VOLUME 9 NUMBER 2 MAY 2012

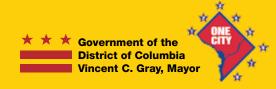
REGULATION EDUCATION PRACTICE

depending healthcare

Canada

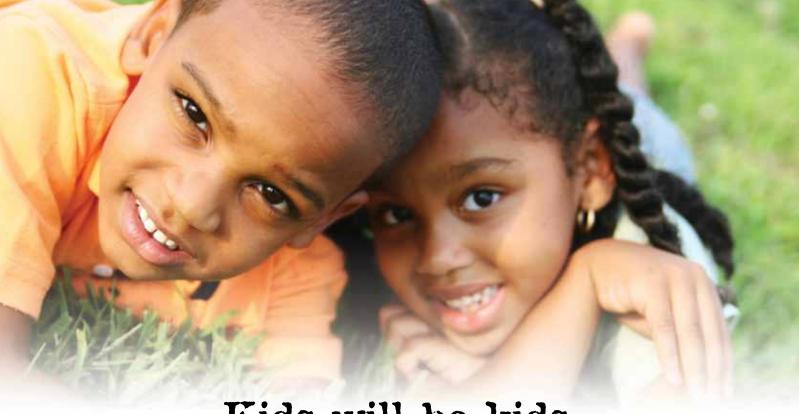
medica

Happy National Murses Week!



RN/APRN Renewals Have Begun (page 8) **Licensed Practical Nurse Forum (pages 6)** Two DC Nurses in Africa (pages 20-26)





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DISTRICT of COLUMBIA NURSE

Edition 33

DIRECTOR, DEPARTMENT OF HEALTH

MOHAMMAD N. AKHTER, MD, MPH

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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

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contents

Message from DOH Director 4

Message from the Chair 5

REGULATION

Board of Nursing Update 6

RN/APRN Renewals Have Begun 8

LPN CE Non-compliance Notice 9

IN THE KNOW 10

COIN CONSULT 11

E D U C A T I O N

Panel Discussion on Direct Care Personnel (NAPs) 12

Patient Care Tech Research 14

Professional/Practical Nurse Programs 15

NCLEX Myths 15

PRACTICE

On Guard 16

Legal Aspects of Documentation 17

Shadowing Nurses in Sierra Leone 20

Tropical Medicine Expedition to Tanzania 22

Wound Care 27

Kudos! 29

Board Disciplinary Actions 30

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.

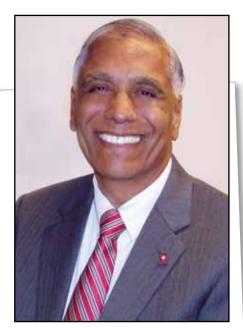
Feel free to e-mail your "Letters to the Editor" for our quarterly column: IN THE KNOW: Your opinion on the issues, and our answers to your questions. E-mail your letters to hpla.doh@dc.gov. (Lengthy letters may be excerpted).

Greetings from DOH Director Mohammad N. Akhter, MD, MPH

HAPPY NATIONAL NURSES WEEK

To the Remarkable Nurses of the District,

The constant care and attention you provide to your patients cannot be measured. I want to thank you for your dedication to the field of nursing and for your commitment to your patients. The theme for National Nurses Week this year is "Nurses: Advocating, Leading, Caring." This year's commemorative theme could not prove to be a more fitting description of the ambitious attributes needed to be a successful nurse. As the first line of care in a hospital, office,



DOH Director Mohammad N. Akhter, MD, MPH

home-health care, public health or any other clinical settings—you play an essential role in helping to advocate for the sick, be a leader for those around you and show an unwavering level of care and compassion for those lives you work so hard to protect and improve.

In addition, I want each of you to know how much I value your expertise and ability to make quick and accurate assessments regarding patient care and safety. Often times, nurses carry the burden of working in strenuous environments that constantly challenge their decision making, as well as their physical and mental well-being. Without your support and devotion to the District of Columbia, our city would not have the type of top-notch, community-level care we are known for. I admire your resilience and want to thank you for all of your hard work, dedication and sacrifice.

