Extended Release/Long-Acting Opioids: Assessing Risks, Safe Prescribing

- Special Alert: Obligation to Report
- LPN Renewal
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Address Change? Name Change? Question?
In order to continue uninterrupted delivery of this magazine, please notify the Board of any change to your name or address. Thank you.

DC BON Mission Statement: “The mission of the Board of Nursing is to safeguard the public’s health and well being by ensuring 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 37,000 licensed nurses, nursing home administrators, nurse staffing agencies and nursing assistant personnel 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.)
Welcome to the first 2015 edition of DC NURSE. As we look forward to National Nurses Week 2015 which is a few months away, now is a good time for us to renew our commitment to excellence in professional practice, and open communication. In our efforts to ensure excellence in nursing we must continue to work on open communication between you, the nursing community and the Board of Nursing. Facilities in the District must communicate with the DC Board of Nursing when they terminate unsafe practitioners. Nurses must share best practices with other nurses and health care providers. Nurses must share innovative nursing practices with one another. Also, as the Board works to regulate the practice of nursing we want to enhance our communication with the nursing and health care community.

We want to help Nursing Assistive Personnel become aware of their role as well as assist nurses in understanding their role as NAP supervisors. As supervising nurses, you must know what task the NAP you are delegating to can legally perform, you must know what level and frequency of supervision is required. NAPs must be clear about their role and the tasks they are allowed perform. They must not hesitate to communicate with the RN or LPN if they observe a change in their client’s status or have questions about the task they may be asked to perform.

This issue of DC NURSE contains many articles related to our goal of ensuring professional practice and opening the lines of communication:

- You will find a reminder to facilities on page 5 regarding their obligation by law to report nurses terminated due to unsafe practice. See article “Special Alert: Obligation to Report.”

- A reminder about e-Notify, which is now free, is on page 8.

- You will find an update regarding the change in the administration of Nurse Staffing Agencies on page 5; find out who at DOH oversees NSAs. See article entitled “Nurse Staffing Agencies.”

- Are you a Licensed Practical Nurse? See our FAQ in the article “Licensed Practical Nurse Licensure Renewal” on pages 6 and 7. There you will find answers on many issues, from renewal, to in-service vs. CE, and other issues.

- A great threat to professionals in the District as well as nationally is substance use disorder, especially the abuse of opioids. On page 10, “COIN CONSULT” shines a light on the abuse of opioids.

- Our enhanced focus on NAPs starts with “NAP NEWS!” on page 14 which contains its own FAQ section. You will also find on page 16 highlights from the recent Health Care Summit on the Delegation to NAPs which we presented by staff from HRLA.

- By the way, the NAP Advisory Committee needs members you! See “NAP Advisory Committee Vacancies” on page 20.

- When new challenges arise, we discover our true worth. Last year, we—healthcare professionals and facility/ agency administrators—were asked if we were prepared when the Ebola virus emerged within the U.S. borders. On page 24 you can read about how the District has prepared in the article “DC Based Hospitals Among 35 Nationally Recognized EBOLA Treatment Centers.”

- Educating, communicating, informing are all key, and if you have knowledge you can pass along to nurses and NAPs about a specific area of practice, be sure to note our call for speakers in the article entitled “Board of Nursing Speakers Bureau.” Found on page 29.

Ensuring that the standards of professional practice our upheld is our goal, but that goal is driven by our mission and responsibility to protect the residents and visitors within the District from those whose practice is unsafe.

You are an important piece of the puzzle, whether you are a nurse, NAP, or facility administrator or nurse staffing manager. Help us protect our citizens. Report unsafe practice, speak to colleagues about the laws governing nursing practice, and make our goal your goal—professionalism which ensures that the people within the District’s borders have access to the best care, the care that they deserve.

Cathy Borris-Hale, RN, MHA, BSN
Chairperson, DC Board of Nursing
SPECIAL ALERT:
OBLIGATION TO REPORT

A recent incident in the District, involving a licensed nurse and an alleged sexual assault, should serve as a reminder about the importance of reporting the termination of a nurse due to unsafe practice(s). While the Board does not need to know about nurses who are terminated for tardiness, or being rude to other employees, we DO need to know about nurses who are terminated due to unsafe practice(s). When in doubt report individuals to (email Felicia.Stokes@dc.gov) and the Board will determine whether or not there is a practice violation.

Nurses play a critical role in the vitality of our health care system. They are often at the frontline of our urgent care system, and offer care when members of the general public are most in need of care. The Board of Nursing, therefore, takes each allegation of impropriety seriously. When an allegation is received, it is treated with the utmost concern and is investigated thoroughly, following strict procedures, to ensure the preservation of evidence, protection of public safety, and to guarantee that all involved are afforded due process.

Unsafe practice is a serious matter and the Board works diligently and carefully in all investigations to protect the integrity of our healthcare systems and provide for the rights of the accused to obtain due process.

With the recent alleged assault incident that occurred in DC, the Department of Health performed a review of its investigative process, and found that our investigators moved swiftly within their legal framework, and followed all procedures pertaining to the investigation of the allegations. Their careful and detailed investigative work provided the Board with the findings needed to go forth with the recommendation for summary suspension.

Please know that without notification from health care facilities the Board is unable to address unsafe practice(s). It is a legal and moral obligation to report unsafe practice to the Board. The Board cannot take action if they are not informed.

If the Board is not informed, the individual will most likely obtain a position at another facility and continue to commit practice violations.

Nurse Staffing Agencies

OVERSIGHT OF NSAs
Effective October 1, 2014, the licensure oversight of Nurse Staffing Agencies was transferred to the Intermediate Care Facilities Division under Sharon Mebane, Program Manager. Questions or concerns should be directed to Ms. Mebane at Sharon.Mebane@dc.gov, (202) 442-4751. (NSAs were formerly under the authority of the Board of Nursing staff.)

CRIMINAL BACKGROUND CHECKS
Effective October 1, 2014, Nurse Staffing Agencies who hire employees to work in a direct patient access position in a long term care facility or residence are required to comply with the DC Department of Health’s National Background Check Program. The DC Department of Health has designed and implemented a new criminal background checking system for this purpose. Please email all questions regarding the implementation of the National Background Check Program to Leatrice.Lee@dc.gov.

SWEARING IN
Welcome New Board of Nursing Appointees!
Margaret Green (new appointee, 3rd from right) and Simmy Randhawa (reappointment, 6th from right) as well as other health professional board appointees were sworn-in last December.
Licensed Practical Nurse Licensure Renewal

Please Note: This renewal period the random CE Audit began prior to the LPN renewal period. You may have already received notification of your selection. If so, you must comply before your license will be renewed.


RENEWAL INFORMATION:
LPN renewal began on January 2015. All LPN licenses expire June 30 of odd numbered years. Upon completion of the renewal application and payment of the renewal fee, your license will be renewed for a two-year period. Licenses not renewed by June 30, 2015 expire and, if needed, will have to be reinstated at an additional cost.

DO
Renew online sooner rather than later by accessing the HRLA website at: https://app.hpla.doh.dc.gov/mylicense/

- Click on Online License Renewal.
- Enter your last name and Social Security number and press search. Your registration page will display (it contains your demographic information; please update your contact information), including your user ID.
- Create a password and enter it in the blank password box, then repeat the same password in the “Confirm Password” box in the next column.
- Press the register button and proceed using the prompts to navigate your way through each part of the renewal application.
- Complete the Workforce Study.
- Enter a Visa or MasterCard credit card number in order to pay the $145.00 LPN licensure renewal fee.

