

NURSE



New Board Chair
Cathy Borris-Hale, RN, MHA, BSN,
and DOH Director
Joxel Garcia, MD, MBA

★ ★ ★ Government of the
District of Columbia
Vincent C. Gray, Mayor



RN/APRN Renewals Have Begun (page 7)
DC Action Coalition:
Removing Practice Barriers (page 18)



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DISTRICT of COLUMBIA NURSE

Edition 40

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JOXEL GARCIA, MD, MBA

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CHPLN

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Winslow B. Woodland, RN, MSN

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8:15 a.m.-4:45 p.m.

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Address Change? Name Change? Question?

In order to continue uninterrupted delivery of this magazine, please notify the Board of any change to your name or address. Thank you.

DC BON Mission Statement: "The mission of the Board of Nursing is to safeguard the public's health and well being by assuring safe quality care in the District of Columbia. This is achieved through the regulation of nursing practice and education programs; and by the licensure, registration and continuing education of nursing personnel."

Circulation includes over 22,000 licensed nurses, nursing home administrators, and nurse staffing agencies in the District of Columbia.

Feel free to e-mail your "Letters to the Editor" for our quarterly column: IN THE KNOW: Your opinion on the issues, and our answers to your questions. E-mail your letters to hpla.doh@dc.gov. (Lengthy letters may be excerpted.)

Message from the Chair

As we begin a new year, I welcome both the opportunity and the challenge of serving as the Chair of the Board of Nursing. As a nurse with over 30 years invested in this profession, I have a deep commitment to the continuous improvement of nursing practice in this evolving healthcare environment. Because of that commitment it is my mission and I feel it should be that of the Board as well, to support nursing students in their development from student nurse to seasoned practitioner. That development begins in the classroom and continues throughout their nursing career.

Nursing plays an integral role in the healthcare of our community and this nation as a whole; it is vital that nursing education be of the highest quality. It is the Board's responsibility to ensure that the educational standards set in forth in the District of Columbia are met to guarantee that the minimal requirements for entry into the nursing profession are being achieved. Undergraduate education must be aimed at producing nurses who are fully capable of integrating critical thinking and evidence based practice into the care they render; that is in the best interest of public health and our profession.

Since I began my tenure, we have implemented procedural changes that allow us to address the mandated board functions while giving more time to anticipate and address the changing needs of nursing practice in this dynamic healthcare environment. For example; with the onset of tele-health, we have been asked the question; where does nursing take place? Should a nurse located and licensed in Maine, be allowed to provide patient care via Skype to individuals residing in the District without a D.C. license? These are serious questions and the Board must be prepared to address them in a way that allows for high level professionalism and stellar nursing care to the public.

The members of the Board of Nursing are dedicated to ensuring that our residents receive quality health care, and that the professionals licensed in the District have high ethical standards. At this time, I would like to acknowledge the vast knowledge and dedication of our Board members, and of our new Vice Chairperson Simmy Randhawa. Thank you all for your invaluable service to our city.

We have a tremendous responsibility as well as a unique opportunity to educate, communicate and share our knowledge. Working together, we can enhance the value of our profession.

I look forward to a wonderful year ahead.



Cathy Borris-Hale, RN, MHA, BSN



Board Chair Cathy Borris-Hale, RN, MHA, BSN, and Vice Chair Simmy Randhawa, DNP, MBA, MS, RN, NE-BC.

Cathy Borris-Hale, RN, MHA, BSN
Chairperson, DC Board of Nursing

Thanks and Congratulations to our Outgoing Chair

IT'S A BOY!!

The Board of Nursing extends its best wishes to our outgoing Chairperson [Mary Ellen Husted, RN, BSN, OCN](#).

Thank you for your dedicated service as Chairperson.

Mary Ellen will now resume her duties as a regular Board member.

Congratulations to Mary Ellen and her husband on the arrival of son Matthew Grant Husted.



Mary Ellen R. Husted, RN, BSN, OCN

Farewell to HRLA Senior Deputy Director Feseha Woldu, PhD

Feseha Woldu, PhD, who served as the Senior Deputy Director of DOH's Health Regulation and Licensing Administration (HRLA) for 14 years, left HRLA in October 2013 to accept the position of Associate Vice President for Clinical Affairs and Quality at Howard University. In this capacity, Dr. Woldu will work with Howard University Hospital executives, the doctors of the Faculty Practice Plan and the deans of the Health Sciences colleges to ensure excellence in all health sciences clinical programs.

At HRLA, Dr. Woldu's mission was to ensure accountability and fiscal integrity



Dr. Feseha Woldu and Councilmember Yvette M. Alexander pose for a photo with current and former Directors of the Department of Health (left to right) Dr. Gregg Pane, Dr. Joxel Garcia, Dr. Pierre N.D. Vigilance, and Dr. Ivan Walks.

in regard to licensing, inspection and regulatory administration, and to utilize technology to improve the efficiency of HPLA operations. During his tenure, Dr. Woldu was able to expedite online licensure renewal and instituted a system to make compliance information available online.

Dr. Woldu's leadership will be missed at HRLA. The Board of Nursing will always value the innovative thinking and support he provided to the Board. Howard

University will benefit from Dr. Woldu's knowledge and his passion for excellence. We are pleased that Dr. Woldu will still be in the District of Columbia so that the health care community can continue to benefit from his influence. No doubt, in his new position, he will have a significant impact, promoting excellence and ensuring quality care in the District.

We wish him all the best in his new position. ■

Welcome New HRLA Senior Deputy Director Rikin S. Mehta, PharmD, JD, LLM

Dr. Rikin Mehta has been appointed Senior Deputy Director for the Health Regulation and Licensing Administration for the DC Department of Health, effective January 13, 2014. Dr. Mehta (or "Rik") comes from the U.S. Food and Drug Administration (FDA) where he served as the Deputy Director for the Division of Medical Policy Programs at the Center for Drug Evaluation and Research (CDER), Office of Medical Policy. As the Deputy, Dr. Mehta created and led the Nonprescription drug Safe Use Regulatory Expansion (NSURE) Initiative exploring regulatory methods to alleviate the undertreatment of common conditions or diseases through the use of innovative technologies or other conditions of safe use to expand access to medications.

Dr. Mehta started his FDA career in CDER, Office of Compliance (OC), where he worked primarily on the Agency's unapproved drugs initiative.



Rikin S. Mehta,
PharmD, JD, LLM

His responsibilities included ensuring industry compliance for the drug approval process, better patient access to safe and effective medicine. Following this work, Dr. Mehta served on detail as Senior Advisor for Globalization. In that role, he advised a working group that published the Commissioner's Special Report on the Pathway to Global Product Safety and Quality. Dr. Mehta was also involved in creating a new sub-office within CDER's Office of Compliance focused on drug security, integrity and recalls to work on domestic and international policies related to supply chain security and anti-counterfeiting. In this position, he enhanced the programmatic mission for global supply chain security by working on a 6-month tour of duty at the World Health Organization in Geneva, Switzerland to further elements of a global surveillance system for detecting and reporting counterfeit drugs. Notably,

Dr. Mehta served as an FDA technical advisor to INTERPOL and member of their coordination committee for a week-long operation called Operation Pangea IV. This operation involved the coordination of 81 countries and resulted in multiple arrests and the seizure of 2.4 million potentially harmful medicines worth USD 6.3 million worldwide.

Prior to FDA, Dr. Mehta worked as a drug store pharmacist as well as an emergency room/critical care pharmacist at a university hospital. Dr. Mehta received his B.S. in pharmacy from Rutgers University and Pharm.D. from the University of Arkansas for Medical Sciences. He later received a J.D. from Rutgers University School of Law and a Master of Laws in Global Health Law and International Institutions through a joint program with Georgetown University Law Center and the Graduate Institute for International and Development Studies in Geneva, Switzerland. Dr. Mehta is originally from Houston, Texas and lives in the District of Columbia with his wife Reema, son Shailen and his puppy Dexter. ■

WORKFORCE SURVEY

Please be reminded that during the renewal process licensees must complete the Board of Nursing's Workforce Survey questionnaire, so that accurate data may be collected which could ultimately impact both public policy and future nursing workforce opportunities in the District. What did we learn from the 2012 survey?

Workforce data was collected from RNs and APRNs during the 2012 renewal period. Over 15,000 renewed their license in 2012. We wanted to share a few of our findings based on a comparing our statistics with HRSA's workforce survey:

Racial diversity

Nationally, ethnic/racial minorities make up 37% of the general population, but in nursing ...

Nationally: 19% of nurses are ethnic/racial minorities.

DC: 55% of nurses are ethnic/racial minorities (Black/African American 36%, and Asian 11%).

Education

Nationally: 42% have a baccalaureate; BSN 34%; 8% BS in other field.

DC: 51% have a baccalaureate; 45% BSN and 6% BS in other field.

Nationally: 3% have Master's degree.

DC: 16% have Master's degree.

Primary employment

Hospitals: Nationally 56%, in DC 67%.

Ambulatory: Nationally 9%, in DC 7%.

LTC Setting: Nationally 6%, in DC 4%.

Home Care: Nationally 6%, in DC 3%.

During the 2014 survey, will we see a change in the primary employment setting from acute care to long term care; has there been a shift in the educational level? How racially diverse is our nursing workforce? We need you to complete 2014 workforce survey..... ■

BOARD OF NURSING MEETINGS *Members of the public are invited to attend...*

Date: *First Wednesday of every **other** month.

Time:
9:30 a.m - 11:30 a.m.