Sincerely,
Dr. Mohammad N. Akhter
Director
DC Department of Health

Message from the Chair

Each and every day nurses in the District of Columbia care for patients and communities, making a positive difference in the lives of many of our residents. As compassionate and competent care givers, the nurses at every level of care, who contribute to the health of those residing in DC are a credit to the field of health care, and their efforts deserve recognition. The DC Board of Nursing would like to extend our thanks to all nurses whose dedication and achievements have contributed to the nursing profession.

National Nurses Week begins each year on May 6th and ends on May 12th, Florence Nightingale's birthday. These permanent dates enhance planning and position National Nurses Week as an established recognition event. As of 1998, May 8 was designated as National Student Nurses Day, to be celebrated annually. As of 2003, National School Nurse Day is celebrated on the Wednesday within National Nurses Week (May 6-12) each year. Interna-



E. Rachael Mitzner, BSN, MS, RN

tional Nurses Day is celebrated around the world on May 12th of each year. The theme for National Nurses Week in 2012 is "Nurses: Advocating, Leading, Caring."

In mid-March three Board of Nursing members attended the National Council of State Boards of Nursing (NC-SBN) midyear meeting which, in many ways, reinforced this year's National Nurses week theme of Advocating, Leading and Caring.

A day was spent with Board Chairs and Executive Directors to enhance leadership and communication skills. When Board leaders become comfortable with each other's expectations and work more closely as a team, the Board as a whole is more effective and efficient.

The second day was spent discussing the role of LPNs in more affordable, accessible and efficient health care. The LPN is utilized differently in various states, and in Canada, and it was interesting to discuss the possibilities for education and utilization of this important segment of our nursing community. As the Board looks at Regulations and scope of practice for the LPN community in DC, we need to ensure that we are allowing them to practice to their level of knowledge and skill, and we are encouraging them to continue their education and improve their skill sets through certification and/or upward mobility in the profession of nursing.

The last day of the meeting focused on disciplinary procedure. It covered how to ask questions to get accurate and truthful answers, to the procedure for running a formal hearing. The three days provided wonderful information for the Board members and staff who attended. Information which can be used by the Board to lead, advocate and care for our residents in DC and the nurses who work to keep our community healthy.

We will continue to provide educational programs to help our nurses in their role of advocate, leader and caregiver. We will continue to include our nurses in our discussions related to healthcare regulation, and we will consistently put the safety and protection of our residents first. We thank each of you for sharing and participating in our vision of healthcare in the District. Thanks for being a nurse; we need and appreciate each of you.

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

Regulation

Board Update



The Board of Nursing has begun working on revising RN and LPN regulations. In considering the LPN regulations, the Board invited feedback from the nursing community regarding the future role of LPNs.

Topics discussed at forum:

LPN EDUCATION

- What educational components are missing from LPN educational programs?
- LPN educational programs cannot find acute care facilities for clinicals.
- Participants discussed LPN-to-BSN articulation and the barriers to obtaining schooling while working full time.
 It is especially difficult for LPNs to gain the general education courses needed.

LPNS IN CLINICAL SETTING

- LPNs are cost-friendly to budgets of facilities. A mix of RNs and LPNs is cost effective.
- LPN jobs will grow due to aging population.
- In the Midwest, there is more LPN utilization in all settings, including acute care.
- LPNs are particularly suited for practice in long term care, home care, and ambulatory centers.
- Better orientation for new hires is needed, especially new graduates in long term care and home health practice.

NURSING ASSISTIVE PERSONNEL (NAPs)

 Many participants expressed concern that Nursing Assistive Personnel (NAPs) are usurping the role of the LPN. One attendee stated that LPNs learn more theory

- and critical thinking skills than NAPs.
- Traditional LPN duties have been given to Patient Care Technicians, eroding the role of the LPN in acute care settings.
- LPNs function as the liaison between the RN and NAPs.

