

NURSE

REGULATION EDUCATION PRACTICE



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District of Columbia
Vincent C. Gray, Mayor



**INSIGHTS FOR
CERTIFIED NURSING ASSISTANTS (CNAs)
(See page 20)**



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DISTRICT of COLUMBIA NURSE

Edition 34

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Address Change? Name Change? Question?

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

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

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

Message from the Chair



E. Rachael Mitzner, BSN, MS, RN

One goal of the DC Board of Nursing is to regulate nursing practice effectively as changes occur, and trends present themselves, in the greater society in which we practice. Technology is advancing so rapidly that many aspects of nursing practice—such as patient care, communication, nursing roles and ethical issues—sometimes get tangled in technology's web. Medications are more sophisticated, surgery is less invasive, people are living longer and the internet has made the world a much smaller place to live and work in. I don't know about you, but when I was in nursing school, I had no idea that someday something called "Twitter" or "Facebook" would impact our practice and be a threat to patient confidentiality. If you spoke to me about obsessive tweeting, back then I would have thought it involved birds outside of the window.

Please take a few minutes and go to page 14 to read the article entitled "Social Media: Are You on Facebook, Twitter?" as well as our excerpt from the National Council of State Boards of Nursing (NCSBN) "White Paper: A Nurse's Guide to Use of Social Media." Many nurses these days possess a Facebook page, or have a cell phone with a camera in it, or tweet. In a society where using Facebook and Twitter to communicate are second nature, nurses must be aware that using social media to communicate to and about patients could pose a threat to their nursing license. These articles are especially important information for nurses who have grown up in the age of internet communication. Information shared on the internet is viral in seconds. When we share information through social media we can no longer control who reads, shares or responds to our communications. As healthcare providers, we must remember to honor patient's rights and confidentiality and ensure that there is a "firewall" of privacy

protection between our high-tech devices and our patients.

In a world of high tech care we must be able to discern when technology should and should not be accessed. This point is brought home in the article, "Swallowing Disorders & Guidelines for Enteral Feeding," on page 24. At a recent continuing education program on this topic, Speaker Sonja Wyche, MD, addressed the ethical dilemma posed when a patient in hospice can no longer swallow, or chooses not to eat. Using Enteral feeding tubes and pumps (technology) may not be appropriate in those circumstances. In this article, we are reminded of the physiology of swallowing and strategies for helping our patients take nutrition orally as long as practicable. Many of the swallow strategies and guidelines discussed can be practiced not only by RNs and LPNs, but also by Certified Nursing Assistants (CNAs).

As you may know, the Board now has authority over CNAs and other Nursing Assistive Personnel (NAPs). CNAs are an essential part of healthcare for the District's vulnerable elderly. The Final Regulations for HHAs was published on Friday, July 13th. This is the first of the new regulations which will guide the Board in ensuring safe care is given at every level of nursing care.

On page 20, you will find the article "Insights for Certified Nursing Assistants," covering the Board's recent continuing education program for CNAs. As one CNA attending the program told DC NURSE, "We are the resident's CNA, their friend, long-lost daughter, psychiatrist, cook and fix-it person." Speaker Mary Sklencar, RN, discussed issues associated with CNA professionalism, standards and boundaries with their residents.

Are you aware of a CNA, RN or APRN whose practice is impaired? Our "COIN CONSULT" column in this issue on page 12 is a concise introduction to the Committee on Impaired Nurses

(COIN) and its mission. Tear it out and pass it on, or post it, to bring this valuable information to your colleagues or supervisor. Let us know if you would like a Board staff member to come to your facility to give a talk about COIN.

In response to the challenges of the Criminal Background Check process (see page 8), our licensure renewal deadline for RNs and APRNs has been extended to August 30th (see page 7).

In conclusion, I would like to take this opportunity to salute each of you for the dedicated care that you offer to your patients every day, and to recognize the DC Board of Nursing and the Board of Nursing staff for recently being awarded NCSBN's TERCAP® Award! For more information about the award and the TERCAP® program, please see our Board Update on page 6.

Please read your DC NURSE. The Board of Nursing strives to make information available, but we need your help in making sure nurses in the District know what is happening.

The Board of Nursing embraces the challenges and changes technology brings to nursing practice. It is only through educational and technological growth that nursing will be able to thrive. As nursing practice changes we must stay true to our nursing values, and not be afraid to challenge others to live up to our vision for nursing's expansive and dynamic future. ■

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

Board Update

MAY, JUNE 2012

PETITION FOR DECLARATORY ORDER SUBMITTED BY THE DISTRICT OF COLUMBIA ASSOCIATION OF NURSE ANESTHETISTS

Issue:

The District of Columbia Association of Nurse Anesthetists requested that the Board of Nursing issue a declaratory order holding that certified registered nurse-anesthetists, or any advanced practice registered nurse may not, in a clinical context, participate in the training or supervision of non-nursing students.

Board Response:

According to the Health Occupations Revision Act of 2009 (HORA), Anesthesiologist Assistants practice under the supervision and direction of an anesthesiologist. Therefore, in the opinion of the Board of Nursing, their training and supervision should be under the direction of the anesthesiologist.

NURSING ASSISTIVE PERSONNEL UPDATE

A meeting was held June 29th with Home Health Agencies, Assistive Living Facilities and Home Health Aide Education Programs to provide an overview of the Board's proposed Home Health Aide Regulations.

The Home Health Aide is one of several Nursing Assistive Personnel placed under the auspices of the Board of Nursing as defined in HORA §3 1201.02(7B).

Issues discussed at the meeting included the following:

Requirements for Current Home Health Aides

The Board will waive the training and examination requirements for persons currently practicing as an HHA provided that the applicant demonstrates, to the satisfaction of the Board, that he or she has been performing the functions of an HHA on a full-time or substantially full-time (a minimum of one thousand (1000) hours per year basis) provided that the HHA complies with the following:

- (a) Has completed a Board approved HHA training program;
- (b) Provides a statement from a supervising nurse or health care professional, indicating the applicant's continued competence to provide care;
- (c) Has worked as an HHA for a period of at least ninety (90) days immediately preceding the date these regulations are published as final;
- (d) Submits an application no later than one hundred eighty (180) days after these regulations are published as final rulemaking; and
- (e) Submits a letter from an employer certifying the applicant's ability to perform specified skills.

Home Health Aide Tasks

Under the supervision of a licensed nurse or health professional the HHA may perform the following new tasks:

- Empty and change colostomy bags and perform care of the stoma;
- Clean around a g-tube site;
- Administer an enema;
- Administer oxygen therapy; and
- Administer medications, provided that the HHA has received the *medication administration training and obtained certification as a medication aide.

*The Board of Nursing is currently drafting Medication Aide-Certified regulations.

List of Criminal Offenses to be Reviewed (consistent with current legislation):

- (a) Murder, attempted murder, or manslaughter;
- (b) Arson;
- (c) Assault, battery, assault and battery, assault with a dangerous weapon, mayhem or threats to do bodily harm;
- (d) Burglary;
- (e) Robbery;
- (f) Kidnapping;

Continued on page 6

NON COMPLIANCE WITH CONTINUING EDUCATION (CE) REQUIREMENTS

Board sanctions regarding CE compliance

Non-compliance with CE requirements include persons who have:

- Indicated on their renewal application that they have completed their CE but have not provided evidence of completion.
- Completed CE requirements prior to or after renewal period.
- Submitted information that is non-compliant with requirement, i.e., in-service courses rather than continuing education courses, insufficient number of CEs.

Sanction

Negotiated settlement agreement: \$500 fine, complete required CEs and NCSBN Ethics course in addition to required CE within 60 days of receipt of letter.

No response to CE audit notice or settlement agreement:

Persons in this category will receive a *Notice of Intent to Discipline

[*Disciplinary decisions made by the Board after issuance of a Notice of Intent to Discipline are reported to NURSIS and the National Practitioners Data Bank.]

PLEASE NOTE: A Continuing Education Audit will be initiated following the RN/APRN renewal period. If you have moved and we are unable to reach you, your lack of response will be considered in the "No Response" category.

Continued from page 5

- (g) Theft, fraud, forgery, extortion or blackmail;
- (h) Illegal use or possession of a firearm;
- (i) Trespass or injury to property;
- (j) Rape, sexual assault, sexual battery, or sexual abuse;
- (k) Child abuse or cruelty to children;
- (l) Adult abuse, neglect or exploitation; or

(m) Unlawful distribution or possession with intent to distribute, of a controlled substance.

HOME HEALTH AIDE TRAINING PROGRAMS

HHA Training Program requirements:

- (a) Must use Board of Nursing model curriculum which will have a minimum of 125 hours of didactic and clinical

training consisting of 65 hours of classroom instruction, 20 hours of laboratory and 40 hours of clinical

- (b) May include bridge course for CNA to be trained as HHA: Total of 32 hours – 16 hours of classroom and laboratory, and 16 hours of clinical
- (c) Will be re-evaluated yearly
- (d) Must provide admission criteria
- (e) Must maintain a ratio of clinical instructors-to-trainees not to exceed 1 instructor to 2 HHAs.

DISTRICT OF COLUMBIA BOARD SELECTED AS A WINNER OF THE 2012 NCSBN TERCAP AWARD.

The *Taxonomy of Error, Root Cause Analysis and Practice-responsibility* (TERCAP®) Award ceremony was held on June 4, during the 2012 NCSBN Attorney/ Investigator Conference in Fort Lauderdale, Florida. Felicia Stokes, BSN, JD accepted the award on behalf of the Board.

TERCAP® was designed as a uniform process to better distinguish human errors from willful negligence and intentional misconduct. The TERCAP® Instrument was developed to describe and distinguish types and sources of nursing errors in an online computerized database. Through identification, analysis and tracking of practice breakdown, generic patterns in error, risk factors, and system contributions can be identified.