Location:
2nd Floor Board Room
899 North Capitol St NE
Washington, D.C. 20002

Transportation:
Closest Metro station is Union Station.

*To confirm meeting date and time, call
(202) 724-8800.*

March 5, 2014
May 7, 2014
July 3, 2014
Sept 4, 2014
Nov 6, 2014

***Please note new schedule**

RN/APRN Renewals Have Begun; Licenses Expire June 30, 2014

Here Are Some Renewal Tips

**PLEASE NOTE: CE AUDIT
WILL BEGIN DURING
RENEWAL PERIOD.**

RN/APRN renewals began April 1, 2014. Licenses will expire June 30, 2014. All RN licenses expire June 30 of even numbered years. The renewal fee will not be prorated. You will be mailed a renewal notice (to your address of record) approximately three (3) months before the expiration of your license/certification. Upon completion of the renewal application and payment of the renewal fee, your license will be renewed for a two-year period.

HERE ARE A FEW TIPS TO AVOID DELAY, NOW AND IN THE FUTURE:

Renew online: RNs/APRNs can renew their licenses by accessing the HPLA website at:

<https://app.hpla.doh.dc.gov/mylicense/>

Web Browser: To renew online, you must use either Internet Explorer or Firefox web browser.

Contact Information: It is important to keep your contact information up-to-date. Please update your contact information by forwarding your updated mailing address and email address to Angela.Braxton@dc.gov.

APRN RENEWAL TIP

Controlled Substance Registration: APRNs, if you also possess a controlled substance registration, your registration is due for renewal. The fee for renewal for your controlled substance registration is \$130.00. You may renew online after you renew your primary requisite RN license. Note that if your RN license is placed on hold for any reason, you will be unable to renew your controlled substance registration until the hold is released.

DON'T LET YOUR LICENSE EXPIRE: Instead of letting your license expire, consider selecting "Paid Inactive" status.

Paid Inactive status allows your licensure to remain dormant until you choose to reactive the status to "Active Status." While on Inactive status, you will not be subject to the renewal fee and you can continue to use your RN title but **you cannot practice, attempt to practice, or offer to practice as an RN.**

WHY PAID INACTIVE? If you don't select this Inactive status, your license will expire. To reactive an expired license, you will need to apply for reinstatement of your license. If on Paid Inactive status, you pay the reactivation fee, currently \$34.00. Licensees on Paid Inactive status must continue to meet the continuing education requirements; CE must be presented to the Board when applying for licensure reactivation.

CONTINUING EDUCATION REQUIREMENTS FOR RENEWAL

LPNs: 18 Contact Hours
RNs: 24 Contact Hours
APRNs: 24 Contact Hours (15 pharmacology*)

*For clarification of this pharmacology requirement, see the yellow box in the IN THE KNOW section on page 11.

(1) Contact Hour Option: Provide an original verification form signed or stamped by the program sponsor.

(2) Academic Option: Provide proof of having completed an undergraduate or graduate course, in nursing or relevant to the practice of nursing.

(3) Teaching Option: Provide evidence of having developed or taught a continuing education course or educational offering approved by the board or a board approved accrediting body. Applicants may receive four (4) contact hours for each approved course contact hour. (This is not an option for nurses required to develop and teach in-service education courses or educational offering as a condition of employment)

(4) Author or Editor Option: Provide evidence of authorship or editor of a book, chapter or published peer reviewed periodical, if the periodical has been published or accepted for publication during the period for which credit is claimed. (Meets continuing education requirement.)

PLEASE NOTE: All continuing education must be relevant to your current field of practice. ■

DUIs—Why Do They Matter?

By Kate Malliarakis, PhD, ANP-BC, MAC

The new requirement for Health Professionals to have background checks has revealed many issues for applicants. One is the issue of DUIs. Applicants now have their driving records identified for DUIs and DWIs. Persons identified as having a DUI or DWI within the last 5 (five) years are referred to the Committee on Impaired Nurses (COIN) for evaluation.

The COIN is a committee of the Board of Nursing (BON) that serves three functions: Identifying substance abuse or mental health issues that interfere with a nurse's ability to safely practice nursing; referring to treatment providers who can assist the nurse towards recovery; and, monitoring for those whose substance abuse or mental health issues have been documented and referred to the Board of Nursing. The BON asked COIN to review the DUI/DWI charges and provide guidance to the Board as to whether the nurse is unsafe to practice nursing.

What is the difference between a DUI and a DWI?

DUI designates driving under the influence, while DWI refers to driving while intoxicated. The difference between them differs by State, but usually refers to the amount of alcohol in your blood at the time of arrest. Driving under the influence (DUI) is considered a lesser charge in some States. In D.C., driving while intoxicated (DWI) means that the driver's blood alcohol concentration exceeded the legal limit. Driving under the influence (DUI) requires the driver's operation to be appreciably impaired as a result of intoxication. Additionally, the term DUI is used if a person is under the influence of drugs.

Why does it matter to the Board of Nursing?

In 2007, a seminal research article by White and Gasperin examined the research on the highest risk DUI offenders. They cited research that noted between 40-70% of first-time DUI offenders have prior alcohol- or drug-related criminal offenses. Furthermore, statistically, a person is not stopped the first time he or she drives drunk or under the influence of drugs. Finally, more than 80% of DUI offenders have a significant problem in their relationship with alcohol and/or other drugs.

Another follow-up study sought to isolate the characteristics of repeat DWI offenders followed over a 12 year period (Cavaiola, Strohmetz, & Abreo, 2007). They analyzed 77 first-time DWI offenders in which 38% were convicted of a subsequent DWI. They found there are only slight differences between first and repeat DWI offenders.

Addiction is a chronic relapsing disease of the brain. No one really knows exactly when addiction begins. What we do know is

"The changes in the brain that allowed the person to decide to drive after drinking or using drugs and thus endangering themselves or others—those changes are still present in the person's brain when he/she sobers up and goes back to work."

that a person's behavior changes as a result of his/her relationship with drugs or alcohol. A person's judgment changes as well and that is evidenced by driving after drinking or using drugs. The changes in the brain that allowed the person to decide to drive after drinking or using drugs and thus endangering themselves or others—those changes are still present in the person's brain when he/she sobers up and goes back to work. A person's judgment may not be accurate, and his/her thinking may be affected as well. In addition, there are many behaviors that demonstrate the disease and may not be apparent to the person. That is what COIN tries to do—assess the behavior patterns of a person who has received a DUI or DWI to see if he or she is in an active disease state. It's that simple!

Please know that referral to COIN is not a disciplinary action. The goal of COIN is to protect the patient by ensuring safe nursing practice.

COIN hopes that you will contact us through Concheeta Wright, our Case Manager, if you have any questions. Concheeta can be contacted at concheeta.wright@dc.gov or 202-724-8870.

REFERENCES

Cavaiola, A., Strohmetz, D., Abreo, S. (2007). Characteristics of DUI recidivists: a 12-year follow-up study of first time DUI offenders. *Addictive Behaviors* 32(4):855-61.

White, W. & Gasperin, D. (2007) The "hard core drinking driver": Identification, treatment and community management. *Alcoholism Treatment Quarterly* 25(3), 113-132. ■

Continuing Education Non-Compliance Notice

The Board of Nursing's Continuing Education (CE) Audit for Registered Nurses, Advanced Practice Registered Nurses and Licensed Practical Nurses began in 2013, following the specific renewal periods.

At the time that this publication went to press, we had not received a response to the Board's request from the persons listed below. Failure to comply with the Board of Nursing's regulatory requirement may result in a fine up to \$500.00 and/or a disciplinary action against your license to practice in the District of Columbia.

RNs/APRNs

Please note that if your name appears on the list of RNs below, **YOU WILL NOT BE ABLE TO RENEW YOUR LICENSE** until you:

- Provide evidence of completion of the continuing education during the timeframe July 1, 2010 – June 30, 2012; OR
- Complete the Negotiated Settlement Agreement that has been sent to the address on file.

RN LIST AS OF 2-03-14

ALLMAN, SONIA E	RN60915
DAUSSES, DEBORAH K	RN63092
EMAMI, SARAH ELIZABETH	RN1015771
GONSALVES, JAMILA A.	RN65783
JONES-REYNOLDS, CRYSTAL D	RN1016377
JUA, PETRA B.	RN1005646
KENNEDY-WATKINS, ANGELA R.	RN965540
LOTT, TIMOTHY C.	RN1005362
LOVELACE, PAULINE W	RN32938
MAYS, BLONDINIA J F	RN68240
MBUIH, SAMUEL N	RN53834
MOYO, VUYELWA E.	RN1004825
NWAOGWUGWU, NDIDI Y.	RN1004266
NYAMBI, CLAUDETTE	RN1014976
OHIRI, IMELDA C.	RN964571
PETRUS, RACHEL	RN1017651
PHILIP, LYNETTE C	RN43242
PICKETT, MELISSA L.	RN1017832
RAHIM, MARIAMA	RN1002350
SIMPSON, PHILOMINA	RN962512
WASHINGTON, LECHELE W	RN1008946
WILLOUGHBY, SUSAN D	RN55483

LPN LIST AS OF 2-03-14

AFOLABI, FAITH O.	LPN1002912
AKINDOLIE, ANDREW O	LPN1004938
ANYANWU, NELSON C	LPN1005399
BABATUNDE, BEATRICE	LPN7250
BEALE, FRANCES Y.	LPN5899
BENJAMIN, MINNETTE V	LPN4963
BUCHANAN, ANGELA T.	LPN1003514
CHE, PHILOMENA S	LPN1004857
COLE, ROSEMOND E	LPN8284

LPNs

Please note that if your name appears on the list of LPNs below:

- Provide documentation of meeting Continuing Education requirements during the timeframe of July 1, 2011 to June 30, 2013.