ADDITIONAL LPN FUNCTIONS AND SKILLS TO CONSIDER

- IV Therapy
- Infusion Therapy
- Central Line
- Assessment

Your feedback is welcomed. Please email to hpla.doh@dc.gov. ■

BOARD VACANCIES: LPN MEMBER AND CONSUMER MEMBER

The Board of Nursing is currently seeking to fill Consumer member and LPN member Board vacancies. If you are a resident of the District of Columbia and interested in applying to serve on the Board, please visit the website of the DC Office of Boards and Commissions at www.obc.dc.gov, for application forms and for information on the application process.











LPN STAKEHOLDERS: Nurse Managers and Nurse Educators share their views and concerns about LPN education and LPN scope-of-practice issues.





LPN STAKEHOLDERS: Nurse Managers and Nurse Educators share their views and concerns about LPN education and LPN scope-of-practice issues.



LPN Board Member Ottamissiah Moore

RN/APRN Renewals Have Begun

Licenses Expire June 30, 2012

RN/APRN RENEWAL TIPS TO AVOID DELAY

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

Renew first and then get CBC: Please renew your license prior to completing your Criminal Background Check (CBC) requirements:

Renew online: RN/APRNs can renew their licenses by accessing the HPLA website at:

https://app.hpla.doh.dc.gov/mylicense/

Web Browser: To renew online, you must use Internet Explorer web browser.

Contact information: 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.

Controlled Substance
Registration: APRNs, 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.

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.

CBC FINGERPRINTING: L-1 ENROLLMENT/MORPHOTRUST

In addition to Criminal Background Check services provided by the District of Columbia Metropolitan Police Department, health professionals applying for licensure or renewing their license in DC can now also receive live scan Criminal Background Check services with L-1 Enrollment Services, which is now operating under a new name-MorphoTrust USA. The company, which was purchased in 2011 by the French-owned company Safran, is still in the process of converting the company brand from L-1 Enrollment to MorphoTrust. MorphoTrust remains a U.S. controlled entity, with all business under the control of U.S. citizens working for MorphoTrust. Applicants who choose to use L-1/

MorphoTrust for a 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/ MorphoTrust.

- 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/ MorphoTrust's Card Scan Processing Program. This program utilizes advanced scanning technology to convert a traditional fingerprint card (hard card) into an electronic fingerprint record. Applicants must go online to the L-1 Enrollment website www. L1ENROLLMENT.com or call 1-877-783-4187. ■

Licensed Practical Nurse Continuing Education Non-compliance Notice

Licensed Practical Nurse The Board of Nursing's Continuing Education (CE) Audit for Licensed Practical Nurses began October 2011 for LPNs renewing their license during the 2011 renewal period. The letter sent from the Board stated:

Our records indicate that you recently renewed your license to practice as an LPN in the District of Columbia. You indicated on your licensure application that 'Yes' you, have acquired the required 18 continuing education hours for LPNs at the time that you submitted your application. At this time, the District of Columbia Health Professional Licensing Administration is conducting an audit to verify your compliance with the continuing education requirements.

Two notices have been mailed to the persons listed below. At the time this publication went to press, we had not received a response to the Board's request. If your name appears on the list below please submit evidence of having completed 18 hours of continuing education. Failure to submit proof of compliance with a Board of Nursing regulatory requirement will result in a fine up to \$500.00 and/or a disciplinary action against your license to practice as an LPN in the District of Columbia.

If you have any questions or need additional information please feel free to send an email to Gwyn Jackson at Gwyn.Jackson@dc.gov or call (202) 442-4764.

