cc3e89964c9
LC-MS/MS Spectrum - LC-ESI-ITFT , positive	LC-MS/MS	splash10-004i-0940000000-59871faec16835eb1b3a
LC-MS/MS Spectrum - LC-ESI-ITFT , positive	LC-MS/MS	splash10-004i-0900000000-ca62e82b4a1dfb81b3b0
LC-MS/MS Spectrum - LC-ESI-ITFT , positive	LC-MS/MS	splash10-004i-0900000000-6c243d7b1c2e8cf69efa
LC-MS/MS Spectrum - LC-ESI-ITFT , positive	LC-MS/MS	splash10-004i-0900000000-441a423105753e2c8b9c
LC-MS/MS Spectrum - LC-ESI-ITFT , positive	LC-MS/MS	splash10-000i-0090000000-24585e7c2431b3b9319e
LC-MS/MS Spectrum - LC-ESI-ITFT , positive	LC-MS/MS	splash10-000i-0290000000-c9d734b085ec94dabd9a
LC-MS/MS Spectrum - LC-ESI-ITFT , positive	LC-MS/MS	splash10-004i-0940000000-054d77385726d4e35e20
LC-MS/MS Spectrum - LC-ESI-ITFT , positive	LC-MS/MS	splash10-004i-0900000000-8c263bb521fb6ebe6cac
LC-MS/MS Spectrum - LC-ESI-ITFT , positive	LC-MS/MS	splash10-004i-0900000000-702873d66ce0d419711d
LC-MS/MS Spectrum - LC-ESI-ITFT , positive	LC-MS/MS	splash10-004i-0900000000-e23ba411aa96df9b5d6f
LC-MS/MS Spectrum - LC-ESI-ITFT , positive	LC-MS/MS	splash10-00di-0090000000-5f14196db213c95f3e71
LC-MS/MS Spectrum - LC-ESI-QQ , positive	LC-MS/MS	splash10-000i-0090000000-85385cf96aa2ac05921a
LC-MS/MS Spectrum - LC-ESI-QQ , positive	LC-MS/MS	splash10-05br-0390000000-

SPECTRUM	SPECTRUM TYPE	SPLASH KEY
LC-MS/MS Spectrum - LC-ESI-QQ , positive	LC-MS/MS	splash10-004i-0910000000-d00d242dae695dc5aff9
LC-MS/MS Spectrum - LC-ESI-QQ , positive	LC-MS/MS	splash10-004i-0900000000-95c2a8805f1587266fea
LC-MS/MS Spectrum - LC-ESI-QQ , positive	LC-MS/MS	splash10-004i-1900000000-9e61adc80771178de9d3
LC-MS/MS Spectrum - LC-ESI-IT , positive	LC-MS/MS	splash10-00di-0190000000-686c139c454aea662d84

Description	This compound belongs to the class of organic compounds known as chlorobenzenes. These are compounds containing one or more chlorine atoms attached to a benzene moiety.
Kingdom	Organic compounds
Super Class	Benzenoids
Class	Benzene and substituted derivatives
Sub Class	Halobenzenes
Direct Parent	Chlorobenzenes
Alternative Parents	Aralkylamines / Aryl chlorides / Cyclic ketones / Dialkylamines / Organopnictogen compounds / Organochlorides / Organic oxides / Hydrocarbon derivatives
Substituents	Chlorobenzene / Aralkylamine / Aryl chloride / Aryl halide / Ketone / Cyclic ketone / Secondary aliphatic amine / Secondary amine / Amine / Organooxygen compound
Molecular Framework	Aromatic homomonocyclic compounds
External Descriptors	secondary amino compound, monochlorobenzenes, cyclohexanones (CHEBI:6121)

Kind	Protein	**General Function**	Protein phosphatase 2a binding
Organism	Human	**Specific Function**	NMDA receptor subtype of glutamate-gated ion channels with reduced single-channel conductance, low calcium permeability and low voltage-dependent sensitivity to magnesium. Mediated by glycine. May ...
Pharmacological action		**Gene Name**	GRIN3A
Actions			

1. Smothers CT, Woodward JJ: Pharmacological characterization of glycine-activated currents in HEK 293 cells expressing N-methyl-D-aspartate NR1 and NR3 subunits. J Pharmacol Exp Ther. 2007 Aug;322(2):739-48. Epub 2007 May 14. [PubMed:17502428]
2. Harrison NL, Simmonds MA: Quantitative studies on some antagonists of N-methyl D-aspartate in slices of rat cerebral cortex. Br J Pharmacol. 1985 Feb;84(2):381-91. [PubMed:2858237]
3. Sinner B, Graf BM: Ketamine. Handb Exp Pharmacol. 2008;(182):313-33. doi: 10.1007/978-3-540-74806-9_15. [PubMed:18175098]
4. Radovanovic D, Pjevic M: [Ketamine: the past 30 years and its future]. Med Pregl. 2003 Sep-Oct;56(9-10):439-45. [PubMed:14740534]

Kind	Protein	**General Function**	Tachykinin receptor activity
Organism	Human	**Specific Function**	This is a receptor for the tachykinin neuropeptide substance P. It is probably associated with G proteins that activate a phosphatidylinositol-calcium second messenger system. The rank order of aff...
Pharmacological action		**Gene Name**	TACR1
Actions		**Uniprot ID**	P25103
		Uniprot Name	Substance-P receptor
		Molecular Weight	46250.5 Da

References

1. Okamoto T, Minami K, Uezono Y, Ogata J, Shiraishi M, Shigematsu A, Ueta Y: The inhibitory effects of ketamine and pentobarbital on substance p receptors expressed in Xenopus oocytes. Anesth Analg. 2003 Jul;97(1):104-10, table of contents. [PubMed:12818951]

Kind	Protein	**General Function**	Potassium channel regulator activity
Organism	Human	**Specific Function**	Dopamine receptor whose activity is mediated by G proteins which inhibit adenylyl cyclase.
Pharmacological action		**Gene Name**	DRD2
Actions		**Uniprot ID**	P14416
		Uniprot Name	D(2) dopamine receptor
		Molecular Weight	50618.91 Da

References

1. Seeman P, Guan HC, Hirbec H: Dopamine D2High receptors stimulated by phencyclidines, lysergic acid diethylamide, salvinorin A, and modafinil. Synapse. 2009 Aug;63(8):698-704. doi: 10.1002/syn.20647. [PubMed:19391150]

Kind	Protein	**General Function**	Opioid receptor activity

Organism	Human	**Specific Function**	G-protein coupled receptor that functions as receptor for endogenous enkephalins and for a subset of other opioids. Ligand binding causes a conformation change that triggers signaling via guanine n...
Pharmacological action		**Gene Name**	OPRD1
Actions		**Uniprot ID**	P41143
		Uniprot Name	Delta-type opioid receptor
		Molecular Weight	40368.235 Da

References

1. Smith DJ, Pekoe GM, Martin LL, Coalgate B: The interaction of ketamine with the opiate receptor. Life Sci. 1980 Mar 10;26(10):789-95. [PubMed:6246318]
2. Hustveit O, Maurset A, Oye I: Interaction of the chiral forms of ketamine with opioid, phencyclidine, sigma and muscarinic receptors. Pharmacol Toxicol. 1995 Dec;77(6):355-9. [PubMed:8835358]

Kind	Protein	**General Function**	Norepinephrine:sodium symporter activity
Organism	Human	**Specific Function**	Amine transporter. Terminates the action of noradrenaline by its high affinity sodium-dependent reuptake into presynaptic terminals.
Pharmacological action		**Gene Name**	SLC6A2
Actions		**Uniprot ID**	P23975
		Uniprot Name	Sodium-dependent noradrenaline transporter
		Molecular Weight	69331.42 Da

References

1. Salt PJ, Barnes PK, Beswick FJ: Inhibition of neuronal and extraneuronal uptake of noradrenaline by ketamine in the isolated perfused rat heart. Br J Anaesth. 1979 Sep;51(9):835-8. [PubMed:508488]

Kind	Protein	**General Function**	Opioid receptor activity
Organism	Human	**Specific Function**	G-protein coupled opioid receptor that functions as receptor for endogenous alpha-neoendorphins and dynorphins, but has low affinity for beta-endorphins. Also functions as receptor for various synt...
Pharmacological action		**Gene Name**	OPRK1
Actions		**Uniprot ID**	P41145
		Uniprot Name	Kappa-type opioid receptor

References

Drugs

1. Smith DJ, Pekoe GM, Martin LL, Coalgate B: The interaction of ketamine with the opiate receptor. Life Sci. 1980 Mar 10;26(10):789-95. [PubMed:6246318]
2. Hustveit O, Maurset A, Oye I: Interaction of the chiral forms of ketamine with opioid, phencyclidine, sigma and muscarinic receptors. Pharmacol Toxicol. 1995 Dec;77(6):355-9. [PubMed:8835358]

Kind	Protein	**General Function**	Voltage-gated calcium channel activity
Organism	Human	**Specific Function**	Receptor for endogenous opioids such as beta-endorphin and endomorphin. Receptor for natural and synthetic opioids including morphine, heroin, DAMGO, fentanyl, etorphine, buprenorphin and methadone...
Pharmacological action		**Gene Name**	OPRM1
Actions		**Uniprot ID**	P35372
		Uniprot Name	Mu-type opioid receptor
		Molecular Weight	44778.855 Da

References

1. Smith DJ, Pekoe GM, Martin LL, Coalgate B: The interaction of ketamine with the opiate receptor. Life Sci. 1980 Mar 10;26(10):789-95. [PubMed:6246318]
2. Hustveit O, Maurset A, Oye I: Interaction of the chiral forms of ketamine with opioid, phencyclidine, sigma and muscarinic receptors. Pharmacol Toxicol. 1995 Dec;77(6):355-9. [PubMed:8835358]

Kind	Protein group	**General Function**	Phosphatidylinositol phospholipase c activity
Organism	Human	**Specific Function**	The muscarinic acetylcholine receptor mediates various cellular responses, including inhibition of adenylate cyclase, breakdown of phosphoinositides and modulation of potassium channels through the...
Pharmacological action			
Actions			

Components:

NAME	UNIPROT ID
Muscarinic acetylcholine receptor M1	P11229
Muscarinic acetylcholine receptor M2	P08172
Muscarinic acetylcholine receptor M3	P20309
Muscarinic acetylcholine receptor M4	P08173
Muscarinic acetylcholine receptor M5	P08912

References

1. [illegible] Vaurset A, Oye I: Interaction of the chiral forms of ketamine with opioid, phencyclidine, sigma and muscarinic receptors. Pharmacol Toxicol. 1995 Dec;77(6):355-9. [PubMed:8835358]

Drugs

Kind	Protein group	**General Function**	Virus receptor activity
Organism	Human	**Specific Function**	G-protein coupled receptor for 5-hydroxytryptamine (serotonin). Also functions as a receptor for various drugs and psychoactive substances, including mescaline, psilocybin, 1-(2,5-dimethoxy-4-iodop...
Pharmacological action			
Actions			

Components:

NAME	UNIPROT ID
5-hydroxytryptamine receptor 2A	P28223
5-hydroxytryptamine receptor 2B	P41595
5-hydroxytryptamine receptor 2C	P28335

References

1. Martin LL, Bouchal RL, Smith DJ: Ketamine inhibits serotonin uptake in vivo. Neuropharmacology. 1982 Feb;21(2):113-8. [PubMed:6460944]

Kind	Protein group	**General Function**	Serotonin receptor activity
Organism	Human	**Specific Function**	G-protein coupled receptor for 5-hydroxytryptamine (serotonin). Also functions as a receptor for various drugs and psychoactive substances. Ligand binding causes a conformation change that triggers...
Pharmacological action			
Actions			

Components:

NAME	UNIPROT ID

NAME	UNIPROT ID
5-hydroxytryptamine receptor 1A	P08908
5-hydroxytryptamine receptor 1B	P28222
5-hydroxytryptamine receptor 1D	P28221
5-hydroxytryptamine receptor 1E	P28566
5-hydroxytryptamine receptor 1F	P30939

References

1. Martin LL, Bouchal RL, Smith DJ: Ketamine inhibits serotonin uptake in vivo. Neuropharmacology. 1982 Feb;21(2):113-8. [PubMed:6460944]

Kind	Protein	**General Function**	Voltage-gated potassium channel activity
Organism	Human	**Specific Function**	This is one of the several different receptors for 5-hydroxytryptamine (serotonin), a biogenic hormone that functions as a neurotransmitter, a hormone, and a mitogen. This receptor is a ligand-gate...
Pharmacological action		**Gene Name**	HTR3A
Actions		**Uniprot ID**	P46098
		Uniprot Name	5-hydroxytryptamine receptor 3A
		Molecular Weight	55279.835 Da

References

1. Appadu BL, Lambert DG: Interaction of i.v. anaesthetic agents with 5-HT3 receptors. Br J Anaesth. 1996 Feb;76(2):271-3. [PubMed:8777109]

Kind	Protein	**General Function**	Not Available
Organism	Human	**Specific Function**	Not Available
Pharmacological action		**Gene Name**	CHRNA7
Actions		**Uniprot ID**	Q693P7
		Uniprot Name	Alpha-7 nicotinic cholinergic receptor subunit
		Molecular Weight	2987.635 Da

References

1. Kohrs R, Durieux ME: Ketamine: teaching an old drug new tricks. Anesth Analg. 1998 Nov;87(5):1186-93. [PubMed:9806706]

Drugs

Kind	Protein	**General Function**	Identical protein binding
Organism	Human	**Specific Function**	Esterase with broad substrate specificity. Contributes to the inactivation of the neurotransmitter acetylcholine. Can degrade neurotoxic organophosphate esters.
Pharmacological action		**Gene Name**	BCHE
Actions		**Uniprot ID**	P06276
		Uniprot Name	Cholinesterase
		Molecular Weight	68417.575 Da

References

1. Kohrs R, Durieux ME: Ketamine: teaching an old drug new tricks. Anesth Analg. 1998 Nov;87(5):1186-93. [PubMed:9806706]

Kind	Protein	**General Function**	Tetrahydrobiopterin binding
Organism	Human	**Specific Function**	Produces nitric oxide (NO) which is a messenger molecule with diverse functions throughout the body. In the brain and peripheral nervous system, NO displays many properties of a neurotransmitter. P...
Pharmacological action		**Gene Name**	NOS1
Actions		**Uniprot ID**	P29475
		Uniprot Name	Nitric oxide synthase, brain
		Molecular Weight	160969.095 Da

References

1. Kohrs R, Durieux ME: Ketamine: teaching an old drug new tricks. Anesth Analg. 1998 Nov;87(5):1186-93. [PubMed:9806706]

Drugs

Kind	Protein	**General Function**	Steroid hydroxylase activity
Organism	Human	**Specific Function**	Cytochromes P450 are a group of heme-thiolate monooxygenases. In liver microsomes, this enzyme is involved in an NADPH-dependent electron transport pathway. It oxidizes a variety of structurally un...
Pharmacological action		**Gene Name**	CYP2C9
Actions		**Uniprot ID**	P11712
		Uniprot Name	Cytochrome P450 2C9
		Molecular Weight	55627.365 Da

References

1. Zhou SF, Zhou ZW, Yang LP, Cai JP: Substrates, inducers, inhibitors and structure-activity relationships of human Cytochrome P450 2C9 and implications in drug development. Curr Med Chem. 2009;16(27):3480-675. Epub 2009 Sep 1. [PubMed:19515014]
2. Preissner S, Kroll K, Dunkel M, Senger C, Goldsobel G, Kuzman D, Guenther S, Winnenburg R, Schroeder M, Preissner R: SuperCYP: a comprehensive database on Cytochrome P450 enzymes including a tool for analysis of CYP-drug interactions. Nucleic Acids Res. 2010 Jan;38(Database issue):D237-43. doi: 10.1093/nar/gkp970. Epub 2009 Nov 24. [PubMed:19934256]

Kind	Protein	**General Function**	Vitamin d3 25-hydroxylase activity
Organism	Human	**Specific Function**	Cytochromes P450 are a group of heme-thiolate monooxygenases. In liver microsomes, this enzyme is involved in an NADPH-dependent electron transport pathway. It performs a variety of oxidation react...
Pharmacological action		**Gene Name**	CYP3A4
Actions		**Uniprot ID**	P08684
		Uniprot Name	Cytochrome P450 3A4
		Molecular Weight	57342.67 Da

References

1. Zhou SF, Zhou ZW, Yang LP, Cai JP: Substrates, inducers, inhibitors and structure-activity relationships of human Cytochrome P450 2C9 and implications in drug development. Curr Med Chem. 2009;16(27):3480-675. Epub 2009 Sep 1. [PubMed:19515014]
2. Preissner S, Kroll K, Dunkel M, Senger C, Goldsobel G, Kuzman D, Guenther S, Winnenburg R, Schroeder M, Preissner R: SuperCYP: a comprehensive database on Cytochrome P450 enzymes including a tool for analysis of CYP-drug interactions. Nucleic Acids Res. 2010 Jan;38(Database issue):D237-43. doi: 10.1093/nar/gkp970. Epub 2009 Nov 24. [PubMed:19934256]

Kind	Protein	**General Function**	Steroid hydroxylase activity
Organism	Human	**Specific Function**	Cytochromes P450 are a group of heme-thiolate monooxygenases. In liver microsomes, this enzyme is involved in
Pharmacological			

an NADPH-dependent electron transport pathway. It oxidizes a variety of structurally un...

References

1. Zhou SF, Zhou ZW, Yang LP, Cai JP: Substrates, inducers, inhibitors and structure-activity relationships of human Cytochrome P450 2C9 and implications in drug development. Curr Med Chem. 2009;16(27):3480-675. Epub 2009 Sep 1. [PubMed:19515014]
2. Preissner S, Kroll K, Dunkel M, Senger C, Goldsobel G, Kuzman D, Guenther S, Winnenburg R, Schroeder M, Preissner R: SuperCYP: a comprehensive database on Cytochrome P450 enzymes including a tool for analysis of CYP-drug interactions. Nucleic Acids Res. 2010 Jan;38(Database issue):D237-43. doi: 10.1093/nar/gkp970. Epub 2009 Nov 24. [PubMed:19934256]

Kind	Protein	**General Function**	Prostaglandin-endoperoxide synthase activity
Organism	Human	**Specific Function**	Converts arachidonate to prostaglandin H2 (PGH2), a committed step in prostanoid synthesis. Involved in the constitutive production of prostanoids in particular in the stomach and platelets. In gas...
Pharmacological action		**Gene Name**	PTGS1
Actions		**Uniprot ID**	P23219
		Uniprot Name	Prostaglandin G/H synthase 1
		Molecular Weight	68685.82 Da

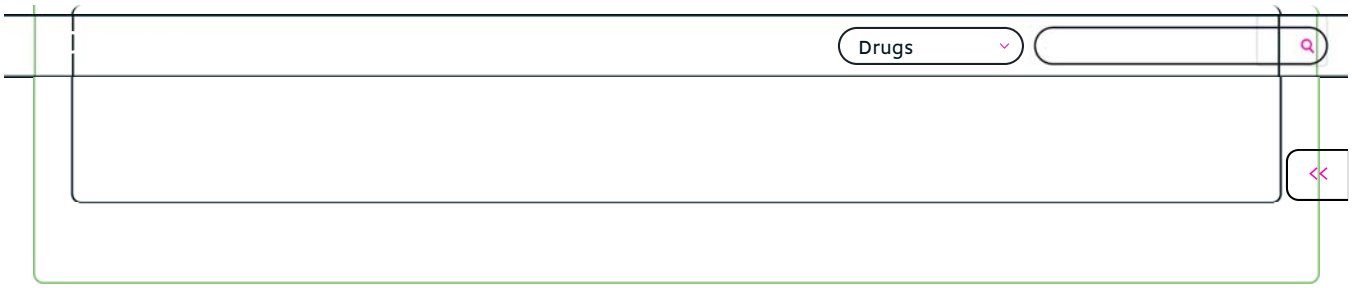
References

1. Zhou SF, Zhou ZW, Yang LP, Cai JP: Substrates, inducers, inhibitors and structure-activity relationships of human Cytochrome P450 2C9 and implications in drug development. Curr Med Chem. 2009;16(27):3480-675. Epub 2009 Sep 1. [PubMed:19515014]

Kind	Protein	**General Function**	Steroid hydroxylase activity
Organism	Human	**Specific Function**	Cytochromes P450 are a group of heme-thiolate monooxygenases. In liver microsomes, this enzyme is involved in an NADPH-dependent electron transport pathway. It oxidizes a variety of structurally un...
Pharmacological action		**Gene Name**	CYP2C8
Actions		**Uniprot ID**	P10632
		Uniprot Name	Cytochrome P450 2C8
		Molecular Weight	55824.275 Da

References

1. Preissner S, Kroll K, Dunkel M, Senger C, Goldsobel G, Kuzman D, Guenther S, Winnenburg R, Schroeder M, Preissner R: SuperCYP: a comprehensive database on Cytochrome P450 enzymes including a tool for analysis of CYP-drug interactions. Nucleic Acids Res. 2010 Jan;38(Database issue):D237-43. doi: 10.1093/nar/gkp970. Epub 2009 Nov 24. [PubMed:19934256]



Drug created on June 13, 2005 07:24 / Updated on August 15, 2018 09:50

This project is supported by the **Canadian Institutes of Health Research** (award #111062), **Alberta Innovates - Health Solutions**, and by **The Metabolomics Innovation Centre (TMIC)**, a nationally-funded research and core facility that supports a wide range of cutting-edge metabolomic studies. TMIC is funded by **Genome Alberta**, **Genome British Columbia**, and **Genome Canada**, a not-for-profit organization that is leading Canada's national genomics strategy with funding from the federal government. Maintenance, support, and commercial licensing is provided by **OMx Personal Health Analytics, Inc.** Designed by **Educe Design & Innovation Inc.**

The Effects of Ketamine Use

REVIEWED BY Eric Patterson, MSCP, NCC, LPC (https://drugabuse.com/author/eric-patterson/)

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It's easy to get ketamine abuse wrong because of its potency; it's more powerful than speed or coke weight for weight, so it's easy to accidenta ly overdose.

Like its sister drug **PCP, ketamine is a dissociative anesthetic (//www.drugabuse.com/library/pcp-abuse/),** and it's popular on the party scene thanks to its high and dissociative effects. However, it's easy to get ketamine abuse wrong because of its potency; it's more powerful than speed or coke weight for weight, so it's **easy to accidentally overdose.**

Ketamine is typically **injected (//www.drugabuse.com/library/dangers-of-shooting-up/)** or **snorted (//www.drugabuse.com/library/snorting-sniffing-drug-abuse/)**, but it can be smoked or taken in pill form. The effects of smoking it or swallowing it tend to be less intense than directly injecting it. In some cases, it's used as a **date rape drug, as it's odorless and colorless. (//www.drugabuse.com/library/date-rape-drugs/)**

Short-Term Effects

Ketamine produces an **abrupt high** that lasts for about an hour. It starts around 2 to 5 minutes after the dose has been smoked or swallowed. With injection, it happens around 30 seconds after the injection has occurred.

The first feeling of the high the user will get is an overwhelming feeling of relaxation, sometimes described as a full-body buzz. Some users feel like they're floating and some even **describe it as being out of their bodies**. Many experience hallucinations that can last longer than the anesthetic effects.

Higher doses can produce more intense effects, with users reporting complete and utter detachment from their bodies. The effects are similar to those described by people who have had near-death experiences, and it's described as being in the **"K-hole".**

Side Effects

The drug does, of course, have side effects, and these can be quite profound. Short-term side effects include bad hallucinations. As with all psychotropic drugs, the pleasantness of the hallucination depends on the user's state of mind, and **if the user is seeking to escape unhappiness, the hallucinations are likely to be unpleasant**.

Naturally, the **side effects** include:

- Disorientation and general confusion due to the drug's anesthetic nature.
- Drowsiness.
- Increased heart rate.
- Elevated blood pressure.

Large doses of the drug can result in what some describe as the "K-hole," which can include intense and unpleasant visual and auditory hallucinations coupled with marked derealization and a frightening detachment from reality.

Perhaps more acutely problematic, users can also become quite **nauseated.** If this progresses to **vomiting,** it can be very dangerous, as those in the midst of state of dissociated confusion frequently end up supine—presenting a serious choking hazard. If you do see someone on ketamine, take a moment to roll them on their side or into the **recovery position if possible to prevent this from happening. (http://www.nsc.org/RxDrugOverdoseDocuments/recovery-position-first-aid.pdf)** Promptly call 911 to get emergency medical assistance.

Long-Term Effects

Powdered ketamine is often **cut with other drugs, so it's very hard to tell what the long-term effects can be (//www.drugabuse.com/library/counterfeit-drugs/)** as interactions can be very unpredictable. Consequently, the long-term effects are varied, but they fall into several main areas.

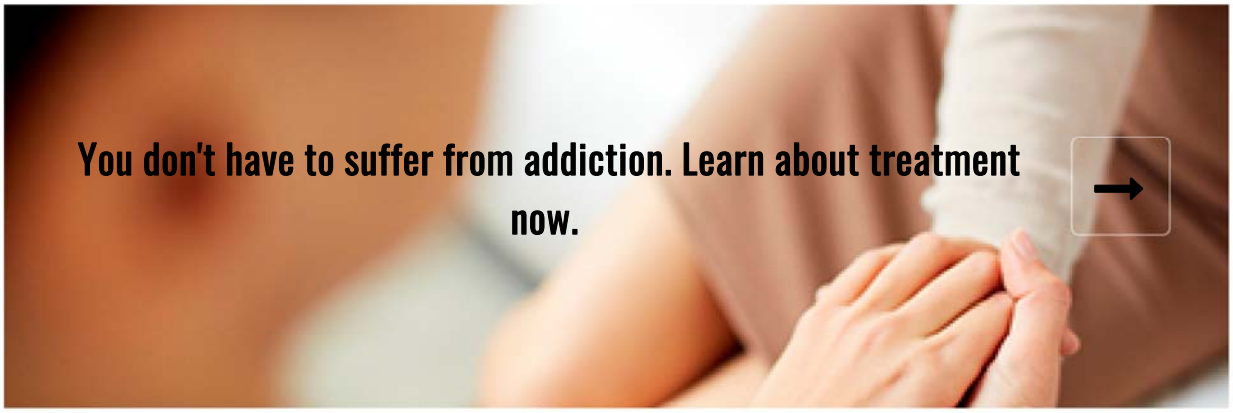
As with any anesthetic, ketamine reduces — or even eliminates — pain**. It's hard for users to tell whether they've injured themselves, so they can end up hurting themselves severely.** Some people have suffered from broken legs and effectively crippled themselves because they couldn't tell that something wasn't right. Walking on a broken leg can result in compound fractures, penetration of the skin, sepsis, and serious nerve damage.

Once the effects of the drug have worn off, users might experience **severe abdominal pain.** It can also cause thickening of the bladder and urinary tract, and this can force some long-term addicts to have their bladders removed as the walls are too thick and prevent urine from passing through.

Other issues include **kidney problems, which are caused by the drug's interaction (//www.drugabuse.com/library/effect-of-drugs-on-the-kidneys/)** with the kidneys as it is reduced into its metabolites.

Amphetamines should never be mixed with ketamine because they can cause very high blood pressure.

Ketamine Dependence



Although the high is extremely pleasant, **(//www.drugabuse.com/library/tolerance-dependence-addiction/) it can lead to serious dependence (//www.drugabuse.com/library/tolerance-dependence-addiction/)**. While you can build up a high tolerance to the drug without experiencing withdrawal, if your life is revolving around using, you need to seek help. Detox doesn't have to result in withdrawal symptoms.

If you find that you're in trouble with the law as a result of using ketamine and don't want to give it up, you may well have an addiction. You might find it's causing you severe financial difficulties, or you might realize it has resulted in you spending more money than you can afford on it.

You may also have experienced severe side effects, such as broken bones on it, but still be taking the drug. Alternatively, you might be committing illegal or morally questionable acts because of it. However, it manifests itself, if you have an addiction to ketamine, you need to seek help.

Ketamine Withdrawal Treatment

Ketamine withdrawal treatment aims to help you get off the drug and stay off it. First, you'll likely undergo withdrawal. Some of the literature in the addiction treatment sphere mentions cases of reported anxiety and/or depression following cessation of ketamine use. But, for many **ketamine abusers, withdrawal isn't a major issue (//www.drugabuse.com/library/how-to-help-a-ketamine-addict/)** as ketamine doesn't produce a clinically significant withdrawal syndrome.

This minimizes the need for close medical supervision throughout a period of withdrawal – allowing those in recovery to move forward and focus on the second stage of their **treatment (//www.drugabuse.com/library/drug-abuse-treatment/)**.

Counseling and psychotherapy (//www.drugabuse.com/library/addiction-treatment-therapies-an-overview/) help you to realize how and why you're abusing ketamine. Whether you have depression or find it hard to de-stress, psychotherapy can help you address the central **underlying reasons you take it.**

(http://www.drugabuse.gov/publications/drugfacts/understanding-drug-abuse-addiction) Counseling can help you resist the lure of the high, and it can give you the skills to find healthy ways to relax and enjoy yourself without turning to drug use. CBT (cognitive behavioral therapy) is particularly valuable for this.

The final stage is, of course, sustained **recovery, and this is often the hardest stage. (//www.drugabuse.com/library/drug-abuse-recovery/)** This is often the stage where relapse (going back to using the drug) happens, but with support and the skills learned in treatment, you can reduce the risk of this happening.

Related Posts:

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Why is Meth So Addictiv (https://drugabuse.com/addiction/)

Curing Alcoholism: We'r Finally Putting MDMA t (https://drugabuse.com/alcoholism-were-finally-putting-mdma-to-the-te

Let's Talk About the Dar Side of Suboxone (https://drugabuse.com/talk-about-the-dark-sid suboxone/)

Ice Bugs: Don't Scratch T Phantom Itch! (https://drugabuse.com/bugs-dont-scratch-that-phantom-itch/)

The Addiction Recovery in 9 Steps (https://drugabuse.com/recovery-process/)

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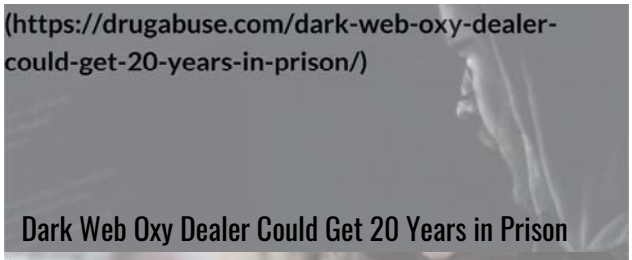

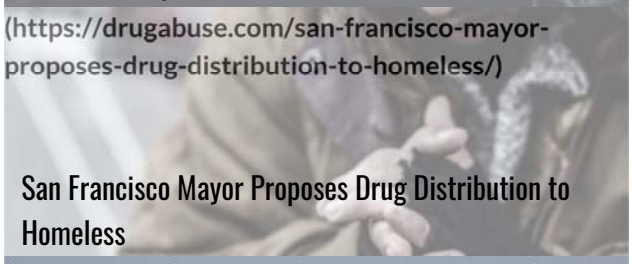

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HEALTH

Doctors Have Found a Big Problem With Using Ketamine to Treat Depression

It's doing something we never knew to your brain.

DAVID NIELD 30 AUG 2018

While ketamine has been doing wonders as an antidepressant, researchers have discovered something concerning about the way it may actually be working on patients' brains.

New research has linked the drug's effects to the brain's opioid system – meaning it potentially acts as an opioid like morphine or oxycodone, but in a different form.

The latest study confirms ketamine's effectiveness in treating depression, but the researchers say the drug's use as an antidepressant might have to be limited, because the biological triggers it pulls could cause problems further down the line.

Specifically, opioid addiction, a reliance upon painkillers that has already reached crisis levels in the US. Ketamine was

previous thought to act solely on the glutamate system in the brain, but this new study tells a different story.

"Before we did the study, I wasn't sure that ketamine really worked to treat depression," says one of the researchers, Alan Schatzberg from the Stanford University School of Medicine in California.

"Now I know the drug works, but it doesn't work like everyone thought it was working."

The FDA (Food and Drug Administration) hasn't approved ketamine for the treatment of depression, but some doctors have been prescribing it as a fast, short-term fix, even though its effects on depression in the brain weren't fully understood. And what we just learned is big.

In a small-scale experiment, 12 volunteers who had previously struggled to find effective treatments for their depression were twice given a dose of ketamine, with a two-week gap – once after being given the either the opioid blocker naltrexone, and once after being given a placebo.

Results showed the symptoms of depression vastly improved in the placebo test, but not the naltrexone test. That suggests ketamine is working on the brain's opioid receptors.

"We would hate to treat the depression and suicide epidemics by overusing ketamine, which might perhaps unintentionally grow the third head of opioid dependence," says neuroscientist Mark George from the Medical University of South Carolina, who wrote an accompanying editorial on the new research.

The researchers suggest that ketamine could still be useful as an antidepressant – it is remarkably effective, after all – but that it should be used carefully.

"I think it's a very interesting paper," Yale University psychiatrist Gerard Sanacora, who wasn't involved in the study, told *Wired*. "It does highlight that there are probably many factors that influence how ketamine is producing its antidepressant-like effect."

The link could also help scientists better understand the connection between depression and pain – depression and opiate use often go hand-in-hand, and understanding that relationship is going to be important in breaking the cycle. With the opioid epidemic accounting for around 49,000 deaths last year in the US alone, time is of the essence.

There are limitations to the study, including the small number of people involved. The research doesn't necessarily prove that ketamine is working through the opioid system, either – it might be that the drug just requires these brain receptors to be operational.

It's also possible that ketamine is just releasing endorphins in the brain, much like an opioid would, rather than acting on the opioid receptors directly. Further research is needed to figure out what's going on, but for now scientists are recommending caution.

"With these new findings, we should be cautious about widespread and repeated use of ketamine before further mechanistic testing has been performed to determine whether ketamine is merely another opioid in a novel form," says George.

The research has been published in the *American Journal of Psychiatry*.

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Ketamine

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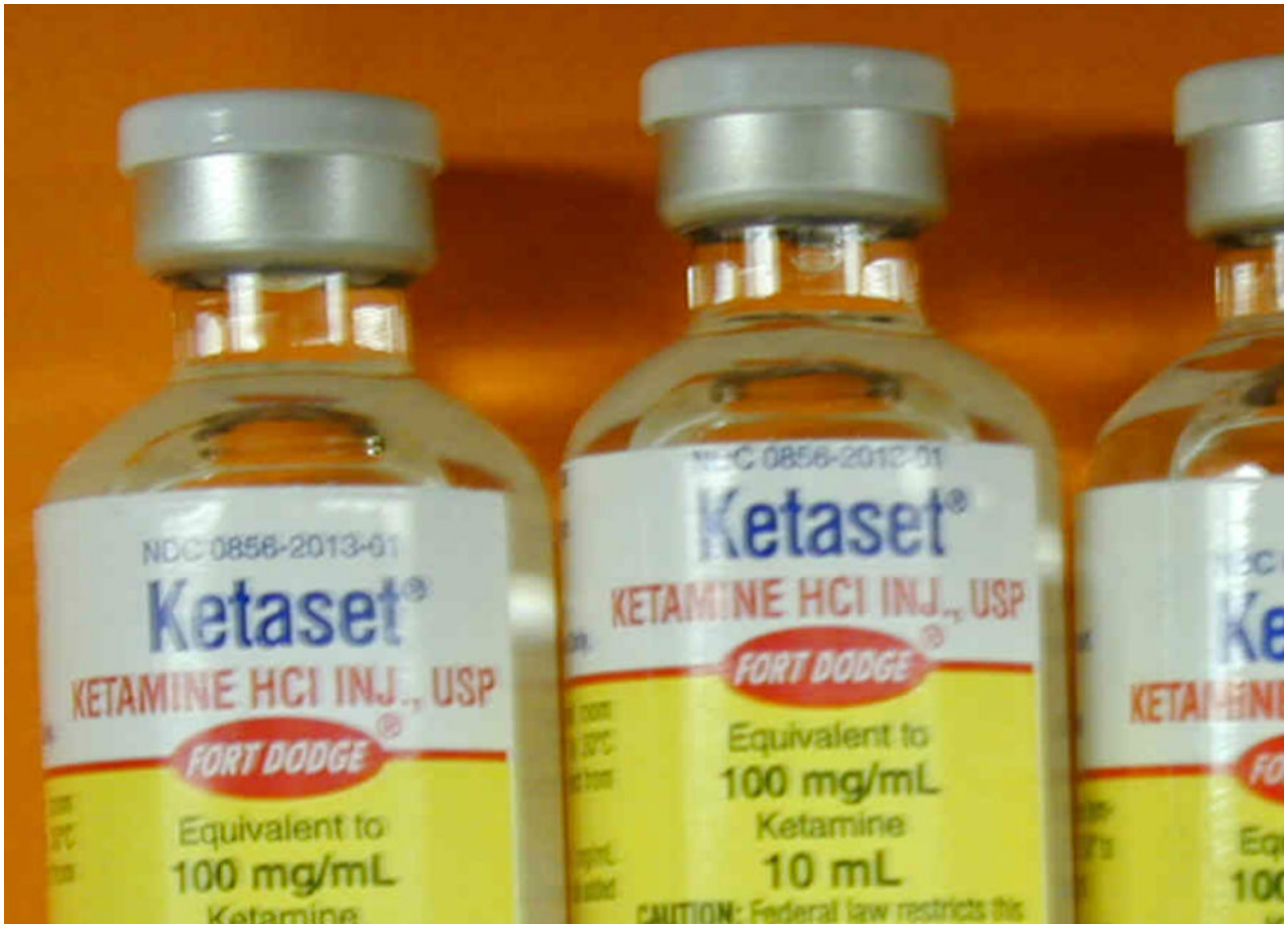

Know the facts about ketamine and ***connect with help and support (/landing-page/get-help-support/)*** *to keep your child safe.*

What is ketamine?

Ketamine is a dissociative anesthetic used in human anesthesia and veterinary medicine. Dissociative drugs are hallucinogens that cause a person to feel detached from reality. Much of the ketamine sold on the street has been diverted from veterinarians' offices. Ketamine's chemical structure and mechanism of action are similar to those of PCP.

What are some slang terms?

Cat Tranquilizer, Cat Valium, Jet K, Kit Kat, Purple, Special K, Special La Coke, Super Acid, Super K, and Vitamin K

What does ketaine look like?

Although it is manufactured as an injectable liquid, in illicit use ketamine is generally evaporated to form a powder.

How is ketamine used?

Ketamine is snorted or swallowed. It is odorless and tasteless, so it can be added to beverages without being detected, and it induces amnesia. Because it has been used to commit sexual assaults due to its ability to sedate and

SIGNS OF KETAMINE USE:

Impaired attention, learning ability, and memory

Delirium

Amnesia

Impaired motor function

High blood pressure

Depression

RECOMMENDED READING:

Is it "Just Experimenting?" (/article/why-just-experimenting-is-a-concern/)

Prepare to Take Action if You Suspect Teen Drug Use (/article/prepare-to-take-action/)

RELATED DRUGS:

incapacitate unsuspecting victims, ketamine is also considered to be a "date rape" drug.

GHB (/drug/ghb/)

Rohypnol (/drug/rohypnol/)

What do young people hear about ketamine?
Ketamine can cause dream-like states and hallucinations. People who use the drug report sensations ranging from a pleasant feeling of floating to being separated from their bodies.

What are the risks of using ketamine?
Some ketamine experiences involve a terrifying feeling of almost complete sensory detachment that is likened to a near-death experience. These experiences, similar to a "bad trip" on LSD, are called the "K-hole." Low-dose intoxication from ketamine results in impaired attention, learning ability, and memory. In high doses, ketamine can cause delirium, amnesia, impaired motor function, high blood pressure, depression, and potentially fatal respiratory problems.

Flashbacks have been reported several weeks after ketamine is used. Prolonged use may also cause agitation, depression, cognitive difficulties, unconsciousness, and amnesia.

SOURCE: NATIONAL INSTITUTE ON DRUG ABUSE (NIDA) (HTTPS://WWW.DRUGABUSE.GOV/DRUGS-ABUSE/COMMONLY-ABUSED-DRUGS-CHARTS#KETAMINE); DRUG ENFORCEMENT AGENCY (DEA) (HTTPS://WWW.DEA.GOV/FACTSHEETS/KETAMINE)REVIEWED & UPDATED: AUGUST 27, 2018

Related Drugs

GHB (https://drugfree.org/drug/ghb/)

Rohypnol (https://drugfree.org/drug/rohypnol/)

Next Steps

Look for Warning Signs (https://drugfree.org/article/look-for-warning-signs/)

Do you think your child may be using drugs? If so, have you noticed any of these changes or warning signs?

Prepare to Take Action if You Suspect Teen or Young Adult Drug Use (https://drugfree.org/article/prepare-to-take-action/)

Is your child using drugs? Use these tips to prepare for the conversation ahead, and lay the foundation for more positive outcomes.

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Spot Early Use (https://drugfree.org/article/look-for-warning-signs/)
Intervene (https://drugfree.org/article/how-to-prepare-to-take-action/)
Find Treatment (https://drugfree.org/article/navigating-the-treatment-system/)
Support Recovery (https://drugfree.org/article/after-drug-treatment/)

More Resources
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Parent Drug Guide (https://drugfree.org/drug-guide/)
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Thanks to SAG-AFTRA and its members for their ongoing generosity and support of the organization and our cause.

Agenda Item

4

Title 12 . Professional and Vocational Regulations

Chapter 52 . Big Game Guides and Transporters

Section 240. Pharmacist collaborative practice authority

12 AAC 52.240. Pharmacist collaborative practice authority

(a) A pharmacist planning to exercise collaborative practice authority in the pharmacist's practice by initiating or modifying drug therapy in accordance with a written protocol established and approved for the pharmacist's practice by a practitioner authorized to prescribe drugs under AS 08 must submit the completed written protocol to the board and be approved by the board before implementation.

(b) A written protocol must include

(1) an agreement in which practitioners authorized to prescribe legend drugs in this state authorize pharmacists licensed in this state to administer or dispense in accordance with that written protocol;

(2) a statement identifying the practitioners authorized to prescribe and the pharmacists who are party to the agreement;

(3) the time period during which the written protocol will be in effect, not to exceed two years;

(4) the types of collaborative authority decisions that the pharmacists are authorized to make, including

(A) types of diseases, drugs, or drug categories involved and the type of collaborative authority authorized in each case; and

(B) procedures, decision criteria, or plans the pharmacists are to follow when making therapeutic decisions, particularly when modification or initiation of drug therapy is involved;

(5) activities the pharmacists are to follow in the course of exercising collaborative authority, including documentation of decisions made, and a plan for communication and feedback to the authorizing practitioners concerning specific decisions made;

(6) a list of the specific types of patients eligible to receive services under the written protocol;

(7) a plan for the authorizing practitioners to review the decisions made by the pharmacists at least once every three months; and

(8) a plan for providing the authorizing practitioners with each patient record created under the written protocol.

(c) To enter into a written protocol under this section, practitioners authorized to prescribe must be in active practice, and the authority granted must be within the scope of the practitioners' practice.

(d) Unless the board is satisfied that the pharmacist has been adequately trained in the procedures outlined in the written protocol, the board will specify and require completion of additional training that covers those procedures before issuing approval of the protocol.

(e) Documentation related to the written protocol must be maintained for at least two years.

(f) The written protocol may be terminated upon written notice by the authorizing practitioners or pharmacists. The pharmacists shall notify the board in writing within 30 days after a written protocol is terminated.

(g) Any modification to the written protocol must be approved by the board as required by this section for a new written protocol.

(h) This section does not apply to participation, by a pharmacist practicing in an institutional facility in drug therapy protocols and guidelines approved by the institutional facility's pharmacy and therapeutics committee or by another medical staff governing body of that institutional facility, if records related to the drug therapy protocols and guidelines are maintained and made available to the board upon request.

History: Eff. 11/10/2001, Register 160; am 2/11/2004, Register 169

Authority: AS 08.80.030

AS 08.80.480

Note to HTML Version:

The Alaska Administrative Code was automatically converted to HTML from a plain text format. Every effort has been made to ensure its accuracy, but neither Touch N' Go Systems nor the Law Offices of James B. Gottstein can be held responsible for any possible errors. This version of the Alaska Administrative Code is current through June, 2006.

If it is critical that the precise terms of the Alaska Administrative Code be known, it is recommended that more formal sources be consulted. Recent editions of the Alaska Administrative Journal may be obtained from the Alaska Lieutenant Governor's Office on the world wide web. If any errors are

found, please e-mail Touch N' Go systems at E-mail. We hope you find this information useful.

Last modified 7/05/2006

Agenda Item

6

October 7, 2018

To: The ABON,

Gail Berth, MSN, APRN, Executive Administrator Alaska Board of Nursing (ABON), and I met with Robert Onders MD, President, Hilton Hallock, PhD, Jessica Downes, DNP, RN, Katie Baraki RN, Laura Hudson, and one more whose name eludes me at this time, the leadership team of Alaska Pacific University (APU).

After introductions were made, I disclosed that in addition to being the educational board member of the ABON, I am also an Assistant Professor of Nursing employed by University of Alaska, Anchorage, Ketchikan Campus and currently the Associate of Applied Science (AAS) RN Program Chair.

Upon review of the APU curriculum, the studies include working effectively within the healthcare team, administering medications to various patient groups, analyzing multiple data types when making client-related decisions, delegating tasks to others, and understanding the pathophysiology underlying a client's conditions. The curriculum will appeal to current APU students by allowing a smooth application process into the program. I feel this program will adequately use information technology and evidence-based practice, integrate pharmacology, pathophysiology and critical thinking throughout the curriculum, teaching content related to the care of client populations as independent courses, and have faculty teaching both didactic and clinical components of the curriculum. Students will have access and share a simulation lab with Alaska Native Medical (ANMC) Center employees. Clinical placement has been secured at ANMC.

I have reviewed the resumes of current faculty and application to the ABON. I believe their application meets the ABON requirements and ask my fellow board members to review the submitted information and recommend the establishment of the Associate Degree in Nursing Program at APU.

Sincerely,

Joe Lefleur, MSN Ed, RN

Alaska Board of Nursing Education Member

ORGANIZATION AND ADMINISTRATION OF THE CONTROLLING INSTITUTION

1.The controlling institution is accredited by:

Regional Agency
Northwest Commission on Colleges and Universities
Spring 2022

State Agency
Alaska Commission on Postsecondary Education
Spring 2021

Note:12 AAC 44.060(a) A nursing education program must be an integral part of an accredited institution authorized by the state to confer credentials in nursing.

2. The institution offers a program in nursing leading to (check all that apply):

Certificate of vocational/practical nursing (graduates to sit for NCLEX-PN)
Associate degree in nursing (graduates to sit for NCLEX-RN)
Baccalaureate degree in nursing for non-RN students (graduates to sit for NCLEX-RN)
X Baccalaureate degree in nursing for already licensed RN students (no NCLEX exam required of graduates to practice professionally).
Master's degree in nursing as the first professional degree (graduates to sit for NCLEX-RN)
Master's degree in nursing as the second professional degree (no NCLEX exam required of graduates to practice professionally)

3.State the title used to designate the program(s) in nursing being surveyed.

Associate Degree in Nursing (ADN)

4.By what authority within the institution is (are) the educational program(s) in nursing offered? (e.g., Board of Regents, Board of Directors, etc.)

Board of Trustees

BSN: October 12, 2017
ADN: October 11, 2018 (pending)

5. Name of Chief Administrative Officer of the controlling institution:

Robert Onders, MD, JD, MPA is the president of Alaska Pacific University. Reporting to the Board of Trustees, the president is the chief administrative officer of the institution.

6. To whom in the controlling institution does the Director of Nursing Education Program report?

The Director of Nursing Programs reports to the Director of the Institute of Health and Wellness. All academic units, including the Institute for Health and Wellness, report to the Provost (chief academic, student affairs, and enrollment officer), who reports directly to the President of APU.

7. Does the nursing program have a separate budget which was administered during the last calendar or fiscal year?

No—The nursing program will have a program budget in FY19. The program director, in collaboration with the Institute Director, will develop and administer that budget.

Who prepared that budget? The projected budget was prepared by the director of the Institute for Health and Wellness, the former Academic Dean, and the CFO.
Who approved that budget? The Board of Trustees
Who administered that budget? N/A

Note:12 AAC 44.060(e) The administrator of a nursing education program is responsible for: (2) preparation and administration of the budget.

8. How is the nursing program funded? Indicate source of funds and percentage of the total budget that each source contributes.

The nursing program is funded 100% by tuition and program fees.

9.Who appoints the nursing program faculty?

All faculty are appointed by the Provost, upon the recommendation of relevant program and APU institute directors.

Note:12 AAC 44.060(e) The administrator of a nursing education program is responsible for: (3) recommendation for appointment, promotion, tenure, and retention of faculty.

10. Are the faculty of the nursing education program governed by the same personnel policies as other employees of the institution?

X Yes No
If no, describe how policies for nursing faculty differ from those that are applicable to other employees of the controlling institution and explain why the policies differ.

11. If the controlling institution is a college or university or if the controlling institution offers other educational programs, are the students in the nursing education program subject to the same policies as students enrolled in other educational programs offered by the institution?

X Yes No
If no, describe how policies for nursing students differ from those that are applicable to other students of the controlling institution and explain why the policies differ.

The Nursing students are subject to the same policies as other students; they may have additional requirements and responsibilities related to clinical placements.

Note:With regard to 10 and 11, 12 AAC 44.060(a) A nursing education program must be an integral part of an accredited institution authorized by the state to confer credentials in nursing.

12.Describe the role of the Director of the Nursing Education Program with regards to:

a. curriculum development and implementation: Working with the program faculty and advisory committee, the Director of Nursing coordinates the ongoing development, implementation, and assessment of nursing curricula. This includes course scheduling and hiring of instructors. The Director of Nursing ensures that the curriculum meets or exceeds standards of best practice, including requirements for accreditation through the Accreditation Commission for Education in Nursing.

b. budget: The Director of Nursing Education will be responsible for developing, administering, and monitoring the program area's budget.

c. faculty appointments: The Director of Nursing will coordinate searches for all full-time and adjunct/clinical faculty for the program. She will collaborate with the Institute Director to make appointment and rank recommendations to the Provost.

d. communication with the Board of Nursing: The Director of Nursing is the main point of contact for the Board of Nursing.

Note:12 AAC 44.060 specifically requires that the administrator of the nursing education program have responsibility for items 12 a through d.

ORGANIZATION AND ADMINISTRATION OF THE NURSING EDUCATION PROGRAM

1. State the name of the Director of the Nursing Education Program.

Jessica Downes, DNP, MSN, RN

2. Describe the qualification of the Director of the Nursing Education Program as listed in the position description.

The qualifications for the position were described in the position description and job posting as follows: “To meet accreditation standards, candidates should have a graduate degree with a major in nursing and a doctorate in nursing, leadership, curriculum and instruction, or related field. Candidates should be able to demonstrate expertise in a core competency area related to nurse education. Successful candidates include those with proficiency in nurse supervision, leadership, curriculum and program development, teaching and mentoring, or those with extensive professional experience and clinical practice. Candidates who can demonstrate expertise in both teaching and professional skills are preferred.” Additionally, candidates were expected to have or attain licensure as a registered nurse in Alaska.

3. Describe the credentials of the individual currently in the position of Director of the Nursing Education Program; if there is a discrepancy between the qualifications as stated in the position description and the credentials of the individual currently holding that position provide a justification for the discrepancy.

Dr. Downes earned an AS in Nursing, a BS in Nursing (cum laude), an MS in Nursing (with distinction), and a doctorate in Nursing Practice with a concentration in Healthcare Systems Leadership. She is a registered nurse in Alaska (license #NURR29030). Prior to joining APU, she served as nurse, nurse/healthcare administrator, and clinical services supervisor. She has professional experience in both the public health system in Anchorage and the Tribal health system in Alaska, including serving as the Director of Nursing at Samuel Simmonds Memorial Hospital in Utqiaġvik, Alaska. She has published on nursing pedagogy in the *Journal of Continuing Education in Nursing* and will teach in core competency areas related to nursing leadership, evidence-based practice, community health, and culturally safe nursing fundamentals.

Note:12 AAC 44.060(d) A nursing education program must be administered by a registered nurse who is currently licensed in Alaska and who has at least a master's degree in nursing and preparation or experience in administration, education, and clinical nursing practice.

4. Describe the structure and organization of the Nursing Education Program including:

a. Channels of communication between Program Director and program faculty
The core (fulltime) nursing faculty meet formally on a bi-monthly basis to discuss curriculum, clinical placements, and other matters requiring attention. During these meetings, program faculty share reports from university-wide and other committees on which they serve. All nursing faculty meet together at least once a semester to plan, coordinate and assess program activities. There is an email distribution list for program faculty as well as a system of shared electronic files which enables faculty to collaborate on curriculum and program development, assessment and accreditation, and scholarship.

b. Committee structure within the Nursing Education Program.
As a relatively small program, there are few standing committees. Most program work is conducted collaboratively by the fulltime faculty. There is a standing Admissions and Advancement Committee, with representation from nursing faculty and Student Enrollment Services.

5. Describe the personnel policies that affect program faculty including:

a. Comparability of salaries for nursing faculty with faculty (or staff) with similar responsibilities and/or qualifications (if faculty are awarded rank, describe the basis for appointment to particular ranks - and associated salary) is determined.
The criteria for faculty rank are outlined in the Faculty Handbook. Categories of criteria include:

- Level of educational credential
- Years of teaching
- Potential for or evidence of effectiveness in teaching and advising
- Potential for or evidence of scholarly, creative, or professional activities
- Evidence of community service

Commented [ST1]: Bulleted list instead of semi-colon paragraph.

The Provost determines the rank assigned for the initial contract period of appointment, in consultation with the relevant search committee and program and institute directors. The determination is referred to the Faculty Review Committee for concurrence.

Ranked faculty are compensated according to their academic background, professional experience and development, level of scholarly activity, and service to the University and community. The Provost, in consultation with the President, determines individual faculty salaries based upon the current salary range established for each level of faculty rank. Salary ranges are established individually for the four academic ranks of instructor, assistant professor, associate professor, and professor, and are currently consistent across disciplines. The university will begin a faculty compensation benchmarking study in Fall 2018 to ensure salaries are aligned with market demand and additional credentials required for accreditation, etc. We intend to incorporate regional and discipline-specific (e.g., American Organization of Nurse Executives) benchmarks in the study.

Non-ranked faculty (e.g., adjunct, clinical) are compensated based on their teaching or supervision load, the nature of the course, and academic/professional credentials. Adjunct faculty in nursing will be compensated based on similar criteria.

b. Comparability of benefits (including educational leave and reimbursement) for nursing faculty with faculty and/or staff with similar qualifications and/or responsibilities.
The university offers a comprehensive benefit package for regular faculty (Section IV of the Faculty Handbook). Part-time regular faculty benefit coverage (e.g., insurance) may be pro-rated. Full-time faculty on 12-month contracts are eligible for paid time off. Nursing faculty receive the same benefits as other faculty with similar appointments.

c. Comparability of opportunities for promotion and/or salary increases with faculty/staff with similar qualification and responsibilities.
Promotion of full-time faculty in the nursing program is governed by the policies outlined in the Faculty Handbook, and therefore, the opportunities are comparable to faculty in other areas. There are no quotas for rank within the program or university. Salaries are adjusted with promotion in rank, and they may be adjusted periodically as a result of cost-of-living increases for all employees or compensation benchmarking for faculty which considers market demand and additional credentials required for accreditation, etc.

d. Comparability of responsibilities (teaching load, expected hours of work, etc.) with faculty/staff with similar qualifications and/or responsibilities.
All full-time, regular ranked faculty have the same general responsibilities related to teaching, scholarship and service, as described in the Faculty Handbook. The typical teaching load associated with a 9-month appointment is 12 credit hours per semester; however, faculty may receive 10-12 month appointments with the load adjusted accordingly, and the Institute Director, in consultation with the Provost, may also grant course/load release for administrative leadership positions, course or program development, accreditation self-studies, or other special assignments. Because the Nursing programs require considerable program development activity and preparation for program approval and accreditation proposals in 2018 and 2019, two nursing faculty members have 12-month appointments with load release for administration, accreditation, and curriculum development and one has a 9-month appointment with a summer stipend for related clinical program development.

6. Describe the personnel policies that affect program staff including:

a. Comparability of salaries for nursing staff with staff who have similar responsibilities and/or qualifications.
The salary of the administrative staff member supporting the Nursing Program is in the same range as other staff with the same position classification (Office Specialist).

b. Comparability of benefits (including educational leave and reimbursement) for program staff with non-Program staff who have similar qualifications and/or responsibilities.
The university's benefit package is the same for all full-time staff.

c. Comparability of opportunities for promotion and/or salary increases with non-program staff who have similar qualifications and responsibilities.
Such opportunities are comparable. Salary increases are implemented university-wide based on comprehensive compensation benchmarking and/or cost-of-living adjustments.

d. Comparability of responsibilities of program staff with the responsibilities of non-program staff who have similar qualifications and/or responsibilities.
The administrative support staff person has general responsibilities comparable to other office specialists in academic units. These responsibilities include scheduling, coordinating purchasing, and developing program communication materials. See section on clerical support for more details about the job description.

INSTRUCTIONAL STAFF OF THE NURSING EDUCATION PROGRAM

1. Describe the credentials for appointment to the faculty - as specified in the faculty position descriptions.

- Nursing Director: Unencumbered RN License in State of Alaska; MS in Nursing; Doctorate; and relevance of experience in area of instruction.
- Nursing Faculty: Unencumbered RN License in State of Alaska; minimum of MS in Nursing; and relevance of experience in area of instruction.
- Adjunct/Clinical Nursing Faculty: Unencumbered RN License in State of Alaska; minimum of BS in Nursing; and relevance of experience in area of instruction.

2. Compare the credentials of the program faculty to those described in the faculty position descriptions; if there is a discrepancy between the qualifications as stated in the position description and the credentials of the individual currently holding that position provide a justification for the discrepancy.

All current faculty hold credentials consistent with the job description. Faculty teaching in the program have at least a Master's degree in Nursing or a closely related field as well as demonstrated expertise in a core competency area related to Nursing Education, unencumbered Registered Nurse licenses in the State of Alaska, and relevant professional nursing experience in area of instruction.

Note:12 AAC 44.090(c) states that faculty who teach in a program offering the practical nurse certificate shall be currently licensed as a registered nurse in Alaska, have a minimum of a baccalaureate degree in nursing, and have one year of clinical nursing experience relevant to areas of responsibility. Section (d) states that faculty who teach in a program offering the associate or baccalaureate degree shall be currently licensed as a registered nurse in Alaska, have a minimum of a masters degree in nursing, and have one year of clinical experience relevant to areas of responsibility. Section (e) states that adjunct nursing faculty may be used for nursing courses and shall be licensed as a registered nurse in Alaska, have a minimum of a baccalaureate degree in nursing, have one year of clinical nursing experience relevant to areas of responsibility, and be supervised by qualified nursing faculty.

3. Describe the methods used to recruit qualified faculty to the program.

Faculty openings are posted on APU's website and various other outlets based on discipline (e.g., Chronicle of Higher Education, Montana Nurses Association, Indian Health Services). APU faculty openings are also posted on Alaska Native Hire (AKNativeHire.com) and links to openings with partner organizations such as ANTHC and Alaska Department of Labor. We also network through professional academic and nursing associations and social media. Our strategic partnership with ANTHC provides a wealth of opportunities for recruiting qualified clinical supervisors and other faculty.

4. Describe the effectiveness of faculty recruitment efforts; if applicable, describe planned changes in faculty recruitment processes.

We are pleased that our early recruitment efforts have yielded a cohort of faculty with complementary areas of expertise and exceptional professional experience.

5. Describe the processes used to orient new faculty to the nursing education program and, if applicable, to the community in which the nursing education program is located.

New faculty meet with the Provost and faculty leaders early in the academic year for an orientation to the university. Following that, individual faculty are mentored by program and/or Institute Directors. APU's faculty review process also involves mentoring; individual faculty select a peer guide of their choice each academic year to promote professional development. Nursing Faculty will have annual retreats focused on program and professional development.

6. Describe administrative positions held by faculty other than the Program Director.

Not applicable.

7. Describe the usual instructional responsibilities of program faculty who do not have administrative assignments (including credits and weekly contact hours taught).

Full-time program faculty without administrative assignments serve either 9- or 12-month appointments. Nine-month contracts included a teaching load of 24 credits. Twelve-month contracts include 36 credits of teaching load. In either case, faculty average 15-20 hours of teaching each week. In the 2018-2019 academic year, because of the amount of work necessary for program development and accreditation, current full-time nursing faculty have either 12-month or 9-month contracts with summer stipend.

8. Describe the usual instructional responsibilities of program faculty who have administrative assignments (including credits and weekly contact hours taught).

Administrative appointments in the Nursing Program are accompanied by credit/course releases. The Program Director receives a 16-credit release per 12-month contract to cover program director responsibilities and accreditation.

9. Describe non-instructional responsibilities of administrative and non-administrative faculty (including advising and counseling students, community service, institutional service, scholarly activities, etc. as applicable).

Nursing faculty hold advising and institutional service duties. Faculty are involved in recruitment and pre-admission advising, and advisees are formally assigned to faculty advisors after the students' first semester of schooling (first-year and transfer students receive academic advising from full-time staff during their first year at APU).

Institutional service includes a load of two faculty or university-wide committee assignments each year.

Scholarly activities vary by field and are dependent upon individual faculty. Nursing program faculty may serve as a preceptor for graduate students at other programs, actively pursue a research program, or coordinate significant community engagement activities.

10. Describe the student-to-faculty ratios used by the nursing education program:

a. Classroom instruction: 16:1

b. Clinical instruction: 8:1
c. Laboratory instruction held outside of the clinical setting: 16:1

Note:12 AAC 44.090(a) state that there must be a sufficient number of qualified faculty to meet the purposes and objectives of the nursing education program; section (b) states that, unless waived by the Board, the minimum ratio of faculty to students in clinical areas involving direct care of patients or clients is one faculty member to ten students.

11. Describe the provisions for providing faculty coverage of instruction in case of faculty illness, emergency leave or educational leave.

Coverage for unplanned leave will be coordinated by program director and approved by the Institute Director and Provost. The program maintains a list of qualified adjunct faculty with a variety of expertise; prior to the beginning of semester the list will be reviewed for backup coverage.