WHAT TO SUBMIT

I have completed CE within Timeframe: If you completed the CE during July 1, 2011 to June 30, 2013, please submit your documentation to the Board. You will not be fined.

I have not completed my CE within Timeframe: If you did not complete the CE during July 1, 2011 to June 30, 2013, you will be fined and you will have to submit documentation in compliance with the CE requirements. (See page 7 for CE options.)

If you have any questions or need additional information, please feel free to send an email to Felicia.Stokes@dc.gov or Bonita.Jenkins@dc.gov or call Gwyn Jackson at (202) 442-4764.

DAMLABEU, DANIELLE L	LPN1006268
DEEN-DURING, OLAIMATU W	LPN1005558
DESMUKES, BRIDGET BECHAM	LPN1004132
EKATAH, MARY O.	LPN1003255
ELEGALAM, AKUNNA U	LPN1002136
FREEMAN, BARBARA	LPN1004112
GIBATEH, TENNEH	LPN1002266
GIWA, TOYIN B.	LPN1002415
GOINS, DORIS V	LPN5524
JEZA, CAROLINE N.	LPN1003747
JOHNSON, LOUISE S.	LPN1814
MYER, SATA	LPN1006058
NANA, ALICE F	LPN1004209
NDAKWAH, DELPHINE A	LPN1005491
NEWMAN-OSIGWE, SHIRLEY	LPN7157
NYARKO, ENOCK NK	LPN1003848
OMOLOLA, KOLAWOLE G.	LPN1003462
OROCK, MAGGIE E	LPN1006179
OSEI-ACHEAMPONG, KOJO S	LPN7173
PEARCE, KUMBA	LPN1005660
SADALAH, MUSTAFA LUBEGA	LPN1006027
SESAY, SONNA HAJA	LPN1003652
SMITH, GENEVA M.	LPN1002979
STOKES, CAROLYN A	LPN5266
UDECHUIKWU, JOHN T.	LPN7479
WALLACE, DEBORAH	LPN7210
WAYNS, TOLUILOPE O	LPN1005908
WHITTINGHAM, SHELLY-ANN O	LPN1005802
WILLIAMS, DENISE	LPN6693
WILLIAMS, LENISE ELSIE	LPN6055
WILLIAMS, STEPHANIE M.	LPN961244

See page 7 to see all the options for meeting the Continuing Education requirements. ■

IN THE KNOW

The Board of Nursing has established the “In The Know” column in response to the many phone calls and e-mails the Board receives regarding licensure and other issues. The Board often receives multiple inquiries regarding the same topic. Please share this column with your colleagues and urge them to read it. The more nurses are aware of the answers to these frequently asked questions, the less our resources will have to be used to address duplicate questions.

CHEATING ON AN EXAM

Q: A candidate was suspected of cheating during an exam. Testing was discontinued and the testing service PSI was informed about the incident. What is the Board’s policy regarding cheating? We follow Rule 17-3303 “Cheating on an Examination” that is found in the DC Regs. (link: <http://www.dcregs.dc.gov/Gateway/RuleHome.aspx?RuleNumber=17-3303>)

TESTING CENTER CHEATING POLICY

No person shall cheat or assist another in cheating on an examination required by an Act listed in § 3300.1 or rules promulgated pursuant thereto.

As used in this section, “cheating” includes, but is not limited to, the following:

- (a) Communication relating to the examination between applicants inside or outside of an examination room or copying another applicant’s answers while an examination is in progress;
- (b) Communication relating to an examination with others outside of an examination room while the examination is in progress;
- (c) Substitution by an applicant of another person to sit in an examination room in the applicant’s place; and
- (d) Use of crib sheets, text books, or other materials not authorized by a board inside or outside an examination room while an examination is in progress.

If a person designated to proctor an examination suspects that an applicant is cheating or has cheated on the examination, the person shall do the following:

- (a) If necessary, seat the applicant in a segregated location for the remainder of the examination;
- (b) Keep a record of the applicant’s seat location and identification number, and the names and identification numbers of the applicants on either side of the applicant;
- (c) Confiscate any materials or devices that are suspected of being used by the applicant to cheat on the examination;
- (d) Permit the applicant to complete the examination; and
- (e) Notify the testing service, the board, and the Director that the applicant is suspected of cheating and provide a board with a copy of the examination booklet and any evidence obtained by the person proctoring the examination.

If a board has cause to believe that an applicant has cheated or has failed to comply with an instruction of a proctor, it may propose to deny a license, impose a civil fine, or take other actions.

BOARD OF NURSING CHEATING POLICY

Board of Nursing examination applicants caught cheating on examinations or submitting fraudulent information will be asked to withdraw their application and will not be able to apply to sit for examination in DC for a period of two years.

HHAS & MEAL PREPARATION

Q: Many of the Home Health Aides working with seniors are not competent in preparing basic meals for their assigned senior clients, even though the care plan requires it and HH Agencies are getting paid for these services. When this occurs, clients are mostly forced to request our Agency to provide home delivered meals so they can eat a basic, but nutritious meal once a day. 17 DCMR, 9315.1(h) states that HHA shall assist with “preparation of meals in accordance with dietary (USA) guidelines.” Unfortunately, a significant number of our clients’ HHAs cannot or do not prepare meals in an acceptable manner for their clients. This may be due to a lack of training and/or knowledge of the American style of cooking.

As a result, this issue places a client with existing physical vulnerabilities and health issues at a greater risk health wise. Also there are many clients who are not eligible for HHA services via Medicaid who could benefit from home delivered meals, which are limited supply throughout the city.

A: Thank you for contacting the Board of Nursing. We would need to know the name of the HHAs or preferably the agency. We have asked agencies to make sure that the HHA is competent to perform the tasks specified in the plan of care. If we know the name of the agency, and/or the HHA, they will be contacted by Board staff.

HHA VS. PCA

Q: What is the difference between a Home Health Aide (governed by one set of regulations) and a Personal Care Aide (PCA) (governed by similar but separate regulations)? It looks like HHAs have to take and pass a different course and exam. Is this right? The PCA regulations don't mention Board of Nursing oversight, whereas HHA regulations do. Are PCAs not subject to Board of Nursing rules, only HHAs (regulations below)? What does this mean for Medicaid State Plan PCA recipients vs. EPD Waiver participants? It seems like the pool of aides are the same, and so a "PCA" might be serving a person who is just getting Medicaid State Plan PCA services OR that same PCA might serve an EPD Waiver beneficiary, ditto for HHA. Clarification would help!

A: While their roles may vary in the District, PCAs and HHAs are used interchangeably. **Therefore, in regulating them the Board did not make a distinction between the two.** The HHA regulations definition is as follows:

"Home health aide (HHA) [is] an individual, **including a personal care aide (PCA)**, who as a result of training and demonstrated competencies, works under the supervision of a nurse or other health professional licensed in the District of Columbia and provides nursing or nursing related services to clients in a home setting or in assistive living facilities."

OUT-OF-STATE REVOCATION

Q: If an RN license is revoked in another state, does that impact their license in DC?

A: It may. When the Board becomes aware of the revocation, it will review the reason for the revocation. The Board may issue a reciprocal order (the nurse's license will be revoked in DC, also); the Board may issue a lesser discipline or, in some cases, no discipline. (Some boards revoke licenses for CE non-compliance. The DC Board would not reciprocate a revoked license for that reason.) If the nurse is currently licensed in DC, the nurse does have the right to a hearing.

PARTIAL RENEWAL CYCLE

Q: If a nurse applies for a DC license in early January 2014, will that license be good until 2016 or will she have to reapply again when the 2014 licenses expire? That is a lot of money for a few months to have to reapply.

A: All RN licenses expire June 30th of even-numbered years.

NON-NURSE MANAGER

Q: Is there a part of the Nurse Practice Act that says "RNs must be evaluated by RNs?" We have a couple of areas where there is no RN in the clinical area and the manager is a non-nurse.

A: There will always be settings in which nurses are supervised by persons who are not licensed as RNs. But in the clinical setting, the scope of nursing as defined by the Health Occupations Revision Act (Section 3-131.02, 17, (J)) specifies:

"(17) **"Practice of registered nursing"**
"(J) Administering nursing services within a health care facility, including the delegation and *supervision of direct nursing functions and the evaluation of the performance of these functions;*

This section of the law has been

interpreted to mean that the supervision of "direct nursing functions" is the role of the RN. This should not be interpreted to mean that RNs cannot be supervised by others in their performance of duties that are non-clinical.

RN-TO-APRN

Q: We have a question from a DC licensee who upgraded from registered nurse to nurse practitioner during the current license period. Questions: (a) When someone goes from RN to NP, do they still have the standard renewal requirements, or are they considered to be in the first renewal since it is a new profession? (b) Would they still keep the RN license or does it just become an NP license and the RN license is understood but not considered a separate license?

A: (a) RNs adding on the APRN authority are NOT considered to be renewing for the first time. (b) Persons applying as APRNs will be issued an APRN license.

PHARMACOLOGY FOR APRNs

Q: Our organization provides continuing education for nurses. I am trying to determine exactly what the DC Board means by "pharmacology" content for the advanced practice RNs. When putting courses into CE Broker, I have to determine if the hours are good for pharmacology or not.

