Official Publication of the

Nevada State Board of NURSING

# Nevada Nursing News

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

# Message From the President

## Lessons Learned from Nursing Disciplinary Trends

The mission of the Nevada State Board of Nursing is to protect the public by ensuring nurses, Advanced Practice Registered Nurses (APRNs), and Certified Registered Nurse Anesthetists (CRNAs) provide safe, competent, and ethical care. While disciplinary actions are an important component of nursing regulation, they also provide valuable opportunities for education and professional reflection. Each case offers insight into practice challenges and reinforces the professional responsibilities expected of all licensees. By recognizing common themes and trends, licensees can identify opportunities for growth and strengthen practices that support patient safety and public trust.

The National Council of State Boards of Nursing (NCSBN) emphasizes that nursing regulation serves to protect the public while promoting safe nursing practice through accountability, education, and professional standards (NCSBN, 2026). Reviewing disciplinary trends is not intended to focus on individual mistakes or punitive outcomes; rather, it encourages licensees to learn from the experiences of others and proactively address areas of risk within their own practice.

One of the most common issues identified in disciplinary matters involves documentation. The medical record serves as an essential communication tool and provides evidence of assessments, clinical reasoning, interventions, and patient outcomes. Documentation that is incomplete, inaccurate, delayed, or inconsistent can compromise patient safety and the quality of care. For APRNs and CRNAs, documentation should also reflect advanced clinical decision-making, including assessment findings, treatment plans, medication management, and follow-up care appropriate to their scope of practice. Clear, objective, and timely documentation remains one of the most effective ways to demonstrate professional accountability and protect both patients and licensees.

Another recurring issue involves practicing beyond one's scope of practice or level of competency. As healthcare continues to evolve, licensees are increasingly involved in advanced technologies and complex clinical decision-making. Every licensee has a professional responsibility to ensure they possess the education, training, competency, and authorization necessary before performing a task or assuming a new responsibility. Maintaining competency, understanding applicable laws and regulations, and practicing according to current standards of care are essential to safe practice.

Medication management remains an important area of regulatory attention, particularly for APRNs with prescriptive authority and CRNAs who administer anesthetic and other medications within their scope of practice. Safe medication management requires a comprehensive patient assessment, sound clinical judgment, accurate documentation, and appropriate monitoring of patient outcomes. Clinical decisions should be evidence-based and comply with applicable state and federal requirements. Seeking consultation when appropriate demonstrates professional responsibility and supports patient safety.

Communication and collaboration are also frequent contributing factors in adverse events and disciplinary cases. Effective communication among healthcare professionals, patients, and families is essential to safe, coordinated care. Licensees must advocate for patients, recognize changes in clinical status, communicate concerns promptly, and escalate issues when appropriate. Strong communication fosters teamwork, improves patient outcomes, and promotes a culture of safety.

Professional boundaries and ethical practice remain foundational expectations for all licensees. The increasing use of electronic communication, telehealth, and social media has created new opportunities as well as potential risks. Maintaining therapeutic relationships, protecting patient confidentiality, and exercising sound professional judgment in all interactions are essential responsibilities that extend beyond direct patient care (NCSBN, 2024). Furthermore, disciplinary processes help ensure public protection by promoting accountability and reinforcing professional standards (NCSBN, 2026).

Another important lesson from disciplinary trends is recognizing when additional education, consultation, or support is needed. Professional accountability includes acknowledging limitations, seeking clarification, participating in continuing education, and using available resources. Asking questions and seeking guidance are hallmarks of responsible professional practice and a commitment to lifelong learning.

Maintaining personal well-being is also an essential component of safe practice. Fatigue, stress, workplace challenges, and personal circumstances can affect clinical judgment and performance. Licensees have a responsibility to recognize factors that may impair their ability to practice safely and seek appropriate assistance when needed. Early recognition and intervention help protect both patient safety and professional longevity.

In conclusion, reviewing disciplinary trends is not intended to create fear, but rather to promote awareness, professional reflection, and continuous improvement. Each case offers valuable lessons that can strengthen clinical practice, reinforce professional accountability, and support the high standards expected of Nevada nursing licensees. By remaining informed, practicing within established standards, maintaining competency, documenting thoroughly, communicating effectively, and prioritizing patient safety, nurses, APRNs, and CRNAs continue to uphold the public's trust and advance the delivery of safe, high-quality healthcare throughout Nevada.

