VOLUME 12 NUMBER 1
FEBRUARY 2015

DISTRICT OF COLUMBIA NURSE

Extended Release/Long-Acting

Opioids:

Assessing Risks, Safe Prescribing

- Special Alert: Obligation to Report
- LPN Renewal

Government of the District of Columbia
Muriel Bowser, Mayor

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DISTRICT of COLUMBIA NURSE

Edition 42

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

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

Circulation includes over 37,000 licensed nurses, nursing home administrators, nurse staffing agencies and nursing assistive 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.)

Message from the Chair

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. When a license expires or board discipline is issued, employers can receive a Nursys email alert. But they cannot get these if they have not signed up. See the article entitled "NCSBN Launches Nursys e-Notify" to find out how to get free updates.

- 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."

Cathy Borris-Hale, RN, MHA, BSN

- 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.

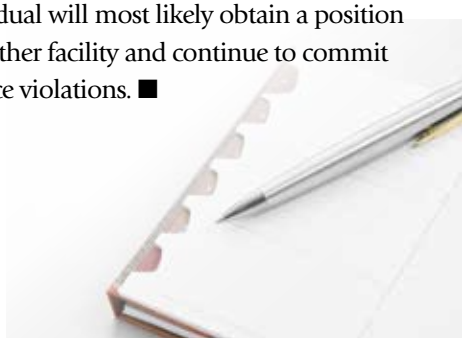
Nurses play a critical role in the vitality of our health care system. They are often at the frontline of our urgent care system, and offer care when members of the general public are most in need of care. The Board of Nursing, therefore, takes each allegation of impropriety seriously. When an allegation 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 pratice 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.

Licensed Practical Nurse (LPN) Renewals Began January 2015.
Current Licenses Expire June 30, 2015.

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 proof of having completed an undergraduate or graduate course, in nursing or relevant to the practice of nursing.

(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. ■

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

***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. ■

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.

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.

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?

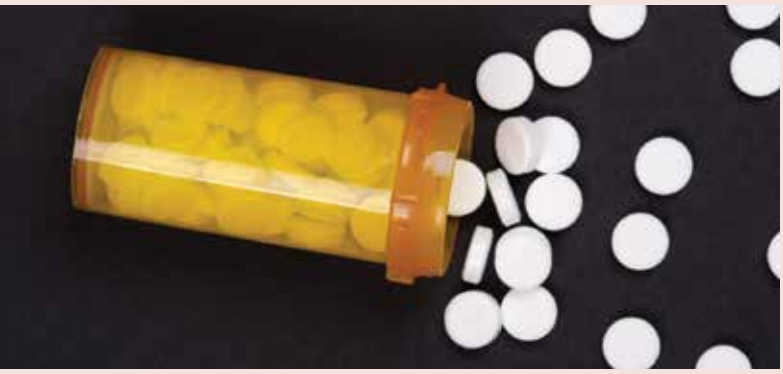
A: Legislation has been proposed to place Certified Professional Midwives under the authority of the Board of Medicine. The Board of Medicine is forming a taskforce to review the proposed legislation. The Board of Medicine has received the names of Certified Nurse Midwives and "non-nurse" midwives that 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. ■

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. ■

ER/LA Opioids: Assessing Risks, Safe Prescribing

By Nancy Kofie



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/rxbrief/).

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/rxbrief/).

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). 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.

Left to right: COIN Chairperson Kate Driscoll Malliarakis, PhD, RN, CNP, MAC, Board Member Chioma Nwachukwu, DNP, PHNCNS-BC, RN, and Board ED Karen Scipio-Skinner, MSN, RN.

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

COIN CONSULT continued

Continued from page 11

- Adaptation
- Improved sleep (better pillow, mattress)
- Psychological Support
- Interests and Hobbies
- Non-opioid neuro-active medication

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 mediation. 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 inter-professional 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.

Left to right: Patricia D'Antonio, RPh, MS, MBA, CGP, Executive Director of the Board of Pharmacy and Program Manager for the Pharmaceutical Control Division; Karen Scipio-Skinner, MSN, RN, Executive Director of the Board of Nursing; Keynote Speaker Beth Murinson, MD, PhD; Janis M. Orlowski, MD, MACP, Chair of the Board of Medicine; and Jacqueline A. Watson, DO, MBA, Executive Director of the Board of Medicine.

