

# NURSE

**R**EGULATION **E**DUICATION **P**RACTICE



**Health Care Activist**  
***Vera Mayer***  
**Retires as Senior Advocate**  
**for IONA Senior Services**

Licensure of Nursing Assistive Personnel (NAPs)

Readers Respond to Nurse Portrayals on TV

Continuing Ed Program in March (see p.8)

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Edition 25

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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](mailto:hpla.doh@dc.gov). (Lengthy letters may be excerpted.)

## Providing Vigilant Care

As our nation undergoes continuous reform of the health care system, a common yet challenging goal of health care providers is to reduce cost while improving quality client care. When discussing providers we often look at doctors and hospitals, but it is nurses who provide most of the skilled and hands-on care to clients in all settings of the health care arena. It stands to reason that nurses then have a large role in not only providing quality care but in containing costs.

Most nurses are beyond busy and trying to function in a world with too many patients and not enough help. "What more do you want us to do?" "We wear too many hats already and now you want to add another responsibility." My answer to those statements is that we want nurses to have more cost awareness and to do what they were taught in nursing programs, provide "vigilant" care.

In facilities, and when providing care in a client's home, nurses can contribute to cost containment through materials management and choosing the least expensive alternatives without compromise to client care. Nurses cannot do this unless

they are educated to the cost of supplies and alternatives, and become motivated to take charge of their own use of supplies to reduce cost.

Along with reduction in cost of supplies the nurse must use her skills to provide "vigilant" care. Vigilance is defined as "being alert to discover and ward off danger or insure safety." Nurses need reasonable nurse-to-patient ratios and good assessment skills. They then need to be sure that when they are at work their attention is 100 percent on the task at hand. In this economy many nurses work double shifts or multiple jobs to make ends meet. When we are tired or over worked we cannot be vigilant. Each nurse must realize his/her own limitations and strive to commit only to work when he/she can deliver "vigilant" care.

Medication errors cost the health care system \$19 billion in 2008. "Vigilant" care by nurses, physicians and pharmacists can reduce the incidence and cost of medication errors significantly. Nosocomial infections, falls and other preventable complications of client care add additional costs to the health care system, areas where vigilance by nurses and other healthcare workers could



E. Rachael Mitsner, BSN, MS, RN

decrease cost. Not only do nurses need to deliver care in a way that prevents adverse consequences, but they need to use their observation and assessment skills to identify problems in the early stages so severe, costly complications are avoided. By monitoring, advocating for clients and teaching, the nurse can prevent costly errors and hospital readmissions. This not only decreases cost but improves quality of life for each client.

As nurses we have an obligation to ourselves, our clients and society to give our clients quality care while controlling cost. There is no better time than now for each of us make a New Year's Resolution to take responsibility for reducing costs and improving client care by being "vigilant" nurses.

E. Rachael Mitsner, BSN, MS, RN  
Chairperson  
DC Board of Nursing

# Health Care Reform Won't Work Without Strengthening the Role of Nursing

by Sandy Summers,  
RN, MSN, MPH

Health care reform is the serious-minded media event of the summer, but one element of the story has inspired relatively little serious discussion: the role of nursing. President Barack Obama has made nurses a visible part of his efforts to spur reform, but to achieve real gains, particularly in access to care and cost containment, we must strengthen nursing and overcome some negative cultural stereotypes that suggest that nurses are nothing more than “doctors’ helpers.”

The standard formulation when discussing providers is “doctors and hospitals,” but it is nurses who provide most of the skilled care hospital patients receive, and the only care that many in underserved communities receive.

Nurses could do far more to improve our health if we let them. With more resources, community health nurses and school nurses could prevent or better manage many illnesses, such as diabetes and heart disease, vastly decreasing the burden these illnesses place on hospitals. Nurses would also provide most of the care in responding to an epidemic like the H1N1 flu.

Studies suggest that increasing nurse staffing levels and the credentials of the nurses in clinical settings could actually cut costs, reducing complications and hospital days and saving lives. Nurses also improve the quality of care through ongoing health management and advocacy efforts, such as increased breastfeeding.

Nurses are also vital to cost-containment efforts. It is nurses who monitor and advocate for patients to prevent costly (and deadly) errors and needless hospital readmissions. Nurses teach patients how to adapt to and manage their conditions. And advanced practice nurses, who combine expertise with a holistic focus, provide cost-effective primary care that studies show is at least as effective as that of physicians.

But despite all the lip service for nursing as the “most trusted” profession, nurses suffer

from a critical lack of resources. Understaffing drives direct-care nurses from the profession, yet the deadly practice remains endemic. Research shows that nursing residencies could save millions of dollars by keeping nurses in the profession, yet such residencies receive only 1/300th of the funding that physician residencies do. Nursing schools lack resources, so they turn away thousands of qualified applicants, despite projections that the nursing shortage will grow much worse. And nursing research remains starved for funding -- receiving less than 1/200th of the National Institutes of Health budget.

How can this dearth of funding persist when nurses are supposedly so revered? Trust is not the same thing as real respect. Although nurses are autonomous, college-educated health professionals who save lives, the profession’s image among those who make key decisions remains trapped in a web of female stereotypes, from the unskilled angel to the physician helper. The media reflects and reinforces these attitudes. Nurse-focused television shows have appeared recently, notably Showtime’s remarkable summer show *Nurse Jackie*, but overall the mass media still strongly reinforce the idea that heroic physicians provide all meaningful care and nurses are their “helpers.”

This disrespect weakens our health system. Decision-makers rightly spend billions on alleviating diseases, but relatively little on the poor nursing infrastructure that allows diseases to spread in the first place. Disrespect leads hospital administrators to replace nurses with less-skilled workers who cannot spot subtle but deadly changes in patient conditions, and who cannot teach or advocate for patients. The overwhelmed nurses who remain may themselves be unable to fulfill these roles, which costs lives and money. And disrespect leads officials to allocate miserly funding for community health nurses, nursing education and research.

We can do better. We should support reform

proposals that increase funding for nursing, promote adequate nurse staffing and recognize the central role of nurse practitioners in the future of health care.

But lasting change actually starts at a level that is deeper than legislation. Reform requires changing how we think about nursing.

Nurses must take the lead, and convey the nature of their work to the public and key decision-makers. But everyone should help.

Health policy makers should publicize their efforts to invest in nursing, and place qualified nurses in visible positions of authority, as Obama has done by appointing a nurse, Mary Wakefield, to head the Health Resources and Services Administration.

Those who create news and entertainment media should try harder to provide a fair picture of nursing. Advertisers should avoid nursing stereotypes, such as the “naughty nurse,” and the common suggestion that health care revolves solely around “doctors.”

Finally, foundations and nonprofits should consider educating the public about nursing through vehicles ranging from interactive nursing museums to a Nobel Prize in Nursing.

Nurses are more than valuable allies in or beneficiaries of the reform effort. Reform can’t work without a stronger nursing profession. And that starts with you and me.

**Sandy Summers** is executive director of the nonprofit organization [The Truth About Nursing](#) and co-author of [Saving Lives: Why the Media's Portrayal of Nurses Puts Us All at Risk](#).

This article was reprinted from [kaiserhealthnews.org](#) with permission from the Henry J. Kaiser Family Foundation. Kaiser Health News, an editorially independent news service, is a program of the Kaiser Family Foundation, a nonpartisan health care policy research organization unaffiliated with Kaiser Permanente.

## Board Welcomes New Consumer Member

The Board of Nursing welcomes consumer member Selena Howell! Ms. Howell, who has a Bachelor of Science in Business with a concentration in hospitality management from Howard University, has been a General Manager for the past few years for several government cafeterias such as those at the Department of Treasury, Library of Congress and the FBI (Federal Bureau of Investigation).

"Initially, I was enamored with the thought of working in luxury hotels all around the world," Ms. Howell says. "However, my career in hospitality [has] never really satisfied my true ambition to serve in the field of health care. One of my fondest early childhood memories is that of my mother taking me to work with her at the hospital. I just remember thinking 'Wow, my mom saves people'. I am from a family with numerous health care workers. My mother was a respiratory therapist

for over 18 years. I have several aunts who are nurses, and a sister who is a health scientist for the CDC (Centers for Disease Control and Prevention).

"So with a downturned economy, and my current work becoming less fulfilling, I started to explore my long standing interest in a profession in the health care field by volunteering at the Washington Hospital Center's Emergency Room. This experience has furthered my curiosity about health care and the many possibilities and avenues the health care industry has to offer.

