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MAY 2010

DISTRICT OF COLUMBIA NURSE

REGULATION EDUCATION PRACTICE

National Nurses Week

May 6–12, 2010

Wound Care Update 2010

Licensure Renewal Q & A

Nurse Volunteers in Haiti

Government of the District of Columbia
Adrian M. Fenty, Mayor

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DISTRICT of COLUMBIA NURSE

Edition 26

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contents

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.)

Government of the District of Columbia
Department of Health
Office of the Director

To the Outstanding Nurses of the District,

Thank you for the constant care you provide, for your devotion to your patients, and the commitment to your field. The theme of National Nurses Week this year is "Nurses: Caring Today for a Healthier Tomorrow." As nurses, you play an essential role in protecting the public's health and promoting wellness. With the implementation of health care reform, more patients will be presenting for medical care in a number of clinical settings. Whether you provide care in an emergency department, doctor's office, nursing home, school or any other clinical setting, your role as the first line of care will become even more critical. Nurses around the country, especially in the District have proven to be one of the keys to good community-level care, and I would like thank the more than 20,000 licensed nurses in the District for their dedication and hard work.

Sincerely,
Pierre N.D. Vigilance, MD, MPH
Director

National Nurses Week

E. Rachael Mitsner, BSN, MS, RN

The efforts of America's nurses to save lives and to maintain the health of millions of individuals is the focus of this year's National Nurses Week, celebrated annually May 6 – 12 throughout the United States. This year, the American Nurses Association (ANA) has selected **"Nurses: Caring Today for a Healthier Tomorrow"** as the theme for 2010.

All across the United States, nurses are being saluted. The DC Board of Nursing would like to join ANA in thanking nurses throughout the country and extend a special thanks to those nurses who work in the District of Columbia. In honor of the dedication, commitment and tireless effort of each one of you to promote and maintain the health of residents in the District, we are proud to recognize you, particularly during Nurses Week, for the quality of work you provide seven days a week, 365 days a year.

As the Board works to ensure quality care through oversight and regulation, it continually asks for your input and support to advance the nursing profession by fostering high standards of nursing practice and projecting a positive, realistic view of nursing.

At this time in history with the recent passage of a health care bill, which will make health care available to more Americans than ever before, nurses have to be more knowledgeable, more culturally diverse and more vigilant than ever. The role of advocate and teacher will become just as important as the role of caregiver if we are to improve health care and contain cost as we meet the expanding health care needs of American society.

We encourage nurses to continue their education and expand their knowledge to best meet the needs of society. Research shows time and time again that increased education and adequate staffing save lives. Research also indicates that advanced practice nurses can provide 60 to 80 percent of primary care as well or better than physicians at a lesser cost. At this time when the need for nurses continues to increase, it is essential that we: recruit young men and women to join the profession, encourage education which allows for articulation into upper level nursing programs, and educate the public, employers and law makers on recognizing the worth of nurses in ensuring the health of the public.

To those nurses in the District involved in bedside nursing in hospitals, long-term care facilities, community health, those involved in educating our future nurses, nurses who work in non-tradition arenas and nurses who are not currently working or have retired but will forever be "a nurse"— THANK YOU.

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

Board of Nursing Update

JANUARY, FEBRUARY, MARCH

Donna Mooney, RN, MBA

Board Member training was held in January in lieu of the Board meeting

TOPICS DISCUSSED

- The History of Regulation
- Role of a Board Member
- Role of Board Staff
- Discipline Processes
- Trends in Regulation
- The Administrative Procedures Act and Its Implications for Board Actions
- Criminal Background Checks
- Continuing Competence

GUEST LECTURER DONNA MOONEY, RN, MBA

Donna Mooney is the manager of disciplinary proceedings for the North Carolina Board of Nursing, where she has served since 1987. Prior to joining the Board of Nursing, Ms. Mooney was with the North Carolina Drug Commission for three years, assigned to the state Bureau of Investigation performing criminal investigations for suspected drug diversion. Prior to that, she held many clinical and administrative nursing positions. She holds a B.S. in Nursing from Western Carolina University as well as an M.B.A. from Meredith College. Ms. Mooney is a two-time Past President of the Council on Licensure, Enforcement and Regulation (CLEAR) and has both chaired and served on many CLEAR committees.

Nursing Assistive Personnel Regulations Update:

The Board received feedback from DC Dialysis Centers regarding the Dialysis Regulations. Issues such as training requirements and "grandfathering" were discussed. The Board also received additional feedback from the NAP Stakeholders Committee.

Nursing Programs

The Board approved the following policies and procedures for nursing programs:

- Prelicensure Program Proposal Approval
- Approval of Prelicensure Nursing Program Application

Board Chair Testifies Before DC Council Health Committee

On March 18, 2010, Rachael Mitzner testified before the DC Council's Health Committee, chaired by David Catania. She expressed the Board's commitment to continue to work with the DC Nursing Community on the development of the NAP regulations. Also, she noted that it will be impossible to implement these regulations without additional Board of Nursing staff.

PLEASE BE REMINDED TO UPDATE YOUR ADDRESS

Licensees sometimes forget to inform the Board when they move or change names. If we do not have your current address, you may not receive renewal postcards or your DC NURSE because we may send it to your former address. All name and address changes must be submitted in writing to our office within 30 days of the change. Failure to do so may result in a $100 fine per section 16A DCMR § 3201.1 (d). Please include your name, address, Social Security number, and license number, if you know it. If you have a name change, you must also enclose a copy of your certificate of marriage, divorce decree, or court order that authorizes the change. Fax your request to (202) 727-8471, or mail your name and address change to:

DC Board of Nursing
Attn: Processing Department
Address/Name Change
717 14th Street, NW
Suite 600
Washington, DC 20005

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.

♦ ♦ ♦

May 5, 2010

June 2, 2010

July 7, 2010

August – no meeting

September 1, 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 a.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.

RN LICENSURE RENEWAL Q & A

Continuing Education (CE) Audit

The Board receives a number of questions during the audit period. Below are typical questions and responses:

Q I have taken classes at work. Can I use these to meet my continuing education requirements?

A If you received a certificate indicating that the class you took was approved by a continuing education provider, you can use it. If not, you may need to check with the person offering the course to determine whether or not it was inservice education or continuing education. The American Nurses Credentialing Center defines inservice education and continuing education as follows:

CONTINUING EDUCATION: Systematic professional learning experiences designed to augment the knowledge, skills, and attitudes of nurses and therefore enrich the nurses' contributions to quality health care and their pursuit of professional career goals.

INSERVICE EDUCATION: Activities intended to assist the professional nurse to acquire, maintain, and/or increase competence in fulfilling the assigned responsibilities specific to the expectations of the employer.

Q What are my options if I will not be practicing in DC during the next two years?