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 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.

NAP NEWS!

Q&A on NAP Performance, Regulations, and Monitoring

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 there 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 is 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. ■

BOARD OF NURSING MEETINGS

Members of the public are invited to attend...

Date:
First Wed. of every **other** month.

Time:
9:30 a.m – 11:30 a.m.

Location:
2nd Floor Board Room
899 North Capitol St NE
Washington, DC 20002

Transportation:
Closest Metro station is Union Station.

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

May 7, 2015

July 2, 2015

September 3, 2015

November 5, 2015

Please note new schedule

NAP NEWS!

Health Care Summit on Delegation to NAPS

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.

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.*

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.

Staff of the Intermediate Care Facilities Division

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

Supervisory Nurse Consultant Veronica Longstreth invited attendees to review the Federal regulations online at: http://cms.hhs.gov/Regulations andGuidance/Guidance/Manuals/downloads/som107ap_b_hha.pdf.

"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.

DIFFERENTIATING CONTINUING EDUCATION FROM IN-SERVICE EDUCATION:

CONTINUING EDUCATION (CE)

(1) Definition: "Systematic professional Learning experiences designed to augment the knowledge, skills, and attitudes of nurses and therefore enrich the nurses' contributions to quality health care and their pursuit of professional career goals" (Scope and Standards of Practice for Nursing Professional Development, ANA, 2000). Continuing education is not: basic skill training, competency training, local policy administrative procedures training, or update briefings.
(2) Characteristics: (a) Content: Reflects current and emerging concepts, principles, Practices, and/or nursing assistive information beyond that which is taught in NAP training program. (b) Application: Immediate or futuristic application in meeting nursing practice needs or goals of the learner. Knowledge and skill may be utilized in a variety of practice and education settings. (c) Examples: Learning activities encompassing topics from the realms of clinical practice, administration, research, and education.

IN-SERVICE EDUCATION

(1) Definition: "Learning experiences provided in the work setting for the purpose of assisting staff members in performing their assigned functions in that particular agency or institution" (Scope and Standards of Practice for Nursing Professional Development, ANA, 2000).
(2) Characteristics: (a) Content: Reflects employer's goals and service commitments; includes, but is not limited to, review of previously learned skills. (b) Application: Knowledge and skills are specific to a given employment setting and are immediately applicable to the learner. (c) Examples: Training in procedures such as Basic Life Support, operation of specific equipment, and standard operating policies and procedures for a particular institution or agency. NOTE: To find approved CE courses, go to www.cebroker.com. Please note that contact hours cannot be awarded for in-service education activities.

Health Care Summit (continued)

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.

NURSE OR NAP DISCIPLINED?
Please contact the Board's Nurse Consultant for Discipline
FELICIA STOKES, BSN, JD
at
felicia.stokes@dc.gov
(202) 724 - 8691

Continued from page 17

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

Gerard Brown, Program Manager of the Rodent and Vector Control Division

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)

Contact Angela.Braxton2@dc.gov to request an application.

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Touching Our Hearts with Love

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to Share,
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The perfect way to honor nurses everywhere, this stunning pendant is available at the remarkable price of just $89*, which you can pay for in 4 easy installments of $19.75. Your pendant arrives in a velvet jewelry pouch and gift box, along with a Certificate of Authenticity and a beautiful poem card. Plus, it is backed by our unconditional, full-money-back, 120-day guarantee. To reserve your pendant, send no money now; just fill out and mail the Reservation Application today!

