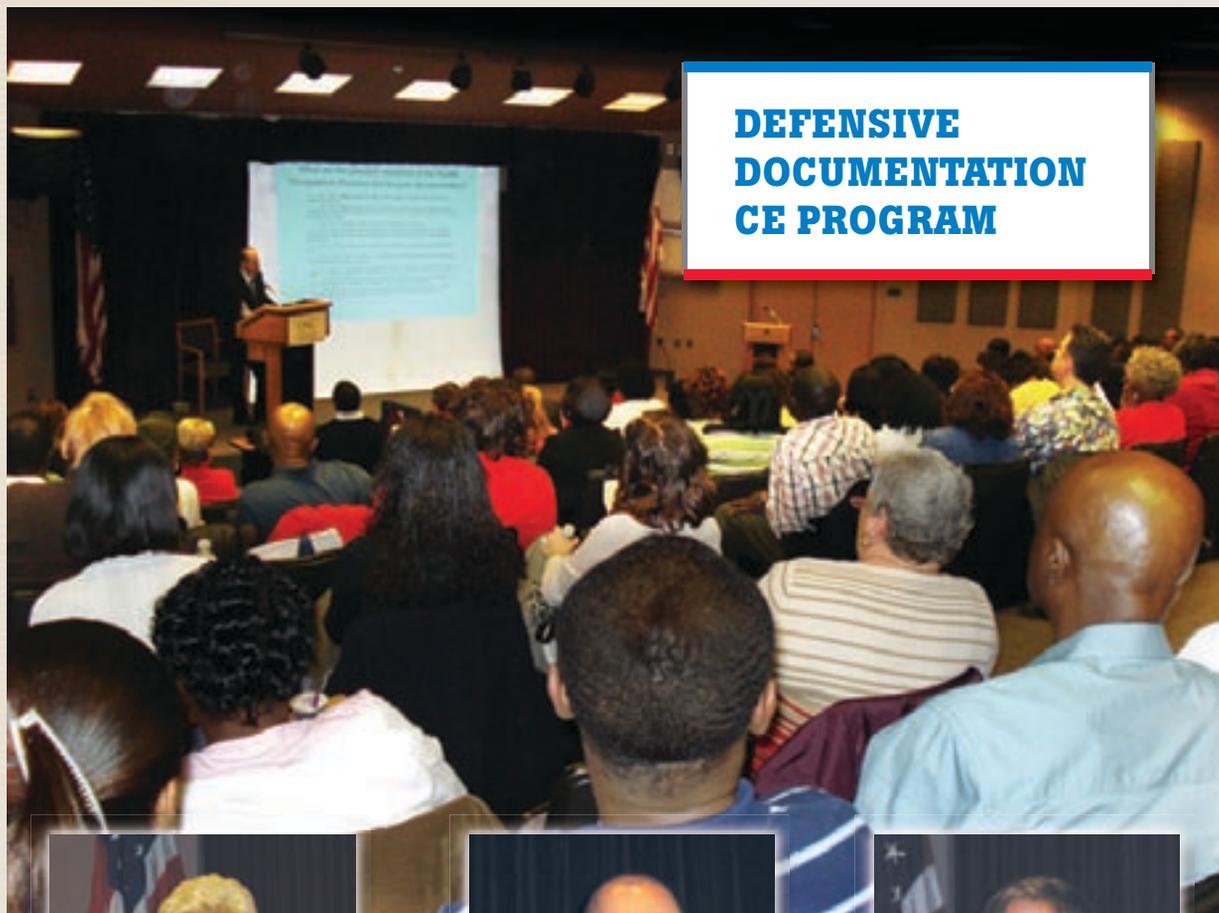


# NURSE

**R**EGULATION **E**DUICATION **P**RACTICE



**DEFENSIVE  
DOCUMENTATION  
CE PROGRAM**



**LPN Renewal  
Nursing Roundtables  
RN/APRN CE Compliance Audit**

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



# DISTRICT of COLUMBIA NURSE

Edition 22

**DIRECTOR, DEPARTMENT OF HEALTH**  
PIERRE N.D. VIGILANCE, M.D., MPH

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

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

# Celebrating National Nurses Week, May 6 – 12, 2009

## A Letter from DOH Director

### Pierre N.D. Vigilance, MD, MPH

*The DC Department of Health joins DC and the nation in celebrating  
"National Nurses Week."*



This year's American Nurses Association's Nurses' Week theme is "Nurses Building a Healthy America." This theme is in line with our mission to improve the health of DC's residents by promoting health

and preventing disease. We want to thank the District's over 20,000 licensed nurses for their help with our public health mission.

Thanks to nurses working in our clinics, hospitals, nursing homes,

community facilities and schools; and thanks to our nurse educators, administrators and researchers. Thanks to all who touch our lives through the skilled care that they provide to us and our loved ones.

**Attention LPNs: The postcard below should have arrived at your home. If not, please fax an address correction letter to (202) 727-8471 if you have moved. You may still renew your license online or with a paper application. See details below.**

★ ★ ★ GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF HEALTH  
DC Board of Nursing

### RENEW YOUR LPN LICENSE BEGINNING APRIL 1, 2009 YOUR LICENSE WILL EXPIRE ON JUNE 30, 2009

To renew, go to the HPLA Web site at: [WWW.HPLA.DOH.DC.GOV](http://WWW.HPLA.DOH.DC.GOV)

- Click on Online License Renewal
- There are two methods for entering the renewal section of our website:
  - (1) Enter your **Social Security Number and Last Name**; then, on the next screen, enter a new User ID and Password.
  - Or (2) Enter your **User ID and Password from the last renewal**.
- Once in the renewal section of the Web site, the screen will display your address and other personal information. Follow the step-by-step instructions.
- To pay fee, enter the credit card information for your Visa or MasterCard number.
- Printout the confirmation screen (to use until your license arrives in the mail).
- After 24 hours, verify renewal at: [WWW.HPLA.DOH.DC.GOV/WEBLOOKUP](http://WWW.HPLA.DOH.DC.GOV/WEBLOOKUP)

#### CONTINUING EDUCATION:

- **LPNs MUST COMPLETE 18 CEs IN THE APPLICANT'S CURRENT AREA OF PRACTICE.** DO NOT send in CE documents unless asked to do so by the Board.
- **FIRST TIME RENEWAL APPLICANTS:** Continuing education is NOT required for those who are first time renewal applicants.

**PLEASE NOTE—ONLY CEs OBTAINED IN THE TWO (2) YEARS IMMEDIATELY PRECEDING THE APPLICATION DATE WILL BE ACCEPTED.**

Should I send in a photo?  
NO. PHOTOS WILL NOT BE REQUIRED FOR THIS RENEWAL.

Should I send in my CE documentation? NO. Only those nurses who are selected during our audit should send in documentation. (Documentation requested and mailed to the board will not be returned.)

When will you select nurses for the CE audit? The board will perform a CE audit following the 2009 renewal period.

TO REQUEST A **PAPER RENEWAL APPLICATION**, OR **APPLY FOR PAID INACTIVE STATUS**: To obtain a paper application to renew, or place your license on Paid Inactive, you may call 1-877-672-2174, or download the application from our renewal Web page. Go to [www.hpla.doh.dc.gov](http://www.hpla.doh.dc.gov).

## Board of Nursing Update DECEMBER, JANUARY, FEBRUARY

### NCLEX Review

#### Board members approves proposal to change the NCLEX-RN Test Plan

The NCLEX Examination committee (NEC) at its Oct. 8, 2008, meeting received results of the practice analysis study entitled "Report of Findings from the 2008 RN Practice Analysis: Linking the NCLEX RN Examination to Practice." Based on the results of the study the committee recommended a proposed revised 2010 NCLEX-RN Test Plan for the National Council Licensure Examination for Registered Nurses. The Board agreed with NEC's recommendations and supported the NCLEX-RX Test Plan revisions.

### Board of Nursing Convenes Nursing Roundtables

Board approved roundtables to be held with DC Nursing leadership over the next few months (see page 7).

The following meetings will be held:  
Directors of Nursing, Practical Nursing Programs (February 6, 2009)  
Deans and Directors, Professional Nursing Programs (March 24, 2009)  
Directors of Nursing, Long Term Care Facilities (February 17, 2009)  
Chief Nursing Officers/Vice-Presidents of Nursing, Hospitals (March 3, 2009)

### NCSBN'S UNIFORM CORE LICENSURE REQUIREMENTS

Board of Nursing reviewed their compliance with NCSBN's Uniform Core Licensure Requirements and determined that the DC BON Regulatory requirements are consistent with the following UCLR:

#### I. COMPETENCE DEVELOPMENT

##### Nursing Education - Registered Nurses (RN)

Graduation from or verification of completion and eligibility for graduation from state-approved registered nursing program.