A: Pharmacology content refers to pharmacokinetic or pharmacodynamic information related to drugs. Because we have a pharmacology continuing education requirement for APRNs, they must have the specific hours listed on their CE certificates.

Continued on page 12

Continued from page 25

APRN IN A HEALTH CARE FACILITY PEER REVIEW

Q: Is it still correct that APRNs peer review as part of the evaluation process to maintain licensing in DC? If so, can you send me the regulation because I could not find it.

A: See relevant section below. This section was included in the regulations to address facilities that require evaluation.

5913 PRACTICE OF A CERTIFIED REGISTERED NURSE-PRACTITIONER IN HEALTH CARE FACILITIES REQUIRING A FORMAL EVALUATION

5913.1 An APRN shall be evaluated by another APRN licensed to practice in the same specialty area.

Q: Do you interpret this regulation to be annual if the evaluations are annual?

A: Yes. The premise of this resolution is that APRN practice should be evaluated by an APRN.

Q: Is the “specialty area” referring to specialty certification (i.e. pediatrics), not the pediatric specialty they are working within (ex, neurology)? Several APRNs are working in a pediatric specialty where they are the only APRN.

A: This regulatory requirement is referring to the certification specialty.

Q: I have my recommendations on how to get an adequate Peer Review when the only observers of your practice are physicians, but are there Board guidelines/recommendations for how to have a peer review you when you do not actually practice in the same area? My suggestion is to send charts

for review to the peer and to meet with the peer periodically for review of your work; I do not tell them they should have the peer come observe them.

A: Sounds good. Your approach is consistent with the intent of this regulation. Please note that we will soon revise the APRN regulations.

CONTINUING EDUCATION

Q: Regarding CE Audit—“Send an **original** verification form.” Is this new? I do not believe I sent originals at the last renewal. If we send the originals, how do we use them for other state licensing or if we are audited?

A: We started asking for originals because we were finding that some were photocopying their colleagues’ CE certificates. If an original is not submitted and we have questions regarding its validity, we will request an original. If you are audited by us and need to send an original, keep a copy for your records. ■

Board Members Sworn In



New Board member Mami Preston, RN (center), with Darryl Gorman, Esq., Director of the Office of Boards and Commissions, and Cathy Borris-Hale, RN, MHA, BSN, Board Chairperson.



Returning Board members Chioma Nwachukwu, DNP, PHNCNS-BC, RN, and Toni A. Easton, DNP, MS, APHN-BC, COHN-S; each sworn in to serve a second term.

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NCSBN News

NCSBN RAISES THE PASSING STANDARD FOR THE NCLEX-PN EXAMINATION

The National Council of State Boards of Nursing (NCSBN) Board of Directors (BOD) voted on Dec. 10, 2013, to raise the passing standard for the NCLEX-PN Examination (the National Council Licensure Examination for Practical Nurses). The passing standard will be revised from the current logits* -0.27 to -0.21 logits beginning April 1, 2014, with the implementation of the *2014 NCLEX-PN Test Plan*. The new passing standard will remain in effect through March 31, 2017.

After consideration of all available information, the NCSBN BOD determined that safe and effective entry-level licensed practical/vocational nurse (PN/VN) practice requires a greater level of knowledge, skills, and abilities than was required in 2010 when NCSBN implemented the current standard. The passing standard was increased in response to changes in U.S. health care delivery and nursing practice that have resulted in the greater acuity of clients seen by entry-level PN/VNs.

In their evaluation the BOD used multiple sources of information to guide its evaluation and discussion regarding the change in passing standard. These sources include the results from the criterion-referenced standard-setting workshop, a historical record of the NCLEX-PN passing standard and candidate performance, the educational readiness of high school graduates who expressed an interest in nursing, and the results from annual surveys of nursing educators and employers conducted between 2011 and 2013. As part of this process, NCSBN convened an expert panel of 13 subject matter experts to perform a criterion-referenced standard-setting procedure. The panel's findings supported the creation of a higher

passing standard. NCSBN also considered the results of national surveys of nursing professionals, including nursing educators, directors of nursing in acute care settings and administrators of long-term care facilities.

In accordance with a motion adopted by the 1989 NCSBN Delegate Assembly, the NCSBN BOD evaluates the passing standard for the NCLEX-PN Examination every three years to protect the public by ensuring minimal competence for entry-level PNs. The 2014 NCLEX-PN Test Plan is available free of charge from the NCSBN website. Inquiries about the NCLEX examination may be directed to the NCLEX information line at 1.866.293.9600 or nclexinfo@ncsbn.org.

*A logit is defined as a unit of measurement to report relative differences between candidate ability estimates and item difficulties.

THE ROLE OF THE SCHOOL NURSE EVOLVING

A recent article in USA Today highlights a number of ways in which the role of school nurses has changed in recent years. Today's school nurses are treating student populations that have increasing medical needs. At the same time, school systems continue to face budget cuts, requiring school nurses to rotate between multiple school assignments during a workweek. According to the National Association of School Nurses, one-third of all school districts reduced nursing staff over the past year because of the recession; a quarter of all school districts do not have a school nurse at all. The article indicates that many school nurses have an increased need to train and maintain a competent team of unlicensed personnel to prevent, recognize and respond to emergencies. Finally, the article notes that recent policy shifts arising out of the Affordable Care Act will lead to greater opportunities for school nurses to focus on prevention and wellness.

AMERICAN COLLEGE OF PHYSICIANS (ACP) ADVOCATES SHIFT FROM INDIVIDUAL CLINICIAN MODEL TO TEAM-BASED CARE

In a recently released position paper published in the *Annals of Internal Medicine*, the ACP suggests that patients should have immediate access to a physician overseeing their care, but inter-professional teams should be organized and managed in a way that best meets patient needs. For example, the position paper states that, while advanced practice registered nurses (APRNs) "cannot substitute" for doctors, patients should be matched with the most qualified member of the care team available at the time. The paper states that APRNs can provide complementary and unique approaches, as well as additional skills in the service of patients and families. However, the position paper is unclear as to whether physicians must lead the care team or whether other professionals may lead.

NUMBER OF U.S. HOSPITAL DEATHS FROM MEDICAL MISTAKES CAUSES ALARM

New research from the *Journal of Patient Safety* estimates the number of preventable medical mistakes contributing to patient death is somewhere between 210,000 to 440,000 each year. These estimates are significant because they are remarkably higher than previous estimates. In 1999, the Institute of Medicine published the famous "To Err Is Human" report, which estimated that 98,000 people a year die because of mistakes in hospitals. In 2010, the Office of Inspector General for the Department of Health and Human Services said that, in a given year, poor hospital care contributed to the death of 180,000 Medicare patients. While no one has definitively established the true number of medical errors attributable to patient death, Dr. David Mayer, vice president of quality and safety at Maryland-based MedStar Health, said that all the estimates, even at the low end, expose a crisis. ■

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District of Columbia NCLEX Pass Rates

October 1, 2012 – September 30, 2013

REGISTERED NURSE PROGRAMS	% Pass
Catholic University of America	67.95
Georgetown University	97.56
Howard University	69.44
Radians College	83.33
Trinity Washington University	44.19
University of District of Columbia Community College	37.14
National Average:	
Baccalaureate Programs	86.08
Associate Degree Programs	82.90
District of Columbia:	
Required Pass rate (95 % of National Average)	
Baccalaureate Programs	81.78
Associate Degree Programs	78.76
PRACTICAL NURSE PROGRAMS	% Pass
Comprehensive Health Academy	85.71
Radians College	100
University of District of Columbia Community College	59.68
National Average:	
Practical Nurse Programs	85.23
District of Columbia:	
Required Pass rate (95% of National Average)	
Practical Nurse Programs	80.97

Nursing program approval/accreditation status is determined annually by the DC Board of Nursing and is based on the performance of the graduates of nursing programs on their first attempt taking the NCLEX as set forth in the regulatory requirements in "17 DCMR Chapter 56."

- 5603.3 The Board may grant full accreditation to a program after the graduation of its first class if:
- The percentage of the program's first time NCLEX test takers passing the exam is not more than five percent (5%) below the national norm. The passing percentage shall be based on the cumulative results of the first two (2) quarters following graduation of the first class; and
 - The program has demonstrated continued ability to meet the standards and requirements of this chapter.

- 5603.7 In order to maintain full accreditation status, a program with full accreditation shall maintain:
- All the standards and requirements of this chapter, as they may be amended or republished from time to time;
 - A minimum pass rate, for first time test takers on the NCLEX, or not more than five percent (5%) below the national norm, based on the cumulative results of the four (4) quarters in each year.