A You can choose to:
Keep your license active, or cancel your license, in which case you will have to apply again as a new applicant when you decide to resume practice in DC; or

Apply for Paid Inactive status. Your license will remain valid, but you will not be able to practice until you apply to reactivate your license and pay a reactivation fee which is currently $34.00.

Paid Inactive status is a non-disciplinary license status that retains a licensee's ability to become licensed in the future without taking another licensing examination, although the Board may require a special purpose examination for licensees who are on paid inactive status for an extended period of time. While on Paid Inactive status, a licensee may not practice his or her profession in the District of Columbia and will not be sent renewal notices for the duration of the Paid Inactive status. A licensee may remain on Paid Inactive status indefinitely.

You can return your license to active status from inactive status by submitting a written request, paying the reactivation fee, and submitting any applicable continuing education documentation.

Q I was audited last time, why am I being audited again?

A The audit is a random audit. There is always the possibility that a person could be audited more than once.

Q I lost my CE Certificate.

A If you have misplaced your CE Certificate, contact the organization that offered the CE program. They will have a record of your attendance and will send you another certificate.

Q I did my CE online, and they did not send me a CE Certificate.

A Contact the online vendor. They will send confirmation of your completion of the online CE course.

Q I have been ill and unable to complete the CE requirement.

A You will be required to send documentation supporting your claim of an extended illness.

Q I was selected for CE Audit, but I have not completed the CE Requirement.

A In order to have received your license, you would have indicated on your license renewal application that you completed the CE requirement. If that is the case, you falsified your application and can be disciplined.

OOPs! Our mistake....

As many of you know by now we inadvertently left the information off the postcard that you would not be able to renew online until April 1st. Our sincere apologies…

RN RENEWAL TIPS: How to avoid delay

RN/APRN renewals began April 1, 2010. Licenses wil expire June 30, 2010. Here are a few tips to avoid delay now and in the future.

Keep your mailing address current

Courtesy renewal notices are mailed prior to license expiration date. All notices are mailed to the address on file. It is important to keep your contact information up to date. Please notify us in writting of any name or address changes. These can be sent via e-mail to hpla.doh@dc.gov, faxed to 202.727.8471 or mailed to 717 14th St., N.W.; Suite 600; Washington, DC 20005.

Renew online

If you renew online, you should receive a hard copy of your license within 48 – 72 hours. Mailed renewals may take up to a week.

Don't have a computer? There are resources available. You may go to the public library, use the computer at your job, or come to our office to renew online.

Controlled Substance Registration

APRNs, please be reminded that you can now renew your controlled substance license online.

What should you do if you don't receive your renewal notice?

You are not required to have a renewal notification prior to renewing. If you did not receive a notification, when you renew online, make sure that your address is correct. But, whether or not you receive a reminder notice, you are required to renew your licensure prior to the expiration date of June 30, 2010.

Licensure Renewal — It's the Nurse's Responsibility

In the District of Columbia, the renewal of a nursing license is required every two (2) years. According to DC Code 17-4006. Term of a License, Certificate, or Registration. 4006.1 *The term of a license, certificate, or registration issued or renewed pursuant to this subtitle shall be two (2) years* ***or for the balance of the license period, whichever is shorter.***

Therefore, renewal of licenses occurs on a specific date and is not based upon the date that you are originally licensed or your date of birth. Renewal of RN and APRN licenses occurs June 30 of even-numbered years, and for LPNs June 30 of odd-numbered years.

Practicing without a valid license is illegal. According to DC Law, "No person shall practice, attempt to practice, or offer to practice a health occupation licensed, in the District, unless currently licensed."

The DC Board finds nurses who have missed several renewal cycles who continue to practice and do not understand the significance of that failure to renew. Along with the licensee, employers share in the responsibility of assuring that the nurse working for them is currently licensed. The nurse that has not renewed is practicing nursing without a license and is subject to disciplinary action by the Board.

The Health Regulation and Licensing Administration sends a courtesy reminder postcard to all licensees scheduled to renew. These renewal reminders do not always arrive at the intended destination for any number of reasons.

We recognize the fact that some nurses have several licenses to keep track of, but it is your responsibility as a professional nurse to assure that the license for the jurisdiction in which you are working is active.

COIN CONSULT: DEVELOPING CONSISTENCY AMONG IMPAIRED NURSE PROGRAMS

COIN and NCSBN Working for Nurses with Substance Use Disorders

By Kate Driscoll Malliarakis, RN, MSM, CNP

Kate Driscoll Malliarakis, RN, MSM, CNP

The District of Columbia Board of Nursing (BON) Committee on Impaired Nurses (COIN) continues to broaden and deepen our commitment to nurses with substance use disorders. COIN is the non-public alternative-to-discipline program for nurses who voluntarily request assistance with alcohol or drug abuse issues. COIN also receives disciplinary referrals for monitoring from the BON.

COIN is supporting the work of the National Council for State Boards of Nursing Chemical (NCSBN) Dependency Committee whose charge it is to review discipline and alternative programs and provide recommended regulatory practices for chemically dependent licensees for protecting the public. The Committee members are from wide geographic areas of the country as well as various disciplines — nurses and nurse practitioners in alternative programs, peer assistance programs, and lawyers from several state boards. The COIN Chair, Kate Malliarakis, is a Chemical Dependency Committee member.

What began as a review has evolved into the development of an evidenced-based handbook. The purpose of *The Handbook for Best Practices for Alternative Programs & Boards of Nursing* will provide practical and evidence-based guidelines for evaluating, treating, and managing health care professionals with substance use disorders. In developing "best practices," the Committee members conducted an exhaustive review of the research literature on alcohol and drug abuse and surveyed alternative-to-discipline programs to assess their current practices. The result is a comprehensive resource of the most current research and knowledge synthesized from the literature and from the field.

While the *Handbook* was developed for alternative-to-discipline programs and boards of nursing in an effort to enhance program content and delivery, it also provides essential theoretical and practical guidelines for clinicians, educators, policymakers, and public health professionals. Information on prevention, detection, and intervention of chemical dependency cases is presented. It contains key research findings, guidelines, and program recommendations and provides examples of model contracts, forms, and reports.

The *Handbook* continues to be a work in progress and will be published in the latter part of this year. In an effort to make the contents of the Handbook more manageable, the Committee developed a companion piece, the *NCSBN Guidelines for Alternative Programs and Discipline Monitoring Programs,* which will advance the regulation of licensees with substance use disorders and enhance communication and exchange of information between alternative programs, disciplinary programs, and boards of nursing. The topic areas in the *Guidelines* include: responsibilities of the alternative program, screening and assessment, contracts, standards for treatment programs, standards for nurse support groups, drug testing, return to work standards, relapse, and completion of the program.

