

REMEMBER

WHEN THE KIDS FIRST GOT ME



I'd fly through the air, they'd bounce me all the way from the house to the school, I would hear their shouts of joy as they played with the other kids. Sometimes we would all play together at the courts!! I miss that... Heck, Dad, all I need is a little air for 60 minutes of play each day. Please ?? I heard basketball is BIG in Indian Country.



P.S. Get ideas. Get involved. Get going at letsmove.gov/indiancountry.



DISTRICT of COLUMBIA NURSE

Edition 37

INTERIM DIRECTOR, DEPARTMENT OF HEALTH
SAUL M. LEVIN, MD, MPA

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Address Change? Name Change? Question?

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

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

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

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

HAPPY NATIONAL NURSES WEEK



Saul M. Levin, MD, MPA

Dear Nurses of the District of Columbia:

In recognition of National Nurses Week, I wanted to let you know how much I appreciate all the work and effort you put into serving the residents of the District. The theme of this year's National Nurses Week is Delivering Quality and Innovation in Patient Care. Nursing is often described as an art and a science, and the nurses of the District, on a daily basis, demonstrate excellence in nursing practice and a creativity for communicating with diverse populations.

Nurses have a special understanding, a special touch, and a special heart. Our world would not be the same without you. Please accept my warmest regards and appreciation.

*Sincerely,
Saul M. Levin, MD, MPA
Interim Director
DC Department of Health*

On behalf of the District of Columbia Board of Nursing, I hope that you enjoyed your National Nurses Week celebration! As National Nurses Week approaches each year, you should be celebrated by your employers and colleagues across the city, and feel fulfilled in your role as a District of Columbia nurse. I often have patients ask why I became a nurse, or how I knew I wanted to be a nurse. When I was about thirteen years old my mother took me to volunteer at the local hospital for the summer as a Candy Striper. My mother thought it was a good way to teach the responsibilities of a job, while also showing how rewarding it could be to help others. You would think transporting people in wheelchairs around the hospital or offering magazines and drinks to patients was a deathly feat the way I acted on the drive in to the hospital my first day. I was nervous, and as often it happens, without reason. I quickly grew to love being a Candy Striper. I found I enjoyed talking with patients and helping people find their way around the hospital. That is when I decided I wanted to help people when I was older.

Here I am, years later and my Candy Stripe uniform is replaced with scrubs, and I am an Oncology nurse. I love what I do and realize I am very lucky in that regard. I love caring for people, and volunteering taught

me that. For the past 5 years, I have volunteered my time with the Board of Nursing and am giving back to the profession that has become my calling.

I urge my fellow nurses to encourage young people in their communities to volunteer at their local hospital, clinic, doctor's office, or care center. Getting young adults involved helps the community and themselves, and who knows - may even shape a career. We were very happy to have so many student nurses attend our April meeting, and we encourage more schools to do the same.

The Board has approved a restructuring which will affect our meeting schedule. We will have a full Board meeting every other month, in which the public can continue to attend our Open Sessions.

We had a full Board meeting this month. The next meeting of the full Board will be in September. On the alternating months, our Board subcommittees will meet to help the Board function more efficiently. These subcommittees consist of Board members and Board staff and are Practice/Legislative, Regulation, Education, and Discipline. It is up to the subcommittee if they would like any part of their meeting to include an advisory group or public comment, as it has been helpful in the past. If that occurs, ample notice will be given to the public and appropriate



Mary Ellen R. Husted, RN, BSN, OCN

persons, so that they can join. The discipline committee will meet on a separate day, and those sessions will be closed. At any time, the committees can choose that a matter returns to the full Board for discussion and vote.

Again, thank you to our nurses for your dedication to your profession and to your patients. Service positions are for the greater good and are often overlooked. Sometimes when you are doing something really hard, someone recognizing it can make a difference. At the Board of Nursing, we want you to know you are recognized, appreciated, and we are grateful. Together, let us continue to keep our residents of the District safe. ■

Mary Ellen R Husted, RN, BSN, OCN
Chairperson
DC Board of Nursing

Board Restructuring

As of June 2013, the full Board of Nursing will be meeting on the first Wednesday of every other month, and its members will divide and meet as subcommittees on the alternate months, on every other first Wednesday. Open Session will be held at full Board meetings only.

To facilitate the work of the board, the board established sub-committees (see below). Sub-committee recommendations will be submitted to the full Board for approval.

Board sub-committees began meeting in May 2013. The full board will meet again June 2013.

Sub-Committee meetings are not open to the public. Board meetings, with Open Session, will be held in June, September and November. Please plan to join us.

The meeting schedule is as follows:

SUB-COMMITTEES

May 1, 2013

July 3, 2013

October 2, 2013

December 4, 2013

FULL BOARD

June 5, 2013

September 4, 2013

November 6, 2013

Below are the four subcommittees of the Board of Nursing:

EDUCATION COMMITTEE

- Conduct Site Visits with nurse education consultant
- Interview and approve new Directors for Nursing Educational Programs (RN/LPN and NAP)
- Review and approve the evaluation of applications for new nursing or NAP programs
- Review problematic CE Audit submissions
- Amend Education Program Regulations
- Draft NAP Education Program Requirements

REGULATION COMMITTEE

- Draft and revise regulations
- Review comments from published proposed regulations

PRACTICE/LEGISLATIVE COMMITTEE

- Address practice issues by draft an advisory opinion or by convening an expert panel to draft recommendations.
- Review and draft comments regarding legislation impacting nursing practice.
- Convene a Taskforce to research and draft a white paper on nursing practice issues.

DISCIPLINE COMMITTEE

(Meets every 3rd Wednesday at 9:00 am)

The Discipline Committee is authorized to:

- Determine the sanction that will be imposed upon a licensee or applicant.
- Request the Office of the Attorney General to issue a Notice of Intent to Discipline.
- Reinstate the license of a licensee currently suspended or revoked. ■

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

Date: First Wednesday of every other month.

Time:

9:30 a.m – 11:30 a.m.

Location:

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

Transportation:

Closest Metro station is Union Station.

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

June 5, 2013

There is no August meeting

September 4, 2013

November 6, 2013

New Board Members (Part 2)

WINSLOW B. WOODLAND, RN, MSN

Why and how did you get involved with the Board? What sparked your interest in service as a Board member?

Nursing practice issues, particularly those that impact how external influences drive nurses' work, have always interested me. Attending the board meetings and seeing first-hand how parties present their particular interests often without careful regard for others really interested me.

Can you tell us (briefly) about your background?