Ms. Stokes, DC BON Nurse Consultant, said "The District of Columbia Board of Nursing is excited to be the newest member of the TERCAP® community." Implementing TERCAP will assist the Board in its focus on safe medication administration, documentation, preventions, professional responsibility, among many other notions of good nursing practice. This type of analysis will facilitate strategic interventions to minimize the risk factors that may endanger patient safety. ■

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Photo by Ed Yourdon

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 - 40 credits for RN licensure
 - 80 credits remaining
 - 28 credits RN to BSN courses
 - 52 credits remaining
 - 3 credits for required statistics course
 - 49 University general education credits remaining

School of Nursing
One John Marshall Drive
Huntington, WV 25755

rntobsn-nursing@marshall.edu
304-696-6751

www.marshall.edu/cohp

Registered Nurse/Advanced Practice Registered Nurse Licensure renewal extended to August 30, 2012

Your license may not have been renewed for one of the following reasons:

1. You have not completed your Criminal Background Check (CBC) Live Scan.
2. The name that you provided is different from the name under which you are licensed.
3. We have not received appropriate supporting documentation pertaining to any one of the following.

You answered "YES" to any one of the following:

- A. "CLEAN HANDS" before licensure requirements
- Owe more than one hundred dollars (\$100.00) to the District of Columbia Government as a result of any of the following:
- Past due taxes
 - Fines, penalties, or interest
 - Past due District of Columbia Water and Sewer Authority service fees.
- B. Since your last renewal:
- Have you been convicted or arrested for a crime or misdemeanor (other than minor traffic violations) not previously reported to the Board?
 - Have you withdrawn an application for licensure/certification/registration to practice your profession in any jurisdiction?
 - Has any authority or peer review board taken adverse action against

your license or privileges?

- Have you been or are you currently being investigated by any authority or peer review board for any violation of state, federal, or local law?
- Has any authority or peer review board informed you of any pending charge(s) or investigation not previously reported to this Board?
- Have you withdrawn an application to practice your profession or voluntarily surrendered a license after formal charges have been filed against you or while under investigation?
- Have you been party to a malpractice action or had a malpractice action brought against you?
- Have you been terminated or asked to resign?
- Do you have a mental or physical condition that currently impairs your ability to practice your profession?

C. You Answered "No" to:

- Will you have completed your continuing education by June 30th?

Once your license expires on August 30th you will have until October 30, 2012, to renew your license with an additional late fee of \$85.00 and complete a CBC fingerprint Live Scan. After that date, you must apply for licensure reinstatement.

Please use the web browser
Internet Explorer 6.0 or higher
when you renew online.

CONTACT INFORMATION:

Licensure renewal: www.hpla.doh.dc.gov
CBC Live Scan: www.L1enrollment.com

If you have questions or need assistance, please send email to
Gwyn.Jackson@dc.gov.

Please note: Continuing education requirements must have been completed by June 30, 2012. ■

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Allow at least 14 days after you have applied for renewal and completed background check for your licensure status to be updated.

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Regulation

CBC FAQs

Criminal Background Check Information

INTERNATIONAL APPLICANTS

Q For applicants living outside the USA, is there a place where they can get a hard [fingerprint] card or are there places internationally recommended to get the fingerprints done?

A The most common location that US citizens working abroad use is their country of residence's US Embassy office. The local police is another option. If all else fails, the FBI does allow applicants to print out the PDF version from the FBI website and use that in place of the standard cardstock. For a link to the

FBI card: <http://www.fbi.gov/about-us/cjis/background-checks/standard-fingerprint-form-fd-258>

Q Is it possible for an international applicant to complete the CBC if they are located outside of the USA?

A For all applicants, a current address within the USA will need to be provided. Our background search capabilities for the state search are not able to conduct any searches for foreign addresses. We are advising applicants to use either their last US based residential address or the address that they currently use



Community Health Center Nursing Career Opportunities

Extended Hours 5pm -10pm (FT, PT, FLOAT, PRN)

Unity Health Care Inc. is a multi-site non-profit organization offering a continuum of medical care and human services primarily to the homeless and medically underserved. In twenty five years of existence, Unity Health Care has grown to be the largest preeminent Health Care Delivery System in Washington, DC. Join Unity Health Care, where last year we made a difference in more than 80,000 DC residents' lives we served. Serve our mission, vision, values and community by applying for the following career opportunities:

- Registered Nurse Manager
- LPN- Nurse Care Manager
- HIV- Nurse Care Manager
- Registered Nurses
- Licensed Practical Nurses

Requirements: Graduate of an accredited school of nursing (PN, AAS, BSN), minimum 1 to 5 years of recent experience in medical surgical, correctional health, community health care and/or emergency care or urgent care, valid CPR certification, licensed in the District of Columbia.

We offer an attractive benefits and compensation package. Visit our Career Center for more details and to apply online at:

www.unityhealthcare.org

Unity Health Care is an Equal Opportunity Employer

in the US for any correspondence. Other than that applicants can register with L1 Enrollment/MorphoTrust and send hard cards for scanning. Once we scan the cards, the FBI search will be conducted and a request will be sent off to conduct the state search as well.

Q My understanding is that foreign candidates, who do not have a Social Security number (SSN), can use a "dummy value" which will allow the applicant to register. Is there one dummy value per candidate?

A The foreign applicants that do not have an SSN can enter all 9's as the SSN value (99999999) as the "dummy" value. This number is allowed to be entered through the registration system and allows these applicants to complete the registration. Additionally, if you or the applicants have any questions on the process please call (877) 783-4187 or email L1ESDInfo@morphotrust.com

Q We have several nurses that may be coming from the Philippines in the near future and some of them already have an active DC License and are planning to renew for June, 2012 or they had their license in an inactive status and are activating it. In both cases, they have to have a criminal background check done but they are unable to do it since they do not have a Social Security numbers. Can a National Bureau of Investigation (NBI) clearance (in lieu of criminal background check) be used for the reactivation of a license? The NBI is what immigration requires for a background check. Will this be sufficient for her to renew her license or in the case of another nurse, reactive a license?

A Other entities, such as the NBI or other boards of nursing are not allowed to provide us with the results of their criminal background checks. Therefore, the applicant will be required to do another CBC.

As noted above, applicants can complete their CBC without a Social Security Number. We will need a Social Security Number to renew and/or reactivate their licensure status.

UNREADABLE FINGERPRINTS

Q Several of our nurses have had to go back to get re-fingerprinted. They were told that if it doesn't work the second time they will have to come a third time and if that doesn't work they will have to be printed on paper. I am very afraid that it will take us a long time to get this done.

A For persons with unreadable prints, an FBI Name Search will be requested by MorphoTrust (formerly doing business as L-1 Enrollment) on behalf of DC DOH if an applicant has received two fingerprint rejections based on quality. Once MorphoTrust receives notice that an applicant has received a second rejection, a name search request form will be submitted to the FBI. ■

Please Note:
L1 Enrollment
is now
MorphoTrust.

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

BOARD OF NURSING MEETINGS

Date: First Wednesday of the 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.**

August - no meeting

September 5, 2012

October 3, 2012

November 7, 2012

December 5, 2012

IN THE KNOW

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

CONTINUING ED

Q Any suggestions as to how I can complete the necessary 24 hours of continuing education by the end of the month? Is it possible to get an extension to complete the necessary hours?

A Extensions are only granted for causes such as protracted illness or military deployment, etc. We recommend that you access CEBroker.com. There you can find hundreds of CE offerings.

MAINTAINING DC LICENSE

Q I have accepted a position in another region and I will be relocating. I am writing to get some advice on what would be the best way to handle my RN / NP licenses. The website is a bit confusing—it seems that going inactive is the same cost as maintaining an active license. I will be coming back to the area in the future so want to make sure I handle things properly. I did complete the background check.

A Congratulations on your new position. The cost is the same for renewal and reactivation. We cannot renew an expired license. Inactive status means that your license stays in that status until you decide to reactivate it. To reactivate you pay the reactivation fee, currently \$34.00, and submit CE verification.

TMEs

Q Can Trained Medication Employees (TMEs) use pulseoximetry in the home setting (the portable devices) and, also, can they administer PRN oxygen if they have the orders written in a manner that relies on the pulsox reading so there is no judgment involved?

A TMEs are not permitted to use the pulseoximetry in the home setting. Based on the current regulations, nursing assistive personnel are not permitted to measure O₂ saturation.

NO SOCIAL SECURITY NUMBER

Q On the application for the license, it states that if you do not have a Social Security number you can submit a sworn affidavit. Does this have to be notarized or can they just say "I, _____, do not have a Social Security number" and then sign it?

A It does not have to be notarized, but the letter can only be used for initial licensure applicants. The affidavit can be found at www.hpla.doh.dc.gov. However, persons applying for renewal or reactivation of licensure must have Social Security numbers.

DUIs

Q I am currently interviewing for a new position as a case manager where I will need to obtain licensure in the states wherein I am responsible for patients. I had two DUIs in the 1990s. Needless to say, I cannot drink anymore. I was able to sit for my

boards in Florida and finished my BSN. In Florida, having two DUIs is considered a misdemeanor. I am uncertain what the rules are in your state with respect to the Board of Nursing. I need to know this answer because I do not want to accept the position if my record will hinder my ability to practice within your state. Thank you so much for your time.

A The Board does not consider arrests or convictions that occurred more than 7 years ago, unless it is a serious crime such as murder or rape. And for DWIs or DUIs that have occurred within the 7 year time period, will be invited to participate in our impaired nurse program, COIN, the Committee on Impaired Nurses. Welcome to DC.

REASON FOR CBCS

Q I am at a loss to understand the reasons and rationale for the CBC fingerprinting requirement for licensure as an RN in the District of Columbia. This is the first year this has been in place and I have seen nothing to explain the reasons/rationale. Can you please respond with the information so I can better understand why this is necessary?

A Thanks for contacting the DC Board of Nursing.

The role of health professional boards is to assure that nurses are safe practitioners. Requiring CBCs for health professionals has been an eye opener. While we ask applicants to self-report arrests and convictions, we find that the information is not always provided, even when the applicant knows that we are doing a background check. CBCs are another means boards use to assure that the health professionals are safe practitioners.