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Signature _____

Mrs. Mr. Ms. _____
Name (Please Print Clearly)

Address _____

City _____ State _____ Zip _____

E-Mail (Optional) _____

01-18342-001-E56401

NCSBN News

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**. ■

PROFESSIONAL NURSING SCHOOLS

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2400 6th St. N.W.
Washington, DC 20059
tammi.damas@howard.edu
PH: (202) 806-7456
FAX: (202) 806-5958
CONDITIONAL - RN Program
FULL APPROVAL - APRN Program

Sandra Marshall, MSN, RN,
Interim Program Director of Nursing
Radians College
1025 Vermont Avenue, NW; Suite 200
Washington, DC 20005
smarshall@radianscollege.edu
PH: (202) 291-9020
FAX: (202) 829-9192
RN Program Only
CONDITIONAL

Denise S. Pope, PH.D.RN
Associate Dean for Nursing and Health Professions
Chief Nursing Officer
Trinity Washington University
125 Michigan Avenue, N.E.
Washington, D.C. 20017
PopeD@trinitydc.edu
Phone: 202-884-9682
Fax: 202-884-9308
RN Program Only
CONDITIONAL

Susie Cato MSN, MASS, RN, Director of Associate Degree Nursing Program, University of District of Columbia Community College
Associate Degree Nursing Program
801 North Capitol Street NE Room 812
Washington, DC 20002
scato@udc.edu
PH: (202) 274-5914 • FAX: (202) 274-5952
RN Program Only
CONDITIONAL

Mary Jean Schumann, DNP, MBA, RN, CPNP, FAAN, Interim Senior Associate Dean for Academic Affairs, The George Washington University Graduate School of Nursing
900 23rd St. NW, Suite 6167 B
Washington, DC 20037
sonemd@gwumc.edu
PH: (202) 994-5192 • FAX: (202) 994-2777
APRN Program Only
FULL APPROVAL

PRACTICAL NURSE PROGRAMS

Michael Adedokun, PhD, MSN, RN, Director of Nursing,
St. Michael School of Allied Health
1106 Bladensburg Road, N.E.
Washington, DC 20002-2512
MAdedokun@comcast.net
PH: (202) 388-5500
FAX: (202) 388-9588
CONDITIONAL

Sandra Marshall, MSN, RN
Interim Program Director of Nursing, Radians College
1025 Vermont Avenue, NW; Suite 200
Washington, DC 20005
smarshall@radianscollege.edu
PH: (202) 291-9020
FAX: (202) 829-9192
CONDITIONAL

Susie Cato, MSN, MASS, RN, Interim Director
University of the District of Columbia Community College
Nursing Certificate Programs
5171 South Dakota Avenue NE
Washington, DC. 20017
scato@udc.edu
PH: (202) 274-6950
FAX: (202) 274-6509
CONDITIONAL

NURSING ASSISTANT AND HOME HEALTH AIDE TRAINING PROGRAMS

CAPTEC Med Care (CNA/HHA)
3925 Georgia Avenue, NW
Washington, DC 20011
CNA email: ukaoba@yahoo.com
HHA email: captecprofessional@gmail.com
PH: (202) 291-7744
FAX: (202) 560-5119
BRIDGE COURSE - HHA
FULL APPROVAL - CNA
CONDITIONAL - HHA

Carlos Rosario International Public Charter School (CNA)
514 V Street, NE
Washington, DC 20002
email: cramirez@carlosrosario.org
PH: (202) 797-4700
FAX: (202) 232-6442
FULL APPROVAL - CNA

Allied Health & Technology Institute (CNA/HHA)
2010 Rhode Island Avenue, NE 2nd Fl
Washington, DC 20018
email: alliedhealthdc@yahoo.com
PH: (202) 526-3535
FAX: (202) 526-3939
BRIDGE COURSE - HHA
FULL APPROVAL - CNA
CONDITIONAL - HHA

HealthWrite Training Center (CNA/HHA)
2303 14th St NW, Suite 100
Washington, DC 20009
www.healthwrite.org
PH: (202) 349-3934
BRIDGE COURSE - HHA
FULL APPROVAL - HHA
INITIAL APPROVAL - CNA

Home Care Partners, Inc (HHA)
1234 Massachusetts Avenue, NW
Suite C-1002
Washington, DC 20005
email: MMuller@homecarepartners.org
PH: (202) 638-2382
BRIDGE COURSE - HHA
CONDITIONAL - HHA

Intellect Health Institute
3811 Minnesota Ave., NE
Washington, DC. 20019
www.intellect-health.com
PH: (202) 239-2666
Email: intellecthealth@yahoo.com
BRIDGE COURSE - HHA
CONDITIONAL - HHA