My first nursing experience came when I was a little boy and had the opportunity to assist my great-grandmother with her bedpan at home. I wasn't afraid, embarrassed, or reluctant to help her. I loved her and today believe love for people assists nurses to succeed. Years passed and I find myself working in maintenance of one of the largest hospitals in DC which opened up applications for Acute Care Technicians. I met some very skilled nurses who served as instructors and prepared us with theory and a practicum during our 8-hour days. I worked a medical surgical unit with some of the most compassionate, hard-working, and dedicated nurses I have encountered to date. They encouraged me to go to school and I attended the University of the District of Columbia earning an Associate degree in 1994 and Baccalaureate degree in 1997 and a Master's of Science degree in 2006 from Walden University. My



Winslow B. Woodland, RN, MSN

first RN position was working in psychiatric nursing. After 11 years, I moved into developmental disability nursing and have been working with that specialty for the past 7 years.

What unique perspective do you bring to the Board?

Having worked as a technician, staff nurse, team leader, nurse manager, and program manager has afforded me varied vantage points. This drives my decision-making process when considering regulation, discipline, and also working for people living with mental health and/or developmental disabilities has afforded me opportunity to advance and stretch my medical surgical, psychiatric and mental health, hospice and community health education, training and experience to new heights. I have to stay current as health care delivery and expectation and outcomes change. An example can be seen in the movement to insure those living with mental illness and/or developmental disability are supported in the least restrictive setting possible without compromising their health. Nurses working with these people have to be balanced and open minded when it comes to community-based settings.

What Board-related issues interest you the most?

The interaction with board members from various professional vantage points and experience is very interesting. Often nurses are limited in their interaction with nurses from other specialty areas, but the board has a varied group.

Is there any aspect of your service as a Board member thus far that has surprised you? Has the experience been what you expected it to be?

The most surprising aspect to date has been the number of practice issues that result in the nurse being referred to the board for discipline. Many of these have cemented in my view the importance of having a board of nursing with a varied membership. Also, I am also surprised that nurses would chance being audited and not complete their continuing education hours. Continuing education provides the nurse with an opportunity to stay current and reinforce knowledge.

Continued on page 8

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JACKSONVILLE
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SCHOOL OF NURSING

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U.S. News & World Report

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What would you tell someone thinking about applying to serve on the Board?

The work is truly rewarding and if interested make certain you can give the time as most of the preparation takes place prior to the monthly board and committee meetings. It's not just showing up to meetings and offering opinions. There is work.

Any message you would like to convey to licensees?

Honor your commitment to this noble and honorable profession. Commit to staying current on issues within your specialty and legislation and regulations that affect healthcare. Never skimp on your patients. This includes documentation, delegation, and decision-making.

VERA WALTMAN MAYER, JD

Why and how did you get involved with the Board? What sparked your interest in service as a Board member?

My involvement with the Board of Nursing began in 2000 because of the work of the Coalition on Long Term Care, a non-profit DC organization of which I was the Coordinator. Organized in 1995 by a city-wide group of health care professionals, advocates and consumers, the Coalition's mission was to expand DC long term care services for low-income residents with chronic health care needs. To this end, the Coalition worked with the District government to develop a Medicaid waiver program, an assisted living residential program and better training, wages and benefits for nursing assistants.



Vera Waltman Mayer, JD, being sworn-in to serve on the Board, by Darryl Gorman, Director of the Office of Boards and Commissions.

Two of these initiatives involved the Board of Nursing. The assisted living residence program, adopted by the DC Council in 2000, included the need to develop regulations and a program for the training of nursing assistants to administer medication. With the expansion of the Medicaid home care program in 2002 through the DC Medicaid waiver, discussions began with the Board as to its possible role in updating training standards for home care nursing assistants.

In 2007, the DC Council adopted comprehensive legislation directing the Board to revise and integrate the training of nursing assistants in hospitals, dialysis centers, home care and nursing homes. This legislation led

the Board to begin the complex process of developing the Nursing Assistants Personnel (NAP) program and the expansion of medicine administration to trained NAP personnel. The Coalition formed a Subcommittee of providers and interested consumers to assist the Board in developing these regulations.

The subject matter before the Board is of great interest to me. I continue to be deeply impressed by the open discussions with the public on regulations, policies and community concerns at its monthly meetings.

In my previous service on the Board (2003-2009), I learned in great detail the complexity of its work and the skills required to reach agreement

and move forward. I am honored to be invited to serve another term as a consumer member of the Board.

Can you tell us briefly about your background?

As a college student from 1948-1952 at the University of Chicago, I completed work on a Bachelor's and then a Master's degree in history. My goal then was to do historical research. My first job was working in the Library of Congress as an assistant to a University professor writing a book on the use of loyalty oaths in American history. Despite the important legal and political implications of the study, I realized I wanted to do direct work in public policy.

To realize this goal, I began the study of law at George Washington University at night, while working by day for the Senate Committee on Antitrust and Monopoly in its extensive investigations of the drug, steel and automobile industries. One result of these investigations was the adoption of legislation supporting generic drugs. After the experience on the Hill, I directed the legislative work of several non-profit organizations. Each had a distinct agenda: protection of migrant farm workers, passage of Medicare legislation and increase in the Federal minimum wage and extending its coverage. A high point of the minimum wage campaign for me was arranging the testimony of Eleanor Roosevelt before the Senate Committee on Labor and Public Welfare. During that work, I met Arnold Mayer who was testifying on the Federal minimum wage legislation as the representative of a labor organization. We married in 1959.

In 1967, I completed the law degree and was admitted to the DC Bar. I worked at the DC Legal Service of the

Poverty Program on public policy. While raising two daughters, I had a private law practice focused on family law.

As I experienced the more traditional aspects of law practice, I explored the growing field of alternatives to litigation. I was trained as a mediator by the DC Superior Court and volunteered for several years as a mediator while working with a committee of the DC Bar to develop new programs for the DC Superior Court. When the DC Superior Court began to develop a program on alternatives to litigation, I worked on the Court staff to develop mediation in the Small Claims Court and an information center.

As part of the interest in resolving disputes without litigation, Ombudsmen programs were springing up in various fields. The Federal government initiated a Nursing Home Ombudsman program to help resolve the large range of disputes in the expanding nursing home industry. I was hired by Iona Senior Services, a DC non-profit community based organization, to be the Nursing Home Ombudsman for nursing homes and community based residential services in northwest Washington, DC.

My experience in nursing homes put me in contact with advocates for the development of alternatives to nursing home placement. The widespread and growing interest in alternative long term care systems enabled me to organize a group of health care providers, advocates and consumers as the DC Coalition on Long Term Care to develop programs for the District. We worked with the DC government on the creation and implementation of a Medicaid waiver program to expand home

care, an assisted living residential program and to improve the training, wages and benefits of long term care workers.

What unique perspective do you bring to the Board?

There are several perspectives which I bring to the Board: practical knowledge of long term care issues and the DC governmental and non-governmental DC agencies involved; experience on medical ethics panels in hospitals, nursing homes, community agencies and the DC Superior Court; advocacy for seniors and persons with disabilities; advocacy to improve the working conditions, wages and benefits of professionals and para-professionals in health care settings and other settings.

