ADVANCED PRACTICE COMMUNITY HEALTH SYSTEMS NURSING (APCHSN)

INTERNSHIP MANUAL

2007-2008

July 12, 2007

Dear Community Liaison,

The Advanced Practice Community Health Systems in Nursing (APCHSN) faculty and staff would like to take this opportunity to thank you for agreeing to be a community internship site for APCHSN students. This manual was created to enhance communication and learning experience between participating organizations, their liaisons, APCHSN students, and University of Washington School of Nursing (SoN) faculty.

The manual contains 1) expectations and the role of the liaison, 2) responsibilities of the student and 3) responsibilities of the UW SoN faculty. In addition, several resources for the liaison are included in the manual. You will find photos of APCHSN faculty along with contact information, student program requirements, competencies, quarterly APCHSN curriculum goals, and curriculum plan.

The liaison manual is divided into tabbed sections for easy location of information. We encourage liaisons to contact faculty and/or staff for any questions or concerns they have with this manual or student practices.

Thank you again for volunteering your organization and supporting the UW SoN and its students.

Respectfully,

APCHSN Faculty and Staff

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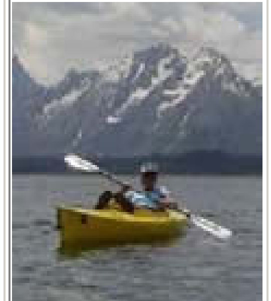	Annie Bruck, MN, RN Phone: (206) 221-5746 Office: Health Sciences, T522E Email Address: abruck@u.washington.edu
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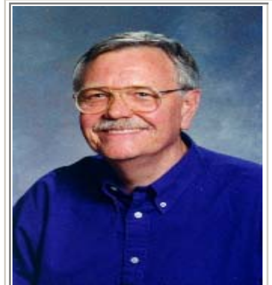	Noel J. Chrisman, PhD Phone: (206) 685-0804 Office: Health Sciences, T-518D Email Address: noelj@u.washington.edu
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About the University of Washington School of Nursing

The University of Washington School of Nursing, is where excellence in nursing education, research and practice, as well as a commitment to service, have always been our primary goals.

The University of Washington School of Nursing, established in 1918. We are ranked the top nursing school in the country by U.S. News and World Report. Globally-renowned UW faculty prepare diverse students for tomorrow's careers, conduct advanced research to find answers to some of the world's most urgent problems, and serve communities as they seek to apply knowledge and technology for the advancement of health.

Our School has been the nation’s top-ranked School of Nursing every year since the first survey was conducted in 1984, and our students are every bit as distinguished. Our more than 10,000 alumni have made significant contributions to health care around the nation and around the world. Our School is also one of the nation’s top recipients of research funds, and we attract world-class nurse scientists to our faculty.

Faculty at the UW School of Nursing are outstanding teachers as well as internationally recognized researchers, and we have an excellent staff who support our efforts in teaching and research. In addition, we have a longstanding tradition of lifelong learning and have used technology to support distance education for more than 20 years.

We invite you to learn more about our School's three major departments and Office of Nursing Research, and about our UW Bothell and UW Tacoma campuses. Read "Connections," the School of Nursing newsletter, and check out "News and Events" feature for an inside look at the UW School of Nursing today.

History

The UW School of Nursing was only the second school of nursing in the United States to be based in a university, and the first on the West Coast. Although nurses were critical to public health in the early Northwest, often providing the only source of health care in rural areas, the only formal training available was as private duty nurses in hospital schools. As greater numbers of girls began completing high school in Washington, and with nurses in short supply because of typhoid and tuberculosis epidemics and an outbreak of influenza that was taking more lives than World War I, state organizations asked the University of Washington to offer public health courses for graduate nurses. In 1918, UW President Henry Suzzalo initiated a summer public health nursing course as well as recommending that a five-year nursing education program be offered. In 1922, the UW Department of Nursing was organized by Elizabeth Sterling Soule, state

supervisor of nurses for the Washington TB Association and Red Cross Visiting Nurses Services, and instructor in the public health nursing course.

The new Department of Nursing was among the first to receive accreditation from the National Organization of Public Health Nurses and began offering graduate nurses a Bachelor of Science in Nursing degree in 1923. Under Soule's leadership, which continued until 1950, all nursing faculty were required to have master's degrees by 1932. That same year, nursing moved into its own building on the UW campus.

In 1940, Soule became the first woman to receive the UW's highest honor, Alumnus Summa Laud Dignatus and, in 1945, nursing became an independent school within UW Health Sciences, with Soule as the first dean. When Soule retired in 1950, Time magazine called her the "Mother of Nursing" in the Pacific Northwest.

The early traditions of academic excellence continue to today. In 1984, in the first nationwide survey of schools of nursing, the UW School of Nursing was ranked #1 in the nation. It has continued to be ranked #1 or to tie for #1 every year since.

Today, the School and its extensive research and teaching laboratories are housed in the health sciences complex. It consistently receives more grants for nursing research than any other school in the country, and 99% of its tenured faculty hold doctoral degrees. Because of this, it attracts outstanding students who study under a world-class nursing faculty.

ABOUT APCHSN INTERNSHIPS

Purpose of Internship:
The purpose of the internship experience is to allow the student to gain practical experience in the community by providing opportunities for students to apply theory, develop public health competencies, and achieve skills in collaborative leadership. Students engage in projects and issues in community/public health settings to integrate and synthesis didactic coursework, and to develop knowledge and skills learned better in the real world.

Students take 14 credits of NCLIN 599 over five quarters. It is preferable that students remain in the same internship site for three quarters, the last two may be at different sites.

Purpose of Manual:
This manual was created to enhance communication and learning experiences among participating organizations, their liaisons, APCHSN students, and University of Washington School of Nursing (SoN) faculty. In addition, the manual was created as a resource to guide and inform liaisons of all parties' responsibilities and student requirements during the students' community health internship.

General Guidelines:
The student will work in conjunction with community liaisons who can support and guide the student experience. The APCHSN faculty supervisor will assist in finding an appropriate internship project or site for the student. Sites are selected for an array of learning opportunities and mutually acceptable by student, faculty, community liaison and organization.

Contractual Arrangement:
A contractual arrangement must be in place with the internship site location and the University of Washington to address professional liability issues. The APCHSN faculty supervisor must be notified of the internship or internship location to ensure that a contract is arranged with that facility. It is not the student's responsibility to establish the contract; rather it is the student's responsibility to let the APCHSN faculty supervisor know which site(s) he or she will be using for learning experiences. This must be done *before* the experience begins.

Goals and Objectives
The first three NCLIN 599 courses has a set of objectives that complement a didactic course: NURSE 578, 557 or 576. The NCLIN 599 objectives are designed to achieve preparation in core public health competencies to provide essential public health services. The essential public health services were

developed by The Public Health Workforce: An agenda for the 21st Century, US Department of Human and Health Services. These public health services are viewed as essential for health promotion, disease prevention and health protection of communities and populations. In addition, students are expected to exercise collaborative leadership skills in each quarter of the internship.

Each quarter the student identifies and writes his or her goals and objectives to be accomplished during the quarter by completing the UW SoN form: NCLIN 599 Independent Study Advanced Clinical Practice Form (see Appendix). These goals and objectives comprise a learning contract between the faculty supervisor, student, and community liaison.

Goals represent the broad statement of what the community organization in partnership with the student from the UW SoN would like to accomplish. Goals provide a general direction for commitment to action. They are ideals and sometimes not achieved.

Objectives represent relevant, attainable, measurable and time-limited ends to be achieved. They reflect the organization's mission and goals and the student's goals. They are stated in behavioral terms and contain strong verbs that describe the action that will be taken toward achievement of the goal. These can be process objectives (how you are going to do it) or outcome objectives (what is to be accomplished).

Definition of Community Liaison

A community liaison facilitates the involvement of APCHSN students in planning, implementing and evaluating community activities that integrates theory taught in class by UW faculty and practical experience in the community.

Community partnerships are held together by individuals who serve as community liaisons who mediate between the community and both faculty and students. Community liaison criteria are:

- knowledgeable of community processes, health issues, assets and strengths, history and culture of communities
- willing to facilitate the movement and access in the community
- desire to serve as a liaison
- open to collaboration
- willing to teach

Community Liaison may have expertise about a population or community, and knowledge about health programs or health policies. They guide faculty to develop experiences to help students accomplish academic objectives and goals while learning community health practice. They work with students, provide feedback on their performance, serve as a professional role model, and practice with underserved populations. Liaisons may be nurses, physicians, social workers, managers, administrators or knowledgeable citizens about particular communities or issues. While community liaisons guide student experiences, faculty provide the supervision for students to accomplish course objectives to develop public health competencies.