Note: A list of current faculty should be attached to the pre-survey report; that list must include a statement of current instructional assignment and a description of the educational and/or experiential background of the faculty member that makes their assignment appropriate. In addition, a current curriculum vitae (resume) of each active faculty member should be available for review by the site visitors at the time of the visit. A suggested form for curriculum vitae is attached; programs are not required to use the suggested form but all elements on the form must be present in the vitae reviewed by site visitors.

12.Describe the usual responsibilities of faculty members (including both instructional and non-instructional expectations).

The contract carries a 12-month teaching load of 32 credit hours per year (typically four three-credit courses per semester with release time for administrative work). Course assignments are based upon expertise and needs of the degree program. Responsibilities include mentorship for students. All faculty are encouraged to develop scholarship or creative work in their chosen field, and faculty are expected to participate in outcomes assessment, curriculum development, student activities, as well as other service to the university and broader community.

13.Specifically describe the minimum and maximum expectations of an individual faculty member in the following activities (expressed in average hours per week).

The distribution of workload will vary over the next few years, as new cohorts of students are added and clinical instruction is integrated into the curriculum. Current estimates are:
a.Classroom Instruction:
15-20 hours
b.Clinical supervision of students:
TBD--Varies by faculty member/course assignment
c.Student advising:
2-4 hours
d.Committee meeting participation:
3-5 hours
e.Other university related activities: (recruitment, faculty assembly, etc.)
2-4
f.Community service activities:
2-4
g.Other activities: (accreditation, partnership development; scholarship)
10-15

14. Have minimum and maximum expectations for committee assignments been established? If yes, describe them:

In addition to program committees (e.g., admission, search), APU faculty serve on two faculty or university wide committees each year. The Nursing Director will represent the program on the Undergraduate Studies Committee.

15. Provide the names and credentials of non-nursing faculty who teach the specified non-nursing courses that nursing students are required to complete.

Anatomy and Physiology: Professor Bob Onders (MD, Northeastern Ohio Universities College of Medicine)
Behavioral Science: Associate Professor Stephanie Morgan (PhD, Psychology, Saybrook University)
Biology: Assistant Professor Nathan Wolf (MSc, Epidemiology, London School of Hygiene and Tropical Medicine; PhD, Biology/Comparative Physiology, University of Wyoming)
Chemistry: Assistant Professor Dee Barker (PhD, Chemistry, University of South Florida, subfields of Chemical Education and Biophysical Chemistry)
Mathematics: Assistant Professor Pam Maslyk (MS, Mathematical Sciences, University of Alaska Fairbanks)
Writing: Assistant Professor David Onofrychuk, (MFA, University of Alaska, Anchorage)

Note: 12 AAC 44.130(e) specifies that support courses must be taught by academic faculty prepared in those disciplines.

STUDENTS OF THE NURSING EDUCATION PROGRAM

1. How are students provided with access to the following?

a. Philosophy of the nursing education program:
Found in the course catalog through the APU website and in the APU Nursing Student Handbook.

b. Course descriptions within the nursing program:
Found in the course catalog through the APU website and in the APU Nursing Student Handbook.

c. Curriculum Plan (course sequencing)
Found in the course catalog through the APU website and in the APU Nursing Student Handbook; program plans also available from Nursing Faculty, admissions staff, and professional advising staff in the Student Success Center.

d. College facilities and services:
Found in the course catalog through the APU website and in the APU Nursing Student Handbook

e. Policies and procedures of the college/institution:
Reviewed at orientation and found in the course catalog through the APU website, in the APU Nursing Student Handbook, and in consultation with the professional advising staff in the Student Success Center.

f. Policies and procedures of the nursing education program:
Reviewed in program orientation, found in in the APU Nursing Student Handbook, and available from program faculty and professional advising staff in the Student Success Center.

2. What methods are used to recruit students to the nursing education program?

In general, APU students are recruited through a comprehensive strategic enrollment management plan that includes:

- National, regional, and local events such as recruitment fairs and open houses
- Print, radio, and social media marketing
- Outreach to high schools, transfer-sending colleges, consortia partner schools, and employers
- The Common Application
- Partnerships with pre-college programs
- Scholarship/financial aid assistance

There is an admissions recruiter dedicated to professional studies programs, including nursing. Recruiters actively engage with rural Alaska communities as well as communities on the road system. We have strategically recruited for Nursing through engagement with hospital HR departments, communications through ANTHC and the Tribal Health system, media ads/coverage, and collaboration with pre-health programs such as AHEC.

3. State the admission requirements:

a. To the institution:

Admission requirements for most APU programs include:

- Completed APU Admissions Application.
- Official final high school transcript or GED score report, with a cumulative high school GPA of 2.5 or higher.
- Post-secondary transcripts from all institutions attended.

Applicants who do not meet the published admission standards may request an Admissions Appeal Form from the Office of Admissions following or in anticipation of a denial of admissions. Appeals will be considered first by the Director of Admissions and may be forwarded to an academic department or committee for review. The applicant will be notified in writing once a decision has been made regarding their appeal.

b. To the nursing education program:

Admission requirements for the nursing education program include:

- Completed APU ADN Program application.
- Official final high school transcript or GED score report, with a cumulative high school GPA of 2.5 or higher.
- Post-secondary transcripts from all institutions attended.
- Completion of 8 pre-requisite courses, with a grade of “C” or better (applications will be reviewed after completion of 4 pre-requisite courses, with provisional admission awarded until all pre-requisite course are completed satisfactorily).
- Cumulative GPA of 2.5 or higher
- 3 letters of recommendation, with at least one letter from an academic or professional reference.
- Summary resume that demonstrates sustained community engagement, with preference for activities completed in Alaskan communities.
- Essay on assigned topic (topic changes per admission cycle)
- Authorization for background check upon admission to the program
- Students who are accepted into the program must complete and pass a criminal background check prior to admission to the program.

4. How are the admission requirements for nursing students similar to and different from admission requirements for students being admitted to other similar programs (if any):

Nursing students will be held to similar admission requirements of general APU undergraduate students, however, additional supplemental materials (as outlined in 3B) will be required. The admission requirements for the APU ADN program are similar to those of other state and national nursing programs.

5. If admission requirements are different for nursing students, provide a rationale for each requirement that differs from those for other students admitted to the institution.

The selective admissions process and additional supplemental materials are required for the nursing program because of the anticipated surplus of applicants to the program versus program capacity. Included in the supplemental material are criteria that address community engagement and employment in the Alaska context. This is important because the APU ADN program is designed to meet the workforce needs of nurses practicing in Alaskan communities. This is a holistic assessment process intended to promote diversity and nurse graduates who are representative of the Alaskan communities that they serve.

6. Are any changes in the admission requirements anticipated? If yes, describe the anticipated changes and the underlying rationale.

We anticipate that as these new processes are rolled out that refinements will be necessary; however, these will become more apparent as we put these new processes into practice.

7. Describe the process by which students are selected for admission to the nursing education program.

Students will initially apply online to the BS in Health Sciences program, indicating interest in the pre-nursing concentration. Students interested in continuing nursing studies after taking pre-requisite courses will apply for internal transfer into the ADN program (transfer students may be accepted on a space available basis). ADN applications will be submitted to the Admissions Office. Completed applications will be forwarded to the Nursing program admissions committee for review and decision/ranking. Because we anticipate a greater number of applicants than the program can accommodate, and we believe that the learning experience will be enriched with students from different backgrounds and experiences, all completed applications will be reviewed in the same round of decision-making so that we can construct a diverse cohort of students. Students will be selected for admission to the nursing program based on a systematic application review process and recommendations from nursing and non-nursing faculty, and Student Enrollment Services staff.

8. What number and percent of applicants are admitted each year?

Not applicable – this program is in proposal stages, so this data is not available at this time.

9. What is the basis for the final selection of students?

Final selections will be determined based on scoring on an ADN admissions scoring rubric. A blank scoring rubric will be posted for applicants online.

10. Who makes the final decision regarding the admission of individual students to the nursing education program?

Faculty members of the nursing program area in collaboration with non-nursing faculty and Student Enrollment staff will make the final decision regarding admission of individual students to the APU ADN Program.

11. What is the minimum number of students admitted per class:

10 students minimum per class.

12. What is the maximum number of students admitted per class:

For the 2019-2020 Academic year, 16 students will be admitted per class.

13. How many classes are admitted per calendar year and what is the timing of the admission (e.g., each Fall and Spring, etc.):

Currently, one cohort of students will be admitted per calendar year. Admission applications and decisions will occur in the late Spring, and a new cohort of students will be admitted each fall semester.

14. On what basis is the decision to increase or decrease enrollment made (e.g., increased student demand, community demand, changes in faculty availability, etc.)?

Increases or decreases to enrollment are based upon institutional capacity.

15.Who makes the decision to increase or decrease enrollment to the nursing education program?

The decision to increase or decrease enrollment in the nursing education program is made by the Provost in consultation with nursing program faculty.

16.Describe the process used to provide academic advising for nursing students.

Professional advisors in the Academic Success Center will provide student advising and registration for pre-nursing students. Students are assigned a nursing program faculty advisor once they are admitted into the nursing program. Nursing faculty will also be available for informal advising during the recruitment and pre-nursing periods.

17.Describe the role of the nursing faculty in student academic advising.

Nurse faculty will work closely with professional academic advisors and will consult and mentor nursing students as needed to support student success. Nursing faculty will be available to pre-nursing students for consultation, advising, socialization to the nursing role, etc. Once Nursing advisees are assigned, faculty advisors will work with those students to assist with academic and career planning and professional socialization.

18.Describe the policies regarding student health that are in effect for:

a. Admission:

Students who are accepted into the program must submit evidence of:

- Successful completion of mandatory training for compliance with Federal Health Insurance Portability and Accountability Act.
- Successful completion of mandatory training for compliance with occupational safety and health administration requirements.
- Current Basic Life Support (BLS) for Healthcare Providers certification from the American Heart Association or other approved alternate providers.
- Current physical screening with a health provider to confirm that students can safely participate in clinical activities.

- Up to date evidence of screening for tuberculosis.
- Up to date evidence of required immunizations.

b. Immunizations, HIV test, etc.:

- Current Tetanus/Diptheria/Pertussis (Tdap)
- Current Measles/Mumps/Rubella (MMR)
- Current Varicella (chicken pox)
- Current and complete Hepatitis B series
- Current seasonal influenza (must be updated yearly)
- Current screening for tuberculosis (must be updated yearly)

c. Continuing in the program:

- It is necessary to maintain current immunizations, tuberculosis screening, CPR, HIPAA and OSHA to maintain clinical placement.
- Information will be submitted to a credential & compliance management service to facilitate easier tracking and to alert students when items need to be renewed.

19. Describe the policies regarding:

a. Class attendance/skills lab attendance:

Attendance expectations are provided in course syllabi. Of note, students must attend a minimum of 80% of required laboratory sessions as one of the components required to successfully pass laboratory courses in the nursing program.

b. Clinical attendance:

Students must attend a minimum of 80% of required clinical sessions as one of the components required to successfully pass clinical courses in the nursing program.

20. Are there policies regarding the following (if yes, please describe and justify):

a. Student employment:
Students must not work in the 8 hours prior to a clinical rotation. This is to ensure that students have the physical faculties needed to provide safe patient care.

b. Student housing:
No, APU does not have specific policies requiring student housing for students in professional programs such as nursing; however, first-year students are required to live on campus unless they qualify for an exemption (adult students, etc.). Upper class students are permitted to live on or off campus. Students electing to live in APU student housing must abide by housing and campus life policies.

c. Student health insurance:
Proof of health insurance is required for students living in the residence halls. APU students paying a wellness fee are eligible to receive free basic primary care services through the Alaska Native Medical Center Internal Medicine Clinic. Students who are injured in the clinical environment must be medically cleared before they are permitted to return. The costs of obtaining the medical clearance are the sole responsibility of the student.

d. Student malpractice insurance:

Students will be required to obtain and maintain individual malpractice insurance throughout the program.

e. Other:
Specific policies and procedures related to students are described in the APU Student Handbook which is available online through the APU website.

21. Where are student academic records stored and who has access to those records?

Student academic records are stored electronically, on a secure server. Access is managed by the Registrar's Office and is limited to those with an educational need to know (e.g., advisors) and according to FERPA compliance standards.

22. What financial aid resources are available to students enrolled in the nursing education program? Please describe the availability of financial aid specific to nursing students.

Students in the nursing program will be provided financial aid services similar to the general APU undergraduate student population. Financial assistance is available from Federal, state, and institutional sources; financial aid counselors are familiar with Federal and employer incentive and loan forgiveness programs available to nursing students.

APU will be growing our ability to support students with the development of more fully-funded institutional scholarship programs. APU provides additional institutional aid to students who are Pell-eligible, and we have developed partnerships with employers, Alaska Native corporations, and other organizations that support student educational scholarships. Specifically, APU offers a scholarship to employees of the Alaska Tribal Health System and their dependents.

23. Is there a student organization on campus? If yes, describe its relationship (if any) to the nursing education program and describe the involvement of nursing students in that organization:

Associated Students of APU (ASAPU), the student government association, is comprised of student officers and class representatives (Years 1-4, graduate years), partnership representatives, and professional student studies representatives. Nursing students are encouraged to apply for any officer or representative position for which they are eligible.

24. Is there provision for student membership on any committees within the nursing education program? If yes, list Committees, describe student role, and provide name of current student representative:

Nursing students will also have representation on the Nursing Program Advisory Committee, which includes stakeholders and focuses on program assessment, planning and processes. Nursing students are also eligible to be appointed to university-wide committees through ASAPU.

Note:12 AAC 44.130(d) specifies that the curriculum must be evaluated by the faculty with provisions for participation by students.

24. What is the cost of the nursing education program to students:

a. by term: Per credit cost is $475 FY19. Average credit load for the program is 12 credits, with an estimated $5700 per semester. Additionally, course fees apply to all courses with laboratory components.
b. by year: 2 semesters per year = $11400 FY19
c. entire program: 3-year program = $34200 FY19

25. What additional one-time costs can students anticipate (uniforms, tuition, etc.)?

Additional one-time costs students can anticipate:

- Uniform, lab coat and nursing patch: ~$60
- Nursing Student Supply Bag (provides student with supplies for skills practice, stethoscope, etc.): $350
- Nursing student malpractice insurance: ~$110/year
- Credential verification services/background check/drug-screening: ~$100

26. Compare the costs to nursing student with those to non-nursing students.

The costs for nursing versus non-nursing students per credit is the same, and textbook costs are comparable. The additional costs to nursing students are for laboratory/simulation fees, supplies and professional insurance, equipment and attire.

27. Describe the current enrollment by term.

a. Total number of students enrolled in program: N/A
b. Total number of students enrolled in clinical courses: N/A

Not applicable – this program is in proposal stages, so this data is not available at this time.

28.Describe the retention rate of students in the:

a. Preclinical nursing courses (if applicable)
Retention Rate: N/A
Major reasons for withdrawal: N/A

b. First clinical nursing course:
Retention Rate: N/A
Major reasons for withdrawal: N/A

c. Subsequent clinical courses:
Retention Rate: N/A
Major reasons for withdrawal from second or later clinical courses: N/A

Not applicable – this program is in proposal stages, so this data is not available at this time.

29. How long does it take for the average student to complete all requirements within the nursing education program? If more than the stated program length, provide an explanation for the discrepancy.

This program is in planning stages; therefore, data are not currently available. If students are able to complete their coursework according to the program of study, students will complete the nursing program in 6 semesters or 2 years 9 months.

30. Describe the minority enrollment in the nursing education program:

a. What ethnic minority groups are represented (give percentage within each class):
Not applicable – this program is in proposal stages, so this data is not available at this time.

31. Describe any special efforts to recruit males and ethnic minority students:

APU seeks to enroll diverse cohorts of students in the Nursing programs. We collaborate on referrals and programming with partner organizations such as AHEC and the CITC Health Professions Opportunity Grant program to engage pre-college students interested in health careers. Some of these programs support students from group underrepresented in healthcare occupations. Outreach to Tribal organizations, including ANTHC and the Alaska Tribal Health System, and scholarship opportunities are provided to recruit Alaska Native/American Indian students.

32. Describe the comparability of retention of minority and non-minority students:

Not applicable – this program is in proposal stages, so this data is not available at this time.

33. Describe any programs designed to facilitate the retention of minority students:

APU provides a variety of services to support retention, including free academic tutoring, counseling, and an "early alert" program to identify and address issues related to performance, attendance, registration holds, etc. in a timely manner. The Student Success Coordinator works closely with advisors, the career services coordinator, and other student affairs staff to develop a variety of programs which support retention, including time and stress management, scholarship/financial aid awareness, and career planning. Several programs are designed for minority students, including Talking Circles for Alaska Native Students and scholarship matching/support. APU also provides professional development for faculty and staff related to indigenization, cultural competency and safety, and retention which promotes the development of a campus culture more supportive of minority students.

CURRICULUM OF THE NURSING EDUCATION PROGRAM

MISSION OF THE NURSING EDUCATION PROGRAM

The mission of the APU Associate Degree Nursing program is to produce associate's prepared nurses with the cultural safety and foundational nursing skills needed to provide holistic, culturally safe care for Alaska Native Peoples and Alaskan communities. To achieve this, the APU ADN program is grounded in cultural safety; it was designed to help pre-licensure nurses develop the self-awareness, knowledge, skills, and understandings that are required to help individuals, families and groups to reach optimal health outcomes.

CONCEPTUAL FRAMEWORK OF THE NURSING EDUCATION PROGRAM

Cultural safety views culture as an individual's unique combination of influences that make them who they are: age, generation, socioeconomic status, ethnic origin, disability, world view, gender, sexual orientation, spiritual beliefs, and values (Baker, 2012). Cultural safety is an ***ethical response*** that considers the dynamic cultural dimensions where people live their lives. In contrast, typical cultural education often reduces culture down to "differences". These "differences" are established through comparing individuals to the "normal" of the

PHILOSOPHY OF THE NURSING EDUCATION PROGRAM

The APU Nursing Program acknowledges that rich personal histories, diverse knowledge backgrounds, broad life experiences, unique talents and earnest aspirations of Alaskan communities, students, alumni, staff, and faculty combine in extraordinary ways to elevate the collective towards reaching their full potential and optimal health outcomes for Alaska's people.

dominant cultural group. "Differences" are then addressed by adapting "normal responses" in ways that "accommodate" the "difference". This reductionist cultural perspective is blind to the dynamic cultural dimensions where people live their lives. Subsequently, the individual is reduced to a combination of idiosyncrasies and conditions and is responded to with "accommodations" that often diminish, demean or disempower those with "differences". (Woods, 2010). Where typical cultural education states "We are different from you, but that's OK with us – we'll figure out how to make it work.", culturally safety responds "We are not different *from* you, we are different *like* you, because we are all different. ***Help me to understand what it's like to be you and how I can be of best help***."

The scope of nursing practice is to treat the human ***response*** to illness. As the conceptual framework of this nursing program, cultural safety is the ethical response to the need for shared understandings of knowledge and health, between the nurse and those needing nursing care. The intent is to learn what is needed to be of best help to individuals, families and groups, in Alaska's community, healthcare, and academic settings. It is the foundation of the academic program, and its principles are embedded within every course, objective and clinical experience with the expressed purpose of making it the stabilizing core of individual and collective nursing practice.

GOALS OF THE NURSING EDUCATION PROGRAM

The goals of the **APU Associate Degree Nursing Program** are to produce graduates who:

1. Integrate knowledge from the humanities, natural sciences, behavioral sciences, and other ways of knowing into a culturally safe nursing practice. This nursing practice is demonstrated through advocating for patients, families, and groups in ways that promote self-determination, integrity, and growth as human beings. *Concepts: Cultural competency and cultural safety*.
2. Integrate principles of verbal and nonverbal communication, practice standards and professional accountability to collaborate with healthcare team members in the delivery of culturally safe, effective, high-quality, relationship-centered care of individuals, families and groups. *Concepts: Professional Communication and Collaboration.*
3. Implement nursing practice decisions utilizing principles of critical thinking, nursing knowledge and substantiated evidence in the delivery of culturally safe, effective, high-

1. Discuss the fit between the philosophy of the nursing education program and the philosophy of the parent institution.

The vision of Alaska Pacific University is to be an institution that honors Alaska's Indigenous heritage, exemplifies excellence, and prepares paths of educational opportunity. Our mission is to provide a world-class, hands-on culturally responsive educational experience in collaboration with our students, communities and Tribal partners. Cultural safety, the conceptual framework upon which the philosophy of the APU Nursing program was built, has at its core principles which reflect APU's vision and mission. Learning is focused on educational experiences that integrate life in Alaska's dynamic cultural communities, and structurally, the ADN is a critical part of a healthcare career pathway which may begin with certification in health occupations and follow through to the BSN and other advanced practice.

The proposed program grows from APU's core themes and strategic plan goals:
One. Learning, Growth and Innovation: The ADN program addresses APU's strategic goal of developing and using relevant curricula as well as culturally relevant delivery methods.
Two. Community Engagement and Impact: The program addresses workforce needs in the State of Alaska, with potential support for rural communities which are adversely affected by high rates of turn-over in professional positions.
Three. Stewardship: The APU ADN program aspires to implement the highest standards of nurse education meeting expectations of the Accreditation Commission for Education in Nursing (ACEN). This accreditation addresses strategic goals in this area related to data-driven decision making and building a reputation that reflects APU's vision, mission, and values.

quality care and health promotion of individuals, families and groups. *Concepts: Professional Nursing Care.*

4. Examine the evidence that underlies nursing practice to challenge the status quo, question underlying assumptions, and offer new insights to improve the quality of culturally safe care of individuals, families and groups. *Concepts: Evidence-Based Assessment.*
5. Implement one's role as a nurse in ways that reflect cultural safety, integrity, responsibility, ethical practices, critical thinking and an evolving identity as a nurse who practices within dynamic cultural contexts. This is demonstrated through a commitment to both traditional and academic ways of knowing, evidence-based practice, caring, and advocacy, in the delivery of culturally safe, effective, high-quality care and health promotion of individuals, families and groups. *Concepts: Personal and Social Responsibility.*

REFERENCES

National League for Nursing. (2010). Outcomes and competencies for graduates of practical//vocational, diploma, associate-degree, baccalaureate, master's, practical doctorate, and research doctorate programs in nursing. NLN: New York.

Woods, M. (2010). Cultural safety and the socio-ethical nurse. *Nursing Ethics*, *17(16), p.715-725.*

2. Describe the fit between the philosophy and the curricular goals.

Cultural safety, the conceptual framework upon which the philosophy of the APU nursing program was built, is integrated within each of the curricular goals provided above. The core of the nursing philosophy is to produce graduates who have cultural safety as the stabilizing core of their nursing practice. This is achieved through demonstrating the application of cultural safety in the educational experiences of students in classroom, laboratory, and clinical environments.

3. Provide a description of the coursework completed by students during each academic term, from beginning to graduation.

PRE-REQUISITE ACADEMIC TERMS

Semester 1

- SC 16100 Principles of Biology I (General Biology)
- XX ##### Behavioral Sciences for Healthcare Professions (General Psychology, General Sociology, and Human Growth and Development)
- MT ##### College Algebra for Health Sciences
- WRIT 10100 Writing & Research 1: Argumentation (College Writing)

Semester 2

- SC 16200 Principles of Biology II (Cell/Microbiology)
- XX ##### Anatomy and Physiology: Inquiry and Lab
- SC 17000 Principles of Chemistry I (General Chemistry)
- XX #####Culturally Safe Healthcare: Inquiry and Practicum

CORE APU AND PROGRAM ACADEMIC TERMS

Semester 3

- NUR 2#### Culturally Safe Nursing Practice Fundamentals, Inquiry & Lab (6 CR)
- NUR 2#### Culturally Safe Nursing Practice 1: Introduction to Concepts & Theory. (3 CR)
- NUR 2#### Foundations of Pathophysiology (3 CR)

Semester 4

- NUR 2#### Holistic Care of the Chronically Ill: Inquiry & Practicum (6 CR)
- NUR 2#### Culturally Safe Mental and Behavioral Health Nursing Practice (3 CR)
- NUR 2#### Culturally Safe Nursing Practice 2: Critical Thinking and Evidence Evaluation (3 CR)

Semester 5

- NUR 3#### Holistic Care of the Acutely Ill: Inquiry & Practicum (6 CR)
- NUR 3#### Holistic Care of Parents & Newborns: Inquiry & Practicum (3 CR)
- NUR 3#### Culturally Safe Nursing Practice 3: Critical Thinking and Evidence Integration (3 CR)

Semester 6

- NUR 3#### Transition to Registered Nursing Practice: Inquiry & Practicum (6 CR)
- NUR 3#### Holistic Care of the Critically Ill: Inquiry & Practicum (3 CR)
- NUR 3#### Culturally Safe Nursing Practice 4: Critical Thinking and Synthesis of Evidence (3 CR)

4. Describe the adjustments that are made (if any) for students who do not meet admission requirements

Any applicant (or student) who does not meet admission requirements will be provided with the opportunity to consult with Academic Advisors to the APU Nursing Program. Academic Advising may include members of the nursing faculty and support professionals. The focus will be to assist any applicant towards growth opportunities to discover their professional passions and how these passions align with the philosophies and goals of the APU nursing

program. Students completing the pre-requisite courses in the BS in Health Sciences but not admitted to the ADN program may continue in other concentrations in the BS in Health Sciences or other APU majors.

5. Identify the placement of content regarding the following:

Concepts of anatomy and physiology
- XX ##### Anatomy and physiology: Inquiry and Lab (6 CR)
- NUR 2#### Foundations of Pathophysiology (3 CR)

Concepts of chemistry, physics and microbiology.
- SC 17000 Principles of Chemistry
- MT 2XXXX College Algebra for Health Sciences

Concepts of communication and interpersonal relations.
- XXX 2XXXX Cultural Safety in Healthcare
- NUR 2XXXX Culturally Safe Nursing Fundamentals
- NUR 2XXXX Culturally Safe Nursing Practice 1

Concepts of growth and development over the life span.
- NUR 2XXXX Holistic Care of the Chronically Ill
- NUR 2XXXX Holistic Care of the Acutely Ill

Concepts of cultural diversity.
- XXX 2XXXX Cultural Safety in Healthcare
- NUR 2XXXX Culturally Safe Nursing Fundamentals
- NUR 2XXXX Culturally Safe Nursing Practice 1
- NUR 2XXXX Culturally Safe Nursing Practice 2
- NUR 2XXXX Culturally Safe Nursing Practice 3
- NUR 2XXXX Culturally Safe Nursing Practice 4

Ethics.
- XXX 2XXXX Cultural Safety in Healthcare
- NUR 2XXXX Culturally Safe Nursing Practice 1
- NUR 3XXXX Transition to Registered Nursing Practice: Inquiry & Practicum

Nursing history and trends.
- NUR 2XXXX Culturally Safe Nursing Practice 1

Vocational or professional and legal aspects of nursing.
- NUR 2XXXX Culturally Safe Nursing Practice 1

Concepts of pharmacology.
- NUR 2XXXX Culturally Safe Nursing Fundamentals
- NUR 2XXXX Holistic Care of the Chronically Ill
- NUR 3XXXX Holistic Care of the Acutely Ill
- NUR 3XXXX Holistic Care of the Critically Ill

Concepts of nutrition and diet therapy.
- NUR 2XXXX Culturally Safe Nursing Fundamentals
- NUR 2XXXX Holistic Care of the Chronically Ill
- NUR 3XXXX Holistic Care of the Acutely Ill
- NUR 3XXXX Holistic Care of the Critically Ill

Concepts of the nursing process.
- NUR 2XXXX Culturally Safe Nursing Practice 1
- NUR 2XXXX Culturally Safe Nursing Practice 2: Critical Thinking and Evidence Evaluation

- NUR 2XXXX Holistic Care of the Chronically Ill
- NUR 3XXXX Culturally Safe Nursing Practice 3: Critical Thinking and Evidence Integration
- NUR 3XXXX Holistic Care of the Acutely Ill
- NUR 3XXXX Culturally Safe Nursing Practice 4: Critical Thinking and Synthesis of Evidence
- NUR 3XXXX Holistic Care of the Critically Ill

Theory and practice in nursing encompassing the attainment and maintenance of physical and mental health and the prevention of illness for individuals and groups throughout the life process.
Infants • NUR 3XXXX Holistic Care of Parents & Newborns: Inquiry & Practicum • NUR 2XXXX Holistic Care of the Chronically Ill: Inquiry & Practicum • NUR 2XXXX Holistic Care of the Acutely Ill: Inquiry & Practicum • NUR 2XXXX Holistic Care of the Critically Ill: Inquiry & Practicum
Children • NUR 2XXXX Holistic Care of the Chronically Ill: Inquiry & Practicum • NUR 2XXXX Holistic Care of the Acutely Ill: Inquiry & Practicum • NUR 2XXXX Holistic Care of the Critically Ill: Inquiry & Practicum
Adolescent • NUR 2XXXX Holistic Care of the Chronically Ill: Inquiry & Practicum • NUR 2XXXX Holistic Care of the Acutely Ill: Inquiry & Practicum • NUR 2XXXX Holistic Care of the Critically Ill: Inquiry & Practicum
Young adults with diagnosed illness • NUR 2XXXX Holistic Care of the Chronically Ill: Inquiry & Practicum • NUR 2XXXX Holistic Care of the Acutely Ill: Inquiry & Practicum • NUR 2XXXX Holistic Care of the Critically Ill: Inquiry & Practicum
Adults during childbearing • NUR 3XXXX Holistic care of Parents and Newborns: Inquiry & Practicum
Elderly clients • NUR 2XXXX Holistic Care of the Chronically Ill: Inquiry & Practicum • NUR 2XXXX Holistic Care of the Acutely Ill: Inquiry & Practicum • NUR 2XXXX Holistic Care of the Critically Ill: Inquiry & Practicum
Clients with disorders of mental health • NUR 3XXXX Mental and Behavioral Health Nursing • NUR 2XXXX Holistic Care of the Chronically Ill: Inquiry & Practicum • NUR 2XXXX Holistic Care of the Acutely Ill: Inquiry & Practicum • NUR 2XXXX Holistic Care of the Critically Ill: Inquiry & Practicum
Concepts of sociology and psychology • Behavioral Sciences for Healthcare Professions • NUR 2XXXX Culturally Safe Mental and Behavioral Health Nursing Practice (3 CR)
Concepts of group dynamics • XXX 2XXXX Cultural Safety in Healthcare • NUR 2XXXX Culturally Safe Nursing Practice 1 • NUR 3XXXX Transition to Registered Nursing Practice
Concepts of pathophysiology

- NUR 2XXXX Foundations of Pathophysiology

Concepts of patient education

- XXX 2XXXX Cultural Safety in Healthcare
- NUR 2XXXX Culturally Safe Nursing Practice 1
- NUR 3XXXX Transition to Registered Nursing Practice: Inquiry & Practicum

Note: 12 AAC 44.130 requires inclusion of the above listed content.

6. Describe any policies regarding failing students (e.g. opportunities for retaking courses).

Students fail a course when they earn a grade less than a "C" or 73% in any given course. The Admissions and Advancement Committee is responsible for evaluating the students progression status once a student has failed a course.

7. Describe any policies regarding the reentry of returning students (who have taken time off from coursework).

Students who have taken time off from course work must complete required admission procedures and policies following an absence of one or more academic terms (excluding Summer Sessions). Students wishing to re-enter the program need to contact the admissions office and complete the "Application Form for Readmission", identifying "ADN Program" as the intended major field of study.

8. Describe procedures used to deal with students transferring from other nursing education programs.

Transferring nursing courses into the nursing program is approved on a case-by-case basis, if space is available, through evaluation of transcripts and a review of nursing course syllabi. Students must provide copies of official transcripts and course syllabi from the institution of transfer to the Registrar's Office. Faculty will review syllabi in consultation with the Registrar's Office and will make recommendations to the Nursing Program Director for transfer of nursing course credit.

9. Describe policies related to credit by exam in clinical nursing courses.

Currently the APU nursing program does not permit credit by exam in clinical nursing courses because the exam does not fulfill the clinical practice experience requirements for clinical courses.

10. Identify the major strengths of the curriculum.

One of the major strengths of the APU ADN Program curriculum is the focus on integrating cultural safety into all learning environments and experiences. This demonstration and emphasis on cultural safety will afford students multiple opportunities to integrate cultural safety practices into a variety of settings and contexts.

Another major strength of the APU ADN Program is the intentional design of the program for modern students, with complex lives and individual needs.

Program is designed with an integration of concepts and topics that scaffold across semesters.

11. Describe the major weaknesses of the curriculum.

One major weakness of the curriculum is that it is that it is under development and has not yet had an opportunity to refine the curriculum through practical application. This will be ameliorated as the program is refined and rolled-out.

12. Describe plans for future changes in the curriculum.

It is anticipated that minor curricular changes, in terms of topic and curricular progression will occur as the program is developed and based on feedback from faculty, clinical site partners, APU Faculty committees, the Alaska State Board of Nursing, and nursing education accreditation body.

13. Describe methods by which the curriculum is evaluated for effectiveness.

The APU ADN program will be held to all current assessment processes at APU, including review that looks at 'critical performances' which are sequenced through all APU undergraduate bachelor's level programs.
1. Writing and quantitative skills are assessed for placement at the point of admissions into appropriate level written communication and quantitative reasoning courses.
2. Foundational level assessment of Effective Communication, Critical Thinking, and Scientific Inquiry occurs through WRIT 20100 (required of students in all programs), with the critical performance of a 'literature review.'
3. Integration of the five Essential Competencies is assessed through 'milestone' critical performances which are specific to programs.

The assessment routine includes faculty in working groups and curriculum committees which score critical performances at different levels. Those data are reviewed by the university-wide Assessment Committee, which in turn, provides data-driven recommendations back to the programs and the curriculum committees for needed changes to courses, curriculum, and program expectations.

Across the APU ADN program, students will develop a professional portfolio that archives critical performances from coursework. At the program level, milestone critical performances will be evaluated in relation to both APU Essential Competencies and End-of-Program Student Learning Outcomes. Levels of milestone performances will be archived and evaluated: 1.) at program start in the Culturally Safe Nursing Practice 1 course; and 2.) through Culturally Safe Nursing Practice 2-4.

The APU ADN program will maintain ongoing systematic review of End-of-Program Student Learning Outcomes to ensure it is meeting the high standards expected in the nursing profession. Annual program assessment will also include review of program and course completion rates, NCLEX pass rates, program satisfaction of current students and alumni (determined through national satisfaction and internal survey instruments), and job placement and employer surveys.

(SEE APU ADN COURSE SYLLABI – ATTACHMENT)

FACILITIES

1. Describe the faculty office space:

Office space is provided for full time, part time and adjunct faculty. Depending on faculty role and physical location, office space that is provided may be single, shared, or a touchdown space provided for adjunct faculty members. Faculty offices include phones and computer set-ups, filing space, desks, visitor seating, and bookshelves.

2. Describe and discuss the adequacy of the classroom space that is used by the nursing education program.

All standard classrooms at APU are large enough to accommodate the ADN cohort of 16. Classrooms are equipped with moveable tables and chairs (or individual desks), whiteboards, and teaching stations with computers, laptop hookups, and audiovisual projection capabilities.

3. Describe and discuss the adequacy of any laboratory facilities that are used by the nursing education program (e.g., simulation, skills, computer, or audiovisual laboratory):

Foundational science courses will be taught in laboratory classrooms on the APU campus which seat 16 students. Through a strategic partnership with ANTHC, the APU Nursing program will have access to low-fidelity and high-fidelity laboratory space on the adjacent Alaska Native Medical Campus. ANTHC is building an education center that will include simulation and skills labs as well as classroom and office spaces. Until this facility opens, APU will use simulation labs at ANMC (see letter of support) or secure rental of a nursing skills and simulation laboratories at the University of Alaska Anchorage (UAA). UAA has a simulation laboratory available for both low-fidelity and high-fidelity simulations. The UAA simulation laboratory includes 3 separate simulation rooms, 3 debriefing rooms, a conference room, and a low-fidelity skills laboratory classroom. Technicians are provided as needed to assist with simulation equipment, supplies and processes.

Computer labs are available to all students at multiple campus locations.

4. Describe and discuss the adequacy of the non-instructional space available for the primary use of the nursing education program:

N/A

5. Describe the clinical practice facilities available for students in the nursing education program:

a. Criteria for selection:

- Provide high-quality nursing care
- Receptive to students acquiring clinical experience in their facility
- Meet accreditation standards of hospital/clinic accrediting bodies
- Units/clinics provide necessary clinical skills and interactions with populations of interest
- Ability to accommodate clinical groups to meet learning requirements and course clinical hours requirements.
- Legal processes for contracts are in place
- Variety of clinical shifts for placement (i.e., not all nights or weekends)

b. Adequacy of experiences provided in the facilities:

The clinical experiences afforded at the Alaska Native Tribal Health Consortium provide experience with individuals from across Alaska and across the lifespan. ANTHC provides experiences for nursing students in both inpatient and outpatient contexts and is inclusive of

the spectrum of specialty nursing experiences required to meet curriculum and programmatic goals.

c. Strengths of clinical facility availability:
Alaska Pacific University and the Alaska Native Tribal Health Consortium are aligned with a strategic partnership and are committed to produce culturally safe, high quality associate's prepared registered nurses to improve the health outcomes of Alaska's people. As such, ANTHC is committed to providing the nursing care experiences needed of nurses in the APU ADN Program. The Alaska Native Medical Center is a Magnet Nursing Facility, with a commitment to high, quality nursing care that is evaluated based on measurable, standardized outcomes and evidence based professional standards. As a magnet facility, ANTHC is also committed to providing nurses with an optimal practice environment, one that provides each nurse a voice in the decisions that impact the individual nursing care provided and facilitates evidence-based practice at all levels of inquiry.

d. Weaknesses of clinical facility availability:
The weaknesses of ANTHC for clinical placement availability are resonated throughout hospital facilities in the Anchorage and surrounding areas – there are challenges in recruiting, hiring and maintaining institutionally established nursing staffing levels in Alaska. ANTHC is committed to ensuring that nursing is staffed at safe nurse-to-patient ratios and fills nursing vacancies with travel nursing staff until permanent staff can be hired. Travel nursing staff are held to institutional standards and can provide students with perspectives of nursing practice external to facility contexts.

e. Discuss the presence of other nursing education in the facility and its impact on both nursing education programs:
ANTHC works with each of the nursing schools who are in their facility to ensure that there are an appropriate number of students and resources on any given unit or in any given clinic at a particular day and time. This occurs prior to the beginning of the semester to ensure that there are appropriate number of nurses and resources for student learning needs.

RESOURCES

LIBRARY:

1. Where is the main library located?

The UAA/APU Consortium Library is located on the UAA campus, which is adjacent to the APU campus. Many services can also be accessed online at consortiumlibrary.org.

2. What hours is the library open?

Typical library hours of operation are:
Monday - Friday, 7:30AM to 8:00PM
Saturday & Sunday, 10:00AM to 8:00PM.

3. What are the annual expenditures on nursing texts and nursing and health-related literature?

Housing the Alaska Medical Library, the Consortium Library does not purchase additional nursing texts but does permit instructors to place copies of textbooks on course reserves

through the library. Other expenditures related to nursing and health-related literature are difficult to determine directly because many of the electronic references for journals, research databases, electronic reference books, etc. are purchased through publishers and are a part of a package that typically encompasses many professions and fields. Of note, the Consortium Library has subscriptions for CINAHL +full text database, and other nursing and allied health databases as well.

4. Is the library staffed adequately?

Yes, the UAA/APU Consortium Library is staffed adequately to meet the needs of nursing students. In addition to general support staff, the library has on staff 15 librarians with diverse specialties; in particular, two librarians specialize in Nursing and Allied Health fields, and they can help students navigate physical and online resources to meet their needs.

5. Evaluate the adequacy of library holdings, staffing and hours in relation to the use of the resource by nursing students and faculty:

APU has perpetual, institutional access to the UAA/APU Consortium Library. The mission of the Consortium Library is to provide and maintain collections and resources that support the educational and research programs of the University of Alaska Anchorage and Alaska Pacific University. The library provides information services for the benefit of the university and research communities and the residents of the state of Alaska. The library emphasizes access to information and instruction on the knowledgeable use of information resources. The library catalog includes over 700,000 titles in its collection.

The Consortium Library already serves many Health Science Programs offered at UAA, including their Associate of Applied Science in Nursing and Bachelor of Science in Nursing Science degrees as well as graduate level programs.

6. What other sources of library materials are available to the nursing education program?

Library materials include not only physical holdings of books, texts, journals and other media, but also includes the ability to access electronic texts, books, journals and other media at the library our through off-campus access to online resources.

If the Consortium Library does not have a particular item in its physical or electronic collection, the library participates in interlibrary loan. Interlibrary loan is a service that borrows materials from libraries around the world. It is a free service that allows students, faculty and staff to order items not found in the library catalog or in the library's online subscriptions. Scans of articles and book chapters typically take only two to seven days to be delivered, with physical items such as books or other unique items taking more time due to delivery methods.

CLERICAL SUPPORT

1. Describe the clerical support available to the nursing education program.

The Nursing Program Area has clerical support from Office Specialist dedicated to the Institute of Health & Wellness. The Nursing and health-related programs, with director and faculty, can expect to have at least 50% of that support staff member's dedicated time.

2. Discuss the adequacy of clerical support for the nursing education program.

The Office Specialist in the Institute of Health & Wellness provides support for a number of general instructional and programmatic responsibilities as well as specialized support for certifying degree programs and accreditation processes.

The Office Specialist:

- Performs general administration and support work requiring field-specific knowledge relevant to the programs assigned
- Greets and assists customers
- Answers phones and directs calls
- Makes travel arrangements for faculty and staff
- Sets appointments, arranging conference rooms and other details as required
- Completes, submits and tracks forms such as travel/expense reports, check requests, company credit cards, purchase requests, and personnel action documents
- Develops and maintains program record-keeping systems, performing general filing and file retrieval
- Sorts and delivers mail
- Sends, receives and distributes faxes
- Makes copies and scans and files electronic documents

Additionally, the IHW Office Specialist:

- Prepares program communication materials, including handbooks, web-postings, fliers, posters, and other media
- Manages communication with adjunct instructors, including documentation of contact information, preparation of contracts, and notifications regarding courses
- Provides support for documentation and archiving of accreditation information
- Provides support for compliance with certification process and accreditation matters
- Supervises student workers as needed

The Office Specialist is expected to have the following knowledge and skills:

- Knowledge of customer services concepts and practices
- Knowledge of multi-line telephone systems operation
- Knowledge of privacy laws and regulations
- Knowledge of basic purchasing processes
- Knowledge of filing procedures
- Skill in operating office equipment
- Skill in oral and written communication
- Skill in maintaining and updating office and administrator schedules
- Skill in establishing and maintaining cooperative working relationships with others
- Skill in operating a personal computer utilizing a variety of software applications

3. Compare the clerical support for the nursing education program with the clerical support available to other similar educational programs offered by the institution.

Per program, faculty, and student enrollment, the Nursing programs in their initial years (2018-19 for BSN, 2020-21 for the associate-level) will have more dedicated clerical support than APU usually affords, sharing the staff position with only one other program area (Counseling Psychology). The overlapping skill set for Nursing and health programs with Counseling Psychology is a good fit because these disciplines require administrative responsibility for certification processes, specialized accreditation processes, facility

coordination, practicum and internship site coordination. As the programs grow and more cohorts are enrolled, APU would add clerical and other staff support particularly for the Nursing programs.

STUDENT SERVICES

1. Is there a special "Student Services" office for students?

Yes. The Student Enrollment Services coordinates admissions, registration and financial aid. The Dean of Students Office coordinates comprehensive student services, including:

- Academic Support Center, which provides math and writing tutoring.
- Academic Advising Center, which provides initial professional advising for first-year and transfer students.
- Career Services (in the Advising Center), that provides one-on-one career counseling and career development.
- The Counseling Wellness Center, which provides students counseling regarding: school, relationships, work, family, and daily life concerns, free of charge.
- The Dean of Students Office, which provides co-curricular learning opportunities, as well as student leadership awards, student grievance resolution, student conduct system, emergency student loans, disability services and student Title IX compliance.
- Disability Services (in the Dean of Students Office), which promotes access to campus facilities, educational opportunities, and public events and coordinates reasonable accommodations for students with disabilities.

AGENCIES PROVIDING CLINICAL EXPERIENCE

AGENCY OVERVIEW - ANTHC	
Legal name of agency	Alaska Native Tribal Health Consortium
Private or public?	Public
By what accrediting body is the agency approved?	Joint Commission for the Accreditation of Hospital Organizations

AGENCY CONTROLLING BODY - ANTHC	
Name the controlling body of the agency:	Board of Directors, Alaska Native Tribal Health Consortium
Date of incorporation of the controlling body:	June 1, 1998

MEMBERS OF THE CONTROLLING BODY - ANTHC		
Name	Office	Occupation/Field of Interest
Andy Teuber	Chairman	Kodiak Area Native Association
Andrew Jimmie	Vice Chair	Tanana Chiefs Conference
Charlene Nollner	Secretary	Copper River Native Association
Evelyn Beeter	Treasurer	Unaffiliated Tribes
Chris Merculief	Member	Aleutian Pribilof Islands Association
Marie Carroll	Member	Arctic Slope Native Association
Robert Clark	Member	Bristol Bay Area Health Corporation
Robert Henrichs	Member	Chugachmiut, Native Village of Eyak
Louie Commack	Member	Maniilaq Association

Linda Clement	Member	Metlakatla Indian Community
Martin Aukongak	Member	Norton Sound Health Corporation
Katherine Gottlieb	Member	Southcentral Foundation
Charles Clement	Member	SouthEast Alaska Regional Health Consortium
Chief Gary Harrison	Member	Unaffiliated Tribes, Chickaloon Native Village
Esai Twitchell	Member	Yukon-Kuskokwim Health Corporation

Person responsible for completion of form:	**Title:**	**Date this form completed:**
Jennifer Schuerch	Business Support Manager	June 28, 2018

HOSPITAL UNITS - ANTHC		
Hospital Unit	Total number of beds	Daily Average Census
Medical	23	20.6
Medical-Surgical/Oncology	23	20.2
Obstetric	L&D: 8, Post partum: 17	L&D: 3, Post partum: 9.5
Pediatric, NICU, & PICU	NICU: 12, Peds/PICU: 17	NICU: 8, Peds/PICU: 17
Orthopedic/Neurosurgery	23	20
Surgical	23	20
ICU/CCU	22	20
Flex Unit	8	8
Annex	4	4

HOSPITAL DEPARTMENTS - ANTHC	
Is there an outpatient department?	Yes, with specialty clinics
Is there an emergency department?	Yes
Is there a physical therapy department?	Yes
Other?:	Pharmacy

RESOURCES - ANTHC	
Is there a centrally located professional library?	No. Online resources are available.
Are there appropriate reference materials available in each clinical area?	Yes. Reference materials are available online, on every inpatient and clinic computer, through Dynamic Health from EBSCO.
Is there a classroom available?	Yes
How many persons can be accommodated in each classroom?	It varies. There are 4 classrooms, with each classroom able to accommodate up to 20 people. There are also numerous conference rooms available, that can accommodate up to 10 people.
Is there a nursing policy/procedure manual available on each clinical service?	Yes. The nursing policy and procedure manual is available through the ANTHC intranet.

PATIENT CARE DELIVERY - ANTHC	
What approach is used to deliver patient care? (team nursing, functional, primary care, etc.)	Inpatient-primary nursing model with RN's and CNA's for assistance.

NURSING DEPARTMENT ADMINISTRATION - ANTHC	
Name of Chief Nurse Executive	Dr. Renee Steffen
Academic and professional preparation of nursing director	Dr. Steffen has been a nurse since 1981. She received her Masters of Nursing, Clinical Nurse Specialist, in 1991 and her Doctorate of Nursing Practice in 2009.
Experience record of Nursing Director for past five years	Dr. Steffen joined the ANMC family in June 2017. Previously, she served as the Chief Nursing Officer for Cuyuna Regional Medical center in Crosby Minnesota. She held that position from 2013-2017.
Number of assistants to nursing director	1

PROFESSIONAL NURSES - ANTHC

Please indicate the number of professional nurses employed for each role and time provided.

	Days	Evenings	Nights
House Supervisors	1 per shift		1 per shift
Clinical Shift Supervisor	1 per unit, per shift		1 per unit, per shift
Head/Charge Nurses	1 per unit, per shift		1 per unit, per shift
Staff	Varies per unit, patient acuity and volume.		

NON-PROFESSIONAL PERSONNEL - ANTHC

Please indicate the number of personnel employed for each role and time provided.

	Days	Evenings	Nights
Licensed Practical Nurses	None		
Nursing Aides	2-3 per unit, per shift		2-3 per unit, per shift
Ward Clerks	1 per unit		
Attendants/Orderlies	None		

NURSING STAFF EDUCATION - ANTHC

Briefly describe the in-service program for nursing staff:
Nursing orientation includes facility-specific presentations on nursing activities and skills common to all clinical settings as determined by nurse leaders.

List other education programs utilizing this agency for clinical experience:
UAA School of Nursing
UAA Allied Health School (paramedic & medical assistant students)
Charter College School of Nursing
There are others – CITC (CNAs); non-nurse and advanced practice nurse students.

Briefly describe methods of orienting staff to responsibilities for nursing students, and lines of communications with nursing instructors:
Preceptor development occurs and is monitored at the unit level for all nurse preceptors.
We have two liaisons for communication with schools.

FACULTY QUALIFICATIONS

Name: Jessica Ann Downes DNP, RN
Title of Position: *Assistant Professor of Nursing and Director of Nursing Programs*

NURSING EDUCATION – Jessica Downes

Undergraduate Nursing Education

Name of school	Chamberlain University, Chamberlain College of Nursing		
Location	Downers Grove, IL		
Degree	Bachelor of Science Nursing	Year of Graduation	2010

Graduate Nursing Education – Jessica Downes

Name of School	Chamberlain University, Chamberlain College of Nursing		
Location	Downers Grove, IL		
Degree	Master of Science in Nursing- Executive Specialties	Year of Graduation	2015

Other Education – Jessica Downes

Name of School	Chamberlain University, Chamberlain College of Nursing		
Location	Downers Grove, IL		
Degree	Doctor of Nursing Practice- Healthcare Systems Leadership	Year of Graduation	2018

Advanced courses related to position – Jessica Downes

EDUCATIONAL PREPARATION AND WORK EXPERIENCE – Jessica Downes

List formal educational preparation and work experience in the area of:
1. Curriculum development: During my work as the Manager of Education, Development and Training I assumed responsibility for all ACCME and ANCC accredited education. As a part of this role I was trained, by both ACCME and ANCC, in curriculum development and accredited education services.

2. Counseling: During my Master's degree I completed courses focused on the role of the nurse leader in staff professional development. This included counseling staff on performance and behavior as well as goal setting and future focused improvement. This work transitions well into student counseling and guidance.

3. Teaching methods: Extensive change management training and experience both on the job and formal education through higher learning institutes. Change management and

organizational development both require extensive educational components including active listening and teach-back as well as formal classroom content review.

4. Supervision: Over 8 years of leadership and supervision experience including management through executive level work. Supervision pool ranging from 4 direct reports to over 100 employees.

5. Other related courses

Give plans for continuing academic preparation and/or maintaining clinical competency: I will continue to volunteer time with the city of Anchorage Public Health Department. Additionally volunteer work with HELPS international for overseas clinical outreach programs.

PROFESSIONAL/CIVIC ACTIVITIES DURING THE PAST YEAR: – Jessica Downes

Municipality of Anchorage Department of Health and Human Services Clinical Services Supervisor. Responsible for supervision and management of the public health clinical services programs.

NURSING EMPLOYMENT EXPERIENCE – Jessica Downes

Complete by indicating present position first followed by previous employment:

Employer	Municipality of Anchorage, Department of Health and Human Services		
Address	825 L Street Anchorage		
Title of position	Clinical Services Supervisor		
Total time employed		From: 1/2017	To: 7/18

Major areas of responsibility: Responsibilities include the overall management and direction of the Clinical Services (CS) Department within the department. Overall management of five separate funding streams totaling over 4.5 million dollars and composed of four grants and one municipal support fund. Maintain and report on all grant requirements for all four grants including monthly and quarterly reporting on measurable objectives. Strong focus on implementing three level interventions at all three levels of prevention.

Employer	Samuel Simmonds Memorial Hospital		
Address	PO Box 29, Barrow		
Title of position	Director of Nursing		
Total time employed		From: 8/15	To: 1/17

Major areas of responsibility: Responsibilities included management and planning of all nursing actives within the hospital. Evaluation and establishment of department and program goal settings and quality improvement projects. Providing executive level administration and leadership to over 50 individuals within the nursing division.

Employer	Alaska Native Tribal Health Consortium
Address	Diplomacy Drive, Anchorage
Title of position	HR Quality Assurance/ Manager of Hospital Education/ Manager of Education, Development and Training

Total time employed From: 8/2012 To: 8/15
Major areas of responsibility: Responsibilities include general supervision of all HR onboarding processes and tasks, direct supervision of Competency Folder and Learning Management Systems administration team and Employee Relations program development. Function as the only manager within HR with a focus on organizational and program development and process improvement. Specific responsibilities include review of all existing HR policies and development of a policy review and revision process that maintains legal, compliance and applicability standards. As Education manager, I assumed responsibility of this team during a time of staffing shortage and leadership changes. I was challenged with developing this program into a program that exceeded the expectation of the consortium while working short on staff and funding.

CURRENT MEMBER PROFESSIONAL ORGANIZATIONS – Jessica Downes

Phi Pi Chapter of Sigma Theta Tau International.
Christian Nurses Association- Practicing Professional Member

LICENSES AND CERTIFICATIONS – Jessica Downes

Alaska RN License	NURR2930	11/30/18
BLS/CPR	185504761599	5/2020

Name: **Laura Hudson**
Title of Position: Assistant Professor

NURSING EDUCATION – Laura Hudson

Undergraduate Nursing Education

Name of school	Texas A&M University		
Location	Corpus Christi, TX		
Degree	BSN	Year of Graduation	1997

Graduate Nursing Education – Laura Hudson

Name of School	Western Governor's University		
Location	Salt Lake City, UT		
Degree	MSN, Nurse Educator	Year of Graduation	2018 (in progress)

Other Education – Laura Hudson

Name of School	Alaska Pacific University		
Location	Anchorage, AK		
Degree	MBA-Health Services Administration Concentration	Year of Graduation	2013

Advanced courses related to position – Laura Hudson

Numerous training courses in continuing education from Montana Nurses Association
GCP-Social and Behavioral Research Best Practices for Clinical Research, GCP for Clinical Trials with Investigational Drugs and Medical Devices – both courses completed June 2018 and the Biomedical Investigators and Key Personnel course completed April 2018. All 3 completed through the Collaborative Institutional Training Initiative (CITI Program) sponsored by ANTHC for my Epidemiology Research Nurse position

ELNEC (End-of-Life Nursing Education Consortium) Advanced Palliative Care Train-the-Trainer workshop August 2017

ACEN Self Study Forum 10/2017, also planning to attend the 2018 event 10/2018

'Preparing for the CNE Exam' (Certified Nurse Educator) sponsored by Charter College 9/15/2017

EDUCATIONAL PREPARATION AND WORK EXPERIENCE – Laura Hudson

List formal educational preparation and work experience in the area of:
1. Curriculum development – Contemporary Curriculum Design and Development in Nursing Education -C920 at Western Governor's University

2. Counseling – Professional Presence and Influence – C351 at Western Governor's University

3. Teaching methods – Facilitation of Context-Based Student-Centered Learning-C919 at Western Governor's University, work experience and extensive training as Primary Nurse Planner with the ANTHC Continuing Education program (accredited by Montana Nurses Association), I continue to be a Nurse Planner to this day, and as faculty in APU's undergraduate and graduate courses within the Health Services Administration Concentration in the Business and Public Policy Institute.

4. Supervision – Evolving Roles of Nurse Educators in Diverse Environments -C918 at Western Governor's University, managed the Clinical Education Department at ANTHC with 12 employees and 3 areas of leadership (American Heart Association Training Center and 3 remote Training Sites across Alaska, Continuing Education for physicians as well as nurses, and managed contracts with nursing and other clinical education programs from across Alaska and the U.S.A., and the E.H.R. Trainers for ANTHC).

5. Other related courses – Policy, Politics, and Global Health Trends -C159, Translational Research for Practice and Populations – C301, Advanced Information Management and the Application of Technology – C791, Organizational Leadership and Interprofessional Team Development – C158, Pathopharmacological Foundations for Advanced Nursing Practice – C155, Comprehensive Health Assessment for Patients and Populations – C350, Essentials of Advanced Nursing Practice Field Experience – C157, Assessment and Evaluation Strategies for Measuring Student Learning – C921, Emerging Trends and Challenges in 21st Century Nursing Education – C922, Nursing Education Field Experience – C946, and Nursing Education Capstone – C947 all at Western Governor's University

Give plans for continuing academic preparation and/or maintaining clinical competency:
I plan to enroll in a doctorate program in 2019.

PROFESSIONAL/CIVIC ACTIVITIES DURING THE PAST YEAR: – Laura Hudson

Vice-Chair and Commissioner of the Anchorage Municipality Health and Human Services Commission (appointed by the mayor for a 3-year commitment)

NURSING EMPLOYMENT EXPERIENCE – Laura Hudson

Complete by indicating present position first followed by previous employment:

Employer	Alaska Native Tribal Health Consortium
Address	3900 Ambassador Drive, Anchorage, Alaska

Title of position	Epidemiology Research Nurse		
Total time employed		From: Mar 2018	To: present

Major areas of responsibility: Manage statewide diabetes registry. Assistance, as needed, for patients and/or nurses/providers for education, consent forms, and assistance with planning, implementing, supporting and reporting on various research projects; depending on which one, my tasks vary, as they are each unique with different goals.

Employer	Alaska Native Tribal Health Consortium		
Address	3900 Ambassador Drive, Anchorage, Alaska		
Title of position	Clinical Education Manager		
Total time employed		From: Oct. 2016	To: Feb 2018

Major areas of responsibility: Successfully completed the re-accreditation process for my department/organization to continue to offer Continuing Education for physicians and nurses through two entities (Montana Nurses Association and Washington State Medical Association). Both were up for re-accreditation in 2017 and we were awarded full accreditation with each entity. The CE program supported 53 learning activities and provided CE to 9,265 students statewide. In 2017 the Training Center Coordinated supported over 547 learning events, these learning events supported certifications for a total of 2,911 students. The combined programs under my leadership and oversight - counting American Heart Association and Continuing Education - have provided educational learning events for 11,652 students statewide!

Managed the overall performance of the Clinical Education Department programs that support the clinical staff of the Alaska Native Medical Center (ANMC) as well as other facilities and clinics across the state that are within the Tribal Health partnership. Oversee the continuing education programs and holds the role of Primary Nurse Trainer for clinical staff (i.e. physicians, physician assistants, nurse practitioners, nurses, etc.). Oversee the ANMC American Heart Association Training Center program and the multiple, rural training sites that report to the training center from across the state.

Employer	Alaska Regional Hospital		
Address	DeBarr Road, Anchorage, Alaska		
Title of position	Cardiovascular Services Manager		
Total time employed		From: Apr. 2015	To: Sep. 2016

Major areas of responsibility: work with key hospital leaders and surgeons to foster exchange of best practices and serve as a resource for reducing the variation in processes throughout our system. Facility lead of Care Assure Nurse Navigator position. Track quality and performance metrics, collaborates with other managers/directors to implement responses to deficiencies. Coordinates and facilitates all aspects of cardiology and cardiac surgery Case Review meetings. Educates and leads clinical hospital staff and physicians in quality improvement processes.

CURRENT MEMBER PROFESSIONAL ORGANIZATIONS – Laura Hudson

Alaska Nurses Association (ANA)
Nursing League for Nursing (NLN)

LICENSES AND CERTIFICATIONS – Laura Hudson

Alaska RN License	18408	11/2018
BLS/CPR	yes	Current through 12/2019

Name: **Katie Baraki, RN, MS**
Title of Position: *Visiting Assistant Professor of Nursing and Community Health*

NURSING EDUCATION – Katie Baraki

Undergraduate Nursing Education

Name of school	University of Utah, College of Nursing		
Location	Salt Lake City, Utah		
Degree	Bachelor of Science Nursing	Year of Graduation	2006

Graduate Nursing Education – Katie Baraki

Name of School	University of Utah, College of Nursing		
Location	Salt Lake City, Utah		
Degree	Master's in Teaching Nursing	Year of Graduation	2008

Other Education – Katie Baraki

Name of School			
Location			
Degree		Year of Graduation	

Advanced courses related to position – Katie Baraki

EDUCATIONAL PREPARATION AND WORK EXPERIENCE – Katie Baraki

List formal educational preparation and work experience in the area of:

1. Curriculum development

I received formal education on curriculum development in my Master's in Teaching Nursing program and have participated and contributed to multiple curriculum redesigns at the University of Utah. I also developed curriculum for two hospital-based new nurse graduate residency programs.

2. Counseling

I received formal education on student mentoring and academic counseling in my Nursing Education Master's program. I have mentored and counseled pre-nursing, pre-licensure, post-licensure and graduate students and nurses. I recognize the limitations of my training and consult or refer students when their issues are beyond the scope of my education.

3. Teaching methods

I received formal education on teaching development in my Nursing Education Master's program. I have taught classes in undergraduate and graduate programs, using a variety of in-person and online teaching approaches. I have also participated in additional opportunities to expand my teaching approach, through training with programs such as the Khan Academy.

4. Supervision

In the Nursing Education Master's program, we received formal training on student supervision in the classroom and clinical environments. I have taught nursing students in a variety of capacities since 2006 and I am comfortable and confident in my ability to supervise students in classroom and clinical contexts.

5. Other related courses
I have completed all of the coursework required for a research doctorate in nursing, which has expanded my knowledge of nursing theories, research approaches and designs, and application of Evidence Based Practice.

Give plans for continuing academic preparation and/or maintaining clinical competency:
I will complete continuing education courses and will arrange trainings and clinical experiences with our ANTHC clinical partners to maintain clinical competency.