What Board-related issues interest you the most?

At this point, I am especially interested in the Board's role in implementing the complex and innovative regulations of Nursing Assistive Persons. The careful administration of these rules promises improvement in health care services in a variety of health settings as well as the enhancement of opportunities for advancement for nursing assistant personnel in the expanding health industry. As part of my legal training and concerns, I have been very interested from the beginning in the Board's role in administering the required Criminal Background Check for licensed health care personnel.

Is there any aspect of your service as a Board member thus far that has surprised you, or has the experience been what you expected in to be?

The one function of the Board

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which surprised me when I first went on the Board was its role in the disciplining of nurse personnel. As my contact with the Board from the beginning had centered on programs and regulations, I was totally surprised at the Board's important role in disciplining its constituency. I admired the Board's careful consideration and discussion of all aspects of the cases before them. I also deeply appreciate the work of the Board's Committee on Impaired Nurses (COIN) providing a path back to health and work.

What would you tell someone thinking about applying to serve on the Board?

I would explain that service on the Board is an extraordinary opportunity to work with people dedicated to improving health care by upholding high standards of professional performance. The Board of Nursing offers participation in a governmental agency charged with making informed and often difficult decisions on developing regulations, policies and disciplining its licensees. The difficulties of the work are ameliorated

by the extraordinary openness and transparency in the way the Board makes decision on regulations and policies combined with its careful consideration given to disciplinary procedures.

Any message you would like to convey to licensees?

I would want to convey to licensees that any professional concern raised with the Board of Nursing and its staff would be treated with respect, fairness and knowledge based on many years of experience in dealing with a wide range of problems and issues in the field. ■

Attention All Mandatory Reporters

The Department of Human Services, Family Services Administration, Adult Protective Services (APS) has published a Mandatory Reporter's brochure and developed an accompanying curriculum. This is a District-wide initiative to better protect our vulnerable adult population 18 years and older, while informing and increasing awareness with regard to mandatory reporting of abuse, neglect, self-neglect and financial exploitation. According to District Law §7-1903, all Mandatory Reporters **must immediately report** all suspected incidents of abuse, neglect, self-neglect or exploitation to Department of Human Services, Family Services Administration, Adult Protective

Services (APS). Contact APS by dialing **(202) 541-3950** 24 hours a day, seven days a week. The implementation of the curriculum is scheduled to occur in two phases. Phase I (instructor led will be available through District Columbia Department of Human Resources by late summer). Phase II (web based) is expected to be available online by the end of the current fiscal year (September 30th).

For more information, please contact Dr. Sheila Jones, Chief, Adult Protective Services, (202) 299-2155, sheilay.jones@dc.gov or Patricia Evans, Senior Advisor, Department of Human Resources, (202) 442-9639. ■

**IMMEDIATELY REPORT ABUSE, NEGLECT,
SELF-NEGLECT, OR EXPLOITATION TO APS
(202) 541-3950
24 hours a day/7 days a week**



Dr. Sheila Jones



Speaker Donna Mooney, RN, MBA, addresses the new board members of the Health Regulation and Licensing Administration.

Board Member Training

The new Board members of the health professional boards gathered for a Board Member training session with speaker Donna Mooney, RN, MBA, who is currently Manager of Disciplinary Proceedings for the North Carolina Board of Nursing.

“It is an honor to serve on the Board and to protect the public,” Ms. Mooney said, to which she added, “and a license is a privilege.” She informed attendees that it is not the Board’s role to advocate for the licensee or for the complainant. “Our role is to conduct a fair and equitable investigation. In decades past, however, she said that boards routinely did not hold hearings or give licensees due process. “The complaint was taken at face value, and the license was taken away for two years.”

To be an effective and ethical Board member, there are some rules. Ms. Mooney warned Board members: “Do not discuss Board cases outside of the Board meeting.” Not in public, not on the phone, not if the individual nurse involved asks for advice. Cases should not be discussed in the hallway, or in the restrooms, during Board breaks. Board members should also NEVER

say ANYTHING to the press. The DOH’s public information officer should speak to the press.

She advised Board members to be prepared, be on time, to be alert at Board functions. She also warned that Board members should not be moved at hearings by a licensee’s tears—but by the facts of the case.

Ms. Mooney also discussed the history of regulation, the role of a Board member, the role of the Board staff, the Discipline process, the Administrative Procedures Act and its implications for Board actions, criminal background checks, continuing competence and trends in regulation.

If you are thinking of applying to serve on a Board, please be prepared for the:

Time Commitment: If Board members do not show up for meetings, the Board cannot function. The Board cannot function without a quorum.

Emotional Commitment: Serving as a Board member can be emotionally taxing because when you are taking action to remove a license, you are impacting that

IF YOU ARE CALLED TO APPEAR BEFORE THE BOARD:

- Be Honest
- Carefully think about what you want to say—be coherent and logical
- Know that the Board is not out to get you
- Be remorseful if you are indeed at fault

licensee’s livelihood. Board actions can have long-range consequences. It can mean lost employment down the line for the individual.

Possible Backlash: When you take action as a Board member, please keep in mind that no matter what you do, someone will be displeased—either the complainant or the licensee.

Expect the Unexpected: Ms. Mooney said that once she witnessed a nurse pop a Vicodin while on the stand during a hearing.

Donna Mooney has held many clinical and administrative nursing positions and performed State Bureau of Investigation criminal investigations for suspected drug diversion. ■

IN THE KNOW: Home Health Aide Certification Forum

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



Home Health and Staffing Agency representatives.

On February 15, 2013 a forum was held to discuss the Home Health Aide (HHA) Certification requirements and regulatory requirements for agencies who hire HHAs and schools who train them. The Board of Nursing Executive Director Karen Scipio-Skinner urged agencies to ask any questions that they may have regarding the process. "There are no stupid questions," she said. HRLA Senior Deputy Director Dr. Feseha Woldu told meeting attendees that the certification of HHAs has been

mandated by the DC Council. HHAs must be competent and professional and possess moral integrity, because they provide critical services and allow elderly and disabled citizens of DC to remain in their homes. "For our seniors," he said, "the Mayor advocates Aging in Place. HHAs help us keep many of our elderly residents out of hospital emergency rooms. [HHAs are key to allowing our citizens to age in place.]

"Home health is a growing

field," Dr. Woldu said, "and we don't want the HHA regulations to be burdensome. Many current HHAs may be 'grandfathered' into certification, but we are depending on you. You are attesting to their skills. You are attesting, 'I know this HHA to be competent and professional.' You are the ones who best know their skills. Let's work together so this process is smooth."