To encourage discussion and participation in the development of the *Handbook* and *Guidelines*, NCSBN is holding a Forum in April for NCSBN members. Over 150 participants are expected to attend. The Chemical Dependency Committee then will take the comments, suggestions, and recommendations and enhance both the *Handbook* and *Guidelines* accordingly.

Kate Malliarakis will be a speaker at the Forum. Karen Skinner, MSN, RN, executive director of the DC Board of Nursing, and Joanne Joyner, PhD, RN, COIN member, will attend the Forum.

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.

Nurses Fired During Snowmageddon

Q As you may have seen in the news, RNs were fired at Washington Hospital Center (WHC) for failing to come to work during the February snowstorms. This is unprecedented in terms of hospital policy, past practice, and the terms of our contract. With one exception, the 14 firings are nurses with no prior disciplines or issues with their nursing practice.

Out of about 250 call-ins during this period, its appears arbitrary why some nurses were fired and others not. It's confusing to everyone why the hospital has taken this new approach, and it's been demoralizing and fear-producing. The union is just beginning contact negotiations with the hospital and it is unclear if management is trying to distract us or make the union seem weak and useless. There is a lot of anxiety among RNs because this is a license renewal year, and these terminations may negatively impact this process for them. Any thoughts you have would be very appreciated.

A The renewal application asks, "Since your last renewal, have you been terminated or asked to resign from employment?" The terminated nurses should fill out their renewal application honestly (i.e., check off that they have been terminated) and then explain the circumstances. Termination for non-practice related issues will not affect their licensure status.

Work Hours

Q Does the DC Board have a requirement for the number of hours a nurse can work?

A The Board has not addressed employment activities or set a limit on the number of hours a licensee may practice within a specific period of time. The Board, however, has disciplined a number of nurses who have worked an excessive number of hours within a specific period of time and as a result were not able to demonstrate a competence or provide consistent performance within their nursing practice.

Spelling Tip

Dear DC NURSE: I was reading the January 2010 DC Nurse publication and saw the message from the chairperson. There was mention of "nosicomial infections" in the article. I learned in nursing school that word was spelled and pronounced "nosocomial." I just double checked a 2008 medical dictionary and the word is still spelled "nosocomial." I hope readers are informed of correct pronunciation and spelling of medical terms. That word is one like "rigmarole," which is constantly mispronounced and misspelled as "rigamorole."

Best Wishes from Carroll Manor Nursing and Rehabilitation Center in honor of National Nurses Week

Nurse Volunteers in Haiti

Tapping into Nursing's Tradition during a Modern Catastrophe

On Jan. 12, 2010, Haiti was hit with a magnitude 7.0 earthquake, and since then, over 7,000 nurses have volunteered to aid those suffering with injuries and illness. The DC Board of Nursing salutes those who have used their nursing skills to offer medical aid to those who would have otherwise gone without. You truly reflect the spirit of the Florence Nightingale Pledge.

The pledge, composed in 1893 by Mrs. Lystra E. Gretter, says in part that each nurse's goal is to maintain and elevate the standards of the profession and to devote herself or himself to the "welfare of those committed to my care."

There could be no greater example of that devotion than the nurses who traveled to Haiti to care for the victims of the earthquake and its aftershocks. The people of Haiti [much like the people of our own Gulf Region during 2005's Hurricane Katrina] have been physically and emotionally devastated by natural disaster, and each hour of nursing care given heals bodies, relieves pain, and brings the Haitian people one step closer to a sense of comfort, well-being and normalcy.

So, thank you to all nurse volunteers! Your courage, professionalism and selfless dedication exemplify the best of the nursing tradition.

Practical Nursing Programs

Year to Date (03/01/2010) Licensure Exam Results and Approval Status

PROGRAM	CURRENT QUARTER 01/01/2010 - 03/31/2010 #Sitting	% Passing	YEAR TO DATE 04/01/2010 - 03/31/2010 # Sitting	% Passing	APPROVAL STATUS
Capital Health Institute	31	77.42	140	80.00	Conditional
Comprehensive Health Academy	16	87.50	115	89.57	Full
JC Inc.	6	0.00	80	45.00	Withdrawn
Radians College (formerly HMI)	12	100.00	63	93.65	Full
University of the District of Columbia	29	72.41	113	78.76	Full
VMT Academy of Practical Nursing	46	67.39	159	64.15	Conditional

Professional Nursing Schools

Year to Date (03/01/2010) Licensure Exam Results and Approval Status

SCHOOL	CURRENT QUARTER 01/01/2010 - 03/31/2010 # Sitting	% Passing	YEAR TO DATE 04/01/2010 - 03/31/2010 # Sitting	% Passing	APPROVAL STATUS
Catholic University of America	1	100.00	61	65.57	Conditional
Georgetown University	48	100.00	118	96.61	Full
Howard University	0	0.00	57	85.96	Conditional
Radians College	15	60.00	54	66.67	Conditional
University of the District of Columbia	12	66.67	53	69.81	Full

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

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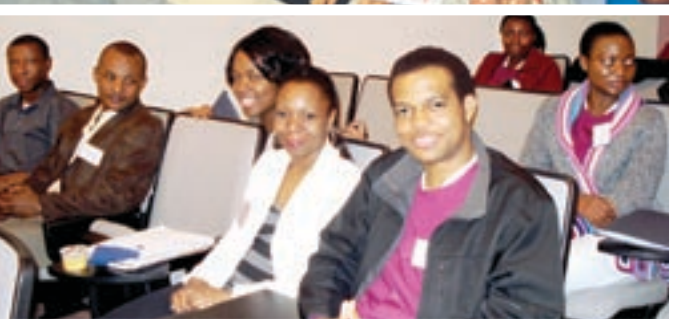


WOUND CARE UPDATE 2010

Article and Photos
by Nancy Kofie











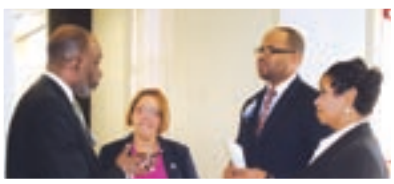

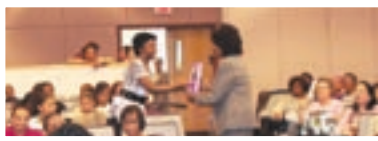



The DC Board of Nursing and the National Alliance of Wound Care® sponsored a continuing education program at Howard University Hospital Towers Auditorium in March 2010.

A variety of speakers revved up the crowd and shared their enthusiasm for the effective treatment and the prevention of wounds. The program was organized by DC BON Board Member Ottamissiah "Missy" Moore.

Ecstatic to Treat Wounds

"I am ecstatic!" **Dr. Macy G. Hall** told attendees, talking about when he has the opportunity to treat wounds. Recognized as one of the District's "Top Docs" in Washingtonian Magazine, Dr. Hall is a retired plastic surgeon who has served as the chair of plastic surgery at Howard University Hospital and Providence Hospital. "A face-lift is well compensated, but I like to see the smile on someone's face when their wound is healed and they say 'Thank you, doctor.'"

