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Nevada Nursing News



THANK YOU FOR ALL
THAT YOU DO

Happy Nurses Week

May 6-12

WORDS

From the Executive Director



Once again, it is time to celebrate Nurses' Week (May 6-12). This should be a time of both reflection and a time to look forward. To honor our past and embrace our future. The Nevada State Board of Nursing was created by statute in 1923 with the signing of AB 82 into law. In 1931, the Nevada Nurses Association (NNA) incorporated, and District 1 was formed. The purpose of the organization was to establish a code of ethics, improve the standards of nursing, and to establish reciprocity between Nevada nurses and those of other countries. In 1949, practical nurses became regulated. In 1957, the first Bachelor of Science in Nursing program was established and in 1965, the first Associate Degree program was established in the state. In 1979, nurse practitioners began to be regulated. In 1989, the Nevada State Board of Nursing was given the authority to regulate nursing assistants. In 2013, APRNs were given full practice authority.

Nevada has a rich nursing history. The Nevada State Board of Nursing has consistently upheld its mission to protect the public's health, safety, and welfare through effective nursing regulation. As we look toward the future, we must consider how technology currently and futuristically will impact patient care. The immergence of AI continues to be at the forefront of health care conversations, both as it relates to education, and patient care. Dr. Eileen Fry-Bowers, Dean of the School of Nursing and Health Professions at the University of San Francisco states, "We must be architects in how AI is integrated into clinical practice." Furthermore, she said, "we must have seats at the table; from design and development, all the way through regulation of its usage."

AI continues to evolve, faster than we can adapt. We must strive to be the creators and not just the consumers. Innovative thinking must be the driver, but patient safety must always be the engine. Caring must always be at the root of healthcare.



Cheryl A. Maes
Ph.D, APRN, FNP-BC,
Board President

Message

From the President

The Power of Nursing in Nevada

As we celebrate National Nurses Week here in Nevada, we take this opportunity to recognize and honor the individuals who are truly the backbone of our healthcare system -- our nurses. For those who wear the badge of nursing each day, pride in the profession extends far beyond a single week or moment of recognition. Nursing is a daily commitment to care, compassion, and healing that strengthens communities across our state.

From bustling hospitals in Las Vegas and Reno to rural communities across Nevada, nurses are present during life's most critical moments. They welcome new life, ease pain, provide comfort through uncertainty, and offer strength in times of loss. They are not only highly skilled clinicians, but also educators, advocates, and trusted lifelines for patients and their families. Through long hours and ever-changing demands, Nevada's nurses remain steady, compassionate, and unwavering.

This commitment is evident at every level of the profession, including the essential contributions of Advanced Practice Registered Nurses and Certified Registered Nurse Anesthetists. Through advanced education and specialized clinical training, these professionals expand access to care across Nevada, particularly in rural and underserved communities. Their expertise, precision, and leadership are critical to delivering high-quality, patient-centered care and ensuring safe, effective outcomes across a wide range of healthcare settings.

To be a nurse is to demonstrate courage in the face of the unknown, resilience during challenging times, and a deep commitment to treating every patient with dignity and respect. It is a role grounded in trust and responsibility, carried out in hospitals, community health centers, long-term care facilities, schools, and beyond. Wherever care is needed in Nevada, nurses are there.

The pride nurses take in their work is both professional and deeply personal. It is reflected in the gratitude of a patient, the progress of recovery, and the reassurance offered through even the smallest acts of kindness. It comes from knowing that their work has a meaningful and lasting impact on the lives of others.

During National Nurses Week, we extend our heartfelt thanks to Nevada's nurses -- not only for what they do, but for who they are. Their strength, grace under pressure, and unwavering dedication to improving care continue to inspire us all. To every nurse across Nevada, your work changes lives, your commitment strengthens our communities, and your pride in your profession

does not go unnoticed. As the Nevada State Board of Nursing, we are grateful for you and proud to stand with you.



WHAT IS A.I.?

Part 3 of 3-part
series



Ethical Guardrails for AI in Nursing Education: A Policy and Organizational Approach

By Dr. Jennifer Vanderlaan, UNLV School of Nursing

Generative Artificial Intelligence (AI) has entered higher education quickly, and nursing programs are no exception. From generating case scenarios to supporting literature reviews, these tools can augment the teaching and learning process. But just as quickly as AI's potential is celebrated, concerns about bias, confidentiality, accountability, and academic integrity arise.

The American Association of Colleges of Nursing (AACN) Essential Domain 8 highlights the importance of nurses understanding information technology. This means educational programs bear an institutional responsibility to ensure that AI use aligns with nursing ethics. Educational programs are also required to demonstrate compliance with state-specific regulations, including regulations about minimum educational preparation for new nurses. In Nevada, these curricular standards are set by the Board of Nursing and include “technological skills commensurate with safely delivering patient care” (NAC 632.690 2b). Given these requirements, how nursing education programs govern AI will shape their credibility with accreditors and regulators.