HRLA Processing Center Manager Shelly Ford Jackson emphasized the

fact that applications need to be complete and legible. "Please place the correct information in the correct fields," she said. "We are finding that Social Security Numbers are being placed in the space designated for phone numbers. This causes delays. We are finding that names are not being listed in the correct order. First, middle, and last names are switched, and nicknames have been used. When the applicant signs a different name than the name placed on the Attestation Form, processing staff must contact the applicants. The processing center has been inundated with HHA applications, and staff have been coming in on Saturdays to input HHA names into the HRLA system. Ms. Jackson noted that there were presently 881 (at the time of the meeting) applications pending. "The number grows every day," she said.

HRLA discontinued accepting applications directly from HHAs because of fraud. "There have been fraudulent educational certificates and applications submitted. We therefore required applications to come directly from the HHA's employers, and for those applying to take the HHA examination, the HHA schools will send lists of graduates to our processing unit and to Dr. Bonita Jenkins, the education specialist for the Board of Nursing."

The waiver was extended 60 days, to May 15th. Certification by examination or endorsement are now the only ways to gain HHA certification. The waiver/grandfathering period has ended.

The list of persons certified and/or pending are on the website (hpla.doh.dc.gov). You can find all HHAs—active or pending. If they are in pending status they may continue to work after May 15, 2013.

NOTES FROM SURVEYORS:

Please be reminded to review and be familiar with DCRA District of Columbia Municipal Regulations (DCMR), Chapter 39: "Home Care Agencies"

<http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Chapter%2039-HCA.pdf>

"...the District of Columbia Municipal Regulations (DCMR), which contains provisions on inspections, licensing and enforcement actions pertaining to home care agencies and other facilities authorized under the Act. Each home care agency serving one or more patients in the District of Columbia under the auspices of the Medicare Program or the D.C. Medicaid Program shall also comply with all applicable requirements and conditions of participation of that program."

Our surveys have determined there is not consistent practice among agencies. HHAs will be certified, but you are still responsible for the care that your beneficiaries receive.

As with RNs, OTs, PTs, you must explain to the beneficiary the services the HHA will provide them. HHAs

must know the Plan of Care. What is to be done for the beneficiary? ADLs? Medication reminders? Taking them to the doctor? There has been an uptick of complaints regarding beneficiaries not knowing why the HHA is there. Individuals have called us saying, "I don't know why they are here."

Explain what the duties of the HHA are, according to the Plan of Care. HHAs are not being told their duties or the beneficiary's diagnosis. They are given a name and an address only. How is the HHA supposed to know? It is not fair to the HHA or their beneficiary if they are not given a Care Plan. The beneficiary may or may not know.

3915.8 Home health or personal care service activities that are performed by an aide shall be explained to the beneficiary by the registered nurse or other health professional, as authorized by a physician and in accordance with the plan of care.

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HRLA Surveyor Veronica Longstreth.

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3915.9 Each home care agency shall define the duties of home health aides and personal care aides

The Care Plan should be explained to both the HHA and to the beneficiary. What service is the HHA expected to offer? Meal preparation? Gait training? Grooming? Bathing? The Plan of Care needs to physically be in the home. In regard to Observing and Recording the Beneficiary's condition: The HHA sees the beneficiary more than the nurse or physician, that is the reason that their observations are crucial. The HHA's documentation doesn't have to be a novel, just something about the beneficiary's appearance. Have they lost weight? Is their gait unsteady? Are they crying? Unhappy? This should be written down. To do this documentation, some agencies have a checklist with boxes to check. Or your form can have lines for comments. Either would satisfy the regulation.

When an HHA is certified, that implies more responsibility. We have gotten calls, for instance from an 85 year old saying, 'My Aide hasn't shown up and I haven't eaten.' Remind your Aides that if they do not come in for duty and they have not called you ahead of time, their names may be submitted to the Board of Nursing. One HHA turned in work hours for a beneficiary who had been transferred to another agency. This is fraud. If the agency receives funds for those fraudulent timesheets, the



Paula Johnson of the Department of Health Care Finance.

agency will be held responsible.

When there is a medical emergency, what is the protocol? HHAs must be told what to do in case of a medical emergency. For some agencies, the protocol says that the beneficiary is to call 911. Does the Plan of Care say what the HHA should do in a life-threatening emergency? The HHA must act in a timely manner. Put on the Plan of Care what it is the HHA is to do. Some agencies have protocols which say that, in a life-threatening situation, the HHA should contact the agency, the caregiver and then 911. This puts your agency at risk. The HHA should call 911 first.

Most agencies and HHAs are doing a great job.

FEEDBACK FROM MEDICAID STAFF

EMPOWER THE HHA: HHAs should be allowed to attend conferences or meetings regarding HHA practice and regulation. Encourage your HHAs to attend. Empower the HHAs and let them know what is expected of them. Pay them. We should not get a call from an HHA who says 'I am not coming back to work tomorrow because I am not getting paid.' HHAs are calling our office because they are not getting paid and they indicate that they have told the beneficiary that they will not return due to payment issues. They should not discuss administrative issues with the beneficiary. The Director of Nursing should communicate with the beneficiary regarding administrative issues.

"Paperwork, pension matters, bills with Social Security numbers—

walking paperwork to your office—the HHA should not be doing this. Transporting paperwork is not in their job description. This private information should not be in the hands of the HHA.” HIPAA dictates that the case manager or RN should be the staff member handling the Medicaid-related matters.

Medical Emergencies:

HHAs should be given leeway when there is a medical emergency. HHAs should be allowed to accompany a beneficiary to the hospital and be paid to remain with the beneficiary until a family member can arrive. Medicaid’s representative stated “I have no problem paying for the HHA to sit with the beneficiary.” HHAs need to be empowered to do so. That is reasonable, not fraud. HHAs in the past have told us ‘I didn’t call 911 because I wouldn’t get paid.’ Nobody wants grandma in the Emergency room all alone.

The agency should provide the HHA with the phone numbers of family members and or close friends, to use in case of emergency. Conversely, the agency should let the family know that they may receive a phone call out of the blue.

Sharing family and friend phone numbers with the HHA:

The Medicaid contract states that the agency will do “anything we deem necessary” to ensure quality care. They should have the phone number of the pastor, neighbor, or granddaughter. HHAs should have access to contact information with the persons that beneficiary trusts. It was noted, “some beneficiaries have closer ties to their church’s pastor than they do to their children. The beneficiary is emotionally close to those they feel are looking out for their interest. Phone numbers of family and friends should be part of Care Plan.

Put it in the Plan of Care: Who does the HHA call if grandma falls?”

Physicians refusing to accept faxes to get Plans of Care signed:

The agency should build a relationship with that physician. Communicate with physician’s staff to determine best way to get paperwork to him/her. What is most convenient for them to receive—faxed, electronically by PDF? Have a conversation with them. Physicians are not getting paid to sign these Plans of Care. Tell beneficiary that the physician is not responding. Have a family member call the office or change physicians if not responsive.