During his talk, Dr. Hall provided participants with principles essential to effective wound care:

EMPATHY: When your patient reveals a wound, do not make faces or make audible sounds of surprise or discomfort. The patient may already feel embarrassed and may have been reluctant to seek treatment.

LISTEN: Listen to the patient and get a full history.

EXAM: Examine the patient from head to toe. Turn that patient over. There may be something happening "that the patient is too embarrassed to tell you about. Blood tests, x-rays, CT scans, MRIs; sometimes we take tissue biopsies are used in assessing the condition of the wound."

GUT FEELING: When obtaining the patient history and listening to the patient's account of recent events, be alert for your "gut reaction" to his or her story. Does it ring true? Is the information they are providing credible? (Dr. Hall told the story of one elderly patient whose wound never seemed to heal. After further investigation — using a solution detectable under infrared light — Dr. Hall discovered that the patient had been using her fingers to disturb the wound to prevent it from healing because her doctor visits were the only occasion she got to leave the house. He also shared the case of a younger patient who had wounds on

Continued on page 14

"As a nurse or doctor, there is always someone with more experience than you. Ask for help."
—Macy Hall, MD

Dr. Macy G. Hall with DC BON Chairperson Rachael Mitzner

Continued from page 15

both hands and said a household iron fell on them; the true story was that the condition was the result of substance abuse.)

DIAGNOSIS: A diagnosis can be missed if you have no knowledge about the condition; a diagnosis can also be missed if you know about a condition but fail to take it into consideration when making a diagnosis. Time may be required to consider all the possible causes of a particular wound. Dr. Hall talked about how some conditions present with the same symptoms, like Stevens-Johnson Syndrome and Toxic Epidermal Necrolysis (TEN).

Stevens-Johnson Syndrome (SJS) and Toxic Epidermal Necrolysis (TEN)

Stevens-Johnson syndrome and toxic epidermal necrolysis are severe cutaneous hypersensitivity reactions. Drugs, especially sulfa drugs, antiepileptics, and antibiotics, are the most common causes. Macules rapidly spread and coalesce, leading to epidermal blistering, necrosis, and sloughing. Diagnosis is usually obvious by appearance of initial lesions and clinical syndrome. Treatment is supportive care; corticosteroids, cyclophosphamide, and other drugs may be tried. Prognosis depends on how early the disorders are diagnosed and treated. Mortality can be as high as 7.5 percent in children and 20 to 25 percent in adults.

Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) are clinically similar except for their distribution. By one commonly accepted definition, changes affect < 10 percent of body surface area in SJS and > 30 percent of body surface area in TEN; involvement of 15 to 30 percent of body surface area is considered SJS-TEN overlap.

The disorders affect between one and five people/million. Incidence, severity, or both of these disorders may be higher in bone-marrow transplant recipients, in *Pneumocystis jiroveci*–infected HIV patients, in patients with SLE, and in patients with other chronic rheumatologic diseases.

GET HELP: Be very cautious about your diagnosis. "As a nurse or doctor, there is always someone with more experience than you. Ask for help."

PRODUCTS: Dr. Hall said when he began his career in medicine in 1968, the only products available for wound care were alcohol and mercurochrome. Today, there is a myriad of products available. (Dr. Hall mentioned more than once his preference for SILVADENE® [silver sulfadiazine]). Once you have determined the cause of the wound, you can select the best products for that patient. Educate yourself about the wound-care products available.

Gratitude to Nurses

Dr. Hall's career had a tentative beginning. As a neophyte physician on the night shift in the emergency room, Dr. Hall said he relied on nurses for their experience and expertise. "I knew the diagnosis," he said, but he relied on a veteran nurse to write the treatment. Initially frustrated by the challenges, he told nurse Nannie Hemphill that he no longer wanted to be a doctor, but she encouraged him to carry on. "If it wasn't for you [nurses]," he said, "I wouldn't be standing here now."

Dr. Hall is presently the co-director of the Center for Advanced Wound Healing at United Medical Center.

Continued on page 18

Continued from page 17

Wounds 24/7

Described by program organizer Missy Moore as a true "Wound Diva," speaker **Nancy Morgan, RN, BSN, MBA, ET, CWCN, WCC,** began her presentation by letting attendees know that she "walks and talks wound care 24/7." A nurse entrepreneur, owner and clinical instructor of the Wound Care Education Institute® (www.wcei.net), Ms. Morgan focused her talk on the topic of the care of bariatric patients.

"In the 1700s, weight used to equate to wealth," she told attendees. Today, however, obesity affects individuals of all income levels, and special care must be taken to prevent and treat wounds for these patients. The more excess weight a patient has, the more likely they are to have pressure sores, she said. "Having 'padding' [fat] does not mean the patient doesn't need to be turned," she said. In fact, excess weight increases the risk of skin breakdown.

> ***"Assess and reassess: What is going on today?" —Donna Johnson, RN***

"It is very difficult for these folks to move," she said. They have problems breathing; however, elevating causes sheer forces that bring weight down on bones. "With some patients, you need six staff members to move the patient." Slings can be used, and since there are variations in how people carry their weight, she said, you should utilize a sling designed for that body type — patients can be apple-shaped or pear-shaped.

Put yourself in their shoes, so to speak: "It can be frightening [being airborne in a sling], and I don't care what size you are," Ms. Morgan said. "Let them know everything you are doing [each step of the way]. Tell them what you are going to do ahead of time to decrease the anxiety.

"These patients require meticulous skin care," Ms. Morgan told participants. "Part of our assessment is we have to separate those folds. Some of you are making faces: 'Do I have to do that?' Yes, you do. BODY GLIDE® products create a barrier to decrease friction forces. To keep skin dry, you may use corn starch-based powders, cotton fabric, gauze, and InterDry™ textiles. In the folds, it is dark and moist." This can harbor yeast. Frequently change their gowns out and change their linens.

To prevent wounds in skin folds, Ms. Morgan recommended attendees use antimicrobial creams/powders or gauze which has the antimicrobial component embedded into the gauze.

> ***"It can be frightening [being airborne in a sling], and I don't care what size you are." —Nancy Morgan, RN***

Speakers Donna B. Johnson, BSN, RN, CWON, and Nancy Morgan, RN, BSN, MBA, ET, CWCN, WCC

Ms. Morgan discussed venous ulcers, which bariatric patients get due to their lack of movement. She said, "If they have that panniculus [subcutaneous fat in the lower abdominal area] compressing the legs, that is going to decrease blood

flow. The blood flows down to the lower extremities and there is no way for it to come back up, so it begins to pool, and it is going to break through the capillaries, break through the skin and cause a venous ulcer."