## References

National Council of State Boards of Nursing. (2024). *A nurse's guide to professional boundaries*. https://www.ncsbn.org/public-files/ProfessionalBoundaries_Complete.pdf

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## *ALOHA, CATHY!*

Thank you doesn't seem to be big enough words and goodbye seems so final. *Aloha* is the Hawaiian word for love, affection, compassion, and mercy. It is often used as a greeting for both hello and goodbye. It denotes a positive attitude and acts of kindness. Different parts of Hawaiian language that make up the word:

- "Alo", meaning "presence"
- "oha", meaning "to receive friendship"
- "ha", meaning "life" or "breath"

I have served as the Director of Nursing Education for 6 ½ years under the leadership of Cathy Dinauer. Her guidance has been unwavering. Her dedication, unparalleled. For me, she has embodied the *Aloha* spirit. Her very presence has breathed life into those who have served under her. So, I choose to say *Aloha*.

The Nevada State Board of Nursing makes the following announcement:

It is with gratitude and appreciation that we announce the retirement of Executive Director, Cathy Dinauer, MSN, RN, FRE, effective July 21, 2026. Cathy began her career with NSBN first as a Board Member appointed in 2012 and transitioned to employment beginning in 2014. For over ten years Cathy has led our organization with dedication, kindness and an unwavering commitment to the mission of the Nevada State Board of Nursing. She has guided us through periods of growth, strengthened our partnerships, and inspired both staff and community members alike.

The Board has begun the process of searching for our next Executive Director to ensure a smooth and seamless transition.

The job posting can be found at: Executive-Director-Job-Posting.pdf

Please join us in expressing our appreciation to Cathy for her extraordinary service and countless contributions to the citizens of Nevada.

Nevada State Board of Nursing

July 21, 2026

Pierron Tackes recently joined the Nevada State Board of Nursing as General Counsel. She brings with her a unique combination of legal and public health expertise, with extensive experience advising state and local health agencies on regulatory compliance, enforcement, emergency preparedness, and public health policy.

Before joining NSBN, Pierron served as the Director of Health and Social Policy at the Guinn Center for Policy Priorities, where she conducted research and developed policy recommendations for Nevada's policymakers. Before that, Pierron served as a Senior Deputy Attorney General for the Nevada Division of Public and Behavioral Health, representing a wide range of regulatory programs including the Bureau of Health Care Quality and Compliance, the Emergency Medical Systems Program, the Environmental Health Section, and others. Earlier in her career, Pierron served as a Deputy District Attorney for the Carson City District Attorney's Office, Civil Division, and completed judicial clerkships at the Second Judicial District Court of Nevada for the Honorable Scott N. Freeman and the Honorable Kathleen M. Drakulich.

While earning her graduate degrees, Pierron worked for the Centers for Disease Control and Prevention in Atlanta, GA, where she worked on global health security initiatives, and she also served as an Honors Law Clerk for the U.S. Environmental Protection Agency, in Washington, D.C., assisting on water enforcement actions.

A Carson City native, Pierron earned a Bachelors of Arts from The George Washington University, and both a Juris Doctor and Master of Public Health from the University of Oklahoma. On the weekends, she enjoys hiking or snowshoeing with her dog, Norman.

# From Passive to Purposeful: Clinical Faculty Engagement Matters

Nina Marcellus-Duong, PhD(c), RN, CHSE, CNEcl

Faculty engagement in simulation-based education is more than a logistical or operational task. Healthcare simulation faculty engagement stands as a critical driver of program quality and learner success. Active participation in healthcare scenario reviews and performance measure discussions ensure clinical simulation activities remain evidence-based, relevant, and aligned with course and program outcomes. Yet many healthcare simulation leaders face persistent challenges in the achievement of this level of involvement. Conflict of priorities, limited familiarity with simulation pedagogy, and organizational dynamics often create barriers that weaken collaboration and threaten consistency. When faculty disengage, the ripple effect reaches learners and negatively impacts educational fidelity and outcomes. Healthcare simulation leaders must move beyond recognition of these obstacles and adopt strategies that foster shared ownership, psychological safety, and a culture of continuous improvement. This HealthySimulation.com article written by Nina Marcellus, PhD(c), RN, CHSE, CNEcl, will offer practical solutions to re-engage faculty and strengthen the collaborative foundation essential for high-quality simulation programs.

## Time and Scheduling Constraints in Healthcare Simulation

Faculty often juggle heavy teaching loads, clinical responsibilities, and administrative duties. If schedules are a challenge, the healthcare simulation program administrator may find the distribution of a survey to determine optimal meeting times for each clinical team beneficial. Organize smaller meetings by course or level for a more focused and meaningful discussion. Record and transcribe meetings to provide concise summaries of discussions, decisions on revisions, and next steps. Aim for majority attendance (>50%) before any revisions that impact the group and course are made. If faculty attendance falls short, consider postponement of the meeting until next semester. Follow up with an email to the group to explain the cancellation and reinforce the importance of faculty input.