##### Nursing Education - Licensed Practical Nurses (LPN)

Graduation from or verification of completion and eligibility for graduation from state-approved practical nursing program.

##### Nursing Education - Foreign-Educated Candidates - RN

Graduation from nursing program comparable to U.S. state-approved RN nursing program as verified by credentials review agency.

##### Nursing Education - Foreign-Educated Candidates - LPN

Graduation from nursing program comparable to U.S. state-approved LPN program as verified by credentials review agency.

#### II. COMPETENCE ASSESSMENT

##### Assessment U.S. Candidates - RN Nursing Knowledge, Skills and Abilities

NCLEX-RN® examination, unlimited attempts

##### Assessment U.S. Candidates - LPN Nursing Knowledge, Skills and Abilities

NCLEX-PN® examination, unlimited attempts

##### Assessment - Foreign-Educated Candidates - RN: Review Process

CGFNS certificate or equivalent credentials review that includes verification of the candidate's education, training, experience and licensure with respect to the statutory and regulatory requirements for the nursing profession, as well as oral and written competence in English.

##### Nursing Knowledge, Skills and Abilities

NCLEX-RN® examination, unlimited attempts

##### Assessment - Foreign-Educated Candidates - PN: Nursing Knowledge, Skills and Abilities

Same requirement as for U.S.-educated candidates.

NCLEX-PN® examination, unlimited attempts

#### III. COMPETENCE CONDUCT

##### Criminal Convictions - RN and LPN

Self report regarding all felony convictions and all plea agreements and misdemeanor convictions of lesser-included offenses arising from felony arrests. Local/state and federal background checks using current technology (i.e., fingerprinting) to validate self-reports.

##### Chemical Dependency - RN and LPN

Self report regarding any drug-related behavior that affects the candidate's ability to provide safe and effective care.

##### Functional Abilities - RN and LPN

Self report regarding any functional ability deficit that would require accommodation to perform essential nursing functions.

##### Licensure Decision Making Competence Development and Competence Assessment

Once a board determines what is to be the content for licensure requirements, the board delegates to board staff the day-to-day processing activities in most jurisdictions. The great majority of candidates either meet the competence development requirements or they do not. There are few cases that require a case-by-case review by the board. Similarly, for competence assessment, candidates either pass the examination, or they do not.

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### Hearing held Feb. 2, 2009 on "Practice of Nursing Amendment Act of 2009: Bill 18-39"

**Practice of Nursing Amendment Act of 2009: Bill 18-39** amends the Health Occupations Revision Act of 1985 to amend the definition of the practice of advanced practice registered nursing, to define the practice by nursing assistive personnel, to amend the definition of the practice of practical nursing, to amend the definition of the practice of registered nursing, to redefine the standards for the approval of nursing schools and programs, to establish the position of executive director for the Board of Nursing and to provide for the registration of nursing assistive personnel in accordance with standards promulgated by mayor.

Amy Filmore-Nassar, MSN, FNP,CDE, Vice-Chair of the Board of Nursing, testified on Feb. 2, 2009, before the DC City Council's Committee on Health, Chaired by David Catania. Her testimony in part was:

*As nursing evolves, it is important that legislation and regulations reflect the changes in practice. These amendments defining nursing practice update the current scope of practice, for licensed nurses and provide the board with direction as it seeks to appropriately delineate the various roles and levels of professional responsibility within nursing practice.*

*As the nursing shortage has grown, there has been, and will be, an increased use of nursing assistive personnel. Therefore, it is important that we begin to clarify their role, train them and regulate their practice. With the Board of Nursing having jurisdiction over licensed nurses and the nursing care they provide, we feel that the Board of Nursing is the logical entity to regulate unlicensed persons who provide assistance to nurses in health care settings.*

*There is no clear consensus as to the best regulatory approach for overseeing nursing assistive personnel. A quagmire of semantics permeate the various job titles and duties given to assistive personnel.*

*Nursing assistive personnel, regardless of title, should receive adequate basic training as well as training customized to the specific work setting and duties to which they are assigned. The board recognizes that nursing assistive personnel provide vital services to our vulnerable patients, often of an intimate nature. It is difficult work. Improved education and training will better prepare assistive personnel to do this work.*

*The board is committed to working with stakeholders, District government agencies and the legislature towards developing a regulatory framework that works for the District. We have begun by speaking with nursing home administrators and directors of nursing in both long term and acute care facilities about the regulation of nursing assistive personnel by the Board of Nursing.*

*The board is awed by the prospect of this increased responsibility, but excited about the opportunity to make a significant impact on the manner in which health care is delivered in the District and the possibility of creating a practice model that other jurisdictions may wish to emulate. The goal of the Board of Nursing is to work with the District's nursing and health care community to assure that nurses continue to provide safe, effective nursing care.*

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

## BOARD OF NURSING MEETINGS

**Date:** First Wednesday of the month

**Time:** 1 p.m. (Time subject to change)

**Location:** 717 14th St N.W.; 10th Floor Board Room, Washington, D.C. 20005

**Transportation:** Closest Metro stations are Metro Center (take 13th Street Exit); McPherson Square (take 14th Street Exit)

**If you plan to attend, please call (202) 724-8800 to confirm meeting date and time.**

◆ ◆ ◆

May 6, 2009	September 2, 2009
June 3, 2009	October 7, 2009
July 1, 2009	November 4, 2009
August - no meeting	December 2, 2009

## ATTEND BOARD MEETINGS

During each board meeting, time is set aside for public comment. This is an opportunity for the public to discuss nursing related matters with the board members. Public Comment is scheduled at 1:00 p.m. (subject to change) at the beginning of the board's open session. You do not need to be on the agenda to speak.

If you are interested in receiving the board's open session agenda, send your request to [hpla@doh.dc.gov](mailto:hpla@doh.dc.gov).

# IN THE KNOW

## Your Questions, Your Opinions

The Board of Nursing has established this IN THE KNOW column in response to the many phone calls and e-mails we receive. The Board often receives multiple inquiries regarding the same issue. Please share this column with your colleagues or urge them to read this column. The more nurses are aware of the answers to these frequently asked questions, the less our resources will have to be used to address duplicate questions.

**Q** I just got married and want to change my name. What do I need to do?

**A** You need to send the Board a copy of your marriage certificate along with a written request for a name change. If you want your license re-issued with the name change, please enclose a check for \$34 made payable to DC Treasurer and mail it to the DC Board of Nursing, 717 14th St, NW, Suite 600, Washington DC 20005.

**Q** Can nurses delegate the administration of medication by gastric tube to TMEs (Trained Medication Employees)?

**A** No. TMEs are trained to administer oral medications. Their training does not include the administration of medication by gastric tube.



## Community Health Center and Correctional Health Career Opportunities Full-time and Part-time, PRN

Unity Health Care is a non-profit organization which provides health care to the medically underserved in the District of Columbia, including almost 12,000 homeless men and women. Unity operates in more than 30 sites, including the DC Jail and Unity's mobile outreach vans. Unity has provided care to more than 80,000 people who accessed services more than 433,450 times. Join our mission and apply online today for the following positions:

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- Registered Nurse
- QI Nurse- All Unity Sites
- Licensed Practical Nurse - Community Health Center
- PRN RN and LPN

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

**[www.unityhealthcare.org](http://www.unityhealthcare.org)**

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# NURSING ROUNDTABLES



Chief Nursing Officer/Vice-Presidents of Patient Care (l. to r.): Debbie Holson, Hospital for Sick Children; Patricia Winston, George Washington University; Rosemary Welch, National Rehabilitation Hospital; Geraldine Feaster, Washington DC Veterans Affairs Medical Center; and Joan Vincent, Sibley Memorial Hospital.



Long Term Care Directors of Nursing (l. to r.): Linda Robinson, Stoddard Baptist Nursing Home; Elizabeth Tabod, Washington Center for Aging Services; and Bridget McKintosh, The Washington Home.