Expectations/Role of the Liaison

1. Introduce the student to the agency(s), partners and key players.

2. Provide the student with information on the organization and community that they serve, including an orientation to the program(s), policies and ethical protective guidelines.

3. Provide to the student guidance on networking with key players.

4. Determine with the student a plan for accomplishment(s) during the quarter:

    a. Review with the student there learning goals/objectives for the quarter.
    b. Negotiate activities that address the needs of the agency /community and student learning goals and objectives.

5. Mentor the student in ways such as:

    a. Reassure that experiences in the community may be confusing at times due to the complexity of processes involving people, organizations and community systems.
    b. Engage student in self-reflection.
    c. Share pertinent information with student.
    d. Help discover learning opportunities.
    e. Provide constructive feedback to meet project objectives.
    f. Assist with problem solving.

6. Contact the faculty supervisor to:

    a. Discuss student issues or if the student is not doing well in context of the community.
    b. Obtain guidance from the faculty supervisor.
    c. Inform faculty supervisor about the site, organization, or community events and/or activities.
    d. Request various resources such as
        - Grant information
        - Journal Articles
        - Referral Contact Information

7. Give evaluative feedback to the faculty supervisor regarding student performance.

8. Liaisons are invited to participate in the monthly NCLIN 599 seminar discussions.

9. The liaison has the right to terminate the internship experience at any time by contacting the UWSoN faculty supervisor.

Expectations/Role of the Student

1. Pre-requisites: Washington state RN licensure, enrolled as a UWSoN graduate student, and enrolled in NCLIN 599.

2. Develop NCLIN 599 goals and objectives for the academic quarter in which:

   a. Student should review NCLIN 599 objectives for the quarter enrolled.
   b. Student should develop goals with the community liaison.
   c. Goals should reflect both NCLIN 599 objectives, the needs of the community, and focus on collaborative leadership.
   d. Goals should be reviewed and approved by the faculty supervisor for the internship site.
   e. A copy of the final approved the set of goals should be completed on the UWSoN NCLIN 599 form and filed in the student's academic folder. The student should distribute copies of the goals to the community liaison, the faculty supervisor of the internship site, and the convener of the NCLIN 599 seminar for that quarter.
   f. Meet with the internship faculty supervisor to document on the UWSoN NCLIN 599 form the achievement of goals and objectives. The student is to submit the form to Academic Services to be placed in their file.

3. The student develops a plan of communication with the community liaison, including method, frequency and content. They communicate with the faculty supervisor through verbal or written reports, eJournal documentation of field notes, and face-to-face meetings. Students communicate as requested by the NCLIN 599 seminar convener.

4. Learn about community processes, agencies and partners through coursework, internship experiences, discussions with the faculty supervisor, community liaison, NCLIN 599 convener and independent study.

5. Practice elements of collaborative leadership in the classroom, internships and community activities.

6. Determine a mutually agreeable presentation format of internship activities with the community liaison and faculty supervisor. Presentations may be made to the internship site, community or other relevant agencies and organizations.

7. Adhere to the rules, regulations, policies and procedures of the UWSoN, the community or internship setting. Follow any verbal or written directives communicated by the community liaison or faculty supervisor.

8. It is expected that students register for credit hours commensurate with their community cognate requirements.

    a. One credit of internship is equivalent to three hours of community activity.
    b. Three hours of NCLIN 599 seminars may be substituted for the equivalent amount of time in the community for that week only.
    c. Attendance at NCLIN 599 seminars is required.
    d. Attendance at APCSHN or UWSoN functions may be required and substituted for internship hours.

9. At the end of the quarter, the student should complete a written evaluation of the community liaison and community experience. These evaluations will be used for program improvement.

10. Meet the expectations of professional conduct set forth by the:

    a. University of Washington
    b. University of Washington School of Nursing
    c. American Nurses' Association Code of Ethnics for Nurses
    d. Nurse Practice Act of Washington State
    e. Other appropriate professional guidelines

11. Students may raise concerns about their internship faculty supervisor with their academic advisor.

Expectations/Role of the Internship Faculty Supervisor

1. Be a resource to students and community liaisons.

2. Assure that an up-to-date affiliation agreement between the UWSoN and the agency is in place before the internship begins

   a. Verify currency with Academic Services.
   b. If an affiliation agreement does not exist, initiate the process.

3. Negotiate with the community liaison the internship placement.

4. Provide the community liaison at internship site with a copy of this manual.

5. Introduce the student to the community liaison (means of introduction determined between faculty supervisor and community liaison).

6. Discuss and approve the student's goal(s), objective(s) and plans to fulfill NCLIN 599 objectives and requirements for course credit.

   a. A copy of the final approved the set of goals should be completed on the UWSoN NCLIN 599 form and filed in the student's academic folder. Ensure that copies are distributed by the student to the liaison, the faculty supervisor of the internship site, and the convener of the NCLIN 599 seminar for that quarter.

7. Develop a plan of communication with the student, including method, frequency and content.

   a. Determine the type of communications required, to include verbal or written reports, eJournal documentation of field notes, and face-to-face meetings.
   b. Determine the time frame for journal entry submissions, content to be included, and a quarter summary entry pertaining to whether or not goals were met.
   c. Communicates as requested with the NCLIN 599 seminar convener.

8. Conduct evaluations.

   a. Request feedback from the community liaison about the student's performance at the end of the quarter.
   b. Request feedback from the student about the contribution of the internship site to accomplishing NCLIN 599 goals and objectives, public health competencies, and collaborative leadership skills.
   c. Monitor the contribution of the community liaison to student learning.

d. Communicate student performance to the NCLIN 599 seminar convener to issue a grade.
e. Meet with the students to document on the UWSoN NCLIN 599 form the achievement of goals and objectives. The student is to submit the form to Academic Services to be placed in their file.

9. Advise students of their responsibilities during the internship using this manual.

10. Plan consultations, as necessary, between the UWSoN faculty and the community liaison to promote exchange of information relevant to the student's experience.

11. Conflicts between the student and liaison or community members will be resolved through negotiation of conflict or termination of student placement.

12. Provide counseling and documentation on unsatisfactory performance(s)/action(s) as warranted through discussions between the student, internship faculty supervisor and community liaison, if necessary.

APCHSN Practice Characteristics/Philosophy

1. Use sound qualitative and quantitative methods to assess disparities in health among populations and communities by examining indicators that measure determinants of health including:

    a. entrenched poverty and/or lack of adequate economic opportunities;

    b. lack of access to appropriate disease prevention and health promotion services;

    c. lack of appropriate medical treatment;

    d. environmental threats to health;

    e. lack of health-supporting social support at work, home and in the community;

    f. system structures and incentives that discriminate against groups with the greatest disparities in education, race, ethnicity, cultural background and environment.

2. Assess the contribution of multiple sectors in the community to health of populations and communities, including:

    a. tribal governments;

    b. medical and hospital payors and providers;

    c. medical equipment and pharmaceutical companies;

    d. high-technology and manufacturing companies;

    e. local and regional retail businesses;

    f. labor unions and professional associations;

    g. fraternal organizations;

    h. communities of faith

3. Support the capacity of community members and health systems to engage in the political processes of developing sound health policies and creating culturally appropriate programs and services. Activities include:

   a. education of community members, health insurers, and health providers about health status disparities and programs of intervention for improved health;

   b. development of leadership capacity in the community through citizen participation, groups process skills, resource development, network skills and identifying community values.

4. Analyze, formulate and evaluate health policies at multiple levels and in various venues, including formalized health systems. Activities focus on:

   a. evaluation of the relationship between health policy and its consequent health status disparities, programs, services, and structures;

   b. evaluation of the relationship between public and corporate health policy with their consequent structures and services and the alleviation of health disparities.

5. Facilitate collaborations, coalitions, and alliances that mobilize individuals, groups and communities, and community agencies across sectors to partner with each other, and with medical and public health systems to develop sustainable programs and to reform health systems to alleviate and prevent health disparities

6. Design, implement and evaluate culturally appropriate intervention programs and policies to protect, promote, and restore health and prevent disease and injury.

7. Monitor and evaluate the performance of health organizations and systems in the delivery of programs and services by using performance indicators and measures of health of populations and communities.

8. Use verbal, written, and cyber skills to communicate health status disparities, analysis of policies and systems, proposals for intervention, and evaluation of performance of health systems to improve health.