## Knowledge Gaps

Some faculty lack familiarity with healthcare simulation pedagogy, scenario design principles, performance metrics, or healthcare simulation standards of best practice. Just as healthcare professionals educate their patients, healthcare simulation professionals must educate faculty and other stakeholders. Provide an overview of the clinical simulation standards your program follows, such as the INACSL Healthcare Simulation Standards of Best Practice. If your center holds or seeks accreditation or endorsement, explain how standards influence that process. Often, a simple conversation to clarify purpose and build understanding of healthcare simulation is all that is needed.

## Personality, Cultural Factors, Value and Ownership

Resistance to change, hierarchical dynamics, or conflicting priorities can create friction. Ask why resistance exists. Does resistance stem from communication style, perception, or historical

precedents that have been set? Is the articulation of the response or the individual's perception causing a barrier? Maybe the friction is a preconceived notion or a historical reason that resistance exists. Find out what the course group prioritizes and why, to ensure healthcare simulation scenarios align with program outcomes. If ideas clash, explore options to find a middle ground.

When clinical faculty fail to see a clear link between revisions and learner success, engagement drops. Reinforce value with the provision of dedicated time and space for clinical team meetings each semester. Encourage questions, concerns, and solutions. Maintain an open-door policy to foster trust and collaboration. Emphasize that healthcare simulation success depends on teamwork and transparent communication. This approach strengthens morale and enhances learner experiences.

**Strategies to Re-Engage Faculty**

- **Clarify the "Why":** Explain how scenario reviews and revisions influence learner outcomes, accreditation standards, and patient safety. Stress the importance of faculty participation which includes attendance at semester meetings. Reinforce that input from both faculty and clinical simulation staff ensures alignment with course objectives, program outcomes, and medical simulation standards, and creates the best possible learning experience for students. Share data or case examples that demonstrate improvements tied to faculty and staff contributions.
- **Reduce Barriers:** Provide flexible options for participation. Virtual meetings work well for programs with tight schedules and heavy workloads. Record sessions and offer transcripts for those who need asynchronous access. During virtual meetings, share screens to display scenarios, performance measures, and other relevant content. After meetings, send a concise summary of key points and planned revisions. Use tools that save time and streamline feedback. Templates for scenario reviews, checklists for performance measures, and feedback forms help faculty provide input efficiently. Electronic surveys offer an easy way to collect feedback, track performance measures, and engage faculty without adding to their workload. Many survey platforms can support this process.
- **Build Capacity:** Offer short, focused sessions on simulated healthcare best practices during department meetings, faculty orientations, debriefing workshops, or development sessions. Record these sessions and upload them to the learning management system (LMS) for future reference. Share opportunities for webinars and seminars so faculty can expand their knowledge beyond the program. Pair less experienced faculty with simulation champions for mentorship when possible. Encourage faculty to visit the simulation center and shadow sessions to gain insight into program operations.
- **Foster Psychological Safety**: Psychological safety matters for faculty and staff as well as for learners. Promote open dialogue so everyone feels their input is valued and respected. Address personality conflicts or hierarchical barriers through structured facilitation to ensure communication remains professional and constructive. Do not tolerate bullying, gossip, or third-party conversations. Direct questions to the source, and if you lack an answer, acknowledge it and work as a team to find the right solution.
- **Leverage Data and Embed Collaboration into Workflow:** Present learner performance trends and feedback to show the benefits of scenario updates. Use dashboards or visual

summaries to make data clear and actionable. Electronic surveys make this process easier to provide trackable data and ready-to-use visual summaries. Integrate scenario and performance measure reviews into current team meetings or assessment cycles. End-of-semester or end-of-year sessions allow for meaningful review and timely decisions before the next term. Adapt this approach to your program's calendar and term structure. Assign clear roles and timelines so faculty and healthcare simulation staff know expectations and deadlines.

**Why Engagement Matters**

- **Quality Assurance**: Regular reviews of scenarios and performance measures maintain integrity, fidelity, validity, and alignment with competencies and program outcomes.
- **Shared Ownership**: Collaborative input fosters a sense of investment and accountability.
- **Innovation and Relevance**: Diverse perspectives help keep nursing simulation activities current and responsive to evolving healthcare standards.