There can be a lot of drainage, full thickness height venous ulcers: "They can drain 60 ccs a day. We need to be smart about the dressings we put on these venous ulcers. We put foams, or you can put calcium alginate or a hydrofiber. If you have a high bacteria load in the wound, you can use a silver foam, a silver hydrofiber, a silver alginate. There are compression wraps made specifically for the bariatric population," with Velcro that they can easily put on and take off.

Ms. Morgan also discussed the difference between edema (too much serous fluid) and lymphedema (an obstruction of the lymphatic vessel). Check in your area for availability of certified lymphatic massage therapists to whom you can refer patients.

The Right Equipment

Bariatric patients also are better served with specialty beds, special sheets and roomy dressing gowns so they will be comfortable (rather than tying two gowns together). Large-size wheelchairs are also available. Despite their unusually high intake of calories, these patients have serious dietary concerns. "These folks are malnourished, believe it or not," she said. Get the patient involved in activities to keep them moving. Refer the patient to Social Services for assistance with the symptoms of depression. Physical therapy is also key to their well-being.

Ms. Morgan urged attendees to NOT show prejudice or judgment against obese patients. "Staff must be educated to take care of this population. A lot of people have misunderstandings about obesity."

Ms. Morgan urged attendees to visit the Wound Care Education Institute Facebook page; Ms. Morgan may be contacted by e-mail at Nancy@WCEI.net.

Passionate About Wound Care

"Focus on the patient, not on product or dressing," speaker **Donna B. Johnson, BSN, RN, CWON**, told program participants. A Board-certified wound and ostomy nurse specialist, Ms. Johnson describes herself as "passionate" about wound care. "We can make a difference, and can prevent wounds," she said.

Once you have determined the cause of the wound and the appropriate treatment for the wound, however, she said to keep in mind that the appropriate treatment today may not be appropriate in a few days. "Assess and reassess: What is going on today?" The dressing used yesterday may not be appropriate today, and the treatment used today may not be appropriate a few days from now, Ms. Johnson said.

When obtaining the patient history, be sure to ask the patient how long they have been using their current treatment. The patient may be using a product that is no longer effective because (1) they didn't go back to the doctor for a follow-up visit, or (2) they want to use up their current container of wound care product because it was expensive ($150+).

"Read and understand the information in the package before using any wound care product," Ms. Johnson told attendees. "You may be liable if products are not used correctly. The nurse is also liable, not just the physician." Do not use the product in a certain manner simply because that is how it was applied by another individual in your facility.

Ms. Johnson discussed pressure ulcers, arterial/vascular ulcers (dry and painful in lower leg or foot), venous ulcers (usually red and wet), and skin tears (especially in long-term care). "Skin tears are NOT pressure ulcers," she said. In addition to monitoring the wound, note the condition of the periwound — the skin surrounding the wound.

NECROTIC TISSUE: "If a wound has a significant amount of slough or eschar, debridement may be necessary. There are dressings that will aid in the debridement process," Ms. Johnson told attendees. "If the wound bed is free of necrotic tissue, the goal is optimal moisture management.

WOUND DEPTH: "Addressing the dead space in the wound bed is crucial to preventing premature closure of the wound. The goal is to allow the wound to close from the 'bottom up' without abscess formation."

IDEAL DRESSING: Should protect from airborne bacteria, reduce and kill bacteria, remove eschar (if present), maintain the perfect level of moisture, maintain warmth, reduce pain, and should be user-friendly. Avoid adhesives. Use a skin protector before you put tape

Continued on page 20

Continued from page 19

> ***"Assess the whole patient, not just the hole in the patient!" —Jackie Todd, RN***

to skin. Do not use skin cleaners on wounds!

Paint a Vivid Picture

"Assess the whole patient, not just the hole in the patient!" speaker **Jackie Todd, RN, CWCN, DAPWCA**, told attendees. A clinical education specialist for the South Central Region of Medline Industries, Ms. Todd told participants that she reviews documentation for litigation. "Your documentation must be impeccable. Paint a vivid picture of what you see. A case can unravel when lawyers obtain the documentation." Your tools for assessment may include a flashlight, cotton-tipped applicators (such as Q-Tip®), camera, forceps, magnifying glass, cleanser and gauze, and measure guide.

Speaker Jackie Todd, RN, CWCN, DAPWCA

Ms. Todd reviewed assessment criteria, staging, pain relief strategies, dressing strategies, methods of measuring, undermining/tunneling, types of necrotic tissue, granulation, hypergranulation, and periwound indicators.

Issues to keep in mind during wound care:

TEMPERATURE: The core temperature of the wound bed drops when you do a dressing change, and it can take five hours for the temperature to return to the point where cell development/granulation can occur.

PREMEDICATE: Medicate the patient one hour before changing the dressing. Get the physician to order topical medication for pain. "Encourage imagery and slow rhythmic breathing, and allow patients to call 'time out.'"

EXUDATE (DRAINAGE): "Exudate is dead cells and liquefied necrotic debris, active WBCs, growth factors, and natural enzymes that stimulate autolysis and healing. The body is trying to heal by creating and maintaining an optimal moist wound environment."

ODOR: "Dead tissue harbors bacteria, and bacteria of different varieties have different odors, colors and consistencies," Ms. Todd said. "All wounds are contaminated, with or without necrotic tissue, and will have odor."

TURNING: When turning/repositioning a patient, make sure to reposition any tubing attached to the patient. Be sure the tubing is not caught up or bent in the process. The timing of turning and repositioning should be based on the individual needs of that particular patient.

BED PANS: Do not shove the bed pan under a patient or drag a bedpan against a patient's skin. Turn the patient on their side to position bed pan. Friction can cause injury/tearing: a pathway for microorganisms. A patient should not be left on a bed pan for an extended period of time.

Dressing Strategies

- Consider non-adherent dressings
- Apply wound cleaners at body temperature and correct pressure (PSI)
- Consider tape alternatives (silicone tape, netting, tubular dressings, Montgomery straps, etc.)
- Choose dressings that are moisture retentive
- Moisten dressings, if necessary, prior to removal

- Assure/provide periwound protection with every dressing change: sealant, second generation barrier.

Use All Senses

When examining a wound, "use all of your senses," speaker **Sarah Lewis, PT, DPT, CWS, FACCWS**, told participants. Ms. Lewis addressed the topic "Skin and Wound Care Considerations in Non-Caucasian Skin." Ms. Lewis said, "Eighty percent of people on earth have pigmented skin. Currently, 29 percent of the U.S. population is non-Caucasian. It is projected that in 2050, 48 percent of U.S. population will be non-Caucasian."

"When examining a wound, use all of your senses," —Sarah Lewis, PT

Sarah Lewis, PT. Her speech is under the heading "Use All Senses".