This article frames the organizational responsibilities of nursing schools regarding generative AI use. Nursing program implementation of AI use begins with ethics, anchors those values in law, and then outlines the operational and strategic structures required for responsible AI integration.

Ethics as the Foundation

The American Nurses Association (ANA) Code of Ethics provides a professional grounding for AI use in nursing education (American Nurses Association [ANA], 2015). While written before generative AI, its principles map directly onto emerging risks. Provision 3 states that nurses advocate for the protection of rights, health, and safety. The

most direct application of this provision for educators working with AI tools is protecting student and patient privacy, guarding against bias in AI tools, and ensuring fairness in evaluation. Provision 4 states that nurses are accountable for nursing judgments and actions, which aligns with the standard that AI may assist, but it cannot replace professional judgment. Faculty remain accountable for assessing student competence, even when AI is used as a teaching tool. Students remain accountable for the accuracy and quality of their course work and must demonstrate clinical judgment whether or not generative AI was used in preparation of an assignment.

AACN Essential Domain 8 underscores that nurses are accountable for the ethical use of information and communication technologies (American Association of Colleges of Nursing, 2021). Aligning program AI policy with this domain ensures faculty and students understand AI as part of professional responsibility. This establishes a common standard across courses, relieving faculty from creating their own isolated rules. Faculty are then responsible for upholding the program's standards, while leadership carries accountability for developing, monitoring, and revising the policies that sustain them.

Legal and Regulatory Guardrails

Ethical obligations are reinforced by law; programs that fail to govern AI risk violating federal requirements that protect student or patient privacy. Uploading identifiable coursework or records into AI systems without privacy safeguards can create a Family Educational Rights and Privacy Act (FERPA) violation. In clinical contexts, any sharing of patient data must remain consistent with Health Insurance Portability and Accountability Act (HIPAA) protections, even when information is de-identified.

Nevada statutes provide additional direction. In the 2025 session, Assembly Bill 406 restricted AI from substituting for licensed counseling and mental health roles in K-12 schools (Nevada Legislature, 2025). This law upholds the standard that AI can support professional work but cannot replace licensed practice or compromise safety, privacy, or fairness. Currently the law does not cover higher education or general health care practice, but the landscape is evolving. Nursing programs should stay aware of the evolving policy landscape to prepare students for the regulatory conditions they will face in practice.

Governance of AI Use

Ethical principles are not self-enforcing. To translate them into daily practice, programs are expected to embed these provisions into institutional policy. Strong governance is the anchor of effective AI policy. Nursing programs are expected to establish oversight structures that demonstrate accountability to regulators and accreditors. Shared governance in nursing schools distributes responsibility and decision-making across faculty, administrators, and students while fostering transparency and collaboration. Curriculum committees or equivalent bodies can draft and review AI policies, with final approval by deans or directors. Within this process, student representatives provide input on how policies affect their learning and practice. Annual review processes then integrate regulator expectations with the evolving perspectives of faculty and students.

Operational practices create consistency and make policies credible. Programs can achieve this by incorporating written AI use standards into student handbooks and faculty guidelines. Orientation sessions for students can introduce program standards, including examples of prohibited (“red zone”) and permissible (“green zone”) applications. Faculty training supports consistent understanding and application of the rules.

Evidence of implementation is critical. Accreditation and regulatory reviews rely on documentation such as faculty training records, results of compliance monitoring, and reports of incidents with corrective actions. Programs that integrate AI oversight into existing quality improvement systems create a sustainable process for gathering and reviewing this evidence. This approach also signals to accreditors and boards that AI governance is fully embedded in the program’s quality framework.

Strategic Implications

Although compliance is a main driver of AI governance, programs also benefit from recognizing AI governance as a strategic matter. Integrating AI oversight into compliance dashboards and risk reports safeguards the program against reputational or legal harm. At the same time, governance structures help ensure equitable access so that all students, regardless of background or resources, are able to engage with AI as part of their professional preparation. Clear guidance on academic integrity provides future students confidence in the program's admissions while equitable access ensures that students graduate with shared competencies. In the same way, clinical partners and health systems gain assurance that students are prepared within rigorous, ethical standards for working with AI.

By modeling transparency, reinforcing accountability, and celebrating ethical practice, program leaders build an AI culture that extends beyond compliance. Faculty can promote fairness by preventing AI use from creating hidden advantages between students and by reviewing AI-generated content for bias in patient portrayals. Programs that consistently attend to these equity concerns demonstrate alignment with both the ANA Code of Ethics and accreditor expectations for diversity and inclusion.

Conclusion

Artificial intelligence will continue to shape healthcare and nursing education. This innovation cannot come at the expense of ethics, compliance, or public accountability. Nursing programs in Nevada are responsible for embedding AI governance into their policies, oversight structures, and quality improvement processes. By grounding AI use in the ANA Code of Ethics, aligning policies with federal and state law, and documenting compliance with accreditation requirements through standardized procedures, programs position AI as a tool for growth rather than a source of risk.

