

NURSE

REGULATION **E**DUICATION **P**RACTICE

THE **REAL** NURSES
OF THE ICU



Reality versus TV Nursing: Send Us Your Views (page 23)

Health Occupations Revision Act Passes (page 26)

Attention TMEs: Important Information inside (page 6)

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



DISTRICT of COLUMBIA NURSE

Edition 24

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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. (Lengthy letters may be excerpted.)

In the middle of the DC dog days of August, Karen Scipio-Skinner (Executive Director of the BON), Ottamissiah Moore (Board Member) and I attended the National Council of State Boards of Nursing (NCSBN) annual delegate meeting in Philadelphia. Being new to the Board of Nursing, this was my first meeting as an NCSBN delegate. Aside from visiting the Constitution Center and sampling the soft pretzels and Philly cheese steaks that make Philadelphia famous, I learned many things about an organization that I thought I knew. Most of us, including my former self, have identified the NCSBN with the NCLEX examination, as this is the organization that initiates RN and PN exam updates and brings them back to the state boards of nursing for approval. This year the delegates voted to approve the 2010 NCLEX-RN Test Plan with a proposed April 2010 implementation date.

Many nurses may not be aware of what NCSBN is or that testing is only one component of accomplishing their mission.

The National Council State Boards of Nursing, Inc. is responsible for NCLEX testing, but it is much more. It is a not-for-profit organization, whose membership comprises the boards of nursing in the 50 states, the District of Columbia, and four United State territories. This year at the annual meeting, Colleges of Nursing from Ontario, Manitoba and Alberta, Canada, were accepted by the delegates as associate members of NCSBN. The main purpose of NCSBN is to provide an organization through which boards of nursing act and counsel together on matters of common interest and concern affecting the public health, safety and

welfare, including the development of licensing examinations in nursing. In addition to developing NCLEX examinations, NCSBN performs policy analysis and promotes uniformity in relationship to the regulation of nursing practice. They are instrumental in disseminating data related to the licensure of nurses, conducting research pertinent to NCSBN's purpose and serving as a forum for information exchange for its member boards. They have multiple committees on education, practice and regulation, and are always looking for interested professionals to serve. They have an excellent support staff, all which support the mission and purpose of the organization.

At a time when health care is being discussed and debated, nursing boards have a large role in determining policy for public protection and safety. The NCSBN and individual boards look at practice, education and regulation as necessary components for carrying out safe, effective health care. Because of the complexities in health care delivery, nursing and health care leaders agree that there is a need to transform how we educate nurses. As part of their mission of public protection, boards of nursing approve nursing programs across the U.S. and its territories. At last week's NCSBN's Annual Meeting, "Innovations in Nursing Education," model rules were adopted which

will foster innovative approaches to nursing education. Each board must look at these model rules, dialogue with the educational programs in their area and determine if these rules are appropriate for inclusion into the current educational regulations. This is an exciting time for those involved in all areas of health care. This is the time of challenge and the time of change. As a Board of Nursing we are in an excellent position to dialogue with area educators to create a favorable climate for innovative change while being diligent in regulating core education standards. I learned that the DC Board is not out in the health care arena alone. We have the support of a national organization and a network of over 60 nursing boards. NCSBN is all of us, as one voice, working to provide leadership to advance regulatory excellence for public protection.

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



Left to Right: Board ED Karen Scipio-Skinner, Board Member Ottamissiah Moore (standing) and Board Chairperson Rachael Mitzner. Photo courtesy of Matt Romano.

Farewell from Board Member Tracy Spann-Downing

It is my pleasure to have been given the opportunity to serve as a Registered Nurse member on the District of Columbia Board of Nursing. I have had the privilege of serving with the District of Columbia Board of Nursing since March 2008. My time served has been rewarding and gratifying. The knowledge that I have gained pertaining to the Health Regulation and Licensing Administration includes, but is not limited to, conducting investigations, implementing applicable disciplinary actions, and improving the nursing licensing process. I am humbled to have been appointed to uphold the standards of practice for improving the safety of our public.

I have participated in the voting process and offered opinions for changing the standards that have resulted in making the practice of nursing safer, as well as efficient. Furthermore, I have participated in the review of education programs for the improvement of nursing practice in our communities. I appreciate the wise counsel from the Board's attorneys and investigators, and unwavering support given to me from the Board's



Tracy Spann-Downing

staff and Board Members. The Executive Director's leadership is undeniable. I would like to say in parting that everyone will be truly missed. I will continue to be an advocate for improving healthcare provided to the citizens of the District of Columbia. I am pleased to say that I have taken a position with the Department of Health, Health Care Facilities Division, as a Nurse Consultant.

Sincerely,

[Tracy A. Spann-Downing, RN, MSN](#)

Board of Nursing Update

July

NCSBN Executive Officers (EOs) Meeting Report

NCSBN Falsified Identity Tracking System (FITS)

NCSBN has introduced a new resource for Boards, the Falsified Identity Tracking System (FITS), a private, interactive tool for member boards to track unlicensed individuals who have represented themselves as licensed or acquired a license using false credentials and/or a stolen identity, and to investigate questionable nursing programs that have misrepresented their qualifications. FITS allows member boards to share information with other member boards in an organized, safe and secure manner.

Licensing requirements of foreign graduates

EOs discussed board requirements for licensure of foreign graduates, including the requirement for a Social Security Number (see July 2009 issue).

Challenges to APRNs

Dr. Jan Towers discussed national trends and issues relevant to APRN practice including Doctorate of Nursing Practice; Restraint of Trade; Scope of Practice.

DISCIPLINE:

Request Notice of Intent to Discipline:	2
COIN Referral:	1
Consent Order:	1
Request for Investigation:	0

Members of the public are invited to attend...

BOARD OF NURSING MEETINGS

Date: First Wednesday of the month

New Time: 9:30 a.m - 11:30 a.m.

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)

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



October 7, 2009

November 4, 2009

December 2, 2009

January 6, 2010

February 3, 2010

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 9:30 p.m. 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.

TRAINED MEDICATION EMPLOYEES (TMEs) PLEASE NOTE

TME APPLICATION & FEE

We are pleased to inform you that there has been an increase in the volume of Trained Medication Employee (TME) applications we are receiving. And as a result, we have streamlined our application system. In the past we would receive one check with a package of several applications. And if any applications were incomplete we would return all of the applications, including the fee, and request the applications to be completed and returned. This process unnecessarily slowed the approval process for those applications that were complete; and required staff to re-review all applications once they are resubmitted. As of August 3, 2009, the TME application process changed.

We will process TME applications as we do all applications. TME application fees will no longer be refunded. Health Regulation and Licensing Administration's policy is to refund the applicant's licensure/certification fee minus the processing fee, if the applicant is not issued a license/certificate. The processing fee is \$85.00 and the application fee for other applications is \$230.00 or more; while, the application fee for TMEs is \$59.00. Therefore since the certification fee does not cover our processing fee we will no longer refund the application fee once we have processed (entered the applicant's information into our

licensure system) the application.

We will process TME applications as we do all applications. We will no longer notify the providers regarding missing information. We will notify the applicant by mail if information is missing from the application.

Applications will be closed if not completed within 120 days.

Once an application has been submitted it will be entered into our licensure system. Each applicant can determine the status of their application by going to <https://app.hpla.doh.dc.gov/mylicense/> or www.hpla.doh.dc.gov; "Check Application Status". It will delineate any documents that are missing.

TME TESTING

We are also pleased to inform you that we have finally been able to secure an examination location that will accommodate all persons applying to sit for the TME examination. Examinations are now being offered at 441 4th Street, NW, convenient to the Metro (Redline – Judiciary Square). Please be reminded that all persons planning to sit for examination must:

- Bring a letter from the Board of Nursing authorizing them to sit for examination
- Arrive 30 minutes prior to the beginning of the examination
- TURN OFF cellular phones, beepers or other electronic devices.
- NOT BRING food or drink into the examination room.