"With my recent appointment to the Nursing board, I am grateful for this opportunity to participate in addressing issues critical to nursing care. *More importantly, I participate in the development*



Selena Howell

and betterment of nursing in the District of Columbia.

"As a consumer member on the board, I hope to bring a unique perspective with me being a student and also a person who has had a family member under the full-time care of a nurse. This position is vital to ensure diversity in the perspectives as regulations are being implemented.

The viewpoint of the nurse and client/consumer are indispensable.

"It is my distinct pleasure to be appointed to the board and I feel I have learned so much thus far, and hope to contribute during my tenure as much as I have garnered from my esteemed colleagues."



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# Board of Nursing Update

## SEPTEMBER, OCTOBER, NOVEMBER, DECEMBER

### Criminal Background Check implementation

In preparation for the implementation of Criminal Background Checks the Board began making policy decisions regarding issues such as:

- Triaging positive CBC results.
- Criteria for evaluating positive CBC results
- How CBC results will be used to make licensure decisions

### Nursing Assistive Personnel Regulatory Model

The Board dedicated their last three meetings, including a full-day devoted to the development of the NAP regulatory model. Some of the requirements considered were:

- Who will be allowed to apply for registration as a NAP, what eligibility requirements must they meet?
- What should the curriculum in the educational program include?
- Grandfathering criteria for persons currently in the NAP role.

See page 9 for more discussion regarding NAPs.

### The Board set goals for revising the following regulations in 2010

- Trained Medication Employee
- Medication Aide Regulations
- RN/LPN Regulations
- Education Program Regulations
- APRN Regulations

### The Board approved the following 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.”

**REMINDER: RN/  
APRN RENEWALS  
TO BEGIN  
APRIL 1, 2010**

*Members of the public are invited to attend...*

## BOARD OF NURSING MEETINGS

**Date:** First Wednesday of the month

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

**Location:** 717 14th St N.W.;  
10th Floor Board Room,  
Washington, D.C. 20005

**Transportation:** Closest Metro stations are Metro Center (take 13th Street Exit); McPherson Square (take 14th Street Exit)

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



**January 6, 2010**

**February 3, 2010**

**March 3, 2010**

**April 7, 2010**

**May 5, 2010**

## ATTEND BOARD MEETINGS

During each board meeting, time is set aside for public comment. This is an opportunity for the public to discuss nursing related matters with the board members. Public comment is scheduled at 9:30 p.m. at the beginning of the board’s Open Session. You do not need to be on the agenda to speak.

If you are interested in receiving the board’s Open Session agenda, send your request to [hpla@doh.dc.gov](mailto:hpla@doh.dc.gov).



District of Columbia Board of Nursing and The National Alliance of Wound Care Present:

## Wound Care Update 2010 CE Program

**Date:** Friday, March 18, 2010

**Time:** 8:00 am to 4:00 pm

**Location:** Howard University Towers Auditorium

Approved by DC Board of Nursing for 6.0 CEUs for Licensed Nurses and Hospital Administrators. To register go to: <http://www.surveymonkey.com/s/dcnurse>. One registrant per email allowed. Include name, address, license number and e-mail. E-mails including more than one name or incomplete information will not be honored. Register Early! Space is limited!

## Criminal Background Check to Begin in 2010

All New Applicants for Licensure, Registration, or Certification

Licensed Health Professional Criminal Background Check Amendment Act of 2006 (D.C. Law 16-222, D.C. Official Code § 3-1205.22 et seq.)

Early in 2010, new applicants seeking a healthcare license, registration or certification will need to obtain a criminal background check as part of the licensure process. The new rules are set forth in Title 17 of the District of Columbia Municipal Regulation Chapter 85. The cost will be fifty dollars (\$50), payable at the time the application is submitted. Applicants will need to start the process by going to the DC Metropolitan Police Department to have their fingerprints taken or, if applying from out-of-state, by obtaining a fingerprint card from HRLA and having their fingerprints taken at the local or state police agency. The criminal background check will take the FBI 48 hours to conduct. Adverse information will be reviewed by the Board to determine—together with all other information—whether an applicant should be licensed.



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# Licensure of Nursing Assistive Personnel (NAPs)



Seated: Susan Walker, Chairperson of the Stakeholders Committee

In September 2009, members of a Subcommittee of DC Coalition on Long Term Care members visited HPLA to discuss NAP licensure. Participants, including employers and agencies for nursing assistive personnel (NAP), expressed support for the District's effort to professionalize the position through licensure.

Attendees noted that good NAPs are valuable team members; it was also noted that infection-control and specialized geriatric and Alzheimer's training should be available for experienced NAPs.

DC BON Chair Rachael Mitzner expressed concern regarding licensure criteria: "What skill sets do we expect

from each of these groups? Where does NAP end and LPN begin?"

Ms. Mitzner thanked the committee for the work that they did in developing a regulatory model for NAPs. "Your concern is the same concern as ours: providing safe care for our citizens."

Board Executive Director Karen Scipio-Skinner said we need to look at transition of aides who want to go from one field to another (articulate from role of NAP to that of LPN or RN.)

A hot topic was the role conflict that might occur, in the Long-Term Care setting, between LPN and NAPs.

As an LTC employer at the meeting told attendees: "I think it is exciting to do this [licensure], but we must not nullify the LPN."



Interview with BON Executive Director on Licensure of Nursing Assistive Personnel (NAPs)

## 1. When will nursing assistive personnel be regulated by the Board of Nursing?

It is not possible at this point to give a definitive date. Once the draft of the NAP regulations are completed by the Board, they have to be approved for legal sufficiency and submitted for public comment. This process can take several months before the regulations are promulgated as final and able to be implemented.

## 2. Which health care workers are we referring to when we say “assistive personnel”?

The law (Health Occupations Revision Act) defines nursing assistive personnel as:

*(7B) “Practice by nursing assistive personnel” means the performance by unlicensed personnel of assigned patient care tasks that do not require professional skill or judgment within a health care, residential, or community support setting; provided, that the patient care tasks are performed under the general supervision of a licensed health care professional. Title Nursing Assistive Personnel includes:*

- (A) Nursing assistants;*
- (B) Health aides;*
- (C) Home-health aides;*
- (D) Nurse aides;*
- (E) Trained medication employees;*
- (F) Dialysis technicians; and*
- (G) Any other profession as determined by the Mayor through rulemaking.*

The current draft of the NAP regulations include the following



titles: Certified Nursing Assistant, Home Health Aide, Patient Care Technician [NAPs who work primarily in acute care settings] and Dialysis Technician. There are currently regulations addressing the role of the Trained Medication Employee. These regulations will be revised by the board in 2010.

## 3. Why is this undertaking important and needed?

The board views this as an important step because of the increasing use of NAPs. As the nursing shortage increases there will be an increased need to train staff to assist nurses in providing care. While nurses need the assistance of others, they also need assurance that the person that they are delegating tasks to have been trained and are able to perform the delegated task. Additionally, it is important for the Board to have the



ability to regulate persons providing nursing care.

According to the National Council of State Boards of Nursing's Working With Others: Position Paper---

"Nursing assistive personnel, regardless of title, should receive adequate basic training as well as training customized to the specific work setting. Basic education should include how the nursing assistant functions as part of the health care team, with an emphasis on receiving delegation. Individuals who successfully complete comprehensive educational and training requirements, including passing a competency examination..." The regulations as currently written will not only require that NAPs be trained but in most cases they will also be required to be certified by a national certifying body.

#### **4. Will those who don't meet the new higher qualifications be "grandfathered" in?**

For the most part, persons currently working in the positions will be grandfathered in. The basic criteria that will be considered are whether or not they are currently certified or trained and the length of time they have worked in their current position as a NAP.

#### **5. How does the regulation of NAPs benefit health care in the District?**

It is important for nurses delegating tasks to and supervising NAPs to have an understanding of what their credential represents in respect to training and demonstration

of skill. This is currently difficult to do in some settings because the training and credentialing requirements have not been defined.

Regulation will require defining task that the NAP will and will not be allowed to perform. It will assure that the NAP has completed a training program and be certified indicating that they met specified competencies.

Regulation will also allow the Board to discipline NAPs when needed --- requiring additional training, closer supervision and when necessary, suspension or revocation of their NAP registration. As with licensed nurses, this will also allow potential employees and the public to identify NAPs who have been disciplined by the Board.