With darker skin, it is more difficult to detect wounding. Use all of your senses:

LISTEN: Is the individual complaining of pain, itching or other sensory changes? Pressure ulcers may not cause pain, but itching.

LOOK: What is normal for the individual? Compare area in question to surrounding skin or contralateral side if applicable. Is the area in question a site of previous injury/scar?

TOUCH: Is the area warmer/cooler? Skin temperature warmer than usual could be sign of inflammation, and/or indicator of infection or pressure damage. Pale or cooler skin may be a sign of poor perfusion or ischemia and may indicate the end stage of nonblanching erythema. Is the area firm/boggy?

SKIN ASSESSMENT COMPONENTS: "D.E.R.M.A.T.O.L.O.G.I.C.A.L."

- Describe integrity
- Edema
- Review sensory status
- Moisture
- Atrophic changes
- Turgor/texture
- Observe nail composition/ hair quality
- Look/feel color and temperature variations
- Observe skin folds
- Gerontodermatoltical changes
- Inquire about allergies and previous medical history
- Callus
- Assess vascular status
- Lesions (rashes, scars, bruising, hermosideran, nevi, etc.)

Using a pen light can assist with skin color change observations, she said. "Early detection of skin legions is a top priority," Ms. Lewis said. "This can be problematic in darker pigmented individuals; erythema and/or blanching are not reliable indicators." In non-Caucasian skin, erythema presents as a darkening of patient's natural skin tone; it will not appear to be red as it does in

Continued on page 22

Jason Henderson, PT, and Aiyat Yiman, PT

"Remember, you can touch the patient!" —Aiyat Yiman, PT

Continued from page 21

Caucasian skin. Caregivers who are not of the same ethnic background as patients may be less sensitive to slight changes in skin color, she said.

Black skin may respond to trauma or inflammatory disease by either an increase or decrease in pigmentation (dyschronmia). Many of these pigmentary alterations normalize over time. When a wound resurfaces, it is closed. It is only truly healed when the maturation phase is complete and scar tissue is mature. This can take up to two or more years in some individuals.

Ms. Lewis also noted that 20 percent of melanoma in African Americans was detected by examination of fingernails.

Ms. Lewis stated that patients may not have pain to alert them that a wound is present. She had one elderly patient, she said, that stepped on a child's toy and did not realize it. When the patient came in, Ms. Lewis saw that the patient had put her shoe on with the small toy lodged in her foot. When Ms. Lewis removed the shoe, two of that patient's toes came off with the shoe.

PHYSICIAL THERAPISTS' PERSPECTIVE

Concluding speaker **Jason Henderson, PT**, used his presentation to review wound care in the long-term care setting from the physical therapist's point of view. "The reason why you will find the therapist as really important and being a vital part of the wound team is for tissue repair. Using modalities like electrical stimulation, they improve circulation by restorating electrical charges in the wound area. There are different choices in electrical stimulation." Electrical stimulation disrupts the synthesis of microorganisms, he said. He

reviewed electrical stimulation theories.

Emphasizing the importance of the interdisciplinary approach, Mr. Henderson spoke about traditional wound care in physical therapy — infection control, wound cleansing, irrigation, hydrotherapy, wound debridement, wound dressing, edema control, positioning, and patient/caregiver education. He also discussed dressings of choice for the various types of wounds, as well as describing the healing process (granulation, angiogenesis, epithelialisation, and maturation).

He recommended that nurses go online and visit www.pubmed.gov for the latest literature; in the search line, type in "wound care and electrical stimulation." [PubMed contains 19 million citations for biomedical articles. Citations may include links to full-text articles or publisher Web sites.]

Mr. Henderson's colleague Aiyat Yiman, PT, whose doctoral dissertation focuses on the racial disparity in the treatment of wounds, spoke briefly to attendees: "Early identification of pressure ulcers involves skin discoloration and perfusion after pressure. However, on dark skin, these conditions are not as apparent. Most researchers have noted that patients with darker skin tones have lower detection rates of Stage I pressure ulcers. If a Stage I pressure ulcer is left untreated, it can progress to higher stages between three to seven days." She noted that researchers advise the use of a convex glass to conduct the blanch test on dark skin, or use thumb and

"The reason why you will find the therapist as really important and being a vital part of the wound team is for tissue repair." —Jason Henderson, PT

Physical Therapist Jason Henderson leads audience in stretching exercises.

Continued on page 24

Continued from page 23

a transparent disc. In both studies, those tools were a good indicator of non-blanching erythma.

Noting that wounds are not always easily visible on brown skin, she emphasized: "Remember, you can touch the patient!"

Mr. Henderson, also a graduating doctoral student, asked the audience members to get out of their seats, to reach up, stretch and bend, to emphasize the importance of movement to health and a feeling of well-being. "I wanted to give everybody the opportunity to see how it feels after you stretch and you feel the increased blood-flow in your body. Changing and shifting positions is really important. This is where you can get your therapist involved in getting the wounds healing."

Top door-prize winner won stylish purse filled with wound care products.

Mr. Henderson is chief information officer with Ergo Solutions Rehabilitation. He has directed four nursing homes in the District area as well as practiced therapy for the past 13 years.

Wound Care 2010 Program Vendors: *KCI (Kinetic Concepts Inc.), Ergo Solutions, Wound Care Education Institute, National Alliance of Wound Care, Pro Stat, Medline Industries, American Medical Technologies, VITAS Innovative Hospice, Coloplast, Acuity Medical, and Pure Heart Home Health.*

Controlled-Release OxyContin

The U.S. Food and Drug Administration today approved a new formulation of the controlled-release drug OxyContin that has been designed to help discourage misuse and abuse of the medication.

OxyContin is made to slowly release the potent opioid oxycodone to treat patients who require a continuous, around-the-clock opioid analgesic for management of their moderate to severe pain for an extended period of time. Because of its controlled-release properties, each OxyContin tablet contains a large quantity of oxycodone, which allows patients to take their drug less often. However, people intent on abusing the previous formulation have been able to release high levels of oxycodone all at once, which can result in a fatal overdose and contributes to high rates of OxyContin abuse.

The reformulated OxyContin is intended to prevent the opioid medication from being cut, broken, chewed, crushed or dissolved to release more medication. The new formulation may be an improvement that may result in less risk of overdose due to tampering, and will likely result in less abuse by snorting or injection; but it still can be abused or misused by simply ingesting larger doses than are recommended.

For more information, please visit: http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm207480.htm

DEA Rules on Electronic Prescribing of Controlled

DEA Rules on Electronic Prescribing of Controlled Substances

On March 24, 2010, the Office of the Federal Register made available for public inspection an Interim Final Rule with Request for Comments from the Drug Enforcement Administration (DEA), Department of Justice, on Electronic Prescribing of Controlled Substances. The regulations are found at: www.federalregister.gov/inspection.aspx.