References

American Association of Colleges of Nursing. (2021). The Essentials: Core competencies for professional nursing education.
<https://www.aacnnursing.org/Portals/0/PDFs/Publications/Essentials-2021.pdf>

American Nurses Association. (2015). Code of ethics for nurses with interpretive statements. Author. <https://codeofethics.ana.org/provisions>

Nev. Assembly Bill 406 (83rd Leg. Sess. 2025), Enrolled Version, https://www.leg.state.nv.us/Session/83rd2025/Bills/AB/AB406_EN.pdf



**NURSING IS AT THE
HEART OF
HEALTHCARE**



HAPPY NURSES WEEK

Hot Topics for Nurse Practitioners to Watch in 2026

By Susan S. VanBeuge, DNP, APRN, FNP-BC, FAANP, FAAN



Full Practice Authority: Why It Matters for Patients

Nevada continues to experience significant growth of advanced practice nursing. According to the most recent Nevada State Board of Nursing Annual Report (2024-2025), the number of active advanced practice nurse practitioners (APRN) is 7,433 (Nevada State Board of Nursing [NSBN], 2025). Of these, 52% reside in Nevada and 48% hold out-of-state licensure, according to the report. APRNs are widely distributed throughout the state with the highest numbers in the most populated counties, Washoe and Clark. However, gaps remain with no APRNs in Esmerelda of Mineral counties. When evaluating the annual reports from 2022-2023 through 2024-2025, the steady increase of APRNs in Nevada continues to demonstrate growth of trained clinicians who provide care across the lifespan.

Nevada is among the fastest-growing states in the United States, driven by the migration for economic opportunities, hospitality, tourism, and the expanding technology sector. With a population exceeding 3.3 million residents, much of this growth is concentrated in Clark County, Las Vegas metropolitan area (World Population Review, 2026). The median age in Nevada is 39.5 years old, with the largest age group 30-34 years old (U.S. Census, 2020). Despite this growth, the state continues to face persistent health care access challenges, particularly in access to primary care, as well as ongoing provider shortages in the rural and frontier regions.

Full practice authority (FPA) refers to state-level regulation where nurse practitioners (NP) are licensed to assess, diagnose, interpret diagnostic tests, treat, prescribe, manage care and is not contingent on physician supervision. Nevada is one of 27 such states where the majority of the licensed advanced practice nurses have FPA (American Association of Nurse Practitioners [AANP], 2025). This policy change was implemented during the 2013 legislative session. This designation is particularly important to note when examining healthcare access, quality, and patient outcomes.

For Nevada residents, the most immediate impact of FPA is improved access to care. While provider shortages continue to exist in Nevada, NPs have increased in number to fill the gaps in the community. Evidence demonstrates NPs are more likely than physicians to practice in underserved and rural areas, helping fill the critical gaps that exist (Auerbach et al., 2020). An increase in primary care providers translates into shorter wait times for appointments, increased availability of primary care services, and greater geographic distribution of licensed providers.

In Nevada's rural and frontier communities, the role of the NPs is especially significant. These regions are often characterized by sparse population, geographic isolation, and limited health care structure. These are substantial barriers to even the most basic care. NPs have steadily

increased in their presence in these communities to fill the gaps to provide timely, high-quality, evidence-based care (Barnes, et al., 2018). Current literature supports that NPs who care for patients with multiple chronic conditions have equivalent or improved quality, lower or comparable costs, and reduced utilization of emergency and inpatient admissions (Fitzpatrick, et al., 2026).

The implications for Nevada are clear. Full practice authority supports a health care system that is more accessible, efficient, and responsive to patient needs. Nurse practitioners are essential partners in care as clinicians, leaders, and members of interprofessional teams dedicated to improving health outcomes across the state. As Nevada grows, NPs will continue to meet health care needs, maintain fiscal responsibility, and enhance the patient experience. During Nurse's week, hats are off to all nurses in every role they serve.

References:

- American Association of Nurse Practitioners, 2025. Issues at a Glance: Full Practice Authority. Downloaded <https://www.aanp.org/advocacy/advocacy-resource/policy-briefs/issues-full-practice-brief>
- Auerbach, D. I., Buerhaus, P. I., & Staiger, D. O. (2020). Implications Of The Rapid Growth Of The Nurse Practitioner Workforce In The US. *Health affairs (Project Hope)*, 39(2), 273–279. <https://doi.org/10.1377/hlthaff.2019.00686>
- Barnes, H., Richards, M. R., McHugh, M. D., & Martsof, G. (2018). Rural And Nonrural Primary Care Physician Practices Increasingly Rely On Nurse Practitioners. *Health affairs (Project Hope)*, 37(6), 908–914. <https://doi.org/10.1377/hlthaff.2017.1158>
- Fitzpatrick, Joyce J. PhD, MBA, RN; Mehlman, Maxwell J. JD; Plemmons, Alicia PhD; Duffy, Evelyn G. DNP, AGPCNP-BC; Votruba, Mark PhD; Gerlick, Joshua A. PhD, MBA, MS; Davis, Summer MSN; Norful, Allison A. PhD, RN, ANP-BC. The Impact of Nurse Practitioner Full Practice Authority on Chronic Condition-Related Readmissions and Emergency Department Visits in the United States. *Medical Care* 64(4):p 192-197, April 2026. | DOI: 10.1097/MLR.0000000000002285
- Nevada State Board of Nursing, 2025. Annual Report 2024-2025. Downloaded <https://nevadanursingboard.org/wp-content/uploads/2025/12/Annual-Report-FY-2024-2025-FINAL-11.21.25.pdf>
- World Population Review, 2026. Nevada. Downloaded <https://worldpopulationreview.com/states/nevada#:~:text=Statehood%20Year:%201864,Annual%20Population%20Growth>
- U.S. Census Bureau, 2020. State of Nevada. Downloaded <https://data.census.gov/profile/Nevada?g=040XX00US32#populations-and-people>

BOARD OF NURSING PRACTICE DECISIONS 2023-2025

The Nevada State Board of Nursing has been very busy over the past two years making sure that the practice decisions that influence clinical practice are the most up-to-date and utilize the latest evidence-based practice.



There have been updates and new practice decisions posted in the following areas:

- Aesthetic/Cosmetologic Procedures
- Apprentice Nurse Skills List
- Central Venous Access Device Insertion
- CNA Skills Guidelines
- Epidural Catheter Removal
- Hemovac and/or Jackson Pratt Surgical Drain
- IV Hydration Out of Hospital Administration of IV Solution/Medications Low Dose Continuous IV Ketamine Treatment Chronic Pain/Depression Nitrous Oxide Outside of the Operating Room
- Peripheral Vascular Access Device Insertion
- Pessary Device Interventions
- Phlebotomy and Blood Sampling Collection (LPN Section)
- School Nursing

<https://acrobat.adobe.com/id/urn:aaid:sc:VA6C2:a6404562-adc8-4a4c-a4c6-645a94296233>

WHEN DO THE MEANINGS OF THE ACRONYMS CNO AND CEO CHANGE IN HEALTHCARE?

By Lauren Jones

We all know that our society generally is in a hurry; not wanting to wait for anything. So, our vocabularies have become acronyms. For those in healthcare, you know that CEO stands for Chief Executive Officer and CNO means Chief Nursing Officer. But can those meanings change and how can they change? Two decades ago, we began to see corporations purchasing hospitals under their corporate logo. Many of the corporations then began the ‘silo structures’’: VP of Finance; HR; Operations; Culture, etc. Unfortunately, that structure established the pyramidal organization separated by the silos within each hospital. In healthcare, there’s a running joke about that: urine flows downhill. When I give seminars, there’s usually laughter and then someone says, “That’s true; just ask the Staff!” Communication is one-way: top-down and rarely engages staff and even more rarely goes down-top. I’m noticing many facilities right now are experiencing reduced retention with staff turnover. That becomes a symptom of the top-down culture. That method of communication also increases the importance of ANY information: true or not. And, then the start of the sacred rumor mill. The weird part about the rumor mill, is that there is usually one piece of information that was accurate; reinforcing the next rumor!

If, regardless of your position, a top-down communication mode only requires obedience, you may be limiting your quality of services. Usually, there’s a corporate code: “don’t argue and just present the data and do your job. If you need help, call the Corporate Consultant”. The unfortunate piece about ‘presenting data’ is often minimized because of the time spent gathering and entering data. Several years ago, I was asked to consult with a large acute care center in San Diego to help with their UTIs. Innocently, I asked the number and was told: “A lot”. When I asked what ‘a lot’ meant, I was told ‘pretty many’. I suggested choosing a unit, dating an entry with hashmarks for every UTI in the next month in that unit. Interestingly, when that was done, and care givers were questioned, it showed that 50% of the MDs were not aware their patients were catheterized.

In your organization, are questions OK? Do the CEO and/or CNO ask questions? Do they welcome questions? When a study begins, is it reported in executive meetings? We all know that when agenda items become dead, they are still listed, but usually not discussed. And asking for help from the Corporate Consultant is difficult because they are inherently part of the culture (collective behaviors). So, it is difficult to truly assess what is written or heard objectively.

If some of the above events are occurring in your organization and actual assessments and cultural changes are not created AND PRACTICED, CEO will become Career Ending Opportunity or CNO will become Consider No Options. There are possibilities to actually change behaviors. In the mid-90’s I was asked to create Shared Governance in Mayo’s two acute care facilities in Rochester, MN. They had 27 Unions and when I left after five years of consulting, I saw a Staff RN and asked him how things were: “Not bad now”. High praise, indeed!