Faculty engagement should not be optional and is essential for the maintenance of the integrity and impact of simulation-based education. Through clarification of the purpose behind scenario reviews, barriers to participation can be reduced. This can lead to capacity building and create an environment of psychological safety. Healthcare simulation leaders can transform engagement from a challenge into a shared commitment. Leverage data and embed collaboration into existing workflows to ensure that faculty see the value of their contributions and remain invested in the success of learners. These strategies do more than improve processes; they cultivate a culture where innovation thrives, quality is assured, and every stakeholder feels empowered to shape the future of healthcare education.

# You are in good company

Active Nevada licenses/certificates as of July 27, 2026

APRN – 8,903 RN – 64,922 LPN – 4,797 CNA – 11,616 CRNA – 333

# NEVADA STATE BOARD OF NURSING
## Practice Decision
## The Role of Registered Nurses in Management and/or Administration of Medications via Epidural or Intrathecal Catheter Routes

It is the opinion of the Nevada State Board of Nursing that it is within the scope of practice of a registered nurse to administer analgesic and anesthetic agents via the epidural or intrathecal routes for the purpose of pain control.

The Nevada State Board of Nursing notes that only licensed anesthesia care providers, as described by the American Society of Anesthesiologists and the American Association of Nurse Anesthesiology, as authorized by applicable laws, should perform insertion and verification of epidural or intrathecal catheter placement. Consistent with state law, the qualified provider must order the drugs, dosages, and concentrations of medications to be administered to the patient through the catheter. These interventions are beyond the scope of the registered professional nurse.

**Matters Considered**

Current literature and trends support the role of the Registered Nurse in the management and administration of medications via epidural or intrathecal catheters. The care and management should be provided by Registered Nurses, who has completed additional training and has supervised clinical practice documented in their personnel file. Institutional policies shall be developed to cover these procedures.

In setting polices, consideration must be given to:

1. Competence of the individual registered nurse;
2. The acuity of the patients who will be recipients of the services;
3. Continued education required to improve theoretical knowledge base and skills;
4. Drugs that cause a local anesthetic effect are not included.

Guidelines for approval of a course for administration of epidural/intrathecal medication for the management of pain are:

1. **<u>General Provisions</u>**
    a. The epidural/intrathecal catheter must be placed by a qualified licensed provider who assumes responsibility for ensuring proper placement.
    b. The patient should be placed on monitoring equipment as dictated by the patient's condition (e.g., apnea and cardiac monitor, etc. as appropriate).
    c. The appropriate reversal agent should be readily available administered in accordance with appropriate provider's orders or agency protocol.
        i. A crash cart should also be readily available.
    d. Only registered nurses who have completed the facility's structured instructional program and who have had supervised clinical practice will be allowed to administer epidural/intrathecal medications.

2. **Course of Instruction**
    a. Educational training should include, but is not limited to:
        i. Anatomy and physiology of the spinal cord and column.
        ii. Purpose of the epidural/intrathecal catheter for pain management.
        iii. Catheter placement and signs and symptoms of misplacement of catheter.
        iv. Effects of medication administered epidurally/intrathecally.
        v. Untoward reaction to medications.
        vi. Complications.
        vii. Nursing care responsibilities:
            1. Observations
            2. Procedures
            3. Accountability
        viii. Removal of Epidural Catheters
            1. Training should include review of the Nevada State Board of Nursing Practice Decision on the scope of practice for the registered nurse in the removal of epidural catheters.

3. **Documentation and Continued Competency**
    a. Documentation of satisfactory completion of the instruction and supervised practice should be placed in the registered nurse's personnel file.
    b. Organizations should have a competency validation mechanism that demonstrates the periodic evaluation of continued competency to manage the care of patients receiving analgesia by catheter.

## References

American Society of Anesthesiologist. (2023) Statement on the role of Registered Nurses in the management of continuous regional analgesia. https://www.asahq.org/standards-and-practice-parameters/statement-on-the-role-of-registered-nurses-in-the-management-of-continuous-regional-analgesia.

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Adopted: 12/6/1985, Approved by the NPA Committee: 10/9/2018,Approved by NSBN: 11/14/2018, Revised by NPAC Committee: 05/05/2026, Approved by NSBN: 5/14/2026.


# Disability Inclusion: Why It Matters in Nursing

Kayla Sullivan, DNP, APRN, FNP-BC, Angela Silvestri-Elmore, PhD, APRN, FNP-BC, CNE, Wendy Huynh, MSN, RN, CNE, Matthew Nishimoto, PhD, & Sigrid Barrett, PhD, RN, PNP, CNE, FAAN

## Introduction

Visualize a nurse. What typically comes to mind? Many envision a professional navigating a frantic emergency room, lifting patients, and enduring long hours on their feet. This common perception of nursing requires physical ability and the capacity to execute strenuous activities without constraint.