PROFESSIONAL/CIVIC ACTIVITIES DURING THE PAST YEAR: – Katie Baraki

Developed new nurse graduate residency program for ANTHC.
Mentor to new nurse graduates at ANMC.
Tutor for pre-nursing junior high and high school students.
Private duty nurse for ill family members.

NURSING EMPLOYMENT EXPERIENCE – Katie Baraki

Complete by indicating present position first followed by previous employment:

Employer	Alaska Pacific University
Address	4101 University Drive, Anchorage, Alaska 99508
Title of position	Visiting Assistant Professor of Nursing and Community Health
Total time employed	From: May 2018 To: Present

Major areas of responsibility

1. Program curriculum and course development, teaching, evaluation and revision for in-person, online, clinical, laboratory and simulation learning environments.
2. Maintaining and expanding clinical competence and participating in role-modeling and mentoring of students in the clinical environment.
3. Mentoring new faculty to the faculty role in didactic, online, clinical, laboratory, and simulation learning environments.
4. Assisting undergraduate nursing students to incorporate evidence-based practice into their professional clinical practice.
5. Active involvement in departmental, college, institutional and professional organizations.
6. Review undergraduate nursing school applications to assure potential candidates met academic and scholastic standards for admittance to the School of Nursing.
7. Monitor the academic and medical procedures training to ensure anticipated performance is being achieved.
8. Develop individual performance improvement plans (PIP) for student nurses who were performing below acceptable levels. Provided regular feedback and suggestions for correction during the PIP process. Instigated removal from the program when nurses failed to correct their deficiencies.
9. Recommend awards and honors for outstanding performance.

Employer	Alaska Native Tribal Health Consortium
Address	4000 Ambassador Drive, Anchorage, Alaska 99508
Title of position	Clinical Nurse Consultant
Total time employed	From: May 2017 To: February 2018

Major areas of responsibility

1. Coordination of the ANMC New Nurse Residency Program. This encompasses: the development, evaluation and revision of curriculum designed for classroom learning environments; management, mentoring and evaluation of nurse residents; and coordination and evaluation activities with inpatient and outpatient managers; and budget planning and accounting.
2. Program development including: creating, evaluating and revising educational program curriculum for the ANMC Nurse Education Department. I work closely with hospital managers, nurses and education staff to create episodic and course curriculum based on institutional and unit focused needs.
3. Active member on hospital and institutional committees.
4. Nurse educator, nurse resident and clinical nurse mentoring. Active mentor for nurse educators, nurse residents and clinical nurses as they transition to their professional and institutional roles.
5. Developed individual performance improvement plans (PIP) for nurses who were performing below acceptable levels. Provided regular feedback and suggestions for correction during the PIP process. Instigated removal from the program when nurses failed to correct their deficiencies.
6. Provided training to both groups and individuals related to relevant and new nursing procedures standards.
7. Participated as a leader and expert reviewing ongoing clinical procedures, equipment, and facilities to ensure they meet or exceed applicable accreditation standards.

Employer	University of Utah, College of Nursing		
Address	10 South 2000 East, Salt Lake City, Utah		
Title of position	Assistant Professor/Adjunct Assistant Professor		
Total time employed		From: [month year]	To: [month year]

Major areas of responsibility

1. Course and curriculum development, teaching, evaluation and revision for in-person, online, clinical, laboratory and simulation learning environments.
2. Maintaining and expanding clinical competence and participating in role-modeling and mentoring of students in the clinical environment.
3. Mentoring new faculty to the faculty role in didactic, online, clinical, laboratory, and simulation learning environments.
4. Assisting undergraduate and graduate students to incorporate evidence based practice into their professional clinical practice.
5. Participation in scholarly activities, including: conference podium and poster presentations, educational and research grants, and publications.
6. Active involvement in departmental, college, institutional and professional organizations, including: Sigma Theta Tau International, Western Institute of Nursing, and Oncology Nursing Society.
7. Reviewed undergraduate and graduate nursing school applications to assure potential candidates met academic and scholastic standards for admittance to the School of Nursing.
8. Monitored the academic and medical procedures training to ensure anticipated performance is being achieved.
9. Developed individual performance improvement plans (PIP) for nurses who were performing below acceptable levels. Provided regular feedback and suggestions for correction during the PIP process. Instigated removal from the program when nurses failed to correct their deficiencies.
10. Recommended awards and honors for outstanding performance.

CURRENT MEMBER PROFESSIONAL ORGANIZATIONS – Katie Baraki

Sigma Theta Tau International, Nursing Honor's Society
Western Institute of Nursing
Alaska Nurses' Association

LICENSES AND CERTIFICATIONS – Katie Baraki

Alaska RN License	120928	11/2018

BLS/CPR	165505504086	02/2019

ALASKA PACIFIC UNIVERSITY

Course:	NUR 2#### Culturally Safe Nursing Fundamentals
Semester:	Fall (Session)
Credit Hours:	6
Credit Allocation:	2 Credits Inquiry: Estimated 30 hours of in class learning, 60 hours out of class learning activities. 4 Credits Practicum: Estimated 120 hours of field learning, 60 hours out of field learning activities. 1 Credit = 45 hours
Class Meeting Times:	TBD
Course Fee:	TBD
Instructor:	TBD
Email:	TBD
Phone:	TBD
Office:	TBD
Office Hours:	TBD

Course Description
This course incorporates fundamental nursing concepts and skills required for the delivery of culturally safe, effective nursing care of individuals across the lifespan. Emphasis is placed on the development of communication skills, physical assessment, nursing skills, and collaborative medical and pharmacologic interventions within a cultural safety context. Upon completion of this course, the student will be able to safely perform specified independent and collaborative nursing interventions.

Learning Objectives
Through the course, students will:
1. Demonstrate physical assessment of the individual patient.
2. Safely and correctly demonstrate fundamental nursing interventions.
3. Demonstrate professional behaviors, including those associated with personal accountability, legal and ethical concepts, and safety in the provision of nursing care.
4. Document performance of assessment, intervention skills and patient response in the health record.
5. Communicate appropriately and effectively with individual patients and others within the patient care environment.
6. Utilize evidence-based practice in the nursing process when planning patient-centered care.

Active Learning
Active learning refers to the process of deep understanding that comes from interactive and reflective education rather than rote memorization and information recall. For this class, active learning involves:
demonstration, media resources (YouTube and others), role playing, simulation, team-based learning strategies, audio-visual aids, computer-assisted instruction, study and practice groups, case studies, clinical assignments and supervision, post clinical conferences,

utilization of the Detailed Nursing Brain Critical Thinking Tool, practice and return demonstration in learning laboratory.

Instructional/Delivery Methods
This course consists of a series of activities and assessments to assist the learner in achieving the outcomes/objectives for the course. Each week you will complete various combinations of online lectures, assignments, active learning activities, readings, etc.

Required Texts, Readings, Materials
Lewis, S. et al (2017). *Medical-surgical nursing: Assessment and management of clinical problems*. St. Louis, Missouri. Elsevier.
Mkandawire-Valhmu, L. (2018). *Cultural safety, health-care and vulnerable populations.* New York, New York. Routledge.

Reading assignments are included for each unit in the online and in class materials. The readings are designed to both clarify and advance your knowledge of the topics covered in the online and in class components of the course. Course faculty will provide guidance on the readings each week.

Attendance & Participation
Attendance in the clinical laboratory component of this course is vital in order to meet course objectives and the criteria for passing this course. Missing scheduled clinical laboratory days or a portion of a clinical laboratory day will result in deductions to your grade. Students who miss more than one laboratory day place themselves at risk for not meeting course objectives and criteria, which may result in receiving a failing course grade regardless of previous academic standing in the course. There are no options to make up laboratory content, hours or days that are missed. Students who are unable to attend scheduled laboratory hours are expected to notify course faculty before the time they are scheduled to arrive. Failure to notify your instructor prior to the beginning of the laboratory day regarding your absence is considered unprofessional behavior and will result in further grade deductions.

Faculty acknowledge that true-life emergencies do exist and will work with students in these situations as they arise.

Communications Expectations
All official communication regarding courses and APU information goes through APU email. Students are expected to be reading APU email routinely.
[describe any other expectations]

Technical Requirements, Applications, & Services
For technical assistance with APU Learn, MY APU, the Student Portal, contact the IT Helpdesk: 907-564-8350, ithelpdesk@alaskapacific.edu

The emergency notification system allows messages to be sent by text, email, and telephone in the event of an emergency to everyone who voluntarily signs up for this service. To sign up, please go to https://www.alaskapacific.edu/campus-safety/apu-emergency-notification-system/ or search the word “Emergency” on the APU Website. There you can use your APU credentials to log in as you do with APU systems, as well as input your personal contact information and identify how you would like to receive emergency notices.

UAA/APU Consortium Library

Developing the essential competency of Critical Thinking, APU students are challenged to grow their information literacy, and analyze and evaluate sources for truth claims, methodologies, and perspectives. The Consortium Library contributes significantly to the information literacy of our community with rich collections and references, as well as expert staff and online services.

Website: http://lib.uaa.alaska.edu/ Phone: 907-786-1871
Ask-a-Librarian: http://lib.uaa.alaska.edu/research/ask/
To activate your library privileges (for both online and onsite access), contact the IT Department.

Disability Services

It is the policy of Alaska Pacific University to make reasonable accommodations for qualified students with disabilities, in accordance with the Americans with Disabilities Act (ADA). If a student with disabilities needs accommodations, the student must notify the Assistant to the Dean of Students in the Atwood Building. Procedures for documenting student disability and the development of reasonable accommodations will be provided to the student upon request. Assistant to the Dean of Students: Kaili Martin, kamartin@alaskapacific.edu , 907-564-8287.

Students will be notified by the Assistant to the Dean of Students when each request for accommodation is approved or denied. In an effort to protect student privacy, the Assistant to the Dean of Students will not discuss the accommodation needs of any student with instructors, without written student consent. Faculty are not expected to make accommodations for individuals who have not been approved in this manner.

Honor Policy

APU is a community of learners in which all enjoy freedoms and privileges based upon mutual trust and respect as well as a clear sense of responsibility. Students are expected to do all work assigned, to do it honestly and with integrity. Cheating on examinations, plagiarism, or submitting the work of others as one's own are specific examples of prohibited conduct. Students who engage in such activities will be subject to disciplinary measures, which may include failure in the course or expulsion from the university.

Risk Management

[if applicable, include statement regarding risk and management of risk for the course; list skill level that is required for field components or other activities given anticipated risk]

Grades & Grading Policies

The student's final grade will be based on pre-work, participation, professionalism, and post-work. Calculation of grades includes rounding to the nearest whole number for the final score only. You must receive a percentage score of ≥73% to pass this course. Scores on individual assignments/quizzes/exams are not rounded. The following scale will be used to convert a percentage score to a letter grade:

GRADING SCALE:

	B+= 87% - 89%	C+ = 77% - 79%	D+ = 67% - 69%
A = 94% - 100%	B = 83% - 86%	C = 73% - 76%	D = 63% - 66%
A- = 90% - 93%	B- = 80% - 82%	C- = 70% - 72%	D- = 60% - 62%
			E < 60%

Grading Disputes

If you wish to dispute the grade you received on any quiz or assignment, you should contact the course coordinator within 5 business days from the date of the posted grade. After that time, the grade will remain as documented.

Graded Assignments & Components

Calendar & Agenda

Course:	NUR 2#### Foundations of Pathophysiology
Semester:	Fall (Session)
Credit Hours:	3
Credit Allocation:	3 Credits Inquiry: Estimated 45 hours of in class learning, 90 hours out of class learning activities. 1 Credit = 45 hours
Class Meeting Times:	TBD
Course Fee:	TBD
Instructor:	TBD
Email:	TBD
Phone:	TBD
Office:	TBD
Office Hours:	TBD

Course Description
This course explores the mechanisms underlying diseased or altered body functioning, with focus on: cellular communication, genes and genetic disease, forms of cellular injury, fluid and electrolyte/acid base balance, immunity, inflammation, stress coping, and illness. Pathophysiology of the most common alterations according to body systems will be discussed, as well as the latest developments in research and patient-centered nursing interventions.

Learning Objectives
Through the course, students will:
1. Describe the pathophysiological mechanisms that result in disease or altered physiology in individuals across the lifespan.
2. Explain the clinical manifestations resulting from disease or altered physiology.
3. Apply physiological and pathophysiological mechanisms to hypothetical client situations.

Active Learning
Active learning refers to the process of deep understanding that comes from interactive and reflective education rather than rote memorization and information recall. For this class, active learning involves:
demonstration, media resources (YouTube and others), team-based learning strategies, audio-visual aids, computer-assisted instruction, study and practice groups, case studies.

Instructional/Delivery Methods
This course consists of a series of activities and assessments to assist the learner in achieving the outcomes/objectives for the course. Each week you will complete various combinations of online lectures, assignments, active learning activities, readings, etc.

Required Texts, Readings, Materials
McCance, K.L., & Huether, S. E. (2014). *Pathophysiology: The biologic basis of disease in adults and children (7th ed).* St. Louis, Missouri. Mosby.
Mkandawire-Valhmu, L. (2018). *Cultural safety, health-care and vulnerable populations.* New York, New York. Routledge.

Reading assignments are included for each unit in the online and in class materials. The readings are designed to both clarify and advance your knowledge of the topics covered in the online and in class components of the course. Course faculty will provide guidance on the readings each week.

Attendance & Participation
This class requires that you be engaged in the subject matter and in the class. Practically, this means that you must be present in class and arrive on time, speak up during discussions, reflect on your reading and experiences, and actively work with others in a collaborative manner.

To receive credit for participation, students must be present in class and participate in the completion of the learning assignment and submit their work by the end of the class period, unless otherwise instructed.

Students who are absent due to illness, an emergency, or an approved planned absence may make arrangements with the instructor prior to the class session, to complete the assignment outside of the scheduled class time and receive credit. Permission from the instructor must be obtained prior to the scheduled class time (exceptions include a medical or family emergency).

Communications Expectations
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[describe any other expectations]

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Risk Management
[if applicable, include statement regarding risk and management of risk for the course; list skill level that is required for field components or other activities given anticipated risk]

Grades & Grading Policies
[include grading scale and graded weight of all assignments/projects/activities]
The student's final grade will be based on pre-work, participation, professionalism, and post-work. Calculation of grades includes rounding to the nearest whole number for the final score only. You must receive a percentage score of ≥ 73% to pass this course. Scores on individual assignments/quizzes/exams are not rounded. The following scale will be used to convert a percentage score to a letter grade:

GRADING SCALE

	B+= 87% - 89%	C+ = 77% - 79%	D+ = 67% - 69%
A = 94% - 100%	B = 83% - 86%	C = 73% - 76%	D = 63% - 66%
A- = 90% - 93%	B- = 80% - 82%	C- = 70% - 72%	D- = 60% - 62%
			E < 60%

Grading Disputes: If you wish to dispute the grade you received on any quiz or assignment, you should contact the course coordinator within 5 business days from the date of the posted grade. After that time, the grade will remain as documented.

Graded Assignments & Components

Calendar & Agenda

Course:	NUR 2#### Culturally Safe Nursing Practice 1: Introduction to concepts and theory.
Semester:	Fall (Block)
Credit Hours:	3
Credit Allocation:	3 Credits Inquiry: Estimated 45 hours of in class learning, 90 hours out of class learning activities. 1 Credit = 45 hours
Class Meeting Times:	TBD
Course Fee:	TBD
Instructor:	TBD
Email:	TBD
Phone:	TBD
Office:	TBD
Office Hours:	TBD

Course Description

In this course you will learn the skill of self-awareness. This skill is essential for you to be open to the possibilities, wonders, and depths of your nursing experiences, as well as grants you the ability to be culturally safe with the people you encounter on your nursing journey. In this course we hope to spark in you a spirit of inquiry, the desire to want to know; we'll teach you how to ask questions in a way that will lead you to important and sometimes unexpected answers. This course will help you learn how to think about your thinking and will introduce and help you integrate critical thinking principles and processes into your daily practice. We will discover how we tell our stories, what we pay attention to, how we connect the details, and what this tells us about the decisions we make about ourselves, others, nursing, healthcare, groups, communities, and life. We will take this awareness and apply the process as we learn together about the cultural stories of nursing, healthcare, and Alaskan peoples and communities, and discover how these stories impact aspects of your nursing story.

Learning Objectives

Through the course, students will:

1. Demonstrate self-awareness skills required for culturally safe nursing practice as defined by the people they serve.
2. Demonstrate open-minded and flexible attitudes toward people who are different from themselves, to whom they deliver service.
3. Develop self-management and academic skills necessary for academic and professional success.
4. Use personal assessment information to identify how learning, personality, and decision-making styles affect academic, interpersonal, and professional success.
5. Identify and apply the principles of resilience and self-care, as related to body, mind, and spirit.
6. Develop a spirit of inquiry and a systematic approach for explorations of health and cultural concepts, in order to generate shared understanding through thoughtful questioning.
7. Identify and apply the components of effective communication and team building.
8. Discuss the principles and processes of critical thinking and strategies for integrating a critical thinking approach into daily decision-making practices.

Active Learning
Active learning refers to the process of deep understanding that comes from interactive and reflective education rather than rote memorization and information recall. For this class, active learning involves:
demonstration, media resources (YouTube and others), role playing, team-based learning strategies, audio-visual aids, computer-assisted instruction, study and practice groups, case study, utilization of the Detailed Nursing Brain Critical Thinking Tool, practice and return demonstration in learning laboratory.

Instructional/Delivery Methods
This course consists of a series of activities and assessments to assist the learner in achieving the outcomes/objectives for the course. Each week you will complete various combinations of online lectures, assignments, active learning activities, readings, etc.

Required Texts, Readings, Materials
Black, B. (2018) *Professional nursing: Concepts and challenges (8th ed.)*. St. Louis, Missouri. Elsevier.
Mkandawire-Valhmu, L. (2018). *Cultural safety, health-care and vulnerable populations.* New York, New York. Routledge.

Reading assignments are included for each unit in the online and in class materials. The readings are designed to both clarify and advance your knowledge of the topics covered in the online and in class components of the course. Course faculty will provide guidance on the readings each week.

Attendance & Participation
This class requires that you be engaged in the subject matter and in the class. Practically, this means that you must be present in class and arrive on time, speak up during discussions, reflect on your reading and experiences, and actively work with others in a collaborative manner.

To receive credit for participation, students must be present in class, participate in the completion of the learning assignment, and submit their work by the end of the class period, unless otherwise instructed.

Students who are absent due to illness, an emergency, or an approved planned absence may make arrangements with the instructor prior to the class session, to complete the assignment outside of the scheduled class time and receive credit. Permission from the instructor must be obtained prior to the scheduled class time (exceptions include a medical or family emergency).

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Risk Management
[if applicable, include statement regarding risk and management of risk for the course; list skill level that is required for field components or other activities given anticipated risk]

Grades & Grading Policies
The student's final grade will be based on pre-work, participation, professionalism, and post-work. Calculation of grades includes rounding to the nearest whole number for the final score only. You must receive a percentage score of $\geq$ 73% to pass this course. Scores on individual assignments/quizzes/exams are not rounded. The following scale will be used to convert a percentage score to a letter grade:

GRADING SCALE

	B+= 87% - 89%	C+ = 77% - 79%	D+ = 67% - 69%
A = 94% - 100%	B = 83% - 86%	C = 73% - 76%	D = 63% - 66%
A- = 90% - 93%	B- = 80% - 82%	C- = 70% - 72%	D- = 60% - 62%
			E < 60%

Grading Disputes:

If you wish to dispute the grade you received on any quiz or assignment, you should contact the course coordinator within 5 business days from the date of the posted grade. After that time, the grade will remain as documented.

Graded Assignments & Components

Calendar & Agenda

Course:	NUR 2#### Holistic Care of the Chronically Ill: Inquiry and Practicum
Semester:	Spring (Session)
Credit Hours:	6
Credit Allocation:	2 Credits Inquiry: Estimated 30 hours of in class learning, 60 hours out of class learning activities. 4 Credits Practicum: Estimated 120 hours of field learning, 60 hours out of field learning activities. 1 Credit = 45 hours
Class Meeting Times:	TBD
Course Fee:	TBD
Instructor:	TBD
Email:	TBD
Phone:	TBD
Office:	TBD
Office Hours:	TBD

Course Description

This course focuses on the role of the nurse in the culturally safe collaborative healthcare management (nursing, medical and pharmacologic) of individuals experiencing chronic illnesses. It adds to foundational knowledge of pathophysiology, traditional, western-medical and pharmacological interventions, and assists learners as they refine their critical thinking using the nursing process grounded in cultural safety with regards to the care of individuals experiencing chronic illnesses.

Learning Objectives

Through the didactic component of this course, students will:

1. Implement holistic, culturally safe, patient-centered care that reflects an understanding of ethical and legal issues, human growth and development, pathophysiology, pharmacology, medical management, and nursing process management across the health-illness continuum for individuals across the lifespan experiencing chronic conditions.
2. Synthesize applicable nursing and non-nursing theories and concepts from liberal education to build an understanding of the human experience from a cultural safety context.
3. Identify the impact of attitudes, values, and expectations on the care of vulnerable populations.
4. Promote factors that create cultural safety for individuals and families.
5. Integrate cultural safety principles in the delivery of patient and family-centered care for individuals at end of life, including support of rituals and respect for patient and family preferences.
6. Advocate for high quality, culturally safe care as a member of the interprofessional team.
7. Give examples of relevant and recent research as they relate to the culturally safe nursing care of individuals across the lifespan experiencing chronic health conditions.
8. Describe the ethical and legal principles impacting healthcare for individuals across the lifespan, including informed consent, diminished autonomy, individual freedom of choice, and confidentiality.
9. Apply the nursing process to individuals experiencing chronic illness.

10. Utilize critical thinking skills to identify concepts related to disruption of growth and development, physiological disorders, and psychological disorders for individuals across the lifespan.
11. Assume and demonstrate accountability for personal and professional behaviors in the classroom.

Through the clinical component of this course, students will:
1. Demonstrate professional standards of cultural safety, moral, ethical and legal conduct.
2. Demonstrate professionalism, including attention to appearance, demeanor, respect for self and others, and attention to professional boundaries with patients and families as well as among caregivers.
3. Implement holistic, culturally safe, patient-centered care that reflects an understanding of ethical and legal issues, human growth and development, pathophysiology, pharmacology, medical management, and nursing process management across the health-illness continuum for individuals across the lifespan experiencing chronic conditions.
4. Deliver culturally safe, patient-centered, evidence-based care.
5. Create a safe care environment that results in high quality patient outcomes.
6. Provide appropriate patient teaching that reflects developmental stage, age, culture, spirituality, patient preferences, and health literacy considerations to foster individual engagement in the care process.
7. Demonstrate critical thinking and cultural safety skills in implementing evidence-based nursing interventions as appropriate for managing the nursing care of individuals experiencing chronic illness(es) across the lifespan.
8. Demonstrate the application of psychomotor skills for the efficient, safe and culturally safe delivery of patient care.
9. Monitor patient outcomes to evaluate the effectiveness of psychobiological interventions.
10. Collaborate with other healthcare professionals and patients to provide appropriate health promotion and disease/injury prevention interventions to individuals across the lifespan.

Active Learning
Active learning refers to the process of deep understanding that comes from interactive and reflective education rather than rote memorization and information recall. For this class, active learning involves:
demonstration, media resources (YouTube and others), role playing, simulation, team-based learning strategies, audio-visual aids, computer-assisted instruction, study and practice groups, case study, clinical assignments and supervision, post-clinical conferences, utilization of the Detailed Nursing Brain Critical Thinking Tool, practice and return demonstration in learning laboratory.

Instructional/Delivery Methods
This course consists of a series of activities and assessments to assist the learner in achieving the outcomes/objectives for the course. Each week you will complete various combinations of online lectures, assignments, active learning activities, readings, etc.

Required Texts, Readings, Materials
Lewis, S. et al (2017). *Medical-surgical nursing: Assessment and management of clinical problems*. St. Louis, Missouri. Elsevier.
Mkandawire-Valhmu, L. (2018). *Cultural safety, health-care and vulnerable populations.* New York, New York. Routledge.

Reading assignments are included for each unit in the online and in class materials. The readings are designed to both clarify and advance your knowledge of the topics covered in the online and in class components of the course. Course faculty will provide guidance on the readings each week.

Attendance & Participation
This class requires that you be engaged in the subject matter and in the class. Practically, this means that you must be present in class and arrive on time, speak up during discussions, reflect on your reading and experiences, and actively work with others in a collaborative manner.

To receive credit for participation, students must be present in class and clinicals, participate in the completion of the didactic and clinical learning assignments and activities, and submit their work as indicated by course instructors.

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Disability Services
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student with disabilities needs accommodations, the student must notify the Assistant to the Dean of Students in the Atwood Building. Procedures for documenting student disability and the development of reasonable accommodations will be provided to the student upon request. Assistant to the Dean of Students: Kaili Martin, kamartin@alaskapacific.edu , 907-564-8287.

Students will be notified by the Assistant to the Dean of Students when each request for accommodation is approved or denied. In an effort to protect student privacy, the Assistant to the Dean of Students will not discuss the accommodation needs of any student with instructors, without written student consent. Faculty are not expected to make accommodations for individuals who have not been approved in this manner.

Honor Policy
APU is a community of learners in which all enjoy freedoms and privileges based upon mutual trust and respect as well as a clear sense of responsibility. Students are expected to do all work assigned, to do it honestly and with integrity. Cheating on examinations, plagiarism, or submitting the work of others as one's own are specific examples of prohibited conduct. Students who engage in such activities will be subject to disciplinary measures, which may include failure in the course or expulsion from the university.

Risk Management
[if applicable, include statement regarding risk and management of risk for the course; list skill level that is required for field components or other activities given anticipated risk]

Grades & Grading Policies
The student's final grade will be based on pre-work, participation, professionalism, and post-work. Calculation of grades includes rounding to the nearest whole number for the final score only. You must receive a percentage score of $\geq$ 73% to pass this course. Scores on individual assignments/quizzes/exams are not rounded. The following scale will be used to convert a percentage score to a letter grade:

GRADING SCALE

	B+= 87% - 89%	C+ = 77% - 79%	D+ = 67% - 69%
A = 94% - 100%	B = 83% - 86%	C = 73% - 76%	D = 63% - 66%
A- = 90% - 93%	B- = 80% - 82%	C- = 70% - 72%	D- = 60% - 62%
			E < 60%

Grading Disputes:

If you wish to dispute the grade you received on any quiz or assignment, you should contact the course coordinator within 5 business days from the date of the posted grade. After that time, the grade will remain as documented.

Graded Assignments & Components

Calendar & Agenda

Course:	NUR 2#### Culturally Safe Mental and Behavioral Health Nursing Practice
Semester:	Spring (Session)
Credit Hours:	3
Credit Allocation:	2 Credits Inquiry: Estimated 30 hours of in class learning, 60 hours out of class learning activities. 1 Credits Practicum: Estimated 30 hours of field learning, 15 hours out of field learning activities. 1 Credit = 45 hours
Class Meeting Times:	TBD
Course Fee:	TBD
Instructor:	TBD
Email:	TBD
Phone:	TBD
Office:	TBD
Office Hours:	TBD

Course Description

This course focuses on the concepts of: utilizing basic human needs, developmental theory, nursing processes, therapeutic communication, and nursing interventions to promote and maintain health for clients and families experiencing mental health issues. The student will examine client response to stressors across the lifespan. Tasks of biological-behavioral concepts in psychosocial nursing care will be addressed, as well as rural and cultural impacts. It includes a clinical that will apply the knowledge of psychiatric and mental health nursing. Students will have mental health focused clinical experiences in a variety of settings across the lifespan.

Learning Objectives

Through the didactic component of this course, students will:

1. Implement holistic, culturally safe, patient-centered care that reflects an understanding of ethical and legal issues, human growth and development, pathophysiology, pharmacology, mental and behavioral health management and nursing process management across the health-illness continuum for individuals across the lifespan experiencing mental health and/or behavioral health conditions.
2. Synthesize applicable nursing, psychological and non-nursing theories and concepts from liberal education to build an understanding of the human experience from a cultural safety context.
3. Identify the impact of attitudes, values, and expectations on the care of vulnerable populations experiencing mental health and/or behavioral health conditions across the lifespan.
4. Promote factors that create cultural safety for individuals and families.
5. Integrate cultural safety principles in the delivery of patient and family-centered care for individuals impacted by suicide.
6. Advocate for high quality, culturally safe care as a member of the interprofessional team.

7. Give examples of relevant and recent research as they relate to the culturally safe nursing care of individuals across the lifespan experiencing mental health and/or behavioral health conditions.
8. Apply the nursing process to individuals experiencing mental health and/or behavioral health conditions across the lifespan.
10. Compare and contrast the difference in mental health and behavioral health resources in urban and rural geographic areas.
11. Assume and demonstrate accountability for personal and professional behaviors in the classroom.

Through the clinical component of this course, students will:
1. Demonstrate professional standards of cultural safety, moral, ethical and legal conduct.
2. Demonstrate professionalism, including attention to appearance, demeanor, respect for self and others, and attention to professional boundaries with patients and families as well as among caregivers.
3. Implement holistic, culturally safe, patient-centered care that reflects an understanding of ethical and legal issues, human growth and development, pathophysiology, pharmacology, mental and behavioral and nursing process management across the health-illness continuum for individuals across the lifespan experiencing mental health and/or behavioral health conditions.
4. Demonstrate increasing competency in using culturally safe, therapeutic communication skills with individuals experiencing mental health and/or behavioral health conditions across the lifespan.
5. Demonstrate the ability to observe and describe problematic behavior in the clinical setting.
6. Analyze clinical therapeutic modalities and their effectiveness with individuals experiencing mental health and/or behavioral health conditions across the lifespan.
7. Assume accountability for personal and professional behaviors.
8. Provide appropriate patient teaching that reflects developmental stage, age, culture, spirituality, patient preferences, and health literacy considerations to foster individual engagement in care processes.
9. Implement evidence-based nursing interventions as appropriate for managing the culturally safe, care for individuals experiencing mental health and/or behavioral health conditions across the lifespan.
10. Monitor individual outcomes to evaluate the effectiveness of psychobiological interventions.
11. Create and maintain a safe and effective therapeutic milieu that results in high quality care outcomes.

Active Learning
Active learning refers to the process of deep understanding that comes from interactive and reflective education rather than rote memorization and information recall. For this class, active learning involves:
demonstration, media resources (YouTube and others), role playing, simulation, team-based learning strategies, audio-visual aids, computer-assisted instruction, study and practice groups, case studies, clinical assignments and supervision, post-clinical conferences, utilization of the Detailed Nursing Brain Critical Thinking Tool, practice and return demonstration in learning laboratory.

Instructional/Delivery Methods
This course consists of a series of activities and assessments to assist the learner in achieving the outcomes/objectives for the course. Each week you will complete various

combinations of online lectures, assignments, active learning activities, readings, etc.

Required Texts, Readings, Materials

Mkandawire-Valhmu, L. (2018). *Cultural safety, health-care and vulnerable populations.* New York, New York. Routledge.

Halter, M. (2017). *Varcarolis' foundations of psychiatric-mental health nursing: A clinical approach (8th ed.).* St. Louis, Missouri. Elsevier.

Reading assignments are included for each unit in the online and in class materials. The readings are designed to both clarify and advance your knowledge of the topics covered in the online and in class components of the course. Course faculty will provide guidance on the readings each week.

Attendance & Participation

This class requires that you be engaged in the subject matter and in the class. Practically, this means that you must be present in class and arrive on time, speak up during discussions, reflect on your reading and experiences, and actively work with others in a collaborative manner.

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Risk Management
[if applicable, include statement regarding risk and management of risk for the course; list skill level that is required for field components or other activities given anticipated risk]

Grades & Grading Policies
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	B+= 87% - 89%	C+ = 77% - 79%	D+ = 67% - 69%
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Graded Assignments & Components

Calendar & Agenda

ALASKA PACIFIC UNIVERSITY

Course:	NUR 2#### Culturally Safe Professional Nursing Practice 2: Critical Thinking and Evidence Evaluation
Semester:	Spring (Block)
Credit Hours:	3
Credit Allocation:	3 Credits Inquiry: Estimated 45 hours of in class learning, 90 hours out of class learning activities. 1 Credit = 45 hours
Class Meeting Times:	TBD
Course Fee:	TBD
Instructor:	TBD
Email:	TBD
Phone:	TBD
Office:	TBD
Office Hours:	TBD

Course Description

In this course you will learn about the multifaceted nursing roles required for culturally safe professional nursing practice. These roles include the nurse as advocate, teacher, caregiver, safeguard, and researcher, practicing in layers of cultural contexts. You will learn about nursing and cultural concepts you will encounter in your nursing practice from different cultural perspectives. You will learn about nursing ethics, including an analysis of the ANA Code of Ethics, ethical decision-making processes, and how to establish and maintain appropriate professional boundaries. You will learn about the nurse as a part of the healthcare team and how to be effective in your roles on that team. You will learn how integrate critical thinking principles and practices into the nursing process to support sound, ethical, effective clinical decision making. We will discuss the current state of nursing's story and the scope of nursing practice in vastly different healthcare contexts. We will discuss questions such as what is currently important to nurses and to nursing, and what is nursing's story about our profession? We will have frank conversations about if that is what we want our story to be and what do we do if it's not. We will take your spirit of inquiry and apply your literature review skills to evaluate health, wellness, illness and healing knowledge from the many ways of knowing – to help inform your culturally safe nursing practice.

Learning Objectives

Through the course, students will:

1. Discover, delineate and discuss the multifaceted roles of nurses, including the nurse as: advocate, caregiver, teacher, safeguard, researcher, and member on the interdisciplinary healthcare team.
2. Compare and contrast nursing and cultural concepts through the lenses of nursing and healthcare team member roles and discuss potential solutions for concepts with competing priorities and resources.
3. Develop a working understanding of nursing ethics, including the ANA Code of Ethics, application of ethical decision-making processes, and how to establish and maintain appropriate professional boundaries.

4. Apply principles of effective communication and team-building to interdisciplinary team scenarios and refine communication and teambuilding skills through practice.
5. Utilize literature review skills to evaluate health, wellness, illness and healing knowledge from the many ways of knowing to inform the development of culturally safe nursing practice.
6. Analyze the current state of nursing in a variety of healthcare contexts and settings, through investigating topics of relevance to nursing in local, state and national contexts.

Active Learning
Active learning refers to the process of deep understanding that comes from interactive and reflective education rather than rote memorization and information recall. For this class, active learning involves:
demonstration, media resources (YouTube and others), role playing, team-based learning strategies, audio-visual aids, computer-assisted instruction, study and practice groups, case studies, utilization of the Detailed Nursing Brain Critical Thinking Tool, practice and return demonstration in learning laboratory.

Instructional/Delivery Methods
This course consists of a series of activities and assessments to assist the learner in achieving the outcomes/objectives for the course. Each week you will complete various combinations of online lectures, assignments, active learning activities, readings, etc.

Required Texts, Readings, Materials
Black, B. (2018) *Professional nursing: Concepts and challenges (8th ed.)*. St. Louis, Missouri. El Sevier.
Mkandawire-Valhmu, L. (2018). *Cultural safety, health-care and vulnerable populations.* New York, New York. Routledge.

Reading assignments are included for each unit in the online and in class materials. The readings are designed to both clarify and advance your knowledge of the topics covered in the online and in class components of the course. Course faculty will provide guidance on the readings each week.

Attendance & Participation
This class requires that you be engaged in the subject matter and in the class. Practically, this means that you must be present in class and arrive on time, speak up during discussions, reflect on your reading and experiences, and actively work with others in a collaborative manner.

To receive credit for participation, students must be present in class, participate in the completion of the learning assignment, and submit their work by the end of the class period, unless otherwise instructed.

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Risk Management

[if applicable, include statement regarding risk and management of risk for the course; list skill level that is required for field components or other activities given anticipated risk]

Grades & Grading Policies

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work. Calculation of grades includes rounding to the nearest whole number for the final score only. You must receive a percentage score of ≥ 73% to pass this course. Scores on individual assignments/quizzes/exams are not rounded. The following scale will be used to convert a percentage score to a letter grade:

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			E < 60%

Grading Disputes:

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Graded Assignments & Components

Calendar & Agenda

Course:	NUR 3#### Holistic Care of the Acutely Ill: Inquiry and Practicum
Semester:	Fall (Session)
Credit Hours:	6
Credit Allocation:	2 Credits Inquiry: Estimated 1 hour of in class learning, 2 hours out of class learning activities. 4 Credits Practicum: Estimated 2 hours of field learning, 1 hour out of field learning activities. 1 Credit = 45 hours
Class Meeting Times:	TBD
Course Fee:	TBD
Instructor:	TBD
Email:	TBD
Phone:	TBD
Office:	TBD
Office Hours:	TBD

Course Description
This course focuses on the role of the nurse in the culturally safe collaborative healthcare management (nursing, medical and pharmacologic) of individuals experiencing acute illnesses. It adds to foundational knowledge of pathophysiology, traditional, western-medical and pharmacologic interventions and assists learners as they refine their critical thinking using the nursing process grounded in cultural safety in the care of individuals experiencing acute illnesses.

Learning Objectives
Through the didactic component of this course, students will:
1. Implement holistic, culturally safe, patient-centered care that reflects an understanding of ethical and legal issues, human growth and development, pathophysiology, pharmacology, medical management, and nursing process management across the health-illness continuum for individuals across the lifespan experiencing acute health conditions.
2. Synthesize applicable nursing and non-nursing theories and concepts from liberal education to build an understanding of the human experience from a cultural safety context.
3. Identify the impact of attitudes, values, and expectations on the care of vulnerable populations.
4. Promote factors that create cultural safety for individuals and families.
5. Integrate cultural safety principles in the delivery of patient and family-centered care for individuals at end of life, including support of rituals and respect for patient and family preferences.
6. Advocate for high quality, culturally safe care as a member of the interprofessional team.
7. Give examples of relevant and recent research as they relate to the culturally safe nursing care of individuals across the lifespan experiencing acute health conditions.
8. Describe the ethical and legal principles impacting healthcare for individuals across the lifespan, including informed consent, diminished autonomy, individual freedom of choice, and confidentiality.
9. Apply the nursing process to individuals experiencing acute health conditions.

10. Utilize critical thinking skills to identify concepts related to disruption of growth and development, physiological disorders and psychological disorders for individuals across the lifespan.
11. Assume and demonstrate accountability for personal and professional behaviors in the classroom.

Through the clinical component of this course, students will:
1. Demonstrate professional standards of cultural safety, moral, ethical and legal conduct.
2. Demonstrate professionalism, including attention to appearance, demeanor, respect for self and others, and attention to professional boundaries with patients and families as well as among caregivers.
3. Implement holistic, culturally safe, patient-centered care that reflects an understanding of ethical and legal issues, human growth and development, pathophysiology, pharmacology, medical management, and nursing process management across the health-illness continuum for individuals across the lifespan experiencing acute health conditions.
4. Deliver culturally safe, patient-centered, evidence-based care.
5. Create a safe care environment that results in high quality patient outcomes.
6. Provide appropriate patient teaching that reflects developmental stage, age, culture, spirituality, patient preferences, and health literacy considerations to foster individual engagement in the care process.
7. Demonstrate critical thinking and cultural safety skills in implementing evidence-based nursing interventions as appropriate for managing the nursing care of individuals experiencing acute health conditions across the lifespan.
8. Demonstrate the application of psychomotor skills for the efficient, safe and culturally safe delivery of patient care.
9. Monitor patient outcomes to evaluate the effectiveness of psychobiological interventions.
10. Collaborate with other healthcare professionals and patients to provide appropriate health promotion and disease/injury prevention interventions to individuals across the lifespan.

Active Learning
Active learning refers to the process of deep understanding that comes from interactive and reflective education rather than rote memorization and information recall. For this class, active learning involves:
demonstration, media resources (YouTube and others), role playing, simulation, team-based learning strategies, audio-visual aids, computer-assisted instruction, study and practice groups, case studies, clinical assignments and supervision, post clinical conferences, utilization of the Detailed Nursing Brain Critical Thinking Tool, practice and return demonstration in learning laboratory.

Instructional/Delivery Methods
This course consists of a series of activities and assessments to assist the learner in achieving the outcomes/objectives for the course. Each week you will complete various combinations of online lectures, assignments, active learning activities, readings, etc.

Required Texts, Readings, Materials
Lewis, S. et al (2017). *Medical-surgical nursing: Assessment and management of clinical problems*. St. Louis, Missouri. Elsevier.
Mkandawire-Valhmu, L. (2018). *Cultural safety, health-care and vulnerable populations.* New York, New York. Routledge.

Reading assignments are included for each unit in the online and in class materials. The readings are designed to both clarify and advance your knowledge of the topics covered in the online and in class components of the course. Course faculty will provide guidance on the readings each week.

Attendance & Participation
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Risk Management
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Grades & Grading Policies
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	B+= 87% - 89%	C+ = 77% - 79%	D+ = 67% - 69%
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			E < 60%

Grading Disputes:

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Graded Assignments & Components

Calendar & Agenda

Course:	NUR 3#### Holistic Care of Parents & Newborns: Inquiry & Practicum
Semester:	Fall (Session)
Credit Hours:	3
Credit Allocation:	1 Credits Inquiry: Estimated 15 hours of in class learning, 30 hours out of class learning activities. 2 Credits Practicum: Estimated 60 hours of field learning, 30 hours out of field learning activities. 1 Credit = 45 hours
Class Meeting Times:	TBD
Course Fee:	TBD
Instructor:	TBD
Email:	TBD
Phone:	TBD
Office:	TBD
Office Hours:	TBD

Course Description
This course focuses on nursing care of childbearing families using both nursing and developmental theories. Biopsychosocial factors, legal, ethical, cultural, and educational considerations related to pregnancy, birth and newborn periods are included. An historical overview of obstetrical advances and parent-child nursing are presented. This course includes practice in providing nursing care to families during each phase of the childbearing cycle in Alaska hospitals and clinics. The nursing process is used with emphasis on the theoretical and empirical basis of practice. Experience in patient/family teaching such as childbirth classes is included.

Learning Objectives
Through the didactic course, students will:
1. Define legal, cultural, ethical, economic, historical, and political factors which impact the delivery of family-centered healthcare.
2. Describe normal and abnormal physiological and psychological changes that occur ding each period of the childbearing cycle and newborn period.
3. Discuss the role of the nurse that reflects a culturally safe understanding of the legal, ethical, and cultural issues that impact the childbearing family.
4. Use relevant evidence-based practice for culturally safe decision making in relation to childbearing families and the newborn.
5. Synthesize theories and concepts from liberal education to build a culturally safe understanding of the human experience.
6. Discuss the role of the nurse and the use of nursing standards to monitor patient/family care.
7. Prepare a teaching plan based on principles of teaching and learning.
8. Discuss caring in relation to nursing the childbearing family and newborn.
9. Demonstrate responsibility for growth and development as a learner and a professional.
10. Apply theory related to cultural safety, ethics, computer-human interfaces, confidentiality and privacy, ergonomics, and nursing informatics to nursing practice.

Through the clinical course, students will:
1. Use evidence-based information to formulate and modify the nursing plan of care.
2. Use the nursing process to plan holistic, culturally safe nursing care for the childbearing family.
3. Demonstrate effective, culturally safe communication with individuals and families to promote optimal well-being.
4. Utilize cultural safety principles, the nursing process, and safety practices in the care of all individuals and families.
5. Implement a teaching plan using principles of nutrition for the antepartum patient and/or the breastfeeding patient.
6. Demonstrate collaborative skills with members of the interdisciplinary healthcare team in planning, coordinating, providing and evaluating patient care for the childbearing client.
7. Perform culturally safe nursing interventions that reflect caring behaviors in response to physical, emotional, cultural, and humanistic care needs.
8. Demonstrate professionalism, including accountability, cultural safety, attention to appearance, demeanor, respect for self and others, and attention to professional boundaries with patients and families as well as among caregivers.
9. Develop patient teaching that reflects developmental stage, age, culture, spirituality, patient preferences and health literacy considerations to foster patient engagement in care.
10. Demonstrate performance of nursing psychomotor skills in a safe manner.
11. Utilize organizational skills and time management concepts in setting priorities in providing patient care.
12. Demonstrate critical thinking decision making based on standards of practice, theory, cultural safety, research, and other ways of knowing.
13. Apply ethical standards related to data security, regulatory requirements, confidentiality, and individual right to privacy.
14. Demonstrate professional standards of moral, ethical, and legal conduct.
15. Create a safe care environment that results in high quality health outcomes.

Active Learning
Active learning refers to the process of deep understanding that comes from interactive and reflective education rather than rote memorization and information recall. For this class, active learning involves:
demonstration, media resources (YouTube and others), role playing, simulation, team-based learning strategies, audio-visual aids, computer-assisted instruction, study and practice groups, case studies, clinical assignments and supervision, post-clinical conferences, utilization of the Detailed Nursing Brain Critical Thinking Tool, practice and return demonstration in learning laboratory.

Instructional/Delivery Methods
This course consists of a series of activities and assessments to assist the learner in achieving the outcomes/objectives for the course. Each week you will complete various combinations of online lectures, assignments, active learning activities, readings, etc.

Required Texts, Readings, Materials
Murray, S., McKinney, E., Holub, K., & Jones, R. (2018) *Foundations of maternal-newborn and women's health nursing (7th ed.).* St. Louis, Missouri. Elsevier.

Reading assignments are included for each unit in the online and in class materials. The readings are designed to both clarify and advance your knowledge of the topics covered in

the online and in class components of the course. Course faculty will provide guidance on the readings each week.

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Risk Management

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Grades & Grading Policies

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GRADING SCALE

	B+= 87% - 89%	C+ = 77% - 79%	D+ = 67% - 69%
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A- = 90% - 93%	B- = 80% - 82%	C- = 70% - 72%	D- = 60% - 62%
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Grading Disputes:

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Graded Assignments & Components

Calendar & Agenda

Course:	NUR 3#### Culturally Safe Professional Nursing Practice 3: Critical Thinking and Evidence Integration
Semester:	Fall (Block)
Credit Hours:	3
Credit Allocation:	3 Credits Inquiry: Estimated 45 hours of in class learning, 90 hours out of class learning activities. 1 Credit = 45 hours
Class Meeting Times:	TBD
Course Fee:	TBD
Instructor:	TBD
Email:	TBD
Phone:	TBD
Office:	TBD
Office Hours:	TBD

Course Description
This course focuses on building the knowledge and skills necessary to take the perspectives of others – a critical skill for patient-centered care. What is their story? How do they see nurses, nursing, and related concepts? What do they need from nurses – and more directly, what do they need from you? This course will challenge you to explore nursing concepts from unique individual perspectives, including concepts such as health and wellness, suffering and healing, age and youth, death and dying, life and living, individual and family, and community and belonging. The intent is to help you gain the awareness and perspective of the unique, unfamiliar other. This course will show you how to apply critical thinking skills and the nursing process to evaluate the value of proposed solutions/interventions from different ways of knowing for your unique, individual patients.

Learning Objectives
Through the course, students will:
1. Develop the skills necessary for perspective-taking to facilitate culturally safe nursing care that is defined by those being served.
2. Explore nursing and cultural concepts of health and illness through unique, individual perspectives to inform culturally-safe, clinical decision-making practices.
3. Apply cultural safety and critical thinking skills to the nursing process in the selection, evaluation, and critique of proposed solutions and interventions derived from different ways of knowing.
4. Develop a literature review on a topic of impact for an Alaskan community utilizing literature review and evaluation techniques.

Active Learning
Active learning refers to the process of deep understanding that comes from interactive and reflective education rather than rote memorization and information recall. For this class, active learning involves:
demonstration, media resources (YouTube and others), role playing, team-based learning strategies, audio-visual aids, computer-assisted instruction, study and practice groups, case

studies, utilization of the Detailed Nursing Brain Critical Thinking Tool, practice and return demonstration in learning laboratory.

Instructional/Delivery Methods
This course consists of a series of activities and assessments to assist the learner in achieving the outcomes/objectives for the course. Each week you will complete various combinations of online lectures, assignments, active learning activities, readings, etc.

Required Texts, Readings, Materials
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Attendance & Participation
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Graded Assignments & Components

Calendar & Agenda

Course:	NUR 3#### Transition to Registered Nursing Practice: Inquiry & Practicum
Semester:	Spring (Full)
Credit Hours:	6
Credit Allocation:	1 Credits Inquiry: Estimated 15 hours of in class learning, 30 hours out of class learning activities. 5 Credits Practicum: Estimated 150 hours of field learning, 75 hours out of field learning activities. 1 Credit = 45 hours
Class Meeting Times:	TBD
Course Fee:	TBD
Instructor:	TBD
Email:	TBD
Phone:	TBD
Office:	TBD
Office Hours:	TBD

Course Description

This course focuses on building the knowledge and skills needed for practice as a registered nurse in the microsystem of a work unit. Emphasis is placed on contemporary healthcare issues and developing skills requisite for high quality, effective, culturally safe care. Legal and ethical issues are discussed with a focus on personal accountability and responsibility. Standards of practice and the significance of functioning according to state regulations and statures within a cultural safety framework are analyzed. Precepted clinical experiences provide the student the opportunity to apply and integrate theoretical concepts, time management, prioritization, nursing and healthcare interventions, and cultural safety into registered nursing practice.

Learning Objectives

Through the course, students will:

1. Discuss the components of cultural safety, clinical reasoning, decision making, communication, and evidence-based practice and how a nurse uses these tools to provide comprehensive, efficient, safe, high quality care for patients.
2. Explain the importance of and demonstrate accountability for: optimal nursing care, legal and ethical standards, lifelong learning, cultural safety, professional development, promoting the nursing profession and participating as an active community member.
3. Identify the benefits of networking, mentoring, and participating in local, state and national nursing, healthcare and community organizations.
4. Use patient care technologies to enhance the safety and quality of nursing care practices.
5. Integrate knowledge of policies, procedures, regulatory standards and evidence-based practice into individual nursing practice.
6. Plan strategies for the successful transition into registered nursing practice, including: NCLEX preparation and licensure, resume development, interviewing skills, self-care and resilience skills.
7. Examine the impact of a unit structure, culture and climate on the delivery of patient-centered care.

8. Implement improvement methods based on outcomes data, to improve the quality and safety of nursing care.
9. Integrate and apply theoretical concepts, time management skills, prioritization and organization strategies, nursing and healthcare interventions, and cultural safety principles to registered nursing practice.

Active Learning
Active learning refers to the process of deep understanding that comes from interactive and reflective education rather than rote memorization and information recall. For this class, active learning involves:
demonstration, media resources (YouTube and others), role playing, simulation, team-based learning strategies, audio-visual aids, computer-assisted instruction, study and practice groups, case studies, clinical assignments and supervision, post-clinical conferences, utilization of the Detailed Nursing Brain Critical Thinking Tool, practice and return demonstration in learning laboratory.

Instructional/Delivery Methods
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Graded Assignments & Components

Calendar & Agenda

Course:	NUR 3#### Holistic Care of the Critically Ill: Inquiry and Lab (Elective)
Semester:	Spring (Session)
Credit Hours:	3
Credit Allocation:	1 Credits Inquiry: Estimated 15 hours of in class learning, 30 hours out of class learning activities. 2 Credits Practicum: Estimated 60 hours of field learning, 30 hours out of field learning activities. 1 Credit = 45 hours
Class Meeting Times:	TBD
Course Fee:	TBD
Instructor:	TBD
Email:	TBD
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Office Hours:	TBD

Course Description
This course focuses on the role of the nurse in the culturally safe collaborative healthcare management (nursing, medical and pharmacologic) of individuals experiencing critical, life-threatening health conditions. It adds to foundational knowledge of pathophysiology, traditional, western-medical and pharmacologic interventions and assists learners as they refine their critical thinking using the nursing process grounded in cultural safety in the care of individuals experiencing critical, life-threatening health conditions.

Learning Objectives
Through the didactic component of this course, students will:
1. Implement holistic, culturally safe, patient-centered care that reflects an understanding of ethical and legal issues, human growth and development, pathophysiology, pharmacology, medical management, and nursing process management for individuals across the lifespan experiencing critical, life-threatening health conditions.
2. Synthesize applicable nursing and non-nursing theories and concepts from liberal education to build an understanding of the human experience from a cultural safety context.
3. Identify the impact of attitudes, values, and expectations on the care of vulnerable populations.
4. Promote factors that create cultural safety for individuals and families.
5. Integrate cultural safety principles in the delivery of patient and family-centered care for individuals at end of life, including support of rituals and respect for patient and family preferences.
6. Advocate for high quality, culturally safe care as a member of the interprofessional team.
7. Give examples of relevant and recent research as they relate to the culturally safe nursing care of individuals across the lifespan experiencing critical, life-threatening health conditions.
8. Describe the ethical and legal principles impacting healthcare for individuals across the lifespan, including informed consent, diminished autonomy, individual freedom of choice, and confidentiality.

9. Apply the nursing process to individuals experiencing critical, life-threatening health conditions.
10. Utilize critical thinking skills to identify concepts related to disruption of growth and development, physiological disorders and psychological disorders for individuals across the lifespan.
11. Assume and demonstrate accountability for personal and professional behaviors in the classroom.

Through the clinical component of this course, students will:
1. Demonstrate professional standards of cultural safety, moral, ethical and legal conduct.
2. Demonstrate professionalism, including attention to appearance, demeanor, respect for self and others, and attention to professional boundaries with patients and families as well as among caregivers.
3. Implement holistic, culturally safe, patient-centered care that reflects an understanding of ethical and legal issues, human growth and development, pathophysiology, pharmacology, medical management, and nursing process management across the health-illness continuum for individuals across the lifespan experiencing critical, life-threatening health conditions.
4. Deliver culturally safe, patient-centered, evidence-based care.
5. Create a safe care environment that results in high quality patient outcomes.
6. Provide appropriate patient teaching that reflects developmental stage, age, culture, spirituality, patient preferences, and health literacy considerations to foster individual engagement in the care process.
7. Demonstrate critical thinking and cultural safety skills in implementing evidence-based nursing interventions as appropriate for managing the nursing care of individuals experiencing critical, life-threatening health conditions across the lifespan.
8. Demonstrate the application of psychomotor skills for the efficient, safe and culturally safe delivery of patient care.
9. Monitor patient outcomes to evaluate the effectiveness of psychobiological interventions.
10. Collaborate with other healthcare professionals and patients to provide appropriate health promotion and disease/injury prevention interventions to individuals across the lifespan.

Active Learning
Active learning refers to the process of deep understanding that comes from interactive and reflective education rather than rote memorization and information recall. For this class, active learning involves:
demonstration, media resources (YouTube and others), role playing, simulation, team-based learning strategies, audio-visual aids, computer-assisted instruction, study and practice groups, case studies, clinical assignments and supervision, post-clinical conferences, utilization of the Detailed Nursing Brain Critical Thinking Tool, practice and return demonstration in learning laboratory.

Instructional/Delivery Methods
This course consists of a series of activities and assessments to assist the learner in achieving the outcomes/objectives for the course. Each week you will complete various combinations of online lectures, assignments, active learning activities, readings, etc.

Required Texts, Readings, Materials
Lewis, S. et al (2017). *Medical-surgical nursing: Assessment and management of clinical problems*. St. Louis, Missouri. Elsevier.
Mkandawire-Valhmu, L. (2018). *Cultural safety, health-care and vulnerable populations.* New York, New York. Routledge.

Reading assignments are included for each unit in the online and in class materials. The readings are designed to both clarify and advance your knowledge of the topics covered in the online and in class components of the course. Course faculty will provide guidance on the readings each week.

Attendance & Participation
This class requires that you be engaged in the subject matter and in the class. Practically, this means that you must be present in class and arrive on time, speak up during discussions, reflect on your reading and experiences, and actively work with others in a collaborative manner.

To receive credit for participation, students must be present in class, clinicals, and participate in the completion of the didactic and clinical learning assignments and activities, and submit their work as indicated by course instructors.

Students who are absent due to illness, an emergency, or an approved planned absence may make arrangements with the instructor prior to the class session to complete the assignment outside of the scheduled class time and receive credit. Permission from the instructor must be obtained prior to the scheduled class time (exceptions include a medical or family emergency).

Communications Expectations
All official communication regarding courses and APU information goes through APU email. Students are expected to be reading APU email routinely.

Technical Requirements, Applications, & Services
- For technical assistance with APU Learn, MY APU, the Student Portal, contact the IT Helpdesk: 907-564-8350, ithelpdesk@alaskapacific.edu
- The emergency notification system allows messages to be sent by text, email, and telephone in the event of an emergency to everyone who voluntarily signs up for this service. To sign up, please go to https://www.alaskapacific.edu/campus-safety/apu-emergency-notification-system/ or search the word "Emergency" on the APU Website. There you can use your APU credentials to log in as you do with APU systems, as well as input your personal contact information and identify how you would like to receive emergency notices.

UAA/APU Consortium Library
Developing the essential competency of Critical Thinking, APU students are challenged to grow their information literacy, and analyze and evaluate sources for truth claims, methodologies, and perspectives. The Consortium Library contributes significantly to the information literacy of our community with rich collections and references, as well as expert staff and online services.

Website: http://lib.uaa.alaska.edu/ Phone: 907-786-1871
Ask-a-Librarian: http://lib.uaa.alaska.edu/research/ask/
To activate your library privileges (for both online and onsite access), contact the IT Department.

Disability Services
It is the policy of Alaska Pacific University to make reasonable accommodations for qualified students with disabilities, in accordance with the Americans with Disabilities Act (ADA). If a

student with disabilities needs accommodations, the student must notify the Assistant to the Dean of Students in the Atwood Building. Procedures for documenting student disability and the development of reasonable accommodations will be provided to the student upon request. Assistant to the Dean of Students: Kaili Martin, kamartin@alaskapacific.edu , 907-564-8287.

Students will be notified by the Assistant to the Dean of Students when each request for accommodation is approved or denied. In an effort to protect student privacy, the Assistant to the Dean of Students will not discuss the accommodation needs of any student with instructors, without written student consent. Faculty are not expected to make accommodations for individuals who have not been approved in this manner.

Honor Policy
APU is a community of learners in which all enjoy freedoms and privileges based upon mutual trust and respect as well as a clear sense of responsibility. Students are expected to do all work assigned, to do it honestly and with integrity. Cheating on examinations, plagiarism, or submitting the work of others as one's own are specific examples of prohibited conduct. Students who engage in such activities will be subject to disciplinary measures, which may include failure in the course or expulsion from the university.

Risk Management
[if applicable, include statement regarding risk and management of risk for the course; list skill level that is required for field components or other activities given anticipated risk]

Grades & Grading Policies
The student's final grade will be based on pre-work, participation, professionalism, and post-work. Calculation of grades includes rounding to the nearest whole number for the final score only. You must receive a percentage score of $\geq$ 73% to pass this course. Scores on individual assignments/quizzes/exams are not rounded. The following scale will be used to convert a percentage score to a letter grade:

GRADING SCALE

	B+= 87% - 89%	C+ = 77% - 79%	D+ = 67% - 69%
A = 94% - 100%	B = 83% - 86%	C = 73% - 76%	D = 63% - 66%
A- = 90% - 93%	B- = 80% - 82%	C- = 70% - 72%	D- = 60% - 62%
			E < 60%

Grading Disputes:

If you wish to dispute the grade you received on any quiz or assignment, you should contact the course coordinator within 5 business days from the date of the posted grade. After that time, the grade will remain as documented.

Graded Assignments & Components

Calendar & Agenda

Course:	NUR 3#### Culturally Safe Professional Nursing Practice 4: Critical Thinking and Synthesis of Evidence
Semester:	Spring (Full)
Credit Hours:	3
Credit Allocation:	3 Credits Inquiry: Estimated 45 hours of in class learning, 90 hours out of class learning activities. 1 Credit = 45 hours
Class Meeting Times:	TBD
Course Fee:	TBD
Instructor:	TBD
Email:	TBD
Phone:	TBD
Office:	TBD
Office Hours:	TBD

Course Description
This course assists the student with applying critical thinking skills and the nursing process in the synthesis of evidence from nursing, healthcare, and traditional ways of knowing into culturally safe recommendations to improve the health of Alaskan communities. Learners will apply principles of Evidence-Based Practice to an approved topic of their choice. For this topic, learners will generate a synthesis of evidence, which will include a list of culturally safe, evidence-based interventions, focused on improving the health of Alaskan communities.

Learning Objectives
Through the course, students will:
1. Identify an area of interest on a clinical or healthcare topic focused on improving the health of an Alaskan community.
2. Apply principles of Evidence-Based Practice to generate a synthesis of evidence on topic of interest, which will include a comprehensive literature review and a prioritized list of culturally safe, evidence-based interventions for an Alaskan community.

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demonstration, media resources (YouTube and others), role playing, team-based learning strategies, audio-visual aids, computer-assisted instruction, study and practice groups, case studies, utilization of the Detailed Nursing Brain Critical Thinking Tool, practice and return demonstration in learning laboratory.

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Graded Assignments & Components

Calendar & Agenda

Agenda Item

7

THE STATE of ALASKA
GOVERNOR BILL WALKER

Department of Health and Social Services

ALASKA PIONEER HOMES
Director's Office

P.O. Box 110690
Juneau, Alaska 99811-0690
Main: 907.465.4416
Fax: 907.465.4108

September 28, 2018

AK Board of Nursing
550 w 7th Ave, Ste 1500
Anchorage, AK 99501

Dear Board of Nursing,

I am writing to request a revision of 12 AAC 44.945, Administration of non-herbal nutritional supplements. This seems like an old regulation that needs to be updated, given the current trend of many people seeking complementary and alternative medicine, including the use of many herbal supplements.

I work for the Alaska Pioneer Homes. We provide three different levels of service to elders in order to meet their medical, social, and emotional needs. We assist all of our level 2 and level 3 elders with medication administration. We are increasingly being asked by elders, their power of attorney, and their medical providers to administer herbal supplements. We are not able to grant these requests, as our direct care providers would be in violation of 12. AAC 44.945

In some cases, we have family members living in the same community as the elder residing at a Pioneer Home. These family members come to the home every day, or multiple times a day, to assist their loved one in taking medical provider ordered herbal supplements. In other cases, the elder does not have family or friends in the community who can assist them in taking herbal supplements. Most of the time, these families are not able to make arrangements to have someone visit the elder to assist with these supplements. Both of these scenarios create an undue burden for both elders and families in the ability for them to follow provider orders.

We fully understand that there are potential safety concerns with administering any drug (including over the counter) or supplement. Our nurses never administer anything without having a provider's order, and our Pharmacy checks every order for potential interactions. We do not see any need for this part of the regulation to change.