Once you have completed your renewal:
- Verify your renewal after 24 hours at www.hpla.doh.dc.gov/weblookup.
- Allow ten (10) business days to receive the renewed license in the mail.

DON’T
- Don’t wait until the last minute to renew.
- Don’t let your license “expire” if you plan to work in DC.
- Don’t disregard the Continuing Education audit notification if you are a random audit selectee.

Frequently Asked Questions

Q: “I am not working in DC” or “I am out-of-work or for personal reasons cannot work right now” but want to maintain my DC license. Is there an option for me?
A: Yes, if you expect to use your DC license again, you may place it on our PAID INACTIVE STATUS. If you don’t select this Paid Inactive status, or do not renew, your license will expire.

Q: What is “PAID” Inactive Status?
A: Paid Inactive status allows you to place your license in a dormant status until you choose to reactivate the status to “Active.” Paid Inactive status requires a one-time fee of $145.00. While on Paid Inactive status you will not be subject to renewal fees or continuing education (CE) requirements or criminal background checks. You may continue to use your LPN title but you cannot practice, attempt to practice, or offer to practice as an LPN.

To reactivate your Inactive licensure status, submit a reactivation application along with 18 continuing education (CE) units, fingerprint scan for criminal background check, if required, and the reactivation fee, currently $34.00.

Q: I applied for licensure renewal but my license has not been renewed.
A: Your license may not have renewed for one of the following reasons:

DID NOT FINISH ONLINE RENEWAL PROCESS
Your renewal effort is successful once you enter payment information, press submit, and the website processes that data and produces a Renewal Payment Receipt for inspection and printing. Note: Please print as evidence of successful renewal.

PAYMENT WAS NOT PROCESSED
Please refer to above response. If payment information is entered and submit button is pressed and that button does not depress and/or no Renewal Payment Receipt is produced, payment was not processed. Retrace your steps and repeat your process.
ANSWERED “NO” TO COMPLETION OF CONTINUING EDUCATION CONTACT HOURS

Result: Your renewal will be on “Hold” even if you answered “No” by mistake.
Remedy: You will be required to submit evidence of satisfactory completion of 18 contact hours of continuing education.

NON-COMPLIANT WITH/UNRESPONSIVE TO RANDOM CE AUDIT

Please refer to DC NURSE Vol. 11 Number 1 (April 2014) for list of LPNs non-compliant with CE audit (Go online at: http://epubs.democratprinting.com/publication/?i=202681&p=1&search_str=april%202014&search_str=april%202014). If your name appears on the list of LPNs noncompliant with random audit notification, your license will not renew until you: 1) Provide documentation of the completion of continuing education sought as a random audit selectee, or, 2) Comply with the Negotiated Settlement Agreement that was sent to the address on file.

ANSWERED “YES” TO SCREENING QUESTION(S) WITHOUT PROVIDING REQUIRED WRITTEN EXPLANATION, OR YOUR EXPLANATION REQUIRES BOARD REVIEW.

Result: “Hold” to renewal of license.
Remedy: Written explanation/documentation is to be emailed to Gwyn. Jackson@dc.gov.

ATTEMPTING TO RENEW ONLINE AFTER AUGUST 30, 2015

Result: If the website indicates that there are no licenses to renew, your license has expired.
Remedy: After June 30, 2015, until August 30, 2015, you can renew by paying the $85.00 late fee. After August 30, 2015 you must reinstate your license. Contact our Processing Center at 1 (877) 672-2174 to request a reinstatement application. The application is not available online.

Q: What do I need know about Continuing Education?
A: Please note the following CE tips:

Continuing Education is not required for those who are first time renewals.

Continuing Education (CE) obtained during the two (2) years immediately preceding the application date satisfies the CE requirement.

Continuing Education (CE) Requirements for Renewal, Reactivation, or Reinstatement

LPNs: 18 Contact Education Options:

(1) **Contact Hour Option**: May be used if you have completed a continuing education offering. Evidence of compliance: Provide an original verification form signed or stamped by the program sponsor.

(2) **Academic Option**: May be used when you have completed a course leading towards a degree in nursing or taken a course relevant to your role as a nurse. Eighteen (18) contact hours awarded – Evidence of compliance: Provide evidence of approval by the board or accrediting body.

(3) **Teaching Option**: May be used if you have developed and taught a course or educational offering approved by board or approved accrediting body. Four (4) Contact Hours Awarded for each contact hour (This is not an option for nurses required to develop and teach in-service education courses or educational offerings as a condition of employment.) Evidence of compliance: Provide evidence of approval by the board or accrediting body.

(4) **Author or Editor Option**: Author of a book chapter or peer reviewed article (if the manuscript has been published or accepted for publication during the period for which credit is claimed) or editor of a book during the renewal period. Eighteen (18) Contact Hours Awarded. Evidence of compliance: Provide evidence of authorship or that you served as an editor of a book, chapter or published peer reviewed periodical, if the periodical has been published or accepted for publication during the period for which credit is claimed.

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NCSBN Launches Nursys e-Notify

**E-NOTIFY is a no cost licensure notifying system that can be used by health care facilities to receive notification of expired licenses and board discipline.**

Employers Emailed Discipline Data as It’s Entered at No Cost: The National Council of State Boards of Nursing (NCSBN) has launched Nursys e-Notify, the national nurse licensure notification system that automatically delivers licensure and publicly-available discipline data directly to employers free of charge as the data is entered into the Nursys database by U.S. boards of nursing. The e-Notify system:

- Alerts subscribers when changes are made to a nurse’s record, including changes to license status, license expirations, pending license renewals, and public disciplinary action/resolutions and alerts. If a nurse’s license is about to expire, employers have the option to receive a notification about the expiration date.
- Employers can also immediately learn about new disciplinary actions issued by a board of nursing for their employed nurse, including receiving access to available public discipline documents.
- Nursys e-Notify eliminates the need for employers to proactively search for nurse data. They are notified when changes occur.

Nursys is the only national database for verification of nurse licensure, discipline and practice privileges for registered nurses (RNs) and licensed practical nurses (LPNs). It is comprised of data obtained directly from the licensure systems of U.S. boards of nursing through frequent, secured updates. Nurse employers are able to subscribe to this service to track licensure and discipline information for or no charge.

Employers can customize how often they receive notifications and when they want to run reports. Another valuable option is the ability to enter nurse contact information so the employer may send licensure renewal reminders to the nurses directly from the e-Notify system.

To view a video about the new e-Notify system, please go to the Nursys website at [www.nursys.com](http://www.nursys.com).

**NURSYS e-Notify provides automatic licensure, discipline and publicly available notifications quickly, easily, securely and free of charge to institutions that employ nurses or maintain a registry of nurses through Nursys e-Notify. Nursys is the only national database for licensure verification, discipline for registered nurses (RNs), licensed practical/vocational nurses (LPN/VNs) and advanced practice registered nurses (APRNs).** For questions, contact nursysenotify@ncsbn.org.