Now, pivot your thinking: how often do we picture a nurse managing their diabetes, wearing a hearing aid, living with multiple sclerosis, or navigating neurodivergence and mental health conditions? What about a nurse utilizing assistive technology for a visual impairment or one who developed a disability mid-career?

These images frequently clash with traditional views of who can serve in the role of a nurse. However, disability is a universal human experience that impacts every community and healthcare environment; nurses are no exception. Numerous nurses and students successfully practice while managing diverse disabilities. Whether they enter the field with a disability or acquire one through injury, illness or aging, they continue to educate, lead, and provide

exceptional patient care, often without their colleagues even realizing a disability exists, and it manifests differently for everyone.

The fundamental issue is not the existence of nurses with disabilities (NWD) but whether nursing has intentionally fostered environments in which they can thrive. As the field addresses workforce shortages and health equity, inclusion has become a central necessity. This is not about compromising safety or standards; it is about acknowledging that clinical competence manifests in various ways and that accommodations ensure access rather than unfair advantage. A profession committed to universal care must reflect the diversity of the communities it serves.

Disability inclusion, primarily of students with physical disabilities within nursing education, represents a complex and underrepresented phenomenon. Nursing is grounded in values of inclusion, equity, advocacy, and patient-centered care, but nursing education continues to be shaped by historical assumptions and expectations regarding physical capability, technical standards, and clinical competence (Ailey & Marks, 2020; Llewellyn et al., 2025). Despite federal protections under the Americans with Disabilities Act (ADA), significant variability persists in how nursing programs and nursing education interpret and implement accommodations (Jackson et al., 2025). These assumptions and inconsistencies create barriers to access, participation, and full inclusion in learning, especially in clinical learning environments (Neal-Boylan & Miller, 2020; Thomson et al., 2024).

**Why This Matters Now**

National nursing organizations lead and guide our professional emphasis on diversity, equity, inclusion, and accessibility as a foundational aspect of nursing education and nursing practice. As the nursing workforce faces shortages and increasing patient diversity, excluding qualified individuals with physical disabilities undermines our workforce sustainability and equity (Marks & Sisirak, 2022).

Nevada, like many states across the nation, continues to face significant nursing workforce challenges. Healthcare systems are caring for increasingly complex patient populations, communities are aging, and the demand for qualified nurses continues to grow. At the same time, nursing programs and healthcare organizations struggle not only to recruit new nurses but also to retain experienced clinicians. Nevada continues to experience significant nursing workforce vacancies, with the state needing an estimated 4,865 additional registered nurses, 3,084 licensed practical nurses, and 5,092 nursing assistants to meet national per capita averages (Packham et al., 2025). These shortages are occurring alongside projected health care sector growth of more than 25,000 jobs over the next decade, reinforcing the need to expand education, clinical capacity, and new graduate transition supports (Packham et al., 2025). The *Nevada's Health Workforce Needs Assessment for 2026* further identifies registered nursing as one of the state's highest-priority workforce needs, noting persistent workforce shortages driven by population growth, an aging workforce, geographic maldistribution of providers, and increasing demand for healthcare services. The report emphasizes that strengthening the healthcare workforce will require expanding educational pipelines, improving recruitment and retention, and reducing barriers to entering health professions (Nevada Health Authority, 2026). According to the 2024 National Nursing Workforce Survey conducted by the National Council of State Boards of

Nursing, nearly 40% of registered nurses reported an intention to leave the workforce or retire within the next five years, highlighting the urgency of strengthening recruitment and retention strategies across the nursing profession (Smiley et al., 2025). Addressing workforce needs requires us to rethink who we envision as part of the nursing profession and how we support them throughout their educational and professional journeys. Creating more accessible and inclusive pathways into nursing education, including for students with disabilities, represents one strategy for expanding the workforce while fostering a profession that better reflects the diverse populations it serves.

Disability inclusion is often discussed as an issue of compliance or accommodation. In reality, it is a workforce issue. According to the Centers for Disease Control and Prevention (2024), approximately one in four adults in the United States lives with a disability. Disability is neither uncommon nor limited to a small segment of society. It is a natural part of human diversity and a reality that many individuals experience across the lifespan. Nurses and nursing students are no exception. Some enter the profession with disabilities, while others acquire disabilities due to illness, injury, aging, or changes in health status during the course of their careers.