#### **6. What has been the reaction of the community and employers to the new licensure of NAPs?**

The reaction from the DC Community has been very positive. A great deal of the ground work for the development of the NAP regulations was spearheaded by a NAP Stakeholders Committee, Chaired by Susan Walker. The committee was composed of representatives from long term care, acute care, community facilities, nursing programs and others. The overall sentiment by the nursing community is that this is needed. And dozens of people demonstrated the importance of this initiative by attending numerous meetings for several months to give



the board the input they needed to develop a regulatory model that will work in our health care community.

*I would like to take a moment to say farewell to Vera Mayer, JD, Coordinator, DC Long-Term Care Coalition. Vera will be retiring at the end of this year. It is most appropriate that Vera was selected to grace the cover of DC Nurse as the only non-health care provider to do so.*

*For those of you who have had the pleasure of meeting her, you know her dedication to the District Health Care community and in particular the patients that we care for. Vera has been the driving force behind the Board of Nursing's effort to develop the Nursing Assistive Personnel Regulations. She ensured that the right people were at table to give the input needed to make the best recommendations to the board.*

*Her drive to the right thing, her tenacity to follow through on any task that she initiates, her willingness to give voice to those who can't speak for themselves ....she will be missed.*

# COIN CONSULT

## LETTER FROM A COIN PROGRAM PARTICIPANT

*When I first walked in those doors three years ago, all I thought about is that I was going to get that same addict song. The shame, and guilt had ridiculed me to the point that of I felt worthless. You see when I became a nurse I took that oath to do no harm. What a disgrace to be an alcoholic nurse and attempting to heal people when I needed the healing.*

*At first, I had to come to terms with what I had become and then what I wanted back in this journey of nursing. First I had to understand my gift and how to deliver it to others. After many years of dealing with other people's defects, I did not attend to my own needs.*

*Thank you to all the wonderful people at the DC BON (COIN) who gave me back my caring hands and the art of nursing.*

*Sincerely,  
Anonymous*

COIN members and staff are available to come to your facility to give a talk on the issue. If you would like to arrange a visit to your facility, or if you or someone you know needs to seek recovery from an addiction, call COIN at (202) 724-8846.

# IN THE KNOW

The Board of Nursing has established this In The Know column in response to the many phone calls and e-mails we receive. The Board often receives multiple inquiries regarding the same issue. Please share this column with your colleagues or urge them to read this column. 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.

**Q** Can an LPN read a PPD [tuberculosis test]? There seems to be some question if this is an "assessment" within the scope of practice for an LPN.

**A** They can read PPDs. Note: at the direction of the Board of Nursing, other BONs were surveyed and of the 31 replying 71 percent allow LPNs to read PPDs.

**Q** Just for clarification: can a DC-certified Trained Medication Employee (TME) administer medications to a DC individual on a trip to Virginia or any other state in the United States? Thanks.

**A** DC law does not prohibit a TME from administering medications to residents in their care in other states. Please note that the state in which the medication is being administered may require that the TME be registered or certified in their jurisdiction.

**Q** I have attempted to recruit LPNs/RNs from Montgomery County (where I was DON for some years) somewhat without success. The word is that licensure in the District is costly and cumbersome. I have been licensed in six jurisdictions and find that the process in DC is indeed cumbersome: I did not ever appear in person, the fee was not more than \$150 and all that was required was paperwork, which I made much easier by the NURSUS system, which I don't think DC is part of. Any relief coming?

**A** The Board has made a few changes recently. We are now part of NURSUS which makes it easy to verify your licensure status. Also, you can either come to our offices and apply for a license and have your license issued the same day if you bring all of your required documents (completed application, application fee, verification[s], passport pictures), or you can submit the documents, and your license will be approved in less than a week. Sorry, can't do anything about the fee.

**Q** I currently employ a Certified Nursing Assistant (CNA) on one of my units. She recently completed her LPN curriculum, and it is my understanding that she is now licensed in Maryland as an LPN. She is not licensed in DC (I checked). Her nurse manager and I wondered if she could actually work as a CNA when she is actually an LPN in another state. Please let us hear your take on this. We just want to make sure this is all legitimate.

**A** We get this question a lot. Yes, she is able to work for you as a CNA with the LPN license, but she must be registered in DC as a CNA. She has to know that she is liable at the level of a LPN, which means that if she has a practice issue it could impact not only her CNA registration, but also her LPN license. She also must be aware of her scope of practice. She cannot practice as an LPN in a CNA position.

## Practical Nursing Programs

### Year to Date (9/30/09) Licensure Exam Results and Approval Status

PROGRAM	CURRENT QUARTER		YEAR TO DATE		APPROVAL STATUS
	07/01/2009 - 09/30/2009		10/01/2008 - 09/30/2009		
	#Sitting	% Passing	# Sitting	% Passing	
Capital Health Institute	64	82.81	117	81.20	Conditional
Comprehensive Health Academy	28	92.86	119	89.08	Full
JC Inc.	25	40.00	118	54.24	Withdrawn
Radians College (formerly HMI)	20	90.00	72	93.06	Full
University of the District of Columbia	39	82.05	112	72.32	Full
VMT Academy of Practical Nursing	65	60.00	185	60.00	Conditional

## Professional Nursing Schools

### Year to Date (9/30/09) Licensure Exam Results and Approval Status

SCHOOL	CURRENT QUARTER		YEAR TO DATE		APPROVAL STATUS
	07/01/2009 - 09/30/2009		10/01/2008 - 09/30/2009		
	# Sitting	% Passing	# Sitting	% Passing	
Catholic University of America	53	66.04	60	66.67	Conditional*
Georgetown University	36	91.67	101	96.04	Full
Howard University	45	84.44	57	82.46	Conditional
Radians College	15	60.00	65	69.23	Conditional
University of the District of Columbia	27	59.26	42	71.43	Full

Source of NCLEX® Scores: NCSBN Jurisdiction Program Summary of All First Time Candidates Educated in District of Columbia

\* indicates a change in status

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## Nurse Portrayals on Television: Readers Respond

**Question:** What do you think are the good and bad aspects of television's portrayal of nursing and the clinical setting today?

**DC NURSE Reader #1:** "I have not seen the shows HawthoRNe or Mercy, but I did see Nurse Jackie. Edie Falco is entertaining and fun to watch, but I was horrified by her portrayal of an Emergency Department charge nurse who obviously works while under the influence of narcotics. Nurse Jackie, a married Catholic woman with small children, has an ongoing relationship with a pharmacist just to get drugs in return for sexual favors, deliberately



committed an ethical error by altering an organ donor card, intentionally injured herself on the job at work to get sympathy from her husband, and openly injected a dying nurse with lethal drugs in a mercy killing episode. She had inappropriate sexual contact with a young doctor several times, as well as the graphically sexual relationship she has with the pharmacist in the call room on work time, and even set up a nursing student to take the fall for a

medication error. Nurse Jackie keeps drugs in sugar packets and takes them throughout the day at work, swipes drugs from the computerized Pyxis, and in the season finale, she steals morphine and deliberately takes an overdose when her lover makes contact with her husband. It's a very poor portrayal for nurses and for hospitals, and it scares people to think that caregivers in hospitals are oversexed, drug addicted maniacs who obsess on topics other than the patients they care for."

**DC NURSE Reader #2:** "I just have to say, as a nurse, the portrayal of a nurse as a drug seeking, sex charged, mindless bimbo, makes my blood boil. It has been a TV staple too many years. Where are the nurses that really practice their profession? Are we too boring? Shock value makes a show, but come on, pick on another profession."

**DC NURSE Reader #3:** "I think it would be wise to be less defensive about nursing stereotypes in the Showtime drama Nurse Jackie. Patients where I work worry less about who their nurse sleeps with and more about whether they're getting good nursing care. The notion that nurses are like Saint Camillus is not reality, and patients know this. Patients trust nurses above all other professions because they see our humanity. They know that in spite of our failings and imperfections, nurses still care about human suffering. Nurse Jackie is a dramatized story of human suffering."





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Saint Elizabeths Hospital, 2700 Martin Luther King, Jr. Ave. SE  
Behavioral Studies Building, Rm 232, Washington, DC 20032, FAX: 202-645-7360  
E-mail: [elizabeth.falodun@dc.gov](mailto:elizabeth.falodun@dc.gov).