Below is a quote from a National Council of State Boards of Nursing publication: "Maintaining a Trusted Profession: Nursing is the most trusted profession (Saad, 2009). Maintaining

the public's trust by providing safe and competent practitioners is paramount for BONs. With recent advances in technology, mobility of nurses from one jurisdiction to another has never been easier. This ease of travel can provide access to care where it had previously been deficient. However, mobility between jurisdictions can also allow a nurse with a criminal history to move from one jurisdiction to another to avoid discipline or criminal charges. This can create potentially dangerous situations for the public."

PALLIATIVE REFERRAL

Q At what point can a nurse determine that a referral to Palliative Care is appropriate? The Palliative Care department is telling me that only physicians can refer.

A DC does not have rules or regulations specific to palliative care referrals for RNs. You would need to comply with your hospital's policy. ■

HOME HEALTH AIDE REGULATIONS FINAL!

As we complete this edition of DC Nurse, we have been informed that the Home Health Aide regulations have been finalized. This places the regulating of HHAs under the authority of the Board of Nursing. Persons currently practicing a HHAs have until March 15, 2013 can apply for HHA Certification by Waiver of Examination. HHAs must be currently practicing as a HHA; or HHA students must be enrolled in a HHA program by August 1, 2012 to meet this requirement. The following information can be accessed at <http://www.hpla.doh.dc.gov/hpla/cwp/view,a,1195,q,502302.asp> or www.hpla.doh.dc.gov:

- o HHA Application
- o HHA Application Instructions
- o HHA Regulations
- o Social Security Number Affidavit (For applicants who don't currently have a SS #)

Persons currently working as HHAs are eligible to submit an application to be approved as a Certified Home Health Aide if they:

- Have worked as a HHA up to 1000 hours prior to March 15, 2013
- Have successfully completed a HHA training program
- Have been supervised by a licensed nurse or other licensed health professional
- Are deemed competent to practice as an HHA

After March 15, 2013, persons applying for certification as a Home Health Aide will be required pass a Board of Nursing approved HHA certification examination.

Additional information regarding the impact of these regulations will be detailed in the next edition of DC Nurse.

Please note that we are depending upon you to inform HHAs regarding this requirement. We don't have a list of HHAs so our only means of informing them is via their employees, supervising nurses and training programs.

HHA Fees

HHA Application fee:	\$50.00
Criminal Background Check fee:	\$50.00

CONTACT INFORMATION

Location/Mailing Address

Department of Health
Health Regulation & Licensing
Administration
Board of Nursing
899 North Capitol Street, NE; First Floor
Washington, DC 20002

HPLA Customer Service

Monday through Friday 8:30 am to 4:30 pm EST

Telephone: (877) 672-2174

Website: www.hpla.doh.dc.gov

Email: bon.dc@dc.gov

LETTER REGARDING ONLINE RENEWAL

Dear Mayor Gray,

I have been a registered nurse since 1984. I received my first nursing license in DC and worked at WHC [Washington Hospital Center] for 15 yrs. I don't know if you are aware of how poorly run the licensing division is in DC or not. But I think it is high time something is done about it. DC is notorious for having the most difficult licensing division. Not because of fees or paperwork or requirements to get your license, but because of the incompetence getting your license sent to you every 2 years. I keep hoping it will get better. However, this year, I once again went online to renew my license. After completing all the information and answering all the questions they required I could not get my payment to go through. I contacted the licensing department by phone. I was informed that DC will not accept payment made through a Mac [computer].????????!!!!!!?!?!?!?!?!?!?!?!?!?!?!? What????????????? It's not like I'm using a brand new system that just came out this year. COME ON.

I have dispensed so much money to the District just to maintain my licensure. Why can't DC maintain its end of the deal with an easy and competent system? Licensure has been around for a long time. I just don't understand how this department could be so incompetent for so long.....IN THE NATION'S CAPITAL. I asked to file a complaint and called the department. I got a message saying they could not take my call. I got another message saying the mailbox was full and could take no more messages. I tried to file a complaint online. But of course!!!!!! They won't accept a complaint filed on Mac. What are they doing with all my money? Going to lunch??????

-- Frustrated Beyond Compare

Board of Nursing Response: I hear the frustration expressed in your email and apologize for the difficulty that you experienced. It is challenging that Internet Explorer is the only browser that we are allowed to use. There is a message at the renewal site that states:

System Requirements: The Online Renewal and Physician Profile processes require the use of Internet Explorer 6.0 or higher. Mozilla Firefox, Safari, Google Chrome or any other browsers CANNOT be used.

Again, I apologize for the difficulty that you experienced in your efforts to renew your license.

COIN CONSULT

A Resource for Impaired Nurses

Did You Know???

By Kate Driscoll Malliarakis, RN, MSM, CNP

Our COIN Program (Committee on Impaired Nurses) is an alternative to discipline program and is one of 41 nationally. We offer assistance to nurses (RNs, LPNs, APRNs) and certified nursing assistants with substance use disorder or mental health issues. We know how hard it is to come to work when you are depressed or have some other mental health issue. Concentrating on your patients can be just too difficult. If you are using drugs or abusing alcohol, you really are unsafe to practice nursing. You should not be at work at all until you are clean, sober, and in a treatment program.

It is frightening to be so caught up in mental health or substance abuse issues. You don't think straight. You lose your ability to make good decisions. Your behavior is out of control. You get trapped inside of yourself. What can you do? GET HELP!

COIN is a voluntary program. That's what alternative programs are—an alternative to discipline program. You can get help with a referral to a mental health or substance abuse specialist. You can work with us to design a monitoring program that helps you

We offer assistance to nurses (RNs, LPNs, APRNs) and certified nursing assistants with substance use disorder or mental health issues.

keep tabs on yourself. You don't have to be alone.

What happens if you don't ask for help? More than likely, your home life is already a mess and then you begin to have disciplinary problems at work. If you are caught diverting drugs, some facilities simply fire you. By getting help before disciplinary process is

enacted, you can often save your job and your life! If you have been fired from your job, it is very difficult to access insurance benefits and getting into treatment is even harder.

Losing your health coverage and livelihood are aspects that can greatly impact your life. However, with the help of COIN, the goal is to protect the public and restore the recovering nurse to full employment. ■

By getting help before disciplinary process is enacted, you can often save your job and your life!

CONTACT COIN

Concheeta Wright is the program manager for the COIN Program. You can call her at **202 724-8870** or email her at **concheeta.wright@dc.gov**. She will be happy to assist you!!

NCLEX Candidate Rules and Confidentiality National Council Licensure Examination (NCLEX)

Part of ensuring exam security is requiring NCLEX candidates to agree to a set of rules and adhere to the confidentiality of exam content. If the candidate rules are not adhered to, candidate results can be cancelled.

CANDIDATE RULES

NCSBN would like to remind candidates that the following rules will be enforced:

- Cell phones may not be accessed at all during the exam appointment (including breaks).
- Educational, test preparation or study materials are not allowed in the testing center.
- The only material that can be written on during the exam is the

white board provided by the test center.

Any other materials brought into the test center (e.g., purses, wallets, food/drink, etc.) can be stored in a locker that can only be accessed during breaks. Visit the NCSBN website for the complete NCLEX Candidate Rules (www.ncsbn.org).

CONFIDENTIALITY

With information sharing via social media steadily increasing, candidates should be aware of and understand that **the disclosure of examination items before, during, or after the examination is a violation of law.** Violations of confidentiality and/or candidate rules can result in criminal prosecution or civil liability and/or disciplinary action.

Candidates are advised to report any such compromise to NCSBN and/or Pearson VUE at 1-866-496-2539, pvtestsecurity@pearson.com or at www.pearsonvue.com/contact/security.

TRANSFERRING NCLEX SCORES

Please note, NCSBN now has an easy process for the transference of NCLEX scores. This occurs when a nurse sits for examination in another jurisdiction and is unable to be issued a license, usually because they don't have a Social Security Number. NCLEX now has a rescind form that applicants can use. The applicant can request to rescind their request to have their NCLEX scores to go to one board and request that they be sent to another. ■

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CONDITIONAL

ARE YOU ON FACEBOOK, TWITTER, OR OTHER SOCIAL MEDIA SITES?

Improper Use Could Result in Licensure Discipline

The advent of Social Media (Facebook, MySpace, Twitter, Flickr, blogs, etc.) created new ways for individuals to communicate with each other as well as voice opinions for the world to read. Millions of people around the world use the various social media tools to invite family members to a reunion, communicate about anti-government protests (as seen in Iran last year), post photos of vacation destinations, and, on some occasions, post inappropriate images and information.

The Board of Nursing investigates written complaints to determine if a violation of the **Health Occupations Revision Act** and **District of Columbia Board of Nursing regulations** has occurred. Nationally, Boards of Nursing have reported a number of cases of inappropriate use of social media which have resulted in discipline of nurses' licenses.

Unprofessional conduct was the violation in each of the cases that resulted in discipline.

How can social media be used to lead to a charge of unprofessional conduct? A licensed nurse posted information on Facebook about her patients. While she did not use names,

she indicated where she worked (name of employer) and the unit where she worked. There was sufficient information about the patients that someone could have figured out who the patients were that she was discussing. It also didn't help that she posted the information while at work!

Nurses who are emergency nurses have seen all sorts of foreign bodies in all sorts of orifices. They also know that patient's often feel humiliated when describing the activity or situation that resulted in a trip to the emergency department. Taking pictures with one's personal cell phone of the foreign body showing on an x-ray and then sending that photo to others is a violation of patient privacy if the patient did not consent.

Facilities have policies about photography of patients and following those policies is especially important when embarrassment may result from a photo being distributed to others. What if the nurse did not take the picture but someone else took the picture? Each licensed nurse still has the responsibility for protecting patient privacy and dignity. If someone else is infringing on the patient's



privacy and dignity, the licensed nurse has a responsibility to protect the patient.