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A true-to-life story of a dual role of a caregiver: A nurse and a daughter providing care at the end of life, inspired by Dr. Jean Watson's Human Caring Theory



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Abstract

This article was inspired by a true-to-life story of a daughter who happened to be a nurse caring for a loving mother with a terminal illness. Watson's Human Caring Theory was used as the contextual lens to understand the experience of the dual role of a nurse and a daughter. Fulfilling the dual role of nurse and daughter at the mother's end of life was profoundly demanding, yet it truly embodied the essence of nursing. In this real-life scenario, the responsibilities and instincts of a nurse naturally took precedence. The professional role emerging before the emotional role of the daughter highlighted the complex interplay between duty and familial love. It illustrated how the nurse's role momentarily overshadowed, yet ultimately deepened, the experience of being a daughter at the mother's end of life.

Inspired by Dr. Jean Watson's Human Caring Theory, this personal journey was deeply enriched through the practical application of the Caritas Processes®, which brought greater meaning and compassion to the caregiving experience.

Keywords: dying, family caregiver, home care, end of life care, Dr. Jean Watson's Theory of Human Caring¹⁰ Caritas Processes, holistic nursing, nursing ethics

Introduction

Though seldom discussed, death is a profound reality that ultimately prepares each of us for the transition to an everlasting existence. It is not a common conversation in the society on what we wish on the moment of death, such as a Living Will. Schott (2023) stated that death may not be a comfortable subject, but it will impact all of humanity.

In the quiet moments of life, we often find ourselves facing the most profound experiences. This was a journey of a true-to-life story of both a nurse and a daughter, who provided care to a beloved mother at the end of her life. Inspired by Dr. Jean Watson's Human Caring Theory, this narrative explores the challenging dual roles and the deep emotional connections that complete the end-of-life caring experience.

As a nurse, the daughter was equipped with the knowledge and skills to provide medical care, but as a daughter, she was driven by love and compassion. The intersection of these roles brought forth a unique perspective on caregiving, one that transcended the boundaries of professional duty and personal devotion. Through this story, we hope to share the lessons learned and the profound influence from the Human Caring Theory of Dr. Jean Watson on the approach to end-of-life care (Watson, 2008).

Watson's (2008) theory advocates the practice of loving-kindness, compassion, and equanimity with patients and their families. Evidence-based practice (EBP) shows that incorporating these humanistic-altruistic values into end-of-life care can lead to better patient outcomes, including reduced anxiety and improved emotional well-being (Watson, 2008; Gómez-Salgado, 2023). Thus, creating a healing environment at all levels is crucial for effective end-of-life care, caring for the physical, emotional, mental, social, and spiritual needs.

Experience of Dr. Zarah Gayrama-Borines

It was not a common experience to witness the death of a loved one, especially a dearly beloved mother. It was a privilege and a sense of fulfillment for me as both a nurse and a daughter. I am forever grateful to my mother for giving me the most incredible opportunity to be with her in her last breath. A noble feeling of satisfaction that will last forever.

It felt as though all the knowledge, skills, and attitudes I gained from nursing school, my emergency nursing experiences, and my training as a Caritas informed Coach/Leaders came together to reinforce the purpose of being a nurse. These factors, enable me to deliver quality care while remaining mindful of the interconnectedness of the body, mind, and spirit. This experience reflects Watson's (2008) Caritas Processes ® *Deepen (Creative Self)* and *Minister (Humanity)*, among other.

Caritas Process ® *Deepen* is an approach that honors the full use of self, using the artistry of caring, healing practices and the "Ways of Knowing". Caring becomes more than an action; it becomes a way of being. This concept emphasizes engaging in all ways of knowing, being, doing, and becoming. It calls upon empirical understanding, ethical awareness, aesthetic sensitivity, personal insight, and even spiritual grounding (Watson, 2008). In practice, this means

approaching challenges not merely with technical skills, but with creativity and compassion that affirms the humanity of both caregivers and patients.

As an emergency room (ER) nurse for 19 years, I witnessed several deaths, and I felt that every death was a unique opportunity. After every post-mortem care, I prayed since it was a common belief that the departed soul can bring prayers to heaven (Tu et al., 2022). The souls can intercede with prayers on our behalf. Some people whisper their greatest dreams with the intention of achieving them someday. As Caritas trained nurses, we know that there is a connectivity between the body-mind-spirit (Watson, 2008).

My mother was diagnosed with breast cancer, a diagnosis that devastated our family. She underwent a mastectomy, followed by a rigorous course of oral chemotherapy. For years, we celebrated her remission and were grateful for every moment we had with her. However, our relief was short-lived as the cancer cells returned, bringing a new set of challenges and heartaches, including death.