# National Council of State Boards of Nursing News

## NCSBN Raises Passing Standard

The National Council of State Boards of Nursing, Inc. (NCSBN) voted on Dec. 10, 2009, to raise the passing standard for the NCLEX-RN Examination. The new passing standard is -0.16 logits on the NCLEX-RN logistic scale, 0.05 logits higher than the previous standard of -0.21. The new passing standard will take effect on April 1, 2010, in conjunction with the 2010 NCLEX-RN Test Plan.

After consideration of all available information, the NCSBN Board of Directors determined that safe and effective entry-level RN practice requires a greater level of knowledge, skills, and abilities than was required in 2007, 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 RNs.

The Board of Directors used multiple sources of information to guide its evaluation and discussion regarding the change in passing standard. As part of this process, NCSBN convened an expert panel of nine nurses 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.

A PDF of the 2010 NCLEX-RN Test Plan is available free of charge from the NCSBN Web site [https://www.ncsbn.org/2010\\_NCLEX\\_RN\\_TestPlan.pdf](https://www.ncsbn.org/2010_NCLEX_RN_TestPlan.pdf).

The definition of a logit may be found on NCSBN's Web site at [https://www.ncsbn.org/02\\_18\\_05\\_brief.pdf](https://www.ncsbn.org/02_18_05_brief.pdf).

## NCSBN Wants You!: Participate in Item Development Program

The National Council Nurse Licensure Examinations (NCLEX®) are designed to test knowledge, skills, and abilities essential to the safe and effective practice of nursing at the entry level. The National Council of State Boards of Nursing (NCSBN) recruits qualified nurses to serve on NCLEX-RN® and NCLEX-PN® Examination Item Writing and Item Review panels which are coordinated by the contracted test service. The process of developing one item (question) for the NCLEX-RN® or NCLEX-PN® examination goes through multiple steps over a 12-18 month period and involves many qualified volunteers to write or review items. The volunteers who participate on panels are an integral part of the item development process. The qualifications for the Item Development Program are outlined in the following brochure: [https://www.ncsbn.org/Item\\_Development\\_2009.pdf](https://www.ncsbn.org/Item_Development_2009.pdf)

Benefits to serving on an Item Development Panel:

- All expense paid trip to Chicago.
- Contribute to continued excellence in the nursing profession.
- Have opportunities to network on a national level.
- Build new skills that are useful in your current position as well as for professional growth.
- Earn continuing education contact hours.

If you know of nurses who are qualified to volunteer, please direct them to our Web site to submit an on-line application at: <https://www.ncsbn.org/1227.htm>.

## NCSBN Publishes 2010 NCLEX-RN Detailed Test Plan

The National Council of State Boards of Nursing (NCSBN) has published the *2010 NCLEX-RN Detailed Test Plan* and has posted it to its Web site at <https://www.ncsbn.org/1287.htm>. The purpose of this document, which is offered in both an Item Writer/Item Reviewer/Nurse Educator version and a Candidate version, is to serve as a guide for both examination development and candidate preparation. Based on the test plans, each unique NCLEX-RN Examination reflects the knowledge, skills and abilities essential for the prospective RN to meet the needs of clients requiring the promotion, maintenance and restoration of health. The NCLEX-RN Test Plan is evaluated every three years and changes are made based on empirical data from a practice analysis, expert judgment and feedback from member boards. The test plan was approved by the NCSBN Delegate Assembly in August and will go into effect on April 1, 2010. In addition to the NCLEX-RN Examination, NCSBN also develops and administers the National Council Licensure Examination for Licensed Practical/Vocational Nurses (NCLEX-PN). A total of more than 250,000 NCLEX-RN and NCLEX-PN Examinations are administered each year. More information

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about NCLEX examinations can be found on the NCSBN Web site [www.ncsbn.org](http://www.ncsbn.org), by calling 866.293.9600 (toll free) or e-mailing [nclexinfo@ncsbn.org](mailto:nclexinfo@ncsbn.org).

## The NCLEX Examination Tutorial

The National Council Licensure Examinations (NCLEX) are designed to test the knowledge, skills and abilities essential to safe and effective practice of nursing at the entry level. Although candidates who sit for the licensure examination have successfully graduated from an accredited nursing program, they still often encounter high levels of anxiety about taking the examination. In order to dispel the examination fears of candidates, it is helpful to encourage a relaxed approach to the NCLEX examination. One of the best ways to ensure this is to familiarize oneself with the format of the examination by using the full interactive tutorial available on the Pearson VUE Web site at [http://](http://www.pearsonvue.com/nclex/#tutorial)

[www.pearsonvue.com/nclex/#tutorial](http://www.pearsonvue.com/nclex/#tutorial). While the content of the tutorial is not nursing centered, it is a beneficial tool for increasing familiarity with the format of the NCLEX examinations. It is encouraged that candidates utilize the tutorial frequently before taking the examination. Additionally, candidates will also complete the tutorial directly before the start of their examination at the test center. An awareness of the examination format will provide a more relaxed examination experience and allow candidates to concentrate on the content of the examination.

## NCSBN Learning Extension

The National Council of State Boards of Nursing's Learning Extension has been re-launched as a virtual community! Your course access is still only a click away—just go to [www.learningext.com](http://www.learningext.com) and click "Enter Online Campus." Join the new community in just a few easy steps: 1. Select the group that is the best fit for you (Students community, Nurses community, or Faculty community for nurse educators). Set up

a profile/add a picture, keep track of your posts, comments and subscriptions, go to Navigating My Pages (under My Home) to learn how to use the new capabilities. Contact NCSBN Learning Extension via email at [learning@ncsbn.org](mailto:learning@ncsbn.org); phone at 312.525.3749 (M-F 9:00-5:00 CT); or visit the web address: [www.learningext.com](http://www.learningext.com).

## ANCC to retire CNS Certification Exam

The American Nurses Credentialing Center (ANCC) will retire the Clinical Nurse Specialist Core certification examination on July 1, 2010, due to the low candidate volume during the exam pilot window (September 1 – December 31, 2009.) Applications for the final cycle of the exam will be accepted from January 1, 2010, through February 15, 2010. Candidates who apply during this period and are determined eligible to sit for the exam will be assigned a testing window between April 1, 2010, and June 30, 2010. Candidates who pass the exam before its retirement will receive the credentials CNS-BC. All CNS-BC credential holders will be able to renew their certification using professional development and practice hours on the regular five-year renewal cycle. Please continue to refer to [www.nursecredentialing.org/NurseSpecialties/CNSCoreExam.aspx](http://www.nursecredentialing.org/NurseSpecialties/CNSCoreExam.aspx) for additional information, exam applications, cut-off dates, and updates. Please call our customer service center at 1.800.284.2378 with any questions. Web address: [www.nursecredentialing.org](http://www.nursecredentialing.org).

## NCSBN CEO inducted as a Fellow into the American Academy of Nursing

Please join the Board of Directors (BOD) of the National Council of State Boards of Nursing (NCSBN®) in congratulating NCSBN CEO Kathy Apple, MS, RN, FAAN, on her induction into the American Academy of Nursing, as a Fellow of the Academy.

Kathy was nominated for this prestigious honor by two current Academy Fellows and selected by the Academy's 15-member Fellow Selection Committee. Kathy brings more than 34 years of nursing and regulation experience to her position as NCSBN CEO. A few highlights of her career include her selection to serve on the International Council of Nurses (ICN) Observatory on Licensure and Registration and being an alumna of the Robert Wood Johnson Foundation Executive Nurse Fellows program.



## Book for foreign educated professionals

A primary resource for foreign-educated allied health professionals has just been published by CGFNS International and



Springer Publishing Company. *The Official Guide for Foreign-Educated Allied Health Professionals, What You Need to Know About Health Care and the Allied Health Professions in the United States* provides invaluable insight about providing safe, competent health care in the United States. The challenges they face in pursuing their dreams to practice in the U.S. range from leaving their home countries to obtaining a U.S. work visa, attaining licensure and employment in the United States, understanding and communicating within the U.S. health care system and adjusting to a new life. Based on 30 years of providing credentials evaluation and verification services pertaining to the education, registration and licensure of health care professionals worldwide, CGFNS International teamed with Springer Publishing Company to publish this guide for foreign-educated allied health professionals who seek to practice in the United States. CGFNS International CEO Barbara L. Nichols, DHL, MS, RN, FAAN, and CGFNS International Director of Global Research and Test Administration Catherine R. Davis, PhD, RN, serve as editors for the book. *What You Need to Know About Health Care and Allied Health Professions in the United States* is now available online from Springer Publishing at <http://www.springerpub.com/cgfn-allied>. For more information about CGFNS, go to their web address at [www.cgfn.org](http://www.cgfn.org).