Roundtables were held with the District's Nurse Leaders in February and March. In February, board members and HPLA staff met with Directors of Nursing (DONs) from the District's Long Term Care (LTC) facilities in the Board of Nursing's board room. In

March, the DC Hospital Association hosted board members, HPLA staff and chief nursing officers/vice-presidents of patient care. They were invited to discuss strategic approaches to improving



Senior Deputy Director of the Health Regulation and Licensing Administration Feseha Woldu, greets Board of Nursing Member Vera Mayer.



CNO/VPPC: Veronica Parham-Dudley, St. Elizabeths Hospital (left); with HRLA/Health Care Facilities Division Program Manager Sharon Lewis (center) and Supervisory Nurse Consultant Veronica Longstretch.



HRLA/HCFD Supervisory Nurse Consultant Sharon Mills.



LTC DON: Malcolm Cook, formerly of the Specialty Hospital of Washington – Hadley Skilled Nursing Facility.

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the delivery of nursing care in the District. Meeting participants discussed current trends in DC Department of Health (DOH) survey reports and disciplinary actions referred to the board of Nursing (BON).

At both meetings the message was the same. We need to work in partnership to assure that the District's patients are provided with quality nursing care.

HRLA Senior Deputy Director Dr. Feseha Woldu, opened the roundtables with an overview of the importance of reporting. He said we must "collectively work to have the best health care facilities in the country. We need to identify the issues. We have now started collecting Adverse Events [reports of incidents that have led to death or unanticipated injury]. We are looking at trends—falls; missed medication and medication errors; abuse and neglect; nutritional issues and dehydration." Complaints and incident reports regarding nurses and nursing support staff alert DOH to issues



CNO/VPPCs: Delores Clair, The Specialty Hospital of Washington-Capitol Hill (I.); with Mayble Craig, Howard University Hospital.



LTC DON: Maureen Seymour, Lisner-Louise-Dickson-Hurt Home.

regarding professional conduct and continued competence, he said. "One nursing home or hospital can destroy the reputation and credibility of all of us," he said. "This is not somebody else's problem, this is our problem—a collective problem which will require a collective solution."

Each roundtable began with a discussion of hospital survey report findings and proper reporting procedures. Sharon Lewis, Program Manager of the Health Care Facilities Division of HRLA, and her staff members Supervisory Nurse Consultant Sharon Mills and Supervisory Nurse Consultant Veronica Longstretch shared frequently cited deficient practices found on survey reports. DC BON Nurse Consultant Concheeta Wright spoke about the importance of alerting the board: "The actions that some nurses have been engaging in (as seen in the DOH survey results) should be reported to the board. There have been a lot of medication errors, infection control issues, documentation

issues, but we don't hear anything about it."

HPLA Lead Investigator Mark Donatelli and Supervisory Investigator Greg Scurlock explained its role. "While their [HRLA surveyors'] shop looks more at facility issues, systemic issues, Mark's and my responsibility is to look at the licensee. [If you fail to



LTC DON: Janice Johnson, Carroll Manor Nursing and Rehabilitation Center.

## DOH HEALTH CARE FACILITIES CONTACT INFORMATION

**DC Department of Health  
Health Regulation and Licensing Administration**  
Health Care Facilities Division  
717 14<sup>th</sup> Street NW  
Suite 600  
Washington DC 20005  
Phone: (202) 442-5833  
Fax: (202) 442-9431  
Web: [www.doh.dc.gov](http://www.doh.dc.gov)



Board of Nursing Member Tracy Spann-Downing.



LTC DON: Terry Woodside, Sibley Memorial Hospital – The Renaissance Unit.



LTC DONs: Sr. Diane Shelby, Isp, Jeanne Jugan Residence; and Ana Dolojan, Washington Nursing Facility.

report someone] it is a reflection on your industry. By reporting them, you are not only helping them, you are helping the patients; you are helping the facility; you

are helping your profession.” He asked the attendees to provide as much documentation as possible up front: “that will greatly expedite the investigatory process.” He said in his 20 years of working with the BON he has found its actions to be “not punitive, but corrective.” Investigator Mark Donatelli noted the trend of problems with Nurse Staffing Agency (NSA) nurses: “With the agency nurses, there seems to be not enough supervision or guidance, and they seem to come before the board more often with their issues [than other nurses].” He noted that NSAs are now licensed and required to report.

BON Executive Director Karen Scipio-Skinner reassured the attendees that loss of licensure is not an automatic consequence of reporting a nurse: “The board has looked more at requiring supervision and requiring additional training. We also refer people to the COIN program for mental incompetence and substance abuse issues.” When a problem is reported, the BON sometimes meets with the nurse and the nursing supervisor to get full information about what happened. It may be a systems issue. “We are willing to work with you. Coming before the Board can be a wake-up call for the nurse.”



COIN Chairperson Kate Malliarakis (left) with JoAnne Joyner, former Chair of DC Board of Nursing.

# Become a Leader in Global Health

You may not have time to fill out a full report, but just let the Board know—especially if it is something serious, she said: “We recently got a report from the police about a nurse they were seeking for drug diversion.” We did not receive a referral from the facility.”

Ms. Scipio-Skinner told the attendees: “If you fire a nurse due to substandard nursing skills, the board of Nursing needs to know.” Van Brathwaite, attorney for the board of Nursing stated that DC Official Code §44-508 requires health care facilities to report. If the board is not made aware, the nurse will continue to practice at another hospital or nursing home. They just go from facility to facility.

The remainder of each roundtable focused on the proper reporting and care of impaired nurses, with presentations on the legal requirements of what and when to report, the investigative process and the role of the Committee on Impaired Nursing (COIN) Program.

Established as an alternative to disciplinary action by the Board of Nursing, the COIN Program requires a participating nurse to sign a contract with the program outlining the conditions that must be met to assure that the nurse’s practice is within the acceptable standards of care. COIN contracts may make recommendations concerning whether or not the nurse will be allowed to work and, if so, the nurse’s work schedule and whether or not they can administer medication. The contracts may also include progress reports from treatment facilities, counselors and/or 12-Step sponsors, random drug and alcohol screenings, reports from employers and self-reports from the nurses.

“In terms of the impaired nurse, if we get impaired nurses in COIN, we will ensure that they are safe to practice, and I promise you ...” said COIN Chairperson Kate Malliarakis, “when the nurse is restored to practice, we are watching them

## Community/Public Health M.S.N. Programs

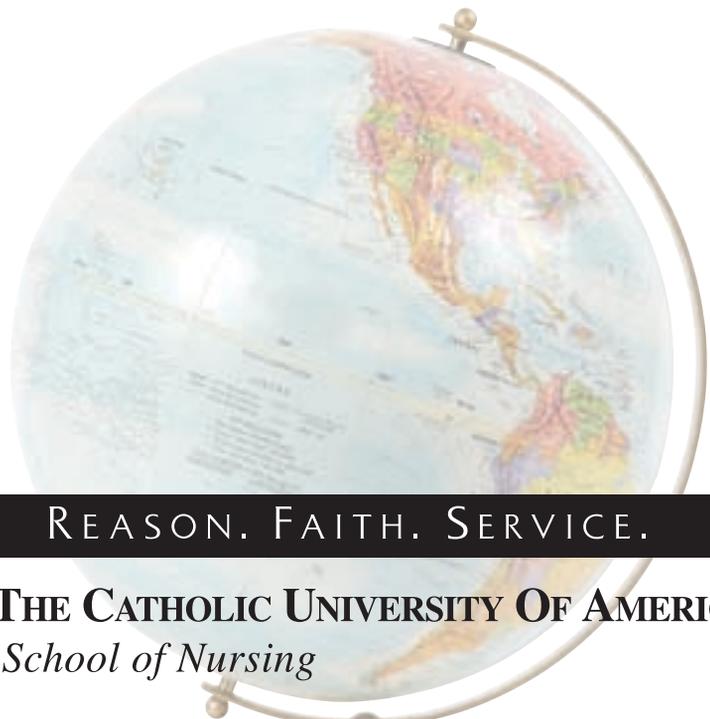
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# Regulation

like a hawk.” Ms. Malliarakis offered to speak at any facility to educate nurses and administrators about the COIN program. She urged DONs to contact Karen Scipio-Skinner or Concheeta Wright if they feel that something is not quite right with a nurse—even if the DON cannot pinpoint the exact problem. You may suspect a substance abuse problem, but “sometimes we have enrolled nurses into the COIN program [who have had] a mental illness that has gone undiagnosed, and we are able to get them to the appropriate resources, get them on the right medications, and put them back to work. It’s wonderful.” Ms. Malliarakis also noted a case



DC Hospital Association's Vice President for Government Relations Stefanie Jones.

where a nurse fell asleep in a patient’s room after a night on the town. “It turned out she had a serious addiction problem. This is compatible with women in addiction as they hide their addiction for a very long time.” She added: “Addiction is a disease of the brain; it is not a matter of will.”