Opportunities Industrialization Center of Washington DC (OIC DC) (HHA)
3016 Martin Luther King Jr. Avenue S.E
Washington, DC 20032
email: dlittle@oicdc.org
PH: (202) 373-0330
(202) 373-0336
CONDITIONAL - HHA

Innovative Institute (CNA/HHA)
1805 Montana Avenue NE
Washington, DC 20002
email: nazoroh@thcii.com
PH: (202) 747-3453/ 202 747-3450
FAX: (202) 747-3481
BRIDGE COURSE - HHA
FULL APPROVAL - CNA
CONDITIONAL - HHA

University of the District of Columbia-Community College (CNA/HHA)
Bertie Backus Campus Certificate Programs
5171 South Dakota Avenue, NE
Washington, DC 20017
email: cthornton@udc.edu
PH: (202) 274-6950
BRIDGE COURSE - HHA
CONDITIONAL - CNA & HHA

VMT Education Center (CNA/HHA)
401 New York Ave, First Floor. NE
Washington, DC 20002
email: cdallas@vmtltc.com
PH: (202) 282-3143
FAX: (202) 282-0012
BRIDGE COURSE - HHA
FULL APPROVAL - CNA
CONDITIONAL - HHA

Nationwide Training Institute (HHA)
6210 North Capitol Street NW
Washington, DC 20011
2004 Rhode Island Avenue NE
Washington, DC 20018
email: wtiinstitute@yahoo.com
PH: (240) 460-7060
FAX: (202) 319-0048

DC Based Hospitals Among 35 Nationally Recognized Ebola Treatment Centers

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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Wed	Belize	8:00 AM	5:00 PM
Thu	Mahogany Bay, Isla Roatan	9:00 AM	5:00 PM
Fri	Fun Day At Sea		
Sat	Fun Day At Sea		
Sun	New Orleans, LA	8:00 AM	

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South Central Accreditation Program (SCAP) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

For more information about the cruise and the curriculum please log on to our Web site at ThinkNurse.com or call Teresa Grace at Poe Travel Toll-free at 800.727.1960.

POETRAVEL

CDC Checklist for Patients Being Evaluated for Ebola Virus Disease (EVD) in the US

Dr. Joxel Garcia, out-going DOH Director speaks to Board members about Ebola preparedness in the District.

UPON ARRIVAL TO CLINICAL SETTING/TRIAGE

Does patient have fever (subjective or ≥101.5°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

testing to those procedures essential for diagnostics and medical care
Carefully dispose of all needles and sharps in puncture-proof sealed containers
Avoid aerosol-generating procedures if possible
Wear PPE (detailed in center box) during environmental cleaning and use an EPA-registered hospital disinfectant with a label claim for non-enveloped viruses*

INITIAL PATIENT MANAGEMENT

Consult with health department about diagnostic EVD RT-PCR testing**
Consider, test for, and treat (when appropriate) other possible infectious causes of symptoms (e.g., malaria, bacterial infections)
Provide aggressive supportive care including aggressive IV fluid resuscitation if warranted
Assess for electrolyte abnormalities and replete
Evaluate for evidence of bleeding and assess hematologic and coagulation parameters
Symptomatic management of fever, nausea, vomiting, diarrhea, and abdominal pain
Consult health department regarding other treatment options

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged. ■

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.

Bernardine Lacey, EdD, RN, FAAN

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/enviroment/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

NAME	LICENSE #	ACTION
Roneka Eaton	*HHA7305*	*Certificate Denied*
Jared Kline	*RN1025204*	*Summarily Suspended*
Richard Kearney	*HHA4916*	*Certificate denied*
Edward Erinle	*RN59341*	*Revoked*
Nicole Squire	*NA604716*	*Suspended*
Anna Sirri	*HHA1118*	*Suspended*
Allison Siebel	*RN1025894*	*Suspended*
Sheila Bean	*RN1005914*	*Suspended*
Dirk Wright	*HHA0716*	*Certificate Denied*
Foluso Faphounda	*RN1032111*	*Revoked*
Collins Nkafor	*HHA03034*	*Revoked*
Julie Udoh	*RN1027996*	*Suspended*
Felicia Williams	*NA604521*	*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 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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- ❑ **2X (22)** 01-16661-015
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