As community health generalists, Advanced Practice Community Health Systems Nursing graduates are qualified to plan and establish programs of health promotion/disease prevention for specific populations. Some graduates work in public health nursing and are involved in such things as influencing policy, program planning, research, maternal child health, AIDS and alcoholism prevention and TB surveillance. Some Advanced Practice Community Health Systems nurses teach in junior colleges. Other graduates will eventually go on

and get doctoral degrees in Nursing. Recent graduates from the University of Washington have worked in such areas as:

- in-service education and staff development office in a hospital providing training for nurses and other hospital personnel,
- community health nurse and health educator on an Indian reservation,
- area of state government policy for long term care facilities,
- faculty in BSN and associate degree programs,
- Director of not-for-profit health agencies
- Consulting for state government
- Director of occupational health programs in industry
- Director of Public Health Nursing or manager of public health programs

Quarterly Internship Competencies Course Objectives for NCLIN 599 A-E

NCLIN 599 A-E is designed for Advanced Practice Community health Systems Nursing students and is intended to provide opportunities for students to apply theory and develop practice competencies to fulfill essential public health functions from a nursing perspective. 17 credits are required in order to fulfill American Nurses Credentialing Center (ANCC) certification requirements.

NCLIN 599 A: Introduction to Community Health

OBJECTIVES: 1. Describe the various ways communities identify and represent themselves. 2. Describe the ways that people express investment in the well-being of their community. 3. Describe community partners as knowledgeable and informed people about their community. 4. Report and awareness of community suffering as a human response to health disparities. 5. Describe sensitivity for the relationship between determinates of health and both population and community level health disparities. 6. Relate consciousness of the relationship between government and organizational health policies and community health. 7. Expands group process and collaborative skills. 8. Explores the meaning of leadership in a collaborative community work.

TOPICAL OUTLINE: During this 1st quarter of community clinical internship, students are introduced to working in the community by becoming familiar with different ways in which the community identifies itself. Students learn the process of entry into a community, and begin to establish partner relationships in the community for collaborative work. Students apply knowledge from NURS 578 to gain appreciation for expressions of human health at individual, population and community levels.

NCLIN 599 B: Cultural Competence in Community Health

OBJECTIVES: 1. Describes the influence of culture, belief, values and customs on human health experiences. 2. Recognizes own position of privilege while engaging in collaborative community work. 3. Shows responsibility in the position of community partners in community-based participatory research. 4. Reports the process of developing partnerships with community members. 5. States evaluation of the relationship between societal-level barriers and health disparities in populations and communities. 6. Describes culturally appropriate expression of leadership in a community.

TOPICAL OUTLINE: During this 2nd quarter of community clinical internship, students continue to work collaboratively in the community by applying lessons from NURS 557. They practice listening to the many points of view of the community that reflect diverse cultures, agency positions, and personal agendas. They develop insight and appreciation for the diversity of positions in relation to their own. Students develop skill in the observation of the practices or

organizations and institutions, and dynamics of communities that relate to health disparities and community empowerment. Students initiate, volunteer or accept variety of roles in collaborative work.

NCLIN 599 C: Community Health Assessment

OBJECTIVES: 1. Report engagement in community-based participatory research to understand population and community health issues. 2. Report respect of different points of view in data production and interpretations. 3. Conduct a community health assessment utilizing multiple sources of data to describe community assess and health issues. 4. Discuss how data from a community health assessment reveal ethical, political, scientific, economic and overall public health issues. 5. Critiques ability to conduct group work in a community mobilizing, coalition development, or community-based participatory research.

TOPICAL OUTLINE: This 3rd quarter of community clinical internship complements concepts in NURS 578. Students engage in community-based partnership research. Students conduct an assessment of the community or population with partners from the community or organizations. Students use multiple so9urces of data, and public health sciences to describe community assets and its health issues. Community work provides opportunities for the student to reflect on their own biases and assumptions in the assessment process, and learn group work as leader or member that is culturally appropriate. Students develop meaning about health disparities highlighted by the assessment, and work with partners to develop a plan to respond to health issues.

NCLIN 599 D: Leadership in Community Health Systems Nursing I

OBJECTIVES: 1. Show responsibility for collaborative work with community stakeholders and partners to respond to health issues identified by the community assessment. 2. Judge community health problems and issues in terms of nursing perspective involving social justice, human health response, determinates of health, closing the gap of health disparities, multi-level approaches, and community participatory research. 3. Works collaboratively with the community to develop a vision to plan action to address health issues identified by the community. 4. Weighs the use of innovative strategies to reach under-served communities and populations through collaborative work. 5. Shows increasing consistency in using process and outcome evaluation methods in community collaborative work. 6. Develops a personal leadership action plan.

TOPICAL OUTLINE: During this 4th quarter of community clinical internship, students apply NURS 561 concepts in an internship experience. The focus of this quarter is to engage the student in beginning synthesis of community health nursing practice. They practice under the supervision of a clinical preceptor. The site may be a community or organization at which the student will develop in depth competencies in a selected community cognate and therapeutic cognate. The emphasis is the development of collaborative leadership using a framework

involving nursing, public health sciences, administration, and knowledge about a community or population to create vision, a plan of action.

NCLIN 599 E: Leadership in Community Health Systems Nursing II
OBJECTIVES: 1. Develop a consistent philosophy that guides a vision to close the gap in health disparities in population and communiti9es. 2. Considers individual, population and community health when devising policies and programs at the systems level. 3. Shows ability to conduct community-based participatory research, including community assessment, program design and program evaluation. 4. Demonstrates developing ease with inter-relationships and patterns involving complex problems. 5. Shows responsibility in consideration of new alternatives and innovations to promote social justice and cultural competent care. 6. Shows readiness to negotiate in light of evidence for better outcome to redefine community care. 7. Critiques budget decisions to advance innovations to close the gap on health disparities. 8. Shows strategic thinking for developing interdisciplinary public and community health workforce. 9. Demonstrates communication skills that reach variety groups.

TOPICAL OUTLINE: This 5th quarter of community clinical internship builds on previous clinical experiences and course work as the student assumes increasing responsibility for leadership in community health. Students will be expected to practice as an advanced practice community health nurse under the supervision of a clinical preceptor. Emphasis will be placed on competencies related to management, budget and innovations in policies and programs.

Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals

Considerations:

In reviewing the recommendations of the expert panel and the work of the five Working Symposium teams that addressed standards for cultural competence education, there emerged a number of principles. These seemed to implicitly guide the development of the specific standards regarding cultural competence, including what should be taught, when it should be taught, how it should be taught and who should teach it. These underlying principles are cross-cutting and apply to various health professionals, in multiple training formats. These guiding precepts are reflected in the more specific Standards in the areas of Attitudes, Knowledge, Skills, methods, Evaluation and qualifications of Educators and Trainers.

Guiding Principles
(This list is **not** ranked in any particular order.)

1. The **goals** of cultural competence training should be: 1) increased self-awareness and receptivity to diverse patient populations on the part of health care professionals; 2) clinical excellence and strong therapeutic alliances with patients; and 3) reduction of health care disparities through improved quality and cost-effective care for all populations.

2. In all trainings, there should be a broad and inclusive definition of cultural and population diversity including consideration of race, ethnicity, class, age, gender, sexual orientation, disability, language, religion and other indices of difference.

3. Training efforts should be developmental, in terms of the institution and the individual. Institutions may start out simply in their inclusion of cultural competency training as a specific area of study but are expected to build in more complex, integrated and in-depth attention to cultural issues in later stages of professional education. Trainees should be expected to become progressively

more sophisticated in understanding the complexities of diversity and culture as they relate to patient populations and health care. Both instructional programs and student learning should be regularly evaluated in order to provide feedback to the on-going development of educational programs.

4. Cultural competence training is best organized around enhancing providers' attitudes, knowledge and skills, and attention to the interaction of these three factors are important at every level of the training. It is important to recognize the extensive preexisting knowledge and skill base of health care professionals, and to seek to promote cultural competence within this context.

5. While factual information is important, educators should focus on process-oriented tools and concepts that will serve the practitioner well in communicating and developing therapeutic alliances with **all** types of patients.

6. Cultural competence training is best integrated into numerous courses, symposia and experiential, clinical, evaluation and internship activities as they occur throughout an educational curriculum. Attention may need to be directed to faculty, staff and administrative development in cultural competence in order to effect this integration.

7. Following on the above, cultural competence education should be institutionalized within a school or health care organization so that when curriculum or training is planned or changed, appropriate cultural competence issues can be included.

8. Cultural competence education is best achieved within an interdisciplinary framework and context, drawing upon the numerous fields that contribute to skill and knowledge in the field.

9. Education and training should be respectful of the needs, the practice contexts and the levels of receptivity of the learners.

10. Education in cultural competence should be congruent with, and, where possible, framed in the context of existing policy and educational guidelines of professional accreditation and practice organizations, such as the Accreditation Council on Graduate Medical Education, the Liaison Committee on Medical Education, the American Academy of Nursing, the National Association of Social Workers, the Society for Public Health Education and the Academies and Colleges of Family Practice, Pediatrics, Emergency Medicine and Obstetrics and Gynecology.