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**ONLINE NURSE LICENSURE APPLICATIONS!**

Online licensure, which will allow persons to apply for nurse licensure online, is the next phase in the Board of Nursing’s “Going Green” initiative. Beginning in 2015, nurses will be able to submit their applications online. This will eliminate lost and unreadable applications. It will assist us in our goal to expedite our licensure application process. We will keep you informed as we move towards this new initiative.
**ENDORSEMENT PROCESS**

**Q**: Two of our staff recently attempted to convert their LPN licenses from Maryland to DC. They each filed their requests and have yet to receive a DC license. Until today, it was our understanding that once LPNs or RNs had a current license from the Maryland Board of Nursing, receipt that they had paid for the DC license and that the status of the license was pending they would be permitted to work, as the approval was merely procedure. Can you clarify the Board’s position regarding this? Moreover, how much longer should we anticipate it will take for the two aforementioned persons to have their reciprocity applications approved?

**A**: The applicants you noted have applied for licensure by endorsement. Persons whose licensure status is pending should not be allowed to work. An RN or LPN applicant can request temporary licensure if there is an urgent need for them to work. Temporary licensure means that they have submitted their application, paid for their verification, and have completed their background check. The reason they cannot be made active, usually, is that we are awaiting either their state or FBI results, or there may be information on their application that requires additional documentation.

**REGULATIONS FOR CPMs**

**Q**: How many Certified Nurse Midwives will serve on the committee reviewing the proposed regulations for Certified Professional Midwives?

**A**: Legislation has been proposed to place Certified Professional Midwives under the authority of the Board of Medicine. The Board of Medicine is forming a taskforce to review the proposed legislation. The Board of Medicine has received the names of Certified Nurse Midwives and “non-nurse” midwives that they are considering for the committee. **Readers please note:** “Non-nurse” midwives generally are not regulated by Boards of Nursing because of the potential confusion it may cause in having the BON issue a midwifery license to a non-nurse midwife as well as a certified nurse midwife.

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**RETIREMENT OF PEDIATRIC CLINICAL NURSE SPECIALIST CERTIFICATION EXAM**

Effective December 31, 2015, the American Nurses Credentialing Center will retire the exam for Pediatric Clinical Nurse Specialist (PCNS-BC) certification. The credential will not be retired (only the exam). Nurses currently certified as PCNS-BC may still use their credentials and maintain the certification through timely renewal. Eligible applicants may take the exam to renew until the final test administration on December 31, 2016. Beginning January 2017, the credential may be renewed if professional development and practice hour requirements are met. ANCC will accept new applications to sit for the Pediatric Clinical Nurse Specialist exam through March 31, 2015. For more information, go to www.nursecredentialing.org/PediatricCNS.
Providers from the disciplines of nursing, medicine, dentistry and pharmacy gathered to discuss the impact of opioid abuse in the District and the strategies professionals can employ to ensure that opioids are prescribed appropriately. The grant-funded program, entitled “Extended Release (ER) / Long-Acting (LA) Opioids: Assessing Risks, Safe Prescribing,” was sponsored by the Health Regulation and Licensing Administration, and held at the MedStar Washington Hospital Center.

**EXTENDED-RELEASE RX = DANGER**

“The number of drug overdose deaths—a majority of which are from prescription drugs—in District of Columbia increased by 55 percent in the last 15 years,” HRLA Senior Deputy Director Rikin Mehta, PharmD, JD, LLM, told attendees at the beginning of the program. Dr. Mehta also reminded professionals about the very specific danger posed by ER/LA opioids: “Extended-release and long-acting opioids have emerged as the medical products with the highest potential for harm, misuse, and abuse,” he said. “The amount of opioid analgesic contained in an extended release tablet can be much more than the amount of opioid analgesic contained in an immediate release tablet because ER tablets are designed to release the opioid analgesic over a longer period of time. The U.S. Food and Drug Administration is requiring a Risk Evaluation and Mitigation Strategy for ER/LA opioid analgesics because...there is a disproportionate safety problem associated with these products that must be addressed.” Dr. Jacqueline Watson, Board of Medicine Executive Director, shared with attendees that the CDC has estimated that opioids cause twice as many deaths as cocaine and heroin combined (see [http://www.cdc.gov/homeandrecreationalsafety/xbrief/](http://www.cdc.gov/homeandrecreationalsafety/xbrief/)).

**PRACTITIONERS UNDEREDUCATED IN PAIN**

There is a great need for opioid education amongst practitioners, keynote speaker Beth B. Murinson, MS, MD, and PhD, told participants. Dr. Murinson, Neurologist/Co-chief of the Chronic pain Program at Washington DC VA Medical Center, and Associate Professor and Director of Pain Education in the Department of Neurology at the Johns Hopkins School of Medicine, said that although pain is the major incentive that motivates patients to seek care, there is little emphasis on pain management in mainstream medical school curriculum. Medical schools only provide about seven hours on pain care, she said.

**HELLO, MY NAME IS**

When a new patient comes into your practice who was previously prescribed opioids by another health care provider, will you write a new prescription? “They still have on-going pain. What are you going to do with them now?” Dr. Murison asked. She called opioid abuse a pandemic in the United States. “There are five states that have a number of opioid prescriptions equivalent to the number of people in that state’s population.”

Opioids are necessary, but they must be used in context of good medicine and proper practices. Dr. Murison noted that in recent years there has been a parallel rise in the number of opioid deaths with the steady rise of opioid sales. These drug-related deaths are rising faster than any other drug deaths. “And deaths are the tip of the iceberg,” Dr. Murison said. For each death, there are 10 addicts admitted to treatment, 32 emergency department visits, 130 people who abuse the drug, and 825 nonmedical users (source: [http://www.cdc.gov/homeandrecreationalsafety/xbrief/](http://www.cdc.gov/homeandrecreationalsafety/xbrief/)).

Although opioids pose a great danger, there are no safe substitutes. “Remember Vioxx?” Dr. Murison asked attendees. “Eighty million people got prescriptions for Vioxx. It was an alternative to opioids.” Vioxx caused strokes, heart attacks, and death. Vioxx was withdrawn from the U.S. market in 2004 ([http://www.drugs.com/vioxx.html](http://www.drugs.com/vioxx.html)). After Vioxx was discontinued, patients were left with not many options. “One hundred and thirty million Americans—one in four—are living with chronic pain. Hip pain, knee pain, back pain, headaches,” Dr. Murison said.

Opioids offer an immediate relief for pain, but the effectiveness fades over time.

**ADDICTS’ STRATEGIES**

What will you do when you suspect your new patient is addicted to opioids? Suppose someone comes into your office...
looking disheveled, smelling like alcohol, and asking for an opioid prescription? Suppose they seek to obtain a prescription by being hostile and demanding? Or what if he or she comes into your office looking clean, well-groomed, and is overly friendly and full of flattery. The patient says everything you want to hear. Suppose the prescription monitoring program reveals that they are receiving twice the amount of opioids that you are prescribing for them?

“You will have to have that hard conversation with the patient,” Dr. Murison said. Prescribing opioids necessitates in-depth conversation, urine screens, and family history. Using a REMS can assist you in assessing the risk.

WHAT IS REMS?

REMS is an acronym for Risk Evaluation and Mitigation Strategy. “The Food and Drug Administration Amendments Act of 2007 gave FDA the authority to require a Risk Evaluation and Mitigation Strategy (REMS) from manufacturers to ensure that the benefits of a drug or biological product outweigh its risks.” (Source and List of links to REMS by medication: http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111350.htm)

Practitioners (and other non-nurse providers) need to extend beyond their usual modes of communication. Questions need to be asked, such as “What is your goal in seeking treatment?” This question is usually a part of nursing practice, but typically not medicine.