5605.1 The Board may place a nursing program that has failed to meet or maintain the requirements and standards of this chapter on conditional accreditation status 5605.2 Conditional accreditation status denotes that certain conditions must be met within a designated time period for the program to be granted or restored to full accreditation. ■

DC National Nurse Aide Assessment Program Pass Rates 2013

Training Programs	% Pass	Status
Captec Med Care	87.30	Approved
Carlos Rosario Int'l	89.48	Approved
DC Institute of Allied Health	74.34	Conditional
Friendship Public Charter	43.34	Conditional
Innovative Institute (formerly Total Healthcare Innovations)	79.47	Approved
University of District of Columbia-Community College	75.32	Approved
VMT Educational Center	74.65	Approved
Required DC Pass Rate	75%	

DC Home Health Aide Exam Pass Rates 2013

Training Programs	% Pass	Status
Bethel	21.46	Conditional
CAPTEC	74.00	Conditional
DC Institute of Allied Health	73.07	Conditional
Healthwrite Training Center	90.00	Approved
Home Care Partners	80.30	Approved
Intellect Health Institute	N/A	Initial
Innovative Institute (formerly Total Healthcare Innovations)	86.05	Approved
Opportunities Industrialization Center	85.71	Approved
University of District of Columbia – Community College	80.00	Approved
VMT Educational Center	87.75	Approved
Washington Training Institute	53.51	Conditional
Required DC Pass Rate	75%	

Gallup Poll: Nurses Still #1

Gallup's annual professional-ethics survey, conducted at the end of last year, place nurses in the number one slot when respondents assessed professionals on their ethics. When 1,031 respondents were polled, 82% rated nurses highly or very highly for honesty and ethical standards. Nurses were followed by pharmacists, grade school teachers, medical doctors, military officers and police officers. The professions which have engendered the least amount of trust are State officeholders, car salespeople, Members of Congress and—in last place—Lobbyists. (Source: <http://www.gallup.com/poll/1654/honesty-ethics-professions.aspx>) ■

DC ACTION COALITION: Removing Practice Barriers



Arlima St. Clair, RN, MSN, Co-Director for the Health Unit at the Organization of American States, and President of the DC Chapter of the National Association of Hispanic Nurses; Pier A. Broadnax, PhD, RN Director/Associate Professor, University of the District of Columbia; Winifred Quinn, PhD, Co-Director of the Center to Champion Nursing in America, AARP.

*Action Coalitions are the driving force of the **Future of Nursing: Campaign for Action**, a broad, national effort to drive implementation of the Institute of Medicine's blueprint for ensuring that all Americans have access to high quality, patient-centered care in a health care system where nurses contribute as essential partners in achieving success.*

Action Coalitions are built to effect long-term sustainable change in moving the recommendations into action. Comprised of diverse groups of stakeholders from a variety of sectors, their mission is to develop an issue strategy plan that will be the basis for coalition implementation efforts. The Action Coalitions will further the overall initiative by capturing best practices, determining research needs, tracking lessons learned and identifying replicable models.

The District of Columbia Action Coalition is a joint effort which unites nurses and nursing champions in calling for the removal of educational obstacles and practice barriers. Action Coalitions have been established throughout the country as part of the **Future of Nursing: Campaign for Action**, initiated by AARP and inspired by the Institute of Medicine's

(IOM) report entitled "The Future of Nursing: Leading Change, Advancing Health."

The DC Action Coalition held its inaugural program late in 2013, at the University of the District of Columbia (UDC), to introduce the coalition, its goals and activities to the DC health care community.

COMING TOGETHER

"The goal of the Coalition is advancing nursing in the community, and creating partnerships and reaching out to the community—universities, churches, and hospitals. The Campaign's success would be removing barriers that hamper consumers' access to care," according to DC Action Coalition member Arlima St. Clair, RN, MSN, President of the DC Chapter of the National Association of Hispanic Nurses and Co-Director for the Health Unit at the Organization of American States. Ms. St. Clair welcomed attendees to the program.

Setting the context for the program was the coalition's Non-nurse Co-lead, Reverend Roy Thomas, pastor of the Nazareth Baptist Church in the District: "The goal of today's program is to introduce the coalition to the health care community and begin the discussion on the future of nursing and health care delivery in DC."



Rev. Roy D. Thomas, Nazareth Baptist Church

The DC Action Coalition brings together nurses, physicians, and faith-based organizations. DC is the only coalition where a Co-leader is faith based, and it is the second coalition to have a physician as Co-leader.

NEED FOR ACTION

With the influx of new primary-care consumers expected to come with the implementation of the Affordable Care Act, health-care leaders are seeking new options for providing primary care to millions of new patients. The solution is clear: nurses should be permitted to practice to the full extent of their knowledge and capabilities. Educational programs should be crafted with an eye on the workforce opportunities in the region and geared to propel more nurses towards obtaining their BSN. The need for advanced-practice nurses, Nurse Practitioners (NPs), in primary practice is apparent, especially as more and more physicians gravitate toward specialty medicine.



Keynote speaker Winifred Quinn, PhD

CRISIS IS OPPORTUNITY

The crisis in primary care provides us with an opportunity to open minds, according to keynote speaker of the program, Winifred Quinn, PhD, Co-Director



Delores Clair Oliver, RN, MHA, CNAA, BC, Chief Operating Officer, Specialty Hospital of Washington

of AARP’s Center to Champion Nursing in America. “Because of the multitude of problems in access to care, people are open to change like never before,” she said. “Nurses are at the center of innovations to improve quality and control costs.

Every single nurse is a leader and a patient advocate and as such it is your job to ensure a high quality of care.”

Continued on page 20



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We are looking for a Clinical Liaison RN to coordinate smooth entry into our hospice service system. This position meets with families referred within assigned facilities to explain care delivery and collaborates with discharge planners and physicians for the entry of patients into hospice. Qualifications include a BSN with at least one year hospice experience preferred. Must be licensed in both DC and Maryland.

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We are also seeking a Clinical Manager to plan, manage, and evaluate 24-hour nursing care on a designated unit. This position will make daily rounds on the nursing unit to ensure that all nursing staff are performing their work in a accordance with our standards. Works closely with the Director of Nursing to shape the structure and future operations of their unit. To qualify, candidates need a minimum of 5 years’ experience in medical/surgical or geriatric nursing, a current DC RN licensure, and current CPR certification. Knowledge of Federal and District regulations for long term care and MS Office are needed to excel in this role. BSN preferred.

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Continued from page 19

Dr. Quinn made reference to the 2010 IOM report which called for nursing transformation—advocating that nurses be allowed to practice to the full capacity of their abilities, so all Americans can have access to high-quality care. “That IOM report has been the most-viewed report in IOM history,” she said. “Robert Wood Johnson initiated the National Campaign for Action to support the implementation of the IOM recommendations.”

DISEASE BURDEN

Pier A. Broadnax, PhD, RN, Director of the Nursing Program in the UDC Department of Nursing and Health Professions, noted that the new (Affordable Care Act) patients will come into the health care setting with more grave health issues: “These patients will enter the health care system with multiple system involvement, and systems which have deteriorated. We must increase the number of nurses and ensure the highest levels of quality in nursing care. We need to increase the number of BSN-prepared nurses.” She said that nursing should be leading at the point of care and developing new models of care.

Nursing’s advocacy for and communication with consumers will continue to be crucial. Dr. Broadnax noted that consumers can be easily lost and overwhelmed in the health-care world. “If the patient is told to come back in three months, does the consumer know what to do during that 3-month period? We need health education and coordination of services,” she said. “People are often stymied at point of diagnosis.”



Karen Skinner, RN, MSN, Executive Director, DC Board of Nursing; Terry R. Goodman, Consumer Representative, Unity Health Care; Pier A. Broadnax, PhD.

EDUCATION AND THE WORKFORCE

During the panel discussion, DC Board of Nursing Executive Director Karen Scipio-Skinner noted: “Nationally, we are seeing healthcare delivery moving from acute care to out-patient care. We need data to determine the workforce needs in DC.” The Board of Nursing renewal process now includes an important job data-gathering component—the Board licensees’ workforce survey.

Ms. Scipio-Skinner shared some of the results of the first workforce survey, and contrasted the District’s numbers with those of the nation as a whole. In the United States, 37% of the population is minority; and 19% of nurses are minority.

In the District, 55% of nurses are minority, but we are lacking in Latino nurses. The District is also atypical because 51% of our nurses are Baccalaureate-prepared. Board of Nursing statistics indicate that DC has the highest per capita ratio of nurse practitioners, 8.7 per 10,000 as compared to the national per capita ration of 3.4 per 10,000. Why the high ratio? DC APRNs were granted practice autonomy in 1994. APRNs can practice independently, without requiring collaborative practice agreements with physicians. They have independent prescriptive authority, without the requirement of prescription protocols. And they can obtain admitting privileges. We are ahead of the curve.

UDC Professor Dr. Connie Webster spoke about the importance of internships. In addition to a degree, students need internships so they get experience — paid experience. “It is unethical to enroll students in a program which does not qualify them for the available jobs,” she said. “No educational program should leave its graduates unemployable.”

In addition to clinical experiences and internships, degrees must be aligned with the job opportunities available. The Coalition and the Board of Nursing have long been advocates for “seamless educational pathways” to expand the nursing workforce and to enhance the diversity of the professional nursing workforce. There needs to be a seamless educational progression model from NAP to BSN.

Innovative programs can greatly facilitate an RN’s effort to attain a BSN. During the panel discussion, attendees were told about a model RN-to-BSN program in Texas that has increased enrollment by 2,000 percent. The program allows nurses to enter the program at seven different points during the calendar year. In addition, scholarships were provided for those who qualified.

DELEGATING TO NAPs

The Board has endeavored to regulate and certify Nursing Assistive Personnel (NAPs) by setting standards. “It has been a challenge,” according to Ms. Scipio-Skinner. Issues which may concern nurses in regarding NAPs include questions such as: “Can I trust when I delegate to them? How, what, and when to delegate?” The Board is working to define the role of the NAP, and to specify what tasks are appropriate for nurses to delegate to an NAP.