Historically, nursing education and practice have often been shaped by assumptions about what a nurse should look like and how nursing tasks should be performed. These assumptions may unintentionally exclude qualified individuals who can meet essential competencies through alternative methods, adaptive strategies, or reasonable accommodations. In doing so, we risk losing talented individuals whose perspectives, experiences, and contributions strengthen our profession.

The National League for Nursing (NLN) recently affirmed that disability inclusion must be an integral component of nursing education, not an afterthought. In its Vision Statement, *Advancing Nursing Education: Disability Access, Retention, and Curriculum*, the NLN calls upon nurse educators and leaders to move beyond a compliance-driven approach and to intentionally create environments in which students with disabilities can access, persist in, and successfully complete nursing programs. The statement recognizes disability as an important dimension of diversity and emphasizes that inclusion is essential to preparing a nursing workforce equipped to meet the needs of an increasingly diverse society.

Importantly, disability inclusion is not about lowering standards or compromising patient safety. Rather, it challenges nursing to examine whether competence is being measured fairly and whether long-standing practices unnecessarily restrict participation. Excellence and inclusion are not competing priorities. In fact, the NLN argues that innovation, accessibility, and inclusion are fundamental to the future of nursing education and practice.

As Nevada seeks solutions to persistent workforce shortages, we cannot afford to overlook qualified individuals who bring unique strengths to the profession. NWD contributes resilience, creativity, adaptability, and often a deeper understanding of navigating healthcare systems from the perspective of those receiving care. Their lived experiences can enrich patient advocacy, foster empathy, and improve our collective ability to provide person-centered care.

If nursing is committed to serving all communities, then our workforce should reflect the diversity of those communities, including disability. The question is no longer whether NWD belongs in our profession. The question is whether we are prepared to remove unnecessary barriers so that they can learn, practice, lead, and thrive alongside their colleagues. The future of nursing depends not only on recruiting more nurses but on ensuring that every qualified nurse has the opportunity to contribute their talents to the profession.

**Challenging Common Misconceptions**

**Myth 1:** NWD cannot provide safe care.
Although concerns regarding the ability of NWD to provide safe care are often raised, there is no evidence to suggest that a student or nurse with a disability has directly jeopardized patient safety because of a physical disability (Neal-Boylan & Miller, 2020). In fact, people with disabilities are often highly aware of their bodies and the accommodations needed to perform competently (Jamal-Eddine et al., 2024). Furthermore, established safety protocols should be required and consistently followed for all nursing students, regardless of disability status (Meeks et al., 2021). When safety is compromised, it is often due to weaknesses in clinical systems and processes that are less apparent, leading to a tendency to incorrectly attribute actual and potential errors to a nurse's disability. When accommodations are used, alternative methods can be just as safe, even if they differ from traditional approaches (Meeks et al., 2021). Assistive technologies and structural accommodations are used in clinical nursing education to empower and support students in providing safe and effective care (Moreland et al., 2020), thereby demonstrating the profession's ability to continuously adapt and innovate.

**Myth 2:** Accommodation lowers standards.
A prevalent misconception is that providing accommodations to nurses or nursing students with disabilities compromises nursing education rigor and/or the profession's standards. The basis of this misunderstanding is rooted in the idea that accommodations somehow subvert rigor, standards, expectations, or competencies (Ailey & Marks, 2017). However, under the ADA, the purpose of accommodations is to ensure equal access to demonstrate competency standards. In this framework, standards are constant and uniform for all students, disability or not. Accommodations do not allow unqualified individuals to bypass requirements; it allows individuals to demonstrate their qualification. What is adjusted is not the standard itself but the pathway or process by which the standard is met. Accommodations function without replacing, altering, or superseding those expectations of nurses and nursing students that are standards and essential functions. In the language of ADA, accommodations cannot "fundamentally alter" these requirements.

For nursing educators, this means that pedagogical integrity is maintained regardless of the accommodations implemented. The same knowledge and skills are assessed for all students. For students with disabilities, this means that there are pathways and means by which to demonstrate their competency while essential programmatic expectations are maintained. For the nursing profession at large, this means that accommodations are not a concession to lower expectations, but a mechanism for ensuring that competent, qualified nurses are not excluded from the

profession by barriers that are unrelated to their clinical ability.

**Myth 3:** Disability is rare in nursing.
One reason disability may appear rare in nursing is the lack of data that is collected regarding NWD (Meeks & Humphrey, 2023), which leads to the assumption that people with disabilities do not work as nurses. Additionally, NWD are underrepresented, including in recruitment efforts (Tanner et al., 2021). The prevalence of disability is expected to rise steadily as the healthcare profession ages and develops aging-related chronic, disabling conditions (Iezzoni & Agaronnik, 2020); however, this does not even account for disabilities that can be caused by sudden trauma or accidents. Furthermore, research reports that school percentages of nursing students with disabilities range from 2% to 21.2%, which include psychological disabilities, chronic health conditions, mobility, and sensory disabilities (Jackson et al., 2025). It is also proposed that 8.4% of total nursing student enrollment reported disabilities (Jackson et al., 2025), likely excluding students who choose not to disclose. When all these factors are considered, disability is not simply a minority issue.