Boards also receive complaints about postings on Facebook and MySpace with photos of the licensed nurse off-duty. When you post pictures and information online, you may not think you are posting for the world to see, but you are. Word travels fast and passed along to friends of friends, and to a larger audience. Boards investigate complaints by reviewing what is on Facebook. Sometimes the postings are borderline acceptable. A photo of a

The **Health Occupations Revision Act of 2009** § 3-1205.14. specifies unprofessional conduct as a basis for discipline, Willfully breaches a statutory, regulatory, or ethical requirement of confidentiality with respect to a person who is a patient or client of the health professional, unless ordered by a court; Demonstrates a willful or careless disregard for the health, welfare, or safety of a patient, regardless of whether the patient sustains actual injury as a result;

nurse who appears drunk and posts information about how much booze they ingested or the newest drug that they tried raises concerns for many members of the public. The nurse may say that the Board has no authority to review what is done during off-duty hours. However, Boards routinely discipline nurses for behavior or conduct that occurred and ended with the licensed nurse having criminal charges.

Storytelling is common among nurses. Sharing information about difficult patients, speaking about the impact our patients have on us, and talking about difficult families helps us get through tough days. When we are treated as servants rather than professionals (room service in a hospital is different than room service in a five-star hotel!), we may want to share our frustrations with our colleagues. Debriefing with members of the health care team following a particularly difficult case may be useful to address the concerns and responses of those caring for the patient. Posting the frustration or concerns about the difficult case on social media sites could result in the reader being offended that a member of the nursing profession complains about patient care. A report to the Board of Nursing may follow.


The next time you think about posting a comment about patient care on one of the social media sites that you use, ask yourself if the same comment (or photo) would be appropriately posted on the front page of a newspaper, along with your identification as the one who posted the comment. If the answer is "No," it would not be appropriate on the front page. Do not post it to a social media site or to the internet at all.

For more information regarding social

media go to www.ncsbn.org.

Many thanks to the Alabama Board of Nursing, the source for this article. We have reprinted with modifications, citing our own regulations for DC licensees. ■





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An Excerpt from White Paper: A Nurse's Guide to the Use of Social Media

INTRODUCTION

The use of social media and other electronic communication is increasing exponentially with growing numbers of social media outlets, platforms and applications, including blogs, social networking sites, video sites, and online chat rooms and forums. Nurses often use electronic media both personally and professionally. Instances of inappropriate use of electronic media by nurses have been reported to boards of nursing (BONs) and, in some cases, reported in nursing literature and the media. This document is intended to provide guidance to nurses using electronic media in a manner that maintains patient privacy and confidentiality.

Social media can benefit health care in a variety of ways, including fostering professional connections, promoting timely communication with patients and family members, and educating and informing consumers and health care professionals.

Nurses are increasingly using blogs, forums and social networking sites to share workplace experiences particularly events that have been challenging or emotionally charged. These outlets provide a venue for the nurse to express his or her feelings, and reflect or seek support from friends, colleagues, peers or virtually anyone on the Internet. Journaling and reflective practice have been identified

as effective tools in nursing practice. The Internet provides an alternative media for nurses to engage in these helpful activities. Without a sense of caution, however, these understandable needs and potential benefits may result in the nurse disclosing too much information and violating patient privacy and confidentiality.

Health care organizations that utilize electronic and social media typically have policies governing employee use of such media in the workplace. Components of such policies often address personal use of employer computers and equipment, and personal computing during work hours. The policies may address types of websites that may or may not be accessed from employer computers. Health care organizations also maintain careful control of websites maintained by or associated with the organization, limiting what may be posted to the site and by whom.

The employer's policies, however, typically do not address the nurse's use of social media outside of the workplace. It is in this context that the nurse may face potentially serious consequences for inappropriate use of social media.

CONFIDENTIALITY AND PRIVACY

To understand the limits of appropriate use of social media, it is important to have an understanding of confidentiality and privacy in the

health care context. Confidentiality and privacy are related, but distinct concepts. Any patient information learned by the nurse during the course of treatment must be safeguarded by that nurse. Such information may only be disclosed to other members of the health care team for health care purposes. Confidential information should be shared only with the patient's informed consent, when legally required or where failure to disclose the information could result in significant harm. Beyond these very limited exceptions the nurse's obligation to safeguard such confidential information is universal.

Privacy relates to the patient's expectation and right to be treated with dignity and respect. Effective nurse-patient relationships are built on trust. The patient needs to be confident that their most personal information and their basic dignity will be protected by the nurse. Patients will be hesitant to disclose personal information if they fear it will be disseminated beyond those who have a legitimate "need to know." Any breach of this trust, even inadvertent, damages the particular nurse-patient relationship and the general trustworthiness of the profession of nursing.

Federal law reinforces and further defines privacy through the Health Insurance Portability and Accountability Act (HIPAA). HIPAA regulations are intended to protect patient privacy

by defining individually identifiable information and establishing how this information may be used, by whom and under what circumstances. The definition of individually identifiable information includes any information that relates to the past, present or future physical or mental health of an individual, or provides enough information that leads someone to believe the information could be used to identify an individual.

Breaches of patient confidentiality or privacy can be intentional or inadvertent and can occur in a variety of ways. Nurses may breach confidentiality or privacy with information he or she posts via social media. Examples may include comments on social networking sites in which a patient is described with sufficient detail to be identified, referring to patients in a degrading or demeaning manner, or posting video or photos of patients. Additional examples are included at the end of this document.

POSSIBLE CONSEQUENCES

Potential consequences for inappropriate use of social and electronic media by a nurse are varied. The potential consequences will depend, in part, on the particular nature of the nurse's conduct.

BON IMPLICATIONS

Instances of inappropriate use of social and electronic media may be reported to the BON. The laws outlining the basis for disciplinary action by a BON vary between jurisdictions. Depending on the laws of a jurisdiction, a BON may investigate reports of inappropriate disclosures on social media by a nurse on the grounds of:

- Unprofessional conduct;
- Unethical conduct;
- Moral turpitude;
- Mismanagement of patient records;

- Revealing a privileged communication; and
- Breach of confidentiality.

If the allegations are found to be true, the nurse may face disciplinary action by the BON, including a reprimand or sanction, assessment of a monetary fine, or temporary or permanent loss of licensure.

A 2010 survey of BONs conducted by NCSBN indicated an overwhelming majority of responding BONs (33 of the 46 respondents) reported receiving complaints of nurses who have violated patient privacy by posting photos or information about patients on social networking sites. The majority (26 of the 33) of BONs reported taking disciplinary actions based on these complaints. Actions taken by the BONs included censure of the nurse, issuing a letter of concern, placing conditions on the nurse's license or suspension of the nurse's license.

OTHER CONSEQUENCES

Improper use of social media by nurses may violate state and federal laws established to protect patient privacy and confidentiality. Such violations may result in both civil and criminal penalties, including fines and possible jail time. A nurse may face personal liability. The nurse may be individually sued for defamation, invasion of privacy or harassment. Particularly flagrant misconduct on social media websites may also raise liability under state or federal regulations focused on preventing patient abuse or exploitation.

If the nurse's conduct violates the policies of the employer, the nurse may face employment consequences, including termination. Additionally, the actions of the nurse may damage the reputation of the health care organization, or subject the organization

to a law suit or regulatory consequences.

Another concern with the misuse of social media is its effect on team-based patient care. Online comments by a nurse regarding co-workers, even if posted from home during nonwork hours, may constitute as lateral violence. Lateral violence is receiving greater attention as more is learned about its impact on patient safety and quality clinical outcomes. Lateral violence includes disruptive behaviors of intimidation and bullying, which may be perpetuated in person or via the Internet, sometimes referred to as "cyber bullying." Such activity is cause for concern for current and future employers and regulators because of the patient- safety ramifications. The line between speech protected by labor laws, the First Amendment and the ability of an employer to impose expectations on employees outside of work is still being determined. Nonetheless, such comments can be detrimental to a cohesive health care delivery team and may result in sanctions against the nurse.

COMMON MYTHS AND MISUNDERSTANDINGS OF SOCIAL MEDIA

While instances of intentional or malicious misuse of social media have occurred, in most cases, the inappropriate disclosure or posting is unintentional. A number of factors may contribute to a nurse inadvertently violating patient privacy and confidentiality while using social media. These may include:

- A mistaken belief that the communication or post is private and accessible only to the intended recipient. The nurse may fail to recognize that content once posted or sent can

Continued on page 18

Continued from page 17

be disseminated to others. In fact, the terms of using a social media site may include an extremely broad waiver of rights to limit use of content.¹ The solitary use of the internet, even while posting to a social media site, can create an illusion of privacy.

¹ One such waiver states, "By posting user content to any part of the site, you automatically grant the company an irrevocable, perpetual, nonexclusive transferable, fully paid, worldwide license to use, copy, publicly perform, publicly display, reformat, translate, excerpt (in whole or in part), distribute such user content for any purpose." Privacy Commission of Canada. (2007, November 7). *Privacy and social networks* [Video file]. Retrieved from <http://www.youtube.com/watch?v=X7gWEgHeXcA>

- A mistaken belief that content that has been deleted from a site is no longer accessible.
- A mistaken belief that it is harmless if private information about patients is disclosed if the communication is accessed only by the intended recipient. This is still a breach of confidentiality.
- A mistaken belief that it is acceptable to discuss or refer to patients if they are not identified by name, but referred to by a nickname, room number, diagnosis or condition. This too is a breach of confidentiality and demonstrates disrespect for patient privacy.
- Confusion between a patient's right to disclose personal information about himself/herself (or a health care organization's right to disclose otherwise protected information with a

patient's consent) and the need for health care providers to refrain from disclosing patient information without a care-related need for the disclosure.

- The ease of posting and commonplace nature of sharing information via social media may appear to blur the line between one's personal and professional lives. The quick, easy and efficient technology enabling use of social media reduces the amount of time it takes to post content and simultaneously, the time to consider whether the post is appropriate and the ramifications of inappropriate content.

HOW TO AVOID PROBLEMS

It is important to recognize that instances of inappropriate use of social media can and do occur, but with awareness and caution, nurses can avoid inadvertently disclosing confidential or private information about patients.