Dr. Jean Watson's Human Caring Theory

The 10 Caritas Processes® of Dr. Jean Watson (2008) was a powerful tool in navigating the end-of-life care and the grieving process. The teachings attained during the Caritas Coach/Leader training sessions were crucial to physical, emotional, and spiritual well-being. These principles provided strength, and resilience offered a profound sense of peace and acceptance. Caritas Processes® are behaviors based on caring consciousness, engaging in reliable human caring relationships for healing support, integrity, loving-kindness including compassion, trusting relationships, authentically presence, and mindfulness (Watson, 2008). Human Caring Theory, as a part of the Health Sciences, was crucial in this moment of end-of-life care (Sitzman & Watson, 2019). Without proper knowledge and training, the outcome of the personal journey could be different.

Bedside Application of the Caritas Processes®

In Watson's theory of Human Caring, there are 10 nursing Caritas Processes®, which helps nurses develop a comprehensive understanding on the relationship between care, caring factors, and the processes of human life (Akbari & Nasiri, 2022). The common themes experienced in this true-to-life story were human touch, patient-centered care, authentic presence, attentive listening, mindfulness, family involvement, spirituality, and creating and managing the healing environment. In this article, six of the ten Caritas Processes are discussed in relation to the dual role of nurse and daughter during the end-of-life care.

Embrace (Loving-Kindness) Sustaining Humanistic-Altruistic Values by Practice of Loving-Kindness, Compassion, and Equanimity with Self/Others

According to the Watson Caring Science Institute (n.d.), Sustaining humanistic–altruistic values call caregivers to embody loving-kindness, compassion, and equanimity, cultivating a therapeutic presence that honors the dignity and inherent worth of every person.

During the end-of-life care, as a nurse caregiver, I provided loving-kindness by attending to the physiologic needs of my dying mother such as providing and monitoring oxygen levels, giving pain medication as needed, feeding accustomed foods, turning every two hours, and providing

spiritual needs were prioritized. Additionally, participating in daily online Catholic Mass and receiving blessed hosts from the church minister brought her comfort and lightened her days. As a daughter caregiver, I dedicated my time to my dying mother by paying attention to every cue that she provided. My mother was very intentional with her instructions such as “be with me at bedside all the time and pray with me for the final moment.” In this end-of-life care, the role of being a daughter was not easy, but it was doable.

Inspire (Faith-Hope) Being Authentically Present, Enabling Faith/Hope/Belief System, Honoring Subjective Inner, Lifeworld of Self/Others

Watson Caring Science Institute (n.d.) emphasized being authentically present invites caregivers to create a space of trust and genuine connection, allowing individuals to draw strength from their own faith, hope, and belief systems during moments of vulnerability.

As a nurse caregiver, I was authentically present, being at my mom’s bedside, anticipating the basic needs such as helping to eat, walking to the bedside commode for urination or defecation, preventing falls, administering prescribed medications, obtaining daily vital signs, bed baths, and other personal random essential needs.

As a daughter caregiver, I practiced this Caritas Process® by paying attention to the personal needs of the dying mother, disengaging from worldly concerns such as receiving phone calls, scanning TikTok, Facebook, Instagram, etc. Watson (2008) emphasized that being authentically present means giving the person full attention and honoring the subjective inner lifeworld of self/others. This means a devoted caregiver tenderly meets most of the basic needs, offering an unwavering presence and compassion that comforts the body, mind, and spirit in vulnerable moments.

Nurture (Relationship) Developing and Sustaining Loving, Trusting-Caring Relationships

Developing and sustaining loving, trusting–caring relationships involves cultivating authentic presence that is grounded in respect and empathy, allowing individuals to feel seen, supported, and valued.

Days before my mother’s passing, she mentioned how to manage her belongings, the properties, what to do with her deceased body, and other confidential matters. She verbalized, “Pray for me, never leave me alone.” Trusting-caring relationships are crucial in this moment since all the wishes were mentioned without hesitation. As both a nurse and a daughter–caregiver, I assumed responsibility for carefully observing and communicating every essential detail to guide my family’s decisions, particularly in the absence of her Living Will.

This practice is more focused on efforts, among other things, to institutionalize provider and family education and help to manifest a practice culture that is collaborative to achieve person-oriented care (Hussain, 2021). In general, educating the family about the wishes and how the individual could be cared for was essential in delivering patient-centered care; the care that the patient wanted. Masters (2026) mentioned that the characteristics of a patient-centered care include respect for patient’s values, preferences, expressed needs, coordination and integration of

care, information, and physical comfort. Nurses as caregivers should initiate patient-centered care.

Deepen (Creative Self) Creatively Problem-Solving-” Solution-Seeking” Through Caring Process; Full Use of Self and Artistry of Caring-Healing Practices via Use of all Ways of Knowing/Being/Doing/Becoming and Co-Create (Caritas Field) Creating a Healing Environment at All Levels; Subtle Environment for Energetic Authentic Caring Presence

At this point, this solution-seeking process transforms problem-solving into a healing encounter. By centering empathy, caregivers cultivate innovative solutions that honor the patient’s needs. Moreover, creating a healing environment involves shaping both the physical space and the emotional atmosphere to promote comfort and inner calm. This also honors the spiritual needs that help individuals find meaning and strength (Watson, 2008).