### “Intellectual Disability” in Federal Terminology

A bill introduced in the U.S. Senate would replace the term “mental retardation” with “intellectual disability” throughout federal health, education and labor statutes. The legislation would not change the services or rights afforded to individuals, but would merely alter the federal government’s terminology. The bill, introduced by Senator Barbara Mikulski (D-MD), and Senator Michael Enzi (R-

WY), is named Rosa’s Law after Rosa Marcellinos, a girl from Maryland with an intellectual disability. Some government agencies already use the term intellectual disability including the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Committee on Individuals with Intellectual Disabilities, which used to be known as

the President’s Committee on Mental Retardation (PCMR). A copy of the “Dear Colleague” letter circulated by Senators Mikulski and Enzi is available here: [http://mikulski.senate.gov/\\_pdfs/Press/RosasLawDearColleagueLetter.pdf](http://mikulski.senate.gov/_pdfs/Press/RosasLawDearColleagueLetter.pdf). Senator Mikulski’s full floor statement is here: <http://mikulski.senate.gov/Newsroom/PressReleases/record.cfm?id=319975>.

# I am

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- OR NURSES – KENSINGTON, MARYLAND
- CLINICAL OPERATIONS MANAGER – KENSINGTON, MD, BALTIMORE, MD (AFTER HOUR CARE), AND WASHINGTON D.C.
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For more information about specific opportunities in Maryland, Northern Virginia, or the District of Columbia, we invite interested individuals to visit [jobs.kp.org](http://jobs.kp.org) for complete qualifications and job submission details.

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# Beyond the Five Rights: Medication Administration





# CE Speakers Remind Nurses that Looking Beyond the Five Rights is an Exercise in Compassion

by Nancy Kofie

On October 30, 2009, the DC Board of Nursing (BON) sponsored a continuing education program entitled "Beyond the Five Rights: Improving Patient Safety In Medication Administration". The program, spearheaded by BON member Ottamissiah "Missy" Moore, featured a variety of speakers, including a pharmacist, DOH facility surveyors, and police detectives. Attendees were provided with handouts with tips and warnings regarding the administration of medications, such as a list of frequently-confused drug names, error-prone abbreviations, and a list of medications that should not be crushed.

University, and Johns Hopkins medical centers. Preventable errors happen every single day, he said, and it is not acceptable. "There is a big chain of events that occurs from the point of the patient being evaluated, to the point when the patient's medication is given. A lot of people are involved. We each play a role. Let's internalize that and make it as personal as we can."

## Compassion Beyond Statistics

"Medication errors cause at least one death every day," program speaker and pharmacist **Fariborz Zarfeshan, RPh**, told attendees. "Those are the reported deaths; some facilities are not willing to report. The actual number is higher." While being mindful of the statistics, he told attendees, always remember the patients behind those statistics; striving to eliminate medication errors, he said, is an exercise in compassion. "Ask yourself: 'What if that person was my family member? How would I feel?' I ask myself: 'What if that person was somebody very close to me—like my father or my daughter?'"

In practice for 25 years, Dr. Zarfeshan has worked as a pharmacist at Georgetown, George Washington



Fariborz Zarfeshan, RPh

## Many Factors

There are many factors that cause medication errors. Poor communication between colleagues and job stress sometimes lead to negligence, he said. Dr. Zarfeshan also spoke of the constant

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influx of new drugs: “[Encountering an unfamiliar drug] happens to me,” he said. Pharmacists are unfamiliar with new drugs—so it is no surprise that nurses encounter medications with which they are unfamiliar.

“Know the generic and brand name, and know why it is ordered. Check the container label when you get the medication, when you administer the medication, and when you put it back. Utilize your drug medication handbook, if you are not sure of a medication and it’s usage, STOP and look it up. If you are still unsure of a medication, do not be wary to ask questions. Pharmacists are your allies,” he said. Speak with the pharmacist about your concerns: “Prescribers are not immune to mistakes. Maybe something doesn’t make sense to you. It is better to be safe than sorry.”

“Labeling and packaging is a huge issue,” he said. Every hospital, every institution, is now trying to find different ways to improve in this area. “Many assisted living institutions are opting to institute blister packaging—which I highly encourage,” he said. “The blister packs are a quick little cross check.

” He noted that ambiguities in product names and directions can be a source of problems, as well as job stress (“you are asked to do too much”). He also noted that lack of product knowledge or training can create problems, especially with agency or temporary staff not familiar with the facility.

## Five Rights and More

Dr. Zarfeshan reviewed with attendees the familiar “five rights”: right drug, right resident (or patient), right dose, right time, right route, and noted that “medication errors can occur anywhere in



the distribution system,” he said. Errors can occur due to a prescriber’s illegible handwriting, or upon repackaging, dispensing, or administration. “Make sure a drug is crushable before you crush it. Some drugs not meant for g-tube.” Pay attention to if a drug is to be given with meals or after meals. It defeats the purpose of the drug if you disregard these instructions.

Dr. Zarfeshan touched upon the many factors affecting absorption of a drug. Although the dosing may be within the guidelines, there are many instances where the disease process, i.e., malnutrition, dehydration, may interfere with how well the body utilizes the drug. “Different drugs have different percentages of protein binding. What happens if we give two drugs that are highly protein-bound to the patient at the same time? At some point, one is going to win over the other. So, drug interactions are extremely crucial.” Dr. Zarfeshan discussed the concept of the “half life” of a drug—the amount of time it takes for the body to eliminate drugs. If mistakes are made in administering

medications, it may take a long time for the effects of that medication to be reversed.

## Patients as Individuals

It is crucial for nurses to notice the variations among individual patients. “We are, hopefully, taking the prescriber’s intention...but along the way making sure dosing is right. Prescribers are not immune to mistakes.

“A typical scenario we find is that, for a patient, Dr. X prescribes a medication. We look in our profile and we see all these other medications that the patient is on. We need to make sure that this prescriber is aware of the other medications that may have been ordered. Prescribers order medications for a patient, but the prescribers are not always communicating with each other. This happens frequently, every single day.

“We have to think of that specific and specialized population we are dealing with and fine tune our clinical judgment based on that.”

There is not one simple solution to



ending medication errors, Dr. Zarfeshan said but everyone has a role to play in lessening the amount of errors: "Identify your system's weak points and create a culture to prevent errors."

### The Patient's Advocate

"The nurse is the patient's advocate," according to speaker **Alpheus "Al" Campbell, MBA, MHA**, who spoke about medication error prevention from a quality-assurance point of view. Currently serving as the Chief Quality Officer for The Specialty Hospitals of Washington (SHW), Mr. Campbell told nurses that all staff members of a facility must work together to ensure the medication administration system is safe. "We must have an interdisciplinary approach," he said. "Medication safety involves multiple disciplines and practitioners, including administrators, CEOs, medical directors, nursing, attending physicians, nurse practitioners, pharmacists, clerical staff, family members, and laboratory staff. You have to bring everything to the



Alpheus "Al" Campbell, MBA, MHA

table to get the most positive outcomes. Medications are not administered by individuals, they are administered by systems. There has to be a genuine institutional commitment."

### Nurse Fatigue

Nurse fatigue and constant interruptions contribute to medication errors, Mr. Campbell said. "Nurses are project

managers who are dealing with more than one issue at a time and are often interrupted mid-act. We are seeing increased patient acuity. The patients we treated in 1979 are not the patients we see today. You may see a patient or resident that has 12 or 15 wounds—on one patient. You have IVs, you have wound

vac. At the same time, there is an influx of new medications, budget restraints, and increased nurse-to-patient ratios. Nurses also face increased fatigue caused by an increased length of shifts. You used to work 3:00 pm to 11:00 pm, and you left at 11:45. Now you leave 1:00 in the morning."

### Root Cause Analysis

An effective system should include methods for evaluating medication errors: "If we have had an adverse event that has occurred in our facility, we want to do a root cause analysis to see exactly where the system breakdown was, who was involved, what systems now need to be in place, and how we move forward from here. You want to always look at

tracking and trending [at your facility]," he said. "Observing the process to see where we can improve." An effective medication safety program should be comprehensive and on-going, with a concentration on system-improvement. The program should include on-going education and competency assessment and evaluation: teaching, coaching, guiding.