TME LATE RENEWAL

With the passage of HORA (see page 26) TMEs as Nursing Assistive Personnel have the same privileges and obligations as other health professionals as such:

- TMEs who have not renewed their certification as of October 31, 2009 may continue to work as TMEs for 60 days beyond the date of expiration of their TME Certification (December 31, 2009) but when applying for recertification, will be assessed a \$20.00 late fee (total recertification fee will be \$79.00).

TME CONTINUED COMPETENCY AUDIT

The TME Audit will begin the beginning of 2010. All TMEs selected for audit must provide evidence of the following:

- Verification of continued adequacy of performance documented by supervisory nurse
- Documentation verifying successful completion of twelve (12) hours of in-service training. In-service training may include:
 - Documentation,
 - Hand-washing,
 - Administering medication to difficult patients,
 - Review of the frequently administered medications,
 - Proper medication storage.

IN THE KNOW

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.

Certified Nursing Assistants (CNAs)

Q What is the difference between a CNA and a GNA, include training for each, and where (DC, MD or VA) each can be employed?

A Certified Nursing Assistants (CNAs) and Geriatric Nursing Assistants (GNAs) are the same, just titled differently. In order to work in a Long Term Care facility they must be certified as CNAs, but they can work in any facility.

Q When a Nursing Assistant's Certification has expired, what is the timeframe for the Nurse Assistant to apply for recertification?

A CNAs can renew their certification 60 days prior to expiration.

Q When a Nursing Assistant's Certification has expired, what is the timeframe for when she/he must return to a training institution again?

A Nursing Assistants must re-train and re-test when their certification has lapsed more than 24 months.

Q What constitutes "In-Service" for the Nursing Assistants Certification renewal?

A In-Service is any training provided by a health care facility that is relevant to the CNA's practice.

For additional information and CNA Handbook, please visit our website at: www.hpla.doh.dc.gov.

Trained Medication Employee (TME) Training

Q I have a question pertaining to the required 12 hour in-service training for TMEs. Which in-service training classes do the Board of Nursing deem as "board approved"? We are currently using training material provided by TME Trainer which we've been using since the inception of the TME program. Would you consider this an appropriate form of in-service training? If not, could you please provide me with recommendations? For instance, is there training provided by a certain individual or company that is already board approved?

A Most TME-supervising nurses use materials from the TME training program. That is appropriate to be used. We also encourage the supervising nurses to offer training based upon the TME's needs. For example, if storing medications, documentation, hand washing are issues for the TME that they work with, that should be the focus of the training.

Dispensing Medications

Q Nurses at my agency fill pill boxes for consumers when deemed necessary. At times, the consumer brings medication from their Primary Care Physician. Is the nurse legally protected when filling pill boxes or administering medications ordered by a physician [or APRN]? Does removing any/all medications from a medication bottle, and placing it in a pill box, meet the criteria of dispensing? The Nurse Practice Act, 3-1205.14 (a) 19 speaks to the issue of dispensing...

A What you have described, "filling pill boxes for consumers" is considered by

the Board of Pharmacy to be dispensing medication. Dispensing is defined as preparing and giving out medicines. Transferring pills from a bottle to a pill box and then giving it to a consumer is interpreted as meeting the definition of dispensing. RNs and LPNs cannot dispense medications. APRNs can because they have prescriptive authority.

The section that you cited "3-1205.14 (a) 19" is under the section that addresses discipline and is entitled "Revocation, suspension, or denial of license or privilege; civil penalty; reprimand." The section, in full, states "(19) Prescribes, dispenses, or administers drugs when not authorized to do so."

Licensed nurses (RN/LPNs) are required to have a doctor's or APRN's order to administer medication. According to the Board of Pharmacy the activity described is not administration of medication, it is dispensing. It is the act of taking a medication for which there is not a specific physician/APRN order and placing it in a pill box to be consumed over a period of time.

Call Center RNs

Q Do RNs providing health information and advice to patients who call an advice call center need to be registered as nurses with the District of Columbia Board of Nursing? The call centers are not located in DC, but residents of the District are likely to contact the call center for advice.

A Nurses who provide advice, consultation or case management services and who are not assessing the patient/caller or charting in the patient/caller's chart are not required to be licensed in the District.

LPN RENEWAL PERIOD ENDS CONTINUING EDUCATION AUDIT BEGINS

The 2009 LPN Renewal period ended August 30, 2009. Beginning this renewal period LPNs licensed in the District must comply with the Board's Continuing Education requirement. This requirement can be met by completing 18 hours of one of the following options:

- Obtain contact hours by attending a continuing education offering
- Complete an academic course in a program leading towards a degree in nursing
- Develop and teach an educational offering
- Author of a book/chapter or peer reviewed article or editor of a book

The Board will begin compliance audits within the next 60 days. If you are selected for audit of your compliance with the Board's continuing education requirements you will be requested to mail one of the following documents to Board of Nursing CE Compliance.

CONTACT HOUR OPTION

This option may be used for persons who have attended a continuing education program. The following continuing education programs will be accepted:

- 1) An undergraduate course or graduate course given at an accredited college or university
- 2) A conference, course, seminar, or workshop
- 3) An educational course offered through the internet
- 4) Other continuing education programs approved by the Board

Supporting Documentation Needed:

Original verification or certificate of attendance

ACADEMIC OPTION

This option can be used when you have

completed any course leading towards a degree in nursing or any college course relevant to your practice. One college credit is equal to 15 contact hours. Most nursing courses are two or more credit hours; therefore, one course will meet your continuing education requirement.

Documentation needed:

- Transcript
- End of the semester grade report

TEACHING OPTION

This option may be used if you have developed and taught a course or educational offering approved by a board approved accrediting body. Four (4) Contact Hours will be awarded each approved contact hour. Please note: This is not an option for nurses required to develop and teach continuing education courses or educational offerings as a condition of employment.

Supporting documentation needed:

- 1). Verification form that includes your name, the name of the accrediting body and the number of contact hours awarded. OR
- 2). Letter from an accrediting body acknowledging their approval of your course and the number of hours awarded.

AUTHOR OR EDITOR OPTION

This option may be used if you are the author of a book/chapter or peer reviewed article or if you are the editor of a book. The book, manuscript or article must have been published or accepted for publication during the 2007 –2009 licensure period. Eighteen (18) Contact Hours Awarded

Documentation needed:

- 1). Letter of acceptance; OR
 - 2). Copy of page listing you as editor.
- For articles, also include name of journal, if not indicated on title page or copy of title page of book or article.

"In-Service" versus "Continuing Education"

The Board often receives certificates from nurses that indicate that the course work that they completed was "In-Service Education" and not "Continuing Education." The Board does not accept in-service education in lieu of continuing education. The American Nurses Credentialing Center defines In-Service education and Continuing Education as follows:

Continuing Education: 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.

In-Service Education: Activities intended to assist the professional nurse to acquire, maintain, and/or increase competence in fulfilling the assigned responsibilities specific to the expectations of the employer.

In-service education is specific to the setting in which you work. Continuing education programs offer course work that can be used in other settings. And continuing education programs must be approved as continuing education by a certifying body or board of nursing. Some in-service education programs could be considered as continuing education, but they must be approved as such.

Educational programs can be approved by the DC Board of Nursing by submitting your information to www.cebroker.com

CRIMINAL BACKGROUND CHECKS TO BEGIN

Beginning November 2009, each applicant for initial licensure, registration or certification shall obtain a criminal background check (CBC).

In March of 2007 the "Licensed Health Professional Criminal Background Check Amendment Act of 2006" was passed requiring background checks for applicants and current licensees. Implementation of this legislation is another step towards Health Professional Licensing Administration's mission to protect the public through the regulation of Health Professionals.