The following guidelines are intended to minimize the risks of using social media:

- First and foremost, nurses must recognize that they have an ethical and legal obligation to maintain patient privacy and confidentiality at all times.
- Nurses are strictly prohibited from transmitting by way of any electronic media any patient-related image. In addition, nurses are restricted from transmitting any information that may be reasonably anticipated to violate patient rights to confidentiality or privacy, or otherwise degrade or embarrass the patient.
- Do not share, post or otherwise disseminate any information, including images, about a patient

or information gained in the nurse-patient relationship with anyone unless there is a patient care related need to disclose the information or other legal obligation to do so.

- Do not identify patients by name or post or publish information that may lead to the identification of a patient. Limiting access to postings through privacy settings is not sufficient to ensure privacy.
- Do not refer to patients in a disparaging manner, even if the patient is not identified.
- Do not take photos or videos of patients on personal devices, including cell phones. Follow employer policies for taking photographs or video of patients for treatment or other legitimate purposes using employer-provided devices.
- Maintain professional boundaries in the use of electronic media. Like in-person relationships, the nurse has the obligation to establish, communicate and enforce professional boundaries with patients in the online environment. Use caution when having online social contact with patients or former patients. Online contact with patients or former patients blurs the distinction between a professional and personal relationship. The fact that a patient may initiate contact with the nurse does not permit the nurse to engage in a personal relationship with the patient.
- Consult employer policies or an appropriate leader within the organization for guidance regarding work related postings.
- Promptly report any identified

breach of confidentiality or privacy.

- Be aware of and comply with employer policies regarding use of employer-owned computers, cameras and other electronic devices and use of personal devices in the work place.
- Do not make disparaging remarks about employers or co-workers. Do not make threatening, harassing, profane, obscene, sexually explicit, racially derogatory, homophobic or other offensive comments.
- Do not post content or otherwise speak on behalf of the employer unless authorized to do so and follow all applicable policies of the employer.

SCENARIO 1

Bob, a licensed practical/vocational (LPN/VN) nurse with 20 years of experience used his personal cell phone to take photos of a resident in the group home where he worked. Prior to taking the photo, Bob asked the resident's brother if it was okay for him to take the photo. The brother agreed. The resident was unable to give consent due to her mental and physical condition. That evening, Bob saw a former employee of the group home at a local bar and showed him the photo. Bob also discussed the resident's condition with the former coworker. The administrator of the group home learned of Bob's actions and terminated his employment. The matter was also reported to the BON. Bob told the BON he thought it was acceptable for him to take the resident's photo because he had the consent of a family member. He also thought it was acceptable for him to discuss the resident's condition because the former employee was now employed at another facility within the company and had worked with the resident. The nurse acknowledged he had no legitimate purpose for taking or showing the photo or discussing the resident's condition. The BON imposed disciplinary action on Bob's license requiring him to complete continuing education on patient privacy and confidentiality, ethics and professional boundaries.

This case demonstrates the need to obtain valid consent before taking photographs of patients; the impropriety of using a personal device to take a patient's photo; and that confidential information should not be disclosed to persons no longer involved in the care of a patient.

SCENARIO 5

Nursing students at a local college had organized a group on Facebook that

allowed the student nurses' association to post announcements and where students could frequently blog, sharing day-to-day study tips and arranging study groups. A student-related clinical error occurred in a local facility and the student was dismissed from clinical for the day pending an evaluation of the error. That evening, the students blogged about the error, perceived fairness and unfairness of the discipline, and projected the student's future. The clinical error was described, and since the college only utilized two facilities for clinical experiences, it was easy to discern where the error took place. The page and blog could be accessed by friends of the students, as well as the general public.

The students in this scenario could face possible expulsion and discipline. These blogs can be accessed by the public and the patient could be identified because this is a small community. It is a myth that it can only be accessed by that small group, and as in Scenario 3, once posted, the information is available forever. Additionally, information can be quickly spread to a wide audience, so someone could have taken a screen shot of the situation and posted it on a public site. This is a violation of employee/university policies.

For article references and to read all of the social media scenarios, please go to NCSBN, www.ncsbn.org.

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CONCLUSION

Social and electronic media possess tremendous potential for strengthening personal relationships and providing valuable information to health care consumers. Nurses need to be aware of the potential ramifications of disclosing patient-related information via social media. Nurses should be mindful of employer policies, relevant state and federal laws, and professional standards regarding patient privacy and confidentiality and its application to social and electronic media. By being careful and conscientious, nurses may enjoy the personal and professional benefits of social and electronic media without violating patient privacy and confidentiality.

ILLUSTRATIVE CASES

The following cases, based on events reported to BONs, depict inappropriate uses of social and electronic media. The outcomes will vary from jurisdiction to jurisdiction.

Continuing Education Update

Insights for Certified Nursing Assistants (CNAs)

Certified Nursing Assistants (CNAs) in the District of Columbia perform a critical role, and providing direct care to some of our most vulnerable citizens requires compassion, integrity and professionalism. “Ninety-nine percent of you are doing a phenomenal job,” speaker Mary Sklencar, RN, told the CNAs who participated in a recent Board of Nursing continuing education program exploring CNA issues and insights.

Ms. Sklencar is a surveyor for the DC Department of Health, and she told attendees that the federal government contracts with the states and District to survey long term care facilities to ensure compliance. She describes herself as the “nurse police,” and as a patient/resident advocate. She urged CNAs to think about the role they play, the ethics and commitment their career demands, and about how to improve their skills. “You chose this profession,” she said. “There is no excuse for abuse.”

SELF-AWARENESS

Know Yourself: “The first step to offering care is to *know yourself*,” Ms. Sklencar said. “Know why you are getting angry or getting upset. Know your physical limits and your spiritual limits.” Ms. Sklencar reviewed the types of abuse, which can include rough handling, yelling, threatening, and ignoring a resident. If a resident asks for water and a CNA walks by and says “that resident is not my resident,” that sends the message to the resident that they are not important.

COMPASSION

Simple Oversights: Please be aware



Nurse Consultant Mary Sklencar, RN, and Gregory N. Scurlock, Chief Compliance Officer, DC DOH Office of Compliance, Quality Assurance and Investigation Division.

that a simple oversight can have dire consequences. Ms. Sklencar spoke of a case where a resident developed Stage IV wounds on the heels of both feet. All of the members of the healthcare team knew the resident did not like to have his socks removed. As a result, staff members never took the socks off to wash his feet. “It doesn’t get like that overnight,” Ms. Sklencar said. “For four months, that man never had his feet washed. He ended up losing both feet.”

Turn and Fluff: Ms. Sklencar emphasized the importance of q2 (repositioning resident every 2 hours). It is an opportunity to monitor the condition of the resident’s skin. Is he or she still breathing? Do they have any unmet needs? “What if you skip turning Mrs. Smith, then two days later Mrs. Smith has a huge ugly bedsore? Remember what profession you are in. This is about the care of the resident. This is a caring profession.”

Speaking and Listening: Be aware that it is your obligation, when speaking, to enable the resident or a fellow staff member to understand what you are

saying. Do you speak very fast or softly? Do you have a thick regional or foreign accent? Be mindful that residents may have dementia or be hearing impaired. Be aware that a resident may not be able to precisely express his or her needs. “I want water” may really mean “I’m not comfortable.” Also, please do not mock a resident with a speech impediment.

Tone: Your tone of voice is important. Ms. Sklencar demonstrated the power of tone by saying “Nice shirt!” with a sincere tone, and then again with a sarcastic tone. “Words can have different meanings for speaker and listener. If I say ‘the big bear was very close,’ do I mean the teddy bear was snuggly and warm, or that an angry grizzly bear was about to attack? Chose your words carefully,” said Ms. Sklencar.

Body Language: “I can look into this audience and read the body language. Some of you are saying “I’m bored, I’m not listening.” Be aware of your body language. If you are dealing with an unpleasant aspect of care, such as bowel issues, do not make a face. That is hurtful to the resident.

Attentiveness: If you couldn’t come

when first summoned, tell the resident, "I'm sorry you're angry. I couldn't come. I am here now to help." Do not say: "I was busy." When speaking with a resident, do not fidget with your cell phone. You are sending the message to the resident: That they are not important. Residents didn't grow up with that technology and don't know what you are doing!

Feeling Lost: Your resident may feel lost: "Everybody tells me I am not their resident. Who is my CNA?"

Empathy: CNAs can tap into their compassion by looking at the big picture, Ms. Sklencar said. "When dealing with a so-called difficult resident, just think "There, but for the Grace of God, go I." There are more young people in the District's long-term care facilities than in the past. You may have a resident who is an IV drug user or who is paralyzed or not in control of their own bodily functions. That could be any one of us. Your residents are at the most vulnerable point in their life. "You will never see them at their best," says Ms. Sklencar.

Handle With Care

- Be respectful of the resident's belongings.
- Do not toss their belongings.
- Do not toss the toothbrush in with the hairbrush.
- Do not be a task robot. You have a lot to do, but allow for flexibility because situations change.

SOCIAL MEDIA

As a CNA, you may have a great bond with your residents, but please remember that they are not family members. Do not take photos with your cell phone and post residents' pictures on your Facebook page or any other mode of social media. Do not put a video clip of your residents singing Christmas carols on YouTube. Such actions could put your certification in jeopardy.

WHAT YOU SAY

Do not tell your residents all of your personal problems or about how you had a great time at the club last night. Do not spread gossip about who is dating who. According to speaker Mary Sklencar: "What the resident hears is: "You are an imposition."

HOW YOU SAY IT

If you speak quickly or with a U.S. regional accent, learn to speak slowly and clearly to be understood by residents and staff. If you are from another country, please speak English on the floor. If your accent is strong, learn to speak slowly and clearly, to both residents and your fellow staff members. "Communication is not just speaking, it is being understood," Ms. Sklencar said.

PROFESSIONAL ATTIRE

Jewelry: Look at yourself from the resident's point of view. Look in the mirror. Do you look professional?

Elderly people may not understand tongue-piercings, nose piercing, and eyebrow piercings. Keep your jewelry to a minimum. A wedding ring and watch are the only thing you should wear. Do not wear dangly earrings.

Attire: Your clothing should be appropriate. "Tight white pants, with heart-decorated undergarments showing through," is not appropriate, said Ms. Sklencar.