CONSUMER SALUTES HIS NURSE “ANGELS”

Terry R. Goodman, the DC Action Coalition’s Consumer Representative, spoke to participants about how nurses were his lifeline. Their presence was his refuge from despair. Mr. Goodman had been a procurement specialist for the U.S. Senate Sergeant at Arms when he suffered a devastating health crisis in 2011 and had to leave his job. “I was scared to go to the doctor,” he said. When he finally went, “I was told I had renal failure. I had fluid in my heart and lungs. They rushed me to Providence Hospital. When got out of surgery, I had a stroke. Then was told I was HIV positive.”

His relationship with his family was thrown into a tailspin with the HIV diagnosis. “My oldest brother said ‘Why didn’t you tell me?’ After that diagnosis, they wouldn’t hug me.” Mr. Goodman spoke of how persons with HIV can be

shunned by family members.

However, Mr. Goodman’s shining light of hope was the nursing staff: “At NRH [MedStar National Rehabilitation Network], my nurse was my angel. When she arrived at work, she came directly to my room and sung to me.”

Mr. Goodman spoke to the nurses in the audience: “You are holy. I couldn’t speak. I was so mad and angry. My family couldn’t understand what I was saying [after the stroke]. Eventually, my family came together,” he said. “I wish I went to the doctor earlier. Now I need a kidney transplant. The majority of kidney patients are Black. Spirituality and laughter has been the key to coping with my medical condition. God comes first.”

Continued on page 22

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HEALTHWAYS



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PHYSICIAN SALUTES HER NURSE COLLEAGUES

Physician Jehan “Gigi” El-Boyouni, MD, FACP, told participants that she had never fully appreciated the value of nursing until she became a patient. A physician at George Washington University, Dr. El-Boyouni came to see her nurse colleagues differently when she was hospitalized subsequent to her breast-cancer diagnosis. In the care of the GWU nursing staff: “I experienced love, care, and advocacy from my nursing angels, my colleagues at GWU.”

Dr. El-Boyouni has a very active clinical practice, and is an associate professor of medicine at GWU. She criticized medical education



Jehan “Gigi” El-Boyouni, MD, FACP, Physician and Founding Director of Rodham Institute.

for desensitizing students to some patients: “Medical education today ensures that graduates objectify patients—poor urban minorities with disease burden. We educators have failed to create an expectation of social accountability. We are number 37 in outcomes in the world. Only 3% of medical students are African American.”

Dr. El-Boyouni cited the need to combat the deficit in the health literacy of children in the District. She

noted that the Association of Black Cardiologists is looking for volunteers to provide health education to schools in wards 5-8 and Prince George’s County, supporting minority student interest in STEM — science, technology engineering and mathematics.

TRANSFORMATION WILL BE THE NEW NORMAL

The transformation of nursing will happen, Dr. El-Boyouni assured participants. When CRNAs (Certified Registered Nurse Anesthetists) began practicing in the District, it caused alarm among some people, Dr. El-Boyouni said. However, now CRNA practice is not questioned.

We must continue the push to remove practice barriers and to get nurses on hospital and health care system boards of directors. We must lobby for nursing BSN programs which welcome working RNs. We must advocate for quality programs for NAPs. Change will happen when we mobilize for this transformation. Removing barriers to nursing will facilitate a transformation which will greatly benefit the health care system and the consumers we serve. ■

NURSING’S FUTURE: AT A GLANCE

Three years ago, the Institute of Medicine (IOM) released the report *The Future of Nursing: Leading Change, Advancing Health*. Its recommendations:

- RN-to-BSN: Nurses should achieve higher levels of education and training.
- NURSE PRACTITIONERS: Advanced-practice registered nurses (APRNs) should be able to practice to the full extent of their education and training.
- IN THE BOARDROOM: More nurse leaders should be tapped to serve on hospital boards, and be provided with opportunities for networking and mentoring.

(Source: www.iom.edu)



Nancie Bruce, RN, PhD, Director of RN-BSN Program, Trinity Washington University; JoAnne Joyner, PhD, APRN, BC; Sonia C. Swayze, MA, RN.

IOM REPORT, THE AFFORDABLE CARE ACT AND THE DC NURSE WORKFORCE

The IOM *The Future of Nursing report issued in (Oct 2010)* was based upon a thorough examination of the nursing workforce. The recommendations offered in the report focus on the critical intersection between the health needs of diverse, changing patient populations across the lifespan and the actions of the nursing workforce. The intent of the recommendations was to support efforts to improve the health of the U.S. population through the contributions nurses can make to the delivery of care.

The report was designed to serve as a framework for changes in the nursing profession and the health care delivery system. The solutions were directed to individual policy makers, national state and local government leaders, payers, health care researchers, executives and professionals – including nurses and others – as well as to larger groups such as licensing bodies, education institutions, and philanthropic and advocacy organizations, especially those advocating for consumers.

There were eight recommendations offered in the report centered on four main issues:

1. Nurses should practice to the **full extent** of their education and training.
2. Nurses should achieve **higher levels of education** and training through an improved education system that promotes **seamless academic progression**.
3. Nurses should be **full partners**, with physicians and other health professionals, in redesigning health care in the United States.
4. Effective workforce planning and policy making require **better data collection** and information infrastructure.

Considering the impact of both the IOM Report and the Affordable Care Act, in DC we anticipate the need for a well-educated nurse workforce — from advanced practice registered nurses to nursing assistive personnel, with a practice model that will allow all levels of nursing personnel to work to fullest extent of their scope of the practice and education; and we can anticipate health care increasingly being provided in community settings.

Allowing nurses to function to the fullest extent of their education has long been a focus of the DC Nursing Community. In 1994 legislation was passed removing practice barriers for the District's advanced practice registered nurse, which has resulted in the largest per capita number of NPs, according to the 2010 Centers for Medicare and Medicaid Services National Plan and Provider Enumeration System's National Provider Identifier (NPI) data; The national per capita ratio of all NPs to 10,000 population was 3.4. with District having the highest per capita ratio of 8.7.

AFFORDABLE CARE ACT REFORMS

- Expand coverage
- Hold insurance companies accountable
- Lower health care costs
- Guarantee more choice, and
- Enhance the quality of care for all Americans.

The Affordable Care Act actually refers to two separate pieces of legislation — the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) — together these laws expand Medicaid coverage to millions of low-income Americans and make numerous improvements to both Medicaid and the Children's Health Insurance Program (CHIP). (Source: www.medicaid.gov).

DC ACTION COALITION LEADERSHIP



Visit the DC Action Coalition webpage at:
<http://campaignforaction.org/state/district-columbia>

FDA: Health Care Professionals should discontinue prescribing drug products with more than 325 mg of acetaminophen

FDA is recommending health care professionals discontinue prescribing and dispensing prescription combination drug products that contain more than 325 milligrams (mg) of acetaminophen per tablet, capsule, or other dosage unit. There are no available data to show that taking more than 325 mg of acetaminophen per dosage unit provides additional benefit that outweighs the added risks for liver injury. Further, limiting the amount of acetaminophen per dosage unit will reduce the risk of severe liver injury from inadvertent acetaminophen overdose, which can lead to liver failure, liver transplant, and death.

We recommend that health care providers consider prescribing combination drug products that contain 325 mg or less of acetaminophen. We also recommend that when a pharmacist receives a prescription for a combination product with more than 325 mg of acetaminophen per dosage unit that they contact the prescriber to discuss a product with a lower dose of acetaminophen. A two tablet or two capsule dose may still be prescribed, if appropriate. In that case, the total dose of acetaminophen would be 650 mg (the amount in two 325 mg dosage units). When making individual dosing determinations, health care providers should always consider the amounts of both the acetaminophen and

the opioid components in the prescription combination drug product.

In January 2011 we asked manufacturers of prescription combination drug products containing acetaminophen to limit the amount of acetaminophen to no more than 325 mg in each tablet or capsule by January 14, 2014. We requested this action to protect consumers from the risk of severe liver damage which can result from taking too much acetaminophen. This category of prescription drugs combines acetaminophen with another ingredient intended to treat pain (most often an opioid), and these products are commonly prescribed to consumers for pain, such as pain from acute injuries, post-operative pain, or pain following dental procedures.

More than half of manufacturers have voluntarily complied with our request. However, some prescription combination drug products containing more than 325 mg of acetaminophen per dosage unit remain available.

In the near future we intend to institute proceedings to withdraw approval of prescription combination drug products containing more than 325 mg of acetaminophen per dosage unit that remain on the market.

Cases of severe liver injury with acetaminophen have occurred in patients who:

- took more than the prescribed dose of an acetaminophen-containing product in a 24-hour period;
- took more than one acetaminophen-containing product at the same time; or
- drank alcohol while taking acetaminophen products.

Inadvertent overdose from prescription combination drugs containing acetaminophen accounts for nearly half of all cases of acetaminophen-related liver failure in the United States, some of which result in liver transplant or death.

Acetaminophen is also widely used as an over-the-counter (OTC) pain and fever medication, and is often combined with other ingredients, such as cough and cold ingredients. We will address OTC acetaminophen products in another regulatory action. Many consumers are often unaware that many products (both prescription and OTC) contain acetaminophen, making it easy to accidentally take too much.

Health care providers and pharmacists who have further questions are encouraged to contact the Division of Drug Information at 888.INFO.FDA (888-463-6332) or druginfo@fda.hhs.gov.

(Source: <http://www.fda.gov/Drugs/DrugSafety/ucm381644.htm>) ■

Use of acetaminophen in pregnancy tied to AD/HD.

One major television network, two major newspapers, Internet media outlets and consumer medical websites cover a study suggesting an association between expectant mothers' use of acetaminophen during pregnancy and an increased risk for attention-deficit/hyperactivity disorder in their children. All of the sources note that

acetaminophen has long been thought to be safe for use during pregnancy.