Uncooperative physician: If the physician won’t cooperate, submit a complaint to the Board of Medicine. Show that you have made attempts to get the paperwork signed. Show the original Physician’s Order for the HHA services. Let the Board of Medicine know about repeat offenders. Physicians feel there is no incentive to sign. However, if the Care Plans are not signed on time, the agency is going to be penalized. There is a problem if the Plan of Care completed by the nurse is not signed and there is no Physician Order for that Plan of Care.

Nurses must provide follow-up: If the HHA has checked boxes or otherwise indicated “beneficiary crying” “losing weight” “refused medication,” the nurse must follow up. If indicated, contact the beneficiary’s primary care



James Brennan of the Department of Health Care Finance.

Continued on page 16



Home health agency staffer asks a question.

Continued from page 15

practitioner. Often the agency is not aware of the beneficiary's day-to-day condition. A person at the agency should review the timesheets and documentation. Discuss documentation and follow-up with HHAs and licensed nurses. If not, it is the beneficiary who suffers. The HHA should feel comfortable to call their agency with their concerns.

Engage your staff and leadership: Make sure that your staff members are competent and knowledgeable. The Department of Health offers continuing education programs that your staff should attend. Programs have been offered on respiratory care, physical assessment, and wound care, among other topics. Make sure your staff members are there.

Don't have enough HHAs on

your roster? Now is not the time to deal with sketchy people. If you don't have staff for a beneficiary, call a fellow agency. Keep in mind that you are sending HHAs into a home. Know who you are sending into the home.

HOME HEALTH AIDE Q & A

APPLICATION PROCESS

Q What happens to the applications after we submit them to your office?

A The processing center enters applicant information into the licensure system, and processing staff keeps the application until there is evidence that the CBC has

been completed. Once the CBC is complete, the application is sent to the Board of Nursing staff. The Board staff reviews the application for other issues: Was application properly signed? Is there a nursing signature and valid RN's license number on application? What is the work history? Has the 500 hours been completed? Are the training programs approved by DC or another jurisdiction?

APPLICATION QUESTIONS

Q Is there an exam waiver for new graduates?

A No. Persons completing an HHA program should be certified before you hire them. The waiver is for HHAs currently working. That is the group who may be grandfathered.

COMMENT: I am very excited about the HHA regulations. It will bring more professionalism to home health care.

COMMENT: HHAs, once certified, can be referred to the Board of Nursing for unsafe practice.

If you have HHAs associated with your agency that you deem unsafe, refer them to the Board. HHAs can also participate in the COIN (Committee on Impaired Nurses) program for substance abuse or mental health issues. It is an alternative to discipline; it is a monitoring program to ensure that participants are safe to provide care. If noncompliant, they are referred to the Board.

Q Can the HRLA provide agencies with the status of licenses? Most HHAs don't know

that the certificate is going to be sent to them directly, so they don't know a delay is occurring as to raise a red flag. They were not expecting to get the certification, so they are not aware that they have not received their certificate. Can you send a list to the agencies once applications are approved?

A We understand your concern but we cannot match the HHA with the agency once the certificate is approved. Check the pending applicants on our website. There is a backlog in the processing of applications because of the volume of applications. **Please don't tell HHAs they will be fired if they don't have certification by a certain date.** You know that we have the applications because you submitted them.

Q How many weeks does it take to get the HHA application processed?

A Due to the volume of applications it may take up to 60 days or more for applications to be approved. If you have submitted the application, it will be reviewed.

Q What does "Pending" mean?

A "Pending" means that the applicant's data has been entered into the Health Professional Licensing Administration's licensure system. Applications will be in a pending status for 60 days or longer due to the volume of applications that we are receiving. But an application may also be pending for any of the following reasons:

- CBC not completed
- CBC has positive hits and Board staff are reviewing the CBC results
- Information on the application or attestation form has to be verified; for example, there may be a problem verifying the school

Q How much time does it take to be approved to take the HHA exam?

A We cannot give you an exact timeframe. Once we receive the application with all of the required documents the applicant is notified that they have been approved to take the exam. The applicant then must *pay* for the exam, *schedule* the exam, *pass* the exam or *reschedule* the exam if they do not pass the first or second time. The certification by exam is a shorter turnaround time than certification by waiver/grandfathering. We are aware that these applicants can't work until they are certified. We don't wait for CBC to be completed. They can take the exam before the CBC is completed but they must have completed their CBC before they are certified.

Q How can we attest to training if the HHA's program has closed?

A Give us the name of the HHA and date of graduation. We have lists of graduates from most of the HHA schools that are closed.

HIRING HHAs

Q Can we hire someone whose application is pending?

A Yes, if you are hiring an experienced HHA. If they are pending for examination, no, they need to be certified before you can hire them as an HHA.

Q What will happen to "pending" applications after the May 15 deadline?

A Those applicants may continue to work. 'Pending' doesn't mean that they have had a bad CBC. It may mean that their application is still being reviewed.

PLEASE NOTE:

As of May 21, 2013 approximately 4,071 HHAs have been certified and 3,959 are pending.

CBC

Q Is fingerprinting the same thing as the CBC?

A Yes. Applicants are fingerprinted via livescan as part of the CBC state and FBI background check.

Q What happens if the applicant has a positive CBC and the Board is denying approval of their application?

Continued on page 18

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A If an applicant has a positive CBC with criminal activity in their background, which the Board deems as potentially leading to harm to a beneficiary:

The applicant is contacted and asked to submit their court record. (The CBC results that we receive only indicate an arrest or conviction, we request records from the applicant to determine the disposition of the case).

After reviewing the records and speaking with the applicant, one of the following actions will be taken:

Application approved.

Applicant asked to withdraw their application in lieu of referral to the Board for possible denial of certification.

Applicant asked to meet with Board's Discipline Committee. Committee may recommend:

Approval of certification.

Denial of certification.

If the Board's Discipline Committee recommends denial of certification and the applicant chooses not to withdraw their application, the applicant is entitled to a hearing. The disciplinary process can take several months. We will not be able to give you a specified timeline for approval.

Applicant referred to the Committee on Impaired Nurses (COIN), if evidence of substance abuse or mental illness.



Alem Ghebrezghi of the Criminal Background Check Unit.

Q How frequently do HHAs have to be fingerprinted for their CBC?

A All health care professionals licensed, certified or registered in DC are required to complete a background check every 4 years.

Q The regulations state that there are 27 crimes that HHAs cannot have in their criminal past in last 7 (seven) years.