As a nurse, critical thinking is an innate practice in day-to-day life, looking for the best options for the state of being. Masters (2026) emphasized critical thinking as an essential component of professional accountability and high-quality nursing care.

During this time, as a nurse caregiver, I used critical thinking by managing resources effectively, planned where to get oxygen supplies, medications, bedside commode, wheelchair, hospital bed, internet Wi-Fi, computer system, religious needs, etc. The goal was to create a sacred healing environment within the home space conducive for my mother’s comfort. Through creative problem-solving, the home space was thoughtfully transformed into a sacred, healing space, that ensured my mother’s essential needs were met.

As a daughter caregiver, I initiated monetary budgeting of funds and prioritization of resources to support the physiologic, physical, emotional, and spiritual well-being. The family saved money for hospitalization since my mother stayed in the comfort of her own home. In applying for this Caritas Process®, I tailored the support and resources that my mother had for her survival needs. Similarly, healthcare is not a one-size-fits-all, and we need to adjust to the patient’s concerns that are met thoroughly (Watson & Clayton, 2020). Caregivers must be mindful to manipulate the environment for the sake of our patient’s references. Moreover, support from multiple sources is essential, but preferably comprehensive support from health professionals (Sturekova & Sanakova, 2023).

Minister (Humanity) Reverentially Assisting with Basic Needs as Sacred Acts, Touching Mind-Body-Spirit of Spirit of Other; Sustaining Human Dignity

According to the Watson Caring Science Institute (n.d.), the Caritas Processes® guide caregivers in enacting caring-healing practices that nurture mind, body, and spirit. Through these sacred acts of care, caregivers sustain and elevate human dignity, honoring the intrinsic worth of the patient. This also fosters a healing environment grounded in respect and holistic empathy. The last two days of my mother’s life, she asked for the presence of the priest, and her wish was granted. The priest gave us a set of prayers for the departure of the souls with specific instructions. The request for a spiritual figure or authority such as a priest during the last days of a person is very important and powerful for the dying person (Sturekova & Sanakova, 2023). In various areas of care, my family did everything for my dying mother. We experienced pain,

mental, physical burdens, and spiritual shortcomings. We also needed support to sustain our own personal well-being.

On my mother's final day, as a nurse caregiver, I guided my family and implemented the plan of care at the bedside until her peaceful passing. For almost two hours of continuous praying and holding of my mother's hands for support, there was a sudden grasping for air, and the breathing stopped. The do-not-resuscitate (DNR) wish was respected at that moment. Upon checking the status using a stethoscope, there was no pulse in the apical site, no rising and falling of the chest, and there was no breathing. She was peacefully gone, and I determined the time of death, as I usually do in the ER. With respect and dignity, we did postmortem care. It was a moment of realization of the essence of becoming a nurse, we will take care of our loved ones until death. Let us pause and say a short prayer for the soul of my loving mother.

As a daughter caregiver, my experience did not come easy. It was only after completing the postmortem care that the weight of reality settled in; in that quiet, sacred moment, I realized, I am no longer that nurse performing the duty, but a daughter mourning the immeasurable loss of my beloved mother. It was the moment of tears and longing to have more quality time. As a general reflection, taking care of loved ones during the end of life was gratifying.

The Caritas Process® Minister was exemplified in this situation by the connectivity of the body-mind-spirit. I provided oxygen as an act of supporting the physiologic needs of the body; guided the family with a continuous prayer, and honoring my mother's final sacred wishes met the spiritual needs. Helping my mother with her final breath brought me a realization "love is the greatest gift we can give". With deep gratitude, I cherished the loving presence of my relatives whose unwavering support brought comfort and light during the darkest hours. This authentic support eased the pain of goodbye and made the journey more bearable.

This moment was described as a state as a kind of timeless vacuum, a "time out" after the death. Sturekova and Sanakova (2023) stated that being present at the death helped the family members say goodbye with a sense of fulfillment.

Conclusion

This article explores the experience of a nurse serving as a primary caregiver for her mother during end-of-life care for breast cancer. It highlights the application of Watson's (2008) Caritas Processes® in providing holistic care while navigating the emotional, mental, and practical challenges of family dynamic caregiving. Doing the daughter's dual roles as nurse and caregiver supports both patient's dignity and caregiver's well-being. The discussion provides insights for nurses, healthcare professionals, and family caregivers seeking to integrate theory-based, patient-centered approaches in challenging care situations.

Nursing Implication

In caring for the mother at the end of life, the daughter's experience emphasizes the profound impact of applying Dr. Jean Watson's Caritas Processes® in real-world settings. Integrating holistic, compassionate nursing care not only enhances the patient's dignity and quality of life but also provides structure and meaning for family caregivers navigating complex emotional and practical responsibilities. This reflection reinforces the importance of supporting both patients

and their caregivers, reminding nurses and all healthcare professionals to honor the human, relational, and ethical dimensions of care in every practice setting. It calls us to lead with compassion, advocate with integrity, and recognize the profound impact our presence can have on those we serve.