Prescribing opioids requires providers to learn from nursing practice regarding patient education, communication and feedback.

DOCUMENTATION

Document the patient’s history and physical. “Have a documented working diagnosis, and have a differential diagnosis.” Use a screening tool, like Opioid Risk Tool (ORT). This will indicate if there is a low, medium, or high risk for the patient. It is important to assess the person’s social history and family history as well.

RED FLAGS & ALARM BELLS

How does the patient describe his or her pain? Can he or she give a detailed account of their pain? If the patient only says, “my whole back hurts,” that is a red flag. The patient may feel that you don’t believe them. That it is why it is necessary to have an objective tool (to assess their risk of abuse) to share with the patient. Their family history and social history should be a documented. The effectiveness of your risk tool, however, depends upon patient being honest in giving answers.

Another objective test is the urine drug screen. It is your right as a provider to mandate this test! Is the patient on cocaine or other opioids, marijuana? You need to know before you prescribe.

GOALS

Ask patients about their goal for treatment. Is their goal to reduce the pain? To regain function? Explain the need for balance, and let them know the potential for abuse. Explain to them the grounds for discontinuation. Opioids are a “Band-Aid” that work best for acute pain. “Opioids work great at the beginning, then fade,” Dr. Murison said. Non-opioid medications are the opposite, she said. They work better two weeks out, or a month out; they work better over time.

Prescribe medication as part of a comprehensive strategy.
All opioids are potentially lethal.
Analgesia = respiratory suppression.

COMPREHENSIVE PLAN

Opioids may be a part of pain management, but not the entire strategy. Medication should be a part of a constellation of measures taken to reduce pain. There are other avenues that can be pursued in tandem with medication. Communicate with your patient about non-opioid options.

PAIN MANAGEMENT PLAN

Here are some other methods for alleviating pain that can be used as part of a comprehensive plan:

- Physical Therapy
- Massage
- Acupuncture
- Aqua Therapy
- Exercise
- Ergonomics

Continued on page 12
SAFETY IS PRIMARY.
- Do not prescribe a medication unless you have read the instructions that come with the drug.
- Increase if disease progresses.
- When you titrate, assess for pain relief, adverse events, and withdrawal symptoms. Give the patient and family instructions and rescue kits.
- If you titrate it too fast it could cause death because the respiratory suppression will outlast the relief of pain.
- Want to discourage the use of opioids? If your patient is male, let the patient know that long-term opioid use can interfere with male sexual function.

“I RAN OUT OF MEDICATION.”
Patient may be diverting, giving medication away, or selling the medication. Perhaps a grandchild is taking the medication from a grandparent.

ADVERSE EFFECTS
Aside from the threat of addiction, there are other consequences of taking opioids. There is opioid-induced constipation. Also, alcohol and opioids do not mix! The combination has been lethal for some entertainers, Dr. Murison noted. Be sure the patient reads medication guide. The patient must not share their prescription or modify their prescription. The patient should report side effects experienced to their health care provider, and call 911 if they encounter respiration problems.

Councilmember Yvette Alexander, Chair of the Committee on Health, spoke to attendees and reiterated the importance of this issue, and noted how important it is for the District to make adjustments to the city’s prescribing policies. The Councilwoman also gave an update on healthcare legislation in the District.

PANEL DISCUSSION
The discussion that followed included panelists Kate Malliarakis, PhD, ANP, Chair of the COIN Committee for Impaired Nurses, dentist Guy Shampaine, DDS, pharmacist Elaine Yip, PharmD, and physician assistant Debra Herrmann, PA-C.

COIN
During the panel discussion, Dr. Malliarakis spoke with attendees about the Board of Nursing’s Committee on Impaired Nurses (COIN). Dr. Malliarakis urged providers to think about what they would do when they get a request for opioids before the scenario actually happens: “In your clinical setting, develop a plan and write it down. You will know what to do ahead of time. The more you practice what you are going to say, the more you will be comfortable with yourself so that it will not be a stumbling block. Find out where that patient is without judgment.

“Diversion is a serious problem for doctors and nurses. Look for patterns of diversion when reconciling medications. Be sure to investigate any discrepancies. We must have a system of accountability. Substance use disorder among healthcare professionals is about 10 percent, which is similar to the general population. Addiction is a chronic relapsing disease of the brain that manifests itself by aberrant behavior. Addiction cannot be cured, but can be contained through a strong recovery program.”

DENTISTRY
Dr. Shampaine spoke about the use of opioids in the dental office: “We give professional guidelines and training. We don’t want to harm people who really need opioids just because of a minority of patients [who abuse opioids].” Dentistry has different challenges, he said, as dentists’ primary problem is managing acute pain. The secondary goal is to not allow the patient to become a chronic opioid user. Addiction causes people to pursue a course of action without any regard for the consequences: Dr. Shampaine noted a case where one patient (not in DC) asked a dentist to remove all of her teeth, just so she could get the opioid prescription.

Board of Medicine Chair Dr. Janis Orlowski noted that dentistry is at the forefront in effective opioid strategies for pain management. “Practitioners prescribing opioids should have the education and experience required, and be capable of meeting the standard of care in the community,” Dr. Orlowski added.

The best approach for opioid prescribing is to have an interprofessional approach, using the expertise of various health care professionals working together in a team, including physical therapy and psychiatric practitioners. The ideal situation would be for the patient to go to a pain management clinic. However, the speaker noted, some communities do not have such facilities, or if available, the patient’s insurance will not pay for it.
PHARMACEUTICAL CONTROL

Trish D’Antonio, RPh, MS, MBA, CGP, the Executive Director of the Pharmacy Board and the Pharmaceutical Control Division, told attendees that the division is forming a workgroup for the establishment of the DC Pharmaceutical Control Registry. All of the states have such registries, except Missouri, and Ms. D’Antonio said that the benefit of our late start is that we can avoid the mistakes made by other states.

RIGHT TO SAY “NO”

In doubt? You may just have to tell the patient “No, I’m sorry. But based on your history [or drug urine screen], I cannot provide you with a prescription. I need to refer you to an addiction specialist.” Dr. Murison reminded attendees about Nancy Reagan’s anti-drug slogan, Just Say No. “No patient has a constitutional right to receive an opioid prescription from you,” she said.

Board of Medicine Chairperson Dr. Janis Orlowski noted that providers should practice within the appropriate scope of their education and experience and the standard of care in your community. The best approach for prescribing opioids is a multidisciplinary team of other health care professionals, including psychiatry. It should be interprofessional and collaborative.

Dr. Orlowski assured participants that the Board of Medicine will do its duty to ensure that physicians are prescribing with caution, and that opioids are prescribed appropriately. The Board of Medicine will be examining “patterns of prescription,” patterns of behavior, and maintaining contact with providers regarding the appropriateness of use.

RISK FACTORS FOR ABUSE

- Younger in Age
- Have a Psychological Disorder
- Personal or Family History of Substance Abuse
- History of Sexual Abuse (For female patients, data shows this is a risk factor)

FIVE C’S OF ADDICTION

- Craving
- Compulsion
- Loss of Control
- Continuing use despite harm
- Chronic

HOW DEATHS OCCUR

“Prescription painkillers work by binding to receptors in the brain to decrease the perception of pain. These powerful drugs can create a feeling of euphoria, cause physical dependence, and, in some people, lead to addiction. Prescription painkillers also cause sedation and slow down a person’s breathing. A person who is abusing prescription painkillers might take larger doses to achieve a euphoric effect and reduce withdrawal symptoms. These larger doses can cause breathing to slow down so much that breathing stops, resulting in a fatal overdose.”