11. Wherever possible, diverse patients, community representatives, consumers and advocates should participate as resources in the design, implementation and evaluation of cultural competence curricula.

12. Finally, cultural competence education should take place in a safe, non-judgmental, supportive environment. While the *Principles and Recommended Standards* are focused on the education and training of health care professionals, the schools and organizations in which they study and work must be settings that are conducive to functioning in a culturally competent way and visibly support the goals of culturally competent care.

Considerations:

While the content and subject matter of cultural competence training/education are extremely varied, they generally fall into three general categories: Attitudes, Knowledge and Skills. Each of these areas is supportive of the other two. Like a three-legged stool, the structure would fail if one "leg" were missing. Most importantly, the knowledge and skills related to cultural competence in health care would be seriously reduced in effectiveness if a committed consciousness and receptive attitude did not underlie their use. From a practical standpoint, these three content areas are applicable in the disciplines and are useful at any stage of the developmental learning process. The basic tenets of Professionalism, Patient-Centeredness and Ethics of Practice education of all professional health care should be a consideration for all movements in medicine.

Attitudes:

• Similar to all aspects of health care professionals' continuing education, cultural competence education should be a continuous learning process as well. Cultural competence education for health care professionals should foster a lifelong commitment to learning and self-evaluation through an ability to recognize and question their own assumptions, biases, stereotypes and responses.

• Health care professionals should be encouraged to adopt attitudes of open-mindedness and respect for all patients including those who differ from them socially or culturally.

• Health care practitioners should be taught techniques that promote patient and family-centered care, along with the understanding that effective therapeutic alliances may be construed differently across patients and cultures.

• As they learn about health care disparities and inequities and the factors that lead to unequal treatment, health care professionals should be encouraged to undertake a commitment to equal quality care for all and fairness in the health care setting.

• To actively serve this commitment, educators can teach students ways to

identify systemic or organizational barriers to access and use of services by their patients and encourage them to be proactive within their practice environments to eliminate these barriers.

Knowledge:

• Self-awareness and self-knowledge are the first types of knowledge cross cultural training would seek to establish. This involves bringing to the learner's awareness internalized beliefs, values, norms, stereotypes and biases. They should be made aware of how ethnocentrism, that is, the belief that one's own culture is superior to others, operates in all cultures and encouraged to be attentive to the possibility of ethnocentrism in their own thinking. They should be made aware of how ethnocentrism may influence their own interaction with patients.

• Essential to their understanding of both themselves and their patients is an understanding of the concept of culture. The theory of culture makes clear the connections between worldview, beliefs, norms and behaviors related to health, illness and care-seeking in different populations. In this regard, practitioners can be taught to explore how their own cultures, including the cultures of biomedicine, inform their perceptions and behaviors. All people operate within multiple cultures.

• Information about local and national demographics would be part of a health professional's cultural competence education. This should include attention to specific populations, immigration and changing demographics, such as alterations in age or occupational distributions. Students/trainees should be encouraged to draw implications from this information for their current and future professional practices. Organizations should have a process in place to reassess relevant demographics on a consistent basis.

• Practitioners need to know the legal, regulatory and accreditation issues which address cultural and linguistic issues in health care**.** These would include such things as the position of the federal Department of Health and Human Services (DHHS) on civil rights and language access, federal and state cultural competence contract requirements for publicly funded health care and state legislation around the provision of language services and culturally sensitive health care. The DHHS Recommended Standards for Culturally and Linguistically Appropriate Health Care Services should be reviewed.

• Health care professionals need to be made aware of any cultural and linguistic policy statements or standards espoused by their own or other professional associations, such as the Society for Teachers of Family Medicine, the American Academies of Family Physicians, Pediatrics or the American Academy of Nursing. They should be given an understanding of how cultural competence fits into the goals of their professional education.

• Health care professionals should know the kinds and degrees of disparities in health status, health care access and use of preventive strategies across racial, ethnic, gender and other discrete population groups in the United States. This information should be placed in a context that allows the learner to understand how class, racial and ethnic discrimination, social variables and structural variables, including the structure of health care, contribute to these disparities.

• Health care professionals should be given a framework for exploring the family structure and dynamics, health beliefs, behaviors and health practices demonstrated in different cultures and population groups, especially those in the local areas of service.

• Practitioners should understand the concept of medical pluralism— the concurrent use of both traditional and biomedical systems of care. Familiarity with the kinds of healers and healing traditions within their communities of practice or those frequently associated with their specialty field should be discussed. Interaction with traditional healers, if possible, is recommended. Improved understanding of traditional practices does not mean endorsing them, but it can lead to improved provider-patient or provider-family interaction.

• In developing understandings about epidemiology and group health practices, the tendency to make inferences from probabilistic, group-level generalizations to individual cases, which, carelessly done, can lead to stereotyping, should be addressed. Its clinical risks and benefits should be carefully explored. Sources of within-group variation, including class and acculturation need to be clarified. A "recipe" approach to cultural and clinical descriptions of groups should be rigorously avoided.

• Emergent data, such as those being developed in genome research and ethnopharmacology, which apply to specific racial and ethnic groups, should be carefully evaluated as to their potential use in enhancing the quality of care for these groups. The positive and negative implications of these types of data for the care of diverse populations should be discussed and well understood.

• Practitioners should learn about the epidemiology of disease among specific populations, both nationally and within their local areas, and be able to use this knowledge in patient assessment, health promotion and other aspects of care. This includes an awareness of the limitations of epidemiological information for diverse populations. For example, there is not much data on epidemiological differences for ethnic sub-populations. Existing broad ethnic group data may not be able to be applied generally across sub-populations.

• Knowledge of the dangers of attempting to care for a patient whose language

they do not understand well and of the problems associated with the use of family members, friends or unskilled interpreters should be part of a health professional's cultural competence training.

• Without using a recipe approach, health care practitioners should become knowledgeable about cross-cultural variations in verbal and non-verbal communication and etiquette and be taught techniques for recovering, if they discover that they have inadvertently breached a cultural norm.

• Trainers and teachers should inform trainees of available resources, such as bibliographies, web sites, case studies and community contacts and resources, so that practitioners can continue to expand their knowledge and education around cultural issues while engaging in professional practice. Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals.

Skills:

• Skills that enable health care professionals to assess their own responses, biases and cultural preconceptions on an ongoing basis are critical baseline skills to be learned.

• Providers need to be given communication tools and strategies for eliciting patients' social, family and medical histories, as well as patients' health beliefs, practices and explanatory models. Communication skills for fostering positive therapeutic alliances with diverse patients should be taught. These would include ways for assessing patients' expectations around levels of interactive formality with providers, valuing and incorporating the patients' beliefs and understanding into diagnosis, treatment options and preventive health care where possible and negotiating conflicting patient/provider perspectives when necessary.

• Health care practitioners should be taught ways of accessing and interacting with diverse local communities for the purpose of understanding their traditional or group specific health care practices and needs. Collaboration with local communities, for example, is useful in tailoring effective outreach, prevention and educational programs and materials.

• Health care professionals should be able to assess patients' language skills as they relate to their ability to communicate fully with the practitioner and staff and to their understanding of written instructions, prescriptions and educational materials. While language and literacy issues may be particularly important in working with limited English speakers, they should be considered in relating to all patients.

• Practitioners should be taught methods of *realistically* assessing their own proficiency in languages other than English and should acquire the skills for

effective use of interpreters, including working with an untrained interpreter, a trained interpreter and telephone interpreting.

• Skills in accessing translated written materials through their organizations and commercial resources; as well as computer programs and web-based resources should be taught.

• Cultural competence education should foster skills for retrieving data concerning cultural issues in health care, population data and epidemiological information on the web.

Core Course Descriptions

NURS 523 Communities, Populations, Systems: Theoretical Perspectives: Focus on construction and analysis of research-based philosophies and theories related to nursing practice at the community, population, and systems levels. Synthesize and apply knowledge about social and environmental justice, determinants of health, and human health responses to populations and communities. Examine and evaluate leadership roles for nurses in community settings.

NURS 557 Health, Culture and Community: A theory and skills class concerning development of personal and organizational cultural competence in community-based participatory research. Core concepts of cultural competence are considered as they are practiced in community settings. Fieldwork required.

NURS 561 Selected Topics in Comparative Nursing Care Systems: In-depth examination of the literature pertinent to major theoretical issues in cross-cultural nursing and health-care systems. Seminar with analysis and discussion of selected topics and readings. Implications for research and health care stressed.

NURS 576 Assessment and Collaboration: Examine, critique and apply theory and practice in assessing and collaborating with communities, populations and systems cross-culturally. Develop techniques for working with communities and systems, including using multiple data sources, performance indicators, community mobilization, capacity building, and coalition development.