Ms. Concheeta Wright talked about the power of the COIN program and one young man who entered the program a few years ago and “now he looks like a different person.”

“Recovery is a transformational process when done correctly,” Ms. Malliarakis added. “Our goal is to protect the patient, and I know that is your goal as well.”

- Tip: Nurses must practice within their scope of practice.
- Tip: A nurse should never sign the “sign-in” sheet for a colleague.
- Tip: After six months is when a graduate nurse feels most discouraged. After a year, nurses begin to feel competent in what they were hired to do. We must look at increasing the amount of time spent orienting nurses.
- Tip: Weigh the cost of providing good orientation with the cost of having to continually recruit new nurses.

**To contact the Board of Nursing or the COIN program, call: (202) 724-8846, or email [concheeta.wright@dc.gov](mailto:concheeta.wright@dc.gov).**

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# NURSYS Update

## Change beginning April 1, 2009

### Attention Employers

**Employers/Public can now verify licenses at NURSYS.COM free of charge.**

If you or your organization need to increase your efficiency in verifying nurse licenses and/or checking a nurse's discipline status for employment decisions, then look no further than the NCSBN's secure, online verification system, Nursys® ([www.nursys.com](http://www.nursys.com)). The [nursys.com](http://nursys.com) Web site contains data obtained directly from the licensure systems of the boards of nursing through frequent, secured updates. Employers and the general public can now verify licenses and receive a report within minutes, free of charge. This report will contain the name, jurisdiction, license

type, license number, license status, expiration date and any discipline against the license of the nurse being verified.

### Attention Nurses

When a nurse applies for endorsement into a state, verification of existing or previously held licenses may be required. A nurse can use [Nursys.com](http://Nursys.com) to request verification of licensure from a Nursys® licensure participating board. A list of licensure participating nursing boards can be found at [www.Nursys.com](http://www.Nursys.com).

Nurses can now pay \$30 to verify their licenses from all jurisdictions in which they are licensed. Previously verification information was available to for only 90 days for all boards, however now

(making the online verification process comparable with the paper verification process) the DC Board will have access to the nurse's verification information for all states, in perpetuity.

The fee for this service is \$30 per license-type for each specific state board of nursing where the nurse is applying. Nursys® license verification is sent to the endorsing board immediately.

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**Ready**



### Family Emergency Plan



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TELEPHONE: \_\_\_\_\_

OUT-OF-TOWN CONTACT NAME: \_\_\_\_\_  
TELEPHONE: \_\_\_\_\_

NEIGHBORHOOD MEETING PLACE: \_\_\_\_\_  
TELEPHONE: \_\_\_\_\_

OTHER IMPORTANT INFORMATION: \_\_\_\_\_

DIAL 911 FOR EMERGENCIES

**Ready** 

### Family Emergency Plan



EMERGENCY CONTACT NAME: \_\_\_\_\_  
TELEPHONE: \_\_\_\_\_

OUT-OF-TOWN CONTACT NAME: \_\_\_\_\_  
TELEPHONE: \_\_\_\_\_

NEIGHBORHOOD MEETING PLACE: \_\_\_\_\_  
TELEPHONE: \_\_\_\_\_

OTHER IMPORTANT INFORMATION: \_\_\_\_\_

DIAL 911 FOR EMERGENCIES

**Ready** 



# Toward an Evidence-Based Regulatory Model for Transitioning New Nurses to Practice

NCSBN is developing an evidence-based regulatory model for transitioning new nurses to practice. Several factors have inspired this inquiry, most notably, the Institute of Medicine's reports of medical errors and the need to transform health care education. In addition, there is an increased complexity of care for sicker patients with multiple conditions, a continued need for systems thinking and an exponential growth of technologic advances. Furthermore, the shortage of nurses and nursing faculty is expected to continue into the future, thus affecting the transition of new nurses to practice.

There have been some national calls for a formal transition program for new nursing graduates, including from the Joint Commission (Joint Commission White Paper, 2002), the draft of the Carnegie study of nursing education recommendations and

Committee identified the evidence that supports a transition regulatory model. Committee members will continue to work this year to refine the model, making it feasible for boards of nursing to implement and develop consensus for the model across regulation, education and practice. (Please refer to the Transition Evidence Grid [NCSBN, 2008a] and the NCSBN Transition to Practice Report [NCSBN, 2008b] for an explication of the available evidence supporting the NCSBN's transition regulatory model.)

NCSBN's transition regulatory model will be implemented through regulation, though collaboration across education, regulation and practice will be essential for this model to be successful. Educators are the experts in curriculum design and evaluation and will be able to assist with the design of transition modules. Practice

provides a crucial link that will equip new graduates with planned, precepted practice experiences. Regulators provide new graduates with information on their scope of practice, the Nurse Practice Act and maintenance of their license throughout their careers.

Regulation will enforce the transition program through licensure. This is an inclusive model, which would take place in all health care settings that hire newly graduated

nurses at all educational levels of nursing, including practical nurse, associate degree, diploma, baccalaureate and other entry-level graduates. It is also intended to be flexible so that many of the current standardized transition programs will meet the requirements of this model.

The new graduate must first take and pass the NCLEX®, obtain employment and then enter the transition program. The

preceptors in this model will be trained to work one-on-one with newly graduated nurses. A preceptor will work with the same graduate throughout the six-month transition program. This model is highly dependent on a well-developed preceptor-nurse relationship; the importance of this relationship is supported in the research. Novice nurses will understand the importance of learning from a seasoned, dedicated preceptor, thus encouraging these nurses to serve as preceptors to new nurses in the future. Therefore, it is hoped that this will bring about cultural change in nursing whereby becoming a preceptor and mentor will be an expected part of professional nursing.

Orientation, defined as being instructed on the policies and procedures of the workplace as well as role expectations, is required before entering the transition program. Therefore, orientation, according to this model, is separate from the concept of transition to practice, which is defined as a formal program designed to support new graduates during their progression into practice.

The eight transition modules supported in the literature (NCSBN, 2008a; NCSBN, 2008b) for this model include: delegating/supervising; role socialization; utilization of research; prioritizing/organizing; clinical reasoning; safety; communication; and specialty content. These modules could be presented at the institution where the new nurse works, in a collaborative program with other institutions or via the Internet. The Transition to Practice Committee envisions the development of a Web site with online learning modules, as well as a way to connect new nurses to preceptors in those settings or regions of the country where preceptors are in short supply.

The time period for this Transition Regulatory Model will be six months, though it is expected that the new graduate will have ongoing support for an additional six months. At the end of the year, the new nurse is expected to have met the Quality



in a synthesis of national reports (Hofler, 2008). Several standardized transition programs around the country have been very successful and worldwide transition programs are being designed (NCSBN, 2008a). Additionally, the Commission on Collegiate Nursing Education (CCNE) has developed an accreditation process for residency programs.

Last year NCSBN's Transition to Practice

and Safety Education for Nurses (QSEN) competencies. The QSEN competencies ([www.QSEN.org](http://www.QSEN.org)), developed by experts across the health care disciplines, were based on the IOM competencies and include: patient-centered care; teamwork and collaboration; evidence-based practice; quality improvement; safety; and informatics.

Lastly, feedback and reflection are essential parts of this model and must be integrated throughout the entire transition program. This should be built into the preceptor-nurse relationship, while also being maintained after the six-month transition period is complete.

It is the vision of this model that new nurses will be required to provide their board of nursing with evidence of completing all the requirements of this standardized transition program in order to maintain their license after their first year in practice. This model will be voted on at the NCSBN Annual Meeting in 2009. If this regulatory transition model is adopted, each jurisdiction will decide whether or not to implement it or to adapt it to meet the particular needs of their state or territory.

Please contact Nancy Spector, PhD, RN, at [nspector@ncsbn.org](mailto:nspector@ncsbn.org) for further information.

#### References

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Joint Commission White Paper. (2002). *Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis*. Retrieved October 6, 2008, from [www.jointcommission.org/NR/rdonlyres/5C138711-ED76-4D6F-909F-B06E0309F36D/0/health\\_care\\_at\\_the\\_crossroads.pdf](http://www.jointcommission.org/NR/rdonlyres/5C138711-ED76-4D6F-909F-B06E0309F36D/0/health_care_at_the_crossroads.pdf).