The Criminal Background Check process will begin this year in November with the requirement for persons regulated by Title 3, Chapter 12 of the Health Occupations Revision Act, who are applying for initial licensure, registration, or certification by examination or endorsement. The requirement for persons currently licensed, registered, or certified will be phased in at a later date.

Any person submitting an initial applicant for licensure, registration, or certification shall not be issued a license, registration or certification until the background check has been completed by the District's Metropolitan Police Department (MPD).

Fingerprinting will be done by MPD and then submitted to the Federal Bureau of Investigation (FBI). The criminal background check will be conducted in accordance with Metropolitan Police Department's and Federal Bureau of Investigation's policies and procedures and in an FBI-approved environment, by means of fingerprint and National Criminal Information Center checks and procedures.

The FBI criminal background check will disclose the criminal history, if any, of the prospective applicant for the previous seven years, in all jurisdictions within which the prospective applicant has worked or resided within the seven years prior to the check. The MPD will conduct a similar criminal background check of any misdemeanor violations.

The results of the check will be forwarded from the FBI back to MPD. MPD will submit the results to the HPLA for dissemination to the respective licensing board for review. The turn-around time for completion of the criminal background check by the MPD/FBI is approximately one week.

Criminal infractions will be reviewed by the respective board and each applicant will be considered on an individual basis.

Rules are promulgated pursuant to the "Licensed Health Professional Criminal Background Check Amendment Act of 2006", effective March 6, 2007, (D.C. Law 16-222, D.C. Official Code § 3-1205.22 et seq.,).

COIN CONSULT

Your questions about the Committee on Impaired Nurses.

Q I have a suspicion that a coworker of mine is having a problem with some kind of substance. To be frank, everything about her seems different since I first started working with her almost a year ago. She's always complaining about being tired and broke, she disappears for periods of time during the shift, and something is always a little funny as far as how she leaves her patients at the end of a shift. I can't put my finger on it, but some of her behavior reminds me of my sister when she had a bad pill habit. I am friends with this nurse, and I would like to help, not hurt her.

A We hope that your coworker will see your obvious compassion. It is never easy to know what the best thing to do is when you have a sinking feeling that someone you know may be abusing drugs or has become dependent on them. Let the COIN Committee help. You may suggest to your friend that the COIN Committee helps nurses who want to address their drug, alcohol or mental health concerns AND keep their nursing licenses through a voluntary contract that keeps them accountable to any combination of drug rehabilitation, psychiatric and/or psychological services, peer and professional support. Often nurses become tired of being tired, or get scared when they know they are putting their professional licenses at risk through compromised behavior. Nurses may come forward and volunteer to comply with a contract so they can help themselves keep their license before they behave in a way that may threaten their practice and their license.

Your friend may feel that he/she needs to inform their supervisor that they need the help of the COIN Committee and get a referral from their supervisor. This is up to the nurse. We will work with the nurse wherever they are in the process and find a strategy that addresses their particular needs.

Another option that you have is to inform your supervisor directly of your suspicions. You may also want to let your supervisor know that the COIN Committee exists as an alternative-to-discipline program so that this nurse, or any others, may find the help they need. Impaired nursing care is a threat to our community and all nurses. However, it is up to us, as nurses, to help find solutions for nurses who are under stress or who have not developed healthy strategies for coping with stress so that good nurses do not have to leave the profession. For information about or referrals to COIN, call (202) 724-8846 or email concheeta.wright@dc.gov.

Practical Nursing Programs

Year to Date (6/30/09) Licensure Exam Results and Approval Status

PROGRAM	CURRENT QUARTER		YEAR TO DATE		APPROVAL STATUS
	04/01/2009 - 06/30/2009		07/01/2008 - 06/30/2009		
	#Sitting	% Passing	# Sitting	% Passing	
Capital Health Institute	18	83.33	90	76.67	Conditional
Comprehensive Health Academy	29	82.76	123	87.80	Full
JC Inc.	37	59.46	107	61.68	Withdrawn
Radians College (formerly HMI)	18	94.44	73	90.41	Full
University of the District of Columbia	23	82.61	122	68.03	Full
VMT Academy of Practical Nursing	30	63.33	154	59.74	Conditional

Professional Nursing Schools

Year to Date (6/30/09) Licensure Exam Results and Approval Status

SCHOOL	CURRENT QUARTER		YEAR TO DATE		APPROVAL STATUS
	04/01/2009 - 06/30/2009		07/01/2008 - 06/30/2009		
	# Sitting	% Passing	# Sitting	% Passing	
Catholic University of America	3	100	62	67.74	Full
Georgetown University	34	97.06	108	98.15	Full
Howard University	10	90.00	74	79.73	Conditional
Radians College	12	58.33	57	75.44	Conditional
University of the District of Columbia	12	100	26	88.46	Full

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

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Palm Vein Pattern Recognition for the NCLEX® Examination

Beginning in the fall/winter of 2009, Pearson VUE will be introducing Palm Vein technology at all their Pearson Professional Centers. This state-of-the-art system offers a comprehensive level of security for the NCLEX® Examination program that is quick and simple to use. Palm vein recognition examines the unique patterns in a candidate's palm veins using a safe, near-infrared light source like that in a TV remote control. This new technology is fast, highly accurate and secure, with many safeguards built in to protect your privacy and give each test-taker a single record that is virtually impossible to forge.

Why is NCSBN using palm vein technology?

NCSBN is using palm vein recognition because it offers a form of positive identification that is much more accurate than older identity verification technologies, such as digital fingerprinting. Palm vein recognition allows NCSBN to accurately identify people trying to take the NCLEX under assumed testers identities. By preventing proxy testers, the technology helps NCSBN maintain the integrity of the NCLEX examination.

How does the palm vein recognition system work, and how do I use it?

Palm vein recognition works by scanning the veins inside of your hand and creating a digital template that represents your vein pattern. To

use the system, place your hand on the device that holds the sensor (see graphic), which records information from the pattern of your palm



use the system, place your hand on the device that holds the sensor (see graphic), which records information from the pattern of your palm

What can I expect at the testing center, and how will my vein pattern be used?

You will have your palm vein patterns (and fingerprint) recorded when you arrive at the testing center to check-in for your exam. Your pattern will be matched when you return to the testing room after a break. Your palm vein patterns will also be compared with those of other candidates to allow Pearson VUE to find people who may have tested under multiple names or identities. When the reader scans

your palm, the information about your vein patterns is stored as a digital template. After you finish taking your exam, the template is

sent via encrypted transmission with your test results to Pearson VUE. Your vein pattern template is stored separately from other information about you in the system.

Will I have to provide both a fingerprint and a palm vein pattern?

Yes. All NCLEX candidates will have to provide a digital fingerprint and have their palm vein scanned. These steps are being done to ensure the security of the NCLEX examination and give boards of nursing a method to verify their candidates. As the palm vein system is phased in, test-takers should plan on an extra 15 to 30 seconds for the check-in process.

The REAL Nurses of the Intensive Care Unit (ICU)

Ella Tann, RN

United Medical Center

Why did you become a nurse?

I became a nurse because I admired my Mom who is a nurse. She portrays nursing as a very caring and helpful profession. I like to take care of people so I made up my mind to become a nurse. My Mom inspired me.

How long have you been an Intensive Care Unit (ICU) nurse?

I have been a nurse for 15 years and all of my experience has been as an ICU nurse. This is all I've ever done.

What drew you to this type of practice?