NURS 578 Social Determinates of Health: Analyze the distribution and causes of health disparities in populations and communities, including but not limited to social, psychological, biological and environmental factors, to assess social determinants of health problems and their remedies.

NMETH 520 Scholarly Inquiry for Nursing Practice: Analyzes conceptual, theoretical, and empirical knowledge as a basis for evidence-based practice. Examines methodological approaches to scholarly inquiry and research applied to nursing practice. Evaluates role of advanced practice nurses in research. Offered: AWS.

NMETH 598/700 Scholarly Project/Master's Thesis: Fulfills the requirements of the non-thesis option for Master's students in nursing. Projects involve scholarly inquiry with in-depth focused analysis, culminating in a written product/report for dissemination.

EPI 511 Introduction to Epidemiology: Epidemiologic methods for non-epidemiology majors. Focuses on research designs and methods to describe disease occurrence and risk factor associations; uses quantitative and biomedical information to infer whether causal relationships exist between potential causes and disease in populations.

HSERV 511 Introduction to Health Services: History, organization, and effectiveness of United States health care and public health systems. Determinants of health, need, and utilization. Public and private financing. Supply and provision of personal and public health services. Managed care. Government and private sector roles.

APCHSN Full-Time Curriculum Plan

Year One	Autumn	Cr.	Winter	Cr.	Spring	Cr.	Summer	Cr.
	NURS 578 Social Determinants of Health	3	NURS 557 Health, Culture and Community	3	NURS 576 Assessment and Collaboration	3	ELECTIVES Community Cognate Therapeutic Cognate Management and Budget	3
	NCLIN 599 A Community Internship	2	NCLIN 599 B Community Internship	3	NCLIN 599 C Community Internship	3		
	EPI 511 Introduction to Epidemiology	4	ELECTIVES Community Cognate Therapeutic Cognate Management and Budget	6	NMETH 520 Scholarly Inquiry for Nursing Practice	4		
	HSERV 511 Introduction to Health Services	3			ELECTIVES Community Cognate Therapeutic Cognate Management and Budget	3		
	Total	***12***	***Total***	***12***	***Total***	***13***	***Total***	***3***
Year Two	**Autumn**	**Cr.**	**Winter**	**Cr.**	**Spring**	**Cr.**	**Summer**	**Cr.**
	NCLIN 599 D Community Internship	3	NCLIN 599 E Community Internship	3	NURS 523 Communities, Populations, Systems: Theoretical Perspectives	3		
	NURS 561 Comparative Nursing Care Systems	3	NMETH 598/700 Scholarly Project/ Master's Thesis	2-3	NMETH 598/700 Scholarly Project/ Master's Thesis	2-3		
	NMETH 598/700 Scholarly Project/ Master's Thesis	2-3	ELECTIVES Community Cognate Therapeutic Cognate Management and Budget	3				
	ELECTIVES Community Cognate Therapeutic Cognate Management and Budget	3						
	Total	***11-12***	***Total***	***8-9***		***5-6***	***Total Program Credits***	***64-67***

ELECTIVES
Community Cognate: Healthy Aging, Rural Health, Cross-Cultural Health, Communities for Youth, Occupational Health (3 credits)
Therapeutic Cognate: Program Development/Evaluation; Health Policy (9 credits)
Management and Budget (3 credits each)

Council on Linkages Between Academia and Public Health Practice
https://www.train.org/Competencies/corecompwoskills.htm

Public Health Core Competencies Without Skill Levels

Analytic/Assessment Skills

- Defines a problem
- Determines appropriate uses and limitations of both quantitative and qualitative data
- Selects and defines variables relevant to defined public health problems
- Identifies relevant and appropriate data and information sources
- Evaluates the integrity and comparability of data and identifies gaps in data sources
- Applies ethical principles to the collection, maintenance, use, and dissemination of data and information
- Partners with communities to attach meaning to collected quantitative and qualitative data
- Makes relevant inferences from quantitative and qualitative data
- Obtains and interprets information regarding risks and benefits to the community
- Applies data collection processes, information technology applications, and computer systems storage/retrieval strategies
- Recognizes how the data illuminates ethical, political, scientific, economic, and overall public health issues

Policy Development/Program Planning Skills

- Collects, summarizes, and interprets information relevant to an issue
- States policy options and writes clear and concise policy statements
- Identifies, interprets, and implements public health laws, regulations, and policies related to specific programs
- Articulates the health, fiscal, administrative, legal, social, and political implications of each policy option
- States the feasibility and expected outcomes of each policy option
- Utilizes current techniques in decision analysis and health planning
- Decides on the appropriate course of action
- Develops a plan to implement policy, including goals, outcome and process objectives, and implementation steps
- Translates policy into organizational plans, structures, and programs
- Prepares and implements emergency response plans
- Develops mechanisms to monitor and evaluate programs for their effectiveness and quality

Communication Skills

- Communicates effectively both in writing and orally, or in other ways
- Solicits input from individuals and organizations
- Advocates for public health programs and resources
- Leads and participates in groups to address specific issues
- Uses the media, advanced technologies, and community networks to communicate information
- Effectively presents accurate demographic, statistical, programmatic, and scientific information for

professional and lay audiences

Attitudes

- Listens to others in an unbiased manner, respects points of view of others, and promotes the expression of diverse opinions and perspectives

Cultural Competency Skills

- Utilizes appropriate methods for interacting sensitively, effectively, and professionally with persons from diverse cultural, socioeconomic, educational, racial, ethnic and professional backgrounds, and persons of all ages and lifestyle preferences
- Identifies the role of cultural, social, and behavioral factors in determining the delivery of public health services
- Develops and adapts approaches to problems that take into account cultural differences

Attitudes

- Understands the dynamic forces contributing to cultural diversity
- Understands the importance of a diverse public health workforce

Community Dimensions of Practice Skills

- Establishes and maintains linkages with key stakeholders
- Utilizes leadership, team building, negotiation, and conflict resolution skills to build community partnerships
- Collaborates with community partners to promote the health of the population
- Identifies how public and private organizations operate within a community
- Accomplishes effective community engagements
- Identifies community assets and available resources
- Develops, implements, and evaluates a community public health assessment
- Describes the role of government in the delivery of community health services

Basic Public Health Sciences Skills

- Identifies the individual's and organization's responsibilities within the context of the Essential Public Health Services and core functions
- Defines, assesses, and understands the health status of populations, determinants of health and illness, factors contributing to health promotion and disease prevention, and factors influencing the use of health services
- Understands the historical development, structure, and interaction of public health and health care systems
- Identifies and applies basic research methods used in public health
- Applies the basic public health sciences including behavioral and social sciences, biostatistics, epidemiology, environmental public health, and prevention of chronic and infectious diseases and injuries
- Identifies and retrieves current relevant scientific evidence
- Identifies the limitations of research and the importance of observations and interrelationships

Attitudes

- Develops a lifelong commitment to rigorous critical thinking

Financial Planning and Management Skills

- Develops and presents a budget
- Manages programs within budget constraints
- Applies budget processes
- Develops strategies for determining budget priorities
- Monitors program performance

- Prepares proposals for funding from external sources
- Applies basic human relations skills to the management of organizations, motivation of personnel, and resolution of conflicts
- Manages information systems for collection, retrieval, and use of data for decision-making
- Negotiates and develops contracts and other documents for the provision of population-based services
- Conducts cost-effectiveness, cost-benefit, and cost-utility analyses

Leadership and Systems Thinking Skills

- Creates a culture of ethical standards within organizations and communities
- Helps create key values and shared vision and uses these principles to guide action
- Identifies internal and external issues that may impact delivery of essential public health services (i.e., strategic planning)
- Facilitates collaboration with internal and external groups to ensure participation of key stakeholders
- Promotes team and organizational learning
- Contributes to development, implementation, and monitoring of organizational performance standards
- Uses the legal and political system to effect change
- Applies theory of organizational structures to professional practice

Code of Ethics for Nurses - Provisions

Approved as of June 30, 2001

The ANA House of Delegates approved these nine provisions of the new *Code of Ethics for Nurses* at its June 30, 2001 meeting in Washington, DC. In July, 2001, the Congress of Nursing Practice and Economics voted to accept the new language of the interpretive statements resulting in a fully approved revised *Code of Ethics for Nurses With Interpretive Statements.*

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1. The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.
2. The nurse's primary commitment is to the patient, whether an individual, family, group, or community.
3. The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.
4. The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care.
5. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.
6. The nurse participates in establishing, maintaining, and improving healthcare environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.
7. The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.
8. The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.
9. The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy.