The Interim Final Rule specifies the rules that health care providers will need to follow to electronically prescribe controlled substances in accordance with the law. The Interim Final Rule is expected to be published in the Federal Register on Wednesday, March 31, becomes effective in 60 days and also includes a 60 day comment period.

DEA has revised its regulations to provide practitioners with the option of electronically writing prescriptions for controlled substances. The regulations will also permit pharmacies to receive, dispense, and archive these electronic prescriptions. These regulations are in addition to, not a replacement of, the existing rules. The regulations provide pharmacies, hospitals, and practitioners the ability to use modern technology for controlled substance prescriptions while maintaining the closed system of control on controlled substances.

Kudos!

DC BON Member Ottamissiah "Missy" Moore recently received The Humanitarian Award from Management Concepts Inc. (MCI), one of the largest management companies in the southeast. The inaugural 2009 Humanitarian Award was developed for Missy, who has worked diligently to bring people together for the good of the whole in the profession of nursing nationwide. She does not discriminate among LPN, RN, APRN, or any other designation in the profession, but utilizes the strengths and resources available to her to ensure the patient will receive the care they deserve. Missy was instrumental in the development and administration of two certification programs for LPNs, and she serves as an instructor in the courses leading up to the exams. She has mentored many young nurses and provided information needed to assist them in becoming the best of the best. Missy has met with leaders in many nursing organizations to share her desire to work together to make the world a better place for not only the nurses but the patients they serve daily. She frequently speaks at conferences across the nation on what is going on in the nursing profession and gives strong advice to the nurses to whom she speaks. "Her unselfish and undying efforts in making our world a safer place to live for all of mankind was the determining factor in presenting her with the MCI 2009 Humanitarian Award!" says Charlene B. Barbour, president and CEO of Management Concepts Inc. The award was presented to Missy during the annual meeting of the National Federation of Licensed Practical Nurses. MCI represents a member base of over 40,000 individuals in its ranks, and each year it awards some type of recognition to a deserving individual.

Ottamissiah "Missy" Moore

Reverend Dr. Mary E. Ivey

DC BON Consumer Member Rev. Dr. Mary Ivey: On February 25, 2010, the Reverend Dr. Mary E. Ivey became the Assistant Chaplain at Reagan National Airport. Dr. Ivey is the first woman to serve in the Chaplaincy Program at the airport. She received her Master of Divinity at Wesley Theological Seminary and Doctorate in Divinity at Howard University School of Divinity. She previously served as pastor of the Church of God's Love and assistant minister at Shiloh Baptist Church of Washington, DC, where she was ordained. Dr. Ivey is also founder, president and CEO of Maine Avenue Ministries.

GWU Department of Nursing: The George Washington University's Department of Nursing received a $900,000 grant to serve as the home for The Nursing Alliance for Quality Care (NAQC) for the Robert Wood Johnson Foundation's (RWJF) latest commitment to improving the quality of health care in the United States. Senior Associate Dean for Health Sciences Jean Johnson, PhD, FAAN, and Ellen Dawson, PhD, ANP, chair of George Washington University's Department of Nursing, will serve as the Co-PIs of the program. The initiative is titled "Implementing a National Nursing Quality and Safety Alliance to Strengthen Nursing's Ability to Influence Health Care Quality and Safety." The NAQC will serve to give a single voice to the nursing profession, thereby strengthening its ability to influence transparency, accountability, and the quality-related health reform agendas.

Children's National Medical Center Achieves Magnet® Designation

One-thousand three-hundred registered nurses were recently honored at Children's National Medical Center (CNMC) by the American Nurses Credentialing Center (ANCC) as CNMC celebrates its Magnet designation. Karen Drenkard, PhD, RN, NEA-BC, FAAN, senior director, Credentialing Operations, Director Magnet Recognition Program®, ANCC, attended a ceremonial event where the institution's registered nurses received Magnet pins. Magnet status is the highest level of recognition for nursing excellence that a medical center can achieve. The Magnet program promotes quality care in an environment that supports innovative nursing practices and positive patient care outcomes. Magnet hospitals are recognized as having improved safety practices, lower patient mortality rates, and higher patient and family satisfaction.

"This has been an important journey for the entire organization," said Nellie Robinson, MS, RN, executive vice president, patient services, and chief nursing officer at CNMC. "Hundreds of nurses representing every unit have participated in this process, which celebrates and documents nursing excellence, quality patient care, and innovations in our professional nursing practice."

"This is a significant day in Children's history," said Edwin K. Zechman Jr., CNMC president and CEO. "Children's National is committed to nursing excellence, and through the Magnet program, our nurses have demonstrated their contribution to the quality care for which we are known. I am proud of the

leadership demonstrated by so many nurses across our organization to earn this important national recognition. Children's National nurses are innovators, leaders, researchers, educators, and advocates for the patients and families for whom they care."

Only 6 percent of hospitals across the country have achieved Magnet status.

"I echo the sentiments of Children's leadership in celebrating with our nurses this designation by the ANCC," said Peter R. Holbrook, MD, executive vice president and chief medical officer of CNMC. "We recognize the day-to-day leadership role nurses play in assuring a safe and caring environment."

Board Disciplinary Actions

NAME	LICENSE #	ACTION
None		

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.

Non-Public Disciplinary Actions:	
Notice of Intent to discipline:	*7*
Referrals to COIN:	*1*
Consent Orders:	*3*
Requested withdrawal of application:	*2*
Requested surrender of license:	*1*
Administrative fines:	*1*
Letters of concern:	*1*

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.*

DC Black Nurses Association 30th Annual Salute

30th Year Celebration

The Black Nurses Association of Greater Washington, DC Area Inc. recently held its 30th Annual Salute to the Black Nurse of the Year and Scholarship Awards Luncheon. The theme of the event was "Integrating Health Care Reform: Challenges For Nursing." The keynote speaker was Linda Burnes Bolton, DrPH, RN, FAAN, vice president for nursing, chief nursing officer and director of nursing research at Cedars-Sinai Medical Center in Los Angeles, Calif. Dr. Burnes Bolton's research, teaching, and clinical expertise include nursing and patient care outcomes, improving organization performance, quality care and cultural diversity within the health professions.

She is a past president of the American Academy of Nursing and the National Black Nurses Association.

Black Nurse of the Year

Dr. Eva W. Stephens, DNP, APRN-BC

Dr. Eva W. Stephens, DNP, APRN-BC, has been named 2010 Black Nurse of the Year by the Black Nurses Association of Greater Washington, DC Area Inc. Dr. Stephens is an assistant professor at Howard University, with 13 years of experience as an educator and advanced practice nurse, and a total of 30 years of nursing experience. Dr. Stephens was the first nurse practitioner credentialed to practice independently as part of the medical staff at Howard University Hospital (in the emergency room), where she has also served as preceptor for medical, FNP and PA students.