On NBC Nightly News (2/24, story 2, 1:10, Williams), medical editor Nancy Snyderman, MD reported on a study that found use during pregnancy of acetaminophen has been tied to an "increased risk of having a child diagnosed

with" attention-deficit/hyperactivity disorder (AD/HD).

USA Today (2/25, Painter) reports that the research, which was published online Feb. 24 in JAMA Pediatrics, is "likely to prompt concerns among women who have been told that the medication – found in Tylenol and many other pain and fever remedies – is safe during pregnancy."

The Los Angeles Times (2/25, A1, Healy) reports that in the study of some

64,000 mothers in Denmark and their youngsters, “researchers found that kids whose mothers took the painkiller at any point during pregnancy were 29% more likely to be diagnosed with AD/HD than were kids whose mothers took none.” Notably, “the risk increased the most – by 63% – when acetaminophen was taken during the second and third trimesters, and by 28% when used in the third trimester alone.” When taken just during the first trimester, however, “the added risk was 9%.”

According to the Cleveland Plain Dealer (2/25, Townsend), an accompanying editorial cautioned that “the study’s findings should not prompt

anyone to stop taking acetaminophen for its designed use.” The editorial pointed out that the findings “underline the importance of not taking a drug’s safety during pregnancy for granted, and they provide a platform from which to conduct further related analyses exploring a potential relationship between acetaminophen use and altered neurodevelopment.”

The Huffington Post (2/25, Pearson) reports, “The findings join a small but growing body of research – some of it led by the same researchers on the new study – linking acetaminophen use during pregnancy with health issues such as increased asthma risk in children and

undescended testes in boys.” One study “published in November linked mothers’ frequent Tylenol use (at least 28 total days) during pregnancy with children’s decreased motor and communication skills as well as behavioral issues.”

Also covering the story are the CBS News (2/25, Jaslow) website, the NBC News (2/25, Fox) website, the Time (2/25, Park) “Healthland” blog, the CNN (2/25, Yanes) “The Chart” blog, Forbes (2/25, Walton), the FOX News (2/25, Kwan) website, HealthDay (2/25, Thompson), Medscape (2/25, Brooks), and AFP (2/25).

(Source: American Medical Association Morning Rounds e-newsletter) ■

Kudos!

Congratulations to **Dr. Bonita Jenkins** and **Dr. Joanne Joyner** on the publication of their article entitled “Preparation, Roles, and Perceived Effectiveness of Unlicensed Assistive Personnel,” published in the October edition of the Journal of Nursing Regulation, the official journal of the National Council of State Boards of Nursing.



Janice Johnson

Congratulations to **Janice Johnson, BSN, RN-BC**, Director of Nursing, Carroll Manor Nursing and Rehabilitation Center. Ms. Johnson was awarded the 2013 Mission of Providence award at the recent annual Providence Hospital Service Awards banquet. This award is given to associates who are outstanding

representatives of the mission of Providence Hospital in action. Providence associates are nominated by their peers, reviewed by previous Mission of Providence Award winners and selected. “Throughout her 24 year career at Providence she has served the mission and demonstrated the values of Providence by improving the quality of life for the residents living at Carroll Manor.

The vision of the Nursing Department at Carroll Manor Nursing and Rehabilitation Center is to integrate care through trusting relationships, unity, integrity, respect, dignity and cultural diversity for all; to serve all with Godliness and dedication to clinical excellence by doing the right thing the first time.”

Congratulations to **Ottamissiah “Missy” Moore, BS, LPN, WCC, CLNI, GC, CHPLN** who has been appointed to serve as Chair of the CGFNS International Licensed Practical Nurse Professional Standards Committee (LPN). ■

Congratulations to **Dr. Andrea Brassard**, recipient of the 2014 American Association of Nurse Practitioners Advocate State Award for Excellence.



Left to right: DC Board of Nursing member Chioma Nwachukwu, DNP, PHCNS-BC, RN; President of the American Association of Nurse Practitioners (AANP) Angela K. Golden, DNP, FNP-C, FAA NP and Andrea Brassard, DNSc, MPH, FNP, FAA NP, Senior Strategic Policy Advisor at the Center to Champion Nursing in America at AARP, and Professorial Lecturer at The George Washington University School of Nursing.

Facilities Must Report Nurse Terminations

The DC Board of Nursing's mission is to protect the public from individuals with unsafe practice. The Board of Nursing seeks to identify nurses whose nursing practice is deemed unsafe or incompetent. We cannot identify such individuals, however, if the Board is not informed about unsafe practice and nurse terminations.



If a nurse is fired, the Board should be apprised of that information. District law requires that the failure to report should result in a fine against the facility.

DISTRICT OF COLUMBIA LAW

According to the DC Code, facilities must report nurse terminations to the Board of Nursing or be fined:

THE DC CODE: § 44-508 REPORTING TO LICENSING AUTHORITY.

- a Except as provided in subsection (b) of this section, in the event that a health professional's: (1) clinical privileges are reduced, suspended, revoked, or not renewed; or (2) employment or staff membership is involuntarily terminated or restricted for reasons of, or voluntarily terminated or restricted while involuntary action is being contemplated for reasons of, professional incompetence, mental or physical impairment, or unprofessional or unethical conduct, a facility or agency shall submit a written report detailing the facts of the case to the duly constituted governmental board, commission, or other authority, if one exists, responsible for licensing that health professional.
- b The reporting requirement in subsection (a) of this section shall not apply to a temporary suspension or relinquishment of privileges or responsibilities if a health professional enters and successfully completes a prescribed program of education or rehabilitation. As soon as there exists no reasonable expectation that he or she will enter and successfully complete such a prescribed program, the facility or agency shall submit a report forthwith pursuant to subsection (a) of this section.

NATIONWIDE PROBLEM

The District is not the only jurisdiction grappling with the problem of unreported terminations. **The problem was recently examined in the article "Fired, they still find jobs as nurses,"** by reporter Brandon Stahl in the Minneapolis Star Tribune [12/9/13]. This piece looked at the case of Kathryn Idovich, a nurse who has held six nursing jobs in the last 12 years.

Ms. Idovich obtained both her LPN and RN licenses without informing the Minnesota Board that she had a history of alcohol abuse. She embarked on a career which featured multiple firings and multiple DWIs. However, "neither the Nursing Board nor Idovich's former employers would discuss how she was **able to lead such a long career, despite events—four firings, five drunken-driving convictions and failing state sobriety monitoring**—that were cited as justification for her license suspension last year."

After being fired by one facility for coming in to work with alcohol on her breath, after "a few beers," she was hired by another facility, Neilson Place long-term care, in February 2011. In December 2012, the Minnesota Board of Nursing suspended her license when she got a felony DWI.

This particular nurse was unsafe to practice and there are others still practicing in the state. The Star Tribune noted the prevalence of unsafe nurses, facilities' hesitance to report terminations, and the Minnesota Board's inability to impose penalties against the non-reporting facilities:

A Star Tribune review of Nursing Board disciplinary actions since 2010 found that at least 173 caregivers lost jobs after allegations of misconduct and managed to find new nursing positions. That includes nurses who have been found responsible for maltreating children and vulnerable adults, stolen drugs from their workplaces, practiced while impaired, or whose care has led to harm of their patients... By law, employers are supposed to tell the Nursing Board when they fire a nurse. But the Nursing Board has not used its power to sanction employers for failing to do so.

The article quoted Patti Cullen, the president of Care Providers of Minnesota (long-term providers), who noted that the state's criminal background check process is flawed and that employers do not share the information with boards of nursing due to a fear of lawsuits.

Some nurses who have been repeatedly terminated are unwilling to leave the field of health care. According to the Star Tribune, Ms. Idovich would still like to work in direct care. After her suspension: "She wanted to be a nurse assistant, but the felony DWI disqualified her from providing direct care." ■

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Nurse Imposters – Practicing Without a License

By Felicia Stokes, BSN, JD, based on article by Valerie Smith, RN, MS, Associate Director of Arizona Board of Nursing. (Portions reprinted/modified with permission of the Arizona Board of Nursing. The original article was entitled “Two Nurse Imposters Practicing Without a License Convicted of Felonies,” and was published in the Arizona Board of Nursing Regulatory Journal.)

Case #1: Mr. A was reported to the Board of Nursing after the Human Resources Department of a facility was unable to verify Mr. A’s license credentials. The copy of the wallet license Mr. A allegedly provided his employer contained his picture, but the license number for someone else; and the signature of the director of the Department of Health was incorrect. In addition, the wall certificate reflected Mr. A’s legal name, but the license number belonged to someone else who was a legitimate (expired) licensee. The Board of Nursing confirmed that Mr. A’s paper license credentials were invalid. In this circumstance, if the facility compared the legitimate licensee’s *number* with legal name of their employee, Mr. A, they would have identified the discrepancy.

Case #2: Ms. B was reported to the Board after a facility discovered the employee they hired was unable to produce a copy of her license. Ms. B allegedly provided a valid license number on her employment application. The legitimate license number

belonged to someone who was in fact a licensee of the Board. The legitimate licensee and Ms. B had a similar first name, but did not have the same last name. The Board of Nursing confirmed that Ms. B’s license credentials were invalid. If the facility compared the legitimate nurse licensee’s *name* with the legal name of their employee or asked Ms. B. for verification of a name change (she indicated that her last name had changed) they would have identified the discrepancy.