In addition, we have concerns with the statement "A nurse licensed under AS 08.68 may administer FDA-regulated vitamins and minerals to a patient in the manufacturer's recommended dosage or as ordered by the patient's health care provider." As you know, the FDA regulates dietary supplements; however, it treats them like foods rather than medications. Unlike drug manufacturers, the makers of supplements do not have to show their products are safe or effective before selling them on the market. The FDA only regulates how a product is labeled and how it can be marketed. The FDA does some monitoring for safety, but they rely on voluntary adverse event reporting from consumers and providers. While supplement firms must report to the FDA any serious adverse events that are reported to them. The FDA does not have a "list" of FDA-regulated vitamins and minerals that a nurse can reference to see if the supplement is safe or unsafe to administer.

As such, we would suggest changing this language to U.S Pharmacopeia (USP) verified, ConsumerLab verified, or NSG International verified. Supplements that carry these organizations' seal must be manufactured properly, contain the ingredients listed on the label, and not include any harmful contaminants.

I understand that regulatory changes take time to process and that there are many different steps in the process. I have worked on regulatory packages for Alaska Pioneer Homes and would be happy to assist in the process of updating this regulation. Our direct care team needs the ability to administer herbal supplements in order to fully care for the elders of Alaska Pioneer Homes.

Sincerely,

Emily Palmer
Social Services Program Coordinator
Alaska Pioneer Homes
907-465-2160
Emily.palmer@alaska.gov

Agenda Item

8

Division Reports are not available at this time.

To be provided at the meeting.

Agenda Item

9

Formal Request to the Alaska Board of Nursing
Regarding Prescription and use of Botulinum Toxin and Dermal Fillers

I, Rachel Arnold, MSN, APRN, FNP-C, am requesting from the Alaska Board of Nursing written verification that under my current license and certification along with the additional training received from the American Academy of Facial Esthetics, the action of safely ordering, prescribing, and administering botulinum toxin and dermal fillers for the purposes of elective cosmetic, non-surgical, minimally invasive facial injections is within my scope of practice. Thus, my performing said actions would not be considered unprofessional conduct (ie practicing outside of one's scope) and consequently not subject to disciplinary action by the sole act of performing them. I am making this request as there is no current policy/position statement for which I am aware of that specifies this action specific to nurse practitioners. Although I know that there are some nurse practitioners that choose to perform such actions without Board approval, I want to ensure that I am protecting my license by working within my scope of practice, while simultaneously respecting the Board's authority.

1) Information on the American Academy of Facial Esthetics (AAFE) Botulinum Toxin and Dermal Filler Training for Healthcare Prefessionals Level I course:

a. Length of program: The course is no less than 16 hours in length, 8 hours of which involved live patient treatment.
b. Accrediting organization: This program has been planned and implemented in accordance with the accreditation Standards of the American Association of Nurse Practitioners (AANP) through the joint providership of AKH Inc., Advancing Knowledge in Healthcare and American Academy of Facial Esthetics (AAFE). AKH Inc., Advancing Knowledge in Healthcare is accredited by the American Association of Nurse Practitioners as an approved provider of nurse practitioner continuing education.
c. Pre-requisites of the program: Licensed doctors, dentists, nurse practitioners, nurses, and other healthcare professionals can register for the course—however a prerequisite to participating in the Live Patient Module portion of the training course is completion of the Prepare On-Demand Modules, which includes the lecture, video and didactic portions of the course.
d. Core competencies of the program: Please see the attached course outline for the Level I Standard Proficiency Course, which has been approved by the American Board of Facial Esthetics' curriculum guidelines and standards for facial esthetics Education. All participants must score a minimum of 80% on the On-Demand Modules posttest and demonstrate proper diagnosis, treatment planning, dosing and delivery of botulinum toxin and dermal fillers under direct one-on-one observation by a currently practicing faculty member.

e. Clinical experience required: There is no minimum clinical experience required to participate in the training course, however 8 hours of the course are dedicated to live patient treatment.
f. Does the program prepare you for national certification: No, there currently is no national certification specific to botulinum toxin and dermal filler injections.

2) How the educational program prepares me to increase my APRN scope of practice:

a. Additional nursing service offered: Botulinum toxin and dermal fillers for use in elective, non-surgical, minimally invasive facial injections for cosmetic purposes.

b. How continued competency in the expanded role will be maintained: I intend to continue my competency by taking courses/attending webinars organized by the American Academy of Facial Esthetics for which I am a member of. Since taking the initial Level I course a month ago, I have already participated in 2 educational webinars and plan to take the Level II course within the next 1-2 years.

3) Description of practice setting:

a. How I will protect patient safety: Patient safety will be protected using several measures to include proper assessment, diagnosis, and creation of a treatment plan AND requirement of signed informed consent prior to any cosmetic procedure being performed. I will also provide each patient with written pre- and post-treatment instructions and have on hand a reliable source of communication should contacting emergency services ever be necessary and at minimum, I will maintain BLS certification (I am currently ACLS certified). Furthermore, I will ensure that an attempt to follow-up has been made with each patient within 1-2 weeks post procedure.

b. Potential risks and complications: 1. Post treatment discomfort, swelling, redness, and bruising, 2. Double vision, 3. A weakened tear duct, 4. Post treatment bacterial and/or fungal infection requiring further treatment, 5. Allergic reaction, 6. Minor temporary droop of eyelid(s) in approximately 2% of injections (this usually lasts 2-3 weeks), 7. Occasional numbness of the forehead lasting up to 2-3 weeks, 8. Transient headache, 9. Flu-like symptoms may occur. Additional risks/complications with dermal fillers include 10. Reactivation of herpes (cold sores), 11. Lumpiness, visible yellow or white patches, 12. Granuloma formation, 13. Localized necrosis and/or sloughing, with scab and/or without scab if blood vessel occlusion occurs.

c. Policy in place to allow the APRN to perform the increased scope of practice: There is no formal policy in place at this time by either the Alaska Board of Nursing or AANP that I am aware of which would allow the APRN to perform the increased scope of practice. However, one document regarding Alaska State Board of Nursing ANP Advisory Opinions, entitled 'Explanatory Statement about Advisory Opinions' revised July 2014 included the following:

Topic	Opinion	Interested Party	Date
Botox— presciption and use of Botox and dermal fillers	The Board interprets AS 08.68.410 and 12 AAC 12.44.440 to allow this prescriptive authority for ANPs	Adele M.K. Gilpin, JD, PhD	April-09

d. Emergency Plan: In the event of an emergency, I would promptly contact emergency services if warranted. There are several hospital systems within 15 minutes that the patient could be taken to. I would administer rescue medication (such as epinephrine) and/or initiate CPR as necessary.
e. Will emergency facilities accept referrals from me: The hospital emergency departments do not require a referral, though if feasible I would give the ED a call for report on the incoming patient. For any none-emergent issues, I have a network of providers both local and nationally that I could consult with or refer to if necessary.

4) Rationale for the proposed change in scope of practice:
a. Personal growth: This request is mainly for personal growth. I have long been interested in dermatology, unfortunately there seems to be a lack of opportunity locally at this time to enter into this specific specialty with an existing clinic and the forward thinking of training an individual with limited experience is lacking. Thus, I have a desire to create an opportunity for myself by pursuing training to continue growth and gain experience towards long-term career aspirations.
b. Lack of access to other providers to serve public need: No
c. Evidence based risk-benefit analysis of the proposed scope of practice: No
d. Other: N/A

5) My qualifications:
a. Current professional nursing license in Alaska: Yes
Currently authorized as an ANP in Alaska: Yes
b. Evidence of competence: I have a certificate and statement of continuing education credit that I have successfully completed AAFE's Botulinum Toxin and Dermal Filler Training for Healthcare Professionals Level I course, which has been included with attachments of other required certifications and licensure supporting my competence as a provider capable of performing this request under my scope of practice as a nurse practitioner.
c. Any complaints or disciplinary action against my nurse's license or ANP certification: None

According to the Alaska Board of Nursing Advisory position statement, neuro-modulator injection procedures for cosmetic purposes are within the scope of nursing for a Registered Nurse (RN) and Licensed Practical Nurse (LPN) provided the specified guidelines are followed (See attachment for reference).

1) I, as an APRN, am competent to perform the procedure and have the documented and demonstrated knowledge, skill, and ability to perform the procedure pursuant to the Nursing Scope of Practice.
2) I would incorporate the AAFE/ABFE instruction on how to perform the procedures with protocols recommended.
3) I am in compliance with licensure or certification by any other regulatory body (other than the ABON) and have met all requirements established by any other regulatory agency which has authority over the procedure.
4) I will maintain accountability and responsibility for nursing care related to the procedure and will follow the accepted standard of care which would be provided by a reasonable and prudent nurse practitioner. An attempt will be made to contact all patients within 2 days post-procedure for follow-up, and all patients having a procedure done for the first-time will be required to schedule a face-to-face appointment within 2 weeks following the procedure for follow-up. Patients will also be provided with contact information for any additional communication needs.
5) I will require that all clients have granted informed consent. In obtaining consent for the procedure/intervention, I will provide the patient/client/family with the nature and consequences of any procedure, the reasonable risks (if any), possible side effects, benefits, and purposes of the procedure and any alternative procedures available.
6) As an APRN, I am authorized to diagnose and prescribe as it is within my scope of practice as an APRN.
7) Pending Board approval, I plan to be able to perform this procedure independently as an APRN and will not be delegating this action to another. This authority seems to be implied if an RN/LPN is authorized to perform the procedure "pursuant to Nursing Standards and Practice and performed under the direct supervision of a physician/APRN/PA who is present at the site where the procedure is performed and has the knowledge, skill, and ability to perform the procedure."
8) It seems implied that a licensed APRN with proper training may also be allowed to execute his or her own medical orders if it is "within the scope of practice for a registered nurse to execute the medical orders from a licensed physician/APRN/PA" who "is properly trained in cutaneous medicine and surgery and in the administration of neuro modulators for cosmetic purposes."
9) I have received and can show appropriate training in anatomy of the facial musculature, proper administration, possible side effects, and post procedure care for the safety and well-being of the patient through the AAFE course. Furthermore, as an APRN, I acknowledge my responsibility to be

aware of the extent of training I receive and my ability to competently perform the injections and meet the standard of care for the procedure.

10) If "the nurse may administer the treatment only after the physician/APRN/PA has assessed the patient and a plan of treatment has been determined" then it is already implied that an APRN has the authority to assess and create a plan of treatment for said patient. Pending Board approval, I plan to administer the treatment only after the patient has been assessed and a plan of treatment has been determined. This plan shall include, but not be limited to the location for injections; dosage, post procedure care and possible follow up.
11) I, as the APRN that would be performing the procedure, will be immediately available on-site, at the time of the procedure for any further consultation and management of any potential adverse events.
12) I will refrain from administering neuro-modulator injections to pediatric patients/client (defined as under the age of 18) for all purposes, unless further training is received along with authorization from the ABON, a medical indication is present, AND the appropriate party grants informed consent. I will refrain from administering neuro-modulator injections to pediatric patients/client (defined as under the age of 18) for any cosmetic purposes.

AAFE

AMERICAN ACADEMY
OF FACIAL ESTHETICS

CERTIFICATE OF TRAINING

THIS CERTIFICATE IS PROUDLY PRESENTED TO

Rachel H. Arnold, NP

Has successfully completed the American Academy of Facial Esthetics Level I training on the use and administration of botulinum toxin injectables.

Botulinum Toxin Training for Healthcare Professionals
Hands-On Training

9/7/2018
DATE

AAFE
AMERICAN ACADEMY OF FACIAL ESTHETICS

DR. LOUIS MALCMACHER, PRESIDENT

Statement of Continuing Education Credit

Rachel Arnold, NP

Credit Claimed: 19.50

Botulinum Toxin and Dermal Filler Training for Healthcare Professionals Level I

Online activity and live activity on:September 7th, 2018 Course Location: Seattle, Wa

ANCC Accreditation Statement

AKH Inc., Advancing Knowledge in Healthcare is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

AANP Accreditation Statement

This activity has been planned and implemented in accordance with the accreditation Standards of the American Association of Nurse Practitioners (AANP) through the joint providership of AKH Inc., Advancing Knowledge in Healthcare and American Academy of Facial Esthetics (AAFE). AKH Inc., Advancing Knowledge in Healthcare is accredited by the American Association of Nurse Practitioners as an approved provider of nurse practitioner continuing education. Provider number: 030803

This enduring activity for a maximum of 12.0 contact hour(s) and live activity for a maximum of 7.50 contact hour(s) which includes 0hour(s) of pharmacology. Activity ID # 21766

Please keep this original statement of continuing education for your records for 4 years.

Steve Eckert
President and CEO
Issue Date: Sep 18, 2018 3:54 PM
Unique Certificate ID: 440094694
AKH Identifier: 21766

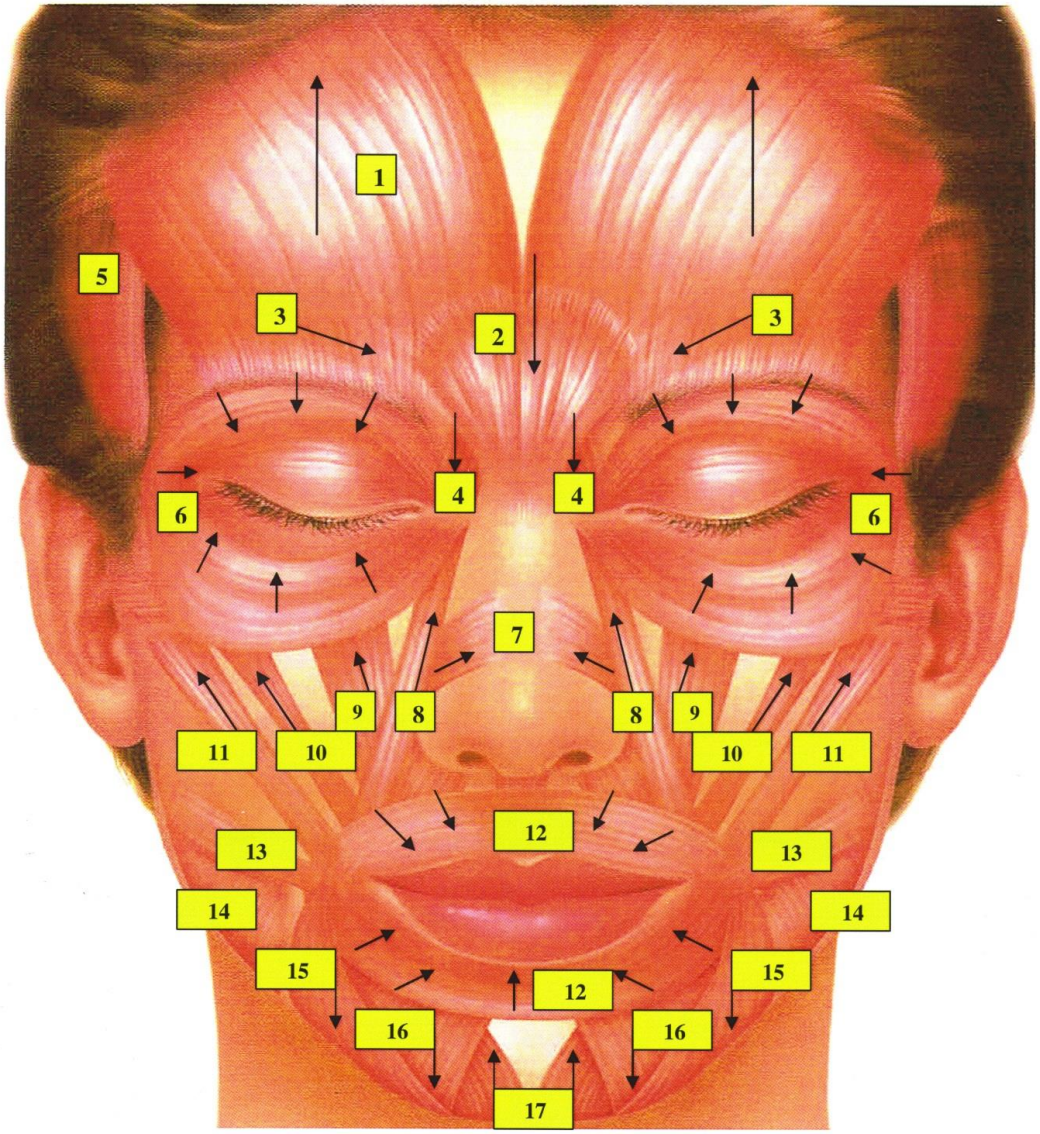
AKH Inc.
Advancing Knowledge in Healthcare

P.O. Box 24104
Jacksonville, FL 32241-4104
904-683-8843
Fax 866-352-6285

AAFE
AMERICAN ACADEMY
OF FACIAL ESTHETICS

2120 South Green Road, Second Floor
South Euclid, OH 44121

800.952.0521 | WWW.FACIALESTHETICS.ORG



1. Frontalis
2. Procerus
3. Corrugator Supercilli
4. Depressor Supercilii
5. Temporalis
6. Orbicularis Oculi
7. Nasalis
8. Levator Labii Sup. Alaque Nasi
9. Levator Labii
10. Zygomaticus Minor
11. Zygomaticus Major
12. Orbicularis Oris
13. Modeolus
14. Platysma
15. Depressor Anguli Oris
16. Depressor Labii
17. Mentalis

Arrows represent the direction of the muscle movement (Elevator or Depressor)

Alaska Board of Nursing Advisory

Neuro Modulator Injections for Cosmetic Purposes

Registered Nurses & Licensed Practical Nurses

POSITION STATEMENT:

Botulinum Toxin Type A is a protein produced by the bacterium Clostridium botulinum. When used in medical settings as an injectable form of sterile, purified botulinum toxin, small doses of the toxin is injected into the affected muscles and block the release of the chemical acetylcholine that would otherwise signal the muscle to contract. The toxin thus paralyzes or weakens the injected muscle. This statement refers only to the use of neuro-modulators for cosmetic purposes and is not to be construed for any other medical uses or medical setting. A neuro-modulator is administered as an intramuscular injection into specific muscle groups in the forehead, glabellar area and around the eyes to smooth outlines and wrinkles.

Neuro-modulator injection procedures are within the scope of nursing for a Registered Nurse and Licensed Practical Nurse provided the following guidelines are followed:

1. The nurse is competent to perform the procedure and has the documented and demonstrated knowledge, skill, and ability to perform the procedure pursuant to the Nursing Scope of Practice.
2. There are agency policies and procedures and any required protocols in place for the nurse to perform the procedure.
3. The nurse is in compliance with licensure or certification by any other regulatory body (other than the ABON) and has met all requirements established by any other regulatory agency which has authority over the procedure.
4. The nurse maintains accountability and responsibility for nursing care related to the procedure and follows the accepted standard of care which would be provided by a reasonable and prudent nurse.
5. Clients have granted informed consent. In obtaining informed consent for a nursing intervention, the nurse shall provide the patient/client/family with the nature and consequences of any procedure, the reasonable risks (if any), possible side effects, benefits, and purposes of the procedure and any alternative procedures available.
6. The use of any of these procedures does not authorize the licensed nurse to diagnose or prescribe.

7. The procedure is not performed independently. It is authorized pursuant to Nursing Standards and Practice and is performed under the direct supervision of a physician/APRN/PA who is present at the site where the procedure is performed and has the knowledge, skill, and ability to perform the procedure.
8. It is within the scope of practice for a registered nurse to execute the medical orders from a licensed physician/APRN/PA. The physician/APRN/PA must be properly trained in cutaneous medicine and surgery and in the administration of neuro modulators for cosmetic purposes.
9. Nurses accepting these orders shall show appropriate training in anatomy of the facial musculature, proper administration, possible side effects, and post procedure care for the safety and well-being of the patient. It is the responsibility of the physician/APRN/PA to be aware of the extent of training and the ability of the nurse to competently perform the injections and meet the standard of care for the procedure.
10. The nurse may administer the treatment only after the physician/APRN/PA has assessed the patient and a plan of treatment has been determined. This plan shall include, but not be limited to the location for injections; dosage, post procedure care and possible follow up.
11. Nurses performing this procedure shall be working under direct supervision of a licensed physician/APRN/PA, who is immediately available on-site, at the time of the procedure for any further consultation and management of any potential adverse events.
12. The RN/LPN is excluded from administering neuro-modulator injections to pediatric patients/client (defined as under the age of 18).

Competence Acquisition

The nurse must acquire education that includes a supervised practicum resulting in a competency evaluation commensurate with the procedure. Components of the education include, as appropriate to the specific procedure, but are not limited to:

- Anatomy and physiology;
- Pathophysiology of the integumentary system and supporting structures;
- Cosmological and dermatologic conditions;
- Wound healing principles;
- Safe use of product/device/equipment ;
- Side effects and management;
- Management of emergencies;
- Patient and environmental safety.
- Training program for healthcare professionals

Practice

Nurses licensed by the Board practice within their scope, are responsible and accountable for their nursing judgments, actions, and competency and do not perform activities outside their scope of practice.

The patient assessment must be performed and documented by a registered nurse and duly authorized prescriber., The performance of the procedure is pursuant to the orders of a duly authorized prescriber. The nurse must verify the orders from a duly authorized prescriber to include the patient's name, valid order date, medication or substance name, dosage, route, anatomical site for administration, specific administration directions and prescriber signature.

It is not within the scope of practice for a nurse who is not authorized to practice as an advanced practice registered nurse (APRN) to medically diagnose, or to prescribe medications or treatments.

It is not within the scope of the RN/LPN who is without APRN licensure and prescriptive authority to:

- select the medication/solution, dosage, device or device setting to be used in the performance of a cosmetic or dermatological procedure;
- purchase or obtain a drug, substance, controlled substance analogue or immediate precursor in any schedule or class to be used in the performance of a cosmetic or dermatological procedure independently or as an agent of the prescriber.

It is the Board's position that nurses whose practice includes neuro-modulators procedures may not practice in an organization that does not have policies and procedures that include:

- A requirement for informed consent;
- No patients under the age of 18 years old are to be administered a neuro-modulator by a nurse
- A requirement for a comprehensive, documented evaluation;
- Recommendations for self-care;
- Follow-up recommendations;
- Situations that require referral;
- Management of side effects; and
- Provisions for emergent care.

Documentation

Documentation criteria must include:

- Review and verification of informed consent that clearly informs the patient of the operator's qualifications, licensure, and expected outcomes of the procedure;
- Assessment data inclusive of past medical, surgical, allergy and medication histories;
- Skin typing/classification;
- Sun exposure history;
- Current cosmetic/dermatologic product usage;
- Exclusion from treatment criteria;
- Identification of and evaluation of test site as indicated;
- Specifics of procedure performed and patient response to procedure; and
- Directions for referral back to or consultation with the duly authorized prescriber of procedure.

The nurse must document and provide the patient with written pre and post procedure education which includes, but is not limited to, self-care instructions and follow-up recommendations inclusive of continued and emergent care needs.

This advisory opinion was adopted by the board on this date and may be amended and updated from time to time by vote of the board.

Chair

2/7/18
Date

Original adoption: 11/7/17
Revised 2/7/18

Alaska State Medical Board

Policies and Procedures

Board Issued Guidelines	Section 6
Subject:	***Guidelines for Physicians in Delegating Procedures to Non-physician Personnel When Performing Certain Dermatological Procedures***
Implemented:	January 16, 2004; updated March 7, 2014; ***new draft for consideration***

The Alaska State Medical Board has adopted the following to be its guideline to physicians licensed to practice medicine in Alaska when considering the delegation of certain procedures to non-physician office personnel.

Non-Physician Practice of Medicine and the Use of Non-Physician Office Personnel

The guiding principle for all physicians is to practice ethical medicine with the highest possible standards. Physicians should be properly trained in all procedures performed to insure the highest level of patient care and safety. A physician should be fully qualified by residency training and preceptorship or appropriate course work. Training should include an extensive understanding of cutaneous medicine and surgery, the indications for each procedure, and the pre- and post-operative care involved in treatment. It is the position of the board that only active and properly licensed doctors of medicine and osteopathy shall engage in the practice of medicine.

Under the appropriate circumstances, a physician may delegate the performance of some non-invasive treatments to non-physician health practitioners (such as registered nurses, physician assistants, cosmetologists, estheticians, etc.) The physician must assure that these practitioners are appropriately trained and licensed, are, and are practicing within the scope of their own license.

Medical treatments require an initial consultation and supervision by a licensed physician. The treatments must be performed under direct supervision by the physician. The supervising physician shall be physician present on-site, immediately available, and able to respond promptly to any question or problem that may occur while the procedure is being performed. It is the physician's obligation to ensure that the practitioners possess the proper training in cutaneous medicine, the indications for the procedure, and the pre- and post-operative care involved, and are provided with written protocols.

There is a separate Board-issued guideline regarding the use of lasers. The Board adopted the AMA policy which defines laser usage and differentiates the appropriate use of ablative treatment ("hot laser") and non-ablative treatment ("cold laser").

Estheticians are prohibited from providing services that are considered the practice of medicine, such as injections, chemical peels, liposuction, autotransplantation, administering Botox or

dermal fillers, or use of certain equipment (such as lasers, etc.) Procedures considered to be the practice of medicine may only be performed by a licensed physician.

Under Alaska law, a licensee may be sanctioned for intentionally or negligently permitting the performance of patient care by persons under the licensee's supervision that does not conform to minimum professional standards even if the patient was not injured; in addition, it is considered unprofessional conduct to delegate professional practice responsibilities that require a license or permit to a person who does not possess the appropriate education, training, or licensure to perform the responsibilities.

Correspondence

Under Alaska law, the scope of practice for a licensed esthetician includes the use of the hands, appliances, cosmetic preparations, antiseptics or lotions in massaging, cleansing, stimulating, or similar work on the scalp, face, or neck, including skin care, make-up and temporary removal of superfluous hair.

Estheticians are prohibited from providing services that are considered the practice of medicine, such as injections, chemical peels, liposuction, autotransplantation, administering Botox or dermal fillers, or use of certain equipment (such as lasers, etc.) Procedures considered to be the practice of medicine may only be performed by a licensed physician.

Medical treatments require an initial consultation and supervision by a licensed physician. The physician may delegate the performance of some non-invasive treatments to non-physician health practitioners (such as registered nurses, cosmetologists, estheticians, etc.) provided the treatments are performed under direct supervision by the physician. The physician must assure that these practitioners are appropriately trained and licensed, are provided with written protocols, and are practicing within the scope of their own license.

There is a Board guideline published on our website regarding the use of lasers. The Board adopted the AMA policy which defines laser usage and differentiates the appropriate use of ablative treatment ("hot laser") and non-ablative treatment ("cold laser"). Basically, all laser procedures are considered to be the practice of medicine and may only be performed by a licensed physician. Physicians may delegate ablative treatment to a nurse practitioner or PA who is appropriately licensed and trained, as long as it is performed under supervision. Physicians may also delegate non-ablative treatment to qualified personnel, as long as the physician does the initial consult, authors the treatment plan, and directly supervises the treatment.

Esthetician issue

Under AS 08.13.220(5), the scope of practice for a licensed esthetician includes "the use of the hands, appliances, cosmetic preparations, antiseptics or lotions in massaging, cleansing, stimulating, or similar work on the scalp, face, or neck, including skin care, make-up and temporary removal of superfluous hair."

The Medical Board has previously determined that the specific procedures noted below are considered the practice of medicine under 08.64.380(5)(A), which defines the practice of medicine as follows: "for a fee, donation or other consideration, to diagnose, treat, operate on, prescribe for, or administer to, any human ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other mental or physical condition; or to attempt to perform or represent that a person is authorized to perform any of the acts set out in this subparagraph."

The Medical Board guidelines include a notation that estheticians are prohibited from providing services that are considered the practice of medicine, such as injections, chemical peels, liposuction, autotransplantation, administering Botox or dermal fillers, or use of certain equipment (such as lasers, etc.) Procedures considered to be the practice of medicine may only be performed by a licensed physician.

Medical Board options re: <u>esthetician</u> practicing medicine

Violations

- 08.64.170 A person may not practice medicine, podiatry, or osteopathy, in the state unless the person is licensed under this chapter…

- 08.64.326. Grounds for imposition of disciplinary sanctions. (a) The board may impose a sanction if the board finds after a hearing that a licensee… (9) engaged in unprofessional conduct,

- 12 AAC 40.967. UNPROFESSIONAL CONDUCT. For purposes of AS 08.64.240(b) and AS 08.64.326, "unprofessional conduct" means an act or omission by an applicant or licensee that does not conform to the generally accepted standards of practice for the profession for which the applicant seeks licensure or a permit under AS 08.64 or which the licensee is authorized to practice under AS 08.64. "Unprofessional conduct" includes the following
  (6) practicing a profession licensed under AS 08.64 without a required license or permit or with a lapsed, expired, retired, or inactive license or permit;

Remedies

- 08.64.331. Disciplinary sanctions. (a) If the board finds that a licensee has committed an act set out in AS 08.64.326(a), the board may
  (1) – (6) are all license actions
  (7) impose a civil fine of not more than $25,000 Note: is this allowed for an unlicensed violator?

- 08.01.075. Disciplinary powers of boards. (a) A board may take the following disciplinary actions, singly or in combination:
  (1) permanently revoke a license;
  (2) suspend a license for a specified period;
  (3) censure or reprimand a licensee;
  (4) impose limitations or conditions on the professional practice of a licensee;
  (5) require a licensee to submit to peer review;
  (6) impose requirements for remedial professional education to correct deficiencies in the education, training, and skill of the licensee;
  (7) impose probation requiring a licensee to report regularly to the board on matters related to the grounds for probation;
  (8) impose a civil fine not to exceed $5,000.

- Sec. 08.01.102. Citation for unlicensed practice or activity. The department may issue a citation for a violation of a license requirement under this chapter, except a requirement to have a license under AS 43.70, if there is probable cause to believe a person has practiced a profession or engaged in business for which a license is required without holding the license. Each day a violation continues after a citation for the violation has been issued constitutes a separate violation. A citation issued under this section must comply with the standards adopted under AS 12.25.175 - 12.25.230.

Also see Sec. 08.01.103. Procedure and form of citation. and
Sec. 08.01.104. Failure to obey citation.

The Medical Board options re: <u>the supervising physician</u> for allowing an esthetician to practice medicine:

Violations

- 08.64.326. Grounds for imposition of disciplinary sanctions. (a) The board may impose a sanction if the board finds after a hearing that a licensee… (9) engaged in unprofessional conduct,

- 12 AAC 40.967. UNPROFESSIONAL CONDUCT. For purposes of AS 08.64.240(b) and AS 08.64.326, "unprofessional conduct" means an act or omission by an applicant or licensee that does not conform to the generally accepted standards of practice for the profession for which the applicant seeks licensure or a permit under AS 08.64 or which the licensee is authorized to practice under AS 08.64. "Unprofessional conduct" includes the following
(7) permitting or employing an unlicensed person to practice a profession licensed under AS 08.64
(A) without the required license or permit under AS 08.64; or
(B) while the person's license or permit was revoked, suspended, surrendered, or canceled in this state;

Remedies

- 08.64.331. Disciplinary sanctions. (a) If the board finds that a licensee has committed an act set out in AS 08.64.326(a), the board may
(1) permanently revoke a license to practice;
(2) suspend a license for a determinate period of time;
(3) censure a licensee;
(4) issue a letter of reprimand;
(5) place a licensee on probationary status and require the licensee to
(A) report regularly to the board on matters involving the basis of probation;
(B) limit practice to those areas prescribed;
(C) continue professional education until a satisfactory degree of skill has been attained in those areas determined by the board to need improvement;
(6) impose limitations or conditions on the practice of a licensee;
(7) impose a civil fine of not more than $25,000; or
(8) impose one or more of the sanctions set out in (1)—(7) of this subsection.

Barbers/Hairdressers Board options re: <u>the esthetician</u> for practicing medicine

Violations

- 08.13.220. Definitions. In this chapter,
(5) "esthetics" means the use of the hands, appliances, cosmetic preparations, antiseptics, or lotions in massaging, cleansing, stimulating, or similar work on the scalp, face or neck,

including skin care, make-up, and temporary removal of superfluous hair, for cosmetic purposes for a fee;

Remedies

- Sec. 08.13.150. Disciplinary sanctions and grounds for refusal of a license or permit. The board may, in addition to the actions authorized under AS 08.01.075, refuse, suspend, or revoke a license, student permit, temporary license, or temporary permit for failure to comply with this chapter, with a regulation adopted under this chapter, with a regulation adopted by the Department of Environmental Conservation under AS 44.46.020, or with an order of the board.

- Sec. 08.01.075. Disciplinary powers of boards. (a) A board may take the following disciplinary actions, singly or in combination:
(1) permanently revoke a license;
(2) suspend a license for a specified period;
(3) censure or reprimand a licensee;
(4) impose limitations or conditions on the professional practice of a licensee;
(5) require a licensee to submit to peer review;
(6) impose requirements for remedial professional education to correct deficiencies in the education, training, and skill of the licensee;
(7) impose probation requiring a licensee to report regularly to the board on matters related to the grounds for probation;
(8) impose a civil fine not to exceed $5,000.

(b) A board may withdraw probationary status if the deficiencies that required the sanction are remedied.

(c) A board may summarily suspend a licensee from the practice of the profession before a final hearing is held or during an appeal if the board finds that the licensee poses a clear and immediate danger to the public health and safety. A person is entitled to a hearing conducted by the office of administrative hearings (AS 44.64.010) to appeal the summary suspension within seven days after the order of suspension is issued. A person may appeal an adverse decision of the board on an appeal of a summary suspension to a court of competent jurisdiction.

(d) A board may reinstate a suspended or revoked license if, after a hearing, the board finds that the applicant is able to practice the profession with skill and safety.

(e) A board may accept the voluntary surrender of a license. A license may not be returned unless the board determines that the licensee is competent to resume practice and the licensee pays the appropriate renewal fee.

(f) A board shall seek consistency in the application of disciplinary sanctions. A board shall explain a significant departure from prior decisions involving similar facts in the order imposing the sanction.

Alaska Board of Nursing

EVALUATION OF LPN, RN & ANP SCOPE OF PRACTICE REQUESTS

Approved June 8, 2007
Revised August 22, 2007
Revised November 17, 2010

Mission of the Alaska Board of Nursing
The mission of the Alaska Board of Nursing is to actively promote and protect the health of the citizens of Alaska through the safe and effective practice of nursing as defined by law.

To that end, the Board of Nursing will evaluate proposals for increasing the scope of nursing practice using the following criteria:

1. Education, training, & proof of competency,
2. Policy that allows the nurse/ANP to perform the increased scope of practice,
3. Licensure, certifications,
4. Applicable statutes and regulations,
5. Methods of emergency referral,
6. Factors such as public access and impact on the public, and
7. Applicant qualifications.

After evaluation of the portfolio, the Board of Nursing will make a determination concerning the proposal.

WHAT TO SUBMIT TO THE BOARD OF NURSING

- Information on the educational program you attended or plan to attend:
  - Length of program
  - What organization accredits the program?
  - What are the pre-requisites?
  - What are the core competencies of the program?
  - How much clinical experience is required?
  - Does the program prepare you for national certification?

- How does the educational program prepare you to increase your scope of practice?
  - What additional nursing service will be offered?
  - How will continued competency in the expanded role be maintained?

- Describe the practice setting for the expanded role you are requesting
  - How you will protect patient safety?
  - What are the potential risks and complications?

- Is there a policy in place to allow the nurse/ANP to perform the increased scope of practice,
- How do you plan to handle emergencies?
- Will emergency facilities accept referrals from you?

- What is the rationale for the proposed change in scope of practice?
  - Personal growth?
  - Lack of access to other providers to serve the public need?
  - Is there evidence based risk-benefit analysis of the proposed scope of practice? Please cite the analysis.
  - Other

- What are your qualifications?
  - Current professional nursing license in Alaska? Currently authorized as an ANP in Alaska?
  - What evidence of competence can you offer?
  - Have there been complaints or disciplinary action against your nurse's license or ANP certification?

Additional information is welcome. The Board of Nursing meets quarterly. The schedule for the next Board meeting where your proposal could be evaluated can be obtained by calling (907) 269-8161.

CRITERIA FOR EVALUATION OF THE REQUEST
(This form will be used by the Board members)

Education/training/proof of competency

Criteria	Is it met? Yes/No	Comments
Is the formal education and training sufficient to ensure competency and patient safety?		
Is the education from an approved/formally accredited institution?		
Are pre-requisites, core education (undergraduate /post-graduate) & clinical experience presented?		
Are additional nursing services to be offered identified?		
Is the education adequate for the increased scope of practice?		
Is a plan for assuring continued competency included?		

Licensure/certification

Criteria	Is it met? Yes/No	Comments
Are core competencies identified?		
Are core competencies within the scope of practice?		
Does a national certifying body find the scope of practice appropriate?		
Does the national certifying body describe the procedure as appropriate for this level of licensure?		

Do other states recognize the procedure as within the scope of practice of a nurse with the same licensure or authorization?		
Is there a policy in place to allow the nurse/ANP to perform the increased scope of practice?		

Statutes and regulations

Criteria	Is it met? Yes/No	Comments
Are there any statutory or regulatory limits that would apply to the activity or procedure?		

Method of emergency referral

Criteria	Is it met? Yes/No	Comments
Is the practice setting for the procedure identified & appropriate?		
Is patient safety assured by procedures?		
Are potential risks and complications identified?		
Is an adequate plan for emergencies set out in the proposal?		
Will the emergency personnel and/or facilities accept referrals from the nurse/ANP?		

Public access and public impact

Criteria	Is it met? Yes/No	Comments

Is the rationale for the change in scope of practice presented?		
Is there lack of access to other providers to serve the public need?		
Has evidence based risk-benefit analysis of the proposed scope of practice been presented?		

Applicant credentials

Criteria	Is it met? Yes/No	Comments
Is the applicant currently licensed as a nurse/ANP in AK?		
Has the applicant demonstrated competence in the past?		
Have there been complaints or disciplinary actions against the nurse's license/authorization?		

EVALUATION

Is it appropriate for the nurse/ANP to expand her/his scope of practice as proposed with the documented training, experience, and certification?

Comments:

Botox PRE - TREATMENT INSTRUCTIONS

In an ideal situation it is prudent to follow some simple guidelines before treatment that can make all the difference between a fair result or great result, by reducing some possible side effects associated with the injections. We realize this is not always possible; however, minimizing these risks is always desirable.

- Patient must be in good health with no active skin infections in the areas to be treated
- Patient should not be needle phobic
- Avoid alcoholic beverages at least 24 hours prior to treatment Alcohol may thin the blood which will increase the risk of bruising.
- Avoid anti-inflammatory / blood thinning medications ideally, for a period of two (2) weeks before treatment. Medications and supplements such as Aspirin, Vitamin E, Gingo Biloba, St. John's Wort, Ibuprofen, Motrin, Advil, Aleve, Vioxx, and other NSAIDS are all blood thinning and can increase the risk of bruising/swelling after injections.
- Schedule Botox® appointment at least 2 weeks prior to a special event which may be occurring, i.e., wedding, vacation, etc. etc. It is not desirable to have a very special event occurring and be bruised from an injection which could have been avoided.

Sample - Adjust for your own office

Botox POST - TREATMENT INSTRUCTIONS

The guidelines to follow post treatment have been followed for years, and are still employed today to prevent the possible side effect of ptosis (drooping of the eyelids). These measures should minimize the possibility of ptosis.

- No straining, heavy lifting, vigorous exercise for 3-4 hours following treatment. It is now known that it takes the toxin approximately 2 hours to bind itself to the nerve to start its work, and because we do not want to increase circulation to that area to wash away the Botox® from where it was injected.
- Avoid manipulation of area for 3-4 hours following treatment. (For the same reasons listed above.) This includes not doing a facial, peel, or micro-dermabrasion after treatment with Botox®. A facial, peel, or micro-dermabrasion can be done in same appointment only if they are done before the Botox®.
- Facial exercises in the injected areas is recommended for 1-hour following treatment. This is to stimulate the binding of the toxin only to the localized area.
- It can take 2 -10 days to take full effect. It is recommended that the patient contact the office no later than 2 weeks after treatment if desired effect was not achieved and no sooner to give the toxin time to work.

Makeup may be applied before leaving the office.

INFORMED CONSENT FOR BOTULINUM TOXIN TREATMENT

PATIENT _____

DATE OF BIRTH _____

ADDRESS _____

PHONE _____

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

THE TREATMENT

Botulinum toxin (Botox®, Xeomin) is a neurotoxin produced by the bacterium Clostridium A. Botulinum toxin can relax the muscles on areas of the face and neck which cause wrinkles associated with facial expressions or facial pain. Treatment with botulinum toxin can cause your facial expression lines or wrinkles to be less noticeable or essentially disappear. Areas most frequently treated are: a) glabellar area of frown lines, located between the eyes; b) crow's feet (lateral areas of the eyes); c) forehead wrinkles; d) radial lip lines (smokers lines), e) head and neck muscles. Botox is diluted to a very controlled solution and when injected into the muscles with a very thin needle, it is almost painless. Patients may feel a slight burning sensation while the solution is being injected. The procedure takes about 15-20 minutes and the results can last up to 3 months. With repeated treatments, the results may tend to last longer.
Initial ____

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1.Post treatment discomfort, swelling, redness, and bruising, 2. Double vision, 3. A weakened tear duct, 4. Post treatment bacterial, and/or fungal infection requiring further treatment, 5. Allergic reaction, 6. Minor temporary droop of eyelid(s) in approximately 2% of injections, this usually lasts 2-3 weeks, 7. Occasional numbness of the forehead lasting up to 2-3 weeks, 8. Transient headache and 9. Flu-like symptoms may occur.
Initial ____

PREGNANCY, ALLERGIES & NEUROLOGIC DISEASE

I am not aware that I am pregnant and I am not trying to get pregnant, I am not lactating (nursing). I do not have any significant neurologic disease including but not limited to myasthenis gravis, multiple sclerosis, lambert-eaton syndrome, amyotrophic lateral sclerosis (ALS), and parkinson's. I do not have any allergies to the toxin ingredients, or to human albumin. **Initial** ____

ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that I have volunteered for have been fully explained to me.

Initial ____

PAYMENT

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment. **Initial** ____ RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time. **Initial** ____

TRAINING COURSE

I understand that I have volunteered to be a model patient in a training course and the doctor/healthcare professional who will be treating me has had limited experience with the method of treatment. **Initial ____**

I hereby indemnify the American Academy of Facial Esthetics LLC from any liability relating to the procedures that I have volunteered for. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. **Initial____**

I hereby indemnify the facility/meeting room/hotel where this treatment is being performed from any liability relating to the procedures that I have volunteered for. **Initial____**

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. During courses given by Common Sense Dentistry and/or The American Academy of Facial Esthetics (AAFE), I understand that photographs and video may be taken of me for educational and marketing purposes. I hold the AAFE harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs. **Initial ____**

RESULTS

I am aware that when small amounts of purified botulinum toxin are injected into a muscle it causes weakness or paralysis of that muscle. This appears in 2 – 10 days and usually lasts up to 3 months but can be shorter or longer. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual and there are some individuals who do not respond at all. I understand that I will not be able to use the muscles injected as before while the injection is effective but that this will reverse after a period of months at which time re- treatment is appropriate. I understand that I must stay in the erect posture and that I must not manipulate the area (s) of the injections for the 2 hours post-injection period. **Initial ____**

I understand this is an elective procedure and I hereby voluntarily consent to treatment with botulinum toxin injections for facial dynamic wrinkles, TMJ dysfunction, bruxism and types of orofacial pain including headaches and migraines. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

Health History Completed? Yes ☐ No ☐ Date: _____ Doctor Initial:_____

Dental / Head and Neck Examination Completed? Yes ☐ No ☐ Date: _____ Doctor Initial:_____

_____ _____

Patient Name (Print) Patient Signature Date

I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

_____ _____

Doctor Name (Print) Doctor Signature Date

_____

AAFE Trainer Name (Print) AAFE Trainer Signature Date

PRE-TREATMENT INSTRUCTIONS

Dermal Fillers

A few simple guidelines before your treatment can make a difference between a good result and a fantastic one.

Patient should be in good overall health. A full medical and dental history must be performed on all patients for optimal results.

If you develop a cold sore, blemish, or rash, etc. prior to your appointment you must reschedule.

If you have a special event or vacation coming up schedule your treatment at least 2 weeks in advance.

Let us know if you are prone to cold sores – a pre-operative medication may help prevent cold sores after treatment.

NO Aspirin, Motrin, Gingko Biloba, Garlic, Flax Oil, Cod Liver Oil, Vitamin A, Vitamin E, or any other essential fatty acids at least 3 days to 1 week before and after treatment.

Discontinue Retin-A two (2) days before and two (2) days after treatment.

AVOID: Alcohol, caffeine, Niacin supplement, high-sodium foods, high sugar foods, refined carbohydrates (you may eat fruit), spicy foods, and cigarettes 24-48 hours before and after your treatment

POST TREATMENT INSTRUCTIONS
Dermal Filler Treatment

DO NOT: touch, press, rub or manipulate the implanted areas for the rest of the day after treatment. Avoid kissing, puckering and sucking movements for the rest of the day as these motor movements can undesirably displace the implanted dermal filler materialYou can cause irritation, sores, and/or problems, and possible scarring if you do.

AVOID: Aspirin, Motrin, Gingko Biloba, Garlic, Flax Oil, Cod Liver Oil, Vitamin A., Vitamin E, or other essential fatty acids at least 3 days after treatment.

AVOID: Alcohol, caffeine, niacin supplement, high-sodium foods, high sugar foods, refined carbohydrates (you may eat fruit), spicy foods, and cigarettes 24-48 hours after your treatment.

AVOID: Vigorous exercise and sun and heat exposure for 3 days after treatment.

DISCONTINUE: Retin 2 days after treatment. It is best to wear no makeup or lipstick until the next day. Earlier use can cause pustules.

One side may heal faster than the other side.

You can expect some bruising and swelling around the areas that were injected. Apply ice for the first hour after treatment for ten minutes on and ten minutes off.

You must wait 2 weeks before any enhancements.

Please report any redness, blisters, or itching immediately if it occurs after treatment.

I certify that I have been counseled in post-treatment instructions and have been given written instructions as well.

_____ _____

Patient Signature Date

INFORMED CONSENT FOR DERMAL FILLER TREATMENT

PATIENT_____

DATE OF BIRTH _____

ADDRESS _____

PHONE _____

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

THE TREATMENT

Treatment with dermal fillers (such as Juvederm, Restylane, Radiesse and others) can smooth out facial folds and wrinkles, add volume to the lips, and contour facial features that have lost their volume and fullness due to aging, sun exposure, illness, etc. Facial rejuvenation can be carried out with minimal complications. These dermal fillers are injected under the skin with a very fine needle. This produces natural appearing volume under wrinkles and folds which are lifted up and smoothed out. The results can often be seen immediately. **Initial ____**

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1) Post treatment discomfort, swelling, redness, bruising, and discoloration; 2) Post treatment infection associated with any transcutaneous injection; 3) Allergic reaction; 4) Reactivation of herpes (cold sores); 5) Lumpiness, visible yellow or white patches; 6) Granuloma formation; 7) Localized necrosis and/or sloughing, with scab and/or without scab if blood vessel occlusion occurs. **Initial ____**

PREGNANCY AND ALLERGIES

I am not aware that I am pregnant. I am not trying to get pregnant. I am not lactating (nursing). I do not have or have not had any major illnesses which would prohibit me from receiving dermal fillers. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine.

ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that I have volunteered for have been fully explained to me. **Initial ____**

PAYMENT

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment. **Initial ____**

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time. **Initial ____**

TRAINING COURSE

I understand that I have volunteered to be a model patient in a training course and the doctor/healthcare professional who will be treating me has had limited experience with the method of treatment. **Initial ____**

I hereby indemnify the American Academy of Facial Esthetics LLC from any liability relating to the procedures that I have volunteered for. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. **Initial____**

I hereby indemnify the facility/meeting room/hotel where this treatment is being performed from any liability relating to the procedures that I have volunteered for. **Initial____**

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. During courses given by Common Sense Dentistry and/or The American Academy of Facial Esthetics (AAFE), I understand that photographs and video may be taken of me for educational and marketing purposes. I hold the AAFE harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs. **Initial ____**

RESULTS

Dermal fillers have been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines and folds in the skin on the face. Its effect can last up to 6 months. Most patients are pleased with the results of dermal fillers use. However, like any esthetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatment to achieve the results you seek. The dermal filler procedure is temporary and additional treatments will be required periodically, generally within 4-6 months, involving additional injections for the effect to continue. I am aware that follow-up treatments will be needed to maintain the full effects. I am aware the duration of treatment is dependent on many factors including but not limited to: age, sex, tissue conditions, my general health and life style conditions, and sun exposure. The correction, depending on these factors, may last up to 6 months and in some cases shorter and some cases longer. I have been instructed in and understand the post-treatment instructions. **Initial ____**

I understand this is an elective procedure and I hereby voluntarily consent to treatment with dermal fillers for facial rejuvenation, lip enhancement, establish proper lip and smile lines, and replacing facial volume. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

_____

Patient Name (Print) Patient Signature Date

I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

_____

Doctor Name (Print) Doctor Signature Date

Agenda Item

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N.C.S.B.N. EDUCATION PROGRAM SUMMARY

Educated in Alaska

TESTED DURING 3rd Quarter 2018 (July 1-September 30 ,2018)

NURSING PROGRAM	FIRST TIME TESTERS	PASS	PASS%	FAIL	FAIL%	REPEAT TESTERS	PASS	PASS%	FAIL	FAIL%
AVTEC LPN	0	0	**0%**	0	**0%**	0	0	**0%**	0	**0%**
AVTEC A.A.S	0	0	**0%**	0	**0%**	1	0	**0%**	1	**100%**
UAA A.A.S	13	11	**85%**	2	**15%**	9	6	**66%**	3	**33%**
UAA B.S.N.	37	34	**92%**	3	**8%**	5	4	**80%**	1	**20%**
CHARTER A.D.N	17	17	**100%**	0	**0%**	0	0	**0%**	0	**0%**

*NOTE: NCSBN does not provide data on “repeat testers” taken in other states. “First time tester” data shown here reflects testing information from all states, whereas “repeat tester” data reflects only our state. This means there may be a repeat testing candidate in another state not included in these totals.

N.C.S.B.N. EDUCATION PROGRAM SUMMARY

Y.T.D Totals (Jan 1-September 30, 2018)

NURSING PROGRAM	FIRST TIME TESTERS	PASS	PASS%	FAIL	FAIL%
AVTEC LPN	0	0	**0%**	0	**0%**
AVTEC A.A.S	0	0	**0%**	0	**0%**
UAA A.A.S	97	81	**84%**	16	**16%**
UAA B.S.N.	119	108	**91%**	9	**10%**
CHARTER A.D.N	49	49	**100%**	0	**0%**

Agenda Item

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State of Alaska
Department of Commerce, Community, and Economic Development
Division of Occupational Licensing
Nurse Aide Registry
550 W 7th Avenue Suite 1500
Anchorage, AK 99501-3567
Phone: (907) 269-8169
Fax: (907) 269-8196
Email: sandi.fredrickson@alaska.gov
Website: www.nursing.alaska.gov

Application for Approval of Nurse Aide Training Program

☒ $500.00 Application fee. Enclose check or money order made payable to the State of Alaska.

1. **Facility Information:** ☐ Nursing Facility ☒ Non-Nursing Facility

Name of training facility: University of Alaska Anchorage/MatSu College

Training facility address:

a) UAA: 3211 Providence Dr., AHS 148 Anchorage, AK 99508
b) MatSu College: 8295 E. College Dr. Palmer, AK 99645

Phone: 907-786-6932 Fax: 907-786-6938

2. **Point of Contact:** (Identify preferred method of communication)

Name LeeAnne Carrothers Phone 907-786-6932 Email lcarrothers@alaska.edu

Address: 3211 Providence Dr., AHS 148 Anchorage, AK 99508

3. **Program Information:**

Program Title: Certified Nurse Aide

Program length (clocked hours): 160
(Min. of 60 hrs classroom/Min. of 80 hrs clinical experience required by State of Alaska)

Projected Date of First offering: Spring, 2019 (course starts 1/19/19)

Number of projected offerings over the next two years: 3-4

Geographic location(s) where the program will be offered: Anchorage, MatSu Valley

Location of clinical resources for clinical learning experience and type of patient care units anticipated for use **[Non-nursing facility only - Attach copy of the contractual agreement signed by program and facility]**

Name of agency/facility: Providence Alaska Medical Center
Address: 3200 Providence Dr, Anchorage, AK 99508

Name of agency/facility: MatSu Regional Health Center
Address: 2500 S. Woodworth Loop, Palmer, AK 99645

Name of agency/facility: Providence Extended Care Center
Address: 920 Compassion Cir, Anchorage, AK 99504

Name of agency/facility: Prestige Care & Rehabilitation Center of Anchorage
Address: 9100 Centennial Cir, Anchorage, AK 99504

Name of agency/facility: Alaska Regional Hospital
Address: 2801 Debarr Road, Anchorage, AK 99508

Note: UAA currently has valid MOAs for one or more programs in Allied Health and/or Nursing. We will be reviewing existing MOAs and securing addenda to include the CNA program as necessary. Copies of all MOAs and pertinent addenda will be provided prior to the November Board meeting.

4. Student population

Eligibility (check one):

☐ Open to all

☒ Restricted to (please specify): Students whose Accuplacer scores qualify them for WRTG A090 or higher
Students whose ALEKS scores qualify them for MATH A055 or higher

☐ Restricted to Agency/Facility Employees

Greatest number of applications anticipated in each program offering: unknown

Faculty/Student ratio: (Classroom max ratio 20 students to 1 instructor/ Clinical - 10 students to 1 instructor)

Classroom: up to 20:1

Clinical: 10:1

5. Faculty and Instructors – Please Attach Current Resumes with Direct Patient Care experience and Adult Education Experience highlighted.

Please see 12 AAC 44.840 for program instructors' qualifications

List Names and RN License Numbers for each Instructor candidate:

Name:
RN license number: [redacted]

Name: We are currently recruiting for additional faculty. Resumes and licens numbers will be provided once they are hired.

Purpose of UAA/Mat-Su College Certified Nurse Aide Course

The University of Alaska Anchorage (UAA) seeks to expand the geographic locations where the Certified Nurse Aide (CNA) course is offered. By offering the course on the Anchorage and Mat-Su campuses, UAA will provide highly skilled and qualified CNAs to meet the growing needs of the State of Alaska and the Matanuska-Susitna Borough. The course has been developed to provide highly skilled and qualified CNAs to meet the growing needs of the State of Alaska and Mat-Su Valley. Demand for nursing and related professions is expected to increase steeply over the next one to three years throughout Alaska. These demands will come from an aging population, new long-term care facilities, and expansions to existing acute-care facilities around the state, most specifically and immediately in the MatSu Valley (MSV).

The Alaska Health Workforce Coalition 2017-2021 Action Agenda[1] includes nursing as an occupational priority. The included Training, Competencies and Professional Development Objective 1 "expand and enhance training and professional development opportunities for all healthcare professionals" specifies certified nurse assistants in the action plan. Further, the population of Alaska is expected to age significantly over the next 27 years. Projections from the Alaska Department of Labor and Workforce Development, Research and Analysis Section demonstrates this trend:

"Alaska's current population aged 65 or older is 74,853 and is projected to increase 86 percent by 2045, reaching 139,309 people. Toward the end of the projection period, all baby boomers will be well into this age group[2].

To support the aging population of the MSV and to address the overall paucity of long-term care options for people in the Anchorage/MSV, Maple Springs Senior Living is currently building senior living villages in Wasilla and Palmer. Each facility will include 60 Skilled Nursing Facility apartments, transitional/post-acute care rehabilitation, long-term care, memory care, and a 10 bed hospice house. The first of the Maple Springs communities is expected to be operational by Fall of 2018. These facilities join the Pioneer Home and numerous other assisted living facilities in the MSV who will be competing for skilled nursing staff and nurse aides.

In addition to services for the elderly, acute medical care services are simultaneously expanding in the MSV. Mat-Su Regional Hospital is bringing an additional 52 medical-surgical beds online during 2018 and building a 36 bed inpatient adult psychiatric and substance abuse treatment center.

All of these projects will require new CNAs, which are already in short supply. In fact, medical facilities in the MSV and Anchorage have been increasingly utilizing traveling CNAs to meet current demand even prior to the medical service expansion. Those who complete the UAA/MSC CNA courses should be able to find immediate employment.

The planned start of the course is in January 2019, with a cohort of 20 students in the spring semester. Additional cohorts will be added in Anchorage as staffing permits.

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[1] Alaska Health Workforce Coalition (2017). Alaska Health Workforce Coalition 2017-2021 Action Agenda," p. 4. Retreived from http://www.alaska.edu/research/wp/plans/health/AHWC-2017-2021-Action-Agenda-September-2017-Final-With-Cover-(2).pdf

[2] Alaska Department of Labor and Workforce Development (2016). "Alaska Population Projections 2015 to 2045," p. 11. Retrieved from http://live.laborstats.alaska.gov/pop/projections/pub/popproj1545.pdf

HCA A105
University of Alaska Anchorage | Mat-Su College
Spring 2019 6 credits

Instructor:

[redacted]

Course Meeting Information: January 19, 2019-April 28, 2019. Class meeting times will be on Saturdays 8am-5pm with clinical dates and sites to be announced.

Catalog Course Description :
Prepares the student to be an Alaska State Certified Nurse Aide (CNA). Includes medical terminology, basic anatomy, first aid, and skills labs. Students receive on-site clinical training at local health care facilities.

Course Prerequisite/Other Restrictions:
English Placement: PRPE A086 or higher
Math Placement: MATH A055 or higher

Required Text and Learning Materials: Hartman's Nursing Assistant Care: The Basics 5th Edition, Hartman and Fuzy with workbook.

Student Learning Outcomes: In this class, learning requires partnership. For each hour spent in class, plan to spend at least two hours studying outside of class each week. At the end of this course, *if you actively engage in class, study outside of class, complete assignments and prepare for exams*, you will be able to:

- Demonstrate knowledge of essential healthcare principles: patient safety, body structure and function, patient physical and emotional needs, ethics, and legal guidelines.
- Correctly and professionally perform all procedures required by a working CNA at the proficiency level required for Alaska board certification.
- Demonstrate additional knowledge in the areas of interpersonal communication and delegation of nursing duties, as well as additional skill development in the required competencies.

Technical Requirements: Students must have regular access to a computer and the internet to access online materials in Blackboard and university email. Students will be expected to download course material as well as upload assignments.

Instructional Methods: Teaching techniques in this course will include course lectures, case studies, small group discussion, use of Blackboard, videos, hands-on skills training, and clinical site experiences.

Assessment of Learning and Grading System:

Grading in this course is A-F. These letter grades carry grade points, which are used to calculate GPAs. Grading in this course will reflect the standards established in the University of Alaska Anchorage Catalog, as follows:

A: Honor grade; indicates comprehensive mastery of required work.
B: Indicates high level of performance in meeting course requirements.
C: Indicates satisfactory level of performance.
D: Indicates lowest passing grade; may not be acceptable to satisfy requirements in certain majors and in graduate programs.
F: Indicates failure.

Assignments and Assessment of Learning:

The instructor reserves the right to change the assignment requirements and exam dates depending upon class progress.

There will be 10 chapter tests, 10 chapter homework assignments, 5 medical terminology assignments, a presentation, 2 skills tests, and a comprehensive final exam. Each homework assignment is due before the beginning of the class day following completion of the chapter lecture.

Clinical performance will be evaluated on a Satisfactory/Unsatisfactory basis. Satisfactory clinical performance is required to pass this course.

Grading Summary:

NOTE: The instructor reserves the right to change the assignments based upon class progress and student need for more time reviewing challenging concepts.

Chapter Homework- 10%
Chapter Tests- 50%
Medical Terminology- 10%
Presentation- 5%
Comprehensive Final Exam-25%

Grading :

Grading will be based upon a *percentage of the total points earned* for homework, exams, attendance, and extra credit. This class is graded on an A-F scale.

A: 94-100%
B: 85-93%
C: 75-85%
D: 61-75%
F: < 60%

Course Policies

Classroom Rules:

In addition to compliance with the UAA Code of Conduct, the following are expected:

1. Cellphones, laptops, tablets, and all electronic devices are to be turned off and put away. Do not take them out during class. Cell phones are not allowed in the patient care areas of clinical facilities.
2. Be on time. Late entrances disrupt others.
3. No eating in class. Beverages in closed containers are acceptable.

4. Please respect the rights of others to learn. Behaviors that distract attention from lecture or class activities will not be tolerated. Conduct that unreasonably interferes with the learning environment or that violates the rights of others is prohibited by the standards and guidelines collectively described as the UAA Student Code of Conduct: https://www.uaa.alaska.edu/students/conduct/index.cshtml
5. No children, pets, or guests are permitted to attend class.

Attendance:
In order to sit for Alaska board certification, there are a certain amount of contact hours requirements. In light of that, Attendance to every class session is expected. Any absences must be approved by the instructor and make-up hours scheduled (preferably in advance) at the convenience of the instructor. Since attendance to class sessions and clinical experiences is required, there are participation points assigned. Absences will result in loss of 5 attendance and participation points. Tardiness of greater than 15 minutes or leaving early without prior approval from the instructor will result in the loss of 2 attendance and participation points, per occurrence.

Clinical Attendance:
The clinical experiences provided in this course serve to prepare the student for professional practice as a CNA. Consequences for not attending clinical can include the inability to obtain the required hours to sit for state examination. Any clinical make-up time will be scheduled at the convenience of the instructor.

Clinical Time Missed	Required make-up hours	Consequence
Tardy 15 minutes-4 hours	4 hours	Warning
One Clinical Experience Day	8 hours	Conference with course instructor
2 or more Clinical Experience Days	Results on failure to meet minimum attendance requirements*	Automatic failure of clinical component and course failure.

*See "Incomplete Grades"

Late Work: Assignments submitted after the due date and time will have 5 points deducted per day the assignment is late. If an assignment is more than 5 days late, a grade of "0" will be automatically assigned to it.

Withdrawal Deadline: Insert date is the last day for student- or faculty-initiated withdrawals.