## The Value of Inclusion in Nursing

Although nursing has traditionally embraced diversity to better serve complex patient groups, disability is frequently omitted from these professional dialogues. Recognizing disability as a vital wellspring of innovation and insight significantly enriches the field. When we actively support and include qualified nursing students and professionals with disabilities, the entire profession is strengthened.

Nurses who possess lived experience with disability offer unique perspectives gained from navigating healthcare systems as advocates, caregivers, or patients. Managing chronic illnesses, coordinating complex care, or dealing with inaccessible clinical spaces provides a profound understanding of the obstacles and vulnerabilities patients encounter. This firsthand knowledge allows nurses to deliver more compassionate, dignified, and truly person-centered care.

Furthermore, healthcare settings demand a high degree of flexibility. Nurses are constantly required to innovate and adapt their approaches to meet patient needs within various resource and time constraints. Professionals who have navigated their own education or careers using assistive technologies and alternative strategies are often exceptionally skilled at creative problem-solving and identifying practical solutions. This inherent adaptability drives innovation across direct care, systems improvement, and policy development.

Critical thinking and resilience are also core to nursing. Many individuals with disabilities have spent years overcoming challenges in environments not originally designed for them, fostering a persistence and flexibility that aligns perfectly with the unpredictable nature of clinical practice.

Inclusion also brings a heightened awareness of accessible communication. NWD may be more sensitive to the diverse ways individuals process information, ensuring clearer communication for all patients, especially those facing sensory, cognitive, or literacy barriers.

Ultimately, personal experiences with systemic inequities can empower nurses to become stronger advocates, helping organizations identify and remove barriers to care. By embracing disability as a form of human diversity, nursing gains valuable colleagues who broaden our collective understanding and enhance our capacity to serve everyone.

**Building Inclusive Learning and Practice Environments**

The encouraging news is that many of the barriers experienced by nursing students and NWD can be addressed through intentional, practical changes that benefit everyone. As part of a Josiah Macy Jr. Foundation grant funded study, UNLV SON conducted an immersive assessment conducted within the UNLV School of Nursing simulation and skills laboratory environment, the on-campus student health center, and UMC inpatient units, a Disability Specialist observed students, faculty, and educational processes over several weeks to identify existing and potential barriers for students with disabilities. The findings revealed that accessibility is not solely about physical spaces; it is also shaped by assumptions, policies, instructional practices, and interpersonal interactions. Creating more inclusive environments does not require lowering standards. Rather, it requires examining whether the ways we teach, assess, and support nurses unintentionally create barriers that limit participation by otherwise qualified individuals.

***For Nurse Educators: Design for Access from the Beginning***

One of the most important findings from the immersive assessment was the distinction in achieving essential outcomes through traditional methods in contrast to use of reasonable accommodations. Faculty frequently emphasized that students first learn foundational skills through standardized approaches, then adapt techniques once competence is demonstrated. This observation raises an important question for nursing education: Are we evaluating whether students can achieve the required outcome, or whether they complete the task exactly as it has always been done? Educators can begin by critically examining essential functions and technical standards to ensure they accurately reflect the competencies required for safe practice rather than rigid processes that may unnecessarily exclude students with disabilities.

Applying principles of universal design can further improve accessibility for all learners. Small changes, such as using multiple indicators rather than color alone in instructional materials, ensuring digital platforms are compatible with assistive technology, and providing information through multiple modalities, can reduce barriers before accommodations become necessary. The immersive assessment noted examples such as color-coded folders without secondary identifiers and software interfaces lacking screen-reader compatibility, both of which represent opportunities for improvement.

Equally important is fostering psychologically safe learning environments. The highly visible, performance-based nature of simulation education means that students' struggles, accommodations, and even disabilities may become apparent to peers. Students expressed concerns that NWD might face stigma or be viewed through a deficit lens, particularly in high-intensity practice areas such as emergency or critical care settings. Educators can address these concerns proactively by discussing disability as a form of diversity, challenging stereotypes

about capability, and reinforcing that accommodations provide equal access rather than unfair advantage.