INDIVIDUALS WHO HAVE NOT RESPONDED TO CE AUDIT

| Hirut | Abraham | LPN1004675 |
|------------|--------------|------------|
| Martin | Adamu | LPN1003494 |
| Adeshola | Adewale | LPN1004049 |
| Cynthia | Anoma | LPN1003224 |
| Nnamdi | Chukwuocha | LPN966856 |
| Cynthia | Devenish | LPN966066 |
| Saudatu | Dumbuya | LPN1003544 |
| Carlyle | Fletcher | LPN962984 |
| Solange | Hangou | LPN1004426 |
| Charlene | Harley | LPN4439 |
| Althea | Isaac | LPN966977 |
| Lorine | Jackson | LPN5656 |
| Sunday | Jolaoso | LPN8381 |
| Adaku | Kalu | LPN1004858 |
| Japhet | Mutanga | LPN1003738 |
| Paula | Neal | LPN1003786 |
| Emergencia | Njekam-Bodog | LPN1004438 |
| Georgina | Ofori-Atta | LPN1004694 |
| Bose | Otugalu | LPN1004537 |
| Deen | Sesay | LPN1004776 |
| Vijaykumar | Shirsat | LPN7670 |
| Maria | Taylor | LPN6167 |

Please note: If you have misplaced your continuing education verification certificate, contact your Continuing Education provider to request a duplicate. ■

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:

2nd Floor Board Room 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.

June 6, 2012

July 11, 2012

August - no meeting

September 5, 2012

October 3, 2012

November 7, 2012

December 5, 2012

IN THE KNOW

The Board of Nursing has established the "In The Know" column in response to the many phone calls and e-mails the Board receives regarding licensure and other issues. The Board often receives multiple inquiries regarding the same topic. Please share this column with your colleagues and urge them to read it. The more nurses are aware of the answers to these frequently asked questions, the less our resources will have to be used to address duplicate questions.

TMEs

Register Trained Medication Employees (TME) able to float among community residential facilities to administer medications?

A: No. TMEs are not allowed to float. Allowing TMEs or nurses to go to multiple residences to administer medication will result in a medication error—untimely administration of medication. Further, leaving the facility after administering the medication does not allow the medication giver an opportunity to observe the resident's reaction to the medication.

RN LICENSE NEEDED?

: If a Quality Improvement Manager is employed by a facility and is a Registered Nurse but does not give any direct resident care, does this person need to have a DC RN license?

A: Yes. If they are using nursing knowledge and the RN title, they need to be licensed as a nurse in the District.

MANDATORY HIV/AIDS CE

: Regarding DC Councilman Catania's plan to require HIV/AIDS continuing education for license renewal: Has it been passed? I would like to respond to this proposed requirement.

A: The hearing regarding this bill has been held and the comment period has ended. But if you wish you can still send comments to the Council's Committee on Health. The Board of Nursing supported the bill.

CRIMINAL BACKGROUND CHECK (CBC)

Q: If a nurse has recently had a CBC for another facility or board of nursing, will they still have to redo it to renew their license?

A: If they completed a CBC for the purposes of licensure in DC, they will not be required to complete another CBC. However, if they did it for another entity, including a hospital or another board of nursing, they will have to do another CBC. Results of the CBC can only be shared with the entity requesting the CBC.

Does DC require a state background check of permanent residence along with the FBI check in order for a license to be issued? If the state does not offer the ability to request is the FBI sufficient?

A: We require state/DC and FBI CBCs. If the state does not offer the ability to provide a state CBC, a state CBC will not be required.

Q: I've received notification that my fingerprints were rejected. What do I do now?

A: If you have received notification that your fingerprints were rejected, you will need to be fingerprinted again. When you schedule your appointment, be sure to note that you have received a rejection notice and this is your second time being fingerprinted. With this rejection notification, you will not have to pay for fingerprinting the second time.

O: Do the nurses have the ability to receive a copy of their background

A: No, the CBC results that come to the Board are the property of the Board. We cannot share the reports with the licensee.

every renewal year from now on?

No. The law requires the CBC be completed every four (4) years.

We are working to have a "wrap-back" program. This will allow persons arrested or convicted to be automatically reported to the Board. If we are able to implement this, we will not require CBCs after the initial one has been completed.

: If a traveler submits fingerprints through L1 Enrollment (Morpho Trust), do they still receive the results in the mail and send to the DC BON?

A: The results will come to us directly from L1 Enrollment.

WEBSITE COMPLIMENTS

Dear Board of Nursing: I just wanted to commend you on your nursing license renewal website. Very easy. Since I am a travel nurse, I have spent a few hours here going to the websites of different states to renew and by far, yours is the easiest. Thank you, very much.

COIN CONSULT

A Resource for Impaired Nurses

Workplace Risk Factors

By Kate Driscoll Malliarakis, RN, MSM, CNP

The prevalence of substance abuse and addiction among nurses and other healthcare professionals is no higher than the prevalence in the general population (Storr, Trinkoff & Hughes, 2000). However, the prevalence of prescription drug misuse is 6.9% among nurses compared with 3.2% among white females (SAMHSA*, 1998a). Thus, many nurses with substance abuse disorders not only provide patient care while impaired, they also divert their patients' prescribed medications, risking patient harm. The top four risk factors for nurses in the workplace are access, stress, lack of education, and attitude.

Access: The ready availability of drugs is an occupational hazard, especially when combined with a poorly managed administration of controlled substances in healthcare facilities (Trinkoff, Storr, Wall, 1999). Sullivan, Bissell, & Leffler (1990) surveyed 300 nurses enrolled in treatment programs and learned that one-sixth changed worksites (usually by internal hospital transfer) to have easier access to drugs in the workplace. On the other hand, Kenna found that reduced workplace access was related to a greater likelihood of using illicit substances among nursing students (Kenna & Wood, 2004b) and that access is an important feature promoting substance use among health professionals (Kenna & Wood, 2004a).

The ongoing lack of institutional controls and oversight in the storing and distribution of narcotics facilitates diversion and its concealment. Loose prescribing practices for one's friends or family is another risk factor and reflects society's tolerance for taking drugs and expectation of receiving prescriptions from office visits. In one study,

nurses did not seek appropriate medical care for self-diagnosed health problems; instead, they obtained prescriptions from physician friends without adequate workups (Solari-Twadell, 1988).

Stress: Nursing is a highly stressful occupation. In fact, nurses reported more on-the-job stress than any other group of healthcare professionals (Wolfgang, 1988). Long shifts, extra shifts, staffing shortages, and shift rotation contribute to increased stress. Trinkoff and Storr (1998b) examined the relationship between work schedule characteristics and substance use and found that in general, the more adverse the schedule characteristics, the greater the likelihood of substance abuse. The schedule characteristic most strongly associated with substance use was a combination of shift rotation and long shifts. Shift work, and long work hours also lead to fatigue, sleep deprivation, circadian rhythm disruption and other psychophysiological consequences (Geiger-Brown and Trinkoff, in press). In a longitudinal study, adverse work schedules, including long work hours and limited time off to recover, were related to musculoskeletal injury, pain, and needle sticks (Trinkoff et al.2006; 2007).

Self-medication for pain is always a concern among nurses. Bugle (1996) compared a group of nurses disciplined for substance abuse (n = 79) with a group of nurses not disciplined for substance use (n = 124). The findings: 40% of disciplined nurses used prescription drugs to control chronic pain compared with 20% of undisciplined nurses, and 42.5% of disciplined nurses used substances for emotional problems compared with 6.5% of undisciplined nurses.

Lack of Education: The lack of education on the addictive process and its signs and symptoms remains one of the more profound—and overlooked—risk factors for nurses. This lack of education contributes to the negative stereotypes of those with substance use disorders, especially nurses

and physicians (Chappel, 1992: Grover & Floyd, 1998). Often, other healthcare professionals hold the most negative views of colleagues with substance use disorders (Howard & Chung, 2000a: Howard & Chung, 2000b).

Darbro (2005) interviewed many nurses who identified a lack of education and a culture of mistreatment in their workplace. Thus, as the adage goes, "ignorance breeds contempt," producing a work environment in which nurses with substance use disorders may take even greater pains to conceal their abuse, thereby increasing the risk of harm to all.

Attitude: Five attitudes can increase the odds of substance use problems in nurses (Clark & Farnsworth, 2006). First, nurses may see substance use as an acceptable means of coping with life's problems and a way of promoting enjoyment, comfort, and the ability to get along. Second, because of their training and daily observations, nurses may develop a faith in drugs as a means of promoting healing. This pharmacological optimism is a profound belief. The third attitude is a sense of entitlement that focuses on the nurse's need to continue working and rationalizations regarding drug use. The fourth attitude deals with the special status of healthcare providers as being invulnerable to the illnesses of their patients; healthcare providers see themselves as caregivers, not care receivers. Fifth, professional training involving powerful drugs leads to an acceptance of self-diagnosing and selfmedicating for physical pain and stress.

Article adapted from Darbro, N. & Malliarakis, K. (2012, April). Substance abuse: Risks factors and protective factors. Journal of Nursing Regulation (in press). ■

Contact the Committee On Impaired Nurses (COIN):

Phone: (202) 724-8870 (202) 724-8818 Email: hpla.doh@dc.gov

*The Substance Abuse and Mental Health Services Administration

Education



L. to R.: Brenda G. Krohn, RN, MS; Pamela Ambush-Burris, RN, MSN; Karen Scipio-Skinner, RN, MSN; and Beverly Lunsford, PhD, RN.

The direct-care workforce (Nursing Assistive Personnel or "NAPs") will play a critical role in health care as America's Baby Boomers age in place at home, or enter Assisted Living and Long Term Care (LTC) facilities. A panel discussion, entitled "Quality Jobs/Quality Care: Building a Regional Direct Care Workforce – Barriers and Opportunities" was recently held at the Meyer Foundation. Among the top issues discussed were NAP job titles, credentialing, education and career mobility.

Job Titles and Credentials: Speaker Judith Levy, Coordinator of the DC Long Term Care Coalition, told attendees that job titles for direct care workers vary from state to state, and that obtaining accurate data about the workforce can be difficult. To catalog these positions for labor statistics can be daunting, she said. Directcare job titles include Home Health Aide, Home Care Aide, Homemaker Health Aide, Personal Care Aide, Chore Aide, Nurse's Aide, Certified Nursing Assistant (CNA), Geriatric Nursing Assistant (GNA), Patient Care Technician (PCT), Medical Care Technician and Consumer-Directed Support Professional.

Now is the opportune time for us

to address concerns about locating NAP workers and ensuring that there are standards in their education and job titling. "Consumers can be confused by the terms," Ms. Levy said. "And some health care professionals don't understand, either." Right now there are no national or regional standards for their education or job titling, and "certified" may not mean "credentialed." A

certification issued through a national or industry-recognized body certifies that [the person] is qualified to perform a defined job, Ms. Levy told attendees. "It also means that others can rely on this proof of your qualifications. It is a type of credential." But every certificate is not a credential, however. "Any organization can award a certificate. Not all certificates prove that the recipient has reached a certain standard (of performance or education)."

Fluid Borders: The District is part of a region with fluid borders. People travel back and forth between Virginia, Maryland and DC; however, each jurisdiction has its own criteria for who can use the CNA title. To be a CNA in Washington you need 120 training hours/45 clinical, in Maryland 100 hours/40 clinical and in Virginia 120 hours/40 clinical. Increased training is necessary. Federal training minimums for CNAs and Home Health Aides have not changed in 20 years and may have less training requirements than dog groomers, cosmetologists and crossing guards, Ms. Levy said. "We need them [NAPs]. They are a very important part of our workforce. There will never be enough nurses or doctors to serve the aging population."

Karen Scipio-Skinner, RN, MSN, DC Board of Nursing:

- The District passed NAP legislation in 2009 allowing the Board of Nursing to regulate NAP practice and educational programs.
- The Board worked with the DC Long Term Care Coalition, a coalition of stakeholders from a wide variety of clinical settings as well as nursing education programs to develop an NAP regulatory model. In developing the model, it became clear that part of the confusion also is that there is a major overlap of roles with NAP and licensed practical nurses. The Board is attempting to make the role deliniation more clear.
- Unless the federal government comes up with titling and regulations, we will not have consistency state to state.
- Stakeholders in the DC community indicate a need for a CNA-to-LPN educational program.
- The DC Board is communicating with other nursing boards as they draft NAP regulations to work towards consistent education and practice requirements.