Email: Email and Blackboard will be the primary means of communication outside of the scheduled class meeting times. I will only use your UAA assigned email address. Please use your UAA email account when contacting me. Please put *the course title and number* in the subject line. UAA uses e-mail to communicate with students about many regulations, requirements and responsibilities. E-mail is often the only way some information is distributed so it's important for you to regularly check your university e-mail account or to forward mail from your UAA account to an account you check frequently. The university automatically assigns you an official UAA e-mail account when you first register for classes. To obtain your user name and create a password, go to: https://me.uaa.alaska.edu/ .You are responsible for knowing — and when appropriate, acting on — the contents of all university communications sent to your official UAA e-mail account. If you want to receive university communications at a different e-mail address, you need to forward e-mail from your assigned UAA account to an e-mail address of your choice. You can easily do this online at https://www.uaa.alaska.edu/email/. If you experience difficulties accessing your email or Blackboard, contact the UAA IT Services Call Center at 907-786-4646 Option 1 or toll-free at 877-633-3888.

Blackboard: Blackboard will be used for announcements and posting of your grades.

Dress Code: Students are expected to follow dress code requirements for this course as well as that of the Clinical Experience sites. Students who fail to do so may be dismissed for the day and will suffer loss of participation points for the day. Scrubs are expected to be worn at all times within the clinical facilities as well as in class on designated Skills Test Days. Additional information will be discussed at class orientation as to specific clinical site requirements.

University Policies and Services

Academic Integrity: Academic integrity is a basic principle that requires that students only take credit for ideas and efforts that are their own. Cheating, plagiarism, and other forms of academic dishonesty are defined as the submission of materials in assignments, examinations, or other academic work that is based on sources prohibited by the faculty member. Substantial portions of academic work that a student has submitted for a course may not be resubmitted for credit in another course without the knowledge and advance permission of the instructor. For more information, refer to the UAA Student Code of Conduct: http://www.uaa.alaska.edu/deanofstudents/academic-integrity/

Disability Support Services: Disability Support Services (DSS) is responsible for coordinating support services for UAA students who experience disabilities. To access support services, students must contact DSS (746-9737) and provide current disability documentation that supports the requested services. Additional information may be accessed on-line at https://matsu.alaska.edu/offices/student-services/msc-policies/disability-support.cshtml

The Learning Center, OLB 121: The Mat-Su College Learning Center has math, writing, and other subject matter tutors available to help students successfully complete the learning activities in their classes. For hours and services: http://matsu.alaska.edu/offices/learning-resource-center/.

Incomplete Grades: An incomplete grade is assigned only at the discretion of the instructor. A student requesting an incomplete grade must have completed 75% of course requirements and have a minimum of a "C" in the course at the time of the request.

Student Code of Conduct and Campus Civility: As with all members of the University community, the University requires students to conduct themselves honestly and responsibly, and to respect the rights of others. Conduct that unreasonably interferes with the learning environment or that violates the rights of others is prohibited by the standards and guidelines collectively described as the Student Code of Conduct. For more information, refer to the UAA Student Handbook: https://catalog.uaa.alaska.edu/handbook/. It is the student's responsibility to know the expectations outlined in the handbook for appropriate campus and classroom behaviors and to adhere to these expectations.

Counseling: Mat-Su College is dedicated to helping students succeed in achieving their academic goals. A wide range of personal challenges may limit or prevent a student from achieving his or her goals. These may include thoughts of self-harm, depression, stress, anxiety, relationship issues, family conflict, substance abuse, etc. Students experiencing any of these or other personal challenges are encouraged to speak with a counselor.

Counseling is meeting with a behavioral health clinician to talk about and work through problems. The clinician will help students develop an individualized, solutions-focused plan to address their needs. Students may meet with an experienced mental health clinician/counselor on the Mat-Su College campus up to three times free of charge. If necessary, referrals will be made for additional services. All services are confidential. Services are provided by Mat-Su Health Services.

To schedule an appointment, call 907-376-2411.

*Services are provided as part of a pilot project funded by the Mat-Su Health Foundation. The free services will be available as the grant funds permit.

Title IX:
University of Alaska Board of Regents have clearly stated in BOR Policy that discrimination, harassment and violence will not be tolerated on any campus of the University of Alaska. If you believe you are experiencing discrimination or any form of harassment including sexual harassment/misconduct/assault, you are encouraged to report that behavior. If you disclose sexual harassment or sexual violence to a faculty member or any university employee, they must notify the UAA Title IX Coordinator about the basic facts of the incident. Your choices for disclosure include:

1. You may confidentially disclose and access confidential counseling by contacting the UAA Student Health & Counseling Center at 907-786-4040 or Alaska Family Services in Palmer at 866-746-4080 (24 hours).
2. You may access support and file a Title IX report by contacting the UAA Title IX Coordinator at 907-786-0818. At Mat-Su College contact the Director of Academic Affairs at 907-746-9316 for more information.
3. You may file a criminal complaint by contacting the Alaska State Troopers, Palmer Office: 907-745-2131.

Course Calendar/Outline

NOTE: The instructor reserves the right to change the assigned readings, homework, and exam dates based upon class progress and student need for more practice on specific concepts.

Class Day	Topics to be covered	Assignments Due
Day 1	Syllabus, Class Overview, Presentation Overview, Chapter 1"The Nursing Assistant in Long Term Care" Lecture, Med. Term. Assignment 1, Introductory Skills	
Day 2	Chapter 1 Test, Chapter 2 " Foundations of Resident Care" Lecture, Med. Term. Assignment 2, Presentation Topic Assignment, 4 Skills	Med Term 1, Chapter 1 Homework
Day 3	Chapter 2 Test, Chapter 6 "Personal Care Skills" Lecture, Med. Term. Assignment 3, 4 skills	Med Term 2, Chapter 2 Homework
Day 4	Chapter 6 Test, Chapter 7 "Basic Nursing Skills" Lecture, Med. Term Assignment 4, 4 Skills	Med Term 3, Chapter 6 Homework
Day 5	Chapter 7 Test, Chapter 3 "Understanding Residents" Lecture, Med. Term. Assignment 5, 4 skills	Med Term 4, Chapter 7 Homework
Day 6	Chapter 3 Test, Chapter 4 "Body Systems and Related Conditions" Lecture, Med. Term Review, 4 skills, Skills Test 1	Med Term 5, Chapter 3 Homework
Day 7	Chapter 4 Test, Chapter 5 "Confusion, Dementia, and Alzheimer's" Lecture, 4 Skills, Presentation Help	Chapter 4 Homework
Day 8	Chapter 5 Test, Chapter 8 "Nutrition and Dehydration" Lecture, 4 skills	Chapter 5 Homework
Day 9	Chapter 8 Test, Chapter 9 "Rehabilitation and restorative Care" Lecture, 4 skills, Presentation Help	Chapter 8 Homework
Day 10	Chapter 9 Test, Chapter 10 " Caring For Yourself" Lecture, Skills Test 2, Presentations	Chapter 9 Homework
Day 11	Presentations (cont.), Final Exam, Paperwork Review for State Exam	Chapter 10 Homework

HCA A105 CNA

Final Exam

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Hartman's Nursing Assistant Care

The Basics

Hartman Publishing, Inc.
with Jetta Fuzy, RN, MS

FIFTH EDITION

Contents

Procedures

STUDENT NAME:_____

Certified Nursing Assistant Skills Evaluation
12 AA C 44.847 Clinical Training Curriculums

I. The Nurse Aide's Role and Responsibility

		DATE	SATISFAC	UNSATISFAC	INITIAL
A	Uses ethical and legal concepts in relationships and communication with others including health care providers and the client.				
B	Maintains confidentiality of client information.				
C	Identifies the lines of authority and reports problems to the appropriate person.				
D	Identifies the range and limitation of certified nurse aid functions.				
E	Accepts responsibility for own actions.				
F	Demonstrates promptness and dependability				
G	Seeks assistance when unsure about appropriate action				
H	Participates as a member of the health care team; provides input to licensed nursing staff in the development and updating of client care plans.				
I	Recognizes and demonstrates client's rights and responsibilities in client relationships.				

II. Basic Nursing Skills

		DATE	SATISFAC	UNSATISFAC	INITIAL
A	Washing Hands				
B	Donning and removing PPE (gown and gloves)				
C	Taking and recording vital signs				
	Temperature				
	Radial Pulse				
	Respirations				
	Blood Pressure				
	Pulse Oximetry				
D	Recording intake and urinary output				
E	Demonstrate and understanding of monitoring body function/s.				
F	Non-invasive physical specimen collection and testing, including recognizing and reporting deviations from normal limits Stool 24 hour urine Clean catch urine Routine urine Stool for occult blood sputum				

G	Recognizing abnormal signs and symptoms including: a. shortness of breath, b. rapid respiration, c. fever, d. chills, e. coughs, f. pain in the chest and abdomen, g. nausea and vomiting, h. blue color to the lips, i. drowsiness, j. excessive thirst or sweating; k. pus, blood or sediment in the urine; urinating difficulties, urinating in frequent small amounts, pain or burning during urination, or urine with dark color or strong odor				
H	Measuring and recording height and weight				
I	Transferring, positioning, and turning of clients				
J	Positioning client on side				
K	Making an occupied bed				
L	Performing passive range of motion				
M	**BLS for Healthcare Providers**				

III.	**Basic Personal Care**	**DATE**	**SATISFAC**	**UNSATISFAC**	**INITIAL**
A	Bathing – bed bath, shower, tub and/or whirlpool				
B	Oral hygiene				
C	Grooming				
D	Dressing				
E	Toileting				
F	Eating and hydration				
G	Proper feeding techniques				
H	Applying knee-high elastic stockings				
I	Skin care				
J	Assisting client with use of bedpan				
K	Cleaning dentures				
L	Providing mouth care				
M	Dressing client with affected (weak) arm				
N	Providing perineal (peri-care)				
O	Providing catheter care for male and female clients				
P	Providing fingernail care				
Q	Providing foot care				

IV.	**Safety Concepts**	DATE	SATISFAC	UNSATISFAC	INITIAL
A	Demonstrates principles of medical asepsis and isolation techniques				
B	Shows proficiency in basic life support and basic first aid				
C	Provides adequate ventilation, warmth, light, and a therapeutic environment				
D	Uses appropriate measures to relieve pain and promote rest and sleep				
E	Maintains equipment and keeps client space clean and orderly				
F	Identifies and demonstrates accident prevention measures				
G	Applies principals of body mechanics in transferring and ambulation of clients				
H	Assists client to ambulate using transfer belt				
I	Transfers client from bed to wheelchair using transfer belt				
J	Demonstrates proper application and release of restraints and other protective devices				
K	Demonstrates the proper care of the client in protective devices				
L	Demonstrates knowledge of fire and disaster procedures				
M	Applies principles of health and sanitation in the service of food to the client: **Alaska Safe Food Worker Card**				

V.	**Communication Skills**	DATE	SATISFAC	UNSATISFAC	INITIAL
A	Listens and responds to clients' verbal and non-verbal communication				
B	Recognizes that the certified nurse aide's own behavior influences a client's behavior				
C	Seeks assistance in understanding clients behavior				
D	Gives appropriate positive and negative reinforcement				
E	Makes adjustments for the physical and mental limitations of a client				
F	Uses technology accepted in the employing facility to record and report observations and pertinent information				
G	Reports and records observations, activities and communications accurately				

VI. Hygiene and Restorative Nursing Care		DATE	SATISFAC	UNSATISFAC	INITIAL
A	Provides appropriate personal hygiene services to the client				
B	Uses measures that promote good skin care including the use of anti-pressure procedures and devices				
C	Carries out preventative maintenance and rehabilitative measures such as therapeutic ambulation, exercise, and bed and chair positioning in daily care				
D	Recognizes and promotes opportunities for self care according to the client's ability				
E	Helps to provide adequate nutrition including fluid intake and progressive self feeding				
F	Identifies and monitors special dietary needs				
G	Follows correct procedures to aid adequate elimination from the bladder and bowel including measuring output				
H	Demonstrates an understanding of the concepts of bladder and bowel retraining				
I	Makes adjustments for physical and mental limitations				

VII. Growth and Development		DATE	SATISFAC	UNSATISFAC	INITIAL
A	Identifies basic human needs				
B	Helps to provide for the client's spiritual needs				
C	Recognizes the client's family as an influence on behavior and care				
D	Identifies developmental tasks associated with aging				
E	Describes the body responses, including sexuality, in the normal life cycle				
F	Identifies cultural factors that may influence behavior				
G	Describes the body responses to loss, dying, and death				
H	Demonstrates knowledge of post mortem care				

VIII. Rights of Clients		DATE	SATISFAC	UNSATISFAC	INITIAL
A	Provides privacy and maintenance of confidentiality				
B	Promotes the client's right to make personal choices to accommodate individual needs				
C	Verbalizes understanding of process to help the client resolve grievances				
D	Helps the client get to and/or participate in family and other group activities				

E	Demonstrates care for and maintenance of the security of a client's personal possessions				
F	Provides care that protects the client from abuse, mistreatment, or neglect				
G	Verbalizes understanding of the process to report any instances of abuse, mistreatment, or neglect to the appropriate authorities				
H	Maintains the clients' environment and provides the level of care that will minimize the need of physical and chemical restraints				
I	Verbalizes the understanding of the need to act as an advocate if a client's rights appear to have been violated by reporting to the appropriate supervisory staff				

Comments

_____ **Student Signature**

Date

_____ **Instructor Signature**

Date

_____ **Instructor Signature**

Date

NURSE AIDE TRAINING PROGRAM
Health Science

Equipment List Skills Evaluation

START–UP FURNITURE AND EQUIPMENT			
ITEM	**YES**	**NO**	**RECOMMENDED AMOUNTS**
Adjustable bed with side rails *(must be working)*			1 per candidate testing
Chair			1 per candidate testing
Clock preferred or Wrist Watch with second hand			1 per candidate testing unless wall clock can be clearly seen from all testing areas
Dedicated Fax machine *(accessible to skills lab)*			1 per testing site
Mannequin with removable catheter *(must be a full female mannequin)*			1 for usage of all candidates
Privacy curtain, Screen or Door if private room			1 per candidate testing
Scale, calibrated *(bathroom/standing)*			1 for usage of all candidates
Signaling device *(may be non-functional)*			1 per skills bed
Sink with running water in room			@ least 1 for usage of all candidates
Soiled linen container			1 per candidate testing
Table, bedside			1 per candidate testing
Table, over bed			1 per candidate testing
Toilet/Bedside Commode/Collection container clearly labeled commode			1 per candidate testing
Wastebasket with liner			1 by each bed used 1 by each sink used
Wheelchair with footrests			1 for usage of all candidates

SUPPLIES			
ITEM	**YES**	**NO**	**RECOMMENDED AMOUNTS**
Basin, bath			4 per candidate testing
Basin, emesis			2 per candidate testing
Bedpan *(standard)*			2 per candidate testing

Blood pressure cuff			1 standard per candidate testing 1 XL for usage of all candidates
Denture cup w/lid			1 per candidate testing
Dentures			1 set or 2 uppers or 2 lowers for usage of all candidates
Knee-high elastic stockings			1 stocking per candidate testing
Measuring container *(graduated – at least 250 ml's/cc's units clearly visible)*			1 per candidate testing
Stethoscope, dual earpiece			1 per candidate testing
Syringe for Catheter			1 per testing
Transfer *(gait)* belt / with extender			1 per candidate testing

DISPOSABLE SUPPLIES

ITEM	YES	NO	RECOMMENDED AMOUNTS
Alcohol swab or Alcohol and cotton ball			2 per candidate scheduled
Antimicrobial Spray/Wipes – *clearly labeled*			1 container per candidate testing
Drinking cup *(disposable)*			8 per candidate testing
Emery board *(can be broken in half)*			4-6 per candidate testing
Food *(typically be eaten with spoon-no finger food)* and beverage *(water)*			2 cups of "fruit cocktail" for each candidate testing
Gloves, large, disposable non-latex			3 pair per candidate scheduled
Gown, Isolation *(long sleeve w/neck & waist ties-cloth or disposable)*			2 per candidate testing
Hand Sanitizer			1 container per candidate testing
Hand Wipes *(may use washcloth)*			2 per candidate scheduled
Lotion, in pump container *(hypoallergenic & unscented)*			1 bottle per candidate testing
Meal tray with client's name on meal card			1 per candidate testing
Napkins/Paper Towels			4-6 per candidate testing
Orangewood stick *(can be broken in half)*			4-6 per candidate testing
Paper plates			8 per candidate testing
Paper towels			2 rolls for usage of all candidates
Plastic bags *(for wastebasket)*			2 per each wastebasket
Soap, liquid in pump container *(hypoallergenic &*			1 per candidate testing

unscented/not rinseless)			
Spoons *(disposable)*			8 per candidate testing
Toilet tissue or Wipes			1 roll per candidate testing or 2 wipes per candidate scheduled
Toothbrush *(individually wrapped)*			4-6 per candidate testing
Toothpaste			1 per candidate testing

LINEN/CLOTHING

ITEM	YES	NO	RECOMMENDED AMOUNTS
Clothing protector *(bib, towel or napkin)*	✓		2 per candidate testing
Clothing *(extra large tops that open in the front – no hospital gowns)*	✓		2 per candidate testing
Gowns *(patient)*	✓		2 per candidate testing
Linens: pillowcase, top and bottom sheets *(fitted or flat)*	✓		3 sets per candidate testing
Pad, waterproof/incontinent *(may use towel or drawsheet as waterproof pad)*	✓		2 per candidate testing
Pillows	✓		1 per skills bed
Towels	✓		2 per candidate scheduled
Supportive devices *(pillows, blanket rolls, wedges)*	✓		3 per candidate testing
Washcloth	✓		3 per candidate scheduled

Checklist: CNA Application for Training Program Approval

Program Name: University of Alaska Anchorage/MatSu College

☑ Completed application submitted: 8-9-18

☐ Survey must be completed by a RN either a member of the board or board staff (12 AAC 44.830(d) Name/Date of Survey_____
(done p provisional approval)

Deadlines/Timelines

☑ Submit a completed application at least 90 days before the date training is expected to begin meeting

- ☑ Deadline: Due by August 10. (12 AAC 44.830(c))
- ☑ Advise UAA of whether additional information is needed to complete the application.
- ☑ Deadline: October 30. Board Book is sent to members for review at the November 7, 8, 9 board meeting
- ☐ November board meeting UAA will receive provisionally approved program
- ☐ On-site review of the training facilities and personnel completed during the first training offered (12 AAC 44.830(d) Date_____
- ☐ Program deficiencies found upon on-site review Yes/No
- ☐ Deadline: February 2019 board meeting the board will review the program and grant program approval

Application Must Include: (12 AAC 44.830(1)(b)(1-8))

☑ Summary of rationale, philosophy and purpose of the program pg. 4

☑ Qualifications of the faculty + staff for Palmer

☑ An outline of the program, including the program's title, objectives, content and teaching methodology and the number of classroom and clinical instruction hours

☑ Copy of the nurse aide skills checklist to be used to measure student clinical skills as required in 12 AAC 44.852

☑ Program location

☑ Name and resume of each classroom instructor instructor Ms. Johnson (for Palmer's)

☑ Schedule of classroom and clinical instruction hours that includes supervised skill and clinical training hours

☑ Copy of the final examination

Training Program Standards: 12 AAC 44.835 (done onsite)

☐ Must be conducted in a manner to assure that clients receive safe/competence care and must train a certified nurse aide to:

- Form a relationship, communicate, and interact competently with the client
- Demonstrate sensitivity to the emotional, social, and mental health needs of a client through skillful and direct interactions
- Assist a client in attaining and maintaining independence
- Exhibit behavior that supports and promotes the rights of a client
- Demonstrate the skills of observing, caregiving, and reporting needed to document the health, physical condition, and well-being of a client

☑ To be approved by the board, a certified nurse aide training program must provide:

✓ Curriculum that meets the requirements of 12 AAC 44.845 and 12 AAC 44.847

✓ Instructors who meet the requirements of 12 AAC 44.840

✓ Classroom and clinical facilities that meet the requirements of (f) of this section

- Clinical sites are:

X Provid. Alaska Medical Center
X Mat-Su Regional Health Center
X Provid. Extended Care Center
X Prestige Care & Rehab Center of anch.
X Alaska Regional Hospital

- Additional requirements must consist of at least 140 hours of training:
  - ✓ Includes a minimum of 60 hours of didactic instruction that meets 12 AAC 44.845
  - ✓ Includes a minimum of 80 hours of supervised skills and clinical training that meets 12 AAC 44.847 and provides an opportunity for students to gain competencies required in 12 AAC 44.847 as follows:
    (A) 48 hours must be in:
      (i) a long-term care facility
      (ii) an assisted living home licensed in this state that has a RN or LPN on staff 24 hours/day
      (iii) an acute care facility
    (B) At least 32 hours must be in learning and practicing the skills under the direct supervision of an approved instructor under 12 AAC 44.830
  - Documents each student's demonstration of skills by completion of the nurse aide skills checklist required under 12 AAC 44.852 (done c onsite)
- ☐ During supervised skill and clinical training ratio of 1:10. Before direct contact with a client student must complete a minimum of 16 hours of classroom training and 16 hours of specific skills training includes: (done c onsite)
  - Communication and interpersonal skills
  - Infection control, including standard precautions
  - Safety and emergency procedures
  - Respecting and promoting the rights of the client
  - Observation, reporting, and documentation of patient status and the care furnished
  - Reading and recording temperature, pulse, and respiration
  - Basic elements of body functioning and changes in body function that must be reported to a nurse aide's supervisor
  - Appropriate and safe techniques in personal hygiene and grooming that includes:

- Bed bath
- Sponge, tub, or shower bath
- Skin care
- Oral hygiene
- Toileting and elimination
- Safe transfer techniques and ambulation
- Positioning

☐ Training includes to a nursing facility's initial employee orientation requirements (done onsite

☑ Classroom and clinical facilities must provide space, comfort, safety, and equipment (12 AAC 44.835(f)(1-8))

N/A ☐ Except as the following point, the board will not approve a training program offered in or by a nursing facility that the state survey and certification agency or the CMS has determined to be ineligible to offer a training/competency program within the 24 months preceding the board's review of the nursing facility's program

N/A Board will approve a training program to be conducted in a nursing facility described under the point above is a program provider other than that nursing facility offers the training program, and if the state survey and certification agency has

- Determined that a similar program is not offered within a reasonable distance of the facility
- Determined that an environment exists that is adequate for the operation of the program in the facility
- Provided notice of its determinations to the office of LTC Ombudsman established under AS 44.21.231

☑ Board shall maintain a current list of approved training programs

☑ Classroom instruction ratio will not exceed 1:20

Program Instructors: 12 AAC 44.840

☑ Non facility-based program

☑ Instructor must be a RN or LPN with current AK license

- ✓ At least 2 years of nursing experience with 1 year in LTC
- ✓ Have either completed a course in teaching adults or experience in teaching adults or supervising nurse aides
- ✓ Be approved by the board to be an instructor

☑ Primary program instructor must assume full responsibility and accountability for the program, including quality of the program and performance of instructors

☑ Primary program instructor: [redacted]

Last Name	License #	Degree	Yrs Exp/Area/Teaching or Supervising NA's
[redacted]			

N/A Facility-based program

- Training done under supervision of the facility DON (does not do training). If DON has at least 1 year of LTC the program instructor must a RN or LPN with:
  - At least 2 years of nursing experience
  - Either completed a course in teaching adults or supervising NA
  - Be approved by the board to be an instructor
- If facility DON does not have at least 1 year of LTC experience, the primary instructor in the training program must be a RN or LPN who has:
  - At least 2 years of experience which 1 year is in LTC
  - Have either completed a course in teaching adults or experience in teaching adults or supervising nurse aides
  - Be approved by the board to be an instructor
- An approved program instructor must be on-site and provide direct supervision to a student during clinical in any facility
- Supplemental personnel may be used to meet the program objectives for specific topics. Must have at least 1 year experience in training provided

Last Name	License #	Degree	Yrs Exp/Area	

Classroom Curriculum: 12 AAC 44.845 (See attached)

☑ 60 hours of classroom required and must include topics in 12 AAC 44.835(c)(1) (See regulations for listing)

Clinical Training Curriculum: 12 AAC 44.847

☑ 80 hours of supervised skills and clinical required in 12 AAC 44.835(c)(2) must provide an opportunity for students to gain competencies. (See regulations for listing)

12 AAC 44.845. CLASSROOM CURRICULUM. The 60 hours of classroom instruction required in 12 AAC 44.835(c)(1) must include the following topics:

(1) the role of a certified nurse aide, including
  (A) ethical standards;
  (B) legal issues;
  (C) the certified nurse aide as a member of the health care team; and
  (D) the client's rights and responsibilities;

(2) basic nursing skills, including
  (A) monitoring body functions;
  (B) taking and recording vital signs;
  (C) measuring and recording a client's height and weight;
  (D) caring for the client's environment;
  (E) non-invasive collection and testing of physical specimens;
  (F) measuring and recording fluid and food intake and output;
  (G) caring for a client if the client's death is imminent; and
  (H) post mortem care;

(3) personal care skills, including
  (A) bathing;
  (B) oral hygiene;
  (C) grooming;
  (D) dressing;
  (E) toileting;
  (F) assisting with eating and hydrating;
  (G) proper feeding techniques; and
  (H) skin care;

(4) safety concepts related to nursing, including
  (A) medical aseptic technique, including isolation;
  (B) basic life support;
  (C) environment;
  (D) body mechanics;
  (E) transfer and ambulation;
  (F) restraints and other protective devices;
  (G) fire and disaster;
  (H) food service; and
  (I) infection control, including standard precautions;

(5) communication skills, including
  (A) psychosocial needs of clients;
  (B) verbal and nonverbal communications;
  (C) knowledge of communication modifications for clients with limited abilities;
  (D) medical and nursing terminology; and
  (E) recording and reporting;

(6) hygiene and restorative nursing care, including
  (A) personal hygiene;
  (B) activities of daily living;
  (C) adequate nutrition and fluid intake;
  (D) excretory system;
  (E) bladder and bowel retraining; and
  (F) preventive maintenance and rehabilitative measures;

(7) human growth and development, including
  (A) basic needs;
  (B) developmental needs;
  (C) care of the cognitively impaired;
  (D) mental health and social service needs;
  (E) cultural factors;
  (F) sexuality;
  (G) process of aging; and
  (H) death and dying.

Authority: AS 08.68.100 AS 08.68.331

12 AAC 44.847. CLINICAL TRAINING CURRICULUM. The 80 hours of supervised skills and clinical training required in 12 AAC 44.835(c)(2) must provide an opportunity for a student to gain the following competencies:

(1) perform according to a nurse aide's role and responsibility by

(A) using ethical and legal concepts in relationships and communication with others, including other health care providers and the client;

(B) maintaining confidentiality of client information;

(C) identifying the lines of authority and reporting problems to the appropriate person;

(D) identifying the range and limitation of certified nurse aide functions;

(E) accepting responsibility for one's actions;

(F) demonstrating promptness and dependability;

(G) seeking assistance when unsure about appropriate action;

(H) participating as a member of the health care team, including providing input to licensed nursing staff in the development and updating of client care plans; and

(I) using the concept of client's rights and responsibilities in client relationships, including the rights described in 7 AAC 12.890;

(2) demonstrate an understanding of the basic nursing skills of

(A) monitoring body functions;

(B) taking and recording vital signs;

(C) non-invasive physical specimen collection and testing, including recognizing and reporting deviations from normal limits;

(D) measuring and recording height and weight;

(E) recognizing abnormal signs and symptoms of common diseases and conditions, including the following:

(i) shortness of breath;
(ii) rapid respiration;
(iii) fever, chills, or coughs;
(iv) pain in the chest or abdomen;
(v) nausea and vomiting;
(vi) blue color to the lips;
(vii) drowsiness;
(viii) excessive thirst or sweating;
(ix) pus, blood, or sediment in urine;
(x) urinating difficulties, urinating in frequent small amounts, pain or burning during urination, or urine with dark color or strong odor;

(F) transfers, positioning, and turning of clients;

(3) demonstrate an understanding of basic personal care skills by assisting clients with

(A) bathing;

(B) oral hygiene;

(C) grooming;

(D) dressing;

(E) toileting;

(F) eating and hydration;

(G) proper feeding techniques; and

(H) skin care;

(4) demonstrate knowledge of safety concepts by
(A) using the principles of medical asepsis and isolation techniques;
(B) showing proficiency in basic life support;
(C) providing adequate ventilation, warmth, light, and therapeutic environment;
(D) using appropriate measures to relieve pain and promote rest and sleep;
(E) maintaining equipment and keeping client space clean and orderly;
(F) identifying and using accident prevention measures;
(G) applying principles of body mechanics in transferring and ambulation of a client;
(H) demonstrating the proper application and release of restraints and other protective devices;
(I) demonstrating the proper care of the client in protective devices;
(J) demonstrating knowledge of fire and disaster procedures; and
(K) applying principles of health and sanitation in the service of food to a client;
(5) demonstrate appropriate communication skills by
(A) listening and responding to a client's verbal and nonverbal communications;
(B) recognizing that the certified nurse aide's own behavior influences a client's behavior;
(C) seeking assistance in understanding a client's behavior;
(D) giving appropriate positive and negative reinforcement;
(E) making adjustments for the physical or mental limitations of a client;
(F) using terminology accepted in the employing facility to record and report observations and pertinent information;
(G) recording and reporting observations, activities, and communications accurately;
(6) demonstrate knowledge of hygiene and restorative nursing care by
(A) providing appropriate personal hygiene services to the client;
(B) using measures that promote good skin care, including the use of anti-pressure procedures and devices;
(C) carrying out preventive maintenance and rehabilitative measures such as therapeutic ambulation, exercise, range of motion, and bed and chair positioning in daily care;
(D) recognizing and promoting opportunities for self-care, according to the client's ability;
(E) helping to provide adequate nutrition, including fluid intake and progressive self-feeding;
(F) identifying and monitoring special dietary needs;
(G) following correct procedures to aid adequate elimination from the bladder and bowel, including measuring output;
(H) demonstrating an understanding of the concepts of bladder and bowel retraining; and
(I) making adjustments for physical or mental limitations;
(7) demonstrate knowledge of growth and development concepts by
(A) identifying basic human needs;
(B) helping to provide for a client's spiritual needs;
(C) recognizing the client's family as an influence on behavior and care;
(D) identifying developmental tasks associated with aging;
(E) identifying cultural factors that may influence behavior;
(F) describing the body responses, including sexuality, in the normal life cycle;
(G) describing the body responses to loss, dying, and death; and
(H) demonstrating knowledge of post mortem care; and
(8) demonstrate behavior that maintains the rights of the client by
(A) providing privacy and maintenance of confidentiality;
(B) promoting the client's right to make personal choices to accommodate individual needs;
(C) helping the client to resolve grievances;
(D) helping the client get to, and participate in, family and other group activities;
(E) helping to care for and maintain the security of a client's personal possessions;
(F) providing care that protects the client from abuse, mistreatment, or neglect;
(G) reporting any instances of abuse, mistreatment, or neglect to the appropriate authorities;
(H) maintaining the client's environment and providing the level of care that will minimize the need for physical and chemical restraints;
(I) acting as an advocate if a client's rights appear to have been violated by reporting to the appropriate

Authority: AS 08.68.100 AS 08.68.331

Nurse Aide Competency Evaluation: 12 AAC 44.850 – for the BoN

- ☐ To be approved by the board a competency evaluation must include:
  - An exam covering subjects specified in 12 AAC 44.845 and 12 AAC 44.847; competency must offer the applicant a choice between a written or oral exam
  - An exam demonstrating the applicant's clinical and practical nurse aide skills
  - Notification to the applicant of his/her performance (pass/fail)
- ☐ Competency evaluation must be administered/evaluated by a RN approved by the board who has at least 1 years' experience in providing elderly care or care of chronically ill of any age
- ☐ Applicants who do not pass competency evaluation may retake the failed portion, upon paying fee to retake
- ☐ Applicants have 3 attempts to pass competency evaluation; after 3 failed attempts they must take a remedial course of training as required by the board, and provide proof of course completion before the board will approve applicant to retake

Nurse Aide Skills Checklist: 12 AAC 44.852 (Site visit)

- ☐ Training programs must maintain a nurse aide skills checklist that records the performance of each student. Checklist includes:
  - Each of the skills listed in 12 AAC 44.845 and 12 AAC 44.847
  - The date each skill was practiced or demonstrated
  - Student's satisfactory or unsatisfactory performance of a skill and each time it was practiced or demonstrated
  - Name and signature of the instructor who supervised the performance of a skill. Students shall receive a copy of the skills checklist after completion of the program

Changes in Training Program: 12 AAC 44.855

- A change in curriculum or a substantive change in an approved certified nurse aide training program may not occur without board approval. The program provider must submit a description of the proposed change in curriculum or other substantive change to the board for review at least 60 days before the provider proposes to implement the changes. The board will base its approval on whether the proposed change meets the requirements of 12 AAC 44.835 – 12 AAC 44.847 and 12 AAC 44.852

Training Program Review: 12 AAC 44.857

- The board will approve a certified nurse aide training program for a two-year period. Within 2 years the board will conduct an on-site review. During a year in which on-site review is not scheduled, the program provider shall complete a self-evaluation form provided by the board.

Agenda Item

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Board Meeting November 2018

CNA Program Report

Program Pass Rates

The cumulative annual pass rate was calculated for FY19 Q1 (last quarter July – Sept 2018), FY18 Q4 (previous quarter April - June), and FY18 Q1 (1 year ago from FY19 Q1 July – Sept 2017). 3 programs fell below 80% in the most current last quarter (FY19 Q1).

Programs	FY19 Q1	FY18 Q4	FY18 Q1
King Career Center (4 testers 1 failed skills)	75.0%	68.8%	100%
Caregiver Training Academy (CTA) (26 testers 3 failed skills 7 failed written)	65.4%	85.7%	71.4%
Kodiak College (2 testers 1 failed skills)	50.0%	83.3%	No Testers

CTA was placed on conditional approval September 8, 2017 per regulations 12 AAC 44.858. CTA will remain on conditional approval until they achieve an 80 percent cumulative pass rate during two consecutive years or approval is withdrawn under 12 AAC 44.862, which states "the board may withdraw approval of a certified nurse aide training program if the board determines that the program no longer meets the requirements of 12 AAC 44.835 – 12 ACC 44.847 and 12 AAC 44.852 – 12 AAC 44.860, or that the program has been unable to achieve minimal standards within two years after being placed on condition approval."

Self-Evaluations Completed per 12 AAC 44.857(c)

The following programs had self-evaluations that were completed and accepted:

UAS - Ketchikan
Alaska Job Corps - Palmer
Chugiak Eagle River Health Education
UAF - Nome
UAS - Sitka
Petersburg General Hospital LTC
King Career Center (now King Tech High School)
Kodiak College
Mat-Su Borough School District
PWSCC - Cordova

On-site Reviews Completed per 12 AAC 44.835 – 12 AAC 44.847 and 12 AAC 44.852 – 12 AAC 44.860

The following programs had on-site reviews and were determined to be in compliance:

Heritage Place – Kenai/Soldotna
Katchemak Bay Community College - Homer
Alaska Technical Center - Kotzebue
Valdez Combined Program
Peninsula College/Kenai Peninsula School District - Kenai

I recommend the Board approve the CNA training programs who had on-site visits and found to be in compliance with the required regulations be approved for the next 2 years.

New Testing Site in Anchorage

September 8 was the first exam on the UAA campus where students were able to have the written and skills exams in one place. It worked out well. So much easier for the students and the proctors.

New CNA Training Program Application

UAA has applied for CNA training programs in Anchorage and Mat-Su (Palmer). The application was given to the Board prior to this board meeting for their review. They have met the requirements of 12 AAC 44.835 – 12 AAC 44.847 and 12 AAC 44.852. UAA is asking for their provisional approval so the training program in Palmer may offer their program January 2019. Program representatives are at the board meeting today to answer any questions the Board may have regarding their program.

I recommend to the Board the University of Alaska – Anchorage's request for provisional CNA training program be approved.

Proctors

We are recruiting for proctors in Sitka, Ketchikan, Fairbanks, Anchorage, Juneau and Kotzebue. Fairbanks, Anchorage, Juneau and Kotzebue currently have proctors but they have requested more proctors due to current proctors wanting more time off and some will be retiring in 2019. Sitka and Ketchikan's proctors have either retired or became instructors. Fortunately, we have had interests in all areas, except Juneau, and resumes are being reviewed and those approved are going through the contract process required by the State.

Licensing

This quarter saw a decrease in the number of temporary certificates issued from 51, in the last quarter, to 14. This quarter 12 certificates were reinstated, 8 were reinstated last quarter. There were 123 permanent certificates issued, 140 were issued last quarter.

Continuing Education Audits

There were 100 CNA's who had continuing education audits. 18 were found to be non-compliant and were forwarded to Marilyn Zimmerman, Paralegal.

Submitted by Joan Green, Nurse Consultant
November 2018 Board Meeting

Agenda Item

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Exam Results by Program - FY19 Q1: July 2018 thru September 2018

All Programs

Program	ID #	First Time Skills	First Time Written	Passed Skills	Skills Pass Rate	Passed Written	Written Pass Rate	Passed Both	Overall Pass Rate
Alaska Job Corps (Palmer)	02246	7	7	7	100.0%	7	100.0%	7	100.0%
Alaska Technical Center (Kotzebue)	02233	8	8	7	87.5%	8	100.0%	7	87.5%
Alaska CNA Program (Anchorage)	02276	15	15	13	86.7%	14	93.3%	12	80.0%
ASD - King Career Center (Anchorage)	02268	4	4	3	75.0%	4	100.0%	3	75.0%
ASD - Service (Anchorage)	02269	0	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
AVTEC (Anchorage)	02266	Program Closed							
Bethel	02271	0	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Caregiver Training Academy (Anchorage)	02264	26	26	23	88.5%	19	73.1%	17	65.4%
Charter College (Anchorage)	02277	0	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Chugiak / Eagle River	02274	7	7	6	85.7%	7	100.0%	6	85.7%
Heritage Place (Soldotna)	02016	5	5	5	100.0%	5	100.0%	5	100.0%
Kachemak Bay CC (Homer)	02020	0	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Kenai Peninsula College / KPBSD (Soldotna)	02226	12	12	12	100.0%	11	91.7%	11	91.7%
Kodiak College	02011	2	2	1	50.0%	1	50.0%	1	50.0%
Mat-Su Career & Tech HS	02259	4	4	4	100.0%	4	100.0%	4	100.0%
Nelle's Nursing Assistant Training	02278	0	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Nursing Students	02237	1	1	1	100.0%	1	100.0%	1	100.0%
Petersburg Medical Center	02019	0	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
PWSCC (Cordova)	02008	0	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
UAF CTC (Fairbanks)	02241	14	14	13	92.9%	13	92.9%	12	85.7%
UAF Nome	02241	0	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
UAS Juneau	02229	8	8	8	100.0%	8	100.0%	8	100.0%
UAS Ketchikan	02236	1	1	1	100.0%	1	100.0%	1	100.0%
UAS Sitka	02223	1	1	0	0.0%	1	100.0%	0	0.0%
Valdez Combined	02275	0	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Wrangell Medical Center	02009	0	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Q1 Totals		**115**	**115**	**104**	**90.4%**	**104**	**90.4%**	**95**	**82.6%**

Exam Results by Program - FY19 Year-to-date: July 2018 thru September

All Programs

Program	ID #	First Time Skills	First Time Written	Passed Skills	Skills Pass Rate	Passed Written	Written Pass Rate	Passed Both	Overall Pass Rate
Alaska Job Corps (Palmer)	02246	7	7	7	100.0%	7	100.0%	7	100.0%
Alaska Technical Center (Kotzebue)	02233	8	8	7	87.5%	8	100.0%	7	87.5%
Alaska CNA Program (Anchorage)	02276	15	15	13	86.7%	14	93.3%	12	80.0%
ASD - King Career Center (Anchorage)	02268	4	4	3	75.0%	4	100.0%	3	75.0%
ASD - Service (Anchorage)	02269	0	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
AVTEC (Anchorage)	02266	Program Closed							
Bethel	02271	0	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Caregiver Training Academy (Anchorage)	02264	26	26	23	88.5%	19	73.1%	17	65.4%
Charter College (Anchorage)	02277	0	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Chugiak / Eagle River	02274	7	7	6	85.7%	7	100.0%	6	85.7%
Heritage Place (Soldotna)	02016	5	5	5	100.0%	5	100.0%	5	100.0%
Kachemak Bay CC (Homer)	02020	0	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Kenai Peninsula College / KPBSD (Soldotna)	02226	12	12	12	100.0%	11	91.7%	11	91.7%
Kodiak College	02011	2	2	1	50.0%	1	50.0%	1	50.0%
Mat-Su Career & Tech HS	02259	4	4	4	100.0%	4	100.0%	4	100.0%
Nelle's Nursing Assistant Training	02278	0	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Nursing Students	02237	1	1	1	100.0%	1	100.0%	1	100.0%
Petersburg Medical Center	02019	0	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
PWSCC (Cordova)	02008	0	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
UAF CTC (Fairbanks)	02241	14	14	13	92.9%	13	92.9%	12	85.7%
UAF Nome	02241	4	4	4	100.0%	4	100.0%	4	100.0%
UAS Juneau	02229	8	8	8	100.0%	8	100.0%	8	100.0%
UAS Ketchikan	02236	1	1	1	100.0%	1	100.0%	1	100.0%
UAS Sitka	02223	1	1	0	0.0%	1	100.0%	0	0.0%
Valdez Combined	02275	0	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Wrangell Medical Center	02009	0	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
YTD Totals		**119**	**119**	**108**	**90.8%**	**108**	**90.8%**	**99**	**83.2%**

THE STATE of ALASKA
GOVERNOR BILL WALKER

Department of Commerce, Community, and Economic Development
DIVISION OF CORPORATIONS, BUSINESS PROFESSIONAL LICENSING

550 West Seventh Avenue, Suite 1500
Anchorage, AK 99501-3567
Main: 907.269.8160
Fax: 907.269.8156

DATE: October 1, 2018

TO: Alaska Board of Nursing

FROM: Dave Worrell – CNA Licensing Examiner

SUBJECT: Nurse Aide Quarterly Report

Quarterly Nurse Aide Statistics **Fiscal 2019 Quarter 1: July 1 – Sept. 30, 2018**
Permanent certificates issued: **123**
Reinstatements issued: **12**
Temporary certificates issued: **14**
Total permanent nurse aide certificates as of September 30, 2018: **2,820**

Yearly statistics				
	Permanent certificates issued	***Reinstatements***	***Temporary certificates issued***	***Total permanent certificates***
FY 19 Quarter 1 7/1/18 – 9/30/18	***123***	***12***	***14***	***2,820***
FY 18 Quarter 2 10/1/17 - 12/31/17	***99***	***2***	***21***	***3,539***
FY 18 Quarter 3 1/1/18- 3/31/18	***137***	***2***	***13***	***2,333 (after renewal)***
FY 18 Quarter 4 4/1/18 – 6/30/18	***140***	***8***	***51***	***2,667***

Agenda Item

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LICENSING SUMMARY

Fiscal 1st Quarter 2018 (July 1-September 30, 2018)

LICENSE TYPE/METHOD		1st Quarter Total	Running Total YTD	Total Active
RN	Exam	89	89	
	Endorsement	387	387	
	Total:	**476**	**476**	**12,532**
LPN	Exam	1	1	
	Endorsement	26	26	
	Total:	**27**	**27**	**914**
ANP		**39**	**39**	**1196**
CRNA		**6**	**6**	**193**
PERMITS	RN	121	121	
	LPN	5	5	
	ANP	0	0	
	CRNA	0	0	
	TOTAL:	**126**	**126**	
REINSTATE	RN	20	20	
	LPN	0	0	
	ANP	0	0	
	CRNA	0	0	
	TOTAL:	**20**	**20**	
ANP PRECEPTORSHIP		**12**	**12**	**42**
GRAND TOTAL:		**706**	**706**	**14,877**

Note:
***Exam permits become void when an applicant is unsuccessful on their exam.

RETIRED STATUS SUMMARY

Fiscal 1st Quarter 2018 (July 1-September 30, 2018)

LICENSE STATUS/TYPE		1st Quarter Total	Running Total YTD	GRAND TOTAL: CURRENT RETIRED LICENSES (since 9/7/16)
RETIRED LICENSES	RN	5	5	
	LPN	3	3	
	ANP	2	2	
	CRNA	0	0	
	TOTAL:	**10**	**10**	**62**
REINSTATED RETIRED	RN	0	0	
	LPN	0	0	
	ANP	0	0	
	CRNA	0	0	
	TOTAL:	**0**	**0**	

Note:
***Total Retired number may fluctuate due to reinstatements.

Agenda Item

17

NURSE LICENSURE COMPACT

Bylaws

The Interstate Commission of Nurse Licensure Compact Administrators

By-Laws

Adopted August 3, 2017, Amended August 15, 2017

INDEX

The Interstate Commission of Nurse Licensure Compact Administrators Bylaws
(Final Adopted August 3, 2017)

Article I
Commission Purpose, Function and Bylaws

Section 1. Purpose.

Pursuant to the terms of the Nurse Licensure Compact, (the "Compact"), the Interstate Commission of Nurse Licensure Compact Administrators (the "Commission") is established as a quasi-governmental and joint public entity of the Party States to fulfill the Compact objectives through a means of joint cooperative action among the Party States. This is accomplished by developing a comprehensive process that facilitates the exchange of information in the areas of licensure and investigative authority of state boards of nursing and providing for mutual recognition of nursing licenses by all Party States, thereby enhancing the portability and mobility of a nursing license and promoting public protection.

Section 2. Functions.

In pursuit of the fundamental objectives set forth in the Compact, the Commission shall, as necessary or required, exercise all of the powers and fulfill all of the duties delegated to it by the Party States. The Commission's activities shall include, but are not limited to, the following: the promulgation of rules; enforcement of Commission Rules and Bylaws; provision of dispute resolution; coordination of training and education; and the collection and dissemination of information concerning the activities of the Compact, as provided by the Compact, or as determined by the Commission to be warranted by, and consistent with, the objectives and provisions of the Compact. The provisions of the Compact shall be reasonably and liberally construed to accomplish the purposes and policies of the Compact.

Section 3. Bylaws.

As required by the Compact, these Bylaws shall govern the management and operations of the Commission. As adopted and subsequently amended, these Bylaws shall remain at all times subject to, and limited by, the terms of the Compact.

Article II
Membership

The Commission membership shall be comprised as provided by the Compact. Each Party State shall have and be limited to one voting Compact Administrator. The Compact Administrator shall be the Commissioner of the Party State. Each Party State shall forward the name of its Commissioner to the Chair of the Commission or designee. A Commissioner may designate a person to serve in place of the Commissioner as the Commissioner's designee with respect to Commission business, including attending Commission meetings and voting. A Commissioner must notify the Chair of the Commission or designee of the scope and duration of the designation, prior to the

meeting. The Chair of the Commission shall promptly advise the Party State of the need to appoint a new Commissioner whenever a vacancy occurs.

Article III
Executive Committee

Section 1.

The Commission shall establish an Executive Committee, which shall be empowered to act on behalf of the Commission between Commission meetings, except for rulemaking or amendment of the Compact. The Commission shall determine the procedures, duties and budget of the Executive Committee. The power of the Executive Committee to act on behalf of the Commission shall at all times be subject to any limitations imposed by the Bylaws, Compact or the Commission.

The Executive Committee shall consist of the Chair, Vice Chair, and Treasurer of the Commission and three additional members of the Commission.

Section 2: Election and Succession.

Following formation of the Commission, nominations for candidates for the initial Executive Committee shall be submitted to the Director of the Compact by Party States, which are eligible to vote. The initial and subsequent Executive Committees shall be elected by the Commission by mail or electronic ballot. For all subsequent elections, an Elections Committee shall send a call for nominations at least 50 days prior to the election, shall announce a slate of candidates to the Commission at least 30 days prior to the election, shall announce voting by mail or electronic ballot at least 10 days prior to the election and shall verify and report the results of the election to the Commission on October 1.

Any election resulting in a tie vote will be decided by lot. No Commissioner shall be nominated or eligible to serve on the Executive Committee if from a Party State in default of its obligations under the Compact.

After the election of the initial Executive Committee, members of the Executive Committee shall serve a term of two years or until a successor is elected. No person shall serve more than two full consecutive terms in the same office. Any candidate for the Executive Committee shall be a Commissioner who has, except for the initial election, previously participated in the meetings of the Commission.

The election of the Executive Committee shall be as follows:

1. Chair: After the election of the initial chair, the subsequent chair shall be elected in odd years;

2. Vice Chair: After the election of the initial vice chair, subsequent vice chair shall be elected in even years;

3. Treasurer: After the election of the initial treasurer, subsequent treasurers shall be elected in even years;

4. Members-at-Large (3 positions): After the election of the initial members-at-large, subsequent members-at-large shall be one member elected in even years; two members elected in odd years.

Section 3. Duties.

The Commission's officers shall perform all duties of their respective offices as the compact and these Bylaws provide. Their duties shall include, but are not limited to the following:

1. Chair: The Chair shall call and preside at Commission and Executive Committee meetings; prepare agendas for the meetings; act on Commission's behalf between Commission meetings.
2. Vice Chair: The Vice Chair shall perform the Chair duties in their absence or at the Chair's direction. In the event of a vacancy in the Chair's office, the Vice Chair shall serve until the Commission elects a new Chair.
3. Treasurer: The Treasurer, with the assistance of the Director of the Compact, shall monitor the Commission's fiscal policies and procedures. If the Commission does not have a Director of the Compact, the Treasurer will also serve as secretary and perform the duties of secretary described in Article IV Section 1 (1).

The Executive Committee shall:

1. Administer the affairs of the Commission in a manner consistent with the Bylaws and purpose of the Commission;

2. Propose budgets, provide fiscal oversight and provide for an annual fiscal review;

3. Propose policies and procedures for consideration by the Commission;

4. Contract for services and monitor contract compliance;

5. Monitor and enforce member compliance with the Compact;

6. Propose standing and ad hoc committees.

7. Approve and maintain its minutes;

8. Perform such other functions as are necessary or appropriate to carry out the purpose of the Commission.

Section 4. Removal of Executive Committee Members.

Any Executive Committee member may be removed from office for good cause by a two-third (2/3rd) majority vote of the Commission.

Section 5. Vacancies

Upon the resignation, removal, or death of a member of the Executive Committee, such vacancy shall be announced to the Commission by the Chair or designee.

An Elections Committee shall send a call for nominations 30 days prior to the election, shall announce a slate of candidates to the Commission 20 days prior to the election, shall announce voting by mail or electronic ballot 10 days prior to the election and shall verify and report the results of the election to the Commission.

Any election resulting in a tie vote will be decided by lot. No Commissioner shall be nominated or eligible to serve on the Executive Committee if from a Party State in default of its obligations under the Compact.

Article IV
Commission Personnel

Section 1. Duties of the Director.

The Commission, through its Executive Committee, may contract for a Director of the Compact. As the Commission's principal administrator, the Director shall also perform such other duties as may be delegated by the Commission or required by the Compact and the Bylaws, including, but not limited to, the following:

1. Serve at its discretion and act as Secretary to the Commission, but shall not be a Member of the Commission;

2. Hire and supervise such other staff as may be authorized by the Commission;

3. Establish and manage the Commission's office or offices as determined by the Commission;

4. Recommend general policies and program initiatives for the Commission's consideration;

5. Recommend for the Commission's consideration administrative personnel policies governing the recruitment, hiring, management, compensation and dismissal of Commission staff;

6. Implement and monitor administration of all policies, programs, and initiatives adopted by the Commission;

7. Prepare draft annual budgets for the Commission's consideration;

8. Monitor the Commission's financial performance for compliance with approved budgets and policies, and maintain accurate records of the Commission's financial account(s);

9. Execute contracts on behalf of the Commission as directed;

10. Receive service of process on behalf of the Commission;

11. Prepare and disseminate all required reports and notices directed by the Commission;

12. Assist the members of the Executive Committee in the performance of its duties;

13. Speak on behalf and represent the Commission;

14. In collaboration with legal counsel, ensure the legal integrity of the Commission and

15. Report about policy, regulatory, political, legal or other developments of relevance to the Commission's operation.

Article V
Meetings of the Commission

Section 1. Meetings and Notice.

The Commission shall meet face-to-face at least twice a year at a time and place as determined by the Commissioners. Members may participate in meetings by telephone or other means of telecommunication. Special meetings may be scheduled at the discretion of the Chair, or shall be called upon the request of a majority of Commissioners.

All Commissioners shall be given notice of Commission meetings at least thirty (30) days prior to the scheduled date. Agendas shall be provided to all Commissioners no later than seven (7) days prior to any meeting of the Commission. If an amendment to an agenda is made after an agenda has been noticed, but forty-eight (48) hours prior to a regular meeting, or twenty-four (24) hours prior to a special meeting, then the agenda is amended upon the posting of the amended agenda.

All Commission meetings shall be open to the public, except as set forth in Commission Rules or as otherwise provided by the Compact. Prior public notice shall be as follows: publication of notice of each meeting will be posted at least seven (7) days prior to the

meeting on the Commission's website or another website designated by the Commission and distribution by e-mail to interested parties who have requested in writing to receive such meeting notices. A meeting may be closed to the public if the Commission determines by a majority vote of the Commissioners that there exists at least one of the conditions for closing a meeting, as provided by the Compact or authorized Rules.

Section 2. Quorum.

A majority of Commissioners shall constitute a quorum for the transaction of business, except as otherwise required in these Bylaws. The presence of a quorum must be established before any vote of the Commission can be taken.

Section 3. Voting.

Each Party State is entitled to one vote. A Commissioner shall vote on such member's own behalf and shall not delegate the vote to another Commissioner, except as permitted by a designation allowed under Article II. Any question submitted for a vote of the Commission shall be determined by a simple majority, except as otherwise required by the Compact or the Bylaws.

Section 4. Procedure.

The rules contained in the then current edition of Robert's Rules of Order Newly Revised shall govern the parliamentary procedures of the commission and its committees in all cases not provided for in these Bylaws or in any policies and procedures or any special rules of order which are duly adopted by the Commission.

Section 5. Public Participation in Meetings.

Upon prior written request to the Commission, any person who desires to present a statement on a matter on the agenda shall be afforded an opportunity to present an oral statement to the Commission at an open meeting. The Chair may, depending on the circumstances, allow any person who desires an opportunity to present a statement on a matter that is on the agenda even in the absence of a prior written request to the Commission. The Chair may limit the time and manner of public statements at any open meeting.

Article VI
Committees

Section 1. Committees.

The Commission shall establish committees, as it deems necessary, to carry out its objectives which shall include, but not be limited, to:

1. Rules Committee

   A Rules Committee shall be established as a standing committee to develop uniform Compact rules for consideration by the Commission and subsequent implementation by the states and to review existing rules and recommend necessary changes to the Commission for consideration.

2. Compliance Committee

   A Compliance Committee shall be established as a standing committee to monitor a Party State's compliance with the terms of the Compact and its authorized rules.

3. Elections Committee

   An Election Committee shall be established as a standing committee to:

   a. Inform the Commissioners on the responsibilities of the office;
   b. Encourage participation by the Commissioners in the elections process;
   c. Announce nominations deadline and anticipated vacancies of the Executive Committee of the Commission;
   d. Communicate with incumbents to determine if they wish to run for re-election;
   e. Accept qualified nominees and prepare a slate of candidates for the election of the officers or members at large of the Executive Committee;
   f. Present a list of candidates to the Commission including the terms of office expiration dates; and
   g. Tally/verify the election results and report to the Commission.

The composition, procedures, duties, budget and tenure of all committees shall be determined through policies approved by the Commission. The Commission may dissolve any committee it determines is no longer needed.

Article VII
Finance

Section 1. Fiscal Year.

The Commission's fiscal year shall begin on October 1 and end on September 30. Membership fees in an amount to be determined by the Commission, are payable by October 1 of each year.

Section 2. Budget.

The Commission shall operate on an annual budget cycle and shall, in any given year, adopt budgets for the following fiscal year or years as provided by the Compact.

Section 3. Accounting and Audit.

The Commission, with the assistance of the Director, shall keep accurate and timely accounts of its internal receipts and disbursements of the Commission funds. The receipts and disbursements of Commission funds are to be audited annually by an independent certified or licensed accountant. The independent audit report shall be made available to the public.

Section 4. Costs and Expense Reimbursement.

Subject to the availability of budgeted funds and unless otherwise provided by the Commission, Commissioners and Executive Committee shall be reimbursed as allowed by state policy for any actual and necessary expenses incurred pursuant to their attendance at all duly convened meetings of the Commission or its committees as provided by the Compact.

Article VIII
Adoption and Amendment of Bylaws

Any Bylaw may be adopted, amended or repealed by a majority vote of the Commissioners, provided that written notice and the full text of the proposed action is provided to all Commissioners at least thirty (30) days prior to the meeting at which the action is to be considered. Failing the required notice, a two-third (2/3rd) majority vote of the Commissioners shall be required for such action.

Article IX
Dissolution of the Commission

The Compact shall dissolve effective upon the date of the withdrawal or the termination by default of a Party State, which reduces membership in the Compact to one Party State as provided by the Compact**.**

Upon dissolution, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Commission shall be concluded in an orderly manner and according to applicable law.

Article X
Affiliation with National Council State Boards of Nursing

The Commission shall be affiliated with and supported by the National Council of State Boards of Nursing, Inc. (NCSBN). The Commission shall negotiate payment for secretariat services by the NCSBN. Payment for the secretariat services shall be made from the funds collected by NCSBN on behalf of the Commission. Funds contributed by Party States shall be held by NCSBN and disbursed for the benefit of the Commission as decided by the Commission.

Nurse Licensure Compact

Approved by the May 4, 2015 Special Delegate Assembly

ARTICLE I

Findings and Declaration of Purpose

a. The party states find that:

1. The health and safety of the public are affected by the degree of compliance with and the effectiveness of enforcement activities related to state nurse licensure laws;
2. Violations of nurse licensure and other laws regulating the practice of nursing may result in injury or harm to the public;
3. The expanded mobility of nurses and the use of advanced communication technologies as part of our nation's health care delivery system require greater coordination and cooperation among states in the areas of nurse licensure and regulation;
4. New practice modalities and technology make compliance with individual state nurse licensure laws difficult and complex;
5. The current system of duplicative licensure for nurses practicing in multiple states is cumbersome and redundant for both nurses and states; and
6. Uniformity of nurse licensure requirements throughout the states promotes public safety and public health benefits.

b. The general purposes of this Compact are to:

1. Facilitate the states' responsibility to protect the public's health and safety;
2. Ensure and encourage the cooperation of party states in the areas of nurse licensure and regulation;
3. Facilitate the exchange of information between party states in the areas of nurse regulation, investigation and adverse actions;
4. Promote compliance with the laws governing the practice of nursing in each jurisdiction;
5. Invest all party states with the authority to hold a nurse accountable for meeting all state practice laws in the state in which the patient is located at the time care is rendered through the mutual recognition of party state licenses;

6. Decrease redundancies in the consideration and issuance of nurse licenses; and

7. Provide opportunities for interstate practice by nurses who meet uniform licensure requirements.

ARTICLE II

Definitions

As used in this Compact:

a. "Adverse action" means any administrative, civil, equitable or criminal action permitted by a state's laws which is imposed by a licensing board or other authority against a nurse, including actions against an individual's license or multistate licensure privilege such as revocation, suspension, probation, monitoring of the licensee, limitation on the licensee's practice, or any other encumbrance on licensure affecting a nurse's authorization to practice, including issuance of a cease and desist action.

b. "Alternative program" means a non-disciplinary monitoring program approved by a licensing board.

c. "Coordinated licensure information system" means an integrated process for collecting, storing and sharing information on nurse licensure and enforcement activities related to nurse licensure laws that is administered by a nonprofit organization composed of and controlled by licensing boards.

d. "Current significant investigative information" means:

   1. Investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the nurse to respond, if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction; or

   2. Investigative information that indicates that the nurse represents an immediate threat to public health and safety regardless of whether the nurse has been notified and had an opportunity to respond.

e. "Encumbrance" means a revocation or suspension of, or any limitation on, the full and unrestricted practice of nursing imposed by a licensing board.

f. "Home state" means the party state which is the nurse's primary state of residence.

g. "Licensing board" means a party state's regulatory body responsible for issuing nurse licenses.

h. “Multistate license” means a license to practice as a registered or a licensed practical/vocational nurse (LPN/VN) issued by a home state licensing board that authorizes the licensed nurse to practice in all party states under a multistate licensure privilege.

i. “Multistate licensure privilege” means a legal authorization associated with a multistate license permitting the practice of nursing as either a registered nurse (RN) or LPN/VN in a remote state.

j. “Nurse” means RN or LPN/VN, as those terms are defined by each party state’s practice laws.

k. “Party state” means any state that has adopted this Compact.

l. “Remote state” means a party state, other than the home state.

m. “Single-state license” means a nurse license issued by a party state that authorizes practice only within the issuing state and does not include a multistate licensure privilege to practice in any other party state.

n. “State” means a state, territory or possession of the United States and the District of Columbia.

o. “State practice laws” means a party state’s laws, rules and regulations that govern the practice of nursing, define the scope of nursing practice, and create the methods and grounds for imposing discipline. “State practice laws” do not include requirements necessary to obtain and retain a license, except for qualifications or requirements of the home state.