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## Exciting News For Nursing Students In DC!

Exciting news for nursing students in DC! The ThinkAboutItNursing (TNSF) Scholarship application is now available for download. Students can go to either of our websites, <http://thinkaboutitnursing.com> or <http://www.stunurse.com>, to find eligibility requirements and details. ThinkAboutItNursing is the nursing publication division of Publishing Concepts, Inc. The purpose of the TNSF Scholarship Program is: To promote public awareness of the nursing profession and the value of nurses to our communities; to encourage nurse education to help reverse the current shortage of nurses; and to encourage current nurses to pursue advanced degrees and become nurse educators. Applications must be received no later than: June 30th.

**On March 24, 2009, the DC Board of Nursing will hold a meeting at our offices for the Deans and Directors of the Professional Nursing Programs in the District of Columbia. Board Executive Director Karen Scipio-Skinner and Board Nurse Consultant/Education Arthuretta "Retta" Zeigler will facilitate a discussion on clinical sites, school annual reports, and regulation updates, among other topics. DC NURSE regrets we are unable to provide further coverage due to press deadline. Thanks to all participants!**

## Schools of Practical Nursing meet at HPLA

DC Practical Nursing (PN) schools are thriving despite several barriers before them. District hospitals have decreased their use of Licensed Practical Nurses (LPNs) and therefore have decreased access to clinical sites for PN Programs. District Long Term Care (LTC) facilities do hire LPNs, but some are limiting the number of PN students.

"The hospitals will not sign a contract with us" one of the PN school reps told meeting participants. But even before a PN student seeks employment, she or he needs to gain clinical experience in preparation, and that can be a problem. One PN school rep said it was "a travesty that hospitals do not offer clinicals to PN students: "Critical thinking is developed in the clinical setting."

DC BON Nurse Consultant Arthuretta ("Retta") Zeigler stressed the importance of preparing students prior to entering the clinical arena.

One school rep suggested that the board place more emphasis on students gaining experience through simulations rather than inadequate clinical experiences, since those are not readily available. HPLA Staff agreed to take that recommendation



HRLA Senior Deputy Director Feseha Woldu.

to the Board for consideration but stressed that "Simulation is not a substitute for, but a complement to, clinical experience." (See NCSBN's position paper on clinical education, 2005).

After gaining clinical experience, and being hired by a facility, there is one more piece needed to ensure quality LPN practice—job orientation. Even the best student will need training to gain knowledge about the policies and procedures of their particular employer.

HRLA Senior Deputy Director Dr. Feseha Woldu spoke about the Adverse Events reports that facilities must submit to the HRLA. "It is not just the quantity, but quality of personnel we produce."

Board Executive Director Karen Scipio-Skinner noted the need to have a meeting between the PN school reps and officials from the District's LTC facilities, to discuss the challenges of best educating and



L. to r.: Solange Vivens, Stephanie Bronsky, BON Chair Rachael Mitzner, Michael Adedokun and India Medley.



L. to r.: BON's "Retta" Zeigler, Susie Cato and Charlease Logan.

employing LPNs and also assistive staff.

Another topic of discussion was the need for articulation models to help LPNs who want to become RNs. In the past, Ms. Scipio-Skinner told participants, there was a nursing consortium in DC which developed an articulation model to move workers from LPN to RN. "We need to talk about what we can do to help the workforce to get workers," Ms. Scipio-Skinner said. "We need to get the message out beyond nursing."

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## Practical Nursing Programs

### Year to Date (12/31/08) Licensure Exam Results and Approval Status

PROGRAM	CURRENT QUARTER		YEAR TO DATE		APPROVAL STATUS
	10/01/2008 - 12/31/2008		01/01/2008 - 12/31/2008		
	#Sitting	% Passing	# Sitting	% Passing	
Capital Health Institute	15	73.33	64	76.56	Conditional
Comprehensive Health Academy	29	93.10	134	88.81	Full
JC Inc.	33	51.52	105	60.95	Withdrawn
Radians College (formerly HMI)	12	91.67	86	80.23	Full
University of the District of Columbia	28	60.71	155	76.13	Full
VMT Academy of Practical Nursing	39	74.36	160	68.13	Conditional

## Professional Nursing Schools

### Year to Date (9/30/08) Licensure Exam Results and Approval Status

SCHOOL	CURRENT QUARTER		YEAR TO DATE		APPROVAL STATUS
	10/01/2008 - 12/31/2008		01/01/2008 - 12/31/2008		
	# Sitting	% Passing	# Sitting	% Passing	
Catholic University of America	3	33.33	66	69.70	Full
Georgetown University	3	100.00	84	95.24	Full
Howard University	2	0.00	69	79.72	Conditional
Radians College	19	84.21	57	75.44	Conditional
University of the District of Columbia	3	66.67	20	85.00	Full

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

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## Warning about MEDCEU!

Please be forewarned about a continuing-education company called MEDCEU. In the past, and more recently, we have received complaints

about MEDCEU. One nurse informed the board that MEDCEU "has not refunded an over payment, nor have they responded to numerous calls. I will

be writing the Better Business Bureau so that they will know of the fraud that many of us have been taken in with. Please alert others if you can."

## CE BROKER: ONLINE TOOLS TO MANAGE YOUR CONTINUING EDUCATION

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requirements. Subscribing and viewing your transcript gives you access to the same data used by the board of Nursing. (If you obtain coursework from a nationally approved provider it is to your advantage to self-submit your hours to CE Broker in order for the courses to be added to your transcript.) Access secure, via individual login and password:

- View individual continuing education transcript that clearly states your personal requirements
- Authorized educational providers report completed course credit to your record
- View Chronological Course History of every program completed and reported
- Receive a message each time completed courses are posted
- View requirements you have not yet fulfilled
- Set automatic deadline reminder notices
- Set license renewal expiration reminder notice
- Set up personalized alert notifications of upcoming courses
- Send an online message to an authorized educational provider or the CE Broker help desk
- Phone the CE Broker helpdesk toll free Monday to Friday 8 a.m. to 5 p.m., except holidays.
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# Continuing Education Compliance Audit

## Registered Nurses/Advanced Practice Registered Nurses

If you have been selected for CE Audit, please respond with documentation according to the categories below:

**FIRST TIME RENEWING**

If this is the first time that you are renewing your license, you are not required to meet the continuing education requirement.

**CE BROKER CE COMPLIANCE SUBSCRIBERS**

If you are a CE Broker CE compliance subscriber:  
**DOCUMENTATION NEEDED:** None

**CONTACT HOUR OPTION**

**DOCUMENTATION NEEDED:** An original verification form from accredited continuing education organization

**ACADEMIC OPTION**

May be used when you have completed a course leading towards a degree in nursing or any academic course relevant to the practice of nursing.  
**DOCUMENTATION NEEDED:** Copy of transcript or end of the semester report.

**TEACHING OPTION**

**DOCUMENTATION NEEDED:** Verification form indicating your name, the name of the accrediting body, and the number of contact hours or letter from an accrediting body acknowledging their approval of your course

**AUTHOR OR EDITOR OPTION**

**DOCUMENTATION NEEDED:** Letter of acceptance or copy of title page of book or article (for articles, include name of journal if not indicated on the title page) or copy of page listing you as editor.

**Registered Nurses:** Twenty-four (24) contact hours of continuing education in the applicant's current area of practice.

**Advanced Practice Registered Nurses:** Fifteen (15) of the (24) twenty-four contact hours in course(s) that includes a pharmacology component.

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ASSISTANT DIRECTOR OF PERIOPERATIVE CARE - KENSINGTON, MARYLAND

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## DEFENSIVE DOCUMENTATION



**“Report every incident, and document what actions were taken to resolve the issue.”**

“As the nursing shortage gets worse, many nurses feel that documentation is a task that they can ignore. Not so,” Board Executive Director Karen Scipio-Skinner told the nursing professionals

attending the board’s January continuing education program on documentation. Documentation is an important element of nursing practice. “The majority of licensees called upon to appear before the Board, have been contacted by the Board due to documentation errors, lack of documentation or poor documentation,” she told attendees. “While the Board is always pleased to have an

### **Tools against malpractice:**

- Documentation, Communication and Reporting
- Risk Management or Quality Assurance
- Malpractice Insurance to protect yourself.

opportunity to speak with its licensees,” she said, “the Board would prefer it not be due to discipline.”