The District of Columbia Board of Nursing discovered that both of these individuals worked for a number of years using “RN” credentials in more than one facility. The DCBON has continued to see a rise in the number of individuals claiming to be licensed nurses or working in positions that require nursing licensure without valid license and credentials. How can you avoid having this occur in your facility?

FIVE WAYS NURSE IMPOSTERS GAIN EMPLOYMENT

1. A person steals the identity of another licensed nurse and practices;
2. An unlicensed person poses as a “nurse” and may subsequently practice nursing or represent to patients and the public that they are a licensed nurse;
3. A person gains nursing licensure based on fraudulent credentials;
4. A person is licensed in one capacity and

alters his/her credentials and practices or attempts to practice in another capacity.
5. A person claiming to be a licensed nurse may have completed a nursing program and may have been licensed at one time, but is not currently eligible for nursing licensure.

FOUR RED FLAGS EMPLOYERS & MANAGERS MUST KNOW

Although the typical impostor often has some prior healthcare related training or exposure, imposters have great potential to place patients at risk as they lack the appropriate training and experience to provide the type and level of care for which they may be employed. Following is a list of red flags for managers and employers that an individual may be a nurse impostor:

- **Failure to provide the license.** Claims to have a license and may even provide you with a license number and expiration date but has multiple reasons why they cannot provide you with the actual license (“It was stolen; I’m waiting for the board to send me a new license.....”)
- **Provides copied & altered license.** You may be provided with a copy of license but not the actual license document issued by the Board. Review of the copied document reflects:
 - The typeset of the name, expiration date and/or license number is different from the typeset otherwise on the license.
 - The expiration date is not consistent with the standard Board issued

DC STATUTES RELATED TO UNLICENSED PRACTICE:

§ 3-1210.01. Practicing without license, registration, or certification.

No person shall practice, attempt to practice, or offer to practice a health occupation licensed, registered, certified, or regulated under this chapter in the District unless currently licensed, registered, or certified, or exempted from licensure,

registration, or certification, under this chapter.

§ 3-1210.02. Misrepresentation.

Unless authorized to practice a health occupation under this chapter, a person shall not represent to the public by title, description of services, methods, or procedures, or otherwise that the person is authorized to practice the health occupation in the District.

§ 3-1210.03. Certain representations prohibited.

(b) Unless authorized to practice as an advanced practice registered nurse under this chapter, a person shall not use or imply the use of the words or terms “advanced practice registered nurse,” “A.P.R.N.,” “certified registered nurse anesthetist,” “C.R.N.A.,” “certified nurse midwife,” “C.N.M.,” “clinical nurse specialist,” “C.N.S.,” “nurse practitioner,”

Nurse Imposter Warning

Kenneth Hopkins came to the attention of the Board when he secured employment with a facility in the District of Columbia. Mr. Hopkins provided credentials under his own name, but using a Registered Nurse license number under a different name. Upon investigation, the Department of Health was unable to find any evidence of licensure and determined that Mr. Hopkins was not licensed as an RN in DC. Please contact the Metropolitan Police Department and the Board of Nursing if he applies for a job as a Registered Nurse at your facility.

If you have any knowledge or information regarding the employment practices of the following individual, please contact the Board of Nursing, (202) 724-8800. ■



- expiration date of 6/30/__.
- The signature from the Director is inaccurate.
- Unusual lines indicative of “cut and paste” may be on the copied document.
- Written/typed information on the copied document is slanted, not level.
- **Demonstration of competencies inconsistent with licensure.** The individual’s of standard nursing duties does not reflect the level of practice that would be expected given the nursing licensure, education or experience that they claim.
- **Inconsistent licensure information.** Individual claims to have a than the name on the nursing license. (“That is my married/maiden name; I have two last names....”)

EMPLOYER & MANAGER SAFEGUARDS AGAINST IMPOSTERS

- **Insist upon seeing the original license, not a copy.** Although easy to alter a copy

“N.P.,” or any similar title or description of services with the intent to represent that the person practices advanced registered nursing.

(p) Unless authorized to practice practical nursing under this chapter, a person shall not use the words or terms “practical nurse,” “licensed practical nurse,” “L.P.N.,” or any similar title or description of services with the intent

- of a document, alterations to the original source document will be more evident.
- **If your organization or facility requires that a copy of the nursing license be maintained in the personnel file, make a copy from the original license.** Do not accept a copy from the applicant/employee.
- **Do not allow an individual to work in a capacity that requires nursing licensure without having visualized the license and verifying the status of the license with the issuing Board of Nursing.** For District of Columbia licenses, verify the license with the DCBON.

You may verify a license through the DC Department of Health’s website, <http://app.hpla.doh.dc.gov/weblookup> and click on Online Professional License Search. Confirm that information provided by DCBON is consistent with information provided by the applicant, including name, license type and number, and expiration date.

to represent that the person practices practical nursing.

(r) Unless authorized to practice registered nursing under this chapter, a person shall not use the words or terms “registered nurse,” “certified nurse,” “graduate nurse,” “trained nurse,” “R.N.,” or any similar title or description of services with the intent to represent that the person practices registered nursing.

- **Be sure that the individual’s name on the nursing license matches the name on his or her identification.** Do not accept if the name does not match the identification. If an individual has a legal name change, he or she is required to submit that to the DCBON. Such a name change will be reflected on their nursing license and on the Online Professional License Search.
- **Maintain the security of files that contain copies of nursing staff’s licenses.** A common way of obtaining another individual’s license is theft from employer records or from the actual nurse.
- **Report all cases of suspected fraudulent representation or practice of nursing to the DCBON.** If you are aware of other ways imposter nurses have been identified but not hired or previously reported, please contact the D.C. Board of Nursing at 202-724-8800. ■

§ 3-1210.07. Criminal penalties.

(a) Any person who violates any provision of this chapter shall, upon conviction, be subject to imprisonment not to exceed 1 year, or a fine not to exceed \$ 10,000, or both. (b) Any person who has been previously convicted under this chapter shall, upon conviction, be subject to imprisonment not to exceed 1 year, or a fine not to exceed \$ 25,000, or both. ■

Board Disciplinary Actions

NAME	LICENSE #	ACTION	Non-Public Disciplinary Actions:	
Anthony Amato	RN1029671	Summarily Suspended	Referrals to COIN	3
Lillian Webb	LPN7069	Reinstated	Notice of Intent to Discipline	9
Jonetta Foster	HHA1772	Revoked	Consent Orders	6
Wendy Duncan	NA604794	Suspended	Requests to Withdraw	20
Senora Seaborne	RN65516	Revoked	Letters of Concern	4
Jasline Jesson	RN1023884	Probation	Requests to Surrender	1

Names and license numbers are published as a means of protecting the public safety, health and welfare. Only Final Decisions are published. Final Orders and the Certified Nurse Aide Abuse Registry can be assessed by going to <http://doh.dc.gov>.

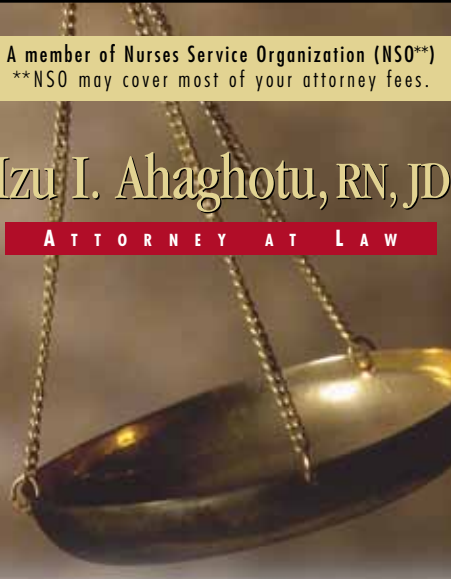
Public vs. Non-Public Discipline

Public Discipline: Disciplinary actions that are reported to Nursys, National Practitioner's Data Bank and viewed in DC NURSE and at <http://app.hpla.doh.dc.gov/weblookup/>.

Non-Public Discipline: Disciplinary actions that constitute an agreement between the Board and the licensee and, if complied, are not made public.

A member of Nurses Service Organization (NSO**)
 **NSO may cover most of your attorney fees.

Izu I. Ahaghotu, RN, JD
 ATTORNEY AT LAW



If you or a colleague is in need of an Attorney to represent you before the D.C. Board of Nursing or FOR ANY OTHER LEGAL MATTER, Call a Nurse Attorney for a confidential consultation.

Please contact Izu I. Ahaghotu, RN, Esquire directly:
Office: 202.726.4171 DIRECT 202.361.6909

www.IZUAHAGHOTU.com
Email: ucheizu@msn.com
 7211 Georgia Avenue, NW
 Washington, DC 20012

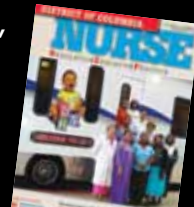
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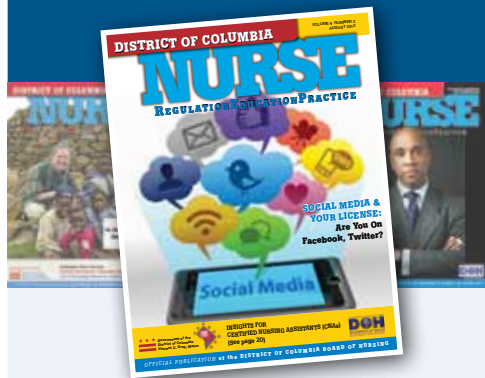
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