American Nurses Association, *Code of Ethics for Nurses with Interpretive Statements*, Washington, D.C.: American Nurses Publishing, 2001

http://www.sfdph.org/NurseWeb/ethics.html

Nurse Practice ACT
RCW 18.79.010

Purpose. RCW 18.79.010

It is the purpose of the nursing care quality assurance commission to regulate the competency and quality of professional health care providers under its jurisdiction by establishing, monitoring, and enforcing qualifications for licensing, consistent standards of practice, continuing competency mechanisms, and discipline. Rules, policies, and procedures developed by the commission must promote the delivery of quality health care to the residents of the state of Washington.

Definitions. RCW 18.79.020

Unless a different meaning is plainly required by the context, the definitions set forth in this section apply throughout this chapter.

(1) "Commission" means the Washington state nursing care quality assurance commission.

(2) "Department" means the department of health.

(3) "Secretary" means the secretary of health or the secretary's designee.

(4) "Diagnosis," in the context of nursing practice, means the identification of, and discrimination between, the person's physical and psychosocial signs and symptoms that are essential to effective execution and management of the nursing care regimen.

(5) "Diploma" means written official verification of completion of an approved nursing education program.

(6) "Nurse" or "nursing," unless otherwise specified as a practical nurse or practical nursing, means a registered nurse or registered nursing.

Licenses required -- Titles. RCW 18.79.030

(1) It is unlawful for a person to practice or to offer to practice as a registered nurse in this state unless that person has been licensed under this chapter. A person who holds a license to practice as a registered nurse in this state may use the titles "registered nurse" and "nurse" and the abbreviation "R.N." No other

person may assume those titles or use the abbreviation or any other words, letters, signs, or figures to indicate that the person using them is a registered nurse.

(2) It is unlawful for a person to practice or to offer to practice as an advanced registered nurse practitioner or as a nurse practitioner in this state unless that person has been licensed under this chapter. A person who holds a license to practice as an advanced registered nurse practitioner in this state may use the titles "advanced registered nurse practitioner," "nurse practitioner," and "nurse" and the abbreviations "A.R.N.P." and "N.P." No other person may assume those titles or use those abbreviations or any other words, letters, signs, or figures to indicate that the person using them is an advanced registered nurse practitioner or nurse practitioner.

(3) It is unlawful for a person to practice or to offer to practice as a licensed practical nurse in this state unless that person has been licensed under this chapter. A person who holds a license to practice as a licensed practical nurse in this state may use the titles "licensed practical nurse" and "nurse" and the abbreviation "L.P.N." No other person may assume those titles or use that abbreviation or any other words, letters, signs, or figures to indicate that the person using them is a licensed practical nurse.

(4) Nothing in this section shall prohibit a person listed as a Christian Science nurse in the Christian Science Journal published by the Christian Science Publishing Society, Boston, Massachusetts, from using the title "Christian Science nurse," so long as such person does not hold himself or herself out as a registered nurse, advanced registered nurse practitioner, nurse practitioner, or licensed practical nurse, unless otherwise authorized by law to do so.

"Registered nursing practice" defined -- Exceptions. RCW 18.79.040

(1) "Registered nursing practice" means the performance of acts requiring substantial specialized knowledge, judgment, and skill based on the principles of the biological, physiological, behavioral, and sociological sciences in either:

(a) The observation, assessment, diagnosis, care or counsel, and health teaching of individuals with illnesses, injuries, or disabilities, or in the maintenance of health or prevention of illness of others;

(b) The performance of such additional acts requiring education and training and that are recognized by the medical and nursing professions as proper and recognized by the commission to be performed by registered nurses licensed under this chapter and that are authorized by the commission through its rules;

(c) The administration, supervision, delegation, and evaluation of nursing practice. However, nothing in this subsection affects the authority of a hospital,

hospital district, in-home service agency, community-based care setting, medical clinic, or office, concerning its administration and supervision;

(d) The teaching of nursing;

(e) The executing of medical regimen as prescribed by a licensed physician and surgeon, dentist, osteopathic physician and surgeon, podiatric physician and surgeon, physician assistant, osteopathic physician assistant, or advanced registered nurse practitioner.

(2) Nothing in this section prohibits a person from practicing a profession for which a license has been issued under the laws of this state or specifically authorized by any other law of the state of Washington.

(3) This section does not prohibit (a) the nursing care of the sick, without compensation, by an unlicensed person who does not hold himself or herself out to be a registered nurse, (b) the practice of licensed practical nursing by a licensed practical nurse, or (c) the practice of a nursing assistant, providing delegated nursing tasks under chapter 18.88A RCW.

[2003 c 140 § 1; 1995 1st sp.s. c 18 § 50; 1994 sp.s. c 9 § 404.]

NOTES:

Effective date -- 2003 c 140: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [May 7, 2003]." [2003 c 140 § 13.]

Construction. RCW 18.79.240

(1) In the context of the definition of registered nursing practice and advanced registered nursing practice, this chapter shall not be construed as:

(a) Prohibiting the incidental care of the sick by domestic servants or persons primarily employed as housekeepers, so long as they do not practice registered nursing within the meaning of this chapter;

(b) Preventing a person from the domestic administration of family remedies or the furnishing of nursing assistance in case of emergency;

(c) Prohibiting the practice of nursing by students enrolled in approved schools as may be incidental to their course of study or prohibiting the students from working as nursing technicians;

(d) Prohibiting auxiliary services provided by persons carrying out duties

necessary for the support of nursing services, including those duties that involve minor nursing services for persons performed in hospitals, nursing homes, or elsewhere under the direction of licensed physicians or the supervision of licensed registered nurses;

(e) Prohibiting the practice of nursing in this state by a legally qualified nurse of another state or territory whose engagement requires him or her to accompany and care for a patient temporarily residing in this state during the period of one such engagement, not to exceed six months in length, if the person does not represent or hold himself or herself out as a registered nurse licensed to practice in this state;

(f) Prohibiting nursing or care of the sick, with or without compensation, when done in connection with the practice of the religious tenets of a church by adherents of the church so long as they do not engage in the practice of nursing as defined in this chapter;

(g) Prohibiting the practice of a legally qualified nurse of another state who is employed by the United States government or a bureau, division, or agency thereof, while in the discharge of his or her official duties;

(h) Permitting the measurement of the powers or range of human vision, or the determination of the accommodation and refractive state of the human eye or the scope of its functions in general, or the fitting or adaptation of lenses for the aid thereof;

(i) Permitting the prescribing or directing the use of, or using, an optical device in connection with ocular exercises, visual training, vision training, or orthoptics;

(j) Permitting the prescribing of contact lenses for, or the fitting and adaptation of contact lenses to, the human eye;

(k) Prohibiting the performance of routine visual screening;

(l) Permitting the practice of dentistry or dental hygiene as defined in chapters 18.32 and 18.29 RCW, respectively;

(m) Permitting the practice of chiropractic as defined in chapter 18.25 RCW including the adjustment or manipulation of the articulation of the spine;

(n) Permitting the practice of podiatric medicine and surgery as defined in chapter 18.22 RCW;

(o) Permitting the performance of major surgery, except such minor surgery as the commission may have specifically authorized by rule adopted in accordance with chapter 34.05 RCW;

(p) Permitting the prescribing of controlled substances as defined in Schedules I through IV of the Uniform Controlled Substances Act, chapter 69.50 RCW, except as provided in (r) or (s) of this subsection;

(q) Prohibiting the determination and pronouncement of death;

(r) Prohibiting advanced registered nurse practitioners, approved by the commission as certified registered nurse anesthetists from selecting, ordering, or administering controlled substances as defined in Schedules II through IV of the Uniform Controlled Substances Act, chapter 69.50 RCW, consistent with their commission-recognized scope of practice; subject to facility-specific protocols, and subject to a request for certified registered nurse anesthetist anesthesia services issued by a physician licensed under chapter 18.71 RCW, an osteopathic physician and surgeon licensed under chapter 18.57 RCW, a dentist licensed under chapter 18.32 RCW, or a podiatric physician and surgeon licensed under chapter 18.22 RCW; the authority to select, order, or administer Schedule II through IV controlled substances being limited to those drugs that are to be directly administered to patients who require anesthesia for diagnostic, operative, obstetrical, or therapeutic procedures in a hospital, clinic, ambulatory surgical facility, or the office of a practitioner licensed under chapter 18.71, 18.22, 18.36, 18.36A, 18.57, 18.57A, or 18.32 RCW; "select" meaning the decision-making process of choosing a drug, dosage, route, and time of administration; and "order" meaning the process of directing licensed individuals pursuant to their statutory authority to directly administer a drug or to dispense, deliver, or distribute a drug for the purpose of direct administration to a patient, under instructions of the certified registered nurse anesthetist. "Protocol" means a statement regarding practice and documentation concerning such items as categories of patients, categories of medications, or categories of procedures rather than detailed case-specific formulas for the practice of nurse anesthesia;

(s) Prohibiting advanced registered nurse practitioners from ordering or prescribing controlled substances as defined in Schedules II through IV of the Uniform Controlled Substances Act, chapter 69.50 RCW, if and to the extent: (i) Doing so is permitted by their scope of practice; (ii) it is in response to a combined request from one or more physicians licensed under chapter 18.71 or 18.57 RCW and an advanced registered nurse practitioner licensed under this chapter, proposing a joint practice arrangement under which such prescriptive authority will be exercised with appropriate collaboration between the practitioners; and (iii) it is consistent with rules adopted under this subsection. The medical quality assurance commission, the board of osteopathic medicine and surgery, and the commission are directed to jointly adopt by consensus by rule a process and criteria that implements the joint practice arrangements authorized under this subsection. This subsection (1)(s) does not apply to certified registered nurse anesthetists.