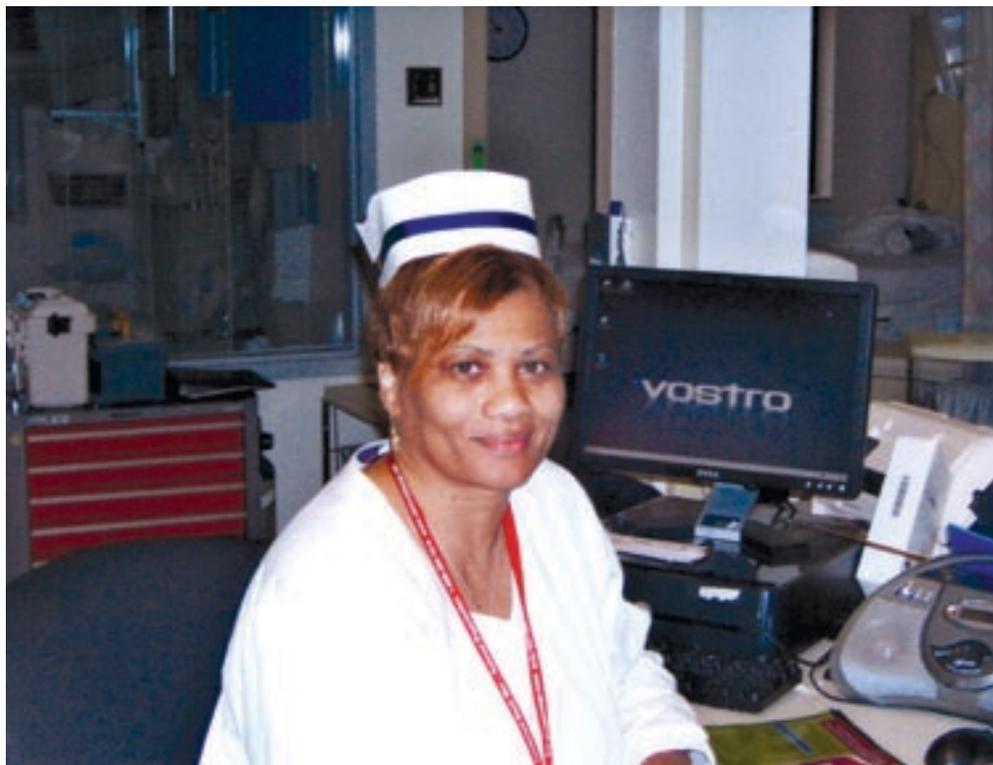
I love the independence and autonomy of this practice. I enjoy the opportunity to critically think and be a part of a health care team that makes a difference.

What do you like most about ICU nursing?

I like the fact that you collaborate more with specialty physicians and you practice by protocols. You do not have much time from decision to intervention. I like the fact that you think and act quickly.

What is the most difficult aspect of ICU nursing?

The most difficult aspect of ICU nursing is the fact that sometimes, regardless of what you do, the patient



Ella Tann

may expire or deteriorate quickly and you wonder if you could have done anything differently.

"I love the independence and autonomy of this practice. I enjoy the opportunity to critically think and be a part of a health care team that makes a difference."

How would you compare it to working in other settings?

There is no comparison. I can only function at my best in ICU.

Are there any specific personality traits which characterize a good Intensive Care Unit nurse?

- Honest, emotionally, and

intellectually stable

- Able to multitask
- Alert to minor subtle changes in the patient
- Be focused
- Make quick decisions and attend to emergencies
- Be competent to work with technological equipment
- Prioritizing under pressure and catch up to new orders quickly
- Be personable, compassionate and caring with a smile.

Are there any misconceptions about your job?

None at all.

Did you always aspire to do this kind of nursing (or did you start out in a different setting)?

Yes. I have always wanted to be an

ICU nurse. This is the only division of nursing I have worked in.

What led you to apply for the job you currently have?

I started at a sister hospital and was transferred here. I love to care for people who are critically ill.

What advice would you give to a nursing student or nurse who is thinking about applying to work in the ICU?

I would advise a new nurse to take a critical care course, be able to precept for six months and determine whether he/she can “fly or retreat.” I do not believe any hospital offers preceptorships for six months now. In that case, I would suggest six months on the medical-surgical unit, six months on a telemetry unit and then move to ICU. Critical care nursing can be overwhelming.

What rewards do you get practicing in your unit that you might not get in another setting?

The satisfaction that I work in a field that I love.

There are many different monitors and machines in the ICU. Do you find that this technology distracts from patient interaction?

I am not intimidated by machines and monitors in the ICU. Once you know how to use them, they are actually very helpful. The monitors assist us in assessing and delivering excellent care to the patients as well as the quality of care we give to our patients.

Anything else you want to add?

I love being an ICU nurse and I want to thank the Department of Health for this opportunity to share my thoughts.

ICU NURSES SPEAK cont'd

Ronald K. Anderson, RN
Providence Hospital



Ronald Anderson

Why did you become a nurse?

Since I was a small child I had always felt a sense of compassion for those around me. The physical/spiritual world was such an intrigue. Learning about how it all worked was fascinating. As I matured it was clear that biology was *one* of my passions and I wanted to use my knowledge to improve the physical and spiritual well being of others. On occasion, spending time in a clinical setting with my aunt, who was a nurse, I saw how she loved nursing and the reward it was to her to make a difference in the life of people. I didn't know any guys who were nurses. And having a pioneer spirit, I recalled the words of one of the old sages in my life, *"Don't let anything stand between you and your dreams. Compromising your dream could ultimately compromise not only who you are, but the world as well. You see one person CAN make a difference. Every person is created with special gifts designed to have a positive effect on the order of things. By realizing your dream, and fulfilling your potential, the possibility for great things is brought into a very real fruition"*. I knew I was a nurse.....it was only up to me to become.

How long have you been an Intensive Care Unit (ICU) nurse?

Twenty-eight years. There is little I haven't done. But then, I'm not finished!

What drew you to this type of practice?

The focus, attention to detail and technology. It's very intense.

What do you like most about ICU nursing?

The focus is on the patient and not just the task. Having two

"TV shows are unrealistic. For example, a practitioner gave mouth-to-mouth on a bloody-faced trauma victim in the clinical setting. I once saw a code on TV where a member of the code team blindly stabbed a patient in the heart—through his clothes—to administer drugs."

patients allows one to focus in extreme detail. The ICU also affords a much higher level of modern technology.

What is the most difficult aspect of ICU nursing?

I don't see it as difficult; I see it as *challenging*. It is up to us as RNs to rise to the challenge to the best of our abilities. The critical care nurse has to adjust to the dynamic/

ever-changing needs of the patient, whatever they may be.

How would you compare it to working in other settings?

I found working on "the floors" to be primarily task/care oriented. Nursing in the ICU is what brings a patient to that point. One must figure out what is going on and support the patient spiritually/physiologically until corrective measures can be made.

Are there any specific personality traits which characterize a good Intensive Care Unit nurse?

Words like focused, anal [-retentive], driven, and intense come to mind.

Are there any misconceptions about your job?

Absolutely! There are persons who have spent too much time watching TV shows like "ER". These programs use the clinical area as the setting to display *drama*. Health care is simply a backdrop. The show really does not reflect the reality of what we do, or the dynamics of the clinical area. But viewers don't know that so when they come into the real world, or the real clinical area, they have many misconceptions.

Follow-up question: Can you tell us about some specific incidents that have happened on TV hospital dramas that would probably never happen in the real life ICU?

Many times on the TV shows/ programs, the situations are unrealistic. For example, a practitioner gave mouth-to-mouth on a bloody-faced trauma victim *in the clinical setting*. Or, in a code/ crash setting, a physician will stop addressing the needs of the patient to converse with a family member. I once saw a code on TV where a member of the code team blindly stabbed a patient in the heart—through his clothes—to administer drugs. My favorite is when a patient is talking to a family member, grabs their chest, the nurse comes running in the room and, of course, the patient is in v-fib. The patient is then shocked and *recovers immediately*. They then sit up and resume conversing with the family member.

The general public may not understand that these situations are acted out on TV for entertainment, and should not be considered to be real clinical settings.

Did you always aspire to do this kind of nursing? (Or did you start out in a different setting?)

I always wanted critical care. But, at the advice of many, I started on the med-surg units to refine the skills I acquired in college.

What led you to apply for the job you currently have?

I moved from my hometown and settled in another city that had a hospital in the same organization.

What advice would you give to a nursing student or nurse who is thinking about applying to work in the ICU?

If they sought out the advice, I would share with them ideas about the level of education, commitment, energy, etc. that is required. I would also share that the expenditure made has the potential to reap rewards that can increase in geometric proportion.

What rewards do you get practicing in your unit that you might not get in another setting?

Many other settings do not deal directly with the human body, human physiology, and the human spirit. Healing is accomplished in a myriad of ways. Seeing another human being healed of infirmity in any form is truly miraculous. *Being a part of and witnessing that process*

is so completely rewarding! In and of itself, it gives the practitioner an overwhelming feeling, a sense of joy!

There are many different monitors and machines in the ICU. Do you find that this technology distracts from patient interaction?

Monitors, machines, technology, etc. *are only* tools! As a nurse, it is up to me to bring the spiritual side, i.e., the person into the equation. Many times, without that human touch, healing cannot be achieved per se. The innate desire of one human being to arm themselves with an ability and then to use that ability to positively impact another human being is the art of nursing. Nursing was once a small tree. It now is an ancient forest of Sequoias!

ICU NURSES SPEAK cont'd

Mosina Sanga, RN Providence Hospital

Why did you become a nurse?

For me it was a second career out of necessity. At the time it was the only career with flexible hours. It turned out to be the best decision I ever made, because I had no idea at the time that it would be so much fun and rewarding, while at the same time heart wrenching and frustrating.

How long have you been an Intensive Care Unit (ICU) nurse?

Ten years.

What drew you to this type of practice?

Autonomy, increased knowledge about my practice and profession.

What do you like most about ICU nursing?

You can literally “snatch someone from the jaws of death”—fascinating.

What is the most difficult aspect of ICU nursing?

When a patient dies, despite the fact that everything was done to save his/her life.

How would you compare it to working in other settings?

There is no comparison: keen assessment skills, titrating pressors, ventilator, etc.

Are there any specific personality traits which characterize a good Intensive Care Unit nurse?

- Willingness to learn something new
- Proactive



Mosina Sanga

- Not timid about what you know, since you are the last line of defense.
- You must be a fierce patient advocate.

Follow-up question: Can you give us an example of when you acted as a “fierce patient advocate”?

Once, I had a patient about age 83, for hip replacement; her husband was also in his 80s. The patient had been self-sufficient until she broke her hip. The insurance company was going to send her home. I said “she still needs care.” They were going strictly by a certain number of days, but this is an 83 year old, not a 20 year old. They didn’t look at the patient, the age of the patient, or what was going on in the household.

I insisted that there be a visiting nurse in place for the home before we send her home. I put it in my note. The insurance

company [healthcare management organization] wanted that note out—but I refused to take it out. We came to sort of an impasse. I literally had to say “I am not going to take it off the patient’s chart,” for them to see the gravity of the situation. I got the head nurse and social worker involved, just to get the basic care. The head nurse came to the bedside and saw that the patient could hardly move. It did not make sense. *(Family members, please come to the hospital, especially for the elderly population.)*

The insurance company’s physicians backed down and let the patient stay a few more days.

Are there any misconceptions about your job?

Yes. One that comes to mind instantly is that it is EASY because we ONLY have TWO patients.

Did you always aspire to do this kind of nursing? (Or did you start out in a different setting?)

No, I started out in medical-surgical nursing.

“When you see a patient that they’ve almost given up on come back to the ICU and say ‘You saved my life—Thank you.’ You get goose bumps every time.”

What led you to apply for the job you currently have?

There was a strike in the last facility where I worked. I came to make ends meet while the strike was going on and liked it so much I decided to stay. Also, the need to try something different.

What advice would you give to a nursing student or nurse who is thinking about applying to work in the ICU?

I understand with the current crisis in nursing many nurses come straight from school, and there are those that can, but for many others I would strongly advise a med-surg route for one year before ICU. The stress level is greatly diminished, and besides one is now familiar with the hospital routine and can now concentrate on what is unique to the ICU.

What rewards do you get practicing in your unit that you might not get in another setting?

When you see a patient that they've almost given up on come back to the ICU and say "You saved my life—Thank you". You get goose bumps every time.

There are many different monitors and machines in the ICU. Do you find that this technology distracts from patient interaction?

Absolutely not.

Anything else you want to add?

It is a great opportunity to talk to patients and family about topics ranging from prevention, lifestyle choices to end-of-life issues. So, one has to be quite knowledgeable and comfortable in how one approaches these topics when one is put on the spot.

ICU NURSES SPEAK cont'd

Ralph Thadeus S. Tuason, RN **Georgetown University Hospital**

Why did you become a nurse?

I became a nurse accidentally. When I was a child, I really wanted to be a doctor, not a nurse. I became a nurse because of my aunt who sponsored me for a Student Visa and introduced me to nursing. My aunt never forced me to be a nurse, but I said to myself, "Why don't I try?" As soon as I started my clinicals and encountered my first patient in the hospital and heard, "Thank you for taking such great care of me," I said this is what I want to be like – a NURSE.

How long have you been an Intensive Care Unit (ICU) nurse?

I have been working in Georgetown Neuroscience ICU since January of 2007.

What drew you to this type of practice?

Ever since I graduated from nursing school, I've always wanted a challenge, and an ICU environment gives me that challenge. ICU patients have multiple problems and you have to critically think to solve problems. The ICU environment always keeps your brain busy because there is always something to solve even with a simple question like: "Why is the patient nauseated?" That question alone can come up with multiple answers and you have to figure out which one is the problem.

What do you like most about ICU nursing?

What I like about ICU nursing is the busy pace and the fact that ICU nursing is very challenging. It challenges several skills – nursing, collaboration, technology, etc. Also, since I work in a teaching hospital, I learn a lot of things in the ICU since patients have a lot of problems that have to be solved. The people that surround me — from doctors to my senior colleagues — are very willing to teach and help you understand things. Also, another thing I like in the ICU is that time goes fast — by the time you look at the clock, it is already time to go home.

"I like the busy pace and the fact that ICU nursing is very challenging. It challenges several skills—nursing, collaboration, technology, etc... Also, another thing I like in the ICU is that time goes fast—by the time you look at the clock, it is already time to go home."

What is the most difficult aspect of ICU nursing?

In Georgetown Neuroscience ICU, what I find most difficult is the emotional toll of talking about withdrawal of care from patients who are dying or are dead on arrival (DOA). It is very difficult to see patients' families grieving because



Ralph Tuason

they've lost or they will lose a special loved one.

I had a patient who suffered a devastating stroke and was dying. That patient had a wife and they were married for about 60 or so years, if I remember. There was nothing that we can do more to save him (very risky to do surgery), despite the wife insisting that we do something. After two hours of talking to the patient's wife, she let him go. The patient's wife told me, "He is all I've got in my life. It is very hard for me." They don't have any children and she is alone now.

I also had another patient that suffered multiple complications from septic shock and he had multiple organ failure. The multidisciplinary team talked to the family about options of treatment. The family took a while to come to a decision of palliative treatment/withdrawal of care, and I was the nurse on that day when withdrawal-of-care family discussions were taking place.

It was heart wrenching to hear stories about the patient because now you see the picture of why it was hard for them to let go.

I am mostly numb to these emotions, but there are times when you just can't help it. You feel their pain — your chest hurts, your heart aches, you want to cry with them, but you can't because as a nurse, you have to be emotionally detached so that you can do your job effectively.

How would you compare it to working in other settings?

I worked on a stepdown floor before I transferred to an ICU setting. There are several differences. One is the pace. When you have a sick patient, you are literally "busy." You have to work fast since minutes count. You can't delay a treatment that is vital to the patient's survival. Also, the ICU is more educationally stimulating since patients have multiple problems.

It doesn't mean that the stepdown unit is not as challenging as the ICU, since stepdown units have a different kind of challenge in terms of nursing care, especially when it comes to discharge planning. Most patients in the stepdown units are just waiting for discharge. Before discharge, you have to anticipate the patient's needs before discharge. This ensures that the patient and patient's family will have what they need and/or know what to expect after discharge, regardless of the discharge setting.

Are there any specific personality traits which characterize a good Intensive Care Unit nurse?

- Organized
- Critical Thinker
- Effective collaborator and communicator
- Efficient
- Team Player
- Knowledgeable

Are there any misconceptions about your job?

I don't know. A nurse who works outside the ICU might be able to answer this.

Did you always aspire to do this kind of nursing? (Or did you start out in a different setting?)

Since I graduated from nursing school, I have always aspired to be an ICU/Trauma nurse. I started out as a stepdown nurse with my director's suggestion. I realized later that it was for my own good that I started out in a stepdown unit. I almost didn't leave our stepdown unit because I am already established in our stepdown unit and because I am afraid of new things. But, with the help of my manager, nursing colleagues, multidisciplinary colleagues, I made it and they made me feel right at home in our ICU. It wasn't an easy and smooth transition. There were several obstacles that I had to overcome. I made some mistakes, but learned from them.

What led you to apply for the job you currently have?

I didn't apply for the ICU job. I was asked if I could transfer to our neuroscience ICU since there was a critical shortage at that time in that unit.

What advice would you give to a nursing student or nurse who is thinking about applying to work in the ICU?

- Listen to your preceptors carefully
- Don't assume you know everything
- Ask when you don't know what you're doing
- Don't take criticisms seriously — take it as something to think about, and learn something from it
- DO NOT FORGET what you learned in school and the critical care course of your hospital — it is very useful in solving problems and answering questions.
- Do not be afraid to ask for help when you are in dire need of help. Remember, you are not a Super Nurse.
- Be a team player; help other nurses who are in need.

What rewards do you get practicing in your unit that you might not get in another setting?

The reward I get as an ICU nurse is the feeling you get when you see somebody recover from the devastating illness that put them in the ICU. You know that you are one of the nurses who helped this patient get better.

There are many different monitors and machines in the ICU. Do you find that this technology distracts from patient interaction?

It depends on the situation. The noise is very distracting. But overall, I think that technology makes you do your job efficiently.

ICU NURSES SPEAK cont'd

Oluwaseyi Gbadamosi, RN

Washington DC VA Medical Center (Veterans Affairs)

Why did you become a nurse?

I became a nurse after watching my mum (who is also a nurse) take care of people and make a difference in their lives. I decided as a little girl that I wanted to be just like my mum, filled with compassion and meeting the needs of others. Although, my mum discouraged me from going this route, I was determined and I have not felt one day of regret since graduating from nursing school in May 2007.

How long have you been an Intensive Care Unit (ICU) nurse?

I have been a surgical ICU nurse since June 2007.

What drew you to this type of practice?

I decided I wanted to be an ICU nurse when I was a student nurse working weekends. I was hired on a medical-surgical unit but sometimes floated to the ICU. I loved the level of acuity and intensity the ICU had, the nurses back then also encouraged me to consider it after seeing my level of interest in their patients. I was also bored as a student on a med-surg unit and there was never a dull moment in the ICU, which propelled me even more to be an ICU nurse.

What do you like most about ICU nursing?

I love the intensity, the pace, level of patient care, the nurse-to-patient ratio, and the challenge it brings along with

it. I love the level of assertiveness that is needed to deal with a multidisciplinary team, patients, and their family members. What I love most is the autonomy I have as a nurse when compared to the medical or surgical wards.

What is the most difficult aspect of ICU nursing?



Oluwaseyi Gbadamosi

The most difficult aspect of working in an ICU is the stress that could come from the complexities of working there. Some examples of those complexities could be dealing with family members of your patient, and ensuring that no mistakes are made on the nurse's part that could jeopardize the life of the patient. Also, there are some days you don't get to sit which could be physically stressful to the nurse.

How would you compare it to working in other settings?

It is highly mentally draining when compared to other settings; there is more autonomy and responsibility for the

nurses in the ICU, as mentioned earlier. The nurses in the ICU are also excellent team players.

Are there any specific personality traits which characterize a good Intensive Care Unit nurse?

I do not believe there are specific personality traits which characterize an ICU nurse, but in my 2 years of working in an ICU, I have noticed that most ICU nurses are assertive, authoritative, intelligent and have "Type A" personalities.

Are there any misconceptions about your job?

Definitely. Some nurses on other wards have said things to me about not being a typical ICU nurse. They expect ICU nurses to be aggressive, cold and rude to others; instead they don't find that in me.

Did you always aspire to do this kind of nursing? (Or did you start out in a different setting?)

I never aspired to be an ICU nurse until I started floating to all the floors in the hospital as a student nurse working weekends. I made up my mind the first few times I floated to the ICU that I would be an ICU nurse and that is what I am today.

What led you to apply for the job you currently have?

I currently work in Washington, DC. I transferred from the hospital in

Indianapolis to the one in Washington, DC, because I got married. The reason why I applied to the hospital in Indianapolis initially was because most places would not accept a new graduate in an ICU so I tried applying to that hospital and I was accepted. I wanted the experience especially from a surgical ICU because my plans for the future include going back to graduate school to become a nurse anesthetist.

What advice would you give to a nursing student or nurse who is thinking about applying to work in the ICU?

My advice would be to go for it. If I can work in the ICU and survive regardless of what I was told by older nurses and people in general, I think

anybody who is determined and willing to learn can also do it.

“My advice would be to go for it. If I can work in the ICU and survive...I think anybody who is determined and willing to learn can also do it.”

What rewards do you get practicing in your unit that you might not get in another setting?

I feel rewarded when a patient comes back to thank me for the wonderful care they received weeks after their discharge. I feel rewarded when a patient who has been on the ventilator for weeks can leave the ICU breathing on their own. I feel rewarded when a doctor comes to ask me questions and the doctor thanks me afterwards. I feel rewarded when

family members are grateful for the care given to their loved ones. I feel rewarded just like any other nurse feels rewarded every day she goes home and knows she made a difference in someone’s life that day. It feels rewarding just to be a nurse.

There are many different monitors and machines in the ICU. Do you find that this technology distracts from patient interaction?

Sometimes it does distract from patient interaction because you are trying to figure out what is going on with the machines, especially when it is new. But for the most part, it does not. There is always time to interact with the patients regardless of their status, this is the part I pride myself mostly in. Being compassionate and attentive to the patients.

ICU NURSES SPEAK cont'd

Bonnie Harper, RN
Sibley Memorial Hospital

Why did you become a nurse?

My mother and grandmother were nurses; I always wanted to “take care of people”.

How long have you been an Intensive Care Unit (ICU) nurse?

Twenty-nine years.

What drew you to this type of practice?

The challenge, new skills, added respect.

What do you like most about ICU nursing?

The complexity of care, assessment and skills utilized; autonomy in the critical care environment.

What is the most difficult aspect of ICU nursing?

Working in ICU can be “all encompassing” and it’s natural to get very involved in what is happening. We know that, as nurses,

we often we play a pivotal role in the care of the patient (and for the family). It can be intense. I would say keeping burn-out at bay can be difficult.

How would you compare it to working in other settings?

Rewarding but can be draining.

Are there any specific personality traits which characterize a good Intensive Care Unit nurse?

- Ability to multitask, to compartmentalize situations so that you can refocus when you go into the next patient’s room or situation.
- Must have good organizational skills.
- Friendly and self-assured.

Are there any misconceptions about your job?

People don’t realize all that we do until they see it firsthand.

“Working in ICU can be ‘all encompassing’ and it’s natural to get very involved in what is happening. We know that as nurses, we often play a pivotal role in the care of the patient (and for the family). It can be intense.”

Did you always aspire to do this kind of nursing? (Or did you start out in a different setting?)

Yes. Although I am also a Research Coordinator at NIH in the Critical Care Medicine Department.

What led you to apply for the job you currently have?

I wanted a less stressful ICU environment as I started my family.

What advice would you give to a nursing student or nurse who is thinking about applying to work in the ICU?

Work med-surg first to gain organizational and assessment skills. Learn how to relate to patients and families before entering the critical care setting.

What rewards do you get practicing in your unit that you might not get in another setting?

Camaraderie and usually feeling like I can do a good job taking care of my patients.

There are many different monitors and machines in the ICU. Do you find that this technology distracts from patient interaction?

No.

NCSBN Adds to Its Body of Research with the Publication of Three New Research Briefs

The National Council of State Boards of Nursing (NCSBN) sets an ambitious research agenda designed to advance the science of nursing regulation. NCSBN

recently added to its body of research with the publication of three new briefs: *Report of Findings from the Post-Entry Competence Study*, *Report of Findings from an Analysis of Nursys*

Disciplinary Data from 1996-2006 and *Report of Findings from the Effect of High-Fidelity Simulation on Nursing Students' Knowledge and Performance: A Pilot Study*.

Report of Findings from the Post-Entry Competence Study explores the characteristics of registered and licensed practical/vocational nursing from entry through five years of practice to discover how nursing practice changed post entry, when the changes occur and the competencies needed by nurses with up to five years of experience.

Report of Findings from an Analysis of Nursys Disciplinary Data from 1996-2006 focuses on the trends of disciplinary actions and the characteristics of disciplined nurses using 11 years of data from NCSBN's Nursys databank of license and discipline information.

Additionally, *Report of Findings from the Effect of High-Fidelity Simulation on Nursing Students' Knowledge and Performance: A Pilot Study* examines the effect of high-fidelity simulation alone and in combination with actual clinical experience on knowledge acquisition, confidence and clinical performance of nursing students with a randomized controlled trial.

"We are proud to add these publications to our growing body of work," said Kathy Apple, MS, RN, CAE, NCSBN CEO. "It is our hope that this research has measurable impact on nursing regulation and can create meaningful change in order to address the challenges that face nursing regulators today."

NCSBN now offers 40 volumes of research that include practice analyses and national surveys of the profession, covering topics such as nursing education and professional issues. Previously only available for purchase through NCSBN, these research briefs are now downloadable free of charge by visiting www.ncsbn.org.

Health Occupations Revision Act (HORA) Amendments Signed Into Law!

As of July 7, 2009, the following amendments to the District of Columbia Health Occupations Revision Act of 1985 (HORA) were signed into law.

Over the coming months the board will work to draft regulations in compliance with the following HORA amendments. Through DC NURSE we will update you on proposed regulatory changes and invite your feedback. Please know that your input is always welcome and much appreciated.

THE PRACTICE OF NURSING

The scope of practice of Advanced Practice Registered Nurses (APRNs), Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) was amended as follows:

Practice of advanced practice registered nursing: The performance of advanced-level nursing actions, with or without compensation, by a licensed registered nurse with advanced education, knowledge, skills, and scope of practice who has been certified to perform such actions by a national certifying body acceptable to the Board of Nursing. The practice of advanced practice registered nursing includes:

- (A) Advanced assessment;
- (B) Medical diagnosis;
- (C) Prescribing;
- (D) Selecting, administering, and dispensing therapeutic measures;
- (E) Treating alterations of the health status; and
- (F) Carrying out other functions identified in title VI of this

act and in accordance with procedures required by this act.

Practice of practical nursing: The performance of specific nursing services, with or without compensation, designed to promote and maintain health, prevent illness and injury, and provide care based on standards established or recognized by the Board of Nursing; provided, that performance of such services is under the supervision of a registered nurse, advanced practice registered nurse, licensed physician, or other health care provider, as authorized by the Board of Nursing. The practice of practical nursing includes:

- (A) Collecting data on the health status of patients;
- (B) Evaluating a patient's status and situation at hand;
- (C) Participating in the performance of ongoing comprehensive nursing assessment process;
- (D) Supporting ongoing data collection;
- (E) Planning nursing care episodes for patients with stable conditions;
- (F) Participating in the development and modification of the comprehensive plan of care for all types of patients;
- (G) Implementing appropriate aspects of the strategy of care within a patient-centered health care plan;
- (H) Participating in nursing care management through delegating to assistive personnel and assigning to other licensed practical nurses nursing interventions that may be performed by others and do not conflict with this act;
- (I) Maintaining safe and effective nursing care rendered directly or indirectly;

- (J) Promoting a safe and therapeutic environment;
- (K) Participating in health teaching and counseling to promote, attain, and maintain optimum health levels of patients;
- (L) Serving as an advocate for patients by communicating and collaborating with other health care service personnel; and
- (M) Participating in the evaluation of patient responses to interventions.

Practice of registered nursing:

The performance of the full scope of nursing services, with or without compensation, designed to promote and maintain health, prevent illness and injury, and provide care to all patients in all settings based on standards established or recognized by the Board of Nursing. The practice of registered nursing includes:

- (A) Providing comprehensive nursing assessment of the health status of patients, individuals, families, and groups;
- (B) Addressing anticipated changes in a patient's condition as well as emerging changes in a patient's health status;
- (C) Recognizing alterations of previous physiologic patient conditions;
- (D) Synthesizing biological, psychological, spiritual and social nursing diagnoses;
- (E) Planning nursing interventions, and evaluating the need for different interventions and the need for communication and consultation with other health care team members;

- (F) Collaborating with health care team members to develop an integrated client-centered health care plan as well as providing direct and indirect nursing services of a therapeutic, preventive, and restorative nature in response to an assessment of the patient's requirements;
- (G) Developing a strategy of nursing care for integration within the patient-centered health plan that establishes nursing diagnoses, sets goals to meet identified health care needs, determines nursing interventions, and implements nursing care through the execution of independent nursing strategies and regimens requested, ordered or prescribed by authorized health care providers;
- (H) Performing services such as:
 - (i) Counseling;
 - (ii) Educating for safety, comfort, and personal hygiene;
 - (iii) Preventing disease and injury; and
 - (iv) Promoting the health of individuals, families, and communities;
- (I) Delegating and assigning interventions to implement a plan of care;
- (J) Administering nursing services within a health care facility, including the delegation and supervision of direct nursing functions and the evaluation of the performance of these functions;
- (K) Delegating and assigning nursing interventions in the implementation of a plan of care along with evaluation of the delegated interventions;
- (L) Providing for the maintenance of safe and effective nursing care rendered directly or indirectly as well as educating and training persons in the direct nursing care of patients;

- (M) Engaging in nursing research to improve methods of practice;
- (N) Managing, supervising, and evaluating the practice of nursing;
- (O) Teaching the theory and practice of nursing; and
- (P) Participating in the development of policies, procedures, and systems to support the patient.

The practice of Nursing Assistive Personnel was defined and placed under the auspices of the Board of Nursing

Practice by nursing assistive personnel: The performance by unlicensed personnel of assigned patient care tasks which do not require professional skill or judgment within a health care, residential or community support setting; provided, that such patient care tasks are performed under the general supervision of a licensed health care professional. Nursing assistive personnel includes:

- (A) Nursing assistants;
- (B) Health aides;
- (C) Home-health aides;
- (D) Nurse aides;
- (E) Trained medication employees;
- (F) Dialysis technicians; and
- (G) Any other profession as determined by the Mayor through rulemaking.

DISCIPLINARY ACTIONS

The following section was revised specifying the number of years required for the revocation or suspension of licensure, registration or certification.

§ 3-1201.01 General Definitions

(12) Revocation: The termination of the right to practice a health profession and loss of licensure, registration, or certification for 5 years or more.

(15) Suspension: The termination of the right to practice a health profession for a specified period of time of less than 5 years or until such time that the specified conditions in an order are satisfied.

The following section was revised to delineate additional categories for board disciplinary action.