(Source: http://www.cdc.gov/homeandrecreationalsafety/rxbrief/)

GET DETAILS

If a patient is truly in pain, they should be able to say more than “My whole back hurts.” Seek details from the patient.

- Quality of pain (sharp, stabbing?)
- Region of pain (where)
- Severity of pain (on a scale of 1-10, how much does it hurt?)
- Timing of pain (onset and duration)
- What are the exacerbating and relieving factors? What makes it worse or better?
- What other symptoms accompany it?

STRATEGIES TO BUILD TRUST

- Be professional
- Be unhurried
- Listen, be empathetic
- Be sensitive to the patient’s culture and language
- Work together to agree on a plan of care
- Avoid medical jargon
- Trust should not be confused with medical competence

(Source: Adapted from Mainous AG, et al. NZFP. 2003; 30:336-341)

ON THE FRONT LINE

The National Drug Control Strategy, the Obama Administration's blueprint for reducing drug use, declares that no one group could be more effective in reducing the trend of opioid abuse than our front-line health care professionals, including physicians, pharmacists, and nurses.
Q: Will Home Health Aides be required to renew this year?
A: Yes. HHA certifications will expire October 30, 2015. An applicant for renewal shall have:
- Completed at least twenty-four (24) hours of continuing education or in-service training in the area of health or nursing needs of an assigned client population during the certification period;
- Practiced a minimum of one hundred (100) hours during the prior twenty-four (24) months as an HHA under the supervision of a licensed nurse or other licensed health professional

PLEASE NOTE: Criminal Background Checks/Fingerprinting WILL NOT be required this renewal period.

The next DC NURSE will have more details regarding HHA and TME Renewal Requirements.

Q: Was BON informed and did it take action regarding the individual aides who were implicated in the fraud indictment? What action was taken?
A: Persons indicted were asked to surrender their certification. Those who surrendered their certification had their certification revoked. Those who chose not to surrender are being scheduled for a hearing before the Board.

Q: What is the role of the Department of Employment Services in addressing the training and other workforce issues?
A: DOES funds training for DC residents in HHA, CNA and other programs as directed by WIC (Women, Infants and Children).

Q: What is being done about the home health care aide offering money to someone in the household to take care of their loved one?
A: All complaints made to the Department of Health regarding alleged illegal activity are investigated. If there is potential fraud identified, the information is referred to the Department of Health Care Finance and the Board of Nursing is notified.

Q: So who exactly is screening the agencies themselves? It seems as if the issues are not just with the workers but with the agency.
A: The Department of Health, Health Regulation and Licensing Administration, conducts initial and annual surveys of providers. The agency assures that the person is certified as a HHA.

Q: Who should we contact when a client is going to be removed from their apartment when a person has control of their money?
A: In addition to other agencies, you may contact Adult Protective Services. “APS investigates reports of alleged cases of abuse, neglect, and exploitation by third parties, and self, of vulnerable adults 18 years of age or older. APS provides protective services to reduce or eliminate the risk of abuse, neglect, self-neglect, and exploitation.” The hotline # is (202) 541-3950 and is available 24 hours a day 7 days a week.

Q: What if an aide is unable to perform their assigned tasks?
A: The first course of action should be contact to the Home Health Agency employing the aide. Pursuant to the regulations (Title 22, DC Municipal Regulations, Chapter 39):
- A complaint may be presented orally or in writing.
- The home care agency shall respond to the complaint within fourteen (14) calendar days of its receipt, and shall document the response.
- If the patient indicates that he or she is not satisfied with the response, the agency shall respond in writing within thirty (30) calendar days from the date of the agency’s initial response. The response shall include the telephone number and address of all District government agencies with which a complaint may be filed and the telephone number of the Home Health Hotline maintained by the Department of Health.

Q: Is there an abuse registry for nurses’ aides? If so, how can employers access that?
A: You can access the CNA abuse registry at http://doh.dc.gov/node/149282. Home Health Aides are found at http://164.82.148.59/weblookup/.

Q: I have CNAs up for license renewal; why are there two different forms that are being
submitted: one sent via mail from the DC Board and a separate, different one pulled up online in a PDF format?

A: The two forms are the same; one is just condensed, the other is one generated from the online PDF format in lieu of the document that is mailed to persons up for renewal. Hypothetically, it can be obtained online when a CNA loses the renewal form mailed.

Q: Section II of the registry renewal application states that an employment agency cannot fill out this form. Please clarify.

A: If the agency exclusively deals with clinical healthcare personnel and or nursing personnel, they can sign. However, there are some agencies that have food service workers, custodial services, etc. and may not sign the form.

Q: Section III of the registry renewal application requires a signature attesting that the nurse aide has been employed for pay, performing nurse aide duties, for at least 8 hours during his/her registration period. Our training period for new staff is greater than 8 hours. May we, as an agency, state that we cannot sign unless a person has completed 40 hours?

A: Because this is a rule enforced by the Board of Nursing, an agency cannot set more stringent rules for a respective facility regarding the mandated number of hours an individual must work prior to signing Section III.

Q: We are an HHA training program. Employers are contacting us asking that we provide them with a skills checklist from our training program for our former students. Are we required to provide this information?

A: Per Ms. Sharon Mebane, Program Manager of the Intermediate Care Facilities Division: Now that HHAs are certified by the BON, HHA employers are no longer required to maintain skills checklists.
In October 2014, the Board of Nursing and the Intermediate Care Facilities Division staff held a Health Care Summit, for nurses and administrators, to provide clarification and guidance regarding nursing responsibilities, and the oversight of Home Health Aides (HHAs) working in home care agencies, assisted living residences, and group homes.

**CLARIFY SCOPE**

One topic covered during the Summit was the scope of the Home Health Aides (HHA) and Trained Medication Employees (TMEs). Administrators and nurse supervisors should be aware of what duties HHAs and TMEs are permitted to do, and those they may not do. One example is wound care. The RN cannot delegate wound care to an HHA. HHAs cannot change a wound dressing. The HHA can reinforce the area with a towel to absorb drainage, but they cannot remove dressing or change dressing.

The key to delegation is to inform the NAP of what to do before the situation occurs. “If this happens, this is what you do,” Board of Nursing Executive Karen Skinner told attendees. “Does the HHA and TME know what is expected of them? Do they know that they are to inform the supervising nurse when there is a change in their patient’s status?” The supervising nurse must address the change in status.

All changes in a patient’s health status must be communicated to the patient’s physician, and documented in the patient’s records. “You will be cited if you fail to document, because if it is not documented, it did not happen.”

TMEs must work under the supervision of an RN. DOH’s surveyors have revealed that many nurses are not aware of their supervisory responsibilities; and, therefore, TMEs and HHAs are working without supervision and performing tasks they are not authorized to perform.

**NURSING ASSESSMENTS AND TIMESHEETS**

Intermediate Care Facilities Division Program Manager Sharon Mebane reminded the administrators and nurses attending the Summit that nursing assessments must reflect accurate information. Surveyors are finding that nurses are not performing their own assessment, but documenting information received from patients as a true nursing assessment.

Example: Review of numerous nursing assessments reflect blood sugar reading and weights. When asked how these values were obtained, the nurse indicated that the patient self-reported the information. When visiting the patients’ home, surveyors discovered that several patients did not possess a glucometer or a home scale.