CHALLENGES & LIMITATIONS

Social Media: "Residents are not your family. There IS a difference. Do not put your residents on Facebook, YouTube, Twitter, Tumblr, MySpace, Space Age! Whatever social media you use. No, no, no!"

Like Family?: Ms. Sklencar warned CNAs to set professional boundaries, for their own protection: "Yes, you have a strong bond with your resident, but please remember the saying 'blood is thicker than water.' In the end, the patient will side with their family, not you."

Hostile Family: One CNA in the audience asked: What do you do when the resident's family is starting a ruckus? Ms. Sklencar stated, "Don't face the family alone, get the charge nurse." When you encounter a hostile family member, "Think about *why* the resident's family member is being hostile. It may have nothing to do with you or the facility.

"Your resident was a superwoman earlier in life, now she can't take care of herself and her daughter cannot either," Ms. Sklencar told participants. "That is her mother, and this is a situation that she cannot control. A resident's daughter wants to know that her mother is not regarded by the facility staff as just Room 32A."



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Violent Residents: Protect yourself and use common sense. If you need two people to tie a resident's shoes, get two people.

Noncompliance: You may have residents who are noncompliant. Think about that resident's total life experience. Earlier in life, your resident may have held down two jobs, or served as a high school principal for 30 years, and they are now being told what to do by a bunch of young whippersnappers. Your resident might have been a beauty queen, ladies man or a person of great status in their social circle.

Breaks and Burnout: Sometimes CNAs simply cannot get a 15-minute break. While doing your job, don't just disappear because you need a break. Approaching your CNA practice with an I'm-taking-my-lunch-break attitude is not professional. Yes, you do need to take a break, for your own peace of mind, but don't just disappear. When you leave the floor, do so in agreement with your co-workers."

RESTRAINTS

- Restraints should be used only according to regulations.
- The safety of the patient is our goal.
- If you think a seatbelt is needed, suggest a seatbelt. You need to have the team agree with doing that. Tell the charge nurse, tell the Director of Nursing.

INCIDENTS

Accusations of Abuse: "Anybody can accuse anybody of anything. When I do an investigation, I speak with everybody who was involved. I look at the medical record. I look at personnel files, your work history, your time, attendance and competencies testing. I take into consideration the positive things people say about you.

Writing Your Statement: If an incident

ROLE PLAYING: PROFESSIONALISM

Five CNAs attending the seminar volunteered to act in two skits about professionalism. In one skit, two CNAs (acting) walked and talked and pushed a "resident" in a wheelchair. "What did the CNAs in the skit do wrong?" Ms. Sklencar asked. Audience members noted the problems in the scenario. The CNAs did everything wrong. They pushed the resident in a wheelchair with no footrests, then proceeded to argue with each other while ignoring the resident's plea to use the restroom. "No, you can't go to the bathroom," the CNA (actress) said coldly to the resident, "you have to get to breakfast."

In the other skit, a CNA assists a "resident" at mealtime. After the skit was complete, Ms. Sklencar asked the audience: "What did the CNA do right?" Audience members offered their input. The CNA in the skit did several things right: She sat at eye-level with the resident, she wiped the resident's mouth and hands, and said what she was going to do prior to doing it. What did she do wrong? The CNA failed to tell the resident her name and didn't ask the resident what alternative food she would like to eat after the resident drank juice, but did not eat the donut provided for breakfast.



Three CNAs participate in role playing exercise.

CNAs SPEAK

What is the biggest misconception about CNAs?

"That it is easy," one CNA said. "People think it is not a job where you use your mind."

Another CNA added: "We are the resident's CNA, their friend, long-lost daughter, psychiatrist, cook, and fix-it person. I have been asked to hook up cable, fix a radio, scrub a toilet, and to answer questions such as 'Why won't my daughter talk to me?'"

Another CNA spoke of the need for personal space. She said her supervisor reached out and pulled her by her uniform while giving instructions. "Instead of getting angry, use that incident as an opportunity to educate your supervisor," Ms. Sklencar said.

CNAs mentioned such problems as coping with facility shortages of hot water, soap or lotion.

What is the worst thing about the job? "The pay, and how we are treated," one CNA said.

What is the best thing about the job? Another CNA replied: "Seeing a smile on a resident's face."

has occurred at your facility, write your statement regarding the incident as soon as possible after it happened so you don't forget the details. Tell the story of what happened and provide the relevant details. Say what you saw. Tell the truth. Use Specific Language. Be accurate and complete. Leave out the extraneous information. Do not say how long you have known the resident or what the weather is outside. Do not write a protest piece: "I know you are going to blame me because I am the CNA."

Falls: A fall occurs when a resident ends up on the floor without the intention of that happening. If you didn't see the actual fall, but you turned and saw the resident on the floor, say that. We do know that there are intentional fallers. I know the residents who throw themselves onto the floor.

Avoidable?: CMS (Centers for Medicare and Medicaid) want to know if the incident was unavoidable. Was the fall or pressure sore avoidable or unavoidable?

Suspension: If you are accused of abuse, you will be put on suspension. It is a CMS requirement and an obligation of the facility to protect residents from potential abuser. DOH investigators are aware that there are some residents who make false accusations. Many of these individuals are known to the surveyors.

STAFF CLASH

During the program, one CNA attending the program was upset and complained that she was expected to get ice for a resident when the nurse was just sitting at the nurses' station: "Why doesn't the nurse get the ice?"

Ms. Sklencar replied: "How can you judge what the nurse is doing? She may be eating bon-bons and smoking a cigarette. You do your job and don't take it out on the resident. Don't worry about the upper echelon. Everyone has a boss to answer to, and the Department of Health also investigates LPNs, RNs, and physicians."

There may be resentments or disagreements between CNAs or between

"WE ARE THE RESIDENT'S CNA, THEIR FRIEND, LONG-LOST DAUGHTER, PSYCHIATRIST, COOK, AND FIX-IT PERSON. I HAVE BEEN ASKED TO HOOK UP CABLE, FIX A RADIO, SCRUB A TOILET, AND TO ANSWER QUESTIONS SUCH AS 'WHY WON'T MY DAUGHTER TALK TO ME?'"

the RN and CNA, but remember it is about the resident. If you are having a disagreement, please de-escalate the situation for the sake of the resident.

MODEL FOR THE NATION

"District CNAs will be a model for the rest of the nation," Ms. Sklencar said. In addition to physicians, nurses, and allied and behavior professionals, the DC Department of Health is now also regulating and licensing Nursing Assistive

Personnel (NAPs), which includes CNAs. The Department of Health is making every effort to protect the public and ensure that the CNAs of the Nation's Capital conduct themselves with professionalism, empathy and competence. ■

CONTACT THE OFFICE OF COMPLIANCE

Let us know if you see inappropriate behavior. You may do so anonymously. **Call our hotline at (202) 442-5833.** The Complaint Coordinator will ask you questions, and ask you to write a statement. Provide the date and document what you saw. For example, "Mr. Smith was hit by CNA so-and-so."

Or you can contact Ms. Mary Sklencar at (202) 724-8781. "Call me if you need me. I would rather hear from you now than hear of a problem in your facility."

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Continuing Education Update Swallowing Disorders & Guidelines for Enteral Feeding

The Board of Nursing offered a continuing education program entitled “Enteral Feeding” at the Washington Center for Aging Services. Speakers discussed swallowing disorders, G tube feeding, G tube medication administration, and the ethics of enteral feeding.



Julieanne M. Schrom, MS, SLP

DYSPHAGIA

Speech Language Pathologist **Julieanne M. Schrom, MS, SLP**, addressed the topic of dysphagia (abnormal swallow). “What we perceive as a reflex, is not a reflex at all,” she said. “Swallowing is a complex process.” Ms.

Schrom provided a very detailed account of the anatomy and physiology of “the swallow journey.” She then discussed dysphagia and the role of the Speech Language Pathologist.

At the beginning of her talk, Ms. Schrom asked nurses to put themselves in the shoes of their patients/residents. “Swallow right now,” she asked audience members. “Now, open your mouth and swallow. With one’s mouth open, it is difficult to get the negative pressure necessary for swallowing. You may have patients or residents who are challenged to eat with their mouth open.”

Next, she asked participants to breathe rapidly. “Try to swallow while you are breathing rapidly.” If you have a resident who is working very hard to breathe, who breathes like a marathon runner, this may make it very difficult for them to swallow. “The body will always choose breathing over eating.” Patients with Chronic obstructive pulmonary disease (COPD), those who have a tracheotomy, or ventilated patients have a hard time coordinating all that

breathing and swallowing.

Positioning can also deter the ability to swallow. Many residents cannot sit at a 90-degree angle. Ms. Schrom noted that when she goes into long term care facilities she asks staff members to lay back at a 30-degree angle, then try to swallow.

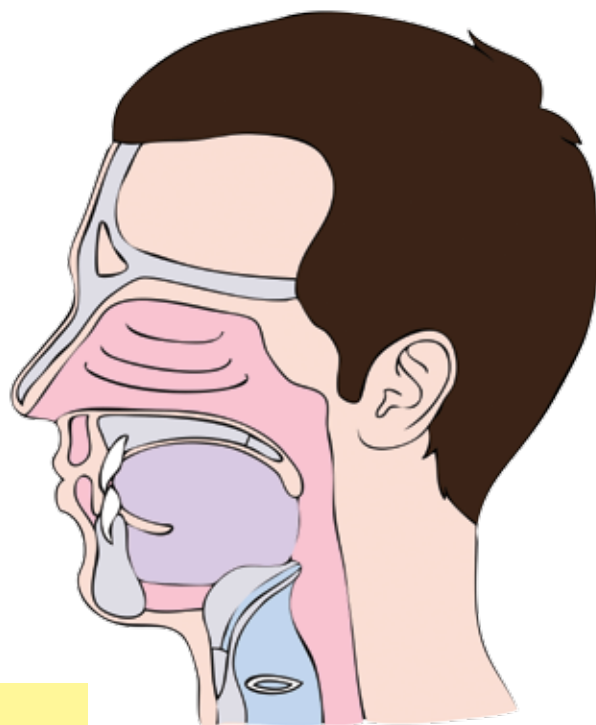
SWALLOW (definition):

Integrated and patterned activity which guides the bolus from the oral origin to the stomach involving the nervous system and the functions of the oral cavity, pharynx, esophagus, and other structures.