(2) In the context of the definition of licensed practical nursing practice, this chapter shall not be construed as:

(a) Prohibiting the incidental care of the sick by domestic servants or persons primarily employed as housekeepers, so long as they do not practice practical nursing within the meaning of this chapter;

(b) Preventing a person from the domestic administration of family remedies or the furnishing of nursing assistance in case of emergency;

(c) Prohibiting the practice of practical nursing by students enrolled in approved schools as may be incidental to their course of study or prohibiting the students from working as nursing assistants;

(d) Prohibiting auxiliary services provided by persons carrying out duties necessary for the support of nursing services, including those duties that involve minor nursing services for persons performed in hospitals, nursing homes, or elsewhere under the direction of licensed physicians or the supervision of licensed registered nurses;

(e) Prohibiting or preventing the practice of nursing in this state by a legally qualified nurse of another state or territory whose engagement requires him or her to accompany and care for a patient temporarily residing in this state during the period of one such engagement, not to exceed six months in length, if the person does not represent or hold himself or herself out as a licensed practical nurse licensed to practice in this state;

(f) Prohibiting nursing or care of the sick, with or without compensation, when done in connection with the practice of the religious tenets of a church by adherents of the church so long as they do not engage in licensed practical nurse practice as defined in this chapter;

(g) Prohibiting the practice of a legally qualified nurse of another state who is employed by the United States government or any bureau, division, or agency thereof, while in the discharge of his or her official duties.

[2003 c 258 § 6; 2000 c 64 § 3; 1994 sp.s. c 9 § 424.]

NOTES:

Severability -- Effective date -- 2003 c 258: See notes following RCW 18.79.330.

Effective date -- 2000 c 64 §§ 1-3: See note following RCW 18.79.255.

Severability -- 2000 c 64: See note following RCW 18.79.255.

Finding. RCW 18.79.330

The legislature finds a need to provide additional work-related opportunities for nursing students. Nursing students enrolled in bachelor of science programs or associate degree programs, working within the limits of their education, gain valuable judgment and knowledge through expanded work opportunities.

[2003 c 258 § 1.]

NOTES:

Severability -- 2003 c 258: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [2003 c 258 § 11.]

Effective date -- 2003 c 258: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [May 12, 2003]." [2003 c 258 § 12.]

RCW 18.79.260
Registered nurse -- Activities allowed -- Delegation of tasks.

(1) A registered nurse under his or her license may perform for compensation nursing care, as that term is usually understood, to individuals with illnesses, injuries, or disabilities.

(2) A registered nurse may, at or under the general direction of a licensed physician and surgeon, dentist, osteopathic physician and surgeon, naturopathic physician, podiatric physician and surgeon, physician assistant, osteopathic physician assistant, or advanced registered nurse practitioner acting within the scope of his or her license, administer medications, treatments, tests, and inoculations, whether or not the severing or penetrating of tissues is involved and whether or not a degree of independent judgment and skill is required. Such direction must be for acts which are within the scope of registered nursing practice.

(3) A registered nurse may delegate tasks of nursing care to other individuals where the registered nurse determines that it is in the best interest of the patient.

(a) The delegating nurse shall:

(i) Determine the competency of the individual to perform the tasks;

(ii) Evaluate the appropriateness of the delegation;

(iii) Supervise the actions of the person performing the delegated task; and

(iv) Delegate only those tasks that are within the registered nurse's scope of practice.

(b) A registered nurse, working for a home health or hospice agency regulated under chapter 70.127 RCW, may delegate the application, instillation, or insertion of medications to a registered or certified nursing assistant under a plan of care.

(c) Except as authorized in (b) or (e) of this subsection, a registered nurse may not delegate the administration of medications. Except as authorized in (e) of this subsection, a registered nurse may not delegate acts requiring substantial skill, and may not delegate piercing or severing of tissues. Acts that require nursing judgment shall not be delegated.

(d) No person may coerce a nurse into compromising patient safety by requiring the nurse to delegate if the nurse determines that it is inappropriate to do so. Nurses shall not be subject to any employer reprisal or disciplinary action by the nursing care quality assurance commission for refusing to delegate tasks or refusing to provide the required training for delegation if the nurse determines delegation may compromise patient safety.

(e) For delegation in community-based care settings or in-home care settings, a registered nurse may delegate nursing care tasks only to registered or certified nursing assistants. Simple care tasks such as blood pressure monitoring, personal care service, or other tasks as defined by the nursing care quality assurance commission are exempted from this requirement.

(i) "Community-based care settings" includes: Community residential programs for the developmentally disabled, certified by the department of social and health services under chapter 71A.12 RCW; adult family homes licensed under chapter 70.128 RCW; and boarding homes licensed under chapter 18.20 RCW. Community-based care settings do not include acute care or skilled nursing facilities.

(ii) "In-home care settings" include an individual's place of temporary or permanent residence, but does not include acute care or skilled nursing facilities, and does not include community-based care settings as defined in (e)(i) of this subsection.

(iii) Delegation of nursing care tasks in community-based care settings and in-home care settings is only allowed for individuals who have a stable and predictable condition. "Stable and predictable condition" means a situation in which the individual's clinical and behavioral status is known and does not require the frequent presence and evaluation of a registered nurse.

(iv) The determination of the appropriateness of delegation of a nursing task is

at the discretion of the registered nurse. However, the administration of medications by injection, sterile procedures, and central line maintenance may never be delegated.

(v) The registered nurse shall verify that the nursing assistant has completed the required core nurse delegation training required in chapter *18.88A* RCW prior to authorizing delegation.

(vi) The nurse is accountable for his or her own individual actions in the delegation process. Nurses acting within the protocols of their delegation authority are immune from liability for any action performed in the course of their delegation duties.

(vii) Nursing task delegation protocols are not intended to regulate the settings in which delegation may occur, but are intended to ensure that nursing care services have a consistent standard of practice upon which the public and the profession may rely, and to safeguard the authority of the nurse to make independent professional decisions regarding the delegation of a task.

(f) The nursing care quality assurance commission may adopt rules to implement this section.

(4) Only a person licensed as a registered nurse may instruct nurses in technical subjects pertaining to nursing.

(5) Only a person licensed as a registered nurse may hold herself or himself out to the public or designate herself or himself as a registered nurse.

[2003 c 140 § 2; 2000 c 95 § 3; 1995 1st sp.s. c 18 § 51; 1995 c 295 § 1; 1994 sp.s. c 9 § 426.]

NOTES:

Effective date -- 2003 c 140: See note following RCW 18.79.040.

Conflict with federal requirements -- Severability -- Effective date -- 1995 1st sp.s. c 18: See notes following RCW 74.39A.030.

Effective date -- 1995 c 295: "This act shall take effect August 1, 1996." [1995 c 295 § 4.]

Full Nurse Practice Act Available by Searching AT
http://apps.leg.wa.gov/rcw/

University of Washington Student Conduct Code

Pursuant to chapter 34.05 RCW and the authority granted by Chapter 28B.20.130 RCW, the Board of Regents of the University of Washington has established regulations on student conduct and student discipline on the University campus.

Violations of the Student Conduct Code could result in a variety of disciplinary actions, including suspension or permanent dismissal from the University. Concerns regarding possible violations should be directed to:

Office of the Vice President for Student Affairs
476 Schmitz Hall
543-4972

University of Washington General Conduct Code

It is the policy of the University of Washington to support and promote each individual's right to express views and opinions, to associate freely with others, and to assemble peacefully. In order to assure those rights to all members of the University community, the General Conduct Code (CH. 478-124 WAC) outlines prohibited conduct on the University campus and identifies applicable disciplinary codes under which sanctions can be applied for violation of the stated rules.

The following is a complete copy of the Student Conduct Code.

WASHINGTON ADMINISTRATIVE CODE
Rules of the University of Washington

- **WAC 478-120-010 Student Conduct Code-Authority**
- **WAC 478-120-020 Standards of Conduct**

STUDENT CONDUCT CODE

WAC 478-120-010 Student Conduct Code- Authority

Pursuant to Chapter 34.05 RCW and the authority granted by RCW 28B.20.130, the Board of Regents of the University of Washington has established the following regulations on student conduct and student discipline on the University campus.