### Blame Free Environment

He urged nurses to avoid the Blame Game: "It was not me, it was Nurse Suzy. Nurse Suzy, I am going to report you to the Board of Nursing." Pinpointing blame will not solve the problem because medication errors are generally a system problem, not an individual problem, he said. "We need a supportive culture that minimizes punitive discipline," he said. "If not, we repeat the same mistakes with other individuals." Staff need to be provided with resources and technology. We must invest in developing effective medication dispensing systems, Mr. Campbell said. "Pay now or pay later. If you don't pay for it on the back side, you will pay for it on the legal side."

Other problems occur when prescribers do not communicate with their colleagues. "You may have the attending physician who writes a prescription. You may have the cardiologist that writes a prescription. You may have the pulmonologist that writes a prescription. The nurse, then, serves as that patient's advocate."

### Surveyors Observe Med Pass

When you are administering medications, do you enjoy being observed when a survey is underway? Probably not, but the DC Department of Health must observe the administration

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of medication in our facilities to ensure patient safety in the District. "You might see a surveyor standing over your shoulder watching your every move as you prepare and administer medications," DOH Surveyor **Cassandra Kingsberry, RN**, told attendees. "We try to take [the nurse's] anxiety into consideration and we try to be as unobtrusive as possible. We know that that is not the ideal situation, but our State operations manual mandates



Cassandra Kingsberry, RN

that we observe 20-to-25 opportunities across the board—oral medication administration, eye drops, ear drops, G-tube feedings. We try to observe a variety of routes. We observe the nurses' technique regarding preparation and administration, and we also look at the pharmacy [and medication] labeling, name, concentration and expiration date. And we look at the security of the medications so that unauthorized individuals will not have access."

## Common Medication Errors

DC Department of Health Surveyor **Charlotte Payne, PA-C**, reviewed the types of medication errors which may be made: "Unauthorized – administering a med that was 'never' ordered, sometimes referred to as 'wrong drug'; Extra dose – a dose is given in excess of the ordered

number of times; Omission – no attempt is made to administer a dose; Wrong dose – the medication contains the wrong number of dose units; Wrong route – administered by a route other than route ordered; Wrong time – administered more than 30 or 60 minutes before or after the scheduled time without a reason; Wrong dose form – different from the ordered form, i.e. pill rather than liquid.

Omission errors are the greatest amount of errors found during the survey process. Surveyors also take into consideration the context of the situation when gauging the significance of a medication omission. Frequency of error is given consideration. One omission as opposed to a pattern of omissions. Ms. Payne and Ms. Kingsberry also spoke about the need to take into consideration the individual patient when following or questioning a prescriber's order. Even if you have a prescriber's order, administering a suppressive medication to a patient that is already respiratory-compromised or giving a diuretic to a resident who is already dehydrated...you would not follow that order. You would contact the prescriber to discuss the order.

Ms. Payne and Ms. Kingsberry urged nurses to follow the manufacturers' specifications when administering medications: "... 'Shake well' ... 'Do not crush' ... It is important to pay attention to the specifications. If I am doing a Med Pass and I observe a nurse administer a medication—insulin, for instance—and she is vigorous shaking the bottle but the manufacturer says 'mix without creating bubbles,' that would be considered a medication error."

During the course of one survey, a nurse

administered drops into a patient's left eye, drops that were supposed to be placed into the left ear. "One error that we see more often than is comfortable is when Percocet to be administered 20 minutes before a painful treatment, like a wound treatment, and it is given after the treatment. That is certainly a significant error."

If the surveyors see an empty space on the MAR, they will be looking for corresponding notes. Ms. Kingsberry and Ms. Payne noted that they are finding that narcotic counts are not consistent in many facilities and that discontinued narcotics have been seen still stocked on medication carts.

"A lot of issues have to do with reconciliation of narcotics. We have even seen circumstances once or twice when an individual staff member went home with the narcotic key, so when we came in, the night shift had not been able to access narcotics all night because they did not have the key."

Nurses should keep in mind the issue of culpability: "If you administer or dispense it, you can be held partially or fully responsible—even if the prescriber may have ordered it. Question and confer with your colleagues, do whatever it takes to be sure that you are administering medications in a safe manner. Clarify, clarify, clarify."

As surveyors "Our enforcement actions are focused on the facility not the nurse." Civil money penalties and fines can be levied against the facility; there could be a ban to accepting new residents. The facility's license could be restricted for three to six months, at which time the facility is expected to address deficiencies. The most severe penalty imposed against a facility is revocation of its license.

Ms. Kingsberry discussed the factors that may contribute



Charlotte Payne, PA-C

to the incidence of medication errors: “Age of patient—the rate of medication errors in the elderly is higher than any other age group; Polypharmacy—nine or more medications; Co-morbidities—contributes to polypharmacy.” Ms. Kingsberry told attendees that they can prevent medication errors if they refrain from implementing orders with any level of ambiguity; clarify orders to ensure concise intent; use Professional Judgment; and “do not converse during medication administration—attentiveness is a very important aspect of safety.”

### Documentation

HRLA Acting Senior Investigator **Mark Donatelli** and Compliance Unit Director **Greg Scurlock** spoke with attendees regarding regulations related to medication errors. Documentation is a key issue in this regard. “If it wasn’t written, then it didn’t happen,” Mr. Donatelli told attendees. “Plain and simple, whatever type of business—whether it is buying a house, getting a loan—if there wasn’t anything written, you can’t prove it happened. The same thing for your clinical practice.” Mr. Donatelli urged nurses to document clearly and completely, and to write legibly and don’t take any short cuts.”

### Common Documentation errors

- Not documenting the completion of all or part of an Order.
- Failure to document in the patient’s Medication Administration Record.
- Making withdrawals from the Med-Dispensing machine without a prescriber’s order.
- Failure to document the administering and/or wasting of medications.
- Writing false notes into a patient’s medical file. (Documenting in advance what you “think” will occur.)



Mark Donatelli

Mr. Donatelli reviewed regulations in the Health Occupations Revisions Act (HORA) regarding documentation violations. The most common violation occurs, he said, when a potential licensee or renewing licensee lies when filling out a licensure application. “If you are not truthful on the application—right there is your violation. No person should make a false statement,” he said. And if a nurse “makes a false statement before the board



Greg Scurlock

or at a hearing, you are compounding a violation on top of the original violation.”

What are the possible violations of the Health Occupations Revision Act for documentation errors?

- Willfully makes or files a false report or record...

*Continued on page 24*

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Continued from page 23

- Willfully fails to file or record any medical report as required by law, impedes or obstructs the filing or recording of the report, or induces another to fail to file or record the report.
- Willfully makes a misrepresentation in treatment.
- Submits false statements to collect fees for which services are not provided or ... not medically necessary.
- Prescribes, dispenses, or administers drugs when not authorized to do so.
- Fails to conform to standards of acceptable conduct and prevailing practice within a health profession.
- Demonstrates a willful or careless disregard for the health, welfare, or safety of a patient....
- Commits fraud or makes false claims in connection with the practice of an occupation regulated by this chapter, or relating to Medicaid, Medicare, or insurance.
- No person shall file or attempt to file with any board or the Mayor any statement, diploma, certificate, credential...that is false or misleading.
- No person shall knowingly make a false statement that is in fact material under oath or affirmation administered by any board or hearing officer.

Mr. Donatelli described investigation process and shared case studies involving medication violations, such as failure to document wasting of medications. One nurse was brought before the Board for writing and phoning-in prescriptions in their name and their child's name.

The Board of Nursing generally learns

of these documentation errors from one or more of the following sources: the employer, a patient, another health professional, through a referral from another DOH agency, cross-jurisdiction referrals, or during the course of an investigation.



Detective Samuel Woodson

### Share Your PIN with NO ONE

DC Metropolitan Police Department Detective **Samuel Woodson** was pretty candid in his opening remarks to attendees: "My job is...to arrest," he told nurses. He spoke of the numerous healthcare professionals he has arrested and added: "During investigation, innocent nurses get caught up [in the investigation]." He urged nurses to avoid placing too much trust in colleagues: "You trust other people. Protect yourself. Drug seekers will do whatever they have to do [to obtain their drugs]. At the Pyxis machine—only log yourself out. A drug diverter can come in after you. Share your pin number with NO ONE and report discrepancies. If you do not report discrepancies, the person coming in behind you might report it."