ORGANIZING THE BOLUS

“The tongue is the magician in the mouth,” she said, “It puts food into a lovely ball, or bolus, and gets the whole swallowing sequence started.” For patients or residents who don’t have sensory-motor ability, it’s really hard for them to organize food into a bolus, she said. In a normal swallow, the back of throat (pharynx) squeezes and contracts the bolus. The esophagus is the trap door. The larynx is the Adam’s apple area that controls swallowing. If there is aspiration, the larynx is not up and forward.

Swallowing requires organized cooperation of many functions. Have you ever laughed while trying to eat or drink at the same time? Disruption of the normal swallowing process causes discomfort in a variety of ways. When there is dysphagia, the patient may tell you, “I get two bites, then it gets stuck.”



MUNCHING

With residents with dementia, she said, you may see oral dysphasia, a munching pattern. Someone with advanced dementia may chew in the front of the mouth, but the bolus does not travel along the swallowing process in an organized bolus. They may take a very long time to eat. If you alternate solid and liquid, the liquid can flush the bolus completely down.

Some elderly long term care residents cannot feel the bolus. A younger person’s sensory system would cause them to cough if the bolus does not travel down the normal route, but the elderly person cannot feel the bolus. “You and I start coughing at the vocal cords.” The caregiver may not realize the resident is aspirating because it is silent aspiration. The resident is not coughing immediately. There may be a delayed reaction. The resident doesn’t begin coughing until food is in his or her lungs. It is dangerous and can develop into aspiration pneumonia.

CONTRIBUTORS TO DYSPHAGIA:

- Neurological – stroke, Amyotrophic lateral sclerosis (ALS), dementia
- Pharmacological – morphine, xerostomia
- Mechanical – trauma, intubation, surgery
- Psychological – conversion disorder, malingering (symptoms that cannot be explained by medical evaluation)
- Many other injuries and health issues can interrupt the ability to swallow, including concussions, brain tumors, or aging process.

SIGNS AND SYMPTOMS OF DYSPHAGIA INCLUDE:

- Coughing
- Wet or gurgly voice
- Extended mastication time
- Leakage/pocketing from mouth
- Running nose
- Tearing
- Weight loss
- Urinary track infection (UTI)
- Dry mouth
- Open mouth posture

SIGNS OF ASPIRATION:

- Congestion
- Temperature spikes
- Pneumonia
- Decreased O₂ sats during meal
- Increased RR during meal
- Food/liquid from tracheostomy tube

ASSESSMENTS

Ms. Schrom shared an x-ray video of normal swallowing, then an x-ray of an elderly resident with dysphagia. Ms. Schrom also shared sample reports assessing a resident's ability to swallow. "The radiologist's report will be basic, noting aspiration with consumption of thin liquids," she said. "The Speech Language Pathologist's report, however, will be a very detailed narrative describing each step of the

swallowing process, noting what happened (and what did not happen) when the resident swallowed different types of foods and liquids."

Abnormal swallowing is a mechanical interruption, she said, just like breaking an ankle. That interruption will cause the patient to function differently than in the past; the patient will move differently than before their injury. With abnormal swallowing, a resident may not be able to swallow as they did in the past, but they may be able to swallow using strategies provided by health care professionals.

STRATEGIES

- **Texture:** The resident may not be able to eat due to the food texture. Thin liquid travels fast. Patients would do well with a thicker liquid.
- **Positioning:** It may be the position while eating causing problems.
- **Environment:** Perhaps there are distractions in the dining area that would not be present in their room.
- **Chin Tuck:** Some patients should be retrained on how to swallow (for instance, patients that have had a laminectomy). A chin tuck can protect the airway.

Speech Language Pathologist

(SLP) Scope: The SLP scope of practice encompasses assessment of swallow, compensatory strategies and remediation, recommendations to consider alternative nutrition/hydration, and recommendations for return to oral route for nutrition/hydration. Ms. Schrom noted that it is outside of the SLP's scope to recommend enteral feeding. That is the physician's decision. The SPL may, however, inform the care team that the resident's swallow is dysfunctional.

WHAT IS ENTERAL FEEDING OR TUBE FEEDING?

"Enteral nutrition is when a special liquid food mixture containing protein, carbohydrates (sugar), fats, vitamins and minerals, is given through a tube into the stomach or small bowel." (Source: American Society for Parental and Enteral Nutrition, at www.nutritioncare.org)

Gastronomy (PEG) tube: A PEG (percutaneous endoscopic gastrostomy) tube must be placed into the abdomen by a surgeon, Dr. Wyche said.

Nasogastric (NG) tube: The nasogastric tube (NG) carries food and medicine to the stomach through the nose. Inserting a tube through the nasal cavity and into the esophagus may be traumatic, Dr. Wyche said, and often requires more than one attempt. There can also be problems such as a gagging effect or aspiration of food or fluid into the lungs. Once a Dobhoff (specific type NG feeding tube) is in place, an x-ray must be taken to ensure proper placement.

Parental Nutrition (PN): Patient or resident receives nutrition intravenously, via a peripheral or central line. Total parental nutrition (TPN) via PICC line (peripherally inserted central catheter) creates a high risk for infection, Dr. Wyche said.

Indications for Gastronomy Tubes: Long term feeding, Swallowing Disorders, MS/Huntington's/Parkinson's, Head Injury, Stroke, Malabsorption problems

Contraindications: Previous gastrectomy, massive ascites, gastric neoplasm, active gastritis or peptic ulcer disease, gastric varices

ETHICS OF ENTERAL FEEDING

If the obstacles to eating normally cannot be overcome, and the patient or resident is in hospice, the healthcare team may need to consider the ethics involved

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in initiating enteral feeding. **Sonja Wyche, MD**, addressed the topic of “Ethical Issues of Gastrostomy Tube Feedings.” Enteral feeding and parental feeding provide nutrition directly to the digestive track, Dr. Wyche told participants. Nutrition can be provided via G-tube, nasal-gastric tube, or by IV.



Sonja Wyche, MD

ETHICS

Ethical use of enteral feeding begins with knowing when and when not to use it. If your patient or resident is not eating, should that resident be provided with nutrition via G tube?

“Why isn’t Mr. Tim eating or drinking?” Dr. Wyche asked attendees, speaking of a hypothetical resident. “It is because his underlying disease process is telling him not to eat or drink.” A big part of ethical decision-making, associated with enteral feeding for residents with dementia, is determining if it should be pursued at all. Extending compassionate, patient-guided care to residents and their families, Dr. Wyche said, may mean not providing enteral feeding. The health care team must determine if providing enteral feeding is what is best for the patient: “A lack of fuel—food—can contribute to a comfortable dying process.”

Dr. Wyche spoke about patients with dementia in hospice and palliative care. If a person has advanced dementia, and you

hand them an object, she said, they may not remember what the object is, what it is for, or what to do with it.

HOSPICE & FOOD

- Disease process is causing the body to shut down and the hospice patient will be unable to take food or fluids by mouth and are uninterested in eating or drinking.
- Hospice patients do not suffer without nourishment and are unlikely to experience pain related to a lack of nutrition.
- Studies show that the body responds to a lack of food by increasing the production of natural pain relievers (endorphins).
- Reintroduction of even a small amount of food/sugar (such as that found in IV fluid) can bring back the sensation of hunger and stop the production of endorphins.
- Advance Directive: If the patient is unconscious, unresponsive or confused, refer to the Advance Directive.

FOR THE PATIENT

- Assess for treatable causes of decreased appetite: oral thrush, nausea/vomiting, metabolic disturbances
- Let resident eat whenever they desire
- Lift dietary restrictions
- Provide smaller plates and portions
- Avoid strong smells, spices, and hot foods

FOR THE FAMILY

- Call the family when the patient doesn’t eat
- Discuss the need for less food and to lift dietary restrictions
- Reassure family that their loved one is not in pain or experiencing hunger or thirst-related suffering
- Teach family other ways to show love and support

Options for alternative nutrition must be weighed in the context of the patient’s/resident’s desired quality of life. The presence of plugs, wires, and strings connected to the resident’s body does not enhance their independence, Dr. Wyche said.



Karen Espenshade, RN, BS

INDICATORS AND GUIDELINES

Speaker **Karen Espenshade, RN, BS**, discussed enteral-feeding devices and guidelines for safe practice and assessment.

She began her talk focusing on the The Joint Commission’s 2006 alert regarding life-threatening tubing and catheter misconnections, which Ms. Espenshade contends are underreported. She noted several types of misconnections, such as IV infusions mistakenly connected to arterial lines, and oxygen tubing connected to IV ports.

Staff must be educated on how



to prevent misconnections, Ms. Espenshade said, and she urged nurses to reach out to colleagues. "It is okay to say 'I have not worked with a G tube in awhile.'"

Root Causes of Misconnections

- Catheters and tubes used for unintended purposes, i.e., IV extension tubing used for enteral feeding tubing extension
- Residents with tubes in close proximity to one another
- Change in setting for resident, hospital to long term care
- Staff Fatigue

TUBE TIPS

- If you are not trained, do NOT do it
- Always start with the smallest bore tubes
- Place of service and age of G tube are very important factors when considering any nursing intervention
- Ask questions if you are unsure and document what you do

STAFF EDUCATION

- Turn Lights on (Turn on the lights in the room in the middle of the night. A lot of things look like the end of a tube.)
- Always trace tubing from patient to point of origin
- Recheck connections
- Never use Luer lock syringes for enteral feeding
- Family and residents should not be allowed to disconnect/connect.

STRATEGIES TO PREVENT MISCONNECTIONS

- Position lines in different directions (i.e., IV towards head and enterals toward feet)

- Avoid staff fatigue
- Familiarize yourself with manufacturers' engineered safety controls (purple color indicates nutritional port, not IV).