Nurses document arrival and departure times for home visits. Surveyors discovered that the timeframe in between home visits did not allow for travel time.

Example: The nurse arrived at Patient A’s home at 11:00 am and departed at 12:00 noon. The next patient (Patient B) lives across town, but the nurse documented an arrival time of 12:00 noon and a departure time of 1:00 pm. In many cases, assessment times reflect one-hour visits.

**EDUCATE THE CLIENT**

The NAP should have the education and training sufficient to effectively meet the needs of their client, and the client should be educated as to what they should expect from the NAP. The nurse supervisor should educate patients on what tasks are to be performed during their personal care services. On each visit, the supervisory nurse should interview the patient as to what has been happening with their care since the last visit. The interview should be private and not in the presence of the NAP. It is paramount that the nurse speak directly with patients and that patients are aware of their rights.

**AFTER DELEGATING A TASK**

- Verify that the NAP knows how to perform delegated task; if not, train them.
- Monitor performance of the delegated task.
- Evaluate the client’s response and the outcome of the delegated nursing intervention.
- Routinely monitor and reassess the client’s condition.
Example: Ms. Mebane noted a case where a patient was prescribed 16 hours of personal care services for 7 days. Although the patient was signing a timesheet reflecting that she was receiving 16 hours of care a day, the survey revealed that the HHA was only providing 8 hours a day. The patient was unaware that by signing the timesheet she was attesting that 16 hours were being provided.

The visiting nurse should be an advocate for the patient and a supervisor for the HHA. The nurse's goal is to ensure the patient's well-being and to ensure that the HHAs are implementing the plan of care as required.

**KNOW THE REGULATIONS**

“Make sure your people are competent. You need to be sure that

**Continued on page 18**

DOH’s surveyors have revealed that many nurses are not aware of their supervisory responsibilities; and, therefore, TMEs and HHAs are working without supervision and performing tasks they are not authorized to perform.
the NAP can perform the duties required for that particular assignment. Do not assume they know until you see that return demonstration. In the past, we had a patient transferred by Hoyer Lift and the patient fell because the NAP did not have the skill to operate the Hoyer Lift.”

IN-SERVICE EDUCATION
Providing in-service education is a vital component for ensuring that NAPs gain and retain the skills they need to provide quality care. During the Summit, staff from HRLA emphasized that in-serve education must be provided for NAPs, and that those sessions should not be scheduled during hours when the NAP is supposed to be working with clients. The NAP cannot abandon a patient to attend an in-service. At the Summit, it was mentioned that one Home Health Aide attended an in-service session and brought her client with her. Abandoning a patient or bringing a patient to the in-service session should not be the only options for HHAs. Sessions should be held when HHAs can attend and devote their full attention to the program. At the workshop, Dr. Bonita Jenkins, the Board’s Specialist for Nurse Education, has explained the difference between Continuing Education programs and in-service programs (see page 17).

INFORM THE BOARD
“Have you terminated an NAP or RN? I need to know when you terminate.” Board of Nursing Consultant for Discipline, Felicia Stokes, BSN, RN, reminded administrators of their responsibility to let the Board know about NAPs or nurses who have not met practice standards. Agencies must keep the lines of communication open between themselves and the Board: “If you have terminated an HHA, let us know because when they leave your agency, they are just going to go to another agency.”

Do you have an HHA who did not show up for work? Have you gone to check up on an HHA on duty, and found that the client was being cared for by the HHA’s relative—not the HHA assigned? “We have had relatives of HHAs show up for duty at clients’ homes,” Ms. Stokes said. “Meanwhile, the HHA is out at a doctor’s appointment or taking care of personal business. The HHA is not on duty; however, her female relative is there. You need to spot check. Go to patient’s home. Is the HHA there? Is some other person there? Speak to the patient when the HHA is not on duty to confirm there is not timesheet fraud, theft or abuse. Forward the complaint or allegation to me and we will follow up.”

AGENCY RECORDS
Plans of Care are required to be individualized. The plan of care must address the specific personal care and health care needs of the patient. Nursing notes should be thorough and reflect changes in the patient’s health, needed services, communications with patient’s health practitioner, the patient understanding of their health care, etc.

APPROPRIATE HHA ASSIGNMENTS
The HHA must be trained and competent to provide care to their assigned patient. Not all HHAs are able to care for all patients. In the District, there was a client who needed psychological care and was placed in a facility where all the other clients were much older than him and the staff was not equipped to address his psychological needs. Just because you have a bed available doesn’t mean you should accept that patient.

BED BUGS
Rodent and Vector Control Supervisor Gerard Brown spoke with participants about bed bugs and the elderly. “Bed bugs do not spread disease,” Mr. Brown said, “They are not a health risk to humans.” However, bed bugs can become infested in the homes of clients who
have a declining ability to keep their homes and bedding clean. Mr. Brown provided tips for nurses and HHAs serving clients whose homes could have bed bugs. “I know many of you like to keep all of your belongings with you, in tote bags, but please do not take them into a patient’s home. Protect yourself. Treat every home like it has bed bugs.”

DOH staff can come to an agency to provide an in-service education program on bed bugs, he said. “We can do a 45-minute presentation of the history of bed bugs and to let your staff know about the simple things they can do to protect themselves and clients from bed bug infestation.” Ms. Mebane added: “We have to have confirmation from a reputable company that the home has bed bugs. If your client has bed bugs, please call Adult Protective Services at (202) 541-3950, 24 hours a day 7 days a week.”

The HHA shall identify himself or herself at all times when participating in client care. The individual shall wear a pictured identification badge with lettering clearly visible to the client, bearing the name of the individual and his or her position title. The position title shall not in any way imply that the individual is licensed or a nurse.

IN-SERVICE SESSIONS
- NAPs must have 12 hours of in-service education a year.
- DOH surveyors will review personnel records to determine in-service education.
- The agencies should ensure through testing or monitoring that HHA’s gained the knowledge and/or the targeted skills that were the objective(s) of the training/in-service.

REINFORCE AND EXPAND THEIR SKILLS
- HHAs welcome an opportunity to learn. They want to be instructed on how to care for their patients.
- HHAs and TMEs should be made aware of the signs and symptoms of illness that must be reported to their supervising nurse.
- The nurse supervisor is required to review the Plan of Care with the HHA.
- Nurses are responsible and accountable for the quality of care delivered by the HHA/TME.

HHAs shall not practice independently but shall work under the immediate supervision of a licensed nurse or other licensed health care professional.

The delegating registered nurse shall be responsible for the adequacy of care provided and shall retain accountability for the nursing task.

On-site supervision of skilled services shall take place at least once every two (2) weeks. On-site supervision of all other services shall take place at least once every sixty-two (62) days.

Written patient care instructions for the HHA must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the HHA.

Home Health Aides are selected on the basis of such factors as a sympathetic attitude toward the care of the sick, ability to read, write, and carry out directions, and maturity and ability to deal effectively with the demands of the job. They are closely supervised to ensure their competence in providing care.

The patient’s current care needs and Plan of Care should match what is happening in the home.
NAP NEWS!