**“THE CHART TELLS THE PATIENT’S STORY”—DEE HUNSBERGER**

“As nurses, you are busy and in demand. Maybe there is only one RN on

the floor," workshop speaker Dee Hunsberger told attendees. "This becomes even more critical. With documentation, just about every word you write counts." Ms. Hunsberger is the vice president of the Healthcare Division for Nurses Service Organization (NSO)/Healthcare Provider Service Organization (HPSO) Affinity Insurance Services, Inc. (AIS). She has been working with nurses over 20 years in insurance and risk management.

Ms. Hunsberger told of a case where a family was going to sue for malpractice when a young man died after going into respiratory distress after what should have been a routine appendectomy. After reviewing the medical record, however the family's attorney advised the family to drop the case because the documentation maintained by the hospital made it perfectly clear that everything that could have been done, for this patient had been done leaving no basis for a claim of negligence or malpractice. "Would your notes have stood up in court?" she asked. "Would your notes protect you or cause you harm?"

Documentation must be factual, accurate, and legible, Ms. Hunsberger said: "Documentation should reflect the nursing process." Documentation should reflect your assessment, intervention and patient response. "Write to the nursing process," she said. Assessment, diagnosis, planning, implementation, evaluation. "The chart tells the patient's story," she said.

### **HELD TO A HIGHER STANDARD**

"Anyone can get sued at any time. However, you are a nurse 24-hours-a-day, 7-days-a-week," Ms. Hunsberger told participants, and your facility's



### **DEE HUNSBERGER**

Dee Hunsberger is vice president of client services of the Healthcare Division of Affinity Insurance Services, Inc., where she is responsible for providing operational leadership for customer service, new business processing, claims notification and model office support for over one million nursing and allied health providers. In addition, she is the executive editor of all health care related publications focusing on risk management. Ms. Hunsberger's role includes both personnel and project management and the coordination of administration, carrier interface, client services, and financial tracking for the allied healthcare individual program. Ms. Hunsberger is a licensed agent who has worked in the insurance industry for 32 years. During her 21-year career with NSO, she has developed expertise in customer service, risk management and marketing of insurance to the healthcare industry.



### **MARK DONATELLI**

Mark Donatelli began his investigative career in 1996 with a private corporation in its Audit & Investigation Division. He primarily conducted fraud, embezzlement and employee misconduct investigations and worked with state police and FBI in criminally prosecuting the offenders. Later, Mr. Donatelli worked for the National Association of Security Dealers (NASD) Investigation Division. There he conducted regulatory and compliance investigations of licensees that violated NASD rules and regulations. In June 2003, Mr. Donatelli joined

the District of Columbia, Health Professional Licensing Administration (HPLA), as an Investigator in its Enforcement Division. He is currently the lead investigator for the HPLA Board's Enforcement Division.



### **MARY SKLENCAR**

Mary Sklencar is experienced in the field of Long Term Care surveying, and additionally acts as the training coordinator and MDS [Minimum Data Set] coordinator for Washington, DC. Ms. Sklencar has been teaching, coaching and working with surveyors and providers for almost 10 years through the Department of Health's Health Regulation and Licensing Administration. A transplanted Washingtonian from Chicago, Ill., Ms. Sklencar began working as a nursing assistant in the geriatric unit of a hospital. She has been a unit charge nurse and unit

manager in nursing facilities for over 10 years. After completing her adult nurse practitioner degree, Ms. Sklencar cared for and managed a daily clinic for the independent residents of a continuing care community.



United Medical Center's Anna White with BON Member "Missy" Moore (who organized the program).



Board member Margaret Green greets attendee.



Board Nurse Consultant Concheeta Wright (center) greets attendees.

malpractice insurance may not extend beyond the grounds of your facility. "If you were on the playground and told a child who had fallen, 'You will be okay,' and that child's parents later determined that child was seriously injured, could they sue you? They could. As a nurse you are held to a higher standard 24 hours a day."

Ms. Hunsberger reviewed the various

types of documentation and discussed the pluses and minuses of the different types: charting by exception; focus (3 columns); narrative; soap (subjective, objective, assessment, plan of care); electronic charting, and open charting. She urged participants to become familiar with all types of documentation.

Good documentation protects you and your facility. Poor documentation can have a financial impact on employer – if you do not document a task that was completed for that patient, the facility (1) cannot charge the patient for that action, (2) could be vulnerable to a law suit years later.

Ms. Hunsberger provided several case studies, one of which told of a nurse who assessed Positive Homan's and told her supervisor and the physician about the patient's Positive Homan's—but the nurse never wrote the words "Positive Homan's" in the documentation. Later, during a malpractice trial, the supervisor and physician both testified that the nurse had never mentioned Positive Homan's.

"In court you may be put on the spot to testify about a patient you have not seen or thought about in three years," Ms. Hunsberger said. Good documentation also will help you remember what occurred.

You need to have excellent communication with your patients and their families, your colleagues, the treatment team so matters will not be misinterpreted or misstated in any way she said.

## SOME "DOS AND DON'TS" FROM DEE HUNSBERGER:

- Documentation should be clear enough so it will be understood ten years from now.
- Document after an action has been completed—not before—because you may be interrupted and may not actually complete an intended task.
- Document in ink. Write on every line. Do not leave blank spaces.
- Rewriting? Strike out old text with a single line; do not completely black out old wording.
- Do not erase, do not use liquid correction fluid, or cross out entries using more than drawing a single line through error.
- Be mindful that altering a record is a criminal offense.
- Use universal abbreviations, not your own made-up abbreviations.
- Place patient's name and identification number on every page of the chart.
- Do not use vague language, such as: "Patient had a good day."
- Do not chart your opinion. [Strive to be objective.] Write "patient tearful and crying constantly" not "patient was depressed."
- If an order is questioned, report that clarification was sought.
- Record each phone call to a physician, including time, message and response.
- Chart patient's refusal if they refuse a treatment.
- Never document for anyone else.
- Learn your institution's documentation guidelines.
- Know your facility's policies and procedures.
- Read your Nurse Practice Act and keep abreast of changes.

Good documentation also helps to ensure continuity of care for that patient when colleagues read what you have written. "Record the date and time of each entry. A big gap is a big concern to juries: 'What happened during that time?'" Structured writing typically inspires structured performance.

### "INSURANCE CAUSES LAWSUITS"

"Get malpractice insurance before an incident occurs," Ms. Hunsberger told nurses. Many times she has received phone calls from nurses seeking to gain malpractice insurance after an incident has already occurred—and then it is too late.

Board member Missy Moore asked Ms. Hunsberger about the belief among some nurses that having malpractice coverage attracts law suits. "If you have car insurance that doesn't mean that more cars are going to hit you," Ms. Hunsberger said. As long as you do not go around telling everyone you meet about your coverage, no one will know if you have it or not.

**TIP:** As the RN, you are expected to co-sign documentation written by nursing assistive personnel (NAP). You are expected to be responsible for that documentation. If you have concerns about what is written, you can put a disclaimer on the chart, or you can

bring the issue to your supervisor. You can also ask the NAP to rewrite it. Urge your facility to offer training and education for NAPs.

### "IF YOU DIDN'T DOCUMENT IT, YOU DIDN'T DO IT"—INVESTIGATOR MARK DONATELLI

"One of the gold rules of business is: 'If it wasn't written, then it didn't happen.' Plain and simple, any type of business. Whether you are buying a house, getting a loan, or having work done. If you hired a mechanic and he botched the job—if you didn't have anything written and you couldn't prove that you went there, you wouldn't be able to prove [he did the work]. Same thing for your clinical practice."

A board investigator's role is to determine the truth: What really happen? When did it happen? Why did it happen? An investigation can substantiate a complaint or determine that the accusation against a licensee is completely unfounded.

"Documentation is key in establishing that a violation occurred," says HPLA investigator Mark Donatelli, "and proper documentation can serve as evidence that a violation did not occur. Proper documentation can shield a licensee from disciplinary action from their Board of Nursing."

Write legibly and in ink, Investigator

Donatelli told attendees. "Use proper medical abbreviations and not your own," he said. "Sometimes a practitioner will use their own [made up] abbreviation. If they do that for 20 years, that becomes part of their standard of practice and it is incorrect. Accurately date and time-stamp the entry. Accurately and completely fill out all required sections. Don't take short cuts."

As a nurse, what are some common documentation errors?