ARTICLE III

General Provisions and Jurisdiction

a. A multistate license to practice registered or licensed practical/vocational nursing issued by a home state to a resident in that state will be recognized by each party state as authorizing a nurse to practice as a registered nurse (RN) or as a licensed practical/vocational nurse (LPN/VN), under a multistate licensure privilege, in each party state.

b. A state must implement procedures for considering the criminal history records of applicants for initial multistate license or licensure by endorsement. Such procedures shall include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant’s criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state’s criminal records.

c. Each party state shall require the following for an applicant to obtain or retain a multistate license in the home state:

1. Meets the home state's qualifications for licensure or renewal of licensure, as well as, all other applicable state laws;
2. i. Has graduated or is eligible to graduate from a licensing board-approved RN or LPN/VN prelicensure education program; or

   ii. Has graduated from a foreign RN or LPN/VN prelicensure education program that (a) has been approved by the authorized accrediting body in the applicable country and (b) has been verified by an independent credentials review agency to be comparable to a licensing board-approved prelicensure education program;
3. Has, if a graduate of a foreign prelicensure education program not taught in English or if English is not the individual's native language, successfully passed an English proficiency examination that includes the components of reading, speaking, writing and listening;
4. Has successfully passed an NCLEX-RN® or NCLEX-PN® Examination or recognized predecessor, as applicable;
5. Is eligible for or holds an active, unencumbered license;
6. Has submitted, in connection with an application for initial licensure or licensure by endorsement, fingerprints or other biometric data for the purpose of obtaining criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state's criminal records;
7. Has not been convicted or found guilty, or has entered into an agreed disposition, of a felony offense under applicable state or federal criminal law;
8. Has not been convicted or found guilty, or has entered into an agreed disposition, of a misdemeanor offense related to the practice of nursing as determined on a case-by-case basis;
9. Is not currently enrolled in an alternative program;
10. Is subject to self-disclosure requirements regarding current participation in an alternative program; and
11. Has a valid United States Social Security number.

d. All party states shall be authorized, in accordance with existing state due process law, to take adverse action against a nurse's multistate licensure privilege such as revocation, suspension, probation or any other action that affects a nurse's authorization to practice under a multistate licensure privilege, including cease and desist actions. If a party state takes such action, it shall promptly notify the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the home state of any such actions by remote states.

e. A nurse practicing in a party state must comply with the state practice laws of the state in which the client is located at the time service is provided. The practice of nursing is not limited to patient care, but shall include all nursing practice as defined by the state practice laws of the party state in which the client is located. The practice of nursing in a party state under a multistate licensure privilege will subject a nurse to the jurisdiction of the licensing board, the courts and the laws of the party state in which the client is located at the time service is provided.

f. Individuals not residing in a party state shall continue to be able to apply for a party state's single-state license as provided under the laws of each party state. However, the single-state license granted to these individuals will not be recognized as granting the privilege to practice nursing in any other party state. Nothing in this Compact shall affect the requirements established by a party state for the issuance of a single-state license.

g. Any nurse holding a home state multistate license, on the effective date of this Compact, may retain and renew the multistate license issued by the nurse's then-current home state, provided that:

    1. A nurse, who changes primary state of residence after this Compact's effective date, must meet all applicable Article III.c. requirements to obtain a multistate license from a new home state.
    2. A nurse who fails to satisfy the multistate licensure requirements in Article III.c. due to a disqualifying event occurring after this Compact's effective date shall be ineligible to retain or renew a multistate license, and the nurse's multistate license shall be revoked or deactivated in accordance with applicable rules adopted by the Interstate Commission of Nurse Licensure Compact Administrators ("Commission").

ARTICLE IV

Applications for Licensure in a Party State

a. Upon application for a multistate license, the licensing board in the issuing party state shall ascertain, through the coordinated licensure information system, whether the applicant has ever held, or is the holder of, a license issued by any other state, whether there are any encumbrances on any license or multistate licensure privilege held by the applicant, whether any adverse action has been taken against any license or multistate licensure privilege held by the applicant and whether the applicant is currently participating in an alternative program.

b. A nurse may hold a multistate license, issued by the home state, in only one party state at a time.

c. If a nurse changes primary state of residence by moving between two party states, the nurse must apply for licensure in the new home state, and the multistate license issued by the prior home state will be deactivated in accordance with applicable rules adopted by the Commission.

    1. The nurse may apply for licensure in advance of a change in primary state of residence.
    2. A multistate license shall not be issued by the new home state until the nurse provides satisfactory evidence of a change in primary state of residence to the new home state and satisfies all applicable requirements to obtain a multistate license from the new home state.

d. If a nurse changes primary state of residence by moving from a party state to a non-party state, the multistate license issued by the prior home state will convert to a single-state license, valid only in the former home state.

ARTICLE V

Additional Authorities Invested in Party State Licensing Boards

a. In addition to the other powers conferred by state law, a licensing board shall have the authority to:

    1. Take adverse action against a nurse’s multistate licensure privilege to practice within that party state.

        i. Only the home state shall have the power to take adverse action against a nurse’s license issued by the home state.

        ii. For purposes of taking adverse action, the home state licensing board shall give the same priority and effect to reported conduct received from a remote state as it would if such

conduct had occurred within the home state. In so doing, the home state shall apply its own state laws to determine appropriate action.

2. Issue cease and desist orders or impose an encumbrance on a nurse's authority to practice within that party state.
3. Complete any pending investigations of a nurse who changes primary state of residence during the course of such investigations. The licensing board shall also have the authority to take appropriate action(s) and shall promptly report the conclusions of such investigations to the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the new home state of any such actions.
4. Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses, as well as, the production of evidence. Subpoenas issued by a licensing board in a party state for the attendance and testimony of witnesses or the production of evidence from another party state shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state in which the witnesses or evidence are located.
5. Obtain and submit, for each nurse licensure applicant, fingerprint or other biometric-based information to the Federal Bureau of Investigation for criminal background checks, receive the results of the Federal Bureau of Investigation record search on criminal background checks and use the results in making licensure decisions.
6. If otherwise permitted by state law, recover from the affected nurse the costs of investigations and disposition of cases resulting from any adverse action taken against that nurse.
7. Take adverse action based on the factual findings of the remote state, provided that the licensing board follows its own procedures for taking such adverse action.

b. If adverse action is taken by the home state against a nurse's multistate license, the nurse's multistate licensure privilege to practice in all other party states shall be deactivated until all

encumbrances have been removed from the multistate license. All home state disciplinary orders that impose adverse action against a nurse's multistate license shall include a statement that the nurse's multistate licensure privilege is deactivated in all party states during the pendency of the order.

c. Nothing in this Compact shall override a party state's decision that participation in an alternative program may be used in lieu of adverse action. The home state licensing board shall deactivate the multistate licensure privilege under the multistate license of any nurse for the duration of the nurse's participation in an alternative program.

ARTICLE VI

Coordinated Licensure Information System and Exchange of Information

a. All party states shall participate in a coordinated licensure information system of all licensed registered nurses (RNs) and licensed practical/vocational nurses (LPNs/VNs). This system will include information on the licensure and disciplinary history of each nurse, as submitted by party states, to assist in the coordination of nurse licensure and enforcement efforts.

b. The Commission, in consultation with the administrator of the coordinated licensure information system, shall formulate necessary and proper procedures for the identification, collection and exchange of information under this Compact.

c. All licensing boards shall promptly report to the coordinated licensure information system any adverse action, any current significant investigative information, denials of applications (with the reasons for such denials) and nurse participation in alternative programs known to the licensing board regardless of whether such participation is deemed nonpublic or confidential under state law.

d. Current significant investigative information and participation in nonpublic or confidential alternative programs shall be transmitted through the coordinated licensure information system only to party state licensing boards.

e. Notwithstanding any other provision of law, all party state licensing boards contributing information to the coordinated licensure information system may designate information that may not be shared with non-party states or disclosed to other entities or individuals without the express permission of the contributing state.

f. Any personally identifiable information obtained from the coordinated licensure information system by a party state licensing board shall not be shared with non-party states or disclosed to other entities or individuals except to the extent permitted by the laws of the party state contributing the information.

g. Any information contributed to the coordinated licensure information system that is subsequently required to be expunged by the laws of the party state contributing that information shall also be expunged from the coordinated licensure information system.

h. The Compact administrator of each party state shall furnish a uniform data set to the Compact administrator of each other party state, which shall include, at a minimum:

   1. Identifying information;
   2. Licensure data;
   3. Information related to alternative program participation; and
   4. Other information that may facilitate the administration of this Compact, as determined by Commission rules.

i. The Compact administrator of a party state shall provide all investigative documents and information requested by another party state.

ARTICLE VII

Establishment of the Interstate Commission of Nurse Licensure Compact Administrators

a. The party states hereby create and establish a joint public entity known as the Interstate Commission of Nurse Licensure Compact Administrators.

   1. The Commission is an instrumentality of the party states.
   2. Venue is proper, and judicial proceedings by or against the Commission shall be brought solely and exclusively, in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.
   3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

b. Membership, Voting and Meetings

   1. Each party state shall have and be limited to one administrator. The head of the state licensing board or designee shall be the administrator of this Compact for each party state. Any

administrator may be removed or suspended from office as provided by the law of the state from which the Administrator is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the party state in which the vacancy exists.

2. Each administrator shall be entitled to one (1) vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. An administrator shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for an administrator's participation in meetings by telephone or other means of communication.
3. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws or rules of the commission.
4. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in Article VIII.
5. The Commission may convene in a closed, nonpublic meeting if the Commission must discuss:
    i. Noncompliance of a party state with its obligations under this Compact;
    ii. The employment, compensation, discipline or other personnel matters, practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;
    iii. Current, threatened or reasonably anticipated litigation;
    iv. Negotiation of contracts for the purchase or sale of goods, services or real estate;
    v. Accusing any person of a crime or formally censuring any person;
    vi. Disclosure of trade secrets or commercial or financial information that is privileged or confidential;
    vii. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;
    viii. Disclosure of investigatory records compiled for law enforcement purposes;
    ix. Disclosure of information related to any reports prepared by or on behalf of the Commission for the purpose of investigation of compliance with this Compact; or
    x. Matters specifically exempted from disclosure by federal or state statute.

6. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the Commission or order of a court of competent jurisdiction.

c. The Commission shall, by a majority vote of the administrators, prescribe bylaws or rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of this Compact, including but not limited to:

1. Establishing the fiscal year of the Commission;
2. Providing reasonable standards and procedures:
   i. For the establishment and meetings of other committees; and
   ii. Governing any general or specific delegation of any authority or function of the Commission;
3. Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the administrators vote to close a meeting in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each administrator, with no proxy votes allowed;
4. Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the Commission;
5. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any

party state, the bylaws shall exclusively govern the personnel policies and programs of the Commission; and

6. Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of this Compact after the payment or reserving of all of its debts and obligations;

d. The Commission shall publish its bylaws and rules, and any amendments thereto, in a convenient form on the website of the Commission.

e. The Commission shall maintain its financial records in accordance with the bylaws.

f. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the bylaws.

g. The Commission shall have the following powers:

1. To promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all party states;
2. To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any licensing board to sue or be sued under applicable law shall not be affected;
3. To purchase and maintain insurance and bonds;
4. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a party state or nonprofit organizations;
5. To cooperate with other organizations that administer state compacts related to the regulation of nursing, including but not limited to sharing administrative or staff expenses, office space or other resources;
6. To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of this Compact, and to establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel and other related personnel matters;

7. To accept any and all appropriate donations, grants and gifts of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the Commission shall avoid any appearance of impropriety or conflict of interest;
8. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, whether real, personal or mixed; provided that at all times the Commission shall avoid any appearance of impropriety;
9. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, whether real, personal or mixed;
10. To establish a budget and make expenditures;
11. To borrow money;
12. To appoint committees, including advisory committees comprised of administrators, state nursing regulators, state legislators or their representatives, and consumer representatives, and other such interested persons;
13. To provide and receive information from, and to cooperate with, law enforcement agencies;
14. To adopt and use an official seal; and
15. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of nurse licensure and practice.

h. Financing of the Commission

1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization and ongoing activities.
2. The Commission may also levy on and collect an annual assessment from each party state to cover the cost of its operations, activities and staff in its annual budget as approved each year. The aggregate annual assessment amount, if any, shall be allocated based upon a formula to be determined by the Commission, which shall promulgate a rule that is binding upon all party states.
3. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the party states, except by, and with the authority of, such party state.

4. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant, and the report of the audit shall be included in and become part of the annual report of the Commission.

i. Qualified Immunity, Defense and Indemnification

1. The administrators, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit or liability for any damage, loss, injury or liability caused by the intentional, willful or wanton misconduct of that person.
2. The Commission shall defend any administrator, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further that the actual or alleged act, error or omission did not result from that person's intentional, willful or wanton misconduct.
3. The Commission shall indemnify and hold harmless any administrator, officer, executive director, employee or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission

employment, duties or responsibilities, provided that the actual or alleged act, error or omission did not result from the intentional, willful or wanton misconduct of that person.

ARTICLE VIII

Rulemaking

a. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in this Article and the rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment and shall have the same force and effect as provisions of this Compact.

b. Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

c. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least sixty (60) days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a notice of proposed rulemaking:

    1. On the website of the Commission; and
    2. On the website of each licensing board or the publication in which each state would otherwise publish proposed rules.

d. The notice of proposed rulemaking shall include:

    1. The proposed time, date and location of the meeting in which the rule will be considered and voted upon;
    2. The text of the proposed rule or amendment, and the reason for the proposed rule;
    3. A request for comments on the proposed rule from any interested person; and
    4. The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

e. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions and arguments, which shall be made available to the public.

f. The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment.

g. The Commission shall publish the place, time and date of the scheduled public hearing.

   1. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing. All hearings will be recorded, and a copy will be made available upon request.

   2. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

h. If no one appears at the public hearing, the Commission may proceed with promulgation of the proposed rule.

i. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

j. The Commission shall, by majority vote of all administrators, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

k. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment or hearing, provided that the usual rulemaking procedures provided in this Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

   1. Meet an imminent threat to public health, safety or welfare;

   2. Prevent a loss of Commission or party state funds; or

   3. Meet a deadline for the promulgation of an administrative rule that is required by federal law or rule.

l. The Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall

be made in writing, and delivered to the Commission, prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

ARTICLE IX

Oversight, Dispute Resolution and Enforcement

a. Oversight

1. Each party state shall enforce this Compact and take all actions necessary and appropriate to effectuate this Compact's purposes and intent.
2. The Commission shall be entitled to receive service of process in any proceeding that may affect the powers, responsibilities or actions of the Commission, and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process in such proceeding to the Commission shall render a judgment or order void as to the Commission, this Compact or promulgated rules.

b. Default, Technical Assistance and Termination

1. If the Commission determines that a party state has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:
   i. Provide written notice to the defaulting state and other party states of the nature of the default, the proposed means of curing the default or any other action to be taken by the Commission; and
   ii. Provide remedial training and specific technical assistance regarding the default.
2. If a state in default fails to cure the default, the defaulting state's membership in this Compact may be terminated upon an affirmative vote of a majority of the administrators, and all rights, privileges and benefits conferred by this Compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.
3. Termination of membership in this Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be

given by the Commission to the governor of the defaulting state and to the executive officer of the defaulting state's licensing board and each of the party states.

4. A state whose membership in this Compact has been terminated is responsible for all assessments, obligations and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.
5. The Commission shall not bear any costs related to a state that is found to be in default or whose membership in this Compact has been terminated unless agreed upon in writing between the Commission and the defaulting state.
6. The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the District of Columbia or the federal district in which the Commission has its principal offices. The prevailing party shall be awarded all costs of such litigation, including reasonable attorneys' fees.

c. Dispute Resolution

1. Upon request by a party state, the Commission shall attempt to resolve disputes related to the Compact that arise among party states and between party and non-party states.
2. The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes, as appropriate.
3. In the event the Commission cannot resolve disputes among party states arising under this Compact:
    i. The party states may submit the issues in dispute to an arbitration panel, which will be comprised of individuals appointed by the Compact administrator in each of the affected party states and an individual mutually agreed upon by the Compact administrators of all the party states involved in the dispute.
    ii. The decision of a majority of the arbitrators shall be final and binding.

d. Enforcement

1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of this Compact.

2. By majority vote, the Commission may initiate legal action in the U.S. District Court for the District of Columbia or the federal district in which the Commission has its principal offices against a party state that is in default to enforce compliance with the provisions of this Compact and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorneys' fees.
3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

ARTICLE X

Effective Date, Withdrawal and Amendment

a. This Compact shall become effective and binding on the earlier of the date of legislative enactment of this Compact into law by no less than twenty-six (26) states or December 31, 2018. All party states to this Compact, that also were parties to the prior Nurse Licensure Compact, superseded by this Compact, ("Prior Compact"), shall be deemed to have withdrawn from said Prior Compact within six (6) months after the effective date of this Compact.
b. Each party state to this Compact shall continue to recognize a nurse's multistate licensure privilege to practice in that party state issued under the Prior Compact until such party state has withdrawn from the Prior Compact.
c. Any party state may withdraw from this Compact by enacting a statute repealing the same. A party state's withdrawal shall not take effect until six (6) months after enactment of the repealing statute.
d. A party state's withdrawal or termination shall not affect the continuing requirement of the withdrawing or terminated state's licensing board to report adverse actions and significant investigations occurring prior to the effective date of such withdrawal or termination.
e. Nothing contained in this Compact shall be construed to invalidate or prevent any nurse licensure agreement or other cooperative arrangement between a party state and a non-party state that is made in accordance with the other provisions of this Compact.

f. This Compact may be amended by the party states. No amendment to this Compact shall become effective and binding upon the party states unless and until it is enacted into the laws of all party states.

g. Representatives of non-party states to this Compact shall be invited to participate in the activities of the Commission, on a nonvoting basis, prior to the adoption of this Compact by all states.

ARTICLE XI

Construction and Severability

This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact shall be severable, and if any phrase, clause, sentence or provision of this Compact is declared to be contrary to the constitution of any party state or of the United States, or if the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this Compact shall be held to be contrary to the constitution of any party state, this Compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.

The Interstate Commission of Nurse Licensure Compact Administrators

Final Rules

Effective January 1, 2019

Table of Contents

SECTION 100. DEFINITIONS

(1) "Commission" means the Interstate Commission of Nurse Licensure Compact Administrators.

(2) “Compact” means the Nurse Licensure Compact that became effective on July 20, 2017 and implemented on January 19, 2018.

(3) “Convert” means to change a multistate license to a single-state license if a nurse changes primary state of residence by moving from a party state to a non-party state; or to change a single-state license to a multistate license once any disqualifying events are eliminated.

(4) “Deactivate” means to change the status of a multistate license or privilege to practice.

(5) “Director” means the individual referred to in Article IV of the Interstate Commission of Nurse Licensure Compact Administrators Bylaws.

(6) “Disqualifying Event” means an incident, which results in a person becoming disqualified or ineligible to retain or renew a multistate license. These include but are not limited to the following: any adverse action resulting in an encumbrance, current participation in an alternative program, a misdemeanor offense related to the practice of nursing (which includes, but is not limited to, an agreed disposition), or a felony offense (which includes, but is not limited to, an agreed disposition).

(7) “Independent credentials review agency” means a non-governmental evaluation agency that verifies and certifies that foreign nurse graduates have graduated from nursing programs that are academically equivalent to nursing programs in the United States.

(8) “Licensure” includes the authority to practice nursing granted through the process of examination, endorsement, renewal, reinstatement and/or reactivation.

(9) "Prior Compact" means the Nurse Licensure Compact that was in effect until January 19, 2018.

(10) “Unencumbered license” means a license that authorizes a nurse to engage in the full and unrestricted practice of nursing.

History: Adopted December 12, 2017; effective January 19, 2018.

SECTION 200. COORDINATED LICENSURE INFORMATION SYSTEM

201. UNIFORM DATA SET AND LEVELS OF ACCESS

(1) The Compact Administrator of each party state shall furnish uniform data to the Coordinated Licensure Information System, which shall consist of the following:

(a) the nurse's name;

(b) jurisdiction of licensure;

(c) license expiration date;

(d) licensure classification, license number and status;

(e) public emergency and final disciplinary actions, as defined by the contributing state authority;

(f) a change in the status of a disciplinary action or licensure encumbrance;

(g) status of multistate licensure privileges;

(h) current participation by the nurse in an alternative program;

(i) information that is required to be expunged by the laws of a party state;

(j) the applicant or nurse's United States social security number;

(k) current significant investigative information; and

(l) a correction to a licensee's data.

(2) The public shall have access to items (1)(a) through (g) and information about a licensee's participation in an alternative program to the extent allowed by state law.

(3) In the event a nurse asserts that any Coordinated Licensure Information System data is inaccurate, the burden shall be upon the nurse to provide evidence in a manner determined by the party state that substantiates such claim.

(4) A party state shall report the items in the uniform data set to the Coordinated Licensure Information System within fifteen (15) calendar days of the date on which the action is taken.

History: Adopted December 12, 2017; effective January 19, 2018; amended August 14, 2018; effective January 1, 2019.

202. QUERYING THE COORDINATED LICENSURE INFORMATION SYSTEM

(1) Upon application for multistate licensure, with the exception of renewal by a nurse, a party state shall query the Coordinated Licensure Information System to determine the applicant's current licensure status, previous disciplinary action(s), current participation in an alternative program, and any current significant investigative information.

(2) Upon discovery that an applicant is under investigation in another party state, the party state in receipt of the nurse licensure application shall contact the investigating party state and may request investigative documents and information.

History: Adopted December 12, 2017; effective January 19, 2018.

SECTION 300. IMPLEMENTATION

301. IMPLEMENTATION DATE

The Compact shall be implemented on January 19, 2018.

History: Adopted December 12, 2017; effective January 19, 2018.

302. TRANSITION

(1) (a) A nurse who holds a multistate license on the Compact effective date of July 20, 2017, and whose multistate license remains unencumbered on the January 19, 2018 implementation date and who maintains and renews a multistate license is not required to meet the new requirements for a multistate license under the Compact.

(b) A nurse who retained a multistate license pursuant to subsection (a) of this section and subsequently incurs a disqualifying event shall have the multistate license revoked or deactivated pursuant to the laws of the home state.

(c) A nurse whose multistate license is revoked or deactivated may be eligible for a single state license in accordance with the laws of the party state.

(2) A nurse who applies for a multistate license after July 20, 2017, shall be required to meet the requirements of Article III (c) of the Compact.

(3) During the transition period, a licensee who holds a single state license in a Compact state that was not a member of the prior Compact and who also holds a multistate license in a party state, may retain the single state license until it lapses, expires or becomes inactive."

(4) After the implementation date, party states shall not renew or reinstate a single state license if the nurse has a multistate license in another party state.

History: Adopted December 12, 2017; effective January 19, 2018.

303. RECOGNITION OF NEW PARTY STATES AFTER JANUARY 19, 2018

(1) All party states shall be notified by the Commission within fifteen (15) calendar days when a new party state enacts the Compact.

(2) The new party state shall establish an implementation date six (6) months from enactment or as specified in the enabling language and shall notify the Director of the date.

(3) Upon implementation, a new state licensee who holds a single state license in a Compact state that was not a member of the prior Compact and holds a multistate license in a party state, may retain the single state license until it lapses, expires or becomes inactive.

(4) At least ninety (90) calendar days prior to the implementation date, all other party states shall notify any active single state licensee with an address in the new party state that the licensee may only hold one multistate license in the primary state of residence. The licensee shall be advised to obtain or maintain a multistate license only from the primary state of residence.

(5) Each party state shall deactivate a multistate license when a new home state issues a multistate license.

History: Adopted December 12, 2017; effective January 19, 2018.

SECTION 400. LICENSURE

401. PARTY STATE RESPONSIBILITIES

(1) On all application forms for multistate licensure, a party state shall require, at a minimum:

(a) A declaration of a primary state of residence and

(b) Whether the applicant is a current participant in an alternative program.

(2) (a) An applicant for licensure who is determined to be ineligible for a multistate license shall be notified by the home state of the qualifications not met.

(b) The home state may issue a single state license pursuant to its laws.

(3) A party state shall not issue a single state license to a nurse who holds a multistate license in another party state.

History: Adopted December 12, 2017; effective January 19, 2018.

402. APPLICANT RESPONSIBILITIES

(1) On all application forms for multistate licensure in a party state, an applicant shall declare a primary state of residence.

(2) A nurse who changes primary state of residence to another party state shall apply for a license in the new party state when the nurse declares to be a resident of the state and obtains privileges not ordinarily extended to nonresidents of the state, including but not limited to, those listed in 402 (4) (a) – (e).

(3) A nurse shall not apply for a single state license in a party state while the nurse holds a multistate license in another party state.

(4) A party state may require an applicant to provide evidence of residence in the declared primary state of residence. This evidence may include, but is not limited to, a current:

(a) driver's license with a home address;

(b) voter registration card with a home address;

(c) federal income tax return with a primary state of residence declaration;

(d) military form no. 2058 (state of legal residence certificate); or

(e) W2 form from the United States government or any bureau, division, or agency thereof, indicating residence.

(5) An applicant who is a citizen of a foreign country, and who is lawfully present in the United States and is applying for multistate licensure in a party state may declare either the applicant's country of origin or the party state where they are living as the primary state of residence. If the applicant declares the foreign country as the primary state of residence, the party state shall not issue a multistate license, but may issue a single state license if the applicant meets the party state's licensure requirements.

(6) An applicant shall disclose current participation in an alternative program to any party state, whether upon initial application or within ten (10) calendar days of enrollment in the program.

History: Adopted December 12, 2017; effective January 19, 2018.

403. CHANGE IN PRIMARY STATE OF RESIDENCE

(1) A nurse who changes his or her primary state of residence from one party state to another party state may continue to practice under the existing multistate license while the nurse's application is processed and a multistate license is issued in the new primary state of residence.

(2) Upon issuance of a new multistate license, the former primary state of residence shall deactivate its multistate license held by the nurse and provide notice to the nurse.

(3) If a party state verifies that a licensee who holds a multistate license changes primary state of residence to a non-party state, the party state shall convert the multistate license to a single state license within fifteen (15) calendar days, and report this conversion to the Coordinated Licensure Information System.

History: Adopted December 12, 2017; effective January 19, 2018.

404. TEMPORARY PERMITS AND LICENSES

A temporary permit, license, or similar temporary authorization to practice issued by a party state to an applicant for licensure shall not grant multistate licensure privileges.

History: Adopted December 12, 2017; effective January 19, 2018.

405. IDENTIFICATION OF LICENSES

A license issued by a party state shall be clearly identified as either a single state license or a multistate license.

History: Adopted December 12, 2017; effective January 19, 2018.

406. CREDENTIALING AND ENGLISH PROFICIENCY FOR FOREIGN NURSE GRADUATES

(1) A party state shall verify that an independent credentials review agency evaluated the credentials of graduates as set forth in Article III (c)(2)ii.

(2) The party state shall verify successful completion of an English proficiency examination for graduates as set forth in Article III (c)(3).

History: Adopted December 12, 2017; effective January 19, 2018.

407. DEACTIVATION, DISCIPLINE AND REVOCATION

A party state shall determine whether a disqualifying event will result in adverse action or deactivation of a multistate license or privilege. Upon deactivation due to a disqualifying event, the home state may issue a single state license.

History: Adopted December 12, 2017; effective January 19, 2018.

SECTION 500. ADMINISTRATION

501. DUES ASSESSMENT

(1) The Commission shall determine the annual assessment to be paid by party states. The assessment formula is a flat fee per party state. The Commission shall provide public notice of any proposed revision to the annual assessment fee at least ninety (90) calendar days prior to the Commission meeting to consider the proposed revision.

(2) The annual assessment shall be due within the Commission's first fiscal year after the implementation date and annually thereafter.

History: Adopted December 12, 2017; effective January 19, 2018.

502. DISPUTE RESOLUTION.

(1) In the event that two or more party states have a dispute, the parties shall attempt resolution following the steps set out in this rule.

(2) The parties shall first attempt informal resolution. The Compact Administrators in the states involved shall contact each other. Each Compact Administrator shall submit a written statement describing the situation to the other Compact Administrators involved

in the dispute. Each Compact Administrator may submit a response. The submission of the statement and the response shall be in a mutually agreed upon time frame. If an interpretation of the Compact is needed, the parties shall request assistance from the Executive Committee. If all issues are resolved, no further action is required and all party state Compact Administrators shall be informed of the result. If any issue remains unresolved, the parties shall notify the Commission and request mediation.

(3)(a) A party state that has a dispute with one or more other party states, and informal resolution was unsuccessful, shall attempt mediation. Mediation shall be conducted by a mediator appointed by the Executive Committee from a list of mediators approved by the National Association of Certified Mediators or as agreed to by all parties. If all issues are resolved through mediation, no further action is required. If mediation is unsuccessful, the parties shall submit to binding dispute resolution.

(b) The costs of mediation shall be shared by all party states involved.

(c) All party state Compact Administrators shall be notified of all issues and disputes that rise to the mediation stage in order to comment on those matters and disputes that may impact all party states.

(4)(a) In the event of a dispute between party states that was not resolved through informal resolution or mediation, the party states shall submit to binding dispute resolution. The parties may choose binding dispute resolution either by submitting the question dispute to the Commission for final action or by arbitration.

(b) All party states involved shall agree in order to proceed with arbitration. In the absence of agreement, the matter shall be referred to the Commission for final determination.

(c) Each party state involved shall be responsible for its own respective expenses, including attorney fees.

(d) The party state Compact Administrators involved in the dispute shall recuse themselves from consideration or voting by the full Commission.

History: Adopted August 14, 2018; effective January 1, 2019.

503. COMPLIANCE AND ENFORCEMENT.

(1) Compliance and enforcement issues shall be initiated by the Executive Committee.

(2) The Executive Committee, through the Director, shall send a written statement to the Compact Administrator in the party state with the alleged non-compliance issue. That

Compact Administrator shall respond to the written statement within thirty calendar days.

(3) The Compact Administrator may appear before the Executive Committee at a time and place as designated by the Executive Committee.

(4) The Executive Committee shall make a recommendation to the Commission concerning the issue of non-compliance.

History: Adopted August 14, 2018; effective January 1, 2019.

Frequently Asked Questions

Q1: I live in a noncompact state. How do I get a compact multistate license?

Only nurses who declare a compact state as their primary state of residence may be eligible for multistate license. As a resident of a noncompact state, you may apply for a license by endorsement in a compact state. Your eligibility will be limited to a single state license that is valid in that state only. As a resident of a noncompact state, you can have as many single-state licenses as you wish, but are not elibible for a multistate license.

Q2: Where is the compact application and what is the application fee?

Use the state board of nursing (BON) application for licensure by exam or by endorsement, as found on your BON's website. Licensure fees vary by state. If your legal residence is in a state that joined the compact as of Jan. 19, 2018 (Florida, Georgia, Oklahoma, West Virginia and Wyoming), and you hold a single state license in that state, then you should complete the application for a multistate license on your BON website.

Q3: I live in a compact state and have a license. How do I know if my license is multistate? How do I get a compact license?

If your legal residence is in a state that joined the compact as of Jan. 19, 2018 (Florida, Georgia, Oklahoma, West Virginia and Wyoming), and you hold a single state license in that state, then you should complete the application for a multistate license on your board of nursing website.

If your legal residence is in one of the original compact states and you held a multistate license on July 20, 2017, you may already have a compact license due to being grandfathered. If you're unsure of your licensure status, use the Nursys® QuickConfirm tool at www.nursys.com. This report will indicate "multistate" or "single state" in the status column. When you click on "Where can the nurse practice?" you will see a map (or a list) of all states where you hold the authority to practice.

Q4: I have a compact license. How long can I work in another compact state?

There is no time limit. As long as you maintain legal residency in the state that issued your multistate license and you remain in good standing, you may practice in other compact states.

If you were to take an action (while practicing in another NLC state or otherwise) which would change your legal residency status (see example below), then you have given up legal residency in that home state and you must now apply for license by endorsement in the new state of residence. The new license issued will replace the former license.

For example, a nurse has legal residency in Arizona and practices temporarily in Colorado for six months under the Arizona multistate license. While the nurse is practicing in Colorado, her Arizona driver's license expires. Rather than renewing the Arizona driver's license, the nurse obtains a Colorado driver's license. Because a Colorado driver's license is only issued to a Colorado resident, the nurse has now become a Colorado resident unintentionally. Nurses must be careful not to take actions that would change their state of legal residency, when practicing in another state where they temporarily reside.

Q5: What if I move to another compact state?

When permanently relocating to another compact state, apply for licensure by endorsement and complete the Declaration of Primary State of Residence form within the application, which can be found on your board of nursing's website.

You may start the application process prior to or after the move. You should not delay applying once you have moved. There is no grace period.

- If you are moving from a compact state, you may not wait until your former multistate license expires before applying in your new state of legal residency. You can only practice on your former home state license until the multistate license in the new NLC home state is issued.
- If you are moving from a noncompact state applying to a compact state in advance of the move, you may be issued a single state license or your application may be held until you move and have proof of legal residency at which time you may be issued a multistate license.

Q6: My primary state of residence is a noncompact state; it is also where I am licensed. I am applying for licensure in a compact state. Do I have to give up my current license?

No, you may choose to keep and renew your current noncompact state license.

Q7: I live in a compact state where I am licensed. How do I get a license in a noncompact state?

Apply for licensure by endorsement to the board of nursing in the state where you seek a license. You may be issued a single

state license valid only in the state of issuance. Applications can be found on that board of nursing's website. Visit ncsbn.org for board of nursing contact information.

Q8: I am graduating from a nursing program. Can I take the NCLEX® in a different state?

The NCLEX® is a national exam and can be taken in any state convenient to you. It is not a state exam. The results will be directed to the board of nursing where you applied for your authorization to test (ATT) and licensure.

- If you are applying to a compact state for a multistate license, you should apply in the state where you intend to legally reside.
- If you are applying for a license in a noncompact state, you should apply for a license in the state where you intend to practice.

Q9: I live in a noncompact state, but I will be changing my primary state of residence to a compact state in a few months for a job. Can I apply for a license in that state now so I can work immediately after moving?

Yes. You may start the application process prior to the move. A new compact license will not be issued until you provide a Declaration of Primary State of Residence (PSOR) form and any proof of residence that may be required by the board of nursing (BON). Some states offer a temporary license; this may enable you to practice before your permanent license is issued. Check with your BON to see if they offer one.

Q10: I live in a noncompact state, but own property in a compact state. Can I get a compact license?

In order to be eligible for a compact license, your declared primary state of residence must be a compact state. Primary state of residence does not pertain to owning property but rather it refers to your legal residency status. Proof of residence includes obtaining a driver's license, voting/registering to vote or filing federal taxes with an address in that state. These legal documents should be issued by the same state.

Q11: I have a compact license and have accepted a temporary assignment in another compact state. My employer is telling me that I need to get that state's license. Is this true?

When hired in a remote state for a temporary position or commuting to a remote state from the primary state of residence (PSOR) (usually an adjacent state), employers should not require you to apply for licensure in the remote state when you have lawfully declared another state as your PSOR. PSOR is based on where you pay federal income tax, vote and/or hold a driver's license. The remote state board of nursing cannot issue a license to a nurse who has declared another compact state as the PSOR, since the multistate license from the home state applies to both states. You have the privilege to practice in any remote compact state with your multistate license issued by your home state.

Q12: How does the compact work for military or military spouses?

See military fact sheet on our Toolkit webpage at www.ncsbn.org/6183.htm for additional information.

Q13: How does the NLC pertain to advanced practice registered nurses (APRNs)?

The NLC pertains to registered nurses and licensed practical/vocational nurses licenses only. An APRN must hold an individual state license in each state of APRN practice. Visit ncsbn.org for BON contact information. Visit aprncompact.com for information on that compact.

Q14: Which nurses are grandfathered into the enhanced Nurse Licensure Compact (eNLC) and what does that mean?

Nurses in eNLC states that were members of the original NLC may be grandfathered into the eNLC. Nurses who held a multistate license on the eNLC effective date of July 20, 2017, in original NLC states, may be grandfathered. You can check if you hold a multistate license and the states in which you have the "authority to practice" by following the steps below.

a. Go to nursys.com and click on nursys quick confirm

b. Search by your name, license number or NCSBN ID

c. Click "View Report."

d. On the report page, click "Where can the nurse practice as an RN and/or PN?"

If you do not have a multistate license and you need to change your single state license to a multistate, contact the board of nursing. They may require proof of residence such as a driver's license prior to issuing you a multistate license.

Q15: Why would a nurse need a multistate license?

Nurses are required to be licensed in the state where the recipient of nursing practice is located at the time service is provided. A multistate license allows the nurse to practice in the home state and all compact states with one license issued by the home state. This eliminates the burdensome, costly, and time consuming process of obtaining single state licenses in each state of practice.

Q16: What is the difference between a compact license and a multistate license?

There is no difference between a compact license and a multistate license. This terminology is used interchangeably to reference the Nurse Licensure Compact (NLC) license that allows a nurse to have one license, with the ability to practice in all NLC compact states.

Q17: What do I need to do before I move to another state?

See moving scenarios fact sheet on our Toolkit wepage at www.ncsbn.org/6183.htm.

Q18: What does Primary State of Residence (PSOR) mean?

For compact purposes, PSOR is not related to property ownership in a given state. It is about your legal residency status. Everyone has legal documents such as a driver's license, voter's card, federal income tax return, military form no. 2058, or W2 form from the PSOR. If a nurse's PSOR is a compact state, that nurse may be eligible for a multistate (compact) license. If a nurse cannot declare a compact state as his/her PSOR, that nurse is not eligible for a compact license. They may apply for a single state license in any state where they wish to practice.

MOVING FROM...

MOVING TO ANOTHER STATE

Noncompact → Compact:

The nurse is responsible for applying for licensure by endorsement in the new state of residence. The nurse may apply before or after the move. A multistate license may be issued if residency and eligibility requirements are met. If the nurse holds a single state license issued by the noncompact state, it is not affected.

Compact → Noncompact:

The nurse is responsible for applying for licensure by endorsement in the new state of residence. The nurse may apply before or after the move. The multistate license of the former NLC state is changed to a single state license upon changing legal residency to a noncompact state. The nurse is responsible for notifying the board of nursing (BON) of the former NLC state of the new address.

Compact → Compact:

When moving (changing primary state of legal residence) to a new NLC state, it is the nurse's responsibility to apply for licensure by endorsement. This should be completed upon moving and the nurse should not delay. There is no grace period. The nurse may not wait until the former license expires to apply in the nurse's new state of legal residency. The nurse may practice on the former home state license only UNTIL the multistate license in the new NLC home state is issued. Proof of residency such as a driver's license may be required. Upon issuance of a new multistate license, the former license is inactivated.

Another Country (International Nurses)

If a nurse on a visa from another country applies for licensure in a compact state, the nurse is responsible for either declaring the country of origin or the compact state as their primary state of residency. If the foreign country is declared the primary state of residency, the nurse may be eligible for a single state license issued by the compact state.

Definition:

Primary State of Residence (PSOR):

The state (also known as the home state) in which a nurse declares a primary residence for legal purposes. Sources used to verify a nurse's primary residence may include driver's license, federal income tax return or voter registration. PSOR refers to legal residency status and does not pertain to home or property ownership. Only one state can be identified as the primary state of legal residence for NLC purposes.

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What Nurse Employers Need to Know

Background

- The NLC allows a nurse (registered nurses [RNs] and licensed practical/vocational nurses [LPN/VNs]) to have one multistate license in the primary state of residence (the home state) and practice in other compact states (remote states), while subject to each state's practice laws and discipline.
- Lawful practice requires that a nurse be licensed or have the privilege to practice in the state where the patient is located at the time care is directed or service is provided. This pertains to in-person or telehealth practice.
- Nurses holding a multistate license are allowed to practice across state lines in other NLC states. However, a multistate license may be converted to single state license when practice is limited to the home state due to a restriction on the license or some level of disciplinary action.
- Advanced practice registered nurses (APRNs) are not included in this compact. APRNs must apply for APRN licensure in each state in which they practice, unless exempted when employed in a federal facility.

Employer Confirmation of a Nurse's Licensure Status

- Employers can confirm a nurse's license and receive a Nursys QuickConfirm report at www.nursys.com at no cost. The report will contain the nurse's name, jurisdiction, license type, license number, compact status, license status, expiration date, discipline against license and discipline against privilege to practice. Employers can also view an individualized authorization to practice map which displays the states where a nurse can legally practice.
- All NLC states provide licensure and discipline data to Nursys® directly from the board of nursing (BON) licensure systems. Nursys is primary source equivalent.
- To confirm APRN and temporary licenses, visit the issuing BON website. A temporary license issued by a compact state is valid in that state only and does not carry multistate status.

Licensure and Privileges

- A nurse licensed in a compact state must meet the uniform licensure requirements in the primary state of residence (home state). When practicing on a privilege in a remote state, the nurse is accountable for complying with the nurse practice act of that state.
- A single state license may be issued to an applicant residing in a noncompact state. A license issued by a noncompact state is valid only in that state.
- The NLC permits a nurse to hold one active multistate license issued by the primary state of residence.
- When a nurse is hired in a remote state for a temporary position or commutes to the remote state from the primary state of residence (usually an adjacent state), employers cannot require the nurse to apply for licensure in the remote state when the nurse has lawfully declared another state as the primary state of residence. This is based on where the nurse pays federal income tax, votes or holds a driver's license. The BON cannot issue a license to a nurse who has declared another compact state as the primary state of residence unless the nurse doesn't meet the multistate license requirements and is limited to a single state license.

Discipline

- It's the responsibility of the nurse to notify the employer of any action taken by the BON against his or her license.
- Under most circumstances, when a license is disciplined, multistate privileges are removed, restricting the nurses' practice to the home state.
- Employers may register their nursing workforce in e-Notify at nursys.com at no cost. Employers will receive e-notifications of disciplinary action taken on any license the nurse holds in the U.S.

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Moving to Another State

Noncompact to Compact:

- The nurse is responsible for applying for licensure by endorsement in the new state of residence. The nurse may apply before or after the move. A multistate license may be issued if residency and eligibility requirements are met. If the nurse holds a single state license issued by the noncompact state, it is not affected.

Compact to Noncompact:

- The nurse is responsible for applying for licensure by endorsement in the new state of residence. The nurse may apply before or after the move. The multistate license of the former NLC state is changed to a single state license upon changing legal residency to a noncompact state. The nurse is responsible for notifying the board of nursing (BON) in the former NLC state of the new address.

Compact to Compact:

- When moving (changing primary state of legal residence) to a new NLC state, it is the nurse's responsibility to apply for licensure by endorsement. This should be completed upon moving and the nurse should not delay. There is not a 90 day grace period. The nurse may practice on the former home state license until the multistate license in the new NLC home state is issued. Proof of residency such as a driver's license may be required. Upon issuance of a new multistate license, the former license is inactivated.

Definitions

- **Compact:** An interstate agreement between two or more states established for the purpose of remedying a particular problem of multistate concern. (*Black's Law Dictionary*)
- **Compact State:** Any state that has adopted the NLC.
- **Home State:** The compact state that serves as the nurse's primary state of residence.
- **Remote State:** A compact state other than the home state where the patient is located at the time nursing care is provided or, in the case of the practice of nursing not involving a patient, a compact state where the recipient of nursing practice is located.
- **Primary State of Residence (PSOR):** The state (also known as the home state) in which a nurse declares a primary residence for legal purposes. Sources used to verify a nurse's primary residence may include driver's license, federal income tax return or voter registration. PSOR refers to legal residency status and does not pertain to home or property ownership. Only one state can be identified as the primary state of legal residence for NLC purposes.
- **Nursys:** This database (www.nursys.com) provides licensure and disciplinary information of all RNs and LPN/VNs, as contributed by compact states. The public can access Nursys for free to look up a nurse's license and discipline status.
- **Privilege to Practice:** Current, official authority from a remote state permitting the practice of nursing as either an RN or an LPN/VN in such party state. All party states have the authority, in accordance with existing state due process law, to take actions against the nurse's privilege, such as: revocation, suspension, probation or any other action which affects a nurse's authorization to practice.

For more information about the NLC, visit **www.ncsbn.org/nlc** or email nursecompact@ncsbn.org.

What Nurse Leaders Need to Know

Introduction

The Nurse Licensure Compact (NLC) allows a nurse (registered nurses [RNs] and licensed practical/vocational nurses [LPN/VNs]) to hold one multistate license in the primary state of residence (the home state) and to practice in-person or telephonically in other compact states (remote states), while subject to each state's practice and discipline laws. Advanced practice registered nurses (APRNs) are not included in the NLC.

Accountability for Nurse Licensure

Health care facilities are accountable to accreditation bodies, regulatory agencies, payers and malpractice carriers for ensuring that nurses under their employment are appropriately licensed. Such entities generally have penalties associated with non-compliance in this area.

Confirmation of Nurse License Status

Employers can confirm a nurse license and view a Nursys® QuickConfirm report at www.nursys.com at no cost. The report contains the nurse's name, state, license type, license number, compact status, license status, expiration date, discipline against license and discipline against privilege to practice. Employers can also view an individualized authorization to practice map which displays the states where a nurse can legally practice.

It is recommended that a facility's employed nurses are registered in e-Notify at www.nursys.com so that the facility will receive automatic updates when a nurse is disciplined or has a license status change for any license the nurse holds.

Where Practice Takes Place

Lawful practice requires that a nurse be licensed or have the privilege to practice in the state where the patient or recipient of practice is located at the time nursing service is provided. This is not to be confused with the state where the patient resides because the patient may not be located in the state of residency at the time practice occurs.

Multistate Health Care Systems

A nurse executive with multistate responsibility for nurses practicing in various facilities, and who may provide guidance or direction to staff in these states, should be appropriately licensed in such states.

Telehealth

Telehealth is not limited to telehealth programs or sophisticated telehealth technology. Rather, telehealth practice may be any communication between a nurse and a patient, for example, by phone, email or text, wherein a nurse is practicing (see definition of nursing practice below). When the patient is located in another state during the telephonic encounter, the nurse should be appropriately licensed or hold the privilege to practice via a multistate license, in the state where the patient is located at that time.

How is Nursing Practice Defined?

Many state boards of nursing will generally define nursing practice as some variation of "when a nurse utilizes his or her education/knowledge, skills or judgment/ decisionmaking."

Travel Nurses

When a nurse is on a travel assignment at a facility and the nurse who holds a multistate license has a primary state of legal residence in the compact home state, that nurse is able to practice in the remote compact state under the multistate privilege to practice as long as the nurse maintains legal residence status in the home state. Should this nurse's residency status change and the state where the facility is located becomes the new home state, then the nurse must immediately apply for license by endorsement in the new home state.

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Hiring Nurses from Other States

Noncompact to Compact:

- When hiring a nurse who resides in a noncompact state for employment in a compact state, if the nurse will reside in the compact state where the facility is located, the nurse is responsible for being licensed in that state and should apply for licensure by endorsement in the new state of residence. In order for the nurse to be able to practice immediately upon moving, the nurse may apply prior to the move. This nurse may opt to obtain a single state license while applying as a resident of a noncompact state. Certain states offer a temporary single state license. This may also be helpful to the nurse who needs to start practice in the short term. A multistate license may be issued if residency and eligibility requirements are met.

Compact to Compact:

- When hiring a nurse who resides in a compact state for employment in another compact state, if the nurse will reside in the compact state where the facility is located, the nurse is responsible for being licensed in that state and should apply for licensure by endorsement in the new state of residence upon moving to that state. The nurse should not delay. There is no grace period. The nurse may not wait until the former license expires to apply in the nurse's new state of legal residency. The nurse may practice on the former home state license only until the multistate license in the new NLC home state is issued. Proof of residency such as a driver's license may be required. Upon issuance of a new multistate license, the former license is inactivated.

Definition:

- **Primary State of Residence:** The state (also known as the home state) in which a nurse declares a primary residence for legal purposes. Sources used to verify a nurse's primary residence may include driver's license, federal income tax return or voter registration. PSOR refers to legal residency status and does not pertain to home or property ownership. Only one state can be identified as the primary state of legal residence for NLC purposes.

Agenda Item

18

Alaska Board of Nursing
Disciplinary Guidelines

Continuing Competency Violations

May 2018: Resolved that the Board of Nursing for the State of Alaska, under authority 08.01.075(a)(8) establishes the following civil fines against licensees who do not meet continuing competency regulations per 08.68.276, 08.68.705, 12 AAC 44.600 Article 6, 12 AAC 44.445, 12 AAC 44.770(34)a:

Occupation	Fine / Hour of missing CE	Reprimand	Mandatory Audit for the next 2 renewals	Required to complete deficient CE
CNA	$20	Yes	Yes	Yes
LPN	$50	Yes	Yes	Yes
RN	$65	Yes	Yes	Yes
APRN	$80	Yes	Yes	Yes

Effective 12/1/2018

Unlicensed Practice Violations
(practicing with a lapsed license)

May 2018: Resolved that the Board of Nursing for the State of Alaska, under authority 08.01.075(a)(8) establishes the following civil fines against licensees who practice with a lapsed license under 08.68.251, 08.68.340, 08.68.360:

Occupation	Flat Fine	Reprimand
CNA	$500	Yes
LPN	$1500	Yes
RN	$1950	Yes
APRN	$2400	Yes
APRN not certified	$2400	Yes

Alaska Board of Nursing
DISCIPLINARY SANCTIONS
Effective 1/18/2013
Revised & re-adopted 10/22/2014

APPLICATION ISSUE:	DISCIPLINARY SANCTION(S):
Non-Reported Criminal History (minor misdemeanor(s) /non- barrier in nature)	Process application, if no fraud, deceit, or misrepresentation was established. Informal, non-disciplinary cautionary letter in the applicant's licensing file from the Board of Nursing's Executive Administrator. *Discipline to be commensurate with the severity of the violation.*
Non-Reported Criminal History (higher misdemeanor(s) &/or felony (felonies) and/or crime(s) listed under 12 AAC.44.705)	If any either 08.68.270(1), 08.68.334(1), 08.68.270(2), or 08.68.334(2) is determined, *reprimand and fine.* Fine guidelines are as follows: CNA: $500 LPN: $1,000 RN: $2,500 APRN: $5,000 If any either 08.68.270(1), 08.68.334(1), 08.68.270(2), or 08.68.334(2) along with 12 AAC.44.705 is determined, *denial of licensure or certification.* If not determined, process application with an informal, non-disciplinary cautionary letter in the applicant's licensing file from the Board of Nursing's Executive Administrator. *Discipline to be commens11rate with the severity of the violation.*
Non-Reported Disciplinary Action occurring anywhere (non-patient care related)	If violation is determined, *reprimand and fine.* Fine guidelines are as follows: CNA: $500 LPN: $1,000 RN: $2,500 APRN: $5,000 If not determined, process application with an informal, non-disciplinary cautionary letter in the applicant's licensing file from the Board of Nursing's Executive Administrator. *Discipline to be commens11rate with the severity of the violation.*

Alaska Board of Nursing
DISCIPLINARY SANCTIONS
Effective 1/18/2013
Revised & re-adopted 10/22/2014

APPLICATION ISSUE:	PROPOSED DISCIPLINARY SANCTION(S):
Non-Reported Disciplinary Action occurring anywhere (patient care related/substance abuse and/or diversion)	If violation is determined, *denial of license.* If not determined, process application with an informal, non-disciplinary cautionary letter in the applicant's licensing file from the Board of Nursing's Executive Administrator. *Discipline to be commensurate with the severity of the violation.*
Reported/Declared Substance Abuse History (1-5 years)	Standard five (5) year substance abuse probation, which is adjusted to reflect previous amount of documented treatment/sobriety by applicant. (i.e. Applicant already has two (2) years of documented treatment/sobriety. Applicant will be put on a three (3) year substance abuse Consent Agreement.) *Discipline to be commensurate with the severity of the violation.*
Reported Criminal History (misdemeanor(s) and/or felony (felonies), and crime(s) listed under 12 AAC.44.705)	If a crime listed under 12 AAC.44.705, *denial of license or certification.* Other misdemeanor(s) and/or felony (felonies), possible probation monitoring with discipline to commensurate with the severity of the criminal conviction(s). *Discipline to be commensurate with the severity of the violation.*

Alaska Board of Nursing
DISCIPLINARY SANCTIONS
Effective 1/18/2013
Revised & re-adopted 10/22/2014

Self-Reported Substance Abuse/Dependence. (no drug diversion)	Standard five (5) year substance abuse Consent Agreement. One-year license/certification suspension, but no suspension period served, stayed status only. *Discipline to be commensurate with the severity of the violation.*

Self-Report Substance Abuse/Dependence with a drug diversion aspect.	Standard five (5) year substance abuse Consent Agreement with added Reprimand and fine (stayed). One-year license /certification suspension, but no suspension period served, stayed status only. Fine guidelines are as follows: CNA/LPN: $1,000 RN: $2,500 APRN: $5,000 *Discipline to be commensurate with the severity of the violation.*

Alaska Board of Nursing
DISCIPLINARY SANCTIONS
Effective 1/18/2013
Revised & re-adopted 10/22/2014

-SUBSTANCE ABUSE/DIVERSION ISSUE:	DISCIPLINARY SANCTION(S):
Mandatory Reported or Other Source Reported with a drug diversion aspect and no patient harm. (may include employer suggested self-report or self-report w/fear of employer reporting)	One-year license /certification suspension Five (5) year total standard substance abuse Consent Agreement and added Reprimand *Discipline to be commensurate with the severity of the violation.*
Mandatory Reported or Other Source Reported with a drug diversion aspect and patient harm or potential for patient harm. (may include employer suggested self-report or self-report w/fear of employer reporting)	Up to revocation of license /certification or voluntary surrender of license /certification. *Discipline to be commensurate with the severity of the violation.*

Implementing a Sanctioning Reference System for the Virginia Board of Nursing

Elizabeth A. Carter, PhD, and Neal B. Kauder, MS

In response to criticism regarding the objectivity and consistency of disciplinary sanctions, the Virginia Board of Health Professions decided to analyze sanctioning decisions and consider developing sanctioning reference points for boards to use in disciplinary cases. As a result, Virginia's Department of Health Professions and the independent consulting firm VisualResearch, Inc., jointly developed a sanctioning reference point system for and with each of the state's 13 professional boards, including the board of nursing. This article describes the system's development, implementation, and effectiveness.

Keywords: Discipline, nursing regulation, sanctioning, sanctioning reference point system

The Virginia Board of Nursing (BON) is housed within the Department of Health Professions, along with the state's 12 other health professional licensing boards and the advisory Board of Health Professions (BHP). Their collective mission is to ensure safe and competent patient care by licensing competent health professionals, enforcing standards of practice, and providing information to health care practitioners and the public (Code of Virginia §54.1-100 et seq; Virginia Department of Health Professions, n.d.).

The licensing boards accomplish this mission through the licensure, regulation, and discipline of over 370,000 health care practitioners across more than 60 professions. BHP does not license professions. Its role is to research and advise on issues regarding the regulation of health professions and agency operations. BHP conducts periodic reviews of agency and board investigatory, disciplinary, and enforcement processes "to ensure public protection and the fair and equitable treatment of health professionals" (Code of Virginia § 54.1-2510 (11)). Appointed by the governor, members of the licensing board and BHP are volunteers who are practitioners licensed by the board and citizen members.

In April 2001, BHP approved a plan to analyze health regulatory board sanctioning and to consider the appropriateness of developing historically based sanctioning reference points for boards to use in disciplinary cases (VisualResearch, Inc., 2001). Respondents, attorneys, public officials, and the media had suggested that sanctioning was too harsh, too lenient, or inconsistent over time. Some critics indicated that the variability in sanctioning could be attributed to extralegal factors, such as the composition of the boards, the geographic location of the hearing, a respondent's representation by an attorney, a respondent's race or ethnicity, and a respondent's gender. The BHP decided that an analysis should be conducted to determine if these assertions were true and what measures should be taken to rectify them.

Following this decision, Virginia's Department of Health Professions and an independent consulting firm, VisualResearch, Inc., jointly developed, implemented, and launched a sanctioning reference point (SRP) system for the state's professional boards, including the BON, for use in disciplinary proceedings. (See Table 1.)

Goals

Recognizing the complexity of sanction decision making, board and staff members indicated that a successful sanctioning system must be "developed with complete board oversight, be value neutral, be grounded in sound data analysis, and be totally voluntary" (VisualResearch, Inc., 2001). With this in mind, the following purposes and goals were established for the SRP system:

- To make sanctioning decisions more predictable
- To provide an education tool for new board members
- To add an empirical element to an inherently subjective process
- To provide a resource for board staff members and attorneys
- To neutralize sanctioning inconsistencies
- To validate board members' or staff members' recall of past cases
- To constrain undesirable influences
- To help predict future caseloads and the need for probation services.

BHP acknowledged that board members are asked to serve in a quasi-judicial role in determining whether misconduct has occurred and the appropriate sanctioning. Although knowledgeable about their profession's regulation and practice standards, board members lack systematized case histories and sentencing guidelines that are both readily available in the criminal justice system to assist justices.

Methodology

The SRP system borrows heavily from Virginia's criminal justice sentencing guidelines research methods because of a lack of any

TABLE 1

Sanctioning Reference Point System Timeline for Virginia

Timeline	
2001	Board of Health Professions work order/directive
2002–2004	Board of Medicine (pilot board) sanctioning reference point (SRP) system kick-off, development, implementation, adoption
2004	Board of nursing (BON) SRP system kick-off
2005	BON SRP development
2006	BON SRP implementation and adoption
2004–2009	Boards of Dentistry, Pharmacy, Optometry, Veterinary Medicine, Social Work, Psychology, Funeral Directors, Counseling, and Physical Therapy SRP development, implementation, adoption
2011	Effectiveness study, including revising worksheets with new data
2013	Revised nursing SRP worksheets adopted

comparable research in the regulatory realm. Virginia's criminal sentencing guidelines were developed in the late 1980s as an empirically based, systematic reference tool to help ensure neutrality, proportionality, and consistency. Essentially, the sentencing system uses multivariate statistical models to determine the relative influence of the offender and the offense factors that judges consider when sentencing convicted offenders. Significant factors are reviewed for their appropriateness, and any "extralegal" factors, such as race and gender, are eliminated from the models.

Following this analytic process, factors are selected and given a score using weights derived from a revised set of statistical models and matrix-based algorithms. Scores are then totaled and used in tables that contain thresholds for different sentencing severity levels—ranging from probation to terms of incarceration. The system is continually monitored, and staff update the sentencing guidelines as needed.

Virginia's regulatory SRP system was developed using similar analytical methods as used in the state's criminal justice sentencing guidelines, but it also uses normative adjustments; this approach combines information from past practice with policy adjustments to achieve the most up-to-date, consistent, and practical sanctioning outcomes (Carter & Kauder, 2004).

For each of the regulatory boards, following the SRP program timeline, researchers conducted in-depth personal interviews with board and staff members to gain insight into the factors that contribute to sanctioning decisions. The purposes of the interviews were to ensure that the factors members consider would be included in the SRP system worksheets and to identify any other factors that may come into play.

From 2004 to 2006, researchers collected detailed information on all BON disciplinary cases ending in a violation. The sample size for nursing licensees was approximately 350 cases, a statistically significant sample. Researchers used data available through the Department of Health Professions case management system and primary data collected from hard copy files. The hard copy files contained investigative reports, board notices, board orders, and all other documentation made available to board members when deciding a case sanction.

More than 100 different factors were collected on each case to describe the attributes that board members identified as potentially influencing sanction decisions. Among the factors that could influence sanctioning decisions were board history, substance abuse, patient injury, and corrective action taken. A comprehensive database was created to analyze the offense and respondent factors that were identified as potentially influencing sanctioning decisions. As was done with the criminal sentencing guidelines, staff used statistical analysis to construct a historic portrait of sanctioning decisions; the factors deemed to be consistently important were identified, and their relative weights (translated into worksheet scores) were then derived to create the SRP system. Over the course of the 15-year project, various multivariate and other statistical methods have been used to test the influence of case and respondent factors on sanctioning decisions for all 13 licensing boards. The details go beyond the scope of the current article, but can be found in Carter and Kauder (2004).

According to SRP system manual instructions (Virginia Department of Health Professions, 2013), the worksheets are completed regardless of whether the board's sanctioning agrees with the SRP in the case. The worksheets are collected to enable BHP's ongoing quarterly monitoring of agreement rates and examination of stated reasons for mitigating or aggravating departure. (See Figure 1.) To keep SRPs current in the face of new laws and regulations, professions, and evolving disciplinary issues, BHP consults the respective licensing boards to evaluate the need for updates.

Implementation Steps

The SRP system was implemented for each of the state's 13 boards following these 10 steps:

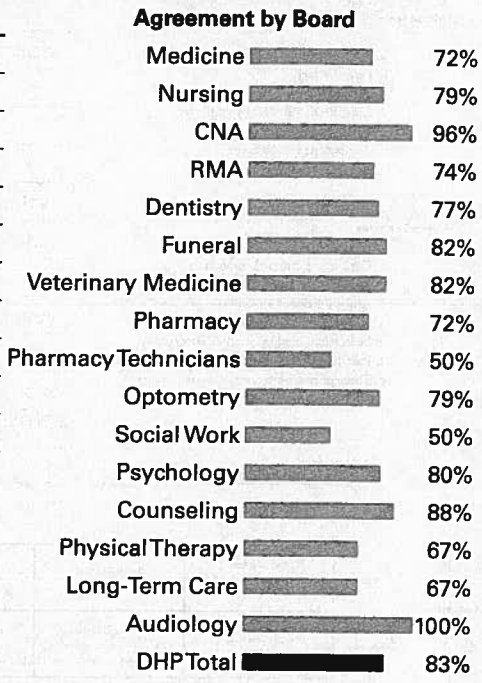
1. Conduct interviews with current and past board members, counsel, staff and members of the attorney general's office to glean information about the boards' past sanctioning, future goals, and expectations regarding uses for the SRP system.
2. Analyze the results of the interviews and obtain board feedback and approval on factors to be collected and the approach for scoring subjective factors.
3. Finalize data from the collection instrument for obtaining sanctioning information from case files, minutes, and notices. Collect data and enter the data into a database.
4. Compile, merge, and clean the database.
5. Determine statistically significant factors through multivariate analyses, report the results of the analysis showing the relative importance of each factor, and determine which factors the board wishes to retain as appropriate and exclude as inappropriate.

FIGURE 1

Sanctioning Reference Points Agreement Analysis

Virginia Department of Health Professions. Data through December 31, 2015. David E. Brown, D.C. Director

Board	Start Date	Completed Worksheets	Agreement		Departures			
					Aggravating		Mitigating	
			#	%	#	%	#	%
Medicine	Aug-04	230	165	72%	10	4%	55	24%
Nursing	Jul-05	1554	1220	79%	283	18%	51	3%
CNA	Jul-05	907	873	96%	19	2%	15	2%
RMA	Jun-13	43	32	74%	10	23%	1	2%
Dentistry	Jun-06	214	165	77%	20	9%	29	14%
Funeral	May-07	38	31	82%	1	3%	6	16%
Veterinary Medicine	May-07	96	79	82%	13	14%	4	4%
Pharmacy	Nov-07	107	77	72%	5	5%	25	23%
Pharmacy Technicians	Jun-13	4	2	50%			2	50%
Optometry	Dec-08	14	11	79%	2	14%	1	7%
Social Work	Jun-09	14	7	50%	2	14%	5	36%
Psychology	Jun-09	10	8	80%	2	20%		
Counseling	Jun-09	17	15	88%	1	6%	1	6%
Physical Therapy	Nov-09	6	4	67%	2	33%		
Long-Term Care	Mar-10	12	8	67%			4	33%
Audiology	Jun-10	2	2	100%				
DHP Total		3268	2699	83%	368	11%	201	6%



Note. CNA = certified nurse aide; RMA = registered medication aide; DHP = Department of Health Professions. Prepared by VisualResearch, Inc.