As nurses, we create the healing environment for our patients, and we are a part of the healing–caring environment (Watson, 2008). Nurses recognize that we are not only facilitators of healing but integral participation in the healing–caring environment itself. Through our authentic presence, intentional compassionate care, and mindfulness of patient’s needs, we help shape a biogenic healing-caring environment where patients and families feel supported, valued, and truly cared for.

References

- Akbari, A., & Nasiri, A. (2022). A concept analysis of Watson’s nursing Caritas process. *Nursing Forum*, 57(6), 1465–1471. <https://doi.org/10.1111/nuf.12771>
- Gómez-Salgado, J., Rodríguez-Almagro, J., Molina-Alarcón, M., Martínez-Galiano, J. M., Solano-Ruiz, M. C., & Martínez, A. H. (2023). Commitment, perception and evidence-based practice training in Spanish nursing students: A multicentre cross-sectional study. *Journal of Clinical Nursing*, 32(5–6), 715–725. <https://doi.org/10.1111/jocn.16280>
- Hussain, N. A. (2021). Nobody should die alone: A father’s message to a physician daughter. *Journal of Palliative Care*, 36(1), 7–8. <https://doi.org/10.1177/0825859720941972>
- Masters, K. (2026). *Role development in professional nursing practice*. Jones and Bartlett.
- Schott, G. R. (2023). *The art of dying: 21st century depictions of death and dying*. Springer International Publishing AG. <https://doi.org/10.1007/978-3-031-35217-1>
- Sitzman, K., & Watson, J. (2019). *Assessing and measuring caring in nursing and health science* (3rd ed.). Watson’s caring science guide. <https://doi.org/10.1891/9780826195425>
- Štureková, L., & Šaňáková, Š. (2023). I’ll do everything for him/her: The experiences of family caregivers caring for a dying patient at home (a phenomenological qualitative approach). *Central European Journal of Nursing and Midwifery*, 14(3), 943–955. <https://doi.org/10.15452/cejnm.2023.14.0011>

Tu, J., Shen, M., & Li, Z. (2022). When cultural values meet professional values: A qualitative study of Chinese nurses' attitudes and experiences concerning death. *BMC Palliative Care*, 21(1), 181. <https://doi.org/10.1186/s12904-022-01067-3>

Watson, J. (2008). *Nursing: The philosophy and science of caring*. University Press of Colorado.

Watson Caring Science Institute. (n.d.). *10 Caritas Processes*®. <https://www.watsoncaringscience.org/jean-bio/caring-science-theory/10-caritas-processes/>

Watson, J. (2019). *Miracles and mysteries witnessed by nurses*. Lotus Library.

Watson, J. & Clayton, M. (2020). *Caring: A passage to heart. An anthology of the Caritas Process*® experienced. Lotus Library.

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Board Meeting Dates

All dates and locations are subject to change
*Virtual/teleconference options available

<p>* January 14-15, 2026 NSBN Conference Room 6005 Plumas Street Ste. 101 Reno, NV 89519</p>	<p>* March 11-12, 2026 Hilton Garden Inn Las Vegas Strip South 7830 S. Las Vegas Blvd Las Vegas, NV 89123</p>	<p>* May 13-14, 2026 NSBN Conference Room 6005 Plumas Street Ste. 101 Reno, NV 89519</p>
<p>July 15-17, 2026 Zephyr Point Presbyterian Conference Center 660 Hwy 50 Zephyr Cove, Nevada 89448</p>	<p>*September 16-17, 2026 NSBN Conference Room 6005 Plumas Street Ste. 101 Reno, NV 89519</p>	<p>*November 18-19, 2026 Hilton Garden Inn Las Vegas Strip South 7830 S. Las Vegas Blvd Las Vegas, NV 89519</p>

Committee Meetings and Openings

<p>Advanced Practice Advisory Committee: February 10, 2026 May 12, 2026 August 11, 2026 November 10, 2026</p>	<p>CNA & Medication Aide – Certified Committee: April 2, 2026 August 6, 2026 October 1, 2026</p>	<p>Disability Advisory Committee: January 8, 2026 April 9, 2026 July 9, 2026 October 8, 2026</p>
<p>Education Advisory Committee: January 9, 2026 April 10, 2026 August 14, 2026 October 9, 2026</p>	<p>LPN Advisory Committee: February 19, 2026 May 21, 2026 August 20, 2026 November 12, 2026</p>	<p>Nurse Practice Advisory Committee: February 3, 2026 May 5, 2026 August 4, 2026 November 3, 2026</p>

CNA Advisory Committee: 2 opening in May 2026 & 1 medications aides-certified
Disability Advisory Committee: 3 openings November 2026
Education Advisory Committee: 1 current opening & 1 opening September 2026
LPN Advisory Committee: 1 opening May 2026
APRN Advisory Committee: 1 opening March 2026