Investigator **Walter F. Staples, GS**, of the Office of Diversion Control at the U.S. Drug Enforcement Agency (DEA) told attendees that drug diversion is defined as: "The diverting of legitimately manufactured Controlled Substances or Listed

Chemicals from the legitimate marketplace to the illegitimate marketplace." Everyone who touches controlled substances must be registered with DEA. DEA registrants include manufacturers-distributors, importers-exporters, researchers-analytical labs, narcotic treatment



Thomas Zeno

programs, hospital/clinics-doctors, and nurse practitioner-pharmacies. In addition to warning signs noted by previous speakers, such as absenteeism and disappearing during work hours, Mr. Staples urged nurses to watch for colleagues whose relationships with colleagues and patients have deteriorated; colleagues who are sloppy in their recordkeeping, false entries; for drug shortages and heavy wasting of drugs; for inappropriate large doses; for individuals who insist on personally administering doses to patients (your patients & theirs); a progressive deterioration in appearance and hygiene; the wearing of long sleeves to hide needle marks; and mood swings. "Get involved—you are ethically and legally responsible: Protect your employment, your employer, your patient, your career and yourself."

"We got to look into it," was the catch-phrase of program speaker and attorney **Thomas Zeno**. When someone calls to report drug diversion, he said, they often want to know



what the final outcome will be with regard to the punishment that will be given to the drug diverter. However, Mr. Zeno emphasized, there is no way that he can tell you what the final outcome will be at the onset of an investigation: "What's going to happen when you turn someone in?" he asked,



Walter F. Staples

rhetorically. "We got to look into it. When an ambulance pulls up [to your facility], do you know what is going to happen?" At the beginning there is no way to know what the consequences will be for the individual in question. "Give us a call," he said. "We are not here to send people to jail. I am going to look into violations of the law, but at the start, we cannot tell you what the final outcome will be."

### Addiction is a Disease

You think an individual you work with may be impaired by drug or alcohol use, but you are not sure what to do about your suspicions. In addition to fixing our medication systems, we must also address practitioner impairment—for the sake of our patients, and for the sake of the impaired individual. Speaking on the topic of "Protecting the Patient while Preserving the Nurse," **Kate Driscoll Malliarakis** (chairperson of the Committee On Impaired Nursing or "COIN" program) reminded attendees that addiction is a disease. During the

course of addiction, chemical changes occur in the brain. "It is not a matter of will," she said. "It is a disease of the brain."

Like chocolate—drugs and alcohol affect the pleasure centers of your brain, but with much more devastating effects. "Addiction is a complex, life-long, biopsychosocial disease with serious physical, emotional, financial and legal consequences," Ms. Malliarakis told attendees. Addiction has a genetic, psychosocial, spiritual component, and it affects every aspect of your life—family, friends, spiritual beliefs.

### Loss of Control

The hallmark of addiction is a loss of control, and continued use despite adverse consequences. When a person is addicted to a drug, judgment is gone: "It is not right to rob, it is not right to leave your [spouse], it is not right to take pills or syringes from their patients," Ms. Malliarakis said.

### What Should You Do?

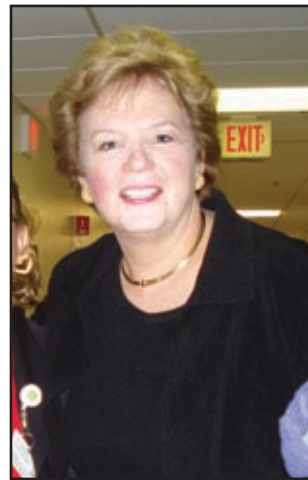
There are several risk factors which can facilitate a dependency on controlled substances: job-related stress; access to narcotics; the tendency to self-medicate; and having a belief that drugs can be controlled. Ms. Malliarakis noted several **WARNING SIGNS** of impairment: 1) Medication discrepancies; 2) Volunteering to give medications for other nurses' patients; 3) Unusual interest in pain control medications; 4) Frequent bathroom trips; 5) Unexplained absences; 6) Requests to work evening/nights/weekends. So, **WHAT SHOULD YOU DO** if you suspect a colleague is using? 1) Identify the specific

"warning signs"; 2) Discuss those examples with a trusted colleague or friend; 3) Present your observations and concerns to your nurse manager; 4) Remember your responsibility to protect your patients.

"Addiction is a chronic relapsing disease," she said. "And the job is usually the last thing to go after [the addict] has lost their family, friends, home, and property. You may be working with end-stage people."

If you identify a nurse who maybe a substance abuser --- drugs or alcohol --- refer them to Board of Nursing's Committee on Impaired Nurses (COIN). Generally, we require persons referred to COIN to be assessed to confirm that the problem is real, and to determine if it is drugs, alcohol, mental illness or some other medical problem. It could be a mix of multiple

problems. The important thing is to take that first step toward getting help.



Kate Driscoll Malliarakis

### The Transformation

When impaired nurses participate in COIN, there is a great transformation. "Nurses come into COIN angry," Ms. Malliarakis said. "They say 'it was an accident—I could give you a clean

urine today,'" she said. "It is like night and day. Participants go from feeling horrible about themselves, to looking people in the eye and saying 'I know who I am, where I am going, and how I am going to get there.'"

See *COIN CONSULT* on page 12 in this issue to read a letter from a COIN graduate.

## Board Disciplinary Actions

NAME	LICENSE #	ACTION
Wigo Akarolo	LPN966305	CONSENT ORDER
Dean Bowens	RN60765	SUSPENSION
Maria Reid	RN1005740	PROBATION
Shirley L. Conley	RN42208	PROBATION

*Names and license numbers are published as a means of protecting the public safety, health, and welfare. Only Final Orders are published. Pending actions against licensees are not published. Consent orders can be accessed by going to Professional Licensee Search at [www.hpla.doh.dc.gov](http://www.hpla.doh.dc.gov).*

# Kudos!

Congratulations to **Dr. Connie Webster**, who has successfully taped her first *Health Matters Report* show on UDC-TV. *Health Matters Report* is a sixty second update on critical health

issues. A second part of the series is a monthly interview program exploring broader health issues



Dr. Connie Webster, former Chair of DCBON.

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that impact an urban community. This production is a partnership with UDC-TV and the UDC Department of Nursing. Please join *DC NURSE* in welcoming Dr. Webster to the world of cable television. Dr. Webster served as Chairperson of the DC Board of Nursing from 2002 to 2004.

Congratulations to **Delia Allanigue** for participating in the Pearson Test of English (PTE) panel that NCSBN hosted in November 2009. PTE is an "exam" similar to the TOEFL. In November, NCSBN is hosting a standard setting panel for this exam. Delia's name was nominated to serve on the panel because she is a nurse that speaks English as a second language and because she works with patients who speak English as a second language.

# Former Board Member Vera Mayer Retires as Senior Advocate for IONA

Vera Waltman Mayer, Esq., who served as a consumer member on the DC Board of Nursing from 2003 through 2009, describes her tenure as “an enormous learning experience and a great joy.” Vera will be missed at Board meetings. Ms. Mayer’s contribution to the Board, and to the DC community, have been truly outstanding.

In addition to retiring from the Board this year, Ms. Mayer is also retiring from her position as Senior Advocate at the IONA Senior Services Center here in the District.

*DC NURSE* would like to publicly thank Ms. Mayer for all her hard work toward ensuring the health and well-being of seniors in DC. When she was awarded the “Public Citizen of the Year” award by the DC Chapter of the National Association of Social Workers in 2009, the organization described Ms. Mayer as “the epitome of a true and sincere champion of the under-served and vulnerable.”

## A Quick Q&A with Ms. Vera Meyer

**DC NURSE:** What has been the most memorable or meaningful



Vera Mayer, JD

thing that has happened during your tenure as a member of the DC Board of Nursing?

**VERA MAYER:** The recent work of the Coalition [DC Coalition on Long Term Care] with the Board of Nursing to create a model for the training of Nursing Assistive Personnel in a wide range of vital healthcare settings. This model, when implemented, will improve the training of these important workers and it will give them an opportunity to advance and acquire

additional skills which are desperately needed in our community to improve and maintain health and well-being. I think when the Board promulgates these rules, it will be the first of its kind in the country to include training for Nursing Assistive Personnel in a wide range of healthcare settings.