CHECK YOUR FACILITY POLICY

"Abdominal assessment is vital," Ms. Espenshade said. Get comfortable with abdominal assessment. "Listen to your own abdomen at home. Eat and listen with a stethoscope." Stages of abdominal assessment: inspection, auscultation, palpation, percussion. Divide abdomen into four quadrants. Look, listen, and feel. "Are bowel sounds present?" she asked. "What do they sound like? Is there gurgling? Is it loud or faint? Are there many sounds or few sounds?" Measure the size of the abdomen with a tape measure. Is the stoma site distended? Look for signs of infection (redness). Is there fluid leaking? You may detect an infection through palpation and percussion. What do you feel and hear? Heat or a lump could be indicators of infection.

Problems may arise such as diarrhea, vomiting, or abdominal cramping. The stomach may be hard or swollen, or there may be overgranulation (tissue, discharge, or blood). There may be aspiration or you may not be able to reinsert G tube. Part of the assessment process is knowing what is normal for that particular resident. If they do something out of the ordinary, that is a red flag. "Does this person always belch like this? Or is this new?" Notify the physician for something outside of the resident's norm.

Educate yourself and do not be afraid to reach out to others if you are not experienced or expert in the arena of enteral feeding.

"We need to understand what has gone wrong in the past to avoid it occurring in the future," Ms. Espenshade said, who is a Nurse Manager for the Covidien Company.

MEDICATION ADMINISTRATION

Nursing Professor **Elizabeth Miller, DNP, RN, CCM**, of Bowie State University, addressed the topic of "Medication and the G Tube Patient." Dr. Miller has practiced as a staff medical-surgical nurse for 17 years, and has worked as a case manager in quality assurance.

"You will need the following for medication administration," Dr. Miller said. "A Toomey syringe or 60 ml syringe; irrigation set (bulb syringe & irrigation bottle); a container with

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a lid (specimen cup); pill crusher or mortar & pestle; and warm water. Warm water is your best friend.”



Elizabeth Miller,
DNP, RN, CCM

Flush tube with water before and after medication administration, Dr. Miller said. “For pills, crush medications into a fine powder using a pestle and mortar, or a pill crusher. Do not crush time-release or extended

release pills. Do not crush or empty capsules that are labeled time-released or extended release. Mix fine powder with warm water.” Request a liquid form of these medications or a non

time released medication. Dr. Miller used a G-tube to demonstrate the proper way to prepare the medication, and addressed special consideration for administering Dilantin or other scheduled medications. “Your dominant hand should do the pouring.”

TIPS

- Remember to check patency of the feeding tube before administering medications.
- Instill 5-10 ml of warm water to ensure tube is patent.
- Water should flow from syringe through the tube by gravity not by force. “You always want things flowing by gravity,” she said.
- If water does not flow by gravity, remove water and attempt to inject air to clear the tube.

MINIMIZE GI UPSET

- Administer the Dilantin along with the other scheduled medications
- Set feeding pump on hold for one hour again
- When pump alarms, set pump to resume feedings
- This process allows the Dilantin to be absorbed and minimize GI upset

Dr. Miller concluded her talk with this thought: Know your policies and procedures and follow them. If you follow protocol all of the time, you don’t have to remember the proper thing to do when DC DOH comes to do a survey. ■



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Carroll Manor Partnership with Japanese Nursing Home



Janice Johnson, BSN, RN-BC, Director of Nursing at Carroll Manor Nursing Home and Rehabilitation Center has been busy establishing a partnership with Geriatric Health Services Facilities in Yokohama, Japan. Ms. Choko Sumiyoshi, RN, MSN served as the liaison between the two nursing homes. During a visit to Providence Hospital early last year, the Administrative staff of the nursing home in Japan came to Carroll Manor for a tour. The Japanese team was very interested in the culture change progress that Carroll Manor had made in making it a more home-like environment. Presentations by Janice Johnson, BSN,

RN-BC on culture change, Jackie Batcha, BSN, MPH, RN-BC on quality indicators, Crystal Scott, MSN, RN-BC on the education provided to the Carroll Manor nursing staff and Tina Sandri, NHA on the importance of relationships were given to the Japanese team. A relationship, mutual respect and admiration were developed immediately.

Dr. Naoto Miyako, President/CEO of the Yokohama nursing home had applied for Joint Commission International (JCI) accreditation. Receiving this accreditation would make them the first long term care facility in Asia to become accredited with the JCI. Realizing that a partnership with Carroll

Manor would enhance their chances, they extended an invitation to Janice Johnson, BSN, RN-BC to come and speak on behalf of Carroll Manor's culture change and work with their staff on best practices in the long term care industry in America. Janice first made the 14 hour journey to Japan in July 2011.

In October 2011, the Japanese Administrative team returned to Carroll Manor for a 3 day workshop. Carroll Manor success stories on quality improvement initiatives were reviewed by Anita Moorthy, MSN, RN-BC, Program Specialist on pressure ulcer reduction and hand hygiene. Deitra Artis, RN, Restorative RN, presented Carroll Manor's initiative on the positive impact that restorative nursing has on falls reduction and incontinence management. The team returned to Japan armed with the knowledge of how to improve the quality of life for the elderly living in nursing homes all over the world. They were determined to bring the best practices and culture change initiatives they learned from Carroll Manor back to Japan for their residents.

In March 2012, The JCI returned to Japan for the final survey. Passing with high scores, they became the first long term care facility in Asia to become JCI accredited. ■

Kudos!



Kate Malliarakis, Gaurdia Banister, and Karen Skinner

Congratulations to **Gaurdia Banister, RN, PhD**, Executive Director of the The Institute for Patient Care at Massachusetts General Hospital. Dr. Banister was awarded the American Nurses Association's Mary Mahoney Award, for

her outstanding service to the nursing profession, during the 2012 ANA House of Delegates meeting at the National Harbor in Maryland.

Congratulations to **Patricia C. McMullen, PhD, JD, CRNP**, who has been inducted into the Fellows of the American Academy of Nurse Practitioners (FAANP). Dr. McMullen is Dean and Ordinary Professor at The Catholic University of America (CUA) School of Nursing.

Dr. McMullen has also served as a community health nurse and a research associate. She has served as an Assistant Professor at the University

of Maryland School of Nursing (UMSON) and the Uniformed Services University of the Health Sciences. Previously at CUA, she served as Associate Provost for Academic Administration.

Dr. McMullen has been a contributing editor for the publications *Nursing Connections* and *The Journal for Nurse Practitioners*. She holds a BSN and MS from UMSON, a JD degree from the University of Baltimore School of Law, and PhD from CUA. ■



Patricia McMullen

Board Disciplinary Actions

NAME	LICENSE #	ACTION
Stacey Ogunleye CNA	801778	Abuse Registry
Stephanie Thompson CNA	364349	Abuse Registry
Elizabeth Henson LPN	1005009	Suspended
Dion Walker LPN	967935	Suspended

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	2
Referrals to COIN	2
Consent Orders	10
Requests to Withdraw Application	0
Requests to Surrender License	0
Letters of Concern	0
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/>.

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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.

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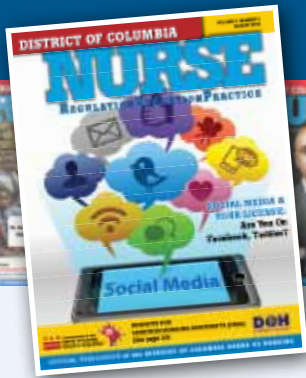
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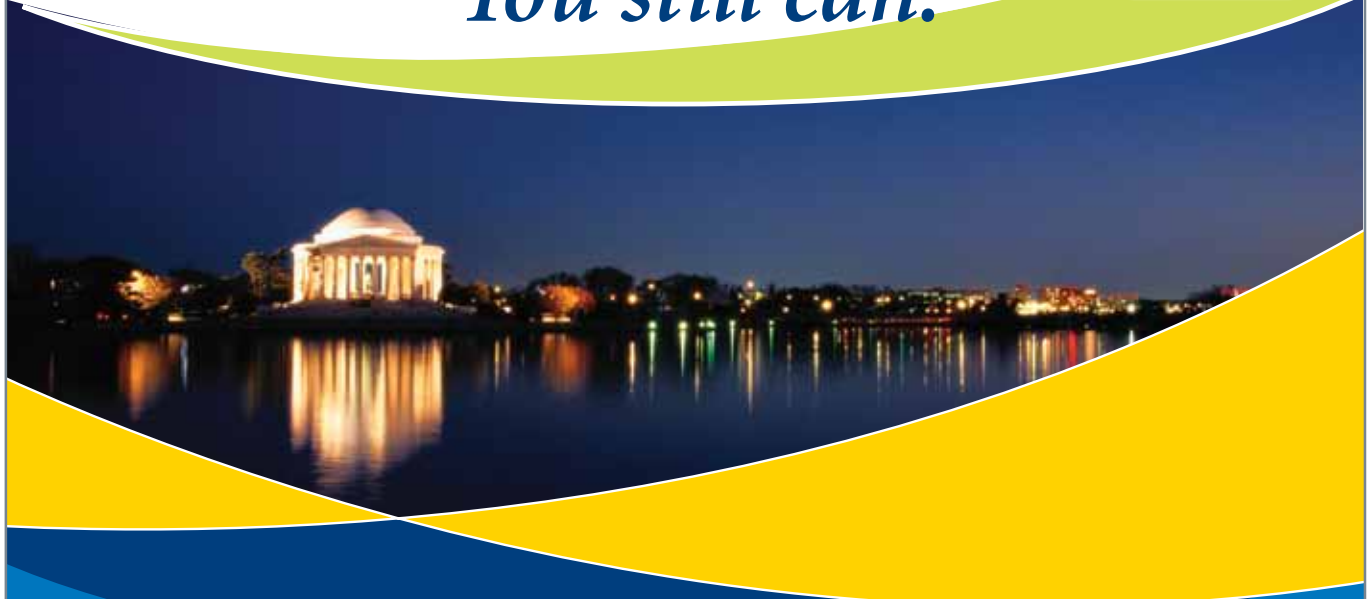
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