She has dedicated her entire nursing career to caring and advocating for the underserved, uninsured, and most vulnerable populations. Dr. Stephen's research, publications and presentations focus on the health consequences and management of obesity among African American women and people of color. Dr. Stephens has presented at many national and international research conferences on obesity disparities affecting the African American community. Dr. Stephens is Board-certified by the American Nurse Credentialing Center (ANCC) as a family nurse practitioner (FNP), earning the credentials BC. Dr. Stephens was the first nurse practitioner credentialed to the medical staff, to practice independently in the Emergency Room at Howard University Hospital, where she also served as preceptor for medical nurse practitioner and PA students.

Black Nurses Association of Greater Washington, DC Area, Inc. President Patricia Tompkins (left) and Treasurer Kim Cartwright, present Dr. Eva W. Stephens with the Black Nurse of Year Award.

100 Extra Ordinary Nurses

Congratulations to the 100 Extra Ordinary Nurse Honorees recognized by the Gamma Beta Chapter of Sigma Theta Tau, the International Honor Society of Nursing, on the evening of May 3, 2010!

Christianah Adepoju
Momina Ahmed
Phillip Akwar
Kent Alford
Maria Andoque
Raymonda Anglade
Myrna J. Arellano
Thresiamma Augestein
Maria Cecelia Balnoves
Marice Beatty
Beth Biggs-James
LaTanyua Blackwell
Comfort Bogunjoko
Geraldine Brown-Madison
Francine Charles
Pushpa Cheriyan
Angella Cole
Janet Crowe
Roshell Dean
Varinda Dham
Simona Duckett
Karl Dunlap
Cynthia Edwards
Melanie Etnill Schwartz
Molly Evenson
Cecelia D. Ferguson
Darlene Foreman
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Colleen Glair
Jennifer Graebe
Danielle Hanna
Coleen Harbin
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Arlene Hawkins
Carrie Helmann
Pandolla Hicks
Alma Holley
Katherine Hubley
Carolyn Hutchins
Sybil N. Ibeh
Semmie Jennings
Megan Johnston
Jasmine Jones
Roxanne Joseph
Anthoina King
Carolyn Kirby
Linda Klingensmith
Hannah Koroma
Cheryl Landry
Jeanette Lee
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Byron Luna
Brenda McCall-Russell
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Margot Moses-Jones
Manimegalai Murugavel
Judith Nwakanma
Hilda Nzuwah
Young Oh
Tracey Ojeniyi
Priscilla Okunji
Ngozi Onianwah
Lakshmi Panicker
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Flora Peri
Bernice Peters
Cythia Pinder
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Ernanie Soriano
Sonia Stanford
Toni Stillinges
Ayesha Swann-Brown
Sharon Tapp
LuCia C. Thomas-Collis
Erica Underdown
Maria E. Villanueva
Eunice Wang
Gloria Washington
Rosemary Welch
Mavis Williams
Monica Williams
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Merriam Yuson-Lowry

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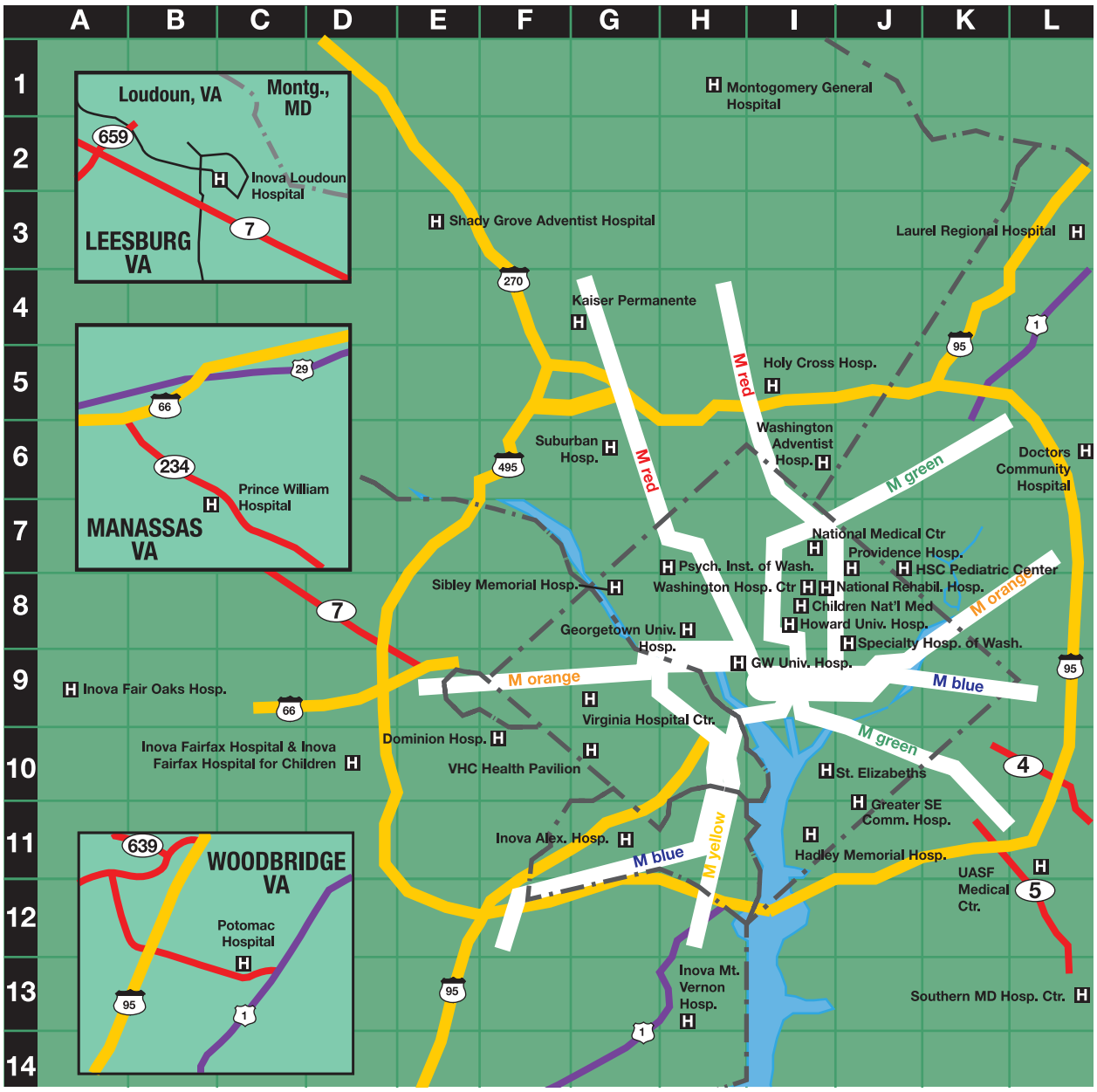

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