6. Introduce board feedback into the statistical model and revise it. Use analysis to predict sanctioning outcomes.
7. Begin developing the SRP worksheet.
8. Finalize the sanctioning worksheet with sanction decision grids that provide for simultaneous consideration of the offense, the respondent, and prior record factors deemed appropriate by the board, making normative adjustments, if any, as the board deems needed.
9. Conduct training sessions for board members, staff, enforcement and adjudicative staff, the press, the attorney general's office, and interested private lawyers. Post the SRP system manual on the board's website.
10. Begin using the SRP system and begin ongoing monitoring of sanctioning worksheets for proper use, including a formal effectiveness study.

System Framework

The SRP system is grounded in a case type–based conceptual framework (VisualResearch, Inc., 2005). The SRP system worksheets for the BON are grouped into three offense types:

- Inability to practice safely
- Standard of care
- Unlicensed activity and fraud.

This organization is based on the most recent historic analysis of board sanctioning. The SRP system factors on each worksheet proved important in determining sanctioning outcomes.

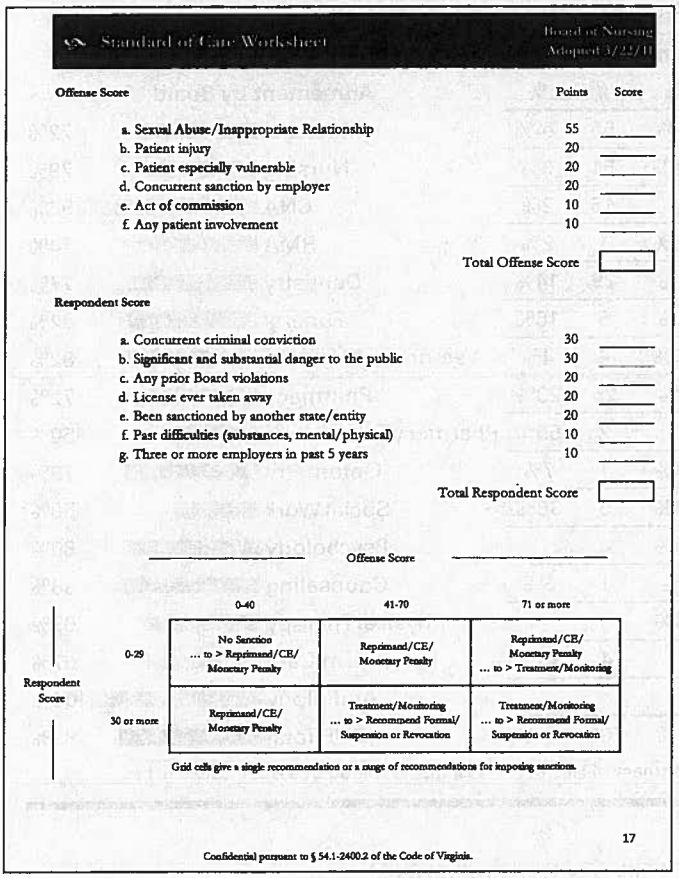
The system uses a two-dimensional sanctioning grid for nursing cases. Analysis supports the idea that both the offense and respondent factors impacted sanction outcomes, so the SRP system makes use of a two-dimensional scoring grid. One dimension scores factors related to the current violation, and the other dimension scores factors related to the respondent. The first dimension assigns points for circumstances related to the violation. For example, the respondent may receive points for an inability to practice safely because of impairment at the time of the offense or because multiple patients were involved. The second dimension assigns points for factors related to the respondent. For example, a respondent before the board for an unlicensed activity may also receive points for having a history of disciplinary violations for other types of cases. That same respondent would receive more points if the prior violation were similar to the current one.

The system uses one of three worksheets depending on the case type. Detailed instructions are provided for each factor on a worksheet and should be referenced to ensure accurate scoring. (See Figure 2). The scoring weights assigned to a factor cannot be

FIGURE 2

Board of Nursing Standard of Care Worksheet

Below is the Standard of Care Worksheet that the board of nursing uses to determine sanctions.



Standard of Care Worksheet

Board of Nursing
Adopted 3/22/11

Offense Score

	Points	Score
a. Sexual Abuse/Inappropriate Relationship	55	
b. Patient injury	20	
c. Patient especially vulnerable	20	
d. Concurrent sanction by employer	20	
e. Act of commission	10	
f. Any patient involvement	10	
Total Offense Score		

Respondent Score

a. Concurrent criminal conviction	30	
b. Significant and substantial danger to the public	30	
c. Any prior Board violations	20	
d. License ever taken away	20	
e. Been sanctioned by another state/entity	20	
f. Past difficulties (substances, mental/physical)	10	
g. Three or more employers in past 5 years	10	
Total Respondent Score		

Offense Score

Respondent Score	0-40	41-70	71 or more
0-29	No Sanction ... to > Reprimand/CE/ Monetary Penalty	Reprimand/CE/ Monetary Penalty	Reprimand/CE/ Monetary Penalty ... to > Treatment/Monitoring
30 or more	Reprimand/CE/ Monetary Penalty	Treatment/Monitoring ... to > Recommend Formal/ Suspension or Revocation	Treatment/Monitoring ... to > Recommend Formal/ Suspension or Revocation

Grid cells give a single recommendation or a range of recommendations for imposing sanctions.

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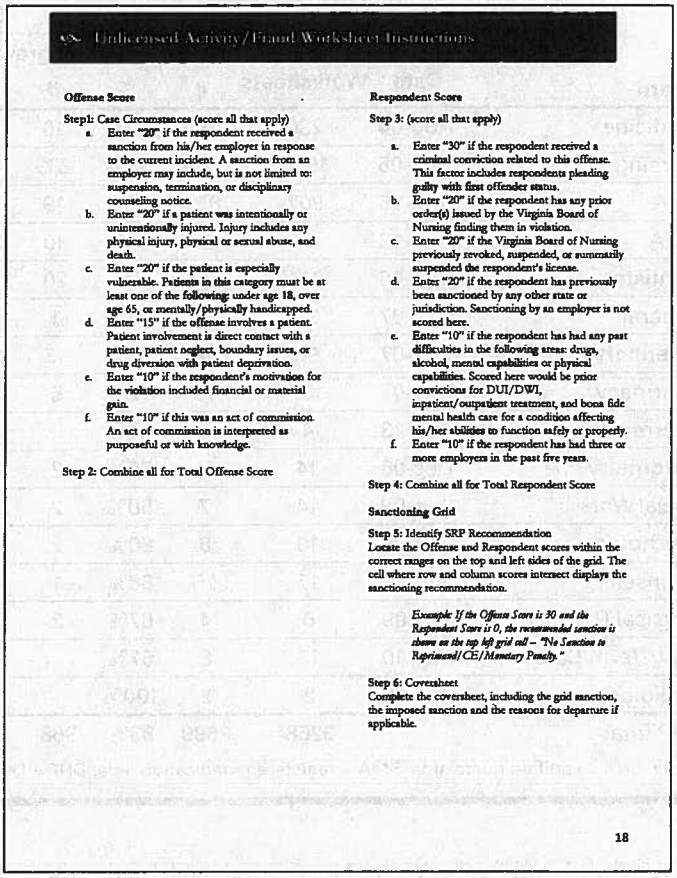
Confidential pursuant to § 54.1-2400.2 of the Code of Virginia.



Unlicensed Activity/Fraud Worksheet Instructions

Offense Score

Step1: Case Circumstances (score all that apply)

a. Enter "20" if the respondent received a sanction from his/her employer in response to the current incident. A sanction from an employer may include, but is not limited to: suspension, termination, or disciplinary counseling notice.
b. Enter "20" if a patient was intentionally or unintentionally injured. Injury includes any physical injury, physical or sexual abuse, and death.
c. Enter "20" if the patient is especially vulnerable. Patients in this category must be at least one of the following: under age 18, over age 65, or mentally/physically handicapped.
d. Enter "15" if the offense involves a patient. Patient involvement is direct contact with a patient, patient neglect, boundary issues, or drug diversion with patient deprivation.
e. Enter "10" if the respondent's motivation for the violation included financial or material gain.
f. Enter "10" if this was an act of commission. An act of commission is interpreted as purposeful or with knowledge.

Step 2: Combine all for Total Offense Score

Respondent Score

Step 3: (score all that apply)

a. Enter "30" if the respondent received a criminal conviction related to this offense. This factor includes respondents pleading guilty with first offender status.
b. Enter "20" if the respondent has any prior order(s) issued by the Virginia Board of Nursing finding them in violation.
c. Enter "20" if the Virginia Board of Nursing previously revoked, suspended, or summarily suspended the respondent's license.
d. Enter "20" if the respondent has previously been sanctioned by any other state or jurisdiction. Sanctioning by an employer is not scored here.
e. Enter "10" if the respondent has had any past difficulties in the following areas: drugs, alcohol, mental capabilities or physical capabilities. Scored here would be prior convictions for DUI/DWI, inpatient/outpatient treatment, and bona fide mental health care for a condition affecting his/her abilities to function safely or properly.
f. Enter "10" if the respondent has had three or more employers in the past five years.

Step 4: Combine all for Total Respondent Score

Sanctioning Grid

Step 5: Identify SRP Recommendation
Locate the Offense and Respondent scores within the correct ranges on the top and left sides of the grid. The cell where row and column scores intersect displays the sanctioning recommendation.

Example: If the Offense Score is 30 and the Respondent Score is 0, the recommended sanction is shown on the top left grid cell – "No Sanction to Reprimand/CE/Monetary Penalty."

Step 6: Coversheet
Complete the coversheet, including the grid sanction, the imposed sanction and the reasons for departure if applicable.

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adjusted. The SRP system is not applied in any of the following circumstances: action by another board, compliance and reinstatement, confidential consent agreements, and mandatory suspensions.

The system ensures wide sanctioning ranges. The SRP system considers and weighs the circumstances of an offense and the relevant characteristics of the respondent, providing the board with a sanctioning model that encompasses approximately 75% of historic practice. In approximately 25% of past cases, respondents received stricter or milder sanctions than the SRP system indicated. In these cases, aggravating or mitigating factors play a legitimate role in sanctions. The wide sanctioning ranges allow the board to customize a particular sanction within the broader SRP system recommended range.

Complying with the SRP recommendations is voluntary. The SRP system should be viewed as a decision aid for the BON. Sanctioning within the SRP system ranges is voluntary, meaning that the system is viewed strictly as a tool and the board may choose any sanction outside of the recommendation. The board maintains complete discretion in determining the sanction. However, worksheets still must be completed and presented in every eligible case.

Effectiveness Study

The purpose of the effectiveness study was to evaluate the SRP system against its own objectives. Although all 13 licensing boards participated in the effectiveness study, which examined each board in turn from 2011 to 2013, this article focuses on the BON's use of the SRP system. The goals of the effectiveness study included the following:

- Examining sanctioning agreement rates and board feedback practices
- Reexamining and modifying the SRP system worksheet factors and scoring weights
- Reexamining and modifying the SRP system sanction recommendation thresholds
- Assessing consistency, proportionality, and neutrality in sanctions
- Determining how board policies fit within the SRP system
- Examining whether or not the SRP system training was adequate
- Identifying unintended consequences and outcomes of the SRP system.

SRP System Coversheets and Worksheets

Completed SRP system coversheets and worksheets were assessed for accuracy and integrity. This assessment entailed comparing the data on the actual, completed coversheets and worksheets against the facts found in the case files, hearing minutes, notices, and reports. Accuracy and completeness were also assessed by evaluating form completeness, checking for mathematical errors, and verifying proper sanction grid cross-referencing. Although the worksheets were found to be very reliable, an ongoing maintenance-training program will mitigate any issues found in this assessment.

SRP System Sanctioning Agreement

Completed SRP system coversheets and worksheets were analyzed to determine what percentage of sanctions handed down by the BON were within the recommended sanction ranges determined by the SRP system. The effectiveness study revealed an agreement rate of approximately 77%, which is nearly the same as the percentage targeted during SRP system development. Sanctioning reference point agreement rates are produced quarterly and reported to BHP (January 2007 to present). These documents are used as working papers, and can be obtained from the Board of Health Professions, as seen in Figure 1.

Sanctioning Departure Reasons

The SRP system is voluntary and is used as a guideline. The BON can choose to sanction respondents outside the recommended sanction range. When the BON departs from the recommended range, the SRP system coversheet captures the departure reason in a free-form field. The departure reasons support the BON's decision to impose sanctions that are harsher or milder than the recommended range. Analysis of the departure reasons led to a number of minor changes to the grid sanction recommendations and worksheet definitions.

Consistency, Proportionality, and Neutrality

Using the goals of Virginia's criminal sentencing guidelines of ensuring consistency, proportionality, and neutrality, the BON's SRP tool was evaluated as to whether it upheld the same three objectives.

Consistency in sanctioning addresses the following question: To what extent do similar respondents and offenses receive similar sanctions? One of the goals of the SRP system is to make concepts such as "similarly situated" measurable. For example, given a combination of offense and respondent factors on the BON's standard of care worksheet, a respondent falls into a certain grid cell. Other respondents in the same grid cell should be comparable in terms of factors deemed relevant in sanctioning and should receive similar outcomes. The primary method for evaluating consistency relies on examining SRP system agreement rates and, as noted above, the agreement rate of 77% coincides with the 75% predicted rate for nursing.

Proportionality in sanctioning addresses the following question: Are the most serious cases getting the most serious sanctions and are less serious cases getting less serious sanctions? The SRP system provides an empirical point system that links offense and respondent characteristics to appropriate sanctions. For rational sanctioning, the proportionality of offense to sanction must be accurately represented by the point system. Inaccurate or unproven numeric proportions could lead to more serious offenders receiving less serious sanctions and vice versa. The analysis resulted in changes to several sanctioning grids, leading to higher agreement rates and thus more proportional sanctioning outcomes.

Neutrality addresses the issue that sanctions could differ based on extralegal characteristics of the respondent or case. For example, older respondents or respondents with attorneys could receive milder sanctions even when other worksheet factors remain constant. Neutrality is traditionally the most difficult criterion to measure when differentiating among sanctioning decisions. The effectiveness study analyzed closed cases using SRP system worksheets and collecting data on extralegal factors. The extralegal factors available for analysis (gender, age, attorney involvement) were not found to be significant factors in determining departures.

SRP System Training

During the implementation phase of the SRP system, formal training was provided to various constituencies, including BON members, the executive director and administrative staff of the BON, attorneys from the attorney general's office, and private attorneys. As a result of normal turnover among personnel from these various groups, many of the people currently using the SRP system have not been formally trained. Ad hoc training has occurred over time but periodic, formal training is required to maintain the integrity of the SRP system. As part of the effectiveness study, training was reviewed and a long-term maintenance training plan was created, and it is currently being implemented.

Conclusion

After using the SRP worksheets on more than 2,200 disciplinary cases, the BON continues to find the system to be a useful and accurate representation of historic sanctioning practice. Not only do Virginia's health regulatory boards feel that the system is beneficial, but the program has been recognized for innovation and excellence by several national health professions associations and organizations. As the analytic knowledge base continues to expand, the BHP has brought a more empirically based structure to the difficult task of sanctioning. With this expansion also comes the measurable benefit of increasing equity and accountability during the health care provider disciplinary process.

The SRP approach has been replicated among the 13 health regulatory boards in Virginia. But SRP worksheets and manuals from these boards cannot be applied interchangeably or "off the shelf" by another state's licensing board for the same profession. The degree to which it may be replicated outside of the state will depend upon the desire and means to replicate the empirical pro-

cesses involved in developing, evaluating, and maintaining a working model.

References

Carter, E., & Kauder, N. (2004). An empirically based structured sanctioning system. *Journal of Medical Licensure and Discipline, 90*(4), 8–17. Retrieved from http://jmr.fsmb.org/Archive/2000s/Journal%20of%20Medical%20Licensure%20and%20Discipline(Vol90N4).pdf?boxtype=pdf&g=false&s=false&s2=false&r=wide

Code of Virginia. §54.1-100 et seq. *Regulations of professions and occupations.* Retrieved from http://law.lis.virginia.gov/vacode/title54.1/chapter1/

Code of Virginia. § 54.1-2510 (11). *Chapter 25: Department of health professions.* Retrieved from http://law.lis.virginia.gov/vacode/title54.1/chapter25/

Virginia Department of Health Professions. (n.d.). *Mission statement.* Retrieved from www.dhp.virginia.gov/

Virginia Department of Health Professions. (2013). *Sanctioning reference points instruction manual.* Retrieved from www.dhp.virginia.gov/nursing/guidelines/90-7%20Sanction%20Reference%20Manual.pdf

VisualResearch, Inc. (2001). *Virginia Board of Health Professions Work Plan.* Internal Working Papers.

VisualResearch, Inc. (2005). *Board of Health Professions Sanction Study Policy Blueprint: Board of Nursing.*

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Neal B. Kauder, MS, is President, VisualResearch, Inc.

FIGURE 2

Board of Nursing Standard of Care Worksheet

Below is the Standard of Care Worksheet that the board of nursing uses to determine sanctions.

Standard of Care Worksheet

Board of Nursing
Adopted 3/22/11

Offense Score

	Points	Score
a. Sexual Abuse/Inappropriate Relationship	55	
b. Patient injury	20	
c. Patient especially vulnerable	20	
d. Concurrent sanction by employer	20	
e. Act of commission	10	
f. Any patient involvement	10	
Total Offense Score		

Respondent Score

	Points	Score
a. Concurrent criminal conviction	30	
b. Significant and substantial danger to the public	30	
c. Any prior Board violations	20	
d. License ever taken away	20	
e. Been sanctioned by another state/entity	20	
f. Past difficulties (substances, mental/physical)	10	
g. Three or more employers in past 5 years	10	
Total Respondent Score		

_____ Offense Score _____

Respondent Score	0-40	41-70	71 or more
0-29	No Sanction .. to > Reprimand/CE/ Monetary Penalty	Reprimand/CE/ Monetary Penalty	Reprimand/CE/ Monetary Penalty .. to > Treatment/Monitoring
30 or more	Reprimand/CE/ Monetary Penalty	Treatment/Monitoring .. to > Recommend Formal/ Suspension or Revocation	Treatment/Monitoring .. to > Recommend Formal/ Suspension or Revocation

Grid cells give a single recommendation or a range of recommendations for imposing sanctions.

Unlicensed Activity/Fraud Worksheet Instructions

Offense Score

Step1: Case Circumstances (score all that apply)

a. Enter "20" if the respondent received a sanction from his/her employer in response to the current incident. A sanction from an employer may include, but is not limited to: suspension, termination, or disciplinary counseling notice.
b. Enter "20" if a patient was intentionally or unintentionally injured. Injury includes any physical injury, physical or sexual abuse, and death.
c. Enter "20" if the patient is especially vulnerable. Patients in this category must be at least one of the following: under age 18, over age 65, or mentally/physically handicapped.
d. Enter "15" if the offense involves a patient. Patient involvement is direct contact with a patient, patient neglect, boundary issues, or drug diversion with patient deprivation.
e. Enter "10" if the respondent's motivation for the violation included financial or material gain.
f. Enter "10" if this was an act of commission. An act of commission is interpreted as purposeful or with knowledge.

Step 2: Combine all for Total Offense Score

Respondent Score

Step 3: (score all that apply)

a. Enter "30" if the respondent received a criminal conviction related to this offense. This factor includes respondents pleading guilty with first offender status.
b. Enter "20" if the respondent has any prior order(s) issued by the Virginia Board of Nursing finding them in violation.
c. Enter "20" if the Virginia Board of Nursing previously revoked, suspended, or summarily suspended the respondent's license.
d. Enter "20" if the respondent has previously been sanctioned by any other state or jurisdiction. Sanctioning by an employer is not scored here.
e. Enter "10" if the respondent has had any past difficulties in the following areas: drugs, alcohol, mental capabilities or physical capabilities. Scored here would be prior convictions for DUI/DWI, inpatient/outpatient treatment, and bona fide mental health care for a condition affecting his/her abilities to function safely or properly.
f. Enter "10" if the respondent has had three or more employers in the past five years.

Step 4: Combine all for Total Respondent Score

Sanctioning Grid

Step 5: Identify SRP Recommendation
Locate the Offense and Respondent scores within the **correct ranges on the top and left sides** of the grid. The **cell where row and column scores intersect** displays the sanctioning recommendation.

Example: If the Offense Score is 30 and the Respondent Score is 0, the recommended sanction is shown on the top left grid cell – "No Sanction to Reprimand/CE/Monetary Penalty."

Step 6: Coversheet
Complete the coversheet, including the grid sanction, the imposed sanction and the reasons for departure if applicable.

FIGURE 2

Board of Nursing Standard of Care Worksheet

Below is the Standard of Care Worksheet that the board of nursing uses to determine sanctions.

Standard of Care Worksheet

Board of Nursing
Adopted 3/22/11

Offense Score

	Points	Score
a. Sexual Abuse/Inappropriate Relationship	55	
b. Patient injury	20	
c. Patient especially vulnerable	20	
d. Concurrent sanction by employer	20	
e. Act of commission	10	
f. Any patient involvement	10	
Total Offense Score		

Respondent Score

	Points	Score
a. Concurrent criminal conviction	30	
b. Significant and substantial danger to the public	30	
c. Any prior Board violations	20	
d. License ever taken away	20	
e. Been sanctioned by another state/entity	20	
f. Past difficulties (substances, mental/physical)	10	
g. Three or more employers in past 5 years	10	
Total Respondent Score		

Offense Score

Respondent Score	0-40	41-70	71 or more
0-29	No Sanction ... to > Reprimand/CE/ Monetary Penalty	Reprimand/CE/ Monetary Penalty	Reprimand/CE/ Monetary Penalty ... to > Treatment/Monitoring
30 or more	Reprimand/CE/ Monetary Penalty	Treatment/Monitoring ... to > Recommend Formal/ Suspension or Revocation	Treatment/Monitoring ... to > Recommend Formal/ Suspension or Revocation

Grid cells give a single recommendation or a range of recommendations for imposing sanctions.

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Offense Score

Step1: Case Circumstances (score all that apply)

a. Enter "20" if the respondent received a sanction from his/her employer in response to the current incident. A sanction from an employer may include, but is not limited to: suspension, termination, or disciplinary counseling notice.
b. Enter "20" if a patient was intentionally or unintentionally injured. Injury includes any physical injury, physical or sexual abuse, and death.
c. Enter "20" if the patient is especially vulnerable. Patients in this category must be at least one of the following: under age 18, over age 65, or mentally/physically handicapped.
d. Enter "15" if the offense involves a patient. Patient involvement is direct contact with a patient, patient neglect, boundary issues, or drug diversion with patient deprivation.
e. Enter "10" if the respondent's motivation for the violation included financial or material gain.
f. Enter "10" if this was an act of commission. An act of commission is interpreted as purposeful or with knowledge.

Step 2: Combine all for Total Offense Score

Respondent Score

Step 3: (score all that apply)

a. Enter "30" if the respondent received a criminal conviction related to this offense. This factor includes respondents pleading guilty with first offender status.
b. Enter "20" if the respondent has any prior order(s) issued by the Virginia Board of Nursing finding them in violation.
c. Enter "20" if the Virginia Board of Nursing previously revoked, suspended, or summarily suspended the respondent's license.
d. Enter "20" if the respondent has previously been sanctioned by any other state or jurisdiction. Sanctioning by an employer is not scored here.
e. Enter "10" if the respondent has had any past difficulties in the following areas: drugs, alcohol, mental capabilities or physical capabilities. Scored here would be prior convictions for DUI/DWI, inpatient/outpatient treatment, and bona fide mental health care for a condition affecting his/her abilities to function safely or properly.
f. Enter "10" if the respondent has had three or more employers in the past five years.

Step 4: Combine all for Total Respondent Score

Sanctioning Grid

Step 5: Identify SRP Recommendation
Locate the Offense and Respondent scores within the correct ranges on the top and left sides of the grid. The cell where row and column scores intersect displays the sanctioning recommendation.

Example: If the Offense Score is 30 and the Respondent Score is 0, the recommended sanction is shown on the top left grid cell – "No Sanction to Reprimand/CE/Monetary Penalty."

Step 6: Coversheet
Complete the coversheet, including the grid sanction, the imposed sanction and the reasons for departure if applicable.

Reentry and Recidivism for Certified Registered Nurse Anesthetists

Heather Hamza, CRNA, MS, and Todd Monroe, PhD, RN-BC

The self-reported prevalence of drug diversion (diverting hospital medications for self-administration) among certified registered nurse anesthetists (CRNAs) is 9.8%. However, much of the addiction literature fails to focus specifically on CRNAs' reentry into practice. This article discusses reentry and recidivism in CRNAs and includes successful strategies, such as medication therapy.

In 1992, Jason Smith entered his first treatment center after turning himself in for fentanyl addiction at the community hospital where he was working. After 28 days in the treatment center, he was assigned to an aftercare program and told to go to Alcoholics Anonymous (AA). He was not enrolled in a monitoring program and attended AA meetings sporadically. Having lost his job, he worked as a traveling certified registered nurse anesthetist (CRNA) and promptly relapsed. A year later, after some clean time, Jason took a full-time position in a neighboring community hospital, which knew about his history of fentanyl addiction. The hospital issued a last-chance contract, did random urine drug screens, and limited his work hours. In 6 months, he was using again. After a positive result on a urine drug screen, the hospital sent him to a 3-week intensive outpatient program but did not fire him. About 6 months later, he used again and was fired. At that point, his wife asked him to leave their house.

At the time, an alternative-to-discipline program was being developed under a mandate of the state legislature. A pharmacist friend who had just completed long-term treatment asked Jason to accompany him to a Caduceus meeting. Jason was able to share his story with 30 recovering health professionals, and when he was done, the medical director stood up and said, "You never received treatment. I want you here tomorrow morning to be admitted for long-term treatment." The next day, Jason was admitted to an inpatient program.

This article explores issues surrounding reentry into practice and recidivism of recovering CRNAs and includes strategies for success, such as the use of medications.

Prevalence of the Problem and Scarcity of CRNA-Specific Studies

The self-reported prevalence of drug diversion for self-administration among CRNAs is 9.8% (Bell, 2006; Bell, McDonough, Ellison, & Fitzhugh, 1999). Thus, of the more than 40,000 CRNAs in the United States, there would be approximately 4,000 who would self-report as diverting drugs. Though cases of trafficking or diverting to others exist, they are rare, and Bell's data specifically examine the far more common scenario of self-medication.

An extensive review of the literature reveals that much of the focus on drug diversion has involved physicians and nurses. Nursing publications that examine nurses who divert drugs by specialty fail to include CRNAs. The sparse literature that exists on CRNAs focuses on the incidence and demographic characteristics of those who divert drugs based on self-report (Bell, 2006; Bell et al., 1999).

About one-third of critical-care nurses report easy access to controlled substances, and the combination of having easy access and working in a critical-care specialty has been associated with the greatest likelihood of illicit drug use (Trinkoff & Storr, 1994). These high-risk factors certainly apply to CRNAs, who work in a critical-care specialty and have easy access to controlled drugs.

Components of Safe Reentry into Practice

Several recommendations have been made for reentry programs for CRNAs, but none has been empirically tested. Generally, these recommendations call for detoxification, treatment, and then gradual reentry into practice when it is deemed safe. Whether or not a recovering CRNA (or anesthesiologist) can safely return to anesthesia practice without relapsing, despite follow-up care and monitoring, remains controversial (Berge, Seppala, & Lanier, 2008; Collins, McAllister, Jensen, & Gooden, 2005). One major risk associated with returning to the practice environment is the presence of cues previously paired with drug use, such as handling anesthetic drugs and paraphernalia (Heinze, Wolfling, & Grusser, 2007).

Reentry of recovering health-care professionals (HCPs) into the workplace is an important issue for administrators, leaders, and the public. The American Association of Nurse Anesthetists (AANA) has traditionally advocated for public safety through the removal and safe return of CRNAs suffering from addiction, yet

the AANA recognizes the precarious nature of this undertaking and maintains high standards for reentry.

Two classic textbooks cover the standard components of a safe, reasonable reentry of the anesthesia practitioner (Angres, Talbott, & Bettinardi-Angres, 1998; Higgins Roche, 2007). These components, which appear frequently in the pro-reentry literature (Monroe, 2009), include, but are not restricted to, the following:

- a solid foundation in a 12-step program
- participation in the state's monitoring program (if applicable)
- attendance at Caduceus (HCP support group) meetings
- a work-site monitor
- random drug screens
- a back-to-work contract
- naltrexone use
- no overtime.

Bryson & Silverstein (2008) recommend 1 year away from anesthesia practice before reentry. They believe the recovering addict must focus on recovery and sobriety versus career. Reentry contracts commonly forbid overtime, so the recovering addict has time for 12-step meetings, aftercare, and Caduceus meetings and can maintain a balanced, healthy life (Angres et al., 1998; Bryson & Silverstein, 2008; Higgins Roche, 2007).

The literature on reentry for HCPs does not support opioid replacement therapy such as the mu agonists buprenorphine and methadone, which are commonly used in other opiate-abusing populations. Instead, the literature advocates the mu antagonist naltrexone (Bryson & Silverstein, 2008; Higgins Roche, 2007; Oreskovich & Caldeiro, 2009).

The alternative-to-discipline programs of many state boards of nursing (BONs) and state medical boards require participation in 12-step programs, such as AA or Narcotics Anonymous (Baldisseri, 2007; DuPont, McLellan, Carr, Gendel, & Skipper, 2009; Hughes, Smith, & Howard, 1998). Attending 12-step meetings is a common stipulation in reentry or back-to-work contracts (Angres et al., 1998; Bryson & Silverstein, 2008; Higgins Roche, 2007).

Despite the common recommendation regarding 12-step programs, research on their effectiveness is limited. Galanter, Talbott, Gallegos, & Rubenstone (1990) surveyed 100 physicians in the Georgia Impaired Physicians Program. The 160-question, multiple-choice or numerical-response survey asked the degree to which certain recommendations contributed to recovery. Respondents indicated that AA was the most potent component in their recovery and that group cohesiveness reflected the camaraderie felt by these physician AA members with other members of AA (Galanter, Talbott, Gallegos, & Rubenstone, 1990).

Although only limited data support the standard recommendations, they appear consistently (Wilson & Compton, 2009). Investigators recognize that retrospective analyses are needed to scrutinize the efficacy of each component, including the correlation of relapse rate with the type of treatment or administration of naltrexone (Oreskovich & Caldeiro, 2009). Berge, Seppala, and Lanier (2008) concur, advocating for data supporting the traditional 3- to 5-year monitoring period set forth by most monitoring programs for nurses and physicians.

Alternative-to-Discipline Programs

An alternative-to-discipline, or diversion, program is a monitoring program for impaired nurses, often run through the state BON (Monroe, Pearson, & Kenaga, 2009). A 2002 seminal study showed that when compared with disciplinary programs, alternative-to-discipline programs had more nurses with active licenses, fewer with criminal convictions, and more employed in nursing (Haack & Yocum, 2002). Clark and Farnsworth (2006) found that nurses who were monitored longer had higher success rates, leading them to recommend increasing the monitoring contract from 3 years to 5 years.

Monroe, Pearson, and Kenaga (2008) note that the information regarding alternative programs is limited, and much of it is dated. Also, some types of monitoring programs may be reluctant to share data, unless the facts cast them in a positive light. See "Model Guidelines for Alternative Programs and Discipline Monitoring Programs" (published here for the first time by the National Council of State Boards of Nursing), on page 42 of this issue.

Physicians also have alternative-to-discipline programs, usually run by the respective state board of medicine and called physician health programs. DuPont, McLellan, Carr, Gendel, & Skipper (2009) retrospectively analyzed 780 nonresident physicians enrolled in physician health programs. The program medical directors were surveyed to analyze their treatment, support, and monitoring regimens. The findings were hopeful: only 22% of physicians tested positive during their 5-year monitoring period, and at 5 years, 71% were still licensed and employed (DuPont et al., 2009).

Measuring Success

Reentry of the CRNA has been considered rarely in nursing publications (Saver, 2008a, 2008b) and even less in physician anesthesiology publications (Berge et al., 2008). The concept of successful reentry into practice has been inferred in this literature—primarily from rates of relapse and recovery from alternative-to-discipline programs.

Monroe and colleagues (2008) found that alternative-to-discipline and disciplinary programs reported success rates for reentry into practice between 68% and 90%. Thus, both types of programs have consistently helped a majority of nurses recovering from addictive disorders to reenter the workforce. However, alternative-to-discipline programs remove impaired clinicians from practice in days to weeks compared with months or years

with disciplinary programs. Thus, the public is protected sooner, and the nurse receives treatment faster.

The success of a program may also be measured in terms of recovery or retention (Monroe et al., 2008). The authors found recovery rates of 47% to 95% and retention rates for nurses in the profession of 61% to 85%. The authors found little empirical evidence in the literature about reentry and monitoring programs. They further caution that success rates may tell us very little about the progress made nationwide in addressing substance use disorders among HCPs (Monroe et al., 2008).

Reentry of Nurses

Data supporting successful reentry of nurses to practice are encouraging. Hughes, Smith, & Howard (1998) evaluated Florida's Intervention Project for Nurses, the first alternative-to-discipline program in the United States, and found that over 80% of impaired nurses reentered nursing, with less than 25% having relapsed (Hughes et al., 1998).

Yocum and Haack (1996) found that alternative-to-discipline programs removed impaired nurses from the workplace faster and had a recovery rate nearly double that of the punitive programs. Baldisseri (2007) reported that up to 75% of HCPs remain sober for more than 10 years after treatment, with 15% to 20% relapsing within 1 to 2 years of initial treatment.

Reentry of CRNAs

Only one study specifically addresses the reentry needs of the CRNA. A retrospective study by Sibert and Demenes (1996) reported results of a four-question survey completed by 60 recovering CRNAs and evaluated important factors for maintaining sobriety to facilitate reentry. Respondents identified these factors as participating in a 12-step program (64.4%), attending support groups (61%), having random drug screening (39%), having sponsorship in support groups (27.1%), and serving as a mentor or sponsor for another addicted CRNA (27.1%). The four most difficult issues related to successful reentry were receiving disciplinary actions from the state BON (69.8%), finding employment (56.6%), working with managers uninformed about chemical dependency (39.6%), and having employers unwilling to monitor the employee adequately (28.3%).

Redirection to Another Specialty

A few studies evaluate reentry programs for anesthesiologists that strongly advocate redirection into another specialty after treatment (Collins et al., 2005). These studies, which are retrospective surveys of academic anesthesiology departments assessing substance abuse and reentry among anesthesia residents, found that when advocating redirection into a different specialty, a program must be aware of the other high-risk settings. In other words, redirecting an addict to another specialty does not automatically remove the risk of relapse. According to Hughes et al. (1998), the highest incidence of chemical dependency is in emergency and psychiatry units. Monroe and colleagues (2008) also suggest that for nurses unable or unwilling to maintain sobriety, redirection out of the profession may be the only option.

Pharmacotherapeutics in Reentry

Two overall classes of drugs can be used to help treat those recovering from addiction: mu opioid antagonists such as naltrexone and partial mu opioid agonists such as buprenorphine. The literature does not support the use of the latter for recovering HCPs, which will be subsequently discussed.

Naltrexone

Naltrexone has been recommended in addictions literature for several decades. The use of naltrexone, a full mu opioid antagonist, has long been known to reduce alcohol cravings in alcoholics (O'Malley, Krishnan-Sarin, Farren, Sinha, & Kreek, 2002). Judson, Carney, & Goldstein (1981) describe its original purpose in 1963, which was for opioid addiction. The premise for its use was Abraham Wikler's 1948 theory of conditioning, in which the addict could return to his or her previous environment and use opioid antagonism to extinguish the urge to use. Today, the issues of drug-related cues, conditioned responses, and reentry still require proper research (Wilson, 2009).

Judson et al. (1981) studied the effects of naltrexone in recovering heroin addicts (n = 119). The authors wanted to know if any difference in safety and efficacy existed between 60-mg and 120-mg naltrexone treatment. The authors found no differences in initial treatment dropout. However, among persons who stayed in treatment more than 3 months, those taking 120 mg of naltrexone stayed longer. Thus, the authors found that so long as abstinence was maintained, naltrexone reduced craving and that reduced craving increased over time with repeated dosing (Judson, Carney, & Goldstein, 1981).

Roth, Hogan, & Farren (1997) retrospectively analyzed success rates of 20 addicted HCPs over a 5-year period. Seventeen were nurses, one was a pharmacist, and two were CRNAs. The authors concluded that the use of naltrexone in addicted HCPs yielded a higher success rate than in the general population because of the motivation to return to work and maintain professional licensure. Several reports specifically recommend naltrexone for addicted anesthesiologists and CRNAs who are returning to work (Bryson & Silverstein, 2008; Higgins Roche, 2007; Oreskovich & Caldeiro, 2009).

Buprenorphine

At least 10 BONs have approved opioid replacement therapy for HCPs returning to work, though no evidence supports the safety of this approach. Buprenorphine is a semisynthetic partial mu opioid agonist and kappa-receptor antagonist (Messinis et al., 2009) used for analgesia and for opioid dependence.

TABLE 1

Summary of Pharmacotherapeutics

Generic Drug Name	Trade Drug Name	Drug Class	Common Dosing Frequency and Administration Route	Diversion and Abuse Potential	DEA Schedule	Potential for Neurocognitive and Psychomotor Impairment	Recommended by AANA for Reentry
naloxone	Narcan	Opiate antagonist	Not applicable (used for overdose)	No	None	No	No (too short-acting)
naltrexone	Revia	Opiate antagonist	Once a day by mouth	No	None	No	Yes
naltrexone	Vivitrol	Opiate antagonist	Once a month intramuscularly	No	None	No	Yes
naltrexone	Addex	Opiate antagonist	Once every 3 to 4 months, subcutaneous pellet	No	None	No	Yes
buprenorphine	Subutex	Partial opiate agonist	Every other day or three times a week; sublingual tablet or film	Yes	Class III	Yes	No
buprenorphine with naloxone	Suboxone	Partial opiate agonist and opiate antagonist	Every other day or three times a week; sublingual tablet or film	Yes	Class III	Yes	No
methadone	Dolophine	Opiate agonist	Every day by mouth	Yes	Class II	Yes	No

DEA = Drug Enforcement Administration
AANA = American Association of Nurse Anesthetists

Compared with full mu agonists, buprenorphine may have a safer pharmacodynamic profile because it slowly dissociates from mu receptors and produces less respiratory depression (Rapeli et al., 2007). This slow dissociation allows for less frequent dosing but can make detoxification difficult. Though it is a partial mu agonist, buprenorphine causes the same physiologic responses as full mu agonists, including cognitive and psychomotor impairment, memory deficits, miosis, respiratory depression, decreased gastrointestinal motility, urine retention, nausea, drug liking, euphoriant effects, drug dependence, and subsequent withdrawal (Messinis et al., 2009; Mintzer, Correia, & Strain, 2004; Rapeli et al., 2007).

Several publications address the abuse and diversion potential of buprenorphine (Higgins Roche, 2007; Mintzer et al., 2004). The indications for buprenorphine are similar to those for methadone, and thus comparisons are common. As a partial mu agonist, buprenorphine is not considered completely free of abuse potential; it just may have less than a full mu agonist such as methadone (Higgins Roche, 2007; Mintzer et al., 2004).

After reports of patients crushing buprenorphine pills and administering them parenterally, the oral tablets were manufactured in a 4:1 ratio of buprenorphine:naloxone. The naloxone is bioavailable only in the intravenous preparation, not in the oral preparation; thus, the active naloxone precipitates opiate withdrawal only if taken parenterally (Mintzer et al., 2004; Rapeli et al., 2007). See Table 1 for a summary of pharmacotherapeutics.

Outcome of Case Study

Following treatment, Jason Smith took a job as a registered nurse in a ventilator-dependent unit. He was under contract, met with his AA sponsor regularly, had quarterly reports sent by therapists, had daily urine drug screens, attended at least five meetings a week, and stayed in contact with his caseworker. When he was considered ready to handle narcotics, he worked in the intensive care unit and then the anesthesia department again. Once he had access to narcotics, he was put on naltrexone. He took the pill every day with his work-site monitor watching, and he was on contract for more than 5 years.

Recently, Jason celebrated 12 years of continuous sobriety, and he has been overwhelmed by remarks about his contributions to other people's recoveries.

Discussion

Reentry of the recovering HCP remains a controversial and a precarious undertaking. The standard recommendations appear consistently in the literature; however, most of them are based on collective expert opinion, not empirical data. The reported successes of the alternative-to-discipline programs do not clearly explain their significant contributions. Studies are largely retrospective analyses and self-reporting, which raises questions. How would one undertake a genuine evidence-based study to assess reentry? Would subjecting participants to reentry methods not yet discussed in the peer-reviewed literature be ethical?

The use of pharmacotherapeutics in HCPs, including CRNAs, needs to be further investigated. Cognitive and psychomotor function has been tested in other drug-abusing populations while taking these maintenance drugs, yet no studies have been done in recovering HCPs. Assessing the effects of these drugs in critical situations that require split-second decision making and precise hand-eye coordination could be done in an operating-room simulator.

The AANA is careful about its reentry recommendations and understands that not every CRNA is an appropriate candidate. Even when people follow guidelines, some relapse, and frequently the least suspected person is diverting medications.

The role of appropriate inpatient and intensive outpatient treatment, aftercare, follow-up treatment, back-to-work contracts, random drug testing, and a solid support system cannot be overemphasized. Addiction must be treated as any other life-threatening illness, and reentry into the workplace must be done with every safeguard available.

The eventual success story reported in this article addresses the relapse potential of a poorly planned reentry-to-work contract. Each relapse makes subsequent reentry attempts more difficult. We must strive for evidence-based, safe, effective standards for reentry that will protect the HCP, the profession and, most importantly, our patients.

References

Angres, D. H., Talbott, G. D., & Bettinardi-Angres, K. (1998). *Healing the Healer: The Addicted Physician*. Madison, CT: Psychosocial Press. Medicine, 35(2), S106-S116.

Baldisseri, M. R. (2007). Impaired healthcare professional. *Critical Care Medicine,35* (2), S106-S116.

Bell, D. M. (2006). The current state of drug misuse by CRNAs: Prevalence, attitudes & controversies. Unpublished data (used with permission).

Bell, D. M, McDonough, J. P., Ellison, J. S., & Fitzhugh, E. C. (1999). Controlled drug misuse by certified registered nurse anesthetists. *AANA Journal, 67*(2), 133–140.

Berge, K. H., Seppala, M. D., & Lanier, W. L. (2008). An anesthesiology community's approach to opioid- and anesthetic-abusing personnel. *Anesthesiology, 109*(5), 762–764.

Bryson, E. O., & Silverstein, J. H. (2008). Addiction and substance abuse in anesthesiology. *Anesthesiology, 109*(5), 905–917.

Clark, C. & Farnsworth, J. (2006). Program for recovering nurses: An evaluation. *MEDSURG Nursing*, 16 (4), 223-230.

Collins, G. B., McAllister, M. S., Jensen, M., & Gooden, T. A. (2005). Chemical dependency treatment outcomes of residents in anesthesiology: Results of a survey. *Anesthesia & Analgesia, 101,* 1457–1462.

Dupont, R. L., McLellan, A. T., Carr, G., Gendel, M., & Skipper, G. E. (2009). How are addicted physicians treated? A national survey of physician health programs. *Journal of Substance Abuse Treatment, 37,* 1–7.

Galanter, M., Talbott, D., Gallegos, K., & Rubenstone, E. (1990). Combined Alcoholics Anonymous and professional care for addicted physicians. *American Journal of Psychiatry, 147*(1), 64–68.

Haack, M. R., & Yocum, C. J. (2002). State policies and nurses with substance abuse disorders. *Journal of Nursing Scholarship, 31*(4), 89–94.

Heinze, M., Wolfling, K. & Grusser, S. M. (2007). Cue-induced auditory evoked potentials in alcoholism. *Clinical Neurophysiology, 118,* 856–862.

Higgins Roche, B. T. (2007). *Substance abuse policies for anesthesia: Time to re-evaluate your policies and curriculum.* Winston-Salem, NC: All Anesthesia.

Hughes, T., Smith, L., & Howard, M. (1998). Florida's intervention project for nurses: A description of recovering nurses' reentry to practice. *Journal of Addictions Nursing, 10,* 63–69.

Judson, B. A., Carney, T. M., & Goldstein, A. (1981). Naltrexone treatment of heroin addiction: Efficacy and safety in a double-blind dosage comparison. *Drug and Alcohol Dependence, 7*(4), 325–346.

Messinis, L., Epameinondas, L., Andrian, V., Katsakiori, P., Panagis, G., Georgiou, V., et al. (2009). Neuropsychological functioning in buprenorphine maintained patients versus abstinent heroin abusers on naltrexone hydrochloride therapy. *Human Psychopharmacology: Clinical & Experimental, 24*(7), 524–531. doi:10.1002/hup.1050

Mintzer, M. Z., Correia, C. J., & Strain, E. C. (2004). A dose-effect study of repeated administration of buprenorphine/naloxone on performance in opioid-dependent volunteers. *Drug and Alcohol Dependence, 74,* 205–209.

Monroe, T. (2009). Addressing substance abuse among nursing students: Development of a prototype alternative-to-dismissal policy. *Journal of Nursing Education, 45*(5), 272–278.

Monroe, T., Pearson, F., & Kenaga, H. (2008). Procedures for handling cases of substance abuse among nurses: A comparison of disciplinary and alternative programs. *Journal of Addictions Nursing, 19,* 156–161.

Monroe, T., Pearson, F., & Kenaga, H. (2009). Treating nurses and student nurses with chemical dependency: Revising policy for the 21st century. *International Journal of Mental Health and Addiction, 7*(4), 530–540.

O'Malley, S. S., Krishnan-Sarin, S., Farren, C., Sinha, R., & Kreek, M. J. (2002). Naltrexone decreases craving and alcohol self-administration in alcohol-dependent subjects and activates the hypothalamopituitary adrenocortical axis. *Psychopharmacology, 160,* 19–29.

Oreskovich, M. R., & Caldeiro, R. M. (2009). Anesthesiologists recovering from chemical dependency: Can they safely return to the operating room? *Mayo Clinic Proceedings, 84*(7), 576–580.

Rapeli, P., Fabritius, C., Alho, H., Salaspuro, M., Wahlbeck, K., & Kalska, H. (2007). Methadone vs. buprenorphine/naloxone during early opioid substitution treatment: A naturalistic comparison of cognitive performance relative to healthy controls. *BMC Clinical Pharmacology, 7*(5), 1–10.

Roth, A., Hogan, I., & Farren, C. (1997). Naltrexone plus group therapy for the treatment of opiate-abusing health care professionals. *Journal of Substance Abuse Treatment, 14*(1), 19–22.

Saver, C. (2008a). Substance abuse in the OR: Saving lives through treatment, prevention. *OR Manager, 24*(6), 1, 12–13.

Saver, C. (2008b). Substance abuse in the OR: Why managers should not ignore it. *OR Manager, 24*(5), 1, 11–12.

Sibert, R. R. & Demenes, M. (1996). Criteria for successful re-entry as a CRNA provider post-addiction treatment. *AANA Journal, 64*(5), 454. Abstract 51.

Trinkoff, A. M., & Storr, C. L. (1994). Relationship of specialty and access to substance use among registered nurses: An exploratory analysis. *Drug and Alcohol Dependence, 36,* 215–219.

Wilson, H. (2009). Environmental cues and relapse: An old idea that is new for reentry of recovering anesthesia care professionals [editorial]. *Mayo Clinic Proceedings, 84*(11), 1040–1041.

Wilson, H., & Compton, M. (2009). Reentry of the addicted certified registered nurse anesthetist: A review of the literature. *Journal of Addictions Nursing, 20*(4), 177–184.

Yocum, C., & Haack, M. (1996). Interim report: a comparison of two regulatory approaches to the management of the chemically dependent nurse. Washington, DC: US government printing office.

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When Caregivers Harm
America's Unwatched Nurses

Weak Oversight Lets Dangerous Nurses Work in New York

New York lags behind other states in vetting nurses and moving to discipline those who are incompetent or commit crimes. Often, even those disciplined by other states or New York agencies hold clear licenses.

by Daniela Porat, Rosalind Adams and Jessica Huseman for ProPublica, April 7, 2016, 4 a.m.

(Andrea Mongia, special to ProPublica and WNYC)

This story was co-published with WNYC and the Albany Times Union.

Thomas Maino knew he was going to die. Suffering from serious ailments, the 93-year-old veteran had rejected invasive treatments and asked only that he be made comfortable after he was admitted to a Syracuse nursing home in November 2008.

But on a snowy Saturday morning the following January, his moans could be heard down the hallway.

Over the next eight hours, coworkers reported to the nurse in charge of Maino's unit that he needed pain medication. That nurse, Maura Quinn, gave him only Tylenol and never alerted the doctor. Other nurses told her Maino was in agony, but she ignored them, even when his moaning turned to yelling, seven staffers at the home later testified in depositions taken during an investigation by the state Attorney General's office.

"Oh great, now people are going to tell me how to do my freaking job," Quinn said when a nurse from a nearby wing left a note for her about Maino, according to one deposition.

Maino died that evening.

After an administrator reported the incident to New York nursing home regulators, Quinn was fired and, in December 2010, convicted of a misdemeanor for providing Maino with inadequate care. The state Attorney General's office reported Quinn to the Office of the Professions, the agency that licenses and disciplines nurses, when she was sentenced two months later.

But it would take another three years for the Office of the Professions to suspend her from nursing. By then, the agency had learned that Quinn lied on her initial licensing application, failing to disclose a 1988 conviction for drug possession, and that she was convicted in 2012 of driving without a license — both grounds for more disciplinary action. The agency finally suspended Quinn's nursing license for three months in May 2014.

Over the past 15 years, nursing boards across the country have taken steps to tighten oversight of nurses, screening applicants more extensively before issuing licenses and instituting swifter, tougher sanctions for problem licensees.

Not New York.

Unlike many states, New York does not require applicants for nursing licenses to undergo simple background checks or submit fingerprints, tools that can identify those with criminal histories and flag subsequent legal problems. And it often takes years for New York to discipline nurses who provide inept care, steal drugs or physically abuse patients.

A ProPublica review of hundreds of disciplinary records, arrest reports and court filings shows New York's system for overseeing nurses is deeply flawed. Among our findings:

The Office of the Professions often fails to act when it is informed that other states or even other New York agencies have disciplined New York nurses. One example: The state health department penalized a nurse in early 2014 for administering an overdose of insulin that nearly caused a patient's death, but the Office of the Professions has taken no action against her license.

Though the Office of the Professions can take immediate action against nurses accused of endangering the public's health or safety, it has not done so, even in egregious cases. After a nurse in the Bronx was caught sexually assaulting a patient in February 2014, the agency didn't revoke his license for more than a year and a half, records show.

New York disciplines nurses far less often than other large states. In 2014, the Office of the Professions disciplined fewer than 350 licensees, which works out to 1 in 1,190. In the same year, Ohio disciplined more than 1,600 (1 in 153), and Texas disciplined almost 2,300 (1 in 167). In fiscal 2014, California disciplined over 1,600 nurses, roughly 1 in 325.

"As a professional nurse who is registered in the state of New York, I'm appalled," said Donna Nickitas, the executive officer of the nursing PhD program at the Graduate Center of the City University of New York. "This is [about] the health and welfare of the general public."

The Office of the Professions is an arm of the New York Department of Education. In response to these ratios, a spokeswoman for the education department said that New York's numbers only reflected actions that needed the approval of the Board of Regents. The department did not respond to multiple requests to quantify or elaborate on this.

Even inside the Office of the Professions, concerns have grown so pronounced that one investigator wrote to New York State Sen. Michael Venditto last July about the consequences of not performing background checks on nurses, as well as delays in disciplinary action, letters obtained by ProPublica show. The investigator cited one nurse who was licensed despite a violent criminal history because he never reported it on his application. Another nurse maintained an active license for three years while she awaited trial on charges of selling prescription drugs, the investigator wrote.

In response to a letter from Venditto about the investigator's concerns, New York State Commissioner of Education MaryEllen Elia said in October 2015 that her agency would support background checks and fingerprinting for nurses if state legislators proposed a measure requiring them. (They have not done so.)

But Elia cited an “extraordinarily high” success rate for the investigations completed by the Office of the Professions. “We are very proud of the work the office does and believe that New York’s licensed professionals are among the safest in the country,” Elia wrote in a second letter in December 2015. She did not clarify how she was defining success, and also declined requests to be interviewed.

Peggy Chase, a member of the New York nursing board, the licensing board for nurses that is part of the Office of the Professions, acknowledged the blind spots in the oversight system. She said she did not remember the issue of background checks being raised at any of the board’s meetings. In a phone interview, she conceded that “people can lie and we will never know,” but said the responsibility for spotting and dealing with problem nurses should not fall exclusively on the Office of the Professions.

In an e-mailed response to ProPublica’s findings, Jeanne Beattie, a spokesperson for the education department, acknowledged that the Office of the Professions had limited ability to discipline nurses.

“We are working with the chairs of the Senate and Assembly Higher Education Committees to improve the disciplinary process to include greater authority and tools for the department,” said Beattie.

Quinn could not be reached by phone and did not respond to a letter sent to her most recent address in Florida. The education department declined to comment on Quinn’s discipline record or the cases of any other individual nurses that ProPublica asked about.

In a handwritten statement three days after Maino died, Quinn said she had left her shift that Saturday afternoon believing Maino was stable and resting. “I was not concerned [with] Thomas’s yelling act because that’s what he had been doing for weeks,” she wrote.

Quinn’s disregard for her patient left a lasting impression on her former colleagues. “Whenever I think about what happened that day I get sick to my stomach,” Veronica Barricella, one of the aides who tended to Maino, said in her February 2009 deposition. “I have also had nightmares.”

There may be no better illustration of the value of checking nurses’ criminal histories than the strange tale of Randall Silsby.

Silsby received a New York nursing license in 1992. Five years later, faced with two divorces and child support payments, Silsby decided to solve his “midlife crisis” by faking his own death. He left Niagara Falls for the Dominican Republic, where he paid a lawyer to draw up a fake death certificate and assumed the name of Julio DiMuerte (*muerte* means “death” in Spanish). When he decided to resurrect himself and head back to New York, the federal government charged him with making a material false statement to the government, a felony. He was sentenced to six months in prison in 2001. As a condition of his release, Silsby was ordered to receive mental health treatment.

But in 2002, Silsby was able to renew his New York nursing license and return to work simply by not disclosing his conviction on the renewal application. As is typical, the Office of the Professions didn’t independently seek out records on his criminal past. It only does this if nurses admit they have been convicted of crimes or are accused of wrongdoing, officials say.

Silsby’s scheme only came to light more than a decade later, when state officials investigated a claim that he touched the breasts of a sedated 85-year-old patient at Wilson Medical Center in Johnson City, New York. According to a 2014 nursing board document, Silsby was not disciplined for the sexual abuse allegation, and was suspended for one month for forging his death certificate. His license is still active in New York.

Silsby did not respond to multiple emails or phone calls.

New York's approach to vetting nurses is increasingly out of step with that of other states. In 2005, the National Council of State Boards of Nursing, the trade group representing state nursing boards, issued a report recommending that nursing boards conduct state and federal criminal background checks on all applicants and licensees. "Consumers needing health care are vulnerable. Nursing is a stressful profession. Stress tends to cause bad habits to reappear," it said, adding that it was "appropriate to establish high behavior standards" for nursing applicants.

In the last decade, a majority of state boards have adopted such measures. In 1998, only five states performed background checks on nurses; by 2014, 37 states did them and more were initiating these procedures.

New York not only relies on nurses to self-report criminal convictions, it also only requires them to do so every three years, when they renew their licenses. Other states mandate that nurses report problems far sooner. Florida, for example, requires nurses to report convictions within 30 days. Georgia gives nurses 10 days to report felony convictions. And nurses in Pennsylvania must report criminal convictions as well as pending criminal charges within 30 days.

As Silsby's case demonstrates, in the absence of background checks, nurses aren't always honest. Kathy Thomas, the executive director of the Texas Board of Nursing, said her board instituted background checks and fingerprinting in 2003 after consulting other state boards that discovered many nurses with criminal histories when they stopped relying exclusively on self-reporting.

"We knew self reports were unreliable," Thomas said. When Texas added background checks, the board discovered "serious criminal history that hadn't been disclosed."

According to data provided by the Texas Board of Nursing, the board received just over 4,000 reports filed against Texas nurses in 2004. The state gradually began implementing the fingerprinting system that year. By 2015, the number of reports against nurses had ballooned to almost 14,000, largely as a result of a system that automatically sends reports of criminal convictions and arrests to the nursing board.

David Keepnews, a professor at the Hunter-Bellevue School of Nursing, said background checks and fingerprinting would likely turn up a relatively small number of nurses with serious criminal convictions. But that should not deter New York from pursuing reform, he said.

The "nursing profession as a whole has an interest in ensuring safe nursing care and in maintaining the public's trust," he said. "We should see this as an opportunity to make the practice even safer by working to plug the holes in our disciplinary system."

Even when nurses do report their own misconduct, New York's system falters. The unit within the Office of the Professions that renews licenses is separate from the unit that pursues investigations, so both processes — renewals and investigations — can proceed simultaneously, on separate tracks.

In August 2012, licensed New York nurse Matthew Schroeder was sentenced to three years in prison for selling a drug without a prescription over eBay. The FDA had initiated an investigation after a Georgia teenager who purchased drugs from him died of an overdose.

"I thought what I was doing was legal. I was trying to branch out and become a self-made business man," Schroeder said in a phone interview, explaining that the drug he sold was not listed as a controlled substance.

In April 2015, Schroeder applied to renew his state nursing license, although he was not released from prison until that July. Schroeder said he admitted his conviction on the application but the state renewed his license anyway, though it later informed him it had opened an investigation.

“I think it is completely OK for me to be a nurse. I have always taken great care of my patients,” he said, adding that he expected to pay a fine but continue practicing.

Schroeder voluntarily surrendered his California license in March 2014 while he was in prison because he said he could not be present for the hearing in front of the state board. States share disciplinary actions against their nurses, but Schroeder’s New York license has remained active.

New York nurses who report minor crimes say the Office of the Professions can take years to complete investigations, leaving their professional lives in limbo.

Registered nurse Danielle DiSciullo was nervous when she reported a December 2010 DUI on her renewal application in 2013, and was relieved when her license arrived in the mail the following month. But months later, DiSciullo received a letter informing her that the nursing board was investigating her. State records indicate she had a hearing in May 2014, nine months after she voluntarily disclosed the conviction. She received a month-long suspension the following September.

“It was torture at times; I just wanted to know what was going to happen,” said DiSciullo, whose license is now clear.

Edie Brous, an attorney who represents nurses in front of the Office of the Professions, said DiSciullo’s situation is not uncommon. Many of her clients have been disciplined for minor crimes several years after admitting to them. The drawn-out process ill serves nurses without protecting the public, she said.

“If you believe that this is a licensee that needs to be disciplined in order to protect the public’s safety, you don’t sit on it for six months or a year.”

In most states, nurses are overseen either by health departments or independent nursing boards. In New York, however, the Office of the Professions, like the rest of the Department of Education, comes under the Board of Regents, whose primary responsibility is to oversee the state’s vast public education system.

The education department once oversaw all licensed professionals, but in 1975, the health department assumed authority over doctors and physician assistants after the Board of Regents was criticized for failing to provide adequate oversight. “It has been our experience that the response of the Regents to our investigations has been inaction,” Dr. Lawrence Essenson, chairman of the Medical Society of the County of New York’s Board of Censors, wrote in a 1975 letter quoted by the New York Times.

Under the Board of Regents’ umbrella, there’s a complex disciplinary process for nurses accused of misconduct. First, a member of the state nursing board partners with an investigator for the Office of the Professions to determine what happened and, in some cases, recommend discipline. Then a member of the Board of Regents’ Professional Practices Committee reviews and refines their recommendation. Then the full Board of Regents has to approve the final recommendation at its monthly meeting, along with recommendations for disciplinary action from the other 53 professions overseen by the Office of the Professions.

Regent Wade Norwood, the co-chair of the regents’ Professional Practice Committee, defended this process, saying the layers involved created a more “fair and thorough review.”

But Regent Catherine Collins, the only licensed nurse on the Board of Regents, was concerned by the comparatively few disciplinary actions against nurses approved by the board and felt the board does not have a deep enough understanding of individual professions. She said it was crucial for the regents to pay special attention to professions that care for those who are vulnerable, such as nurses.

"People look for loopholes when they want to commit bad behavior. If there is a hole in our system we need to plug it," Collins said.

Doctors received closer scrutiny after the health department took over their discipline, but legislators say it would be near-impossible to shift authority over nurses.

"There would be a lot of logic to that, but it would be like moving heaven and earth in terms of a legislative task," said Assemblyman Richard Gottfried, who chairs the Assembly Committee on Health and sits on the Committee on Higher Education.

Legislative oversight of nurses falls to higher education committees, so the committees charged with overseeing health have no ability to initiate legislation concerning the profession.

Kemp Hannon, chair of the Senate Standing Committee on Health, said there had been "incredible" resistance from the higher education committee when his committee had attempted to write measures that included nurses.

Some have pointed to budgetary issues as an explanation for the inefficiency of the Office of the Professions. Democrat Deborah Glick, who chairs the state Assembly's Higher Education Committee, said the professions office had been "systematically starved" of finances since it doesn't have the power to raise licensing fees without legislative approval.

But data from the National Council of State Boards of Nursing shows New York's licensure fees are comparable to other states across the country.Ohio charges lower licensing fees than New York but disciplined almost five times as many nurses in 2014. ProPublica requested a breakdown of the Office of the Professions' spending to compare with that of other state nursing authorities, but a spokeswoman was unable to provide one beyond aggregate numbers for revenue and expenses.