WAC 478-120-020 Standards of Conduct

(1) The University is a public institution having special responsibility for providing instruction in higher education, for advancing knowledge through scholarship and research, and for providing related services to the community. As a center of learning, the University also has the obligation to maintain conditions conducive to freedom of inquiry and expression to the maximum degree compatible with the orderly conduct of its functions. For these purposes, the University is governed by the rules, regulations, procedures, policies, and standards of conduct that safeguard its functions and protect the rights and freedoms of all members of the academic community.

(2) Admission to the University carries with it the presumption that students will conduct themselves as responsible members of the academic community. As a condition of enrollment, all students assume responsibility to observe standards of conduct that will contribute to the pursuit of academic goals and to the welfare of the academic community. That responsibility includes, but is not limited to:

(a) Practicing high standards of academic and professional honesty and integrity;

(b) Respecting the rights, privileges, and property of other members of the academic community and visitors to the campus, and refraining from any conduct that would interfere with University functions or endanger the health, welfare, or safety of other persons;

(c) Complying with the rules, regulations, procedures, policies, standards of conduct, and orders of the University and its schools, colleges, and departments.

(3) Specific instances of misconduct include, but are not limited to:

(a) Conduct that intentionally and substantially obstructs or disrupts teaching or freedom of movement or other lawful activities on the University campus and is not constitutionally and/or legally protected;

(b) Physical abuse of any person, or conduct intended to threaten imminent bodily harm or to endanger the health or safety of any person on the University campus;

(c) Conduct on the University campus constituting a sexual offense, whether forcible or nonforcible, such as rape, sexual assault, or sexual harassment;

(d) Malicious damage to or malicious misuse of University property, or the property of any person where such property is located on the University campus;

(e) Refusal to comply with any lawful order to leave the University campus or any portion thereof;

(f) Possession or use of firearms, explosives, dangerous chemicals or other dangerous weapons or instrumentalities on the University campus, except for authorized University purposes, unless prior written approval has been obtained from the Vice President for Student Affairs, or any other person designated by the President of the University (see WAC 478-124-020 (2)(e)) (legal defense sprays are not covered by this section);

(g) Unlawful possession, use, distribution, or manufacture of alcohol or controlled substances (as defined in chapter 69.50 RCW) on the University campus or during University-sponsored activities;

(h) Intentionally inciting others to engage immediately in any unlawful activity, which incitement leads directly to such conduct on the University campus;

(i) Hazing, or conspiracy to engage in hazing, which includes:

(i) Any method of initiation into a student organization or living group, or any pastime or amusement engaged in with respect to such an organization or living group, that causes, or is likely to cause, bodily danger or physical harm, or serious mental or emotional harm, to any student or other person attending the University; and

(ii) Conduct associated with initiation into a student organization or living group, or any pastime or amusement engaged in with respect to an organization or living group not amounting to a violation of (i)(i) of this subsection, but including such conduct as humiliation by ritual act and sleep deprivation. Consent is no defense to hazing. Hazing does not include customary athletic events or other similar contests or competitions;

(j) Falsely reporting a violation of the Student Conduct Code.

(4) Disciplinary action may be taken in accord with this chapter regardless of whether that conduct also involves an alleged or proven violation of law.

(5) An instructor has the authority to exclude a student from any class session in which the student is disorderly or disruptive. If the student persists in the disorderly or disruptive conduct, the instructor should report the matter to the dean of the school or college in which the student is enrolled. (See WAC 478-120-030(3).)

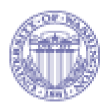
(6) Nothing herein shall be construed to deny students their legally and/or constitutionally protected rights.

Adopted by the University of Washington Senate,
May 27, 1969,Confirmed by the Board of Regents, June 27, 1969
Amended by the University of Washington Senate, April 8, 1971, Confirmed by the Board of Regents, June 18, 1971

Washington Administrative Code,
Filed November 30, 1972; Effective December 30, 1972

Confirmed by the Board of Regents,
April 19, 1996

Washington Administrative Code Amended,
Filed April 29, 1996; Effective May 30, 1996



University of Washington School of Nursing
Advanced Practice Community Health Care Systems

Guidelines the NCLIN 599 eJournal

Overview

The eJournal is an electronic method for the student to demonstrate achievement of objectives designated for each quarter of the NCLIN 599 Collaborative Leadership Internship (see the APCHSN Internship Manual for the list of objectives of each NCLIN 599.) The student is expected to complete five NCLIN 599 Collaborative Leadership Internships. For each NCLIN 599, the student will identify objectives to achieve:

1) 1 objective from the list of objectives from a NCLIN 599 Collaborative Leadership course. These objectives are derived from Public Health Competencies
2) 1 objective to achieve a practice of Collaborative Leadership
3) 1 objective to contribute a product or deliverable to the agency
4) 1 objective that the student desires to achieve for personal growth

(1) NCLIN 599A	(2) NCLIN 599B	(3) NCLIN 599C	(4) NCLIN 599D	(5) NCLIN 599E
First 3 objectives	All 4 objectives	All 4 objectives	All 4 objectives	All 4 objectives

Staying on Target

You may find it helpful to attach a date when you hope to achieve the objective, and the evidence that documents your achievement. Attaching an achievement date and what you hope to achieve for an objective will help you to stay on target.

Writing the eJournal

It is recommended that the activities conducted in the field for NCLIN 599 are written in Word, and attached to the eJournal designated by a date. Faculty may use the Word editing function to provide feedback to you.

Write about the activities that you did to achieve each objective. At the end of each description draw a conclusion or reflection about your experiences.

Discuss with your faculty internship supervisor about other ways in which she or he wants you to document your experiences in the community. For example, faculty may want you to write notes using the anthropologic field note tradition. Faculty may want you to document the time spent in the field.

Frequency of writing the eJournal

Discuss with your faculty internship supervisor the frequency of writing in your eJournal. Each has a different way of working with students using the eJournal.

Using NCLIN 599 field time for writing, meeting with faculty etc.
In general, one hour per week for field time may be used to write the eJournal, meet with faculty, or conduct other logistical activities related to NCLIN 599.

Working with Community Liaisons
Per the guidance of your faculty internship supervisor, provide a copy of your objectives with the community liaison along with days and time frame you plan to be at the agency or community.

Some community liaisons want a written summary of your activities that is separate from your eJournal. Discuss their preference with them.

University of Washington School of Nursing
Academic Services

NCLIN 599 – INDEPENDENT STUDY ADVANCED CLINICAL PRACTICE FORM

Student ____________________ Faculty Supervisor_______________________

Quarter/year_________________ Credits_________________________________

This form has been modified for Advanced Practice Community Health Systems Nursing students. For other NCLIN 599 course work, please use the standard School of Nursing form at
http://www.son.washington.edu/students/docs/NCLIN599.doc

SECTION I. This section is to be completed by the student with assistance from the faculty supervisor by the third week of each internship quarter. Objectives must be approved by the faculty supervisor prior to the student obtaining the signatures of approval below.

A. OBJECTIVES:

B. PLAN FOR ACHIEVING OBJECTIVES:

Approved________________________________ ________________________________
Faculty Supervisor's signature Date Student's signature Date

____
Community Liaison's signature Date

SECTION II. This section is to be completed by the faculty supervisor in conjunction with the student.

C. COMMENTS ON ACHIEVEMENTS:

Final grade ______________

________________________________ ________________________________
Faculty Supervisor's Signature Date Student's Signature Date

____
Community Liaison's Signature Date

Three copies needed: student file/department/student

Office of the Vice President for Student Affairs
ovpsa@u.washington.edu
Modified: January 26, 1998

University of Washington
School of Nursing
Advanced Practice Community Health Systems Nursing

EVALUATION OF INTERNSHIP SITES
By Student

This is an informal evaluation, which is for the exclusive use of APCHSN Faculty and students. Your student colleagues and future APCHSN students will have the opportunity to peruse these evaluations in order to make more informed decisions about their own internship(s). Your frank and honest insights on the site itself and/or the liaison(s) are very much appreciated. Please return completed evaluations to the APCHSN Faculty coordinator. Compiled evaluations will be available in the APCHSN Faculty coordinator's office.

Name of Site/Location

____

Liaison(s)

____

Quarter and Year

____

Impressions of the Site: (opportunities and experiences available; appropriateness of level of work provided/required; relevance to current or future CHN practice; availability of projects; accessibility for times available, etc.).

Impressions of the Liaison(s): (availability to provide direction and support; clarity of direction and expectations; effectiveness of teaching; expertise; etc.)

Would you recommend this location/liaison(s)? Yes No

Additional thoughts on why or why not: