VOLUME 9 NUMBER 1
FEBRUARY 2012

# DISTRICT OF COLUMBIA NURSE

## RegulationEducationPractice


Government of the District of Columbia
Vincent C. Gray, Mayor

ONE CITY



GOVERNMENT OF THE DISTRICT OF COLUMBIA
DOH
DEPARTMENT OF HEALTH
Promote. Prevent. Protect.

*OFFICIAL PUBLICATION* **of the DISTRICT OF COLUMBIA BOARD OF NURSING**

# Protected Security LLC

888-680-4900

**Security Alarms**
**CCTV**
**Card Access & Door Control**

FREE PRICE QUOTES & BEST PRICES GUARANTEED

## PROFESSIONAL SURVEILLANCE SYSTEM

DIGITAL VIDEO RECORDER WITH 8 SECURITY CAMERAS




## Watch Over the Internet from Anywhere!*

This Watchguard™ Surveillance System is capable of offering mobile surveillance via many popular mobile models such as iPhone & BlackBerry, and devices running Windows Mobile, Android & Symbian operating systems.

Network surveillance can be accessed through a web browser.

* Broadband internet required for remote access.

Monitor from your smart phone! Camera access via web browser

**888-680-4900**

**www.ProtectedSec.com**

Nationwide Sales & Service

24/7/365 Service

# DISTRICT of COLUMBIA NURSE

Edition 32





**OFFICE LOCATION TELEPHONE NUMBER**
DC Board of Nursing
899 North Capitol St. NE
Washington, D.C. 20002
E-mail: hpla.doh@dc.gov
Phone: (877) 672-2174
Phone: (202) 724-4900
Fax: (202) 724-8677
Web site: www.hpla.doh.dc.gov


**OFFICE HOURS**
Monday thru Friday:
8:15 a.m.-4:45 p.m.



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


*Created by*
**Publishing Concepts, Inc.**
Virginia Robertson, Publisher
vrobertson@pcipublishing.com
14109 Taylor Loop Road • Little Rock, AR 72223
**For advertising information contact:**
Tom Kennedy at
**800.561.4686 or 501.221.9986**
tkennedy@pcipublishing.com
ThinkNurse.com


## contents



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

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

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

# Message from the Chair

As I was sitting, thinking what message I could send to the nurses and nursing students in DC in this issue of DC NURSE, the following was sent to me, via Facebook, by a friend who is an operating room nurse in New Jersey.

"Oh…you're a nurse? That's cool. I wanted to do that when I was a kid. What do you make?"

"What do I make? I make holding your hand seem like the most important thing in the world when you are scared. I can make your child breathe when they stop. I can help your father survive a heart attack. I can make myself get out of bed at 5:00 am (to work a 12+ hour shift) to make sure your mother has the medicine she needs to live. I work all day to save the lives of strangers. Today, I might save your life. I make a difference, what do you make?"

In these times of economic hardship, when people are turning to the healthcare professions because that's where jobs are available, and people in the healthcare professions are working more jobs and longer hours to survive, I think we all need to stop and remember our goals. We all need to "make" enough money to survive, but more importantly—for ourselves and the nursing profession—we need to continue to "make a difference" to each client, patient, or resident's life we touch.

"What do you make?"

* * *

DIABETES ISSUE: Please take a few minutes to read the article on our continuing education program focusing on Diabetes (see page 16). As we go to print with this issue, we join *The Washingtonian* magazine in recognizing former Board of Nursing member Deborah Thomas, CDE, RN, a diabetes educator *(see KUDOS! below)*. ■

E. Rachael Mitzner, BSN, MS, RN

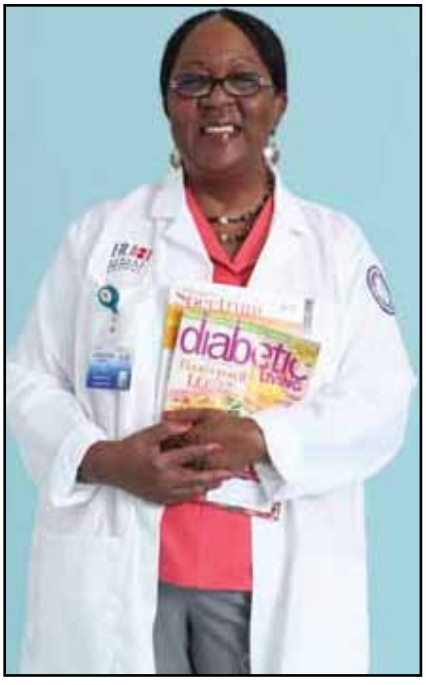
# KUDOS! to Former Board Member and Diabetes Educator Deborah Thomas

Congratulations to Clinical Diabetes Educator Deborah Thomas, RN, CDE, who has been selected as one of ten winners of The Washingtonian Excellence in Nursing Awards. Ms. Thomas was featured in the December 2011 issue of the magazine.

A native Washingtonian, and former member of the Board of Nursing, Ms. Thomas was initially inspired to become a nurse as a youngster, when she read the juvenile novels about a mystery-solving nurse named Cherry Ames, a series written by author Helen Wells.

During her 20 years as a Diabetes Educator at Howard University Hospital, Ms. Thomas has worked to address the diabetes epidemic and treat an increasing number of young people with the disease. In her role as Diabetes Educator, Ms. Thomas established a support group for parents of children with diabetes. Ms. Thomas tailors her educational tools to meet the cultural backgrounds of her clients and has become the primary educational resource in the hospital for assisting nurses and other hospital staff offering care to clients/patients with diabetes.

Diabetes education is her passion: "To teach people that they have control and can take care of themselves is what keeps me in nursing."




Deborah Thomas, RN, CDE

*A custom-crafted design exclusive*

# The Art of Caring
## QUILTED TOTE

*Fashionable take-anywhere tote features symbols of the nursing profession and a touching message*

*Custom crafted of softly quilted fabric*

*Fabric-lined interior includes two pockets to protect your valuables*

*Includes matching cosmetic bag*


**FREE COSMETIC CASE**

**Actual size of tote is 14" wide with a 9" drop. Cosmetic case is 8" by 4"**

## *For Those Who Have the Healing Touch*

Dedicated and compassionate, those in the nursing profession provide us with the ultimate in comfort, healing and caring. Honor those who follow this noble calling with our exclusive *"The Art of Caring" Quilted Tote*. This stylish and contemporary tote features luxurious quilted fabric a striking color combination of black and pink. The distinctive pattern features a pink and white scrollwork design, with pink hearts and white nurse's caps and cadueus symbols against a black background. Incorporated into the design is the heartfelt message, *"Nursing is the art of Caring."* Delicate pink trim and handles provide a beautiful contrast. Both fashionable and practical, the tote features a zippered closure on the top and two inner pockets. Imported.

### A REMARKABLE VALUE... PLUS A FREE GIFT!

This exclusive quilted tote is available at the remarkable price of just $69.95*, payable in 3 convenient installments of $23.32 each. Your purchase is backed by our 90-day unconditional guarantee. Plus, it comes with a FREE matching cosmetic bag! To reserve, send no money now, just mail the Reservation Application. Strong demand is expected from those in the nursing profession as well as from those who have a special nurse in their life. So don't miss out—order today!

**www.bradfordexchange.com/nursetote**



**RESERVATION APPLICATION** **SEND NO MONEY NOW**

THE BRADFORD EXCHANGE
APPAREL & ACCESSORIES

9345 Milwaukee Avenue · Niles, IL 60714-1393

**YES!** Please reserve the *"The Art of Caring" Quilted Tote* for me as described in this announcement.

Please Respond Promptly

Signature _____

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

Address _____

City _____

State _____ Zip _____

**01-14354-001-E56401**

*Plus $9.99 shipping and service. Please allow 8-10 weeks after initial payment for shipment. Sales subject to product availability and order acceptance.

# Board Update

## *OCTOBER, DECEMBER*

*November Board meeting was cancelled due to lack of quorum.*

### LICENSING CERTIFIED MIDWIVES (NON NURSE MIDWIVES)

The Board was asked to consider whether or not certified midwives should be regulated. The Board convened an advisory committee and, based upon their recommendation and a review of regulatory practices in other jurisdictions, the Board agreed to recommend to the Health Professional Licensing Administration that non-nurse midwives be licensed in DC. They also noted that while they support the regulation of certified midwives, that they are not regulated by nursing boards in any jurisdiction.



### TESTIMONY BEFORE DC COMMITTEE ON HEALTH

The Board testified before Councilmember David Catania, Chairperson of the DC City Council's Committee on Health, in support of the HIV/AIDS Continuing Medical Education Amendment Act of 2011. This legislation will require a specified number of mandatory HIV/AIDS continuing education hours each renewal period for RNs, Physicians and Physician Assistants.

### NURSING PROGRAM APPROVAL STATUS

The Board reviewed annual reports submitted by nursing programs and the nursing programs' National Council Licensure Exam (NCLEX) scores. The nursing program approval status can be found on page 27.

### EARLY CRIMINAL BACKGROUND CHECKS

The Board authorized allowing RNs and APRNs to obtain their Criminal Background Checks prior to April 1, 2012.

### HOME HEALTH AIDE REGULATIONS

The Board reviewed recommendations for revision of the proposed Home Health Aide regulations. As a result of the substantial revisions made to these proposed regulations, they will be resubmitted for legal sufficiency and public comment. ■

# RN/APRN RENEWAL BEGINS

## *The 2012 Renewal period is April 1, 2012 – June 30, 2012*

Beginning April 1, 2012 RN/APRNs will be able to renew their licenses by accessing the HPLA website at: https://app.hpla.doh.dc.gov/mylicense/

**Please note: As DC Nurse goes to print, we are working to initiate the RN/APRN Renewal prior to April 1st. Renewal reminder postcards will be mailed to you with additional information. Please make sure that we have your current address.**

### RN RENEWAL TIPS: HOW TO AVOID DELAY

RN/APRN renewals begin April 1, 2012. Licenses will expire June 30, 2012. Here are a few tips to avoid delay now and in the future.

#### KEEP YOUR MAILING ADDRESS CURRENT

Courtesy renewal notices are mailed prior to license expiration date. All notices are mailed to the address on file. It is important to keep your contact information up to date. Please notify us, in writing, of any name or address changes. These can be sent via e-mail to hpla.doh@dc.gov, faxed to 202.727.8471 or mailed to the Board of Nursing at 899 North Capitol Street NE, First Floor, Washington, DC 20002.

#### RENEW ONLINE

If you renew online, you should receive a hard copy of your license within 48 – 72 hours. Mailed renewals may take up to a week.

Don't have a computer? There are resources available. You may go to the public library, use the computer at your job, or come to our office to renew online.

#### CONTROLLED SUBSTANCE REGISTRATION

APRNs, please be reminded that you can now renew your controlled substance license online.

If you also possess a controlled substance registration, your registration is due for renewal. The fee for renewal for your controlled substance registration is $130.00. You may renew online after you renew your primary requisite license. If you choose to use the paper-based renewal method, you may download an application from the website http://hrla.doh.dc.gov/pcd or contact the Health Professional Licensing Administration to obtain a copy of the application at 1-877-672-2174. Note that if your primary requisite license is placed on hold for any reason, you will be unable to renew your controlled substance registration until the hold is released.

#### WHAT SHOULD YOU DO IF YOU DON'T RECEIVE YOUR RENEWAL NOTICE?

You are not required to have a renewal notification prior to renewing. If you did not receive a notification, when you renew online, make sure that you provide your correct address. But, whether or not you receive a reminder notice, you are required to renew your licensure prior to the expiration date of June 30, 2012. ■

# Licensure Renewal — It's the Nurse's Responsibility

In the District of Columbia, the renewal of a nursing license is required every two (2) years. According to DC Code 17-4006. **Term of a License, Certificate, or Registration. 4006.1** The term of a license, certificate, or registration issued or renewed pursuant to this subtitle shall be two (2) years or for the balance of the license period, whichever is shorter.

Therefore, renewal of licenses occurs on a specific date and is not based upon the date that you are originally licensed or your date of birth. Renewal of RN and APRN licenses occurs June 30 of even-numbered years, and for LPNs June 30 of odd-numbered years.

Practicing without a valid license is illegal. According to DC Law, "No person shall practice, attempt to practice, or offer to practice a health occupation licensed, in the District, unless currently licensed."

The DC Board identifies and penalizes (with monetary fines) nurses who have missed several renewal cycles who continue to practice and do not understand the significance of that failure to renew. Along with the licensee, employers share in the responsibility of assuring that the nurse working for them is currently licensed. Nurses that have not renewed and are as practicing nursing without a license will be subject to disciplinary action by the Board.

The Health Regulation and Licensing Administration sends a courtesy reminder postcard to all licensees scheduled to renew. These renewal reminders do not always arrive at the intended destination for any number of reasons. This is why it is important to update all current contact information with the Board.

We recognize the fact that some nurses have several licenses to keep track of, but it is your responsibility as a professional nurse to assure that the license for the jurisdiction in which you are working is active. ■

# New Criminal Background Fingerprinting Service Available

In addition to Criminal Background Check (CBC) services provided by the District of Columbia Metropolitan Police Department, health professionals applying for licensure or renewing their license in the District of Columbia can now also receive live scan Criminal Background Check services with L-1 Enrollment Services. For more information on how to receive a live scan Criminal Background Check via L-1 Enrollment Services visit www.L1ENROLLMENT.com or call 1-877-783-4187. Applicants who choose to use L-1 for CBC will pay the $50.00 fee to L-1 directly for this service.

**Applicants have two options to schedule fingerprinting appointments with L-1 Enrollment Services.**

1. **On-line Live-Scan Scheduling:** Available 24 hours a day, 7 days a week
   - Go to www.L1ENROLLMENT.com
   - Click on the map link to DC
   - Choose Online Scheduling; enter required information; select desired appointment location and date

2. **Call Center Scheduling:** Available Monday - Friday, 9am – 5pm EST at (877) 783-4187
   - Operators will collect required information and schedule your appointment.

**Applicants who are physically unable to go to a location to be fingerprinted may use L-1's Card Scan Processing Program**

This program utilizes advanced scanning technology to convert a traditional fingerprint card (hard card) into an electronic fingerprint record. Converting a "hard card" into an electronic record enables an applicant to have their fingerprint record processed as quickly as if they had traveled to an electronic fingerprint processing location. Applicants must go online to the L-1 Enrollment website www.L1ENROLLMENT.com **or call 1-877-783-4187.** ■

## DC BOARD OF NURSING WORKFORCE SURVEY

Please be reminded that beginning with the RN/APRN renewal the Board of Nursing will ask its RN and APRN licensees to respond to survey questions to assess the DC nurse workforce. Please see the November 2011 (Vol 8, No 3) for a preview of the questions that you will need to respond to.

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

## BOARD OF NURSING MEETINGS

**Date:** First Wednesday of the month.

**Time:**
9:30 a.m – 11:30 a.m.

**Location:**
899 North Capitol St NE
Washington, D.C. 20002
Transportation: Closest Metro station is Union Station.

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

**February 1, 2012**

**March 7, 2012**

**April 4, 2012**

**May 2, 2012**

**June 6, 2012**

**July 11, 2012**

**August – no meeting**

**September 5, 2012**

**October 3, 2012**

**November 7, 2012**

**December 5, 2012**

# NURSING RENEWAL FAQs

## CRIMINAL BACKGROUND CHECK

**Q: Can I complete my CBC prior to the renewal period?**

A: At press time, we are working to allow you to renew your license and complete your CBC early. Please call the Board at 877-672-2174 for the latest details.

**Q: What will happen if I have had a previous arrest or conviction?**

A: Once we receive evidence that you have completed your live scan, your license will be approved for renewal. If the CBC report indicates that you have had a previous arrest or conviction, you may be asked to submit court papers. If the nature of your arrest or conviction appears to have a potential impact on your ability to practice safely, your information will be referred to the Board for possible discipline. [Please note: Persons completing their CBC with L-1 Enrollment can pay an additional fee to have their court records forwarded to the Board].

Please note: Your renewal application will ask "Have you ever been arrested or convicted of a crime?" If the answer is "yes" please indicate "yes." Otherwise, you will be submitting a falsified document to the Board for which you can be disciplined even though you had a minor arrest or conviction (other than minor driving violation)."

## LICENSE RENEWAL QUESTIONS

**Q: If I was recently licensed, do I have to renew?**

A: If you are newly licensed within 120 days of the expiration date, after February 15, 2010, your license will carry over to the next expiration period.

**Q: What are my options for licensure if I will not be practicing in DC during the next two years?**

A: You can choose to:

- Keep your license active
- Cancel your license, in which case you will have to apply again as a new applicant when you decide to resume practice in DC
- Apply for Paid Inactive status. Your license will remain valid, but you will not be able to practice until you apply to reactivate your license and pay the licensure reactivation fee which is currently $34.00.

**Q: What do I need to do if I wish to place my License on Paid Inactive status?**

A: Go on to our website and print out a paper renewal application. Complete and sign the paper renewal application indicating your desire to go on "Paid Inactive Status," and then mail the renewal application and fee to the address below:
DC Board of Nursing
899 North Capitol Street NE
First Floor
Washington DC 20002
Our website: www.hpla.doh.dc.gov

**Q: Can I go Paid Inactive if I do not renew my license?**

A: No. You have to have an *active* license to request that you be placed on Paid Inactive status. If your license is not currently active, you will have to reinstate your license. You would then request your license to go Paid Inactive after your license has been approved for reinstatement. You must have an active license in order to request to place it on inactive status.

## CONTINUING EDUCATION

**Q: I am not currently working, what courses should I take?**

A: If you are not currently working you must assess your future continuing education needs by considering the following: Do you plan to return to work in your previous area of practice? If so, what updated information do you need to obtain before you return to work? If you plan to change practice areas, what education do you need to meet those needs? Or you can take courses that cover any area of nursing such as legal issues, ethics and documentation.

**Q: Will all applicants have to submit evidence of having completed the required number of contact hours?**

A: No. Continuing education documentation should not be sent when you renew unless you are asked to do so. The Board will conduct an audit after the renewal period. Notices will be sent to those selected to submit proof of completion of their continuing education requirements.

**Q: What happens if I don't complete the required number of contact hours?**

A: If you have not completed your contact hours you will not be eligible for the renewal of your license. It is a requirement for licensure renewal in the District of Columbia.

**Q: Are there specific courses that I have to take?**

A: The only requirement is that it be applicable to your current area of practice.

**Q: I have been ill and have not been able to meet the Board's continuing education requirement. Will I be penalized?**

A: The Board may grant an extension for good cause. Good cause would include military deployment or extended illness. You may be asked to submit documentation validating your extended illness or military service.

**Q: I just completed a nursing course in a school of nursing. Do I need to take continuing education courses as well?**

A: All course work that you take toward obtaining your degree, including liberal arts courses, will meet your CE requirements. ■

# Continuing Education Options

## CONTACT HOUR OPTION

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

1) A conference, course, seminar, or workshop
2) An educational course offered through the internet

**Supporting Documentation Needed:**

Original verification or certificate of attendance.

## 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.

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.

**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.

**Contact hours awarded:**

Four (4) Contact Hours will be awarded each approved contact hour.

## 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.

**Documentation needed:**

Transcript
End of the semester grade report

**Contact hours awarded:**

Two or more credit hours will meet your continuing education requirement.

## 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 licensure period.

**Documentation needed:**

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

**Contact hours awarded:**

Meets continuing education requirement.

***Board approved CE accreditation or approval organizations:**

a) State Board of Nursing
b) American Nurses Credentialing Center (ANCC)
c) Accreditation Council for Continuing Medical Education (CME)
d) Other health professional board or accediting body approved by the Board.

# 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 regarding licensure and other issues. The Board often receives multiple inquiries regarding the same topic. Please share this column with your colleagues and urge them to read it. The more nurses are aware of the answers to these frequently asked questions, the less our resources will have to be used to address duplicate questions.*

### LPN-TO-PCT?

Q: I have a staff person who just passed the LPN licensure examination. We don't have LPN positions, but we do have Patient Care Tech (PCT) positions. Can I hire him as a PCT?

A: We get this question a lot. The answer is yes, you can. But you must ensure that the person is practicing as a PCT and not an LPN. They must be clear about the boundaries of their role. The person must also know that if we receive a report of unsafe practice, even though they are practicing in the role of PCT, they can still be disciplined. The Board of Nursing regulates the practice of nursing assistive personnel (NAPs).

### RENEWAL ALREADY?

Q: I just got my license (Fall 2001) and it expires June 30th. I had to spend a lot of money for such a short period of time.

A: Board of Nursing renewal periods differ based upon laws in the various jurisdictions. Some expire on the applicant's date of birth, some expire based upon the date the applicant was approved for licensure and some expire on a specific date. DC law for licensure renewal period for all health professionals falls in the latter category. If an application for RN/APRN licensure is received and approved prior to March 1, 2012 the license will expire June 30, 2012 and the applicant will be required to renew their license beginning April 1, 2012 (CBC will not be required if previously submitted). Applications submitted and approved after March 1, 2012 will be issued licenses that will expire June 30, 2014.

### CBC FINGERPRINT OPTIONS

Q: A few of our area hospitals are in desperate need of nurses. We have been sending nurses in to get their temporary licenses, and it seems there is a wait to get the required Criminal Background Check (CBC) fingerprinting done. Is there another location that I can send our nurses to, to get that done and have them bring a receipt to you? If you do not know of a location, can you tell me exactly what they need to have done and bring to you?

A: Licensees now have the option of receiving Live Scan CBC services through the L-1 ENROLLMENT SERVICES (as an alternative to the Metropolitan Police Department). Applicants may schedule fingerprinting appointments online at www.L1enrollment.com or by phone at (877) 783-4187. Also, please see a list of approved FBI-Channelers at http://www.fbi.gov/about-us/cjis/background-checks/list-of-fbi-approved-channelers. ■

## CE VS. IN-SERVICE EDUCATION

Q: Please explain the distinction between continuing education (CE) programs and in-service education.

A: Please note language below, from the American Nurses Credentialing Center, **which explains the difference between Continuing Education and In-service Education:**

**a. Continuing Education**

(1) Definition: "Systematic professional learning experiences designed to augment the knowledge, skills, and attitudes of nurses and therefore enrich the nurses' contributions to quality health care and their pursuit of professional career goals" (Scope and Standards of Practice for Nursing Professional Development, ANA, 2000). Continuing education is not: basic skill training, competency training, local policy administrative procedures training, or update briefings.

(2) Characteristics:

(a) Content: Reflects current and emerging concepts, principles, practices, theories, and/or nursing or related research, information beyond that which is taught in a BSN program. It must be at the post-BSN level of nursing education.

(b) Application: Immediate or futuristic application in meeting nursing practice needs or goals of the learner. Knowledge and skills may be utilized in a variety of military nursing practice and education settings.

(c) Examples: Learning activities encompassing topics from the realms of nursing clinical practice, administration, research, education, and military field operations.

**b. In-service Education**

(1) Definition: "Learning experiences provided in the work setting for the purpose of assisting staff members in performing their assigned functions in that particular agency or institution" (Scope and Standards of Practice for Nursing Professional Development, ANA, 2000).

(2) Characteristics:

(a) Content: Reflects employer's goals and service commitments; includes, but is not limited to, review of previously learned skills.

(b) Application: Knowledge and skills are specific to a given employment setting and are immediately applicable to the learner.

(c) Examples: Training in procedures such as Basic Life Support, operation of specific equipment, and standard operating policies and procedures for a particular institution.

(d) In some cases, refresher courses provide nurses re-entering employment, following an absence of several years, with new information or a new skill set that has developed in the previous years. In this type of refresher course, the content area would be eligible for continuing education contact hours (ANCC 2009).

**NOTE:** Contact hours cannot be awarded for in-service education activities. ■

# COIN CONSULT

## A Resource for Impaired Nurses

# Substance Use Disorders In Nursing

*Valerie Smith RN, MS, FRE*
*Associate Director of Investigations & Compliance*
*Reprinted with permission from the Arizona Board of Nursing*

Addiction is an illness that follows a predictable and progressive course that may result in death if left untreated. Symptoms of addiction include compulsion, loss of control over the use of the drug/alcohol, continued use despite negative consequences or high potential for negative consequences, and changes in tolerance. The National Council on Alcoholism and Drug Dependence (www.Ncadd.org) sites the following statistics:

Approximately 18 million Americans have alcohol problems.

Approximately 5 to 6 million Americans have drug problems.

There are more deaths and disabilities each year in the United States from substance abuse than from any other cause.

Almost half of all traffic fatalities are alcohol-related.

One-quarter of all emergency room admissions, one-third of all suicides, and more than half of all homicides and incidents of domestic violence are alcohol-related.

Untreated addiction is more expensive than heart disease, diabetes and cancer combined.

According to a recent national survey on drug use and health completed by the U.S. Department Of Health And Human Services, Substance Abuse and Mental Health Services Administration (SAMSHA), in 2008, an estimated 22.2 million persons (8.9 percent of the population aged 12 or older) were classified with substance dependence or abuse in the past year based on criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSMIV).

Of these, 3.1 million were classified with dependence on or abuse of both alcohol and illicit drugs, 3.9 million were dependent on or abused illicit drugs but not alcohol, and 15.2 million were dependent on or abused alcohol but not illicit drugs. (SAMSHA)

Nurses are no more immune from developing substance use disorders and addiction than the general population.

Although the actual rate of addiction in nurses is unknown with estimates ranging from 6% to 20%, what is known is that one of the most common complaints received by Boards of Nursing and that forms the basis for licensure disciplinary action is substance misuse, abuse or addiction related. In the current Journal alone, approximately 50% or more of the disciplinary actions taken by the Board against nurse licensure (RN and LPN) was directly related to inappropriate substance use, abuse or addiction.

### RECOGNIZING WORKPLACE INDICATORS OF SUBSTANCE USE DISORDER

Despite the prevalence of substance use disorders within society and, within the nursing profession, many co-workers, supervisors, employers and others have difficulty recognizing or assisting a nurse colleague with an apparent substance use disorder. This is alarming considering the inherent responsibilities nurses have for patient care and safety and the potential fatal nature of the disease of addiction. The last step on the downward spiral of addiction occurs at the professional worksite as nurses and other healthcare professionals take great effort to protect their professional and nursing identity. Evidence of the disease on the job usually indicates a late stage disease process. Their denial, shame and fear of consequences prevent many individuals, including nurses, from proactively seeking treatment. Denial and self-deception are the most difficult obstacles to overcome for both the nurse and their colleagues.

It is not uncommon that they initially continue to often perform adequately while afflicted with a substance use disorder.

When job performance deteriorates, managers and colleagues may accept or provide excuses like “stress” or “fatigue” rather than consider substance abuse.

Managers and co-workers may unintentionally enable the disease to progress by ignoring or excusing poor performance, incomplete work, attendance issues and other symptoms of a substance use disorder.

Another way in which the disease is enabled is when an employer recognizing symptoms consistent with a possible substance use disorder and opts to terminate the nurse without addressing the concerns and/or reporting the nurse to the Board. When this happens, the nurse

is allowed to continue with a potentially deadly disease and patient care with the next employer who is potentially negatively impacted.

Workplace indicators of a substance use disorder may include and is not limited to the following.

Attendance: progressive absences, both on the job (unexplained frequent or prolonged absences from the unit) and/or off the job (difficulty adhering to the work schedule); unusual explanations for absences; difficulty meeting deadlines;

Interpersonal: complaints from coworkers or patients or others; increased isolation from others; unpredictability; changes in mood and/or energy level (alert to appearing sedated); increased conflict with others; legal problems; family or social problems.

Job Performance: difficulty in organizing and prioritizing duties and responsibilities; deterioration in quality of work; poor judgment; forgetfulness; below standard practice; odor of alcohol on person or breath; inappropriate, inadequate or missing documentation; discrepancies with controlled drugs or the amount removed as compared to co-workers without a corresponding change in the patient condition that would explain the need for additional medications; discrepancies in the accounting for controlled medications signed out; unauthorized removal of controlled substances or other medications of abuse by accessing or use of another's password; missing medications.

## WHAT TO DO

One of the first steps is the awareness and recognition that substance use disorders does affect nurses. It is an equal opportunity disease that is often misunderstood by those with or impacted by the disease, including employers and co-workers. Nurses with an active substance use disorder have potential to not only harm patients but also cause harm or death to themselves. Be observant for indicators of substance abuse.

Document your observations with objective data that includes date, time and description of the incident. Colleagues who work closely with a nurse struggling with a substance use disorder often recognize that something is wrong before the supervisor who may not have as frequent encounters. If you are a colleague, do not assume the supervisor is aware. Share your concerns with the supervisor. Anytime that there is reasonable concern that a nurse, for whatever reason, is currently unable to safely practice, they should immediately be removed from patient care until further assessment can be completed. If employer policies permit, and there is reasonable suspicion that the nurse may be under the influence of a substance, a drug test should be obtained and the panel of drugs tested should include the drug(s) that are of suspect. A nurse with a suspected substance use disorder should be referred for further evaluation for possible treatment and a report submitted to the Board for further review and investigation by the Board to determine safeness to practice.

## WHAT NOT TO DO

Do not ignore your observations. Do not allow the nurse who is demonstrating active signs and symptoms of impairment to continue to provide patient care or make decisions impacting patient care until further expert assessment can be completed and evidence of ability to safely perform. Do not allow the nurse to resign or be terminated without addressing identified concerns, providing resources for further evaluation and treatment and without notifying or causing the Board to be notified. Do not encourage the nurse to hide information from the Board.

At times, and perhaps well meaning friends, colleagues, and others advising the nurse in how or what to share with the Board or assigned investigative staff, encourage the nurse to not disclose their substance abuse history or substance use disorder with the Board. Not disclosing can put patients at risk and can have deadly consequences for the nurse. Addiction is a chronic progressive disease that may and often does result in death if left untreated.

## SUMMARY

Substance use disorders in nursing are not a modern day phenomenon.

Florence Nightingale reportedly addressed in her writings the need to dismiss nurses for being "dead drunk." In a 1900 nursing ethics book, the author described "encountering members of our own profession who have lost their power of self control and have become victims to the abuse of some powerful drug or alcoholic stimulant with all of it's attending evils (O.M. Church 1985). Today we understand more about substance use disorders and evidence shows that a combination of treatment, involvement in 12-step meetings and licensure/practice monitoring requirements established by healthcare regulatory boards can have positive impact on facilitating remission of the disease and returning licensee's, when appropriate, to patient care. When you suspect a nurse has a substance abuse disorder, dare to do the right thing and make your concerns known to those who have the ability to intervene in behalf of the nurse and patients. ■

**COIN contact info:**
**For confidential referrals to the DC Committee on Impaired Nurses, please call (202) 724-8870.**

## *Continuing Education Update*

# Diabetes Update: Insulin Use in Multiple Settings

In September 2011, DC Board of Nursing and Howard University Hospital sponsored a continuing education program exploring the diagnosis and treatment of Diabetes.

### DIABETES CHALLENGES

"Diabetes affects 25.8 million people or 8.3% of the population in the United States," opening speaker GAIL NUNLEE-BLAND, MD, told program participants. The rate of diabetes among the minority population in the District is 13.8%, she said. "Diabetes is on the rise and a lot of it is undetected," she said. Dr. Nunlee-Bland is an Associate Professor of Medicine, as well as Director of the Diabetes Treatment Center (DTC) at Howard University Hospital. Dr. Nunlee-Bland noted the four Diabetes classifications:

- Type 1 diabetes (T1DM)
- Type 2 diabetes (T2DM)
- Gestational diabetes (GDM)
- rare insulin resistance, mitochondrial syndromes.

Nationally, only 10% of diabetics have Type 1 diabetes. Ninety percent have Type 2 diabetes, she said. Today, many more young people are getting Type 2 diabetes. "Thirty years ago, it was unheard of for children to have Type 2 diabetes," Dr. Nunlee-Bland told attendees, however today—because of lifestyle changes over the past few decades and obesity—more and more children are getting Type 2 diabetes.

Criteria for Diagnosis of Diabetes

- A1C > 6.5% or
- FPG > 126 mg/dl or
- 2-h-plasma glucose > 200 mg/dl or
- Random plasma glucose of > 200 mg/dl

*Gail Nunlee-Bland, MD*

Dr. Nunlee-Bland also spoke about the pathophysiology of diabetes. With Type 1 diabetes, she said, the body's cells do not recognize the action of the insulin. With Type 2 diabetes, there is destruction of beta cells (a type of cell in the pancreas). Because diabetes is affecting younger people, more women of child-bearing age are affected by the disease.

Screening and Diagnosis of GDM (gestational diabetes mellitus)

- Perform a 75-g OGTT, with FPG at 1 and 2 h, at 24-28 weeks gestation
- Diagnosis of GDM is made if:
  - Fasting > 92 mg/dl
  - 1h > 180 mg/dl
  - 2h > 153 mg/dl

Dr. Nunlee-Bland reviewed various methods available for insulin delivery, including syringes, insulin pens and insulin pumps.

Basal insulin provides the body with a steady level of insulin, and Bolus insulin is taken to deal with the spike in glucose which occurs when a patient eats a meal.

Physiologic Multiple Injection Regimens: The Basal-Bolus Insulin Concept

- Basal insulin
  - Controls glucose production between meals and overnight
  - Near-constant levels
  - Usually ~50% of daily needs
- Bolus insulin (mealtime or prandial)
  - Limits hyperglycemia after meals
  - Immediate rise and sharp peak at 1 hour postmeal
  - 10% to 20% of total daily insulin requirement at each meal
- For ideal insulin replacement therapy, each component should come from a different insulin with a specific profile or via an insulin pump (with one insulin)

**Dr. Nunlee-Bland's Self Monitoring of Blood Glucose (SMBG) Goals and Timing**

| | | |
|---|---|---|
| Fasting | 80–120 mg/dL | Test on waking to evaluate basal insulin |
| Premeal | 70–130 mg/dL | Test before each meal to determine bolus doses |
| Peak postmeal | <180 mg/dL | Test 2 hours after a meal to confirm adequate bolus |
| 10:00 PM–6:00 AM | 80–120 mg/dL | Test at bedtime and/or in middle of the night to make adjustments in basal insulin (2:00–4:00 am if nocturnal hypoglycemia is suspected) |

**DIABETES BASICS**

**GLUCOSE (OR "SUGAR")** is the fuel for all cells of the body.

**CARBOHYDRATES** break down in the stomach and in the small intestines, turn into glucose (or sugar), which then moves into the bloodstream.

From the bloodstream, glucose is then moved to all the cells of the body by a naturally-occurring hormone called **INSULIN**. The **PANCREAS** is the organ of the body that makes insulin.

When people have **DIABETES**, the pancreas does not make enough insulin, or the cells do not respond to insulin normally.

Patients with diabetes take two types of **INSULIN**.

- **BASAL** insulin provides the body with a normal level of insulin; this insulin keeps cells and organs functioning normally.
- **BOLUS** insulin is taken at mealtime to compensate for the spike in the blood glucose level caused by eating carbohydrates at mealtime; it is known as "food or emergency insulin."

*Prior to the 1970s, insulin medications were made from insulin obtained from cows, pigs or salmon. The "human insulin" used today does not come from human beings—rather, it is a synthetic insulin manufactured from DNA sources, in a laboratory. This synthetic insulin is almost identical to the hormone produced by the human pancreas.*

Patients must inject themselves, with a pen or syringe; motivated patients can do well using an external programmable pump connected to an indwelling subcutaneous catheter. Pump use, however, is expensive and requires a support system of providers.

**SYMPTOMS**

**Type 1 Diabetes**

In type 1 diabetes, the body does not produce insulin. Insulin is a hormone that is needed to convert sugar, starches and other food into energy needed for daily life.

- Frequent urination
- Unusual thirst
- Extreme hunger
- Unusual weight loss
- Extreme fatigue and Irritability

**Type 2 Diabetes***

In type 2 diabetes, either the body does not produce enough insulin or the cells ignore the insulin. Insulin is necessary for the body to be able to use glucose for energy. When you eat food, the body breaks down all of the sugars and starches into glucose, which is the basic fuel for the cells in the body. Insulin takes the sugar from the blood into the cells.

- Any of the type 1 symptoms
- Frequent infections
- Blurred vision
- Cuts/bruises that are slow to heal
- Tingling/numbness in the hands/feet
- Recurring skin, gum, or bladder infections

*Often people with type 2 diabetes have no symptoms

Source: www.diabetes.org

**HYPERGLYCEMIA**

Blood Sugar/Glucose Level is Too High

- Too much food
- Too little insulin
- Illness or
- Stress

**HYPOGLYCEMIA**

Blood Sugar/Glucose Level is Too Low

- Too little food
- Too much insulin or diabetes medicine, or
- Etra exercise

*Sources: A.D.A.M. Medical Encyclopedia at www.ncbi.nlm.nih.gov, www.carbs-information.com, http://abcnews.go.com/Health, and www.lifeclinic.com*

## WEIGHT GAIN

"Does insulin cause gain weight?" an audience member asked Dr. Nunlee-Bland. It is the food the patient eats that causes the weight gain, not the insulin itself. "Before a diabetes patient begins taking insulin, his or her body is not absorbing the calories," she said. "The calories have been wasted into their blood and urine. If they eat the same amount of food while taking insulin, the food will be properly absorbed and they will then gain weight."

Another attendee noted that physicians in her emergency department are not familiar with insulin pumps. Dr. Nunlee-Bland cautioned that monitoring is very important when a patient utilizes an insulin pump. The patient in the emergency room may have a pump that has become dislodged or the pump may be malfunctioning.

## MULTIDISCIPLINARY

"Diabetes is a complex disorder that requires a multidisciplinary approach

***Continued on page 18***

*Continued from page 17*

in management, multiple medications, and lifestyle modifications through diet and exercise," she said. "Chronic complications associated with poorly-controlled diabetes, hypertension and dyslipidemia can be minimized with adherence to treatment guidelines and monitoring."

"Patients need to know that diabetes is something that can be controlled," Dr. Nunlee-Bland said. By monitoring their blood sugar and taking their insulin, we can help patients prevent bad outcomes such as blindness, amputations, stroke and kidney disease.

*Catherine Burnett, RD, CDE, with Deborah Thomas, RN, CDE.*

*Dr. Nunlee-Bland is the recipient of the 2010 Outstanding Service Award in the Promotion of Endocrine Health in an Underserved Population from the American Association of Clinical Endocrinologists.*

*Dennis Sanders, PharmD*

## PHARMACY PERSPECTIVE

Program speaker and HUH Pharmacist DENNIS SANDERS, PHARMD, began his presentation with enthusiasm usually reserved for a pep rally: "After you receive insulin from the pharmacy, you can use it for how long?" he asked audience members. Many participants called out the correct answer: "28 days." As an intro to diabetes medication, he offered participants a warning: "Insulin is considered a High Alert medication. Many insulin products sound alike and look alike." Always proceed with caution. This caution should also be exercised when asking new patients what diabetes medications they are taking. "Ask patients to bring in their diabetes medication for visual validation."

Get the Patient's History

- Type of medications
- Storage of medications
- Dosage
- Times
- Route, use
- Blood Glucose monitor
- Meals: are you compliant with dietary plan?
- Sleeping patterns
- Hypoglycemic symptoms?
- Complaint with insulin regimen
- How well do they understand their disease and treatment

Dr. Sanders reviewed the physiological patterns of insulin replacement and informed attendees about several insulin regimens. "Nurses administering insulin should be KNOWLEDGEABLE about insulin products and their use," Dr. Sanders said, "in the management of glycemia, in complex hospitalized patients, recognition and management of hypoglycemia, and proper methods for bedside monitoring (ISMP, TJC)." Regarding patients and their self-monitoring of blood glucose: "It is a burdensome disease, but patients learn to take care of themselves and can live long and happy lives."

Tips

- Patients need to eat immediately after taking Aspart (Novolog®),

Glulisine (Apidra®) or Lispro (Humalog®) to prevent hypoglycemia
- Regular insulin should be taken ~30 minutes before eating (unless blood sugar is low) so that onset of insulin action has begun by the time the patient starts to eat
- Insulin can be stored at room temperature for up to 4 weeks as long as the temperature is above 32° F and below 87° F
- Extra unopened bottles of insulin should be stored in the refrigerator. Once punctured, a bottle of insulin starts to loose its potency and should be discarded after 28 days
- Glargine (Lantus®) and Detemir (Levemir®) should never be mixed with any other insulin

*Pharmacist William Sanders served 20 years in Military Medicine as an active duty Naval Officer, Director of Pharmacy, Director for Clinical Support Services and Assistant Director for Administration with an emphasis in Homeland Security. He has extensive experience in Community Emergency Management Issues.*

## WHAT CAN I EAT?

The most frequent comment you may hear from your patients regarding food is: "What can I eat? You have taken everything away from me!" During her presentation, Dietitian CATHERINE BURNETT, RD, CDE, sought to help nurses steer patients toward a more up-beat attitude toward healthy eating.

She challenged audience members to help patients view meals in terms of choices, portions and control, rather than through the lens of limitations, restrictions and "forbidden" foods. "There is no bad food. Sugar is not poison. It is not so much *what* you eat, it is how much. It is up to us to show the patient how to include their favorite foods in their meal planning," she said.

"Maintaining pleasure in eating is extremely important for patients with diabetes," she said. "Food is often a part of social interaction and a patient's life-long eating habits may be difficult to change." At family and social gathering, patients will want to eat what everyone else is eating.

"Meal planning is a crucial part of diabetes management. Without meal planning, insulin is not enough," Ms. Burnett said. "Meal planning is as important as medication."

Goals of Medical Nutrition Therapy

- To achieve and maintain optimal metabolic outcomes:
  - Blood glucose levels as close to normal as possible
  - Lipid and lipoprotein profile that reduces the risk of macrovascular disease
  - Blood pressure levels in normal range
- Provide adequate calories to achieve and maintain a reasonable body weight, normal growth, and development
- Prevent, or at least slow, the rate of development of chronic complications
- Address individual nutrition needs, giving consideration to personal and cultural preferences and willingness to change
- Maintain the pleasure of eating by limiting food choices only when indicated by scientific evidence

"There is no meal planning method that is right for everyone," she said. "Portion control is important—it is not what you eat but portion size." Here are some methods for meal planning:

- Plate Method (Fill a 9-inch plate: 1/2 of the plate for vegetables; 1/4 for potatoes, rice or pasta; and 1/4 for meat, poultry or fish.)
- Calorie Counting
- Exchange Lists
- Sample Menus
- Carbohydrate Counting

Ms. Burnett shared some hints healthcare professionals can use to guide patients toward adhering to healthy portion sizes.

Help your patients with diabetes learn to estimate appropriate serving sizes with common objects:

| | |
|---|---|
| 1 cup | baseball |
| 3/4 cup | tennis ball |
| 1/2 cup | computer mouse |
| 1/4 cup | egg |
| 3 oz. | deck of cards |
| 2 tablespoons | ping pong ball |

*The more starch and sugar you eat, the higher your blood sugar is going to be.*

Ms. Burnett shared nutrition recommendations with regard to the balance of carbohydrates, protein, fat and cholesterol. "Insulin therapy should be integrated into an individual's dietary and physical activity pattern," she said. The insulin taken at meal time should be sufficient to address the level of carbohydrates eaten during that meal.

Hidden Carbohydrates

- Breading on chicken or fish
- Barbecue Sauce
- Salad dressings
- Cream-based soups
- Specialty Coffee beverages
- Alcoholic beverage mixers
- Sugar-free foods

***Continued on page 20***

*Continued from page 19*

Patient Education is Important

- Patients are often surprised to find out that fruit has carbohydrates and that fat-free ice cream has the same carb count as regular ice cream.
- Bottled juice portions can be deceiving. Have your patient check the "serving size" on the label. A bottle of juice may actually be two servings, according to the nutrition label.
- If a patient uses the plate method for meal planning, and the pasta is falling off the plate on to the placemat—the portion is too large!
- Check glucose levels before, during and after exercise.

"It breaks my heart when patients are given the wrong information regarding nutrition and diabetes," she said. Ms. Burnett serves as the Dietitian at the HUH Diabetes Treatment Center.

## ACUTE AND LONG TERM CARE

Clinical Diabetes Educator DEBORAH THOMAS, RN, CDE, spoke to attendees about the use of insulin in the acute setting, Long Term Care setting, and in the schools.

"Diabetes is the fourth most common co-morbid condition complicating all hospital admissions," according to Ms. Thomas. Hyperglycemia management is essential in assuring treatment outcomes. Hyperglycemia, Ms. Thomas noted, causes an increase in infection rates, cardiovascular events, clotting potential, and an increase in morbidity of patients experiencing major medical conditions. "Insulin dosing is computed according to the patient's weight in kilograms, and adjusted if they are a renal/ dialysis patient, elderly or insulin sensitive, average or obese patient with significant insulin resistance," said Ms. Thomas.

**Types of Insulin and Action Times**

| Type if Insulin | Category | Onset | Peak | Duration |
|---|---|---|---|---|
| Aspart (Novolog®) | Rapid | 5-15 min | 40-50 minutes | 3-5 hrs |
| Glulisine (Apidra®) | Rapid | 5-15 min | 50-60 minutes | 3-5 hrs |
| Lispro (Humalog®) | Rapid | 5-15 min | 1-1.5 hrs | 3-4 hrs |
| Regular | Short | 15-30 min | 1-3 hrs | 5-7 hrs |
| NPH | Intermediate | 2-4 hrs | 8-12 hrs | 18-24 hrs |
| Glargine (Lantus®) | Long | 1.5 hrs | peak less | 24 hrs |
| Detemir (Levemir®) | Long | 2-4 hrs | 6-10 hrs | 12-18 hrs |

Total daily requirement of insulin: 50% Basal & 50% Bolus. Hypoglycemia is an adverse reaction to medication therapy.

**INSULIN USE ERRORS**

- WRONG INSULIN TYPE!
- Administration of medication to the wrong patient
- Wrong timing of doses
- Wrong dose
- Omission of doses
- Wrong route
- Failure to properly adjust insulin therapy
- Improper monitoring, timing, and assessment of blood glucose (BG) results

High Alert Medications: P.I.N.C.H.

P IV Potassium
I IV Insulin
N Narcotics
C Chemotherapy
H IV Heparin

Precautions with insulin administration:

- ☐ Insulin must be given in conjunction with meals and glucose monitoring.
- ☐ Insulin orders should be clear, written without abbreviations. (preprinted protocols).
- ☐ Insulin requirements decrease with improvement in the patient's condition and should be evaluated daily.
- ☐ For NPO patients taking insulin there should be IV glucose, TPN or tube feeding support.
- ☐ Basal insulin should not be held on patients that have exogenous insulin deficiency. (Type 1, some Type 2).
- ☐ Oral secretogues should be used with caution in patients taking insulin.
- ☐ For patients on liquid diets insulin should be decreased and given as basal rather than mealtime dosing. These diets should not contain sugar free selections.
- ☐ Insulin requirements in elderly patients should take into account co-morbidities.

- ☐ The patient should always take one type of basal or bolus only.

"In the Long-Term Care setting," Ms. Thomas told attendees, "identifying symptoms presents a challenge because of cognition, incontinence, poor appetite. Dementia and disease co-morbidities and poly-pharmacy have to be considered."

**ASSESSMENT**

- ☐ Increased Incontinence – Polyuria
- ☐ Impaired cognition - dehydration, hypoglycemia
- ☐ Lethargy, weakness - hyperglycemia, hypoglycemia
- ☐ Decreased appetite - hyperglycemia
- ☐ Protocol
- ☐ Give insulin after meals
- ☐ Monitor fluid intake
- ☐ Monitor levels of incontinence, new cognition or behavior problems
- ☐ Monitor glucose at peak times of insulin.

## IN SCHOOL

"The youngest child I have treated for diabetes was 18 months old," Ms. Thomas told attendees. While younger children may not understand their condition, she said, teens better understand the disease but don't want people to know they have it. It is important for everyone to work together and to be vigilant when a child in school has diabetes. "Cafeteria workers should be part of the care team," she said. They should know what to do when there is an emergency, such as hypoglycemia. Diabetic ketoacidosis (state of insulin deficiency) can cause brain damage. Yet, strangely enough, Ms. Thomas noted, it is difficult to get some parents to cooperate. "One of the biggest challenges is to get the parents to be a part of the team," she said.

Children with diabetes should have 3 meals, 3 snacks! Basal insulin has usually been given before the child arrives at school. Replacement of insulin in school is for meal time (bolus) and (correction) for hyperglycemia.

## SCHOOL ROLES FOR DIABETES CONTROL

**Parent –** Provides Individual health Plan (IHP), medication and snacks. Participates in overall planning (504). All medications should be provided by parents including insulin, needles, glucagon kit and snacks. *Section 504* of the Americans with Disabilities- The child cannot be excluded from programs or activities receiving federal funding based on their disability. Gives guidelines for school to make accommodations.

**Child-** Follows prescribed protocol, wears medical identification. Children ages 8 to 12 have the requisite motor skills and maturity necessary to participate in skills such as insulin administration and blood glucose monitoring but require supervision.

**Healthcare Team / School Nurse-** Coordinates medication, diet and activity. Provides preventive care following the IHP. Provides education and training to other personnel. Mealtime surveillance should be done to make sure adequate nutrients are eaten. *IHP- Individual Health Plan-* Provides treatment plan for medication use and treatment of acute complications. *IEP- Individual Education Plan-* allows for planning and modification if a child needs educational accommodations due to disease related limitations.

Hypoglycemia occurs as a side effect of medication therapy, when there is an imbalance between food and insulin. Inadequate food intake can occur when children skip meals, if they are "picky" eaters or if they exercise without a snack before and after. Hypoglycemia occurs when blood glucose levels are below 90mg/dl in young children (0-6 years old) and below 70mg/dl in older children (7-18 years old).

Signs and Symptoms of Low Blood Sugar

**Phase 1**
Sweating
Weakness
Hunger
Anxiety
Trembling
Fast heartbeat
Irritability
Behavior problems

**Phase 2**
*Prevention of progression to this stage is important.*
Confusion
Coma
Seizure

**Repeated hypoglycemia can lead to brain damage, contribute to other medical problems, and death.**

## PREGNANCY

"Diabetes and pregnancy affect about 3 to 10 percent of the population," SUSAN HERBERT, RN, CDE, told participants. Ninety percent have gestational diabetes, and ten

***Continued on page 22***

*Continued from page 21*

*SUSAN HERBERT, RN,*

percent have preexisting diabetes. "It is one of the most common medical complications of pregnancy," Ms. Herbert said. "There is an increased risk of stillbirth and impaired lung maturity if there is fasting and/or post prandial hyperglycemia and macrosomia. Birth traumas such as, shoulder dystocia, pre-eclampsia and related complications may result due to macrosomia." These moms also have triple the C-section rate.

**Conversations with Expectant Mom:** Patient education is extremely important, as is assessment. Care planning is based on assessment, according to Ms. Herbert: "You must determine if the expectant mother has the skills needed to care for herself," she said. "As with all patients with diabetes, it is essential that they monitor their blood sugar, engage in meal planning, and take their insulin."

**Encourage Mom:** "Assure her that blood glucose testing is a teaching tool that allows us to see how her body is responding to treatment," Ms. Herbert said. "It is a valuable source of information for the physician. It is not a test to determine if [the mom] is a good or bad person."

**Demonstrate for Mom:**

a. proper hand washing,
b. proper use of glucose meter
c. times for testing and proper finger stick technique
d. testing for ketones
e. drawing up and injecting insulin
f. site selection and rotation
g. use of insulin pen
h. needle disposal

**Reinforce Routine:** "Express to the patient the importance of sitting down at the table and eating right after she has taken her insulin--away from distractions. I had one patient that got up to answer the phone, forgot about food and passed out."

**Questions for Expectant Moms:** Does your daily schedule allow for frequent glucose monitoring? Do you understand the relationship between poor control and your baby's well being?

**TIPS FOR EXPECTANT MOMS**

1. Insulin should be injected into the fatty tissue of the mid and lower abdomen, the hanging fat of the upper arms, or the thighs.
2. Insulin injections should be routinely rotated among these sites.
3. Caution should be used in the overuse of any site because this will cause a decreased effect of the insulin.
4. Check for urine ketones every morning.
5. Keep a food diary. Do not skip meals. No juice or fruit for breakfast. See a dietitian as soon as possible.
6. Always wear diabetes identification.
7. Monitor glucose before driving.

## COMPLICATIONS

Pregnancy complicated by diabetes is characterized by:

a. hypoglycemia – occurring during periods of fasting and interprandially in response to constant glucose demands from the fetus,

b. hyperglycemia – post prandial and fasting in response to insulin deficiency and/or resistance and high hormone levels,

c. ketoacidosis – in response to hyperglycemia or fasting hyperglycemia,

d. macrosomia – excessive fat production in the fetus in response to hyperglycemia,

e. first trimester action – glucose levels are low to normal with adequate insulin response,

f. second and third trimester action – starts increased insulin demands due to high hormone levels which result in insulin resistance.

"If insulin response is not adequate, hyperglycemia results," Ms. Herbert said.

*Hyperglycemia is the single factor which is responsible for poor outcomes in pregnancy complicated by diabetes mellitus.*

## KETOACIDOSIS

Ketoacidosis during pregnancy may occur with prolonged hypoglycemia "starvation ketosis". The fetus continues to draw glucose across the placenta even during periods of fasting. This contributes to fasting and interprandial (between meal) hypoglycemia in the mother. Free fatty acids are used for energy causing the "starvation ketosis".

Diabetic ketoacidosis (DKA) occurs as a result of hyperglycemia (blood glucose > 200 mg/dl). If insulin hyperglycemia goes unchecked in pregnancy the result is a state of insulin deficiency that leads to DKA.

Symptoms of ketoacidosis include:

1. high ketone levels in urine or blood,
2. glucose levels below 60 mg/dl in the morning
3. nausea, vomiting and abdominal pain,
4. SOB and sweet smelling breath,
5. changes in level of consciousness

## RX ALTERNATIVES

Ms. Herbert also discussed alternative solutions for pregnant patients. "There is higher patient satisfaction with oral medications," she said, "and this may also improve patient compliance." Sulfonylureas are the only non-insulin medication approved for use in pregnancy; this drug stimulates the pancreas to produce and release more insulin into the bloodstream. "During the latter part of the pregnancy, the patient may need to be switched over to insulin as resistance increases," Ms. Herbert said. "After 20 weeks gestation, peripheral insulin resistance increases insulin requirements up to 2 to 3 times that of pre-pregnancy levels."

*Ms. Herbert has been an RN for 17 years. She has been involved with diabetes education for the past four years.*

## LEGAL ALERTS

Addressing the legal aspects of patient education and medication reconciliation, HUH Director of Professional Development and Quality Management SANDRA MAVIN, MS, RN, brought participants' attention to the issue of communication. Failed communication is crucial during vulnerable points of care: admission, at transfer, and at discharge. "According to the Joint Commission, miscommunication is the cause of fifty percent of medication errors," Ms. Mavin told attendees. Errors often occur because of poor transitional care when a patient is transferred from a nursing/rehab facility to acute care or vice versa. "When a new patient is admitted," she asked,"what was last medication taken? When was last dose given?"

*Sandra Mavin, MS, RN*

At discharge, the discharging facility should provide a list of the discharge medications to provide the admitting facility the up-to-date information, she said. A patient should not receive a duplicate dose of insulin when the patient is transferred to the other institution. With the patient, there should be clear documentation. Ms. Mavin told attendees that nurses at her facility now routinely call the nursing home upon admission and also when the patient is sent back to the nursing home.

Ms. Mavin also alerted nurses to the occurrence of indiscrepancies in documentation, medication bottles, in a patient's actual use of medications. Communicate with your patients thoroughly. Patients tend to go to different pharmacies upon discharge. "One patient went into insulin shock when he took his new insulin medication, but did not discontinue taking old insulin," she said. Another patient had insulin pens but not the pen needles, so she simply ceased taking insulin altogether and was readmitted with hyperglycemia.

## SAFETY ALERT REGARDING INSULIN ADMINISTRATION

The Institute for Safe Medication Practices (ISMP) collects data on medication errors and has become aware of numerous reports of serious errors associated with the misadministration of insulin. These events have involved various practitioners, including physician house officers, nurses, and a pharmacist. Human error (e.g., mental slips, lapses, forgetfulness) associated with insulin dose measurement and hyperkalemia treatment was the predominant proximate cause of these events; **most of the human errors were associated with knowledge deficits regarding insulin concentration** (specifically that "U-100" means the concentration is 100 units per mL), the differences between insulin syringes and other parenteral syringes, and a perceived urgency with treating hyperkalemia. **With insulin, it should not be assumed that all healthcare practitioners are knowledgeable and skilled with measuring doses, preparing insulin infusions, and recognizing doses that exceed safe limits.**

For recommendations to enhance safety with this high-alert medication, please visit the ISMP website at: www.ismp.org

***Continued on page 24***

*Continued from page 23*

**PRACTICE BREAKDOWN**

To alert participants to the danger of issues which could harm patients and cause a nurse to be called before the Board of Nursing, DC Board of Nursing Executive Director KAREN SCIPIO-SKINNER, MSN, RN provided attendees with examples of care that fall below good nursing practice.

SAFE MEDICATION ADMINISTRATION: The nurse administers the right dose of the right medication via the right route to the right patient at the right time for the right reason.
**PRACTICE BREAKDOWN:** Nurse misreads the glucometer and administers medication that results in the death of the patient.

DOCUMENTATION: The nurse ensures complete, accurate and timely documentation.
**PRACTICE BREAKDOWN:** The nurse does not document medication administered for several weeks.

ATTENTIVENESS: The nurse is knowledgeable about the patient's care and maintains vigilance to be aware of what is happening with the patient and staff. The nurse observes and stays on top of what is happening with the patient, the clinical condition and responses to therapy, as well as potential hazards or errors in treatment.
**PRACTICE BREAKDOWN:** The nurse notes a negative reaction but does not attribute the negative action to the administration of the medication. The patient's condition exacerbates.

CLINICAL REASONING: The nurse demonstrates appropriate decision-making, critical thinking and sound clinical judgment. Clinicians use scientific and technology in making clinical decisions as well as taking into account the current clinical condition.
**PRACTICE BREAKDOWN:** Nurse asks a medication aide to administer medications poured by the nurse. Nurse asks a medication aide to observe the reactions to a medication and leaves the facility. The patient's condition exacerbates and the medication aide is not aware of the critical nature of the symptoms.

PREVENTION: The nurse follows usual and customary measures to prevent risks, errors, threats to patient safety and hazards or complications due to illness or hospitalization. Hazards of immobility include skin breakdown, kidney stones, contractures, etc.
**PRACTICE BREAKDOWN:** The nurse does not monitor glucose level. The nurse does not properly educate the patient.
The nurse does not prevent skin breakdown or note skin breakdown and not interceding to prevent further skin breakdown.

INTERVENTION: The nurse properly executes healthcare procedures aimed at specific therapeutic goals. Interventions are implemented in a timely manner. Nurses perform the right intervention on the right patient.
**PRACTICE BREAKDOWN:** Administering the wrong medication to the wrong patient.

INTERPRETATION AND IMPLEMENTATION OF AUTHORIZED PROVIDER ORDERS: The nurse interprets and carries out authorized provider orders.
**PRACTICE BREAKDOWN:** Having orders to prevent skin breakdown and not implementing them, or administering medication without authorization.

PROFESSIONAL RESPONSIBILITY AND PATIENT ADVOCACY: The nurse demonstrates professional responsibility and understands the nature of the nurse-patient relationship. The nurse puts the needs of the patient first. Advocacy refers to the expectations that a nurse acts responsibly in protecting patient/family vulnerabilities.
**PRACTICE BREAKDOWN:** The nurse tells unauthorized family member information regarding the patient's condition, or the nurse places patient's picture on "Facebook" page. ■

*Nursing Students attending the CE program.*

# Fetal Alcohol Spectrum Disorder (FASD): CAPTA's New CPS Notification Requirement

*By Cheryl R. Williams, MD*
*Deputy Director*
*Office of Clinical Practice*
*DC Child and Family Services Agency*

## WHAT IS FASD?

The FASD acronym refers to a larger population of children than those who are affected by fetal alcohol syndrome (FAS). The "spectrum" covers a broad range of symptoms associated with a child's pre-natal exposure to alcohol. According to the Centers for Disease Control, FASDs are a leading known cause of intellectual disability and birth defects. This spectrum includes physical (craniofacial) abnormalities associated with FAS, but also more subtle cognitive and/or developmental issues that manifest themselves as the child ages. Many of these symptoms are not evident immediately after birth.

## OVERVIEW OF THE NEW CAPTA REQUIREMENT

In its December 2010 reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA), the US Congress introduced a new requirement that health care providers notify their local child protective services (CPS) system when they are involved in the delivery or care of infants affected by a Fetal Alcohol Spectrum Disorder (FASD).

In affirmation of the federal requirement, the DC Council in September 2011 passed the Child Abuse Prevention and Treatment Emergency Amendment Act of 2011, which requires licensed health professionals to make a report to the District's Child and Family Services Agency (CFSA) Child Protective Services Hotline when providing services to a child under the age of 12 months old who is diagnosed with a FASD.

The local legislation updated the mandated reporter statute (at DC Official Code § 4-1321) to include this notification requirement, but it did not update the statutory definition of a "neglected child" to include a child born with a FASD. The local legislation simply requires medical professionals to call CFSA's CPS Hotline (202-671-SAFE), which is the District's single point of entry for abuse and neglect reports as well as referral and information inquiries, when they recognize that a child in their care is affected by a FASD.

## LEGISLATIVE SUMMARY AND FEDERAL INTENT

Citing numerous studies concluding that early intervention and treatment can improve outcomes for children affected by FASDs, the National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect published *A Call to Action: Advancing Essential Services and Research on Fetal Alcohol Spectrum Disorders*. Within the report, the Task Force made ten recommendations to improve and expand efforts regarding early identification, diagnostic services, and quality research on interventions for individuals with FASDs and their families, one of which was to add prenatal alcohol exposure to the existing CAPTA provision requiring social services and health care professionals to refer drug exposed infants to child protective services systems for early intervention.

Ultimately, Congress updated the CAPTA language with reference to FASD, which is narrower in scope than "prenatal alcohol exposure." CAPTA's FASD provisions for CPS notification are specific to symptoms that are detectable in infants, and are generally on the higher end of the spectrum. The provisions do not require child protective service agencies to determine FASD-affected newborns to be neglected children and subjects of CPS investigations. Rather, the CAPTA provisions are intended to promote early intervention services for these children and to improve safety and well-being outcomes.

## FASD RESOURCES

For more information on FASDs, please contact the District's Perinatal and Infant Healthline at 1-800-MOM-BABY (666-2229). ■

## PROFESSIONAL NURSING SCHOOLS

Patricia McMullen, PhD, JD, CNS, CRNP, Dean
Catholic University School of Nursing
620 Michigan Avenue, N.E.
Washington, DC 20017
mcmullep@cua.edu
PH: (202) 319-5400
FAX: (202) 319-6485

Jeanne Matthews, PhD, RN, Chair, Department of Nursing
Associate Professor & Program Director for Nursing Education
Georgetown University School of Nursing & Health Studies
3700 Reservoir Road N.W.
Washington, DC 20007
MATTHEJE@georgetown.edu
PH:(202)687-0754

Mary H. Hill, DSN, RN, Associate Dean
Howard University College of Nursing
2400 6th St. N.W.
Washington, DC 20059
MarHill@Howard.edu
PH: (202) 806-7456
FAX: (202) 806-5958

India M. Medley, MSN, RN, CPNP, Dean of School of Nursing
Radians College
1025 Vermont Avenue, NW; Suite 200
Washington, DC 20005
imedley@radianscollege.com
PH: (202) 291-9020
FAX: (202) 829-9192

Nancie Pardue Bruce PhD, RN, Director of Nursing, School of Professional Studies, Trinity Nursing Program
Trinity University
125 Michigan Avenue, N.E.
Washington, D.C. 20017
BruceN@trinitydc.edu
PH: (202) 884-9207X9672
PH: (202) 884-9245
FAX: (202) 884-9308

Susie Cato, MSN, MASS, RN Director of Nursing
Associate Degree Nursing Program
Community College of the District of Columbia
Building 53 Room 812
801 North Capitol Street NE
Washington, DC 20002
Ph (202) 274-5914
FAX (202) 274-5952

## PRACTICAL NURSE PROGRAMS

Wusa Jibril, MSN, Director of Nursing
Capital Health Institute
7826 Eastern Ave., Suite 515
Washington, DC 20012
www.capitalhealthinstitute.com
psimon9@msn.com
PH: (202) 722-8830
FAX: (202) 722-722-8831
wjibril@capitalhealthinstitute.com

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

India M. Medley, MSN, RN, CPNP, Dean of School of Nursing
Radians College
1025 Vermont Avenue, NW; Suite 200
Washington, DC 20005
imedley@radianscollege.com
PH: (202) 291-9020
FAX: (202) 829-9192

Jonas Nguh, PhD, MSN, MHSA, RN
Practical Nursing Program
Community College of the District of Columbia
Bertie Campus-Nursing Certificate Programs
5171 South Dakota Avenue NE
Washington, DC. 20017
jnguh@udc.edu
PH: (202) 274-6950
FAX: (202) 274-6509

Litty Abraham Pattammady, MSN, RN
VMT Academy of Practical Nursing
4201 Connecticut Ave, NW; Suite 301
LPattammady@vmtltc.com
Washington, DC 20008
PH: (202) 282-3016
FAX: (202) 282-0012

# Board Staff Member Attends CAC Discipline Conference

In November 2011, Board of Nursing staff member Concheeta Wright, BSN, RN (at right) who serves as Nurse Consultant for Practice, attended the Citizen Advocacy Center's annual meeting, which focused on the disciplinary process. The meeting was entitled "Achieving Regulatory Excellence," and Ms. Wright said of the meeting: "I came away from the conference with an understanding of the importance of communication between the Board of Nursing, the public, and Board attorneys and investigators. This includes written and oral communication. Appropriate communication is the key to ensuring that complaints are acted on in a timely and precise manner, and all necessary information is shared with necessary staff. This assists with the completion of Board cases." Also in attendance at the conference were Health Regulation and Licensing Administration Senior Deputy Director Feseha Woldu, PhD (center),and Jacqueline A. Watson, DO, MBA, the Executive Director of the DC Board of Medicine (at left). ■

# PROGRAM STATUS: Annual NCLEX Performance

## *October 1, 2010 – September 30, 2011*

| Practical Nursing Programs | NCLEX Pass Rate | Approval Status |
|---|---|---|
| Capital Health Institute | 77.17 | |
| Comprehensive Health Academy | 80.26 | Full Approval |
| Radians College | 95.83 | Full Approval |
| University of District of Columbia Community College | 81.44 | Conditional |
| VMT | 66.09 | Closed (voluntarily)* |
| **Registered Nursing Programs** | **NCLEX Pass Rate** | **Approval Status** |
| Catholic University of America | 76.47 | Conditional |
| Georgetown University | 98.44 | Full Approval |
| Howard University | 78.38 | Conditional |
| Radians College | 82.86 | Full Approval* |
| Trinity Washington University | 66.67 | Conditional |
| University of District of Columbia Community College | 50.00 | Conditional |

** Change in Status*

**National Council Licensure Examination (NCLEX) Annual Performance**

Program status is determined by the Board of Nursing and is based on the performance of the graduates of nursing programs on their first attempt taking the NCLEX as set forth in the regulatory requirements in "17 DCMR Chapter 56."

5603.3 The Board may grant full accreditation to a program after the graduation of its first class if:

(a) The percentage of the program's first time NCLEX test takers passing the exam is not more than five percent (5%) below the national norm. The passing percentage shall be based on the cumulative results of the first two (2) quarters following graduation of the first class; and

(b) The program has demonstrated continued ability to meet the standards and requirements of this chapter.

5603.7 In order to maintain full accreditation status, a program with full accreditation shall maintain:

(a) All the standards and requirements of this chapter, as they may be amended or republished from time to time;

(b) A minimum pass rate, for first time test takers on the NCLEX, or not more than five percent (5%) below the national norm, based on the cumulative results of the four (4) quarters in each year.

5605.1 The Board may place a nursing program that has failed to meet or maintain the requirements and standards of this chapter on conditional accreditation status

5605.2 Conditional accreditation status denotes that certain conditions must be met within a designated time period for the program to be granted or restored to full accreditation.

# Lead Poisoning: What Health Professionals Need to Know about Requirements in the District

*By Pierre R. Erville, JD, MS*
*Associate Director*
*Lead and Healthy Housing Division*
*DC Department of the Environment*

## I. WHAT DC DATA IS SHOWING

As we all know, exposure to lead—a powerful neurotoxin—produces long-term adverse health effects, in particular for young children. These can range from reduced IQ to stunted growth, and can result in learning disabilities and behavior problems, increased high-school drop-out rates and likelihood of violent or even criminal acts. It's critical to diagnose lead exposure as early in childhood as possible, both to minimize the harm done and to eliminate the sources of the exposure. The only way to diagnose lead exposure is to test children's blood.

District data are showing some disturbing trends. Under our local law, as explained in further detail below, all children must get a blood lead test during 2 well-child visits: once at around age one (between 6 and 14 months of age), and the second time at more or less age two (between 22 and 26 months of age). While some effort at compliance with the first required blood screen is being made, there is poor compliance with the second. Our data shows that for the 2007 birth cohort, some 53% got their initial blood lead test prior to age 15 months, while only 21% received their second test prior to age 27 months.

It would be very helpful if all health professionals kept in mind the importance of ensuring both required blood lead tests are administered, and in a timely way.

## II. LEAD SCREENING AND REPORTING REQUIREMENTS

When it comes to lead exposure, children who are residents of the District of Columbia are subject to what's called "universal screening" requirements. This means that, regardless of the family's income status and regardless of the location of the family's home, all children who live in the District of Columbia are subject to the same legal requirements when it comes to the need to be screened for exposure to lead. These rules boil down to the following key requirements:

- Children must be screened as part of a well-child visit between the ages of 6 and 14 months.
- Children must be screened a second time as part of a well-child visit between the age of 22 and 26 months.
- Additional screenings are required by law whenever the physician learns that:
  - A parent has a history of occupational lead exposure;
  - There is a history of lead poisoning in siblings or playmates;
  - A child lives in, or frequently visits, deteriorated housing built before 1978;
  - A child lives in, or frequently visits, housing built before 1978, with recent, ongoing, or planned renovation or remodeling;
  - A child's siblings, housemates, or playmates have confirmed lead poisoning;
  - A child's parent, guardian, or other household members participate in occupations or hobbies that may result in exposure to lead;
  - A child lives, or has lived, near industrial facilities or operations that may release atmospheric lead;
  - A child exhibits pica, or presents frequent hand-to-mouth activity;
  - A child has unexplained seizures, neurological symptoms, abdominal pain, or other symptoms consistent with lead poisoning, including growth failure, developmental delay, attention deficit, hyperactivity, behavioral disorders, school problems, hearing loss, or anemia.

- The US Centers for Disease Control and Prevention, in a study released in late 2010, concluded that an increased risk of lead exposure in tap water exists in housing connected to a lead service line. Accordingly, health professionals should ask parents and guardians of children under 6 years of age whether they live in a home connected to a lead service line.

If they do, health care providers should recommend that they get their water tested by DC Water (formerly known as WASA), and in the meantime avoid using tap water for drinking and cooking. They should also consider conducting another blood lead test.

- If a child is a new resident of the District of Columbia, or for some other reason the child has not already been screened twice by age 26 months, the child must be screened twice prior to the 6 years of age, and those two tests must ideally be performed at least 12 months apart.

Whenever a child's blood lead test result reveals an elevated blood lead level (equal to or greater than 10 micrograms of lead per deciliter of blood), the provider must immediately inform the child's parent or guardian of the result and the measures recommended for follow-up treatment and care.

- Regardless of the blood lead test result, if a parent or guardian requests it, providers must issue a certificate of testing that includes the test date and the specific number associated with a test result under 10 micrograms per deciliter.
- Note that during the past ten years, research has demonstrated that health effects are observed at levels of lead in blood below 10 micrograms per deciliter.

## III. REQUIREMENTS FOR INDIVIDUALS WHO OWN RENTAL PROPERTY

The District's lead law includes requirements that apply to owners of rental housing built prior to 1978 and located in the District of Columbia, which can be summarized as follows:

- Paint must be maintained in intact condition.
- Paint is presumed to be lead-based paint, unless documentation proves otherwise.
- Presence of non-intact paint is a violation of the lead law, unless documentation proves it is not lead-based paint.
- Owners must provide tenants with a copy of the Tenant Rights form available from the District Department of the Environment's website (green.dc.gov)
- If a new tenant household includes a child under 6 years or a pregnant woman, the new tenant must receive:
    - A Clearance Report issued by qualified personnel within the previous 12 months preceding the new tenancy, which states that the property or apartment does not contain any lead-based paint hazards; and
    - A Disclosure Form completed by the property owner, disclosing information reasonably known to the owner about the presence of any lead-based paint or any lead-based paint hazards, and about any pending actions the property is subject to under the lead law.

For more information about lead poisoning prevention and the District's lead laws, visit the District Department of the Environment's website at green.dc.gov and select "Lead and Healthy Housing." ■

# Board Disciplinary Actions

| NAME | LICENSE # | ACTION |
|---|---|---|
| None | | |

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

**Non-Public Disciplinary Actions:**

| | |
|---|---|
| *Notice of Intent to Discipline* | *3* |
| *Referrals to COIN:* | *0* |
| *Consent Orders:* | *18* |
| *Request to Withdraw Application* | *0* |
| *Request to Surrender License* | *1* |
| *Letters of Concern:* | *0* |

## Public vs. Non-Public Discipline

***Public Discipline:*** *Disciplinary actions that are reported to Nursys, National Practitioner's Data Bank and viewed in DC NURSE and at http://app.hpla.doh.dc.gov/weblookup/.*

***Non-Public Discipline:*** *Disciplinary actions that constitute an agreement between the Board and the licensee and, if complied, are not made public.*

**DC Board of Nursing**
**899 North Capitol Street NE**
**First Floor**
**Washington, DC 20002**

Presorted Standard
U.S. Postage Paid
Little Rock, AR
Permit No. 1884