NAP Advisory Committee Vacancies

NAP COMMITTEE CHARGE:
- Provide advice regarding regulatory requirements
- Recommend NAP in-service/continuing education needs
- Provide advice regarding training programs
- Provide advice regarding disciplinary options

Please be reminded to submit your name for the Board of Nursing’s NAP Advisory Committee. NAP Committee Charge:
- Provide advice regarding regulatory requirements
- Recommend NAP in-service/continuing education needs
- Provide advice regarding training programs
- Provide advice regarding disciplinary options

We still have vacancies for positions:
- Certified Nursing Assistant currently working in a DC LTC facility
- Patient Care Technician currently working a DC acute care facility
- RN or LPN educator currently teaching or administering a NAP Program
- RN or LPN currently supervising the practice of NAPs
- Consumer member (New position)

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NCSBN REVISES DEFINITION OF ENTRY-LEVEL NURSE:
The National Council of State Boards of Nursing (NCSBN) Board of Directors has approved a revised definition of the entry-level nurse in the NCLEX environment, which was the result of analysis leading to the question of what constitutes the length of the entry-level period. The designation of entry-level will now be defined as a nurse having no more than 12 months of experience; previously it was defined as a nurse having no more than six months of experience. NCLEX examinations are developed to measure the minimum knowledge, skills and abilities required to deliver safe, effective nursing care at the entry level. Part of the development process is to periodically review and define the examinee profile, the practice environment for entry-level nurses and the environment’s effect on the length of the entry-level period. NCSBN conducts the NCLEX practice analyses every three years to examine entry-level practice. For more details on the research behind the change in the entry-level definition, go online at: https://www.ncsbn.org/Review_EntryLevel_Characteristics_and_NCLEX.pdf.

NCSBN RELEASES RESULTS OF NATIONAL SIMULATION STUDY:
The National Council of State Boards of Nursing (NCSBN) has released the findings of its award-winning research, “The NCSBN National Simulation Study: A Longitudinal, Randomized, Controlled Study Replacing Clinical Hours with Simulation in Prelicensure Nursing Education,” which concluded that substituting high quality simulation experiences for up to half of traditional clinical hours produces comparable end of program educational outcomes to those students whose experiences are mostly just traditional clinical hours and produces new graduates that are ready for clinical practice. The largest and most comprehensive research to date examining the use of simulation in the prelicensure nursing curriculum, this longitudinal study included incoming nursing students from 10 prelicensure programs across the US. The full report is available as a supplement to the Journal of Nursing Regulation (JNR) and can be accessed on our website: https://www.ncsbn.org/2094.htm.

NCSBN AFFIRMS COMMITMENT TO FACILITATING INTERSTATE PRACTICE:
The NCSBN passed a resolution affirming its commitment to facilitating interstate practice at its Delegate Assembly and Annual Meeting held in Chicago, August 2014. With this resolution, NCSBN affirms its endorsement of a uniform mutual recognition model for state-based nurse licensure to enhance public protection and use of telehealth technology for access to health care as well as facilitate the mobility of nurses. Over the past year, the NCSBN Executive Officer Forum has engaged in a dialogue about the mutual recognition model of licensure and has reached consensus to propose revisions to the Nurse Licensure Compact that will allow for its expeditious adoption by states. Additionally, the Advanced Practice Registered Nurse (APRN) Compact has been proposed and is being aligned with the NLC. Visit the NCSBN website for more information about the NLC: https://www.ncsbn.org/nlc.htm.

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Fax: (202) 319-0048

e-mail: hpla.doh@dc.gov  •  web: http://doh.dc.gov/bon
The DC Department of Health (DOH) reaffirms its commitment to preparing for potential cases of Ebola Virus Disease by announcing the first tier of acute care hospitals ready to address Ebola in the District of Columbia. DOH, with the support of the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC) has identified Children’s National Medical Center, Medstar Washington Hospital Center and George Washington University Hospital as the first group of nationally recognized Ebola preparedness hospitals in the District of Columbia. The CDC and DOH have visited, evaluated and determined these facilities capable of providing extensive clinical treatment.

DOH, in partnership with all area hospitals and the District of Columbia Hospital Association (DCHA) continues to set the standard for public health response to emerging infectious diseases.

“Over the past six months, we have been focused on developing a strategy that will allow us to efficiently identify, monitor and treat potential Ebola cases identified in the District of Columbia. Through collaboration with federal and local partners including the CDC and DCHA, we have created a unique standard, as well as an optimal system for preparing the city for Ebola or any other emerging public health threat,” said DOH Director, Dr. Joxel Garcia. “I strongly believe we have the best public health system in the nation and we will be ready if and when the time comes to address this public health concern.”

The District of Columbia has developed a three tiered approach to hospital readiness. First tier of acute care hospitals are capable of identifying, isolating and treating patients infected with the Ebola Virus. The second tier will have the same capabilities and will serve as overflow should the tier one institutions be at capacity at the time of need. Tier three institutions will be capable of evaluating and isolating patients at risk for Ebola, and be able to stabilize these patients for transfer to a higher tier facility.

“To be identified as a designated site in Washington, D.C. is an honor and recognition of the tremendous work we do every day,” said Barry Wolfman, chief executive officer and managing director of GW Hospital. “If called upon, we are ready to provide outstanding care of the highest quality. That’s what our record shows we do and what people in this region and our country expect from GW Hospital.”

Moving forward, DOH will continue to work with community based organizations, local health care facilities, fellow District agencies and all District hospitals on Ebola preparedness.

For more information on Ebola, please visit www.ebola.dc.gov.
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<thead>
<tr>
<th>Day</th>
<th>Port</th>
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<th>Depart</th>
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<tr>
<td>Sun</td>
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<tr>
<td>Mon</td>
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<td>New Orleans, LA</td>
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Who says Continuing Education can’t be fun?

Join ThinkNurse and Poe Travel for our 9th Annual CE Cruise. Cruise the Caribbean on Carnival’s Dream while you earn your annual CE credits and write the trip off on your taxes! Prices for this cruise and conference are based on double occupancy (bring your spouse, significant other, or friend) and start at only $838 per person (not including airfare to New Orleans) A $250 non-refundable per-person deposit is required to secure your reservations. Please ask about our Cruise LayAway Plan!

South Central Accreditation Program (SCAP) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.
CDC Checklist for Patients Being Evaluated for Ebola Virus Disease (EVD) in the US

UPON ARRIVAL TO CLINICAL SETTING/TRIAGE
Does patient have fever (subjective or $\geq 101.5^\circ F$)?
Does patient have compatible EVD symptoms such as headache, weakness, muscle pain, vomiting, diarrhea, abdominal pain or hemorrhage?
Has the patient traveled to an Ebola-affected area in the 21 days before illness onset?