**DC NURSE:** What is something people don’t know about you?

**VERA MAYER:** I was born on April 1, 1931, in New York City and, therefore, did not learn to drive until I was 35 years of age. I graduated from the University of Chicago with a master’s degree and thought I wanted to do research in history. I got a job researching a book on civil rights with a wonderful history professor, but I soon realized I wanted to work with people and on current public policy. This led me to work for the Congress, for the Senate Subcommittee on Anti-Trust and Monopoly, and subsequently with public interest groups on Medicare, the minimum wage and migrant farm labor.

*Continued on page 28*



Ms. Mayer and her husband Arnold on the front page of an April 1997 issue of *The Current* newspaper's Guide to Senior Living. The headline reads: "Resident battles use of restraints in hospitals." In the article, Ms. Mayer is quoted: "[Restraints] can have terrible side effects on the elderly, and also doesn't do what they want it to do. It will cause agitation, which is what the hospital staff is trying to relieve."

**Continued from page 24**

## Accomplishments at a Glance

**Awards:** June 2007, DC Primary Care Association "Never Say Die Award" in recognition of superlative persistence in advocacy and dedication to the District's health care community; May 2004, Laura Lisner Award, for enhancement of the quality of life of the aging population of the District of Columbia; November 2000, Mid-Atlantic Non-Profit Healthcare Association (MANPHA) for skill in knitting together networks and coalitions into powerful coalitions to improve the quality of life of others; April 2009, Public Citizen of the Year, National Association of Social Workers, DC Chapter.

**Recent Positions:** Coordinator, DC Coalition on Long-Term Care: organized consumers, advocates and health care providers to work with the District on expanded options for long term care services for low-income District residents with

chronic care needs; Senior Advocate, IONA Senior Services: developed and sought implementation of public policies and programs to advance the health and well-being of seniors in the District; Consumer Member, District Board of Nursing: represented consumer interests in rule making and the disciplining of nurses; Biomedical Ethics Consultant to the Probate Division, DC Superior Court: led interdisciplinary team

in the investigation and analysis of biomedical ethical problems in guardianship cases when requested by judges; Board Member, Disability Rights Council of Greater Washington: develop strategies to further the implementation of the Americans with Disabilities Act (ADA).

**Past Positions:** Northwest DC Long Term Care Ombudsman (1987-1995); Staff member, DC Superior Court Multi-Door (1984-1985); Mediator, DC Superior Court Citizens Complaint Center (1981-1984); Staff Attorney, Neighborhood Legal Services, (1966-1967); Executive Director, Physicians Committee for Health Care through Social Security (1962-1964); Executive Director, National Consumers League (1958-1961); Staff Member, Senate Subcommittee on Anti-Trust and Monopoly (1956-1958).

**Education:** Bachelor's and Master's Degrees, University of Chicago; Law Degree, the George Washington University Law School.



Ms. Mayer holds one of the pens used by President Lyndon Johnson when, on July 30, 1965, he signed H.R. 6675 into law: "An Act to provide a hospital insurance program for the aged under the Social Security Act with a supplementary medical benefits program and an expanded program of medical assistance, to increase benefits under the Old-Age, Survivors, and Disability Insurance System, to improve the Federal-State public assistance program, and for other purposes." In other words, to create the Medicare system.

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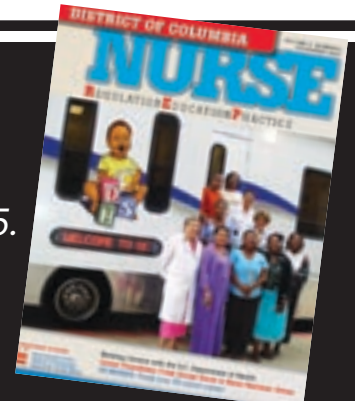
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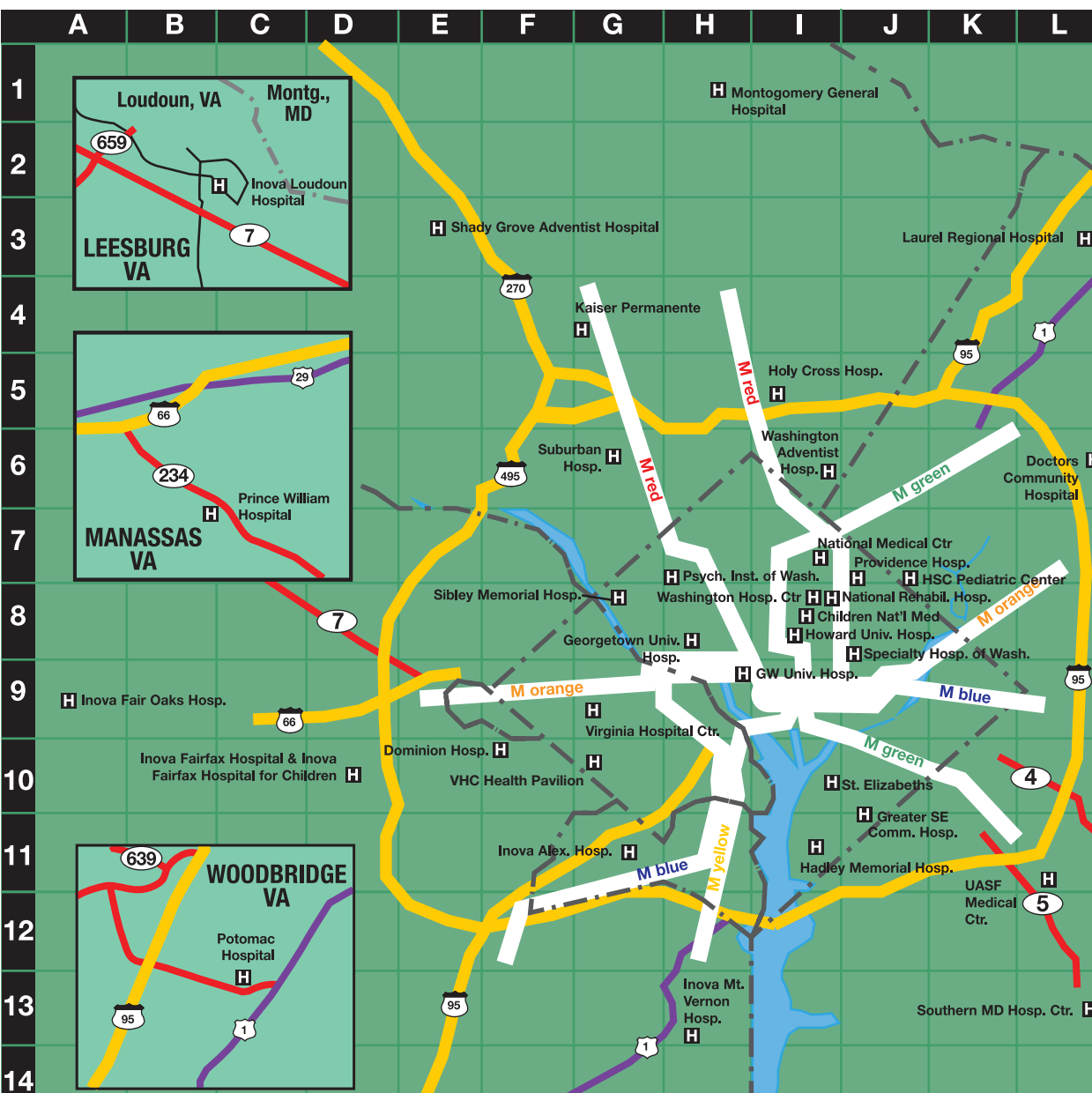
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Surprisingly, although we are among the region's largest academic institutions, we have maintained a community spirit. Georgetown Magnet Nurses are friendly and extremely supportive. As soon as you step inside our doors, you will experience a family feeling that exceeds all others. And the administration is your true advocate since nurses hold a significant role in the organization.

Visit us and apply online or send your resume to Georgetown University Hospital, Attn: Eileen Ferrell, RN, MS, Nurse Recruitment and Retention, 3800 Reservoir Rd., NW, Washington, DC 20007, phone: (877) 486-9676, fax: (202) 444-4080, e-mail: ferreleb@gunet.georgetown.edu. AA/EOE



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