- Not documenting the completion of all or part of a Physician's Order.
- Failure to document the patient's Medication Administration Record.
- Failure to document the administering and/or wasting of medications.
- Willfully writes false notes into a patient's medical file.
- Submits false statements to collect fees for which services are not provided.
- Files a false or misleading statement to the Board.

He shared a list of violations relevant to the topic of documentation:



Speaker Mark Donatelli shares PowerPoint presentation.



Participants gather in vendor area.



Registration table.



Vendor display area.

What are the possible violations of the Health Occupations Revision Act for poor documentation?

- Willfully makes or files a false report or record in the practice of a health occupation.
- Willfully fails to file or record any medical report as required by law, impedes or obstructs the filing or recording of the report, or induces another to fail to file or record the report.
- Willfully makes a misrepresentation in treatment.
- Submits false statements to collect fees for which services are not provided or submits statements to collect fees for services which are not medically necessary.
- Prescribes, dispenses, or administers drugs when not authorized to do so.
- Fails to conform to standards of acceptable conduct and prevailing practice within a health profession.
- Demonstrates a willful or careless disregard for the health, welfare, or safety of a patient, regardless of whether the patient sustains actual injury as a result.

Common violation for nurses would be “not documenting the complete physician’s order.” Mr. Donatelli shared case studies with attendees.



Continuing Education program participants. Thanks for attending!

Other common violations are “failure to document the patient’s medication administration record; failure to document the administering or wasting of medication; willfully writing false notes in a patient’s medical file.” A member of the audience added to the list of violations: the practice of documenting in advance before the action occurs.

How does the Board learn of possible violations? The employer contacts the Board, the patient files a complaint, a colleague reports an incident to the Board; the Board is also able to find out from other boards of nursing when they discipline a licensee.

## DOCUMENTATION OF NEGLIGENCE

Investigator Donatelli shared exhibits of false documentation that had been made by a nurse who was diverting drugs. And he spoke about the COIN [Committee on Impaired Nurses] Program established to assist nurses who are impaired due to substance abuse—it is an alternative to disciplinary action.

If it is determined that a nurse is of immediate danger to the safety of patients — due to the amount of and schedule of drugs diverted — the nurse may be issued a Notice of Summary Suspension. “The nurse is Summarily Suspended upon service of a Summarily

Suspended order, they cannot practice at all and have 72 hours to request a hearing. The employer will be notified too. This individual cannot work.” Then the matter goes before an administration law judge to determine whether or not the order is withheld. The nurse is also referred to the Board of Nursing for possible discipline and possible referral to COIN. And because they are part of the public record, summary actions are posted online.

### CROSS JURISDICTION PARTNERSHIP

Donatelli told of a case where the North Carolina Board of Nursing informed the DC Board that a practical nurse licensed in both jurisdictions was terminated in North Carolina for drug diversion.

Investigator Donatelli also noted that practitioners sometimes commit a violation of false documentation outside of the medical setting when they apply for licensure reinstatement or when they fill out a new-license application and are not truthful on the application, and knowingly filing a false statement.

### “WHAT DID YOU DO AND WHY DID YOU DO IT?”—SURVEYOR MARY SKLENCAR

DC Department of Health Surveyor Mary Sklencar, RN, began her presentation with a line that brought chuckles from the entire audience: “I’m the person you just *love* to see come in your facility,” she said. “And it doesn’t matter what facility you are in, whether you are a hospital, or a nursing home, or a home care, ESRD [end-stage renal disease], or home health. It doesn’t matter. There are plenty of us to go around.”

Good documentation is a reflection of your abilities. “Good writing is clear thinking made visible,” Ms. Sklencar told attendees. “If you don’t have a clear idea of what you are doing, or if you are doing something [just] because someone *told* you to and you don’t have any idea of what you are doing, your documentation is not going to be good.” Documentation is also a reflection of your integrity. Ms. Sklencar urged nurses to report the facts: “Just tell me the truth. I have

done this long enough to know when you are lying.”

### TIPS FROM MARY SKLENCAR, RN:

- Document with accuracy, clarity, legibility and completeness
- Document objectively
- Place the resident’s [patient’s] name on the top of each page
- Document what you did and why you did it
- Date and sign each note
- Document what you see, hear and smell
- Document in real time
- Correct mistakes correctly
- Documentation should be readily accessible and systematically organized
- Documentation should be factual and relevant



Audience members chat with speaker Dee Hunsberger after workshop.



Participants received a free canvas totebag.



Participants discuss documentation issues.



New DC BON Chair Rachael Mitzner with BON Executive Director Karen Scipio-Skinner.

## RED FLAGS

Documentation can raise a lot of red flags for the surveyor entering your facility. For instance, Ms. Sklencar says, “when I see the dietician saying [in the



Workshop attendees.

documentation]: ‘I asked nursing to weigh the resident, and the resident wasn’t weighed.’ That is a major red flag. I just love when I see charts like that. Or the doctor writes ‘I told the nurse to order a test, and the nurse didn’t do it.’ ‘Again requesting...’ That is a major issue. What does that tell me about your organization? It tells me that people aren’t talking to each other. If your departments aren’t talking to each other, then I know there is a major

problem.” Surveyors are looking to see if systems are in place to correct these issues, Ms. Sklencar said. Staff arguments within the documentation is evidence that “systems aren’t in place.”

## STATUS OF THE RESIDENT

“When I look in documentation, I am looking to see what the status of the resident is,” she said.

“If I read the record and I look at the resident, does it make sense? If I see that a resident has contractures of both upper extremities, I know they are not using the side rail to help roll themselves over. Right? If I have a resident [who is a] bilateral amputee with no prosthetics, I know they are not going to have an ‘unsteady gait.’”

Care Plans should tell the surveyor what you know about the resident currently, not about what happened “three months ago.” And remember that if you put something in the Care Plan you must do it or explain why it was not done.

## HOLDING HANDS TOGETHER

In her Power Point presentation, Ms. Sklencar used a graphic of paper dolls holding hands to convey the message that nursing staff, physicians, and all other staff members who write in a patient’s documentation are all linked together.

“Who has to document defensively? Anybody who writes in that record. When you document in a record, you are holding hands with everybody else” who writes in that record. Ms. Sklencar compared it to the kids’ game Red Rover (outdoor game where children hold hands, and the opposition tries to break the chain).

Ms. Sklencar noted the current trend of physicians coming into Long Term Care facilities and signing paperwork without actually looking at the patients. She told

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attendees she has seen staff “shoving” lab reports and other documents, and the physician “furiously signing” the paperwork. “But tell me what happens when, in January, the resident’s H&H [hemoglobin and hematocrit] is 9.27, then in February it’s 8.24. Do you see that that is a problem? Do you see that everyone is responsible for that problem?” Whatever is happening with that patient, the physician needs to know, and the physician needs to write about it.

Documentation must be consistent and the patient monitored accordingly. Ms. Sklencar told attendees of situations of great concern she has seen in records that were allowed to continue needlessly:

- She spoke of a resident, age 40, with a fecal impaction (“in Long Term Care, a fecal impaction is something that should never, ever happen because you are supposed

to be monitoring that person’s bowel function”). He had a gunshot wound and not functional from the waist down. “On his ADL [activities of daily living] sheets we saw ‘C, C, C, C, C, C’ [Continents] under bowel function. There was no further evidence that the resident was asked about their bowel functioning. Consequently, the young man ended up with a colostomy.”

- She spoke of a resident who hit, kick, spit, and threw a chair, but because it was not consistently documented for months, the psychiatrist looked at the records and then reduce the patient’s medication based on the record.
- She spoke about nurses signing out narcotics, but then “there is no documentation to show that it was ever given to the residents, and

that is a problem,” Ms. Sklencar said. “This is an across-the-board issue that happens in all facilities. ‘I forgot’ doesn’t fly in front of an administrative law judge,” she said.

**START WITH THE VERY BASICS!**

“In long term care, some of our residents stay five, 10, 15, 20 years,” she said. “Please put their name at the top of each piece of paper.” Ms. Sklencar noted another trend she is seeing in long term care: nurses signing their names, but then failing to put a date or time.

When you write your documentation, Ms. Sklencar said, be sure to put the proper gender of your patient.

Another very basic tip she gave was: Be sure you have written all the words you intend to. For instance, write “Admitted with right leg fracture” not “Admitted with right leg.”