***For Employers: Focus on Competence and Retention***

Healthcare organizations also play a critical role in advancing disability inclusion. Accommodation processes should be transparent, accessible, and normalized. Nurses should not fear that requesting support will be interpreted as a lack of competence or commitment. Many nurses acquire disabilities during the course of their careers through injury, illness, chronic health conditions, or aging. Retaining these experienced professionals preserves valuable clinical expertise, institutional knowledge and the opportunity to support, nurture and mentor the next generations of nurses.

Employers can shift the conversation from "Can this nurse perform the job exactly as everyone else does?" to "Can this nurse safely and effectively achieve the essential outcomes of the role?" Focusing on outcomes rather than traditional methods encourages flexibility while maintaining standards of patient safety and quality care. Creating environments where nurses feel comfortable discussing needs and requesting accommodations ultimately strengthens workforce retention and communicates that disability inclusion is an expected component of professional practice rather than an exception.

***For Colleagues: The Power of Everyday Allyship***

Inclusive environments are shaped not only by policies but also by the attitudes and behaviors of those who work and learn alongside us. The immersive assessment revealed that nursing students often worried less about accommodations themselves and more about how others might perceive them. Students voiced concerns that nurses with visible disabilities could be underestimated, judged unfairly, or viewed as less capable despite demonstrating competence. Some also feared that peers might resent accommodations, mistakenly perceiving them as "extra help" rather than mechanisms that provide equitable access.

As colleagues, we can challenge these assumptions. Avoid making judgments about what someone can or cannot do based on appearance or diagnosis. Ask rather than presume what support may be helpful. Respect privacy and confidentiality regarding disability status. Speak up when stereotypes or misconceptions arise. Recognize that there are many ways to practice safely and effectively as a nurse. Perhaps most importantly, be an ally. Allyship can be as simple as creating space for colleagues to share concerns without fear of judgment, supporting inclusive practices, and recognizing that disability is an ordinary aspect of human diversity rather than something that diminishes professional identity.

**Inclusion Is a Shared Responsibility**

Building inclusive learning and practice environments is not the responsibility of disability resource professionals alone. It requires partnership among educators, employers, students, nurses, and healthcare leaders. The immersive assessment demonstrated that many barriers can be addressed through thoughtful dialogue, intentional design, and a willingness to question long-

held assumptions about what nursing must look like.

The goal is not to create a separate pathway for NWD. The goal is to ensure that every qualified individual has equitable access to education and practice, the opportunity to demonstrate competence, and the support necessary to contribute fully to our profession. When we design nursing environments that anticipate human differences rather than react to them, we strengthen nursing for everyone.

**A Call to Action**

The responsibility for disability inclusion does not rest exclusively with human resources or disability offices. Rather, it is a collective obligation of every nurse dedicated to excellence, equity, and compassionate care. Nursing's future is defined not by the individuals we shut out, but by our deliberate efforts to build a profession in which all qualified practitioners have the resources to succeed and thrive.

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*Technology & Computer Systems Specialist*

**Kristie Neuhauser, MBA**
*Accountant*

BOARD TALK

# Board Meeting Dates

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

*** January 14-15, 2026**
NSBN Conference Room
6005 Plumas Street Ste. 101
Reno, NV 89519

*** March 11-12, 2026**
Hilton Garden Inn Las Vegas Strip South
7830 S. Las Vegas Blvd
Las Vegas, NV 89123

*** May 13-14, 2026**
NSBN Conference Room
6005 Plumas Street Ste. 101
Reno, NV 89519

**July 15-17, 2026**
Zephyr Point Presbyterian Conference Center
660 Hwy 50
Zephyr Cove, Nevada 89448

***September 16-17, 2026**
NSBN Conference Room
6005 Plumas Street Ste. 101
Reno, NV 89519

***November 18-19, 2026**
Hilton Garden Inn Las Vegas Strip South
7830 S. Las Vegas Blvd
Las Vegas, NV 89519

## Committee Meetings and Openings

**Advanced Practice Advisory Committee:**
February 10, 2026
May 12, 2026
August 11, 2026
November 10, 2026

**Education Advisory Committee:**
January 9, 2026
April 10, 2026
August 14, 2026
October 9, 2026

**CNA & Medication Aide – Certified Committee:**
April 2, 2026
August 6, 2026
October 1, 2026

**LPN Advisory Committee:**
February 19, 2026
May 21, 2026
August 20, 2026
November 12, 2026

**Disability Advisory Committee:**
January 8, 2026
April 9, 2026
July 9, 2026
October 8, 2026

**Nurse Practice Advisory Committee:**
February 3, 2026
May 5, 2026
August 4, 2026
November 3, 2026

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