A CBCs are reviewed and evaluated case by case. Generally, offenses that occurred more than 7 years ago are not considered, but it is a judgment call regarding whether or not to consider arrests or convictions that occurred more than 7 years ago. If the crime

was egregious it may be considered, or if there is a lengthy pattern of criminal behavior the applicant may be referred to the Discipline Committee. Each positive CBC will be reviewed based on criteria such as, the severity of the crime, was it a one-time offense or a pattern, and the age of the applicant when the offense occurred.

Q How often do HHAs have to get a CBC?

A As of now, every four years. The next CBC is slated for 2017. However, we are working on getting a 'wrap back' CBC system, which will inform us automatically of new criminal hits as they happen—so we won't have to do CBCs every four years. The state-level background check shows offenses such as DWIs; the FBI CBC provides more accurate "bigger" hits for serious crimes. ■

MagMutual Welcomes Ed Lynch as Senior Vice President of Business Development



Atlanta (November 5) – MagMutual Insurance Company, the Southeast’s foremost medical malpractice insurance company, recently added Ed Lynch to the senior management team. Appointed Senior Vice President of Business Development, Lynch will lead the sales, service and marketing divisions for the physician-owned mutual.

“With more than 17,500 insured physician-owners across the Southeast, it’s important that we serve and defend them while continuing to build a true partnership with them,” says Neil Morrell, President and Chief Operating Officer of MagMutual. “Ed’s extensive healthcare industry and liability insurance experience will enable us to continually improve our focus on creating strategic alliances, retaining and developing client relationships and leveraging the company’s leading malpractice coverage and additional product offerings to the benefit of our owners.”


Lynch brings more than 20 years of professional liability insurance experience in both the intermediary and company side of the insurance industry, almost exclusively working in the healthcare market. Most recently he was the Area Senior Vice President and Director for the national healthcare practice of Arthur J. Gallagher Risk Management Services, Inc. in Princeton, NJ. Gallagher is one of the world’s largest insurance brokerage and risk management firms.

He holds a master’s degree from the University of Pennsylvania, attended the Weatherhood School of Management at Case Western Reserve University and has a bachelor’s degree from Hiram College. Lynch is a member of several insurance and reinsurance societies and a frequent speaker on risk management topics for practitioners and their professional associations.

About MagMutual

MagMutual provides medical professional liability (malpractice) insurance in Alabama, Arkansas, Florida, Georgia, Kentucky, North Carolina, South Carolina, Tennessee and Virginia. Founded in 1982 by physicians and led by a physician Board of Directors, MagMutual is one of the largest medical liability insurers in the U.S., with offices throughout the Southeast. The company is rated A (Excellent) by A.M. Best. Visit MagMutual.com for more information. Insurance products and services are issued and underwritten by MAG Mutual Insurance Company and its affiliates.




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LETTER FROM A COIN PARTICIPANT

Here's my story on how my addiction began and has ended.

I grew up in an alcoholic environment but back then no one knew they were alcoholics. It was called relieving stress, or relaxing after work, or one for the road. I later found out that it was just a reason to have a drink.

I started out at 12 years old. Sneaking sips of beer or wine at the grown-up's party, not knowing what was ahead. It would make me silly and giggly which was fun. It also took my mind off of the abusive stepfather that I had. As I got older I tried pot. That was the thing in high school. I was afraid at first because I heard bad things about it. I was an "A" Honor Roll student, on Student Council, a majorette. Very active. Kept a summer job. Was a "God Child." When things got rough, fights between my mom and stepfather. He was mean as hell. I would smoke a joint. It took me away from the reality of it all.

After I entered college, I met a new crew. Someone introduced me to cocaine. I don't know why, but I tried it. Maybe it was the addictive behavior. I did this for a while, but became too expensive so back to drinking with cocaine on occasions. I still, however, maintained very good grades, a job, and never thought I had a serious problem. As years went by, I continued drinking more and more. I was "abinger." When I would start I couldn't stop. As I got older, I started missing work, calling in, just spiraling out of control.

"Until one day it hit me: you are out of control and your life has become unmanageable." I was scared, and didn't know what to do. I couldn't do it by myself I knew.

I prayed one night for "God to Give me the Answer." The next day I went to work and told my manager of my problem. She asked me did I really want help and I said YES!! From there I met the COIN Committee and it was the Best Thing to Happen To My Life. They were stern but caring and compassionate. Just what I needed. I got into a program. I have 17 months sobriety. I am an active member of AA, with a wonderful sponsor and group of Home Girls. I am also a Blessed Breast Cancer Survivor. Without meeting the COIN Committee, I would have none of this. But the Grace of God has helped me save myself.

I am truly a grateful recovering alcoholic and addict with such a beautiful new way of life. All praises to God for heading me to the COIN Committee. ■

-Anonymous



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New Cell Phone Policy at Test Centers

As part of the annual update to exam day processes for NCLEX candidates, NCSBN and Pearson VUE introduced a new policy regarding cell phones.

Currently, candidates agree via the Candidate Rules to not access cell/mobile/smart phones, pagers or other electronic devices during the exam (including breaks). They are instructed to keep their phones in their provided locker and are reminded that they cannot access the phones at any point during the

exam. When a candidate violates this rule, NCSBN, with the board of nursing's approval, pursues a result cancellation.

The new cell phone policy requires candidates to store their electronic devices in their locker in a sealable bag. This bag is provided to the candidate at check-in by the test administrator (TA) and is inspected by the TA at the end of the exam. The candidate is informed that any evidence of bag tampering will result in an incident, which

could lead to a result cancellation.

Provided there is no evidence of tampering with the bag, the candidate will be permitted to remove items from the bag and the TA will dispose of the bag at the test center. If there is evidence of tampering, an incident will be reported and further investigation will take place. It is our hope that this new policy will prevent candidates from inadvertently touching their cell phones, thus reducing result cancellations. ■

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Continuing Education Update

Ostomy And Fistula Workshop

The Board of Nursing offered a continuing education program at United Medical Center, focusing on ostomy care and fistula management, featuring speakers Eileen McCann, RN, BSN, CWOCN, Donna Johnson, RN, BSN, CWOCN, and Donna L. Sellers, RN, BSN, CWOCN.

Below are some tips regarding ostomy and fistula management.

- Educate the patient to become independent and self-sufficient. Reassure the patient that they are up to the challenge: "You were going to the bathroom by yourself before your surgery; you will be able to change your pouch yourself."
- Patient education is crucial, from the very beginning. Always verbalize any aspect of care. Break down teaching into manageable steps. You never know what they will retain.
- Be sure to protect peristoma skin from leakage. Provide appropriate skin barriers so you don't traumatize skin.
- Match dressing to the type of drainage present.
- Teach your patient to use gentle techniques, using skin protector wipes.
- The pouch that works for patient A will not work for patient B.

Tell patient that you will find the right pouch for him or her.