§ 3-1205.14: Revocation, suspension, or denial of license or privilege; civil penalty; reprimand.

(a) Each board subject to the right of a hearing as provided by this title, on an affirmative vote of a majority of a quorum of its appointed members may take one or more of the disciplinary actions provided in subsection (c) of this section against any applicant for a license, registration, or certification, an applicant to establish or operate a school of nursing or nursing program, or a person permitted by this title to practice a health occupation regulated by the board in the District who:

- (1) Fraudulently or deceptively obtains or attempts to obtain a license, registration, or certification for himself, herself, or another person;**
- (2) Fraudulently or deceptively uses a license, registration, or certification;**
- (3) Is disciplined by a licensing or disciplinary authority or peer review body or convicted or disciplined by a court of any jurisdiction for conduct that would be grounds for disciplinary action under this section;** for the purpose of this paragraph, the term "convicted" means a judgment or other admission of guilt, including a plea of nolo contendere or an Alford plea;

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- (4) Has been convicted in any jurisdiction of any crime involving **moral turpitude**, which for the purposes of this paragraph means a crime that:
- (A) **Offends the generally accepted moral code of mankind;**
- (B) **Is one of baseness, vileness, or depravity in the conduct of the private and social duties** that an individual owes to his or her fellow man or to society in general; or
- (C) Is one of **conduct contrary to justice, honesty, modesty, or good morals.**
- (10) Upon proper request, and payment of a reasonable copy fee, if required, **fails to provide, within a reasonable period of time, a copy or summary report,** if the patient or client consents, of the patient's or clients health care record to the patient or client, his or her legal representative or guardian, a hospital or third-party health professional licensed under this act or under the laws of another jurisdiction; for the purposes of this paragraph, the term "health care record" means any document, or combination of documents, except for a birth or death record or a record of admission to or discharge from a hospital or other health-care facility, that pertains to the history, diagnosis, or health condition of a patient or client and is generated and maintained in the process of providing health-care treatment, regardless of whether the health care record originated with or was previously in the possession of another health care provider.
- (23) Engages in:

- (A) **Sexual harassment of a patient or client;**
- (B) **Sexual contact with a patient or client** concurrent and by virtue of the practitioner-patient or practitioner-client relationship;
- (C) At any time during the course of the practitioner-patient or patient-client relationship, in **conduct of a sexual nature that a reasonable patient or client would consider lewd or offensive; or**
- (D) **Sexual conduct with a former patient or client when the patient or client may still be vulnerable** by virtue of the power imbalance that existed in the practitioner-patient or practitioner-client relationship, even if the relationship may appear to be or is mutually consensual when such contact is likely to have an adverse impact on the patient or client;
- (25) **Violates any District of Columbia or federal law, regulation, or rule related to the practice of a health profession or drugs, or fails to conduct business with honesty and fair dealing with employees or students in his or her school of nursing or nursing program,** the District of Columbia, a state, the federal government, or the public;
- (30) Abandons a patient; for the purpose of this paragraph, the term "abandons" means **termination, without adequate notice, of the professional relationship between a health care provider and a patient or client at a time when the patient or client is in need of further emergency care;**
- (31) **Knowingly fails to report suspected child abuse** in violation of section 2 of an act to provide for the mandatory reporting by physicians and institutions

- in the District of Columbia of certain physical abuse of children, approved November 5, 1966 (80 Sta. 1354; D.C. Official Code § 4-1321.02);
- (32) **Refuses, withholds from, denies, or discriminates against an individual** with regard to the provision of professional services that the licensee, registrant, or person certified is licensed and qualified to render **because the individual is HIV positive;**
- (33) **Refuses on ethical, moral, or religious grounds to provide services** to a patient, customer, or client;
- (34) **By corrupt means, threats, or force, intimidates or influences, or attempts to intimidate or influence an person for the purpose of causing any person to withhold or change testimony in hearings or proceedings before a Board,** court of law, or to the Office of Administrative Hearings;
- (35) **By corrupt means, threats, or force, hinders, prevents, or otherwise delays any person from making information available to a board,** court, or the Office of Administrative Hearings in furtherance of any investigation of a Board, court, or the Office of Administrative Hearings;
- (36) **Intentionally misrepresents credentials for the purpose of testifying or rendering an expert opinion** in hearings or proceedings before a Board, court, or the Office of Administrative Hearings;
- (37) **Fails to keep adequate medical, dental, health, or client records** as determined by a review of a Board;
- (38) **Makes any misrepresentations or false promises, directly or indirectly, to influence, persuade or induce patronage;**

- (39) Practices under a name other than the name under which the individual is licensed, registered, or certified;
- (40) Makes a false or misleading statement regarding skill or the efficacy or value of a medicine, treatment or remedy prescribed or recommended by him or her at his or her discretion in the treatment of any disease or other condition of the body or mind;
- (41) Is subject to repeated or recurring health claims or client liability claims that in a board's opinion evidence professional incompetence likely to injure the public;
- (42) Fails to cooperate in an investigation or obstructs an investigation ordered by a board;
- (43) Continues to practice a health profession when the licensed, registered, or certified individual knows he or she has an infectious, communicable or contagious disease and there is a high probability that the disease may be transmitted to a patient or client;
- (44) Falsifies an application to establish a school of nursing or nursing program; or
- (45) Commits fraud or makes false claims in connection with the practice of an occupation regulated by this act, or related to Medicaid, Medicare, or insurance.

The following section is amended to extend the authority of the Mayor to summarily suspend a person licensed, registered or certified to practice

§ 3-1205.15. Summary action.

(a)(1) The Mayor may summarily suspend or restrict, without a hearing, the license, registration or certification of a person:

- (A) Who has had his or her license, registration, or certification to practice the same profession or occupation revoked or suspended in another jurisdiction and has not had the license, registration, or certification to practice reinstated within that jurisdiction;
 - (B) Who has been convicted of a felony;
 - (C) Who has been adjudged incapacitated;
 - (D) Whose conduct presents an imminent danger to the health and safety of the public, as determined by the Mayor following an investigation;
- (a)(2) A suspension or restriction shall not be stayed pending any appeal of the revocation, suspension, conviction, or judgment of incapacity.

NEW SECTIONS ADDED

3-1205.23 Suspension of license, registration, or certification during incarceration for felony or misdemeanor conviction.

A board may suspend the license, registration, or certification of a person during any time that the person is incarcerated after conviction of a felony or misdemeanor, regardless of whether the conviction has been appealed. A board, immediately upon receipt of a certified copy of a record of a criminal conviction, shall notify the person in writing at that person's address of record with the board, and at the facility in which the person is incarcerated, of the suspension and that the person has a right to request a hearing. If requested, the hearing shall be held within 6 months of the release of the licensee, registrant, or person certified.

3-1210.11 Patient or client records.

(a) Upon written request from a patient or client, or person authorized to have access to the patient's record under a health care power of attorney for the patient or client, the health care provider having custody and control of the patient's or client's record shall furnish, within a reasonable period of time, a complete and current copy of that record. If the patient or client is deceased, the request may be made by:

- (1) A person authorized immediately prior to the decedent's death to have access to the patient's or client's record under a health care power of attorney for the patient;
- (2) The executor for the decedent's estate;
- (3) The temporary executor for the decedent's estate;
- (4) The administrator for the decedent's estate;
- (5) The temporary administrator for the decedent's estate; or
- (6) Any survivor of the decedent.

(b)(1) A health care provider may require the patient or client, or person authorized to have access to the patient's or client's record, to pay a reasonable fee for copying, as determined by the board through rulemaking.

(b)(2) For the purposes of this subsection, the term "record" includes a copy of a bill that has been requested by an individual but excludes x-rays.

(c) Medical or client records shall be maintained for a minimum period of 3 years from the date of last contact for an adult and a minimum period of 3 years after a minor reaches the age of majority.

You can access the Health Occupations Revision Act (HORA) in its entirety at www.hpla.doh.dc.gov.

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