The Office of the Professions also does not post disciplinary documents online (as its neighbors, New Jersey, Connecticut and Pennsylvania, do), instead providing short summaries for why nurses have been disciplined on its website. The summary of Silsby's case, for example, simply states that he made a false statement to the government and not that he faked his own death.

While it is routine for states to track the average time it takes to discipline a nurse, New York could not provide this information. Beattie, the education department spokeswoman, said because "there is no average case, it is nearly impossible to define an average time."

While the Office of the Professions has sole authority over nurses' licenses, multiple other agencies have a hand in investigating misconduct by nurses.

The state health department enforces care standards at many types of health facilities, from hospitals to nursing homes. If regulators find facilities have not met nursing requirements, they can levy civil fines and report nurses to the Office of the Professions. The state attorney general's office also tells the Office of the Professions when nurses are convicted of crimes, including cases involving Medicaid fraud.

Still, even when the Office of the Professions is alerted to wrongdoing by other agencies, it re-investigates the allegations from square one.

Between 2013 and 2015, 48 nurses with active licenses were convicted of crimes related to Medicaid fraud investigations, according to data provided by the New York Attorney General's office. All were referred to the Office of the Professions for disciplinary action, yet 17 have not been disciplined. The office has not disciplined a nurse convicted of Medicaid fraud since November 2014.

The Office of the Professions also rarely acts on cases referred over by the health department, ProPublica found. Documents obtained under New York's Freedom of

Information Law show that out of 54 nurses the health department recommended for discipline in 2014, only 13 were disciplined by the end of 2015.

In March 2012, on her first unsupervised day as a nurse, Linda Ansa administered insulin to a resident of the Mary Manning Walsh Nursing Home on Manhattan's Upper East Side. The 99-year-old patient was supposed to receive two units of the drug, but Ansa recorded that she'd administered 100. The nurse who took over on the next shift found the patient with labored breathing, sweating, and unresponsive. It took 24 hours to get her blood sugar back to normal, and days later she was still disoriented. Records show the patient nearly died.

The Health Department investigated. Ansa claimed in a hearing that the entry of "100" was simply a clerical error, and that the patient's symptoms could have reflected her age or other circumstances. In October 2013, a Department of Health administrative judge ruled that Ansa had neglected the patient and therefore violated public health law, though he did not levy a fine. "The Petitioner has been fired from this position and will, in all likelihood, lose her license for her deeds. This is a severe enough penalty for the proven facts of this case," he wrote.

But even though the health department reported Ansa's case to the Office of the Professions in January 2014, no action has been taken on her license since then. When reached by telephone, Ansa declined to comment on the case. A health department spokesperson said in an email that "the New York State Department of Education is responsible for overseeing the Office of the Professions, not [the] State Department of Health."

In addition to receiving reports when other New York agencies sanction nurses, the Office of the Professions is also alerted automatically when other states discipline New York practitioners through NURSYS, a national system run by the National Council of State Boards of Nursing.

But an analysis of disciplinary records in Connecticut, Pennsylvania and New Jersey shows that the Office of the Professions routinely does not sanction New York licensees disciplined by those states. Of 13 nurses disciplined by Connecticut since 2013 who also held active New York licenses, the Office of the Professions has only imposed its own sanction in three cases. In the same time span, it took action against four of 17 nurses disciplined in Pennsylvania who also had active New York licenses and zero out of 26 disciplined in New Jersey.

In March 2012, Heather Graham was summoned before the Pennsylvania nursing board. A physical examination done that month at the board's request showed she was suffering from "opiate dependence in full early remission" as well as ongoing anxiety and depression due to medical and legal problems, Pennsylvania disciplinary records say.

Court records show Graham was arrested with three other nurses in June 2013 for stealing 31 vials of hydromorphone, an opioid pain medication, from a Watertown, N.Y. hospital where she was employed. She then made false entries in the medication dispensing system to cover up the theft, according to the testimony of a narcotics investigator for the state health department.

In August 2013, New York received a notification through NURSYS that Pennsylvania had revoked Graham's license. The following year, Graham was convicted and sentenced to three years' probation in a New York court for falsifying business records and acts prohibited under the public health law.

Yet the Office of the Professions took no action on Graham's New York license until September 2015. At that time, she was fined $500, but her license was not suspended, according to a summary of her disciplinary action. Graham's New York license remains active to this day.

Graham could not be reached for comment through her former attorney.

Cindy Powell, a former nurse who worked for the investigative arm of the Office of the Professions for more than two decades until 2011, said she often handled cases of nurses stealing medications who had already been disciplined by another state. Asked whether New York should screen applicants for out-of-state discipline, she said, “That would have made our job so much easier.”

ProPublica’s analysis turned up several other nurses with troubling records in other states and clear licenses in New York.

Celeste Nwanna voluntarily surrendered her New Jersey license in February 2013 while facing criminal charges for improperly drugging an elderly resident of a group home, landing the patient in the emergency room. She had previously been disciplined in New Jersey for making up entries on a patient’s chart. Two years later she applied for a license in Connecticut and to renew her license in New York. Connecticut denied her application because she lied about her criminal history. New York approved the renewal and Nwanna’s license remains active in the state. (Nwanna could not be reached for comment.)

Diane Posthauer voluntarily surrendered her Connecticut nursing license in February 2015 after she was caught taking oxycodone from her hospital. A few months later, Wyoming and North Carolina revoked her licenses in those states. But the same month that she surrendered her Connecticut license, Posthauer’s license was renewed by New York. New York is the only state where her license remains active.

Contacted by phone, Posthauer said she had been prescribed the drug by a doctor and was not addicted. She said that instead of undergoing an expensive drug treatment program, she decided to retire.

Just after 1 a.m. on a February morning in 2014, a nurse’s aide walked in to find Nanic Aidasani in the bed of a 64-year-old dementia patient at a Bronx nursing home. The nurse was moving his body back and forth on top of the patient, according to a police report. The woman had suffered a stroke, which left her unable to speak. Her gown was found unsnapped and her vagina was exposed, the police report said.

Aidasani was charged with attempted rape, sexual abuse and endangering the welfare of an incompetent person, and the story soon made the local news. The day after his arrest, the National Council of State Boards of Nursing sent a news article to the Office of the Professions to alert it to the incident, a spokeswoman for the NCSBN confirmed.

The Office of the Professions can suspend a nurse’s license on an emergency basis, pending a full hearing, in cases in which it decides someone could pose a serious public safety risk. Aidasani’s case appeared tailor-made for such a step. But for more than a year and a half, Aidasani’s license remained active in New York.

It remained active after Aidasani posted $20,000 bail and walked out of Rikers Island days after his arrest. It was active in April 2015, when he was sentenced to prison and agreed to relinquish his license to the court under the terms of a plea deal. Although the Bronx District Attorney’s office notified the Office of the Professions of his sentence, and Aidasani submitted paperwork to voluntarily surrender his license at the time of his sentencing, his license remained active and reflected no punishment even when he was released from jail in August.

Aidasani’s license was finally revoked in September, and he was deported to the Philippines in November.

Loida Rivera, whose mother was sexually assaulted by a nurse, was surprised by how long it had taken for the nurse's license to be revoked. (Edwin Torres for ProPublica)

"A discipline that takes that long is an injustice," said Barbara Zittel, the former executive secretary to the New York Board of Nursing, when told of Aidasani's case. The Office of the Professions declined to comment on Aidasani's case, other than to say officials had "cooperated fully" with the investigation and his sentencing.

Loida Rivera, the victim's daughter, was surprised to learn it had taken so long for the Office of the Professions to revoke his license. She had been disappointed with the six-month prison sentence and hoped at least his license would be revoked immediately so others wouldn't be hurt.

After the attack, Rivera's mother suffered nightmares and broke out into cold sweats, and it took her months to trust the home health aide that now cares for her. In the first few months, she trembled and clutched onto her diaper when the aide tried to help her change it.

"It's something she is unable to understand because she is disabled," said Rivera. "She just knows something happened to her body."

The family is now suing Manhattanville Health Center, the nursing home that employed Aidasani. The home did not respond to calls about the case.

In the last 10 years, the Office of the Professions has used its emergency suspension powers just twice, according to a review of disciplinary action summaries posted online. Both times, it was in response to a nurse sexually abusing a patient.

By comparison, the Department of Health levied 89 summary suspensions against physicians between 2011 and 2013. Other nursing boards in large states often use this power, saying they view it as a critical tool to protect patients. The Florida board of nursing issued 87 emergency orders against nurses in the 2013–2014 fiscal year, while Michigan filed 134 emergency suspensions in the same period.

These suspensions allow the state "to act quickly to ensure public safety," said Michael Loepp, a spokesman for Michigan's Department of Licensing and Regulatory Affairs. Without them, "a licensee who presents a risk to patients could continue to practice for months before a decision to suspend the license could be reached through the administrative process.".

Florida even created a special unit to handle emergency actions.

New York's education department said that in part, the low number of emergency suspensions against nurses is due to how the law was written.

Unlike other states, which often can issue summary suspensions before a hearing, New York nurses can only be summarily suspended after a hearing and with the approval of the Regents board. This process said Beattie, the education spokesperson, "takes a fair amount of time, which makes it not as an effective tool" when compared to the authority the health department has over its physicians.

Beattie added that the numbers for emergency suspensions do not reflect cases in which the Office of Professions initiated actions and nurses voluntarily surrendered their licenses before this process was finished. She did not say how many such cases there have been.

Even when New York's nurses face accusations of horrible abuse, discipline comes slowly. In April 2015, nurse Oluyemisi Adebayo was accused of killing a 2-year-old toddler by submerging her in a bath so hot that her skin peeled off, police said. The national nursing board trade group sent New York nursing overseers a news notification the day after Adebayo's arrest, a spokeswoman said. But nearly a year later, the state has not taken any action.

The family of the toddler is suing Adebayo and the agency that employed her. Adebayo is currently in jail facing second-degree murder charges. A lawyer for the family, Mark Shaevitz, was surprised to learn that despite the charges, Adebayo's license remains active.

"For someone to do something like this, even to be alleged, and still be able to retain their nursing license is absolutely ludicrous," he said.

Support for this project was provided by the Stabile Center for Investigative Journalism at Columbia University. Reporting research was contributed by Nina Agrawal, Malena Carollo, Darwin Chan, Tyler Daniels, Folasade Falebita, Zoe Kirsch, Alexandra Levine, Liza Lucas, Emily Silber, Miriam Sitz, Tal Trachtman and Mohamad Yaghi. The project was supervised by Columbia University adjunct professor Charles Ornstein, a senior reporter at ProPublica.

Agenda Item

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PDMP REPORT FOR THE BOARD OF NURSING - SEPTEMBER

10/02/2018

Intent:

This report contains high-level information on the Prescription Drug Monitoring Program (PDMP) and is intended to provide a summary of registration and reporting data specific to your profession. This report includes data through September 30, 2018.

Overview:

The PDMP began in 2008 and is housed with the Board of Pharmacy under the Department of Commerce, Community, and Economic Development (DCCED) – Corporations, Business, and Professional Licensing (CBPL) section. Mandatory registration, reviewing, and reporting requirements went into effect in July 2017. All actively licensed practitioners with a valid DEA registration are required to register with the database; however, there are both practice-specific and supply-duration exemptions in AS 17.30.200(k) and (u) in which practitioners are not required to consult the PDMP. Generally, practitioners are required to review patient prescription history before prescribing, administering, and/or directly dispensing a federally scheduled II – IV controlled substance. If directly dispensing, practitioners must report this information to the PDMP on a daily basis. Information on exemptions can be found www.pdmp.alaska.gov under the Registration and Use Exemptions tab and includes information for federally-employed practitioners and pharmacists as well as information on situational exemptions to PDMP use. If mandatory registration and use exemptions do not apply and a licensee fails to register with the PDMP, disciplinary action may be taken by the State Medical Board.

Delegate access is allowed so long as the delegate holds an active license, certification, or registration under AS 08. Delegate access can help relieve time-constraints as reviewing and reporting tasks can be distributed to qualified staff.

With regards to prescriptive guidelines, CBPL's Joint Committee on Prescriptive Guidelines met in 2016 and came up with several recommendations, namely to recommend Washington's prescriptive guidelines, with the exception of reducing from a 120 morphine milligram equivalent (MME) threshold to a 90 MME threshold for consultation with a pain specialist. A summary of the recommendations and a copy of Washington's *Interagency Guideline on Prescribing Opioids* for Pain can be found on the PDMP website at www.pdmp.alaska.gov under the Prescribing Resources tab.

Updates and Imminent changes:

- PDMP fees for initial and continued access went into effect on April 22, 2018 by authority of AS 17.30.200, which was subsequently implemented under 12 AAC 02.107. This requires a $25.00 fee to be submitted before access to the controlled substance prescription database is granted.
- Effective July 1, 2018, applicants seeking licensure and intending to pursue prescriptive authority must complete no less than two hours of education in pain management and opioid use and addiction within two years immediately preceding the date of application. Similarly, licensees with DEA registrations must complete at least two hours of continuing education for license renewal and remain registered with the PDMP (new section to 12 AAC 44 effective August 8, 2018).
- PDMP renewal for Advanced Practice Registered Nurses (PDMP) will be due by 11/30/18; licensees are encouraged to renew within 90 days of this deadline to ensure renewal through 11/30/20.
- Beginning June 2018, the PDMP began separating federal practitioners and pharmacists from non-federal practitioners and pharmacists register by updating user roles, e.g.: 'Nurse

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Practitioner/Clinical Nurse Specialist' to 'IHS Prescriber'. APRNs working under the IHS, VA, or military who hold an active Alaska license, has controlled substance prescriptive authority, and an active personal DEA registration are still required to register with the PDMP.

- Beginning June 2018, all newly registered and renewed PDMP users are issued separate PDMP registration numbers and are searchable by name under the program 'Prescription Drug Monitoring Program' at: https://www.commerce.alaska.gov/cbp/main/Search/Professional

Data:

The Alaska State Board of Nursing regulates several license types, including registered nurses, licensed practical nurses, and advanced practice registered nurses (certified nurse practitioner, certified nurse anesthetist, clinical nurse specialist, and certified nurse midwife). All licensees required to register with the PDMP register using the user role 'Nurse Practitioner/Clinical Nurse Specialist'. As of September 30, 2018, there are a total of 6,375 registered users, 879 of which are Nurse Practitioners/Clinical Nurse Specialists "APRNS" (Figure 1). While APRNs represent the top three professions of registered users, the proportion of total licensed APRNs with the PDMP is 14% and have reached 69% registration compliance (Figure 2). Additional licensed pharmacists not represented under the 'Pharmacist' user role may be inclusive of other dispenser roles, including IHS Dispenser or VA Dispenser; the compliance rate may be higher than depicted in Figure 2 due to registration under other relevant user role categories.

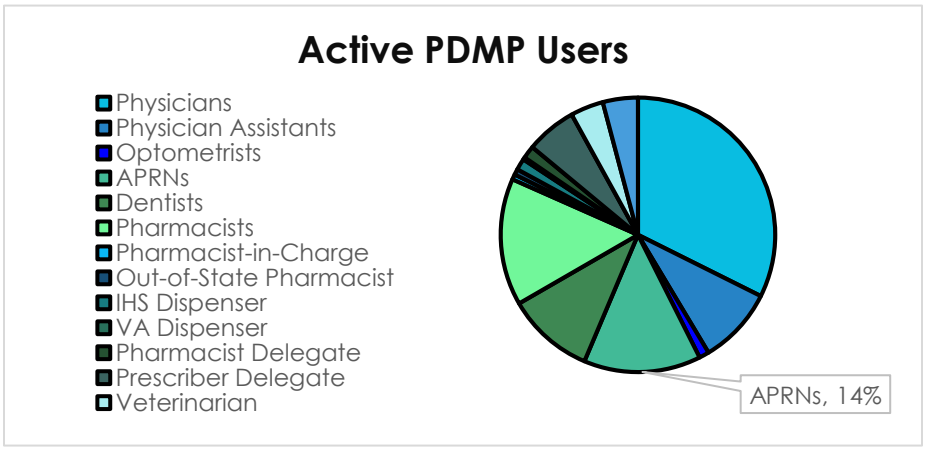

Figure 1. APRNs make up 14% of total registered PDMP users. *Other includes IHS, VA, and military prescribers and dispensers, admin, medical residents, coroners, and out-of-state pharmacists. The number of APRNs inclusive in the 'Other' category is not known.

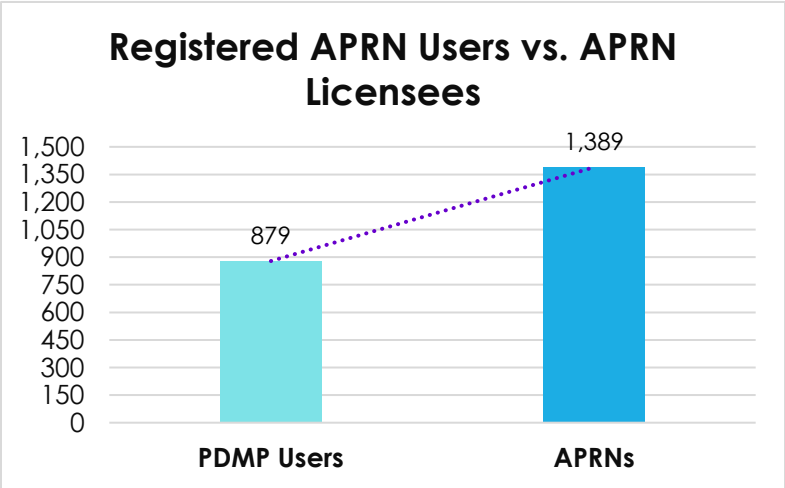

Figure 2. The proportion of licensed APRNs with controlled substance prescriptive authority to registered PDMP users. This represents a compliance rate of 63%, meaning 37% of licensees potentially required to register are not yet registered. This figure is an estimation as the exact number of APRNs with federal Drug Enforcement Agency registrations is not known; the Board of Nursing issues separate controlled-substances prescriptive authority designations, which provides an indicator of the closest approximation to compliance rates. Additionally, some APRNs may be registered under federal user roles.

Contact: Laura Carrillo, PDMP Manager | 907-269-8404 (phone) | akpdmp@alaska.gov

The next two graphs (Figures 3 and 4) reflect the interaction activities of APRNs captured from January 2017 to September 2018.

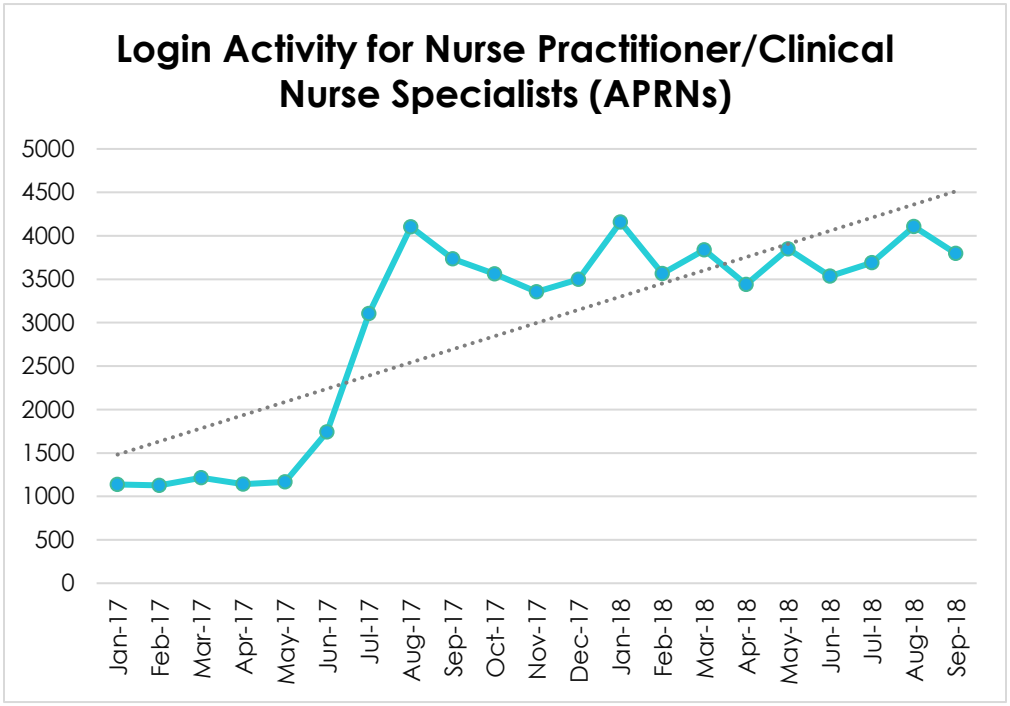

Figure 3. Login activity for APRNs has been on a steady incline since 2017, demonstrating increased compliance with PDMP utilization.

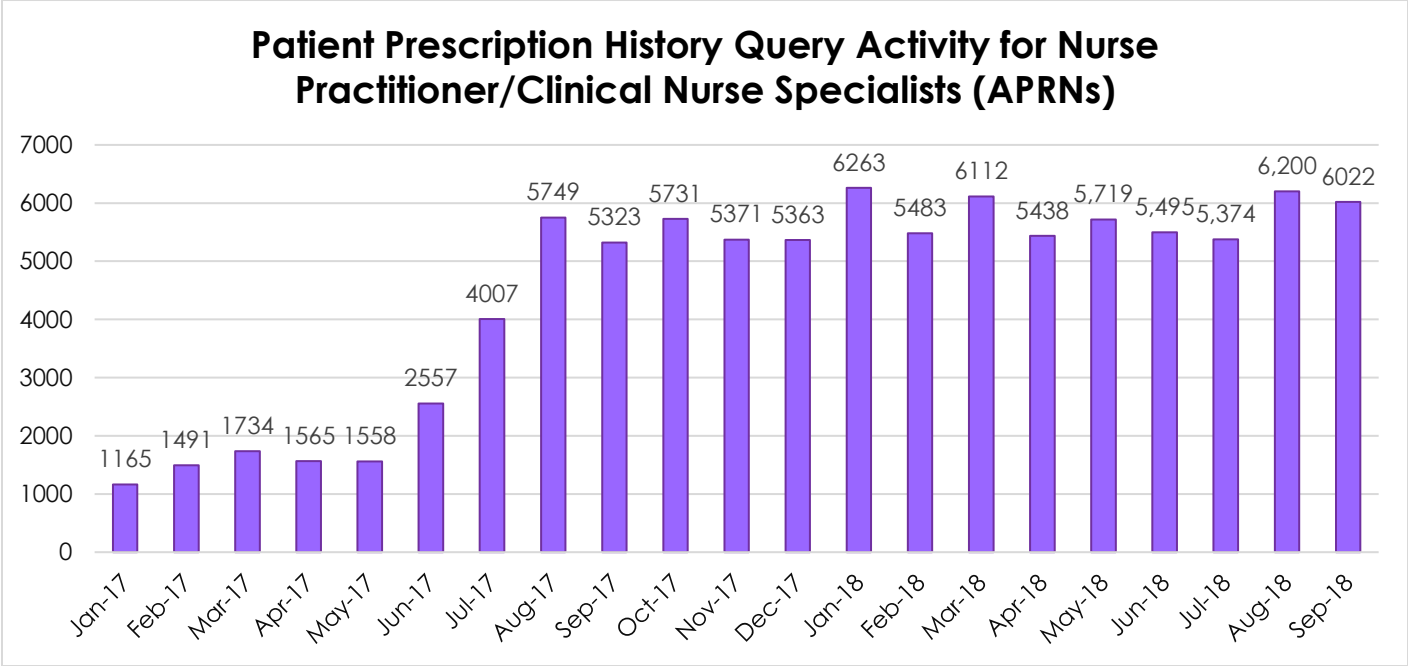

Figure 4. Patient prescription history queries have increased substantially over the last year with a 437.6% increase from the beginning of the year in 2017 to the beginning of the year in 2018, owing to mandatory reviewing requirements effective July 2017. Rx queries peaked in January 2018 with 6,263 requests.

Contact: Laura Carrillo, PDMP Manager | 907-269-8404 (phone) | akpdmp@alaska.gov

Figure 5 below shows the number of morphine milligram equivalents (MME) prescribed (subsequently dispensed) by profession. MMEs is a standardized measurement used to represent the potency of opioids but excludes buprenorphine as a partial opioid agonist.

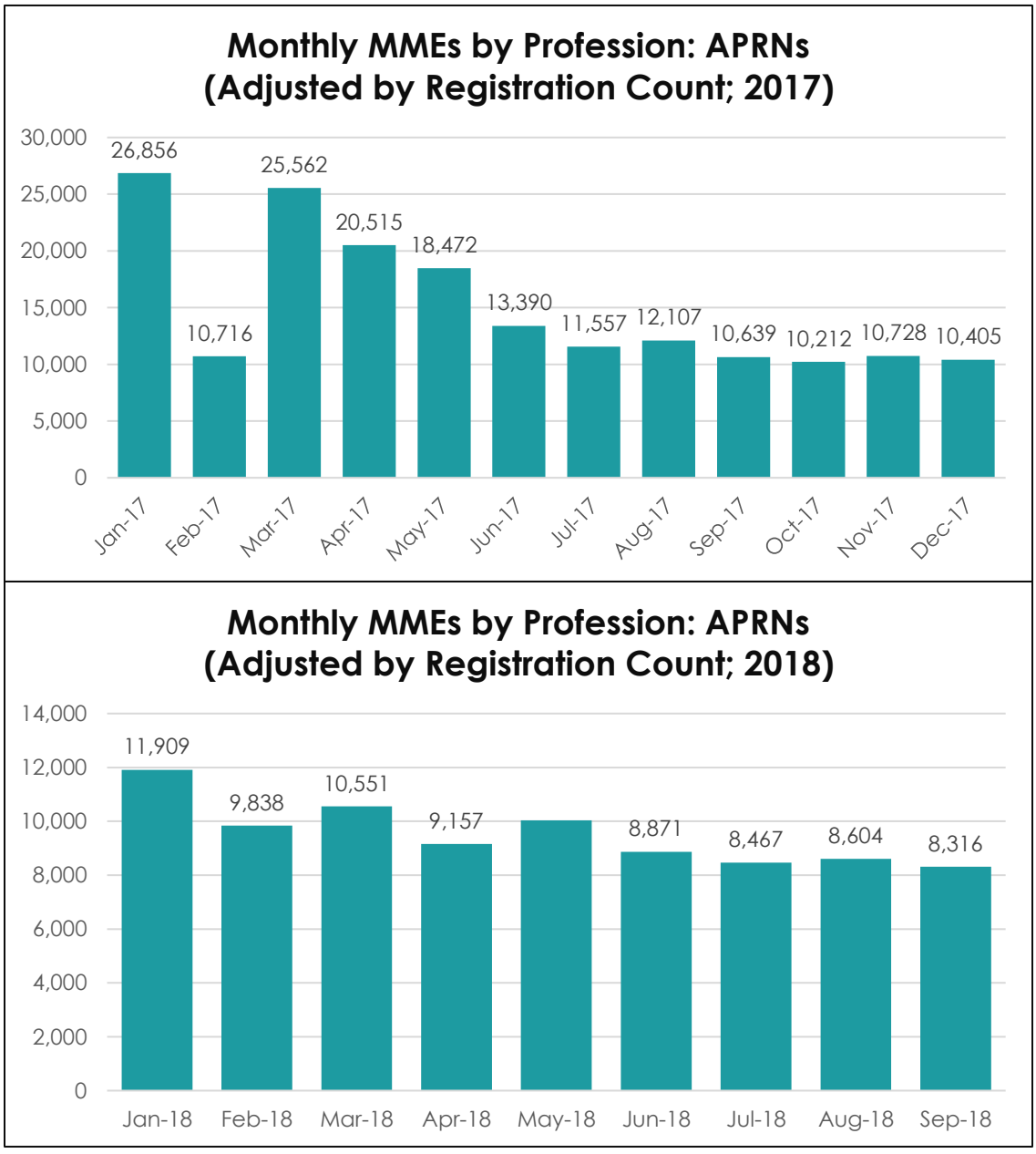

Figure 7. MMEs per month by profession and adjusted by registration count.

The following data (Figures 6 through 8) represents information not specific to any given profession and provides a general summary of PDMP trends as recorded in the controlled substance prescription database.

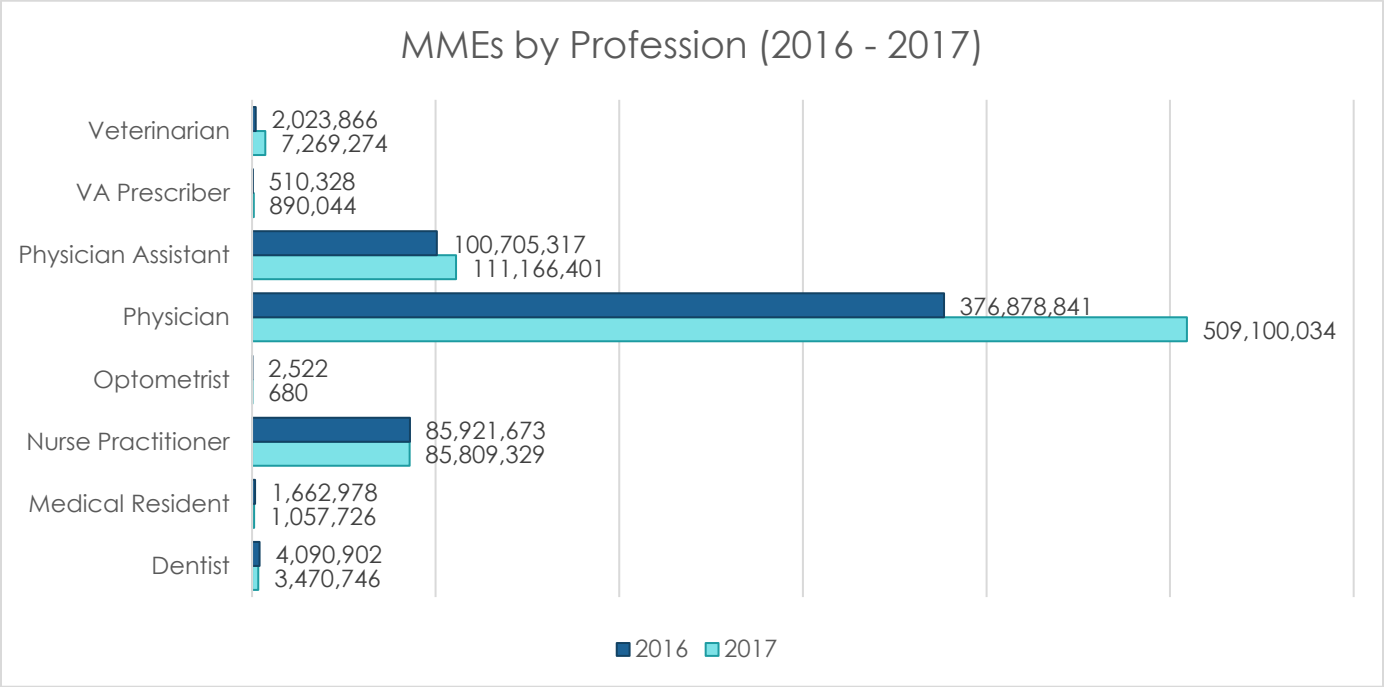

Figure 6. Of the total MMEs dispensed in 2016, 15% originated from prescriptions written by APRNs with controlled substance prescriptive authority. This represents a relative decrease of .13% since 2017, where these practitioners prescribed 11.9% of total MMEs dispensed.

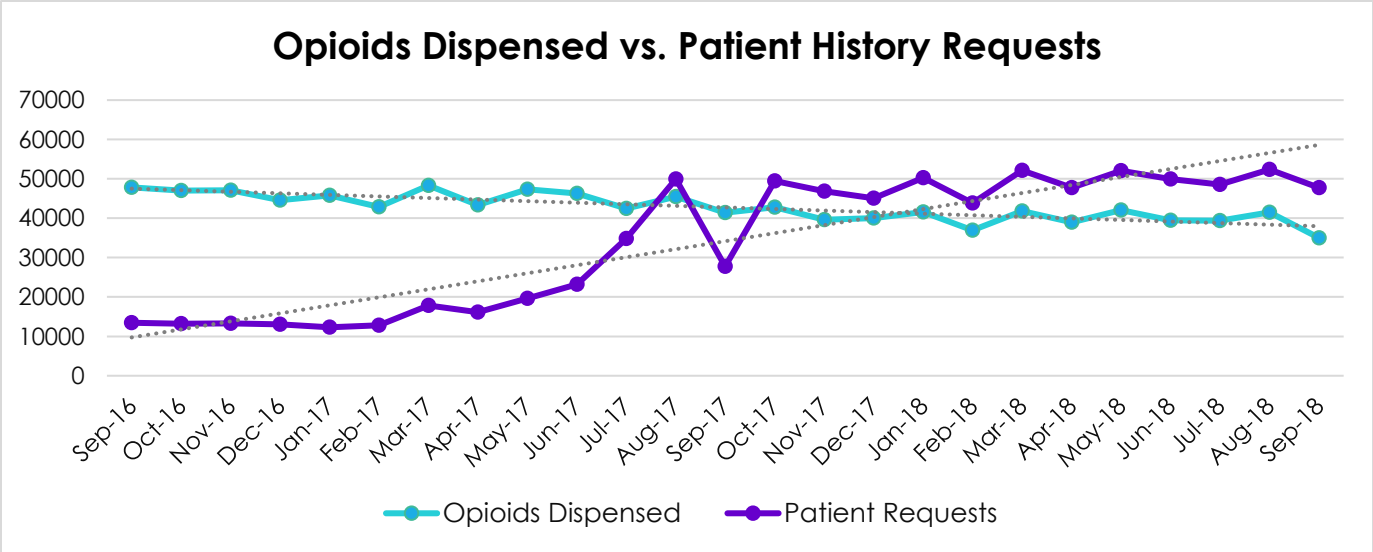

Figure 7. This graph shows the upward trend of patient prescription history requests in the PDMP, suggesting an inverse relationship between overall opioid dispensing in the state. The decrease in opioid dispensations may also be attributed to other factors, including prescriptive policies and salience of increased state-wide monitoring of prescribing practices as reflected in individual prescriber report cards.

Contact: Laura Carrillo, PDMP Manager | 907-269-8404 (phone) | akpdmp@alaska.gov

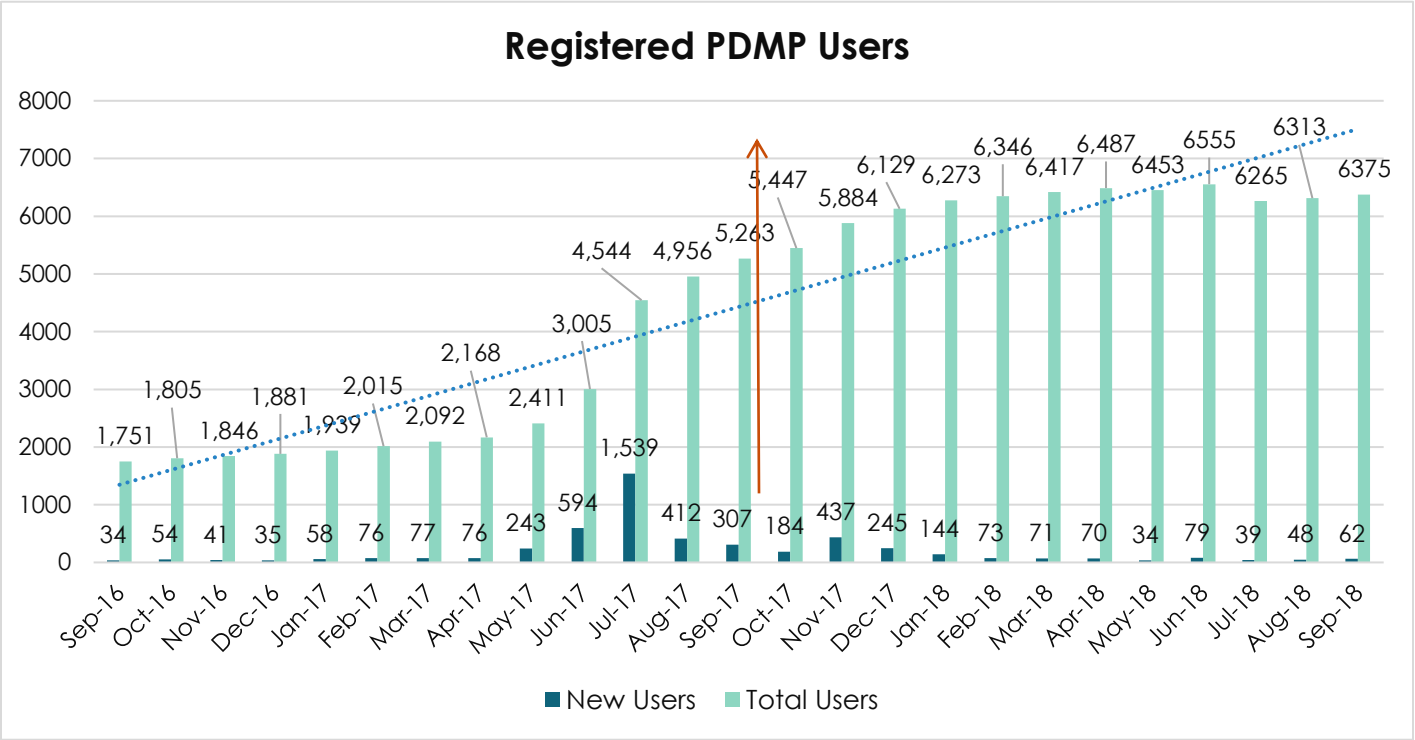

Figure 8. Registered users have steadily increased. New registrations peaked with 1,539 new practitioners and pharmacists, coinciding with the mandatory registration date of July 2017. The increase of new registrations for May and June may not correlate with the total number of registered users as PDMP registrations were deactivated and user roles changed due to filtering and clean-up processes beginning June 2018 for registration renewal.

Agenda Item

20

THE NATIONAL FORUM
OF STATE NURSING WORKFORCE CENTERS

111 E. Wacker Drive, Suite 2900 · Chicago, IL 60601-4277

Gail Bernth
550 West Seventh Avenue
Suite 1500
Anchorage, Alaska 99501

Dear Gail Bernth:

The National Council of State Boards of Nursing (NCSBN) and The National Forum of State Nursing Workforce Centers are thrilled to share with you state-level data from the 2017 National Nursing Workforce Study. Since 2013, we have collected essential information on the supply of registered nurses (RNs) and licensed practical/vocational nurses (LPNs/VNs) in the United States. Responses from 48,704 RNs and 40,272 LPN/VNs, are indicative of an increasingly younger, slightly more diverse and educated workforce.

The attached file includes nursing workforce information on demographics, educational attainment, employment, telehealth and more in your individual state. Having access to these data not only allows your state to uncover workforce trends, but also forecast for the future of nursing. Look for complete study results in the October 2018 issue of the Journal of Nursing Regulation. If you have any questions or concerns, please contact NCSBN at research@ncsbn.org.

Sincerely,

Richard A. Smiley, MS, MA
Statistician
The National Council of State Boards of Nursing

Cynthia Bienemy, PhD, RN
President
The National Forum of State Nursing Workforce Centers

312.525.3600
ncsbn.org

NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.

Minutes of the 40th Annual Delegate Assembly

August 15-17, 2018 • Minneapolis, MN

First Business Meeting • Wednesday, August 15, 2018

Call to order

The first business meeting of the 40th Annual Delegate Assembly of the National Council of State Boards of Nursing was called to order at 9:30 am at the Minneapolis Hilton, Minneapolis, Minnesota by President Kathy Thomas.

The national flag was honored by the singing of the national anthem of the United States of America by the Twin Cities Women's Choir.

Welcome

President Thomas presented opening remarks and greetings. She then recognized and welcomed all first-time attendees and asked them to stand.

Introductions

President Thomas then introduced the following past presidents of the Board of Directors:

Shirley Brekken - MN
Myra Broadway - ME
Donna Dorsey - MD
Faith Fields - AR
Marcia Rachel - MS
Laura Rhodes - WV-RN
Joey Ridenour - AZ
Joyce Schowalter - MN

President Thomas then introduced past members of the Board of Directors:

Kathleen Dwyer - RI
Joe Baker - FL
Betsy Houchen - OH
Randall Hudspeth - ID
Polly Johnson - NC
Rose Kearney-Nunnery - SC
Mark Majek - TX
Suellyn Masek - WA
Paula Meyer - WA
Susan Odom - ID
Ellen Watson - VT

President Thomas then introduced Kathy Apple, Past Chief Executive Offer of NCSBN.

The following special guests were introduced:

American Association of Colleges of Nursing
Joan Stanley

American Association of Nurse Anesthetists
Anna Polyak

American Nurses Association
Loressa Cole

American Organization of Nurse Executives
Bob Dent

CGFNS International, Inc.
Franklin A. Shaffer

Federal Nursing Service Council, American Red Cross
Sharon Stanley

National Forum of State Nursing Workforce Centers
Sofia Aragon

National Student Nurses' Association
Diane Mancino

Organization for Associate Degree Nursing
Donna Meyer

President Thomas recognized and welcomed associate members. She then introduced the following regulatory colleagues including:

Federation of State Medical Boards (FSMB)
Dr. Humayan "Hank" J. Chaudhry, CEO
Dr. Pat King, President

President Thomas then recognized international and US territorial nursing regulatory colleagues who were present including:

Nursing and Midwifery Council of Botswana
Registrar, Hannah Kau-Kigo

Nursing Council of Jamaica
Council Chair, Dr. Leila McWhinney-Dehaney

Nursing Council of Trinidad and Tobago
President, Mr. David Murphy

Oman Ministry of Health
Director General of Nursing Affairs, Dr. Majid Al-Maqbali

Puerto Rico Board of Nursing
President, Dr. Carmen T. Lopez

Republican Center for Health Development of Kazakhstan
General Director, Ainur Aiypkhanova

Thailand Nursing and Midwifery Council
President, Tassana Boontong

Board of Directors

Members of the 2018 Board of Directors seated at the head table were:

Director-at-Large, Libby Lund - TN
Director-at-Large, Lori Scheidt - MO
Director-at-Large, Valerie Smith - AZ
Director-at-Large, Karen Scipio-Skinner - DC
Area IV Director, Valerie Fuller - ME
Area III Director, James Cleghorn - GA
Area II Director, Adrian Guerrero - KS
Area I Director, Cynthia LaBonde - WY
Treasurer, Gloria Damgaard - SD
President-elect, Julie George - NC
President, Katherine Thomas - TX

Staff

Staff seated at the head table were:

Legal Counsel, Tom Wilde
Chief Executive Officer, David Benton
Parliamentarian, Dr. Leonard M. Young

President Thomas recognized and thanked the following Delegate Assembly committees and their members:

Credentials Chair
Kaci Bohn - AR

Committee to Approve the Minutes
Pam Hagan - KY
Blair Train - GA

Elections Committee
Kristin Benton, Chair – TX, Area 3
Carrie Nutsch – ID, Area 1
Rene Cronquist – MN, Area 2
Angela Ellis – NC, Area 3
Gary Hicks – MD, Area 4

Resolutions Committee
Jennifer Burns, Chair – WY, Area 1
Charity Cooper – IL, Area 2
Christie Mumford – AL, Area 3
Phyllis Mitchel – VT, Area 4

President Thomas reviewed Delegate Assembly rules and procedures, and identified staff ushers, timekeepers and their duties. She announced that convention parliamentarian Dr. Leonard M. Young would be holding office hours in the Directors Row 1 room from 3:00-5:30 pm on Wednesday, August 15 and from 2:00-3:30 pm on Thursday, August 16 to answer any questions members might have.

The Chair further announced that the Resolutions Committee would meet at 3:30 p.m. on Thursday, August 16, 2018 in Board Room 3 to consider submitted motions and resolutions. The makers of resolutions/motions were required to attend the Resolutions Committee meeting.

Electronic Voting Instructions and Mock Voting

President Thomas explained the electronic voting procedure that would be utilized. Mock voting exercises were performed. Delegates were instructed to leave the voting devices in the room at the end of each business meeting.

Election Announcement

The Chair announced that elections would be held Thursday, Aug. 16, 2018, at 8:30 am and indicated that an election committee member and NCSBN lead election staff member would be stationed at the front of the room to answer any questions. Voting delegates were instructed to be in the room at 8:30 am sharp to vote. It was indicated that following voting there would be a one-hour education session during which time the Elections Committee would meet to verify election results and that election results would be announced immediately following that session during the Delegate Assembly meeting at 10:00 a.m.

Board of Directors Dialogue Session

President Thomas announced that the Board of Directors dialogue session entitled "What's on Your Mind about the Future of Nursing Regulation? Q&A with the NCSBN Board of Directors" would take place on Thursday, August 16, 2018 at 11:30 a.m. using a social Q&A platform for submitting questions.

Remarks by Mayor of St. Paul

Melvin Carter, Mayor of St. Paul then addressed the delegates and welcomed them to Minnesota. He congratulated NCSBN on its 40th Anniversary. The Mayor spoke about issues facing Minnesota and the importance of education and health. He thanked the members of NCSBN for their work in providing an excellent regulatory environment to promote outstanding nursing care to the patients of the nation.

Remarks by CEO David Benton

President Thomas introduced CEO David Benton who welcomed the attendees to Minneapolis and then made several administrative announcements concerning being recognized to speak during meetings of the Delegate Assembly and how to use the electronic Business Book. He further gave information about the NCSBN meeting app and continuing education (CE) contact hours available as well as the electronic check-in system for CE contact hours. Mr. Benton then announced that the Founders' Luncheon would take place on August 15, 2018 in the Grand Ballroom ABC and that networking sessions are scheduled for Thursday, August 16, 2018 from 12:00 noon to 3:30 p.m.

Mr. Benton concluded by introducing the members of the Resolutions Committee and describing the use of the forms that were available for submitting proposed resolutions.

Credentials Committee Report
Kaci Bohn, chair of the Credentials Committee, called the roll of delegates. Following the roll call the chair of the committee reported that as of 9:30 a.m. there were 116 delegates representing 58 boards of nursing in attendance. The following board was absent: New York.

On behalf of the Credentials Committee, Kaci Bohn moved that the roll of delegates just submitted be the official roll of the voting members of the Delegate Assembly. The motion was **adopted** by a vote of 110 (100%) in the affirmative and 0 (0%) in the negative.

Quorum
There being delegates from more than a majority of their member boards and at least two officers present, President Thomas declared a quorum present.

Standing Rules
The Chair recognized Treasurer Gloria Damgaard who made reference to page 295 in the *Business Book* and who, on behalf of the Board of Directors, moved adoption of the Standing Rules as printed in the *Business Book*. The Standing Rules were **adopted** as printed by the required two-thirds (2/3rds) vote with a vote of 102 (99.1%) in the affirmative and 1 (.9%) in the negative.

Business Agenda
At this juncture, the Chair recognized Area I Director Cynthia LaBonde who made reference to page 11 in the *Business Book* and who, on behalf of the Board of Directors, moved adoption of the Business Agenda as printed in the *Business Book*. The Business Agenda as printed was **adopted** by a vote of 105 (100%) in the affirmative and 0 (0%) in the negative.

2017 Delegate Assembly Minutes
President Thomas announced that the minutes of the 2017 Delegate Assembly were determined to be complete and accurate by the Committee to Approve the Minutes and were distributed to member boards last September.

2018 Minutes Review Committee
President Thomas appointed the following persons as the Committee to Approve the Minutes of the 2018 Delegate Assembly:
Pam Hagan - KY
Blair Train - GA
Chief Executive Officer, David Benton, corporate secretary
Dr. Leonard Young, Parliamentarian.

Leadership Succession Committee Report
President Thomas recognized Committee Chair Tony Graham who made reference to page 52 in the *Business Book* and presented the following Board of Directors candidates for a two-year term:

President-elect:
Jim Cleghorn, GA, Area III
Paula Meyer, Washington, Area I

Director-at-Large (4 Positions) (two-year terms)
Peggy Benson, AL, Area III
Cathy Borris-Hale, DC, Area IV

Tammy Claussen Vaughn, AR, Area III
Ann Coughlin, PA, Area IV
Elizabeth Lund, TN, Area III
Mark Majek, TX, Area III
Lori Scheidt, MO, Area II
Sharyl Toscano, AL, Area I
Ellen Watson, VT, Area IV

Nominations from the Floor

Following each position, the Chair opened the floor for further nominations. Nominations from the floor were received as follows:

President-elect:

There were no nominations from the floor.

Directors-at-Large:

There were no nominations from the floor for director-at-large positions.

Nominations for the Leadership Succession Committee

President Thomas then asked for the Committee Chair Tony Graham to present candidates for the Leadership Succession Committee. He made reference to page 314 in the *Business Book* for a proviso on the Leadership Succession Committee election schedule. The following were presented as candidates for the terms indicated as provided in the provision adopted in 2017:

Area I (one-year term): VACANT

Area II (two-year term): Lori Glen and Melissa Hanson.

Area III (one-year term): Sandra Culpepper and Sara Griffin.

Area IV (two-year term): VACANT

The Chair then asked if there were any nominations for any of these positions from the floor.

Area I: None Received

Area II: None Received

Area III: None Received

Area IV: Jennifer Laurent, VT was nominated from the floor.

The Chair thanked the 2018 Leadership Succession Committee for compiling the slate and indicated that the candidates' forum would be held at 2:45 pm August 15, 2018 and that elections would be conducted by electronic ballot on Thursday, August 16, 2018 at 8:30 a.m. President Thomas reminded delegates that no electioneering for candidates was allowed in the vicinity of the polling place and that in the case of a runoff, the need for re-balloting would be announced immediately following voting and delegates would re-vote at that time.

Adjournment

At 10:25 a.m., without objection, President Thomas declared the Delegate Assembly adjourned for the day to meet again at 10:00 a.m., Thursday, August 16, 2018.

Second Business Meeting • Thursday, August 16, 2018

Call to Order

President Kathy Thomas called the second business meeting of the 2018 Delegate Assembly to order at 10:00 a.m. on Thursday, August 16, 2018.

Credentials Committee Report

The first item of business was the consideration of the second credentials report given by Kaci Bohn, chair of the Credentials Committee. The committee reported that as of 9:30 a.m. there were 118 delegates representing 59 boards of nursing in attendance.

On behalf of the Credentials Committee, Kaci Bohn moved that the roll of delegates just submitted be the official roll of the voting members of the Delegate Assembly. The motion was **adopted** by a vote of 112 (99.2%) in the affirmative and 1 (.8%) in the negative.

Quorum

There being delegates from more than a majority of their member boards and at least two officers present, President Thomas declared a quorum present.

Report of the Elections Committee

The Chair recognized Kristin Benton, chair of the Elections Committee, who reported that the elections had been conducted using electronic devices and that the number of votes each candidate received will be listed in a printed report which will be included as an addendum **(See Attachment A)** to the minutes of this meeting.

Announcement of the Election Results

Then, on behalf of the Elections Committee, Chair Kristin Benton reported that the following persons had been elected to the offices indicated:

President-elect: Jim Cleghorn

Director-at-Large (4 Positions for 2-year terms): Elizabeth Lund, Mark Majek, Lori Scheidt, Cathy Borris-Hale

Election of Leadership Succession Committee Members

Kristin Benton, chair of the Elections Committee, then reported that the Area I position will be filled as a vacancy according to the provisions of Article VII, Section 1e of the NCSBN Bylaws. She then reported that the following persons were elected as members of the Leadership Succession Committee for a two-year term:

Area II Member: Melissa Hanson

Area III Member: Sara Griffith

Area IV Member: Jennifer Laurent elected by acclamation.

President Thomas then **declared of the persons listed above duly elected** to the positions indicated and thanked the Elections Committee for their work.

Adjournment for the Day

At 10:03 a.m., without objection, President Thomas declared the Delegate Assembly adjourned for the day to meet again at 11:00 a.m., Friday, August 17, 2018.

Third Business • Meeting Friday, August 17, 2018

Call to Order

President Kathy Thomas called the third business meeting of the 2018 Delegate Assembly to order at 10:55 a.m. on Friday, August 17, 2018.

Credentials Committee Report

The first item of business was the consideration of the third credentials report given by Kaci Bohn, chair of the Credentials Committee. The committee reported that as of 10:30 a.m. there were 118 delegates representing 59 boards of nursing in attendance. On behalf of the Credentials Committee, Kaci Bohn moved that the roll of delegates just submitted be the official roll of the voting members of the Delegate Assembly. The motion was **adopted** by a vote of 105 (100%) in the affirmative and 0 (0%) in the negative.

Quorum

There being delegates from more than a majority of the member boards and at least two officers present, President Thomas declared a quorum present.

Terms and Conditions of NCSBN Exam User Membership

The Chair recognized President-elect Julie George who referenced page 28 in the *Business Book*. On behalf of the Board of Directors, President-elect George moved to adopt the Terms and Conditions of NCSBN Exam User Membership. The motion was **adopted** by a vote of 106 (99.1%) in the affirmative and 1 (.9%) in the negative.

College of Registered Nurses of British Columbia – Exam User Member

The Chair recognized Director-at-Large Karen Scipio-Skinner who called attention to page 31 in the *Business Book*. On behalf of the Board of Directors, Director Scipio-Skinner moved that the College of Registered Nurses of British Columbia be approved as an Exam User Member of NCSBN. The motion was **adopted** by a vote of 107 (100%) in the affirmative and 0 (0%) in the negative.

College of Registered Nurses of Manitoba – Exam User Member

The Chair recognized Area IV Director Valerie Fuller who called attention to page 34 in the *Business Book*. On behalf of the Board of Directors, Director Fuller moved that the College of Registered Nurses of Manitoba be approved as an Exam User Member of NCSBN. The motion was **adopted** by a vote of 107 (100%) in the affirmative and 0 (0%) in the negative.

College of Nurses of Ontario – Exam User Member

The Chair recognized Director-at-Large Val Smith who asked the delegates to turn to page 37 in the *Business Book*. On behalf of the Board of Directors, Director Smith moved that the College of Nurses of Ontario be approved as an Exam User Member of NCSBN. The motion was **adopted** by a vote of 107 (100%) in the affirmative and 0 (0%) in the negative.

National Center for Independent Examination – Kazakhstan – Associate Member

The Chair recognized Area II Director Adrian Guerrero who asked the delegates to turn to page 85 in the *Business Book*. On behalf of the Board of Directors, Director Guerrero moved that the National Center for Independent Examination – Kazakhstan be approved as an Associate Member of NCSBN. The motion was **adopted** by a vote of 104 (98.2%) in the affirmative and 2 (1.8%) in the negative.

2019 NCLEX-RN Test Plan

The Chair recognized NCLEX Committee Chair Betsy Houchen who referred the delegates to page 85 of the *Business Book*. On behalf of the NCLEX Committee Chair Houchen moved that the 2019 NCLEX-RN Text Plan be adopted. The motion was **adopted** by a vote of 106 (100%) in the affirmative and 0 (0%) in the negative.

New Business

President Thomas indicated there was one item of new business and recognized Resolutions Chair, Jennifer Burns who stated that the proposed item of new business had been reviewed by the committee and found to be in accordance with the established review criteria as outlined in the Standing Rules of the Delegate Assembly.

Linda Young (South Dakota) moved the following resolution:

> Whereas, The APRN Consensus Model is ten years old; and
>
> Whereas, Inconsistencies exist in the regulatory interpretation and implementation of the model among various states; and
>
> Whereas, The 2017 NCSBN APRN Roundtable Meetings revealed these inconsistencies; therefore, be it
>
> ***Resolved,*** That NCSBN convene a forum of state board regulators with expertise in APRN issues to discuss these inconsistencies as well as challenges and strategies; and be it further
>
> ***Resolved,*** That following this forum, the NCSBN Board of Directors evaluate how to address the challenges Boards of Nursing are experiencing in relation to the implementation of the APRN Consensus Model; and be it further
>
> ***Resolved,*** That the progress of these activities be reported to the 2019 NCSBN Annual Meeting.

The resolution was seconded by Laura Hudson (Iowa).

After debate, the resolution was **adopted** by a vote of 106 (99.1%) in favor and 1 (.9%) opposed.

Recognition of Outgoing Board Members

President Thomas then led the assembly in recognizing outgoing Board of Directors members Karen Scipio-Skinner and Val Smith for outstanding service to NCSBN.

The President offered the following: "The National Council of State Boards of Nursing and its membership bear witness to the dedication, imagination and foresight of your leadership. We thank you for the time, ability and interest that you have generously shown through the year. We would like to express our appreciation with the following resolution:

> WHEREAS, You have upheld the mission of NCSBN to lead in nursing regulation, and to promote safe and effective nursing practice in the interest of protecting public health and welfare; and
>
> WHEREAS, You have demonstrated qualities of service, integrity, accountability, expertise, courage, progressiveness and open-mindedness; and

WHEREAS, You have contributed to the strength of NCSBN by promoting collaborative relationship with Members Boards working synergistically and helping them to build upon expertise within the membership; therefore, be it

RESOLVED, That the members of the National Council of State Boards of Nursing express their sincere appreciation for the service and dedication you have shown to this organization.

A plaque of appreciation was presented to the retiring board members and the assembly rose and adopted the resolution of appreciation unanimously.

Introduction of Officers and Board Members

President Thomas introduced and welcomed those officers and board members elected earlier to serve on the 2018-2019 Board of Directors. The delegates then expressed their appreciation in applause. The President asked the continuing directors to stand. All were acknowledged in applause.

Presentation of the Gavel

President Thomas asked incoming president Julie George to come forward. The president thanked Julie for her help and support during the past nine years she had served on the board of directors. The president then passed the president's gavel to the incoming president. The assembly rose in applause.

President's Ceremonial Pin

Julie George then presented the Presidential Ceremonial pin and a crystal gavel to outgoing NCSBN President Kathy Thomas. The assembly again rose in applause.

Announcement

President Thomas announced that the 41st Annual Meeting of NCSBN will be held August 21-23, 2019 in Chicago, Illinois.

Adjournment

There being no further business to come before the Delegate Assembly, President Thomas declared the 40th Annual Session of the National Council of State Boards of Nursing adjourned *sine die* at 11:21 a.m.

Dr. Leonard M. Young
Secretary Pro Tem

Committee to Review and Approve the Minutes:

Leonard M. Young — 9/13/18 Date

Blair Train — 9/18/18 Date

Pamela C. Hagan — 9/21/18 Date

Dan Jo Bowen — 10/2/18 Date

National Council of State Boards of Nursing						
2018 Election Committee Report - Main Election						
Total Number of Eligible Ballots: 118			Area I: 34	Area II: 30	Area III: 28	Area IV: 26
Board of Directors						
President-elect						
Number of Ballots cast:	114		Number necessary for election:			58
Jim Cleghorn	71	Georgia	Area III			Elected
Paula Meyer	43	Washington	Area I			
Director-at-Large (Four positions)						
Number of Ballots cast:	111		Number necessary for election:			56
Peggy Benson	26	Alabama	Area III			Run-Off
Cathy Borris-Hale	44	District of Columbia	Area IV			Run-Off
Tammy Claussen Vaughn	18	Arkansas	Area III			
Ann Coughlin	24	Pennsylvania	Area IV			
Elizabeth Lund	68	Tennessee	Area III			Elected
Mark Majek	65	Texas	Area III			Elected
Lori Scheidt	63	Missouri	Area II			Elected
Sharyl Toscano	24	Alaska	Area I			
Ellen Watson	21	Vermont	Area IV			
Leadership Succession Committee						
Area I Member						
Number of Ballots cast:	NA		Number necessary for election:			Plurality
Vacant						
Area II Member						
Number of Ballots cast:	99		Number necessary for election:			Plurality
Lori Glenn	29	Michigan	Area II			
Melissa Hanson	70	North Dakota	Area II			Elected
Area III Member						
Number of Ballots cast:	107		Number necessary for election:			Plurality
Sandra Culpepper	37	Mississippi	Area III			
Sara Griffith	70	North Carolina	Area III			Elected
Area IV Member						
Number of Ballots cast:	NA		Number necessary for election:			Plurality
Jennifer Laurent		Vermont	Area IV			Elected
Kristin Benton 8/16/18					Witnessed By	
Kristin Benton, Chair, Elections Committee 08/16/2018						

Angela Ellis 8/16/18

8/16/18

8/16/18

National Council of State Boards of Nursing						
2018 Election Committee Report - Run-off For Director-at-Large						
Total Number of Eligible Ballots: 118			Area I: 34	Area II: 30	Area III: 28	Area IV: 26
Director-at-Large (**enter number** position)						
Number of Ballots cast:	107		Number necessary for election:			54
Peggy Benson	39	Alabama	Area III			
Cathy Borris-Hale	68	District of Columbia	Area IV			Elected

Kristin Benton 8/16/18
Kristin Benton, Chair, Elections Committee 08/16/2018

Witnessed By

Angela Ellis 8/16/18

8/16/18

Rene Cranfield 8/16/18

From: NCSBN
To: Bernth, Gail A (CED)
Subject: Good Morning Members
Date: Thursday, October 11, 2018 9:59:54 PM

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Oct. 12, 2018

Congress Passes Opioid Legislation

Congress recently passed the Substance Use-disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. NCSBN posted a policy briefing on the new legislation. The SUPPORT for Patients and Communities Act grants permanent authority for nurse practitioners (NP) and physician assistants to prescribe buprenorphine through medication-assisted treatment (MAT), permanently extending authority granted originally by the 2016 Comprehensive Addiction and Recovery Act (CARA). Nurse practitioners are now eligible to treat up to 275 patients, an increase from 100 patients per year under CARA.

In addition, clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs) and certified nurse midwives (CNMs) were given the MAT prescribing authority for a period of five years. The secretary of Health and Human Services and the Drug Enforcement Administration will be required to write a report within two years of this legislation detailing the treatment of individuals receiving MAT by qualifying practitioners. There are also multiple provisions in the legislation pertaining to telehealth and the ability for providers to use telehealth as a way to treat substance use disorder.

American Nurses Association (ANA) Issues Brief on the Role of Nursing in the Opioid Epidemic

The ANA issued a brief, *The Opioid Epidemic: The Evolving Role of Nursing*. The brief "provides an overview of the role of registered nurses (RNs) and advanced practice registered nurses (APRNs), summarizes ANA initiatives and outlines the federal government's response related to the opioid epidemic." The brief notes the importance of RNs as they "are on the front lines of addressing the epidemic by educating patients to understand the risks and benefits of pain treatment options, to include opioids, and by recognizing those at risk for substance use disorder."

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