- Use care when applying wound and fistula pouch. PLEASE READ PRODUCT INSTRUCTIONS. Do not "wing it."
- Your patient will be aware of odor issues; address the challenges involved in fistula and address quality of life issues.
- Most patients will change their pouch every 4-5 days.

- There will be complications if stoma is too long, too short, in a bad location.
- Look for signs of infection.
- Your patient may have 15 to 20 years with stoma, so provide the patient with a toll-free customer service number to speak with a certified ostomy nurse.

Continued on page 24



Eileen McCann, RN, BSN, CWOCN and Lisa Khan, RN.



Donna Johnson, RN, BSN, CWOCN.

Continued from page 23

WHAT IS A STOMA?

A permanent or temporary opening made in the abdominal wall during a surgical procedure.

DRAINAGE

Leaving drainage is like leaving a baby in a dirty diaper.

TEAM WORK

It requires a whole team, as well as trial and error, to find effective treatment.

WHAT IS A FISTULA?

An abnormal communication/passage between two or more structures. Fistulas may be classified by location, complexity and volume of output.

FACIAL EXPRESSION

“Do not frown while changing pouch! It is very important to control your facial expression. You, as the nurse to that patient, represent the way the rest of the world will react to the patient having a pouch.”

EMOTIONS

Look for the patient’s emotional response. Connect the patient with support, pastoral care, psychological counseling.

A DAUNTING EXPERIENCE

“Stoma care can be daunting to even the most competent nurse.”

COLOR

1. Stoma should be red and moist—not dusky and necrotic
2. Odor can be an issue with necrotic stoma
3. Necrosis may resolve on its own or surgical intervention may be necessary



PSYCHOLOGICAL BENEFIT OF EATING

Ostomy patients may get depressed if they are not permitted to eat. Patients must obtain physician approval before they resume eating. They may be required to eat a soft diet.

PATIENT TEACHING

1. Verbalize to patient as you perform care, even in the initial post-op period
2. Begin by teaching patient to empty pouch and work end closure—when able, promote “practice”
3. Verbalize steps involved performing pouch change procedure, with patient observation
4. Provide written information to supplement verbal information
5. Videos, computers, stoma models promote “practice”
6. Provide constant encouragement and reinforcement
7. Make patient and family aware of resources upon discharge

DOCUMENTATION

Documentation is very important. The patient may have done well in the hospital, but then they may tell the visiting nurse: “No one showed me how to change it.” Patients who don’t want to change their pouch, may “play dumb.”

STOMA COMPLICATIONS

Complications can include stenosis (narrowing of opening), hernia (bulging), prolapse (increase in size), mucocutaneous separation (separation at the mucocutaneous junction), stomal laceration (bleeding), double-barreled stoma, and recessed stoma (below skin level). There can also be peristomal skin complications such as dermatitis (rash), candidiasis (fungal rash yeast infection), or injury due to improper removal of pouch, etc.

POUCH OPTIONS

- Drainable pouch for frequent emptying.
- Closed-end pouch for less frequent emptying or time when convenience is a primary concern (intimacy, travel).
- Mini-pouch for physical activities (intimacy, swimming).
- Stoma cap for patients with a descending or sigmoid colostomy who irrigate.
- Filtered drainable and closed-end pouches to minimize pouch ballooning and help odor control.
- Drainable pouch with a traditional tail clip or clipless closure.

PATIENTS CAN BE ACTIVE

- When choosing products for a patient, take into account their daily activities and the type of clothing the patient wears.
- Tell your patients that there are undergarments for swimmers available.
- Protect the integrity of the incision.
- There are different types of skin barriers: Extended wear skin barrier and standard-wear barrier.
- There are products you can put in pouch to minimize mucus formation.



Donna L. Sellers, RN, BSN, CWOCN.

THIS IS WHAT A HEART ATTACK FEELS LIKE TO A WOMAN.

(SHORTNESS OF BREATH)



Other Heart Attack Symptoms to Watch Out For:

Chest pain, discomfort, pressure or squeezing, like there's a ton of weight on you • Nausea • Light-headedness or sudden dizziness • Unusual upper body pain, or discomfort in one or both arms, back, shoulder, neck, jaw or upper part of the stomach • Unusual fatigue • Breaking out in a cold sweat

If you experience any one of these symptoms, don't make excuses for them. Make the Call. Don't Miss a Beat.

To learn more, visit WomensHealth.gov/HeartAttack



LPN Renewal Reminder

Attention LPNs! LPN licenses expire on **JUNE 30, 2013**.

To renew, go to the Board of Nursing web page at <http://doh.dc.gov/bon>.

- Enter your Social Security number and your last name. Then, on the next screen, enter a new User ID and Password.
- Once in the renewal section of the website, the screen will display your address and other personal information. Follow the step-by-step instructions.
- To pay fee, enter the credit card information for your Visa or MasterCard number.
- Printout the confirmation screen (to use until your license arrives in the mail).

- After 24 hours, verify renewal at: www.hpla.doh.dc.gov/weblookup/

Continuing Education:

- LPNs must complete 18 CEs in the applicant's current area of practice.
- Please note—only CEs obtained in the two (2) years immediately preceding the application date will be accepted.
- Do not send in CE documents to the Board unless asked to do so by the Board.
- First time renewal applicants: Continuing Education is not required for those who are first-time renewal applicants.

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Board Research on the Role of the Patient Care Tech (PCT)

This spring, Dr. Bonita Jenkins and Dr. JoAnne Joyer presented the final report of the Board of Nursing study of Patient Care Technicians (PCTs) before an audience of staff from the participating hospitals and other stakeholders. In the study, the **investigators looked at the titles, preparation and duties** of PCTs at hospitals in the District and Virginia. The goal is to determine the value and effectiveness of having PCTs in the workplace.

"We appreciate all the hard work," said Dr. Feseha Woldu, of the Health Regulation and Licensing

Administration. "Dr. Jenkins has worked diligently getting this project complete. This will go into our PCT regulations." Dr. Woldu also noted the Omnibus legislation giving the Board of Nursing oversight regarding nursing assistive personnel (NAPs). This legislation is necessary because the Board has been tasked with regulating NAPs whose roles vary greatly from facility to facility. **The fluidity of NAP titles and duties can cause problems for nurses** who are often rightly unsure if certain tasks can be delegated to various NAPs. ■



Bonita Jenkins, EdD, RN, CNE

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It's one thing to work with a healthcare provider that treats symptoms. But it's quite another to work directly with individuals in your community to help improve their health, and create lasting solutions. This is a unique position—and a rare opportunity to offer the patient education, care management, and care coordination others will need to learn in order to maintain healthier habits—and build longer, happier lives.