## DEA to Allow E-Prescribing of Controlled Substances

The Drug Enforcement Agency (DEA) recently proposed regulations to allow the electronic prescribing of controlled substances. The specific security and record-keeping measures may also prove too onerous and costly for practitioners who practice independently or outside hospitals and other institutions. The rule does not currently account for situations where prescriptions must be signed by more than one person. The proposed rule can be found at 73 Federal Register 36721, June 27, 2008. For more information, see: <http://www.regulations.gov/fdmspublic/component/main?main=DocumentDetail&o=090000648072d416>.

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# Kudos!

### Thanks to nurses volunteering for the DC Medical Reserve Corps: **NURSES VOLUNTEER IN RECORD NUMBERS!**

In preparation for President Obama's Inauguration, Beverly A. Pritchett, MHA, FACHE, senior deputy director of the DC Health Emergency Preparedness and Response Administration spoke to the Board regarding the need for volunteers for the DC Medical Reserve Corps (MRC). The response to assist with inaugural events was overwhelming.

While the immediate need during the inauguration was met, there continues to be a need to maintain the MRC.

The MRC is a trained group of medical (and non-medical) volunteers who support the District of Columbia Department of Health during responses to public events such as Inaugurations and 4th of July Celebrations on the National Mall; or in the event of natural disasters such as floods or hurricanes, or "man-made" disasters, such as terrorist acts. The mission of the MRC is to establish a network of local volunteers who are willing to donate their time and expertise to supplement existing public health and

local resources during emergencies and other time of community need. The DC MRC recruits volunteers of all skill levels and experiences and offers free emergency preparedness training to all volunteers.

### TO BECOME A DC MRC VOLUNTEER, PLEASE REGISTER

**AT:** <https://dcresponds.dchealth.com>. For additional information, please contact Sharon Pellum, MRC Coordinator: E-mail: [dcresponds@dc.gov](mailto:dcresponds@dc.gov); Phone: 202-671-0806 / Fax: 202-671-0707.

## DC Team Participates in Summit to Tackle Nursing Shortage

The Center to Champion Nursing in America, a joint initiative of AARP, the AARP Foundation and the Robert Wood Johnson Foundation, in collaboration

with the Division of Nursing in the U.S. Department of Health and Human Services' Health Resources and Services Administration and the U.S. Department of Labor recently held an "all country summit," bringing together multi-stakeholder teams from nearly all 50 states to create solutions to the nursing shortage. The Nursing Education Capacity Summit, held in Baltimore, brought together 18 "lead" state teams that have been implementing state-specific solutions to mentor representatives from 29 additional states and Washington, DC. The 18 lead state teams share best practices to expand nursing education and foster action in four key areas: strategic partnerships and resource alignment, policy and regulation, increasing faculty capacity and diversity, and redesigning educational curriculums. States have been advocating for policy changes and fostering multistakeholder partnerships that increase nursing school enrollment and bring more nurses into the

workforce. Qualified students are being turned away from nursing schools every year because of challenges, including a lack of funds to hire enough faculty to teach the number of students applying. Considering there are about 116,000 unfilled nursing positions in American hospitals and nearly 100,000 empty nursing and related care jobs in nursing homes, immediate solutions are critical to keeping the health care system working.

*DC Team Members: Veronica A. Damesyn-Sharpe, MHSA, Executive Director, DCHCA; Joyce E. Johnson, RN, PhD, FAAN, NEA-BC; Sr Vice President, Operations and Chief Nursing Officer, Georgetown University Hospital; Keith Mitchell, Executive Director, District of Columbia Workforce Investment Council; Karen Scipio-Skinner, RN, MSN, Executive Director, DC Board of Nursing; Connie M. Webster, PhD, RN, CNA, BC, CNE, Professor, Nursing, Research Infrastructure in Minority Institutions [RIMI] Project Director.*

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## Board Disciplinary Actions

NAME	LICENSE #	ACTION
Olga Hall	RN1010834	Summarily Suspended
Sonja Lee	RN1007551	License Revoked
Jon D. Jones	APRN 964929	License Revoked
Patricia E. Contee	LPN3468	License Revoked
Michael Lee Allison	RN1006099	Summarily Suspended

Names and license numbers are published as a means of protecting the public safety, health, and welfare. Only Final Orders are published. Pending actions against licensees are not published. Consent orders can be accessed by going to Professional Licensee Search at [www.hpla.doh.dc.gov](http://www.hpla.doh.dc.gov).

## ANA CALIFORNIA VICTORY ENFORCING CA NURSING PRACTICE ACT

The American Nurses Association (ANA) achieved a major victory in a California Superior court by obtaining a court order to stop the unlawful use of unlicensed personnel to administer insulin to school children in California. Judge Lloyd G. Connelly issued a ruling in the legal case, *American Nurses Association, et al vs. Jack O'Connell, State Superintendent of Public Instruction* stating that the Department of Education does not have concurrent authority over the administration of medications and cannot override the Nursing Practice Act. Only persons specifically authorized to administer insulin are allowed to do so.

"Our faith in the judicial system has been well placed, because the judge recognized that the scope of practice for registered nurses is established by the Nursing Practice Act, with oversight by the Board of Registered Nursing. We are pleased that the judge specifically stated that the Department of Education did not have authority to re-define the scope of practice for registered nurses, even regarding issues that arise in the schools," remarked ANA President Rebecca M. Patton, MSN, RN, CNOR. "This is a victory for all registered nurses, because ANA and its co-plaintiffs,

ANA/C and CSNO, have established that state agencies cannot play fast and loose with the scope of practice

for nurses," said ANA Chief Executive Officer Linda J. Stierle, MSN, RN, NEA-BC.

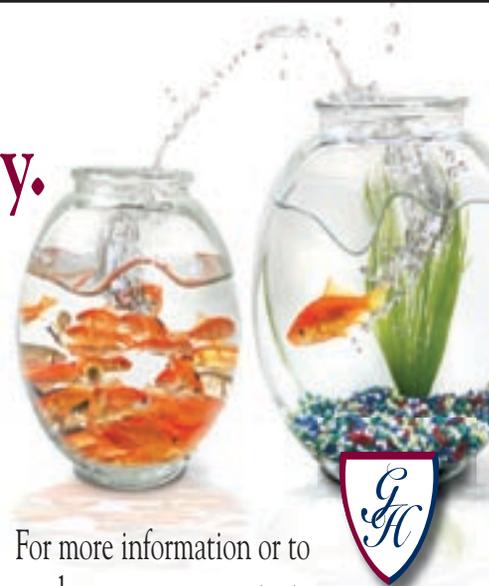
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# THE USE OF STANDING ORDERS IN HOSPITALS

OCT. 29, 2008

### DEAR HOSPITAL COLLEAGUE:

I am very pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) issued a memorandum on Oct. 24 that clarifies the use of standing orders in hospitals. This clarification was sought by The Joint Commission and brings CMS' interpretation of standing orders into alignment with The Joint Commission's view on how to facilitate the timely treatment of certain patients, particularly those who need medications, not previously ordered, to be administered within brief timeframes. The Joint Commission identified the issue through concerns raised by the field and brought it to the attention of CMS. The Joint Commission has been working with CMS on this issue for some time, advocating on behalf of Joint Commission accredited hospitals. Subsequently, other organizations and hospitals voiced support for this CMS change.

The new memorandum clarifies an earlier CMS memo issued in Feb. 2008, and removes a requirement to obtain patient-specific practitioner approval for standing orders that meet the CMS' criteria prior to treatment. With this new memo, timely treatment can be provided to patients and the order can be signed by the physician at a later time. The Joint Commission believes this approach provides the safest, most expeditious way to provide timely care and treatment to patients. CMS' previous interpretation of its conditions of participation on this issue raised serious questions about whether common safety practices in the care of newborns, patients with asthma and other acute conditions, and deteriorating patients would be permitted to continue.

The clarification in the Survey and Certification Group memo states: *The use of standing orders must be documented as an order in the patient's medical record and signed by the practitioner responsible for the care of the patient, but the timing of such documentation should not be a barrier to effective emergency response, timely and necessary care, or other patient safety advances.*

In the memo, CMS notes its intention to work with the professional community to develop an understanding of best practices and definitions for standing orders, pre-printed order sets, and effective methods to promote evidence-based medicine. The Joint Commission will continue to work with CMS and other stakeholders on these issues.

Please direct any questions to The Joint Commission's Standards Interpretation Group at (630) 792-5900 or via the online submission form at <http://www.jointcommission.org/Standards/OnlineQuestionForm/>.

Sincerely yours,

Mark R. Chassin, MD, MPP, MPH

President

Joint Commission

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