UPON INITIAL ASSESSMENT
Isolate patient in single room with a private bathroom and with the door to hallway closed
Implement standard, contact, & droplet precautions
Notify the hospital Infection Control Program
Report to the health department

CONDUCT A RISK ASSESSMENT FOR: HIGH-RISK EXPOSURES
Percutaneous (e.g., needle stick) or mucous membrane exposure to blood or body fluids from an EVD patient
Direct skin contact with skin, blood or body fluids from an EVD patient
Processing blood or body fluids from an EVD patient without appropriate PPE
Direct contact with a dead body in an Ebola-affected area without appropriate PPE

LOW-RISK EXPOSURES
Household members of an EVD patient or others who had brief direct contact (e.g., shaking hands) with an EVD patient without appropriate PPE
Healthcare personnel in facilities with EVD patients who have been in care areas of EVD patients without recommended PPE

BEFORE ENTERING PATIENT ROOM, WEAR:
Gown (fluid resistant or impermeable)
Facemask
Eye protection (goggles or face shield)
Gloves

IF LIKELY TO BE EXPOSED TO BLOOD OR BODY FLUIDS, ADDITIONAL PPE MAY INCLUDE BUT ISN'T LIMITED TO:
Double gloving
Disposable shoe covers
Leg coverings

UPON EXITING PATIENT ROOM
PPE should be carefully removed without contaminating one’s eyes, mucous membranes, or clothing with potentially infectious materials

Discard disposable PPE
Re-useable PPE should be cleaned and disinfected per the manufacturer’s reprocessing instructions
Hand hygiene should be performed immediately after removal of PPE

DURING AEROSOL-GENERATING PROCEDURES
Limit number of personnel present
Conduct in an airborne infection isolation room
Don PPE as described above except use a NIOSH certified fit-tested N95 filtering facepiece respirator for respiratory protection or alternative (e.g., PAPR) instead of a facemask

PATIENT PLACEMENT AND CARE CONSIDERATIONS
Maintain log of all persons entering patient’s room
Use dedicated disposable medical equipment (if possible)
Limit the use of needles and other sharps
Limit phlebotomy and laboratory
SecureTech360: HRLA Technology Upgrade

The Health Regulation and Licensing Administration Board room will soon get an extensive technology upgrade. Below, the project manager from the SecureTech360 company, Danielle Webb, answers questions about our new multi-media Smart Board:

How will HRLA’s new SecureTech360 unit differ from the Smart Board currently in the Board room?

What new features and functions will be available?

SecureTech360 will install a wireless integrated system that is tied into the data center. These rooms become part of an enterprise wide solution, which will have video conferencing, live streaming, recording, and digital play out capabilities on any device, anywhere, anytime.

What will be the dimensions of the new system?

This is a full enterprise solution; there is no one dimension available. Part the install will include a four panel Video Wall, which is 110” x 110”, and a 65” Smart Board.

HPLA’s new unit will be have a multi-panel screen. What is the advantage of this for staff/members who are holding meetings?

This solution allows you to view multiple content simultaneously.
Kudos!

Congratulations to Dr. JoAnne Joyner, who was appointed as a Commissioner to the District of Columbia Education Licensure Commission.

Congratulations to Karen Scipio-Skinner, MSN, RN, who was one of 15 women selected to receive the 2014 Distinguished Woman Healthcare Leadership Award from the National Association of Health Executives.

Bernardine Lacey, EdD, RN, FAAN was one of four nurses honored by the American Academy of Nursing as a “Living Legend.” The Academy recognizes a small group of fellows as Living Legends in honor of their extraordinary contributions to the nursing profession, sustained over the course of their careers. Dr. Lacey started the movement to include care of the underserved in the nursing curriculum. Because of this movement, the profession is better prepared to care for the most vulnerable in our society.

Scholarship Opportunity for Nursing Students

Each year the Black Nurses Association of Greater Washington, DC, Area offers four scholarships to African American licensed nurses and student nurses who are residents of the District of Columbia and adjacent counties of the State of Maryland (Anne Arundel, Calvert, Charles, Howard, Montgomery and Prince Georges counties). Interested individuals may go online and download a copy of their desired scholarship application from www.bnaofgwdca.org.

The Black Nurses Association of Greater Washington, D.C. Area (BNA of GWDCA) mission is “Empowering the Community through Education, Service and Caring.” BNA of GWDCA was officially chartered in February 1976. As a local chapter of the National Black Nurses Association, BNA of GWDCA endeavors to support NBNA and provide service to the Greater Washington, D.C. Area community. Members are encouraged to maintain membership in all professional nursing organizations. Membership is open to all licensed nurses and nursing students.

MRSA ALERT

Methicillin-resistant Staphylococcus aureus (MRSA) is a bacteria that is resistant to many antibiotics. In the community, most MRSA infections are skin infections. In medical facilities, MRSA causes life-threatening bloodstream infections, pneumonia and surgical site infections. For information about "Environmental Cleaning & Disinfecting for MRSA," please visit http://www.cdc.gov/mrsa/community/environemnt/index.html on the CDC website.
Board of Nursing Speakers Bureau:

Are you an RN or Healthcare Professional with excellent speaking skills and knowledgeable in Faculty Development, Risk Management, Wound Care, RN Physical Assessment – Update, Professional Ethics, Patient Safety and Quality, Delegation, and Preventing Patient Abuse. Join our Speakers Bureau for Board-sponsored continuing education programs. Please send an email with your resume/CV to Dr. Bonita Jenkins at bonita.jenkins@dc.gov.

Derek Brooks, MSA, CFE, gave a presentation to the Board on the Pharmaceutical Control Division’s new Prescription Fraud Reporting Website. Pharmaceutical Control’s website will assist health care professionals in reporting lost, stolen, and fraudulent prescriptions (please visit http://doh.dc.gov/page/prescription-fraud-reporting). This method will provide an accessible way for licensed practitioners and pharmacies to notify HRLA of incidents of fraudulent prescriptions.
**Board Disciplinary Actions**

<table>
<thead>
<tr>
<th>NAME</th>
<th>LICENSE #</th>
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<tr>
<td>Roneka Eaton</td>
<td>HHA7305</td>
<td>Certificate Denied</td>
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<tr>
<td>Jared Kline</td>
<td>RN1026204</td>
<td>Summarily Suspended</td>
</tr>
<tr>
<td>Richard Kearney</td>
<td>HHA4916</td>
<td>Certificate denied</td>
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<tr>
<td>Edward Erinle</td>
<td>RN59341</td>
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<tr>
<td>Nicole Squire</td>
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</tr>
<tr>
<td>Anna Sirri</td>
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<tr>
<td>Allison Siebel</td>
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<tr>
<td>Sheila Bean</td>
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<tr>
<td>Dirk Wright</td>
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<td>Foluso Faphounda</td>
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<td>Collins Nkafor</td>
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<tr>
<td>Julie Udoh</td>
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<tr>
<td>Felicia Williams</td>
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</tr>
</tbody>
</table>

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

**Non-Public Disciplinary Actions:**

- Referrals to COIN = 2
- Notice of Intent to Discipline = 12
- Consent Orders = 5
- Requests to Withdraw = 14
- Letters of Concern = 0
- Requests to Surrender = 5

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**Izu I. Ahaghotu, RN, JD**

ATTORNEY AT LAW

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

Please contact Izu I. Ahaghotu, RN, Esquire directly:

Office: 202.361.6909  
www.IZUAHAGHOTU.com  
Email: ucheizu@msn.com  
3724 12th St NE  
Washington, DC 20017
FOR THOSE WHO HAVE A HEALING TOUCH

With a constant devotion to comfort and compassion, nurses truly make a difference. Our “The Art of Caring” Embroidered Hoodie brings recognition to this profession in the everyday style of a hoodie.

Practical and comfortable with outstanding design features, this machine-washable hoodie is crafted in a dark charcoal easy-care cotton blend. The front and back of this wardrobe essential are embroidered with the word “NURSING” in white script. Pink sparkling rhinestones adorn the heart on the front while embroidered hearts and a nursing hat complete the design on the back. Exclusive design detail includes, a jersey lined hood, side seam pockets in the front, knit cuffs and a straight hem for an extra comfortable fit. An exquisite metallic nurse hat zipper pull adds extra style. Imported.

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☐ XL (18) 01-16661-013

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☐ 2X (22) 01-16661-015
☐ 3X (24) 01-16661-016

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