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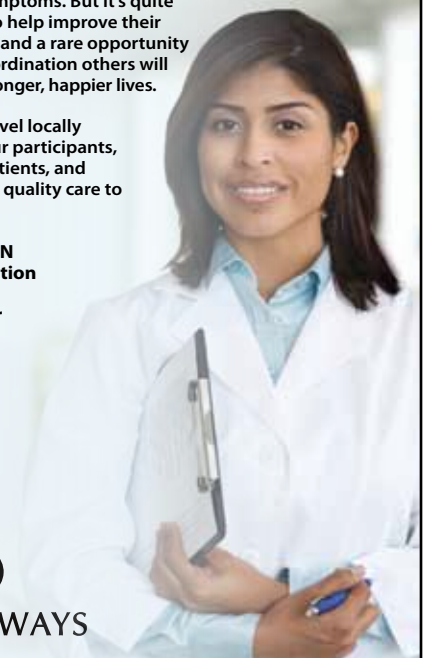
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Hair, Heart & Health:

Barbers Connect with Clients with Nursing Services



Seeking Barbershop

Do you know a barber? Please inform your local barbershop owner that the Hair, Heart & Health program is seeking another shop to participate. Interested barbershop owners may email Carmen Berry at Carmen.A.Berry@medstar.net.

The Hair, Heart and Health program is tapping into District barbers' community connections to guide DC residents toward cardiac awareness, screenings, better health habits, and resources. The Department of Health has joined forces with MedStar Health, Washington Hospital Center, and AstraZeneca HealthCare Foundation to equip a group of DC Barbers with the training and resources to help address the risks posed by heart disease and stroke in Washington, DC. Barbershop operators provide blood pressure screenings, urge clients to develop cardiovascular disease awareness, as well as self-management education. Through Hair, Heart and Health, men

in DC gain more power to prevent heart disease, diabetes and stroke. In addition, the www.eHealth2go.com website allows barbershops to guide clients toward maintaining personal health records online. So far, more than 750 DC residents have

participated in the program. Through the program, barbers are trained to screen for high blood pressure, take measurements to determine body mass index, and to provide medical referrals to health care professionals. ■



Nurses in Program

Suzette Van Buren Hayes, RN

Keyoana White, LPN

Kudos!

DC Board of Nursing member [Cathy A. Borris-Hale, RN, MHA, BSN](#), has received a promotion to Chief Operating Officer/Chief Nurse Executive at Specialty Hospital of Washington – Hadley. ■

Janice Johnson Selected as Black Nurse of the Year

This spring, **Janice M. Johnson, BSN, RN-BC**, Director of Nursing at Carroll Manor Nursing and Rehabilitation Center, was honored at the 2013 Annual Salute to the Black Nurse of the Year and Scholarship Awards Luncheon sponsored by the *Black Nurses Association of Greater Washington, DC Area, Inc.*

As Director of Nursing (DON) at the Carroll Manor center at Providence Hospital, Ms. Johnson is responsible and accountable for the overall management of the quality of care delivered to the residents living in Carroll Manor. Her huge responsibilities require not only clinical expertise but sound judgment, an ability to strategize as well as lead by example—all qualities that Ms. Johnson exemplifies. As a transformational leader, she has made a profound impact in education by ensuring the promotion and delivery of optimal health care to the geriatric community, the underserved as well as vulnerable populations. She is responsible for implementing research and evidence based practices that improve the quality of care to the elderly living in nursing homes. These innovative ideas have brought national and international recognition from The Joint Commission International, the accrediting agency for health care facilities and Delmarva Foundation.

Her gift of mentoring raised the standard of nursing practice by enabling nurses of all levels to receive their certification in gerontology. Her entire Nursing Administration team followed her lead and is now certified in gerontology. Her brilliant efforts have been recognized globally and were locally published in *The DC Nurse* magazine in April 2011. As a visionary at heart, she has demonstrated championship with the success of innovative ideas in



Janice Johnson, BSN, RN-BC

the areas of career ladder development for Certified Nursing Assistants. Her leadership style and professional passion are contagious attributes that have magnetized others to enter the nursing profession.

She has a passion and a spark for her profession. “I LOVE OLD PEOPLE!” she unabashedly will tell you. As a young adult living in Japan and working for the Corp of Engineers, she came to appreciate the reverence for the elderly that is so engrained in the culture. This experience coupled with her love of nursing and the elderly, inspired her to visit China on a nursing tour to gather more data on Asian cultures in caring for the elderly. Her enormous knowledge capacity for acute and long term care allowed her to serve as the ambassador to effectively communicate a model or resident-centered care in implementing Joint Commission International standards for long term

care in Asia. She used these practices at Carroll Manor to enhance culture change initiatives and to create a more home-like environment, thereby improving the quality of life for the elderly living in nursing homes. As a result, her vision enabled her to be an instrumental force in assisting a Japanese health care team to become the first nursing facility in Asia accredited by Joint Commission International in April 2012.

Ms. Johnson has been recognized as Nurse of the Year (1999) Providence Hospital; Lexington Who’s Who Award (1999/2000); 100 Extraordinary Nurses Award (2006) Sigma Theta Tau International Honor Society Gamma Beta Chapter; Employee of the Month (2007) Providence Hospital; and Employee of the Year at Providence Hospital in 2007 among others.

She received an Associate degree in nursing from Prince George’s Community College in 1982 and relocated to Honolulu, Hawaii, where she lived and practiced nursing for 4 years. Married to a military man, she relocated again and continued her nursing practice in the Washington DC area. She joined the Providence Hospital family in 1988 where she served in various capacities and transferred to Carroll Manor in 2006. She achieved a long time professional goal by earning a Bachelors of Science degree in Nursing from Chamberlain College of Nursing in 2010, graduating with President’s honors. One of her most proud accomplishments is when she received her national board certification in gerontology in 2012.

She is married to John (JJ) Johnson, lives in Largo, Maryland, and has three cherished grandchildren. In her spare time, she loves to travel and enjoy life. ■

Board Disciplinary Actions

NAME	LICENSE #	ACTION
Denise Bain	RN1025455	Summarily Suspended
Jasline Jesson	RN1023884	Summarily Suspended
Jennifer Reid	RN1026065	Suspended
Dedicated Care, LLC	NSA-0179	Revoked
Prime Consulting Staffing, LLC	NSA-0311	Revoked

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

Non-Public Disciplinary Actions:

Notices of Intent to Discipline	3
Referrals to COIN	1
Consent Orders	17
Requests to Withdraw Application	4
Requests to Surrender License	1
Letters of Concern	1
Licensure Denied	0

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.

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 ATTORNEY AT LAW

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

Please contact Izu I. Ahaghotu, RN, Esquire directly:
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MedStar Georgetown Lombardi Comprehensive Cancer Center and John Theurer Cancer Center, part of Hackensack University Medical Center, have recently established an oncology affiliation agreement that will bring a new blood and marrow stem cell transplant program to MedStar Georgetown.

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