Brenda G. Krohn, RN, MS, Deputy Executive Director of the Virginia Board of Nursing:

- We regulate CNAs. Many Assisted
 Living facilities (AFLs) have no
 RNs or LPNs on staff, and the ALFs
 pushed for legislation requiring
 CNAs to be regulated by the Virginia
 Board of Nursing and for more
 training because there were so many
 medication errors.
- The VA board regulates CNA schools as well as Home Health Aide (HHA) educational programs. However, HHA practice is not regulated.
- A lot of CNAs become LPNs.

- Regarding our CBC requirements for NAPs, we look at convictions on an individual basis. How long ago were they convicted? Candidates with crimes of moral turpitude—lying, cheating, stealing—must come and talk to the board.
- Virginia's current Governor is moving toward decreasing regulations.

Pamela Ambush-Burris, RN, MSN, Director of Nursing Licensure, Maryland **Board of Nursing:**

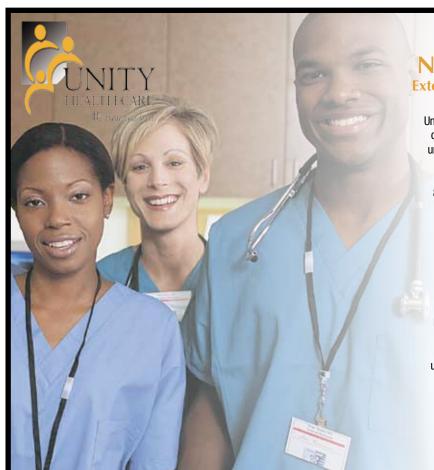
• We have had a problem with companies offering fraudulent courses—courses that start on Monday and graduate on Friday. Such courses are "cash cow" courses, but do not provide adequate training.



- We have a high acuity-level of people at home. In Maryland, you must be a CNA first before you can be a Home Health Aide.
- Some trade associations will fight against increased regulation if it increases their costs. That is one of our major obstacles.
- Input from the community indicates that stakeholders are looking for direct care workers with a good work ethic—a good attitude, punctual, who will call if they cannot come to work, who can work as part of a team and who have good communication skills.
- In Maryland, a CNA cannot work

in LTC; they must be a Geriatric Nursing Assistant (GNA). Maryland GNAs receive training beyond that of a Maryland CNA. A GNA in Maryland has the same training and certification requirements as a CNA in the District of Columbia.

The program was moderated by Beverly Lunsford, PhD, RN, Associate Research Professor at the School of Nursing at The George Washington University Medical Center, and director of the Washington DC Area Geriatric Education Center Consortium. ■



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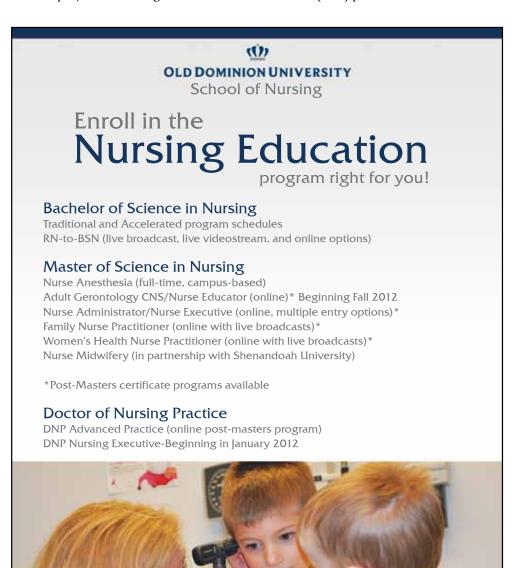
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Education

Patient Care Tech Research



In February, the Board of Nursing held a breakfast briefing on the "DC Metropolitan Region Patient Care Technician Research Project." After a welcome from Board Executive Director Karen Scipio Skinner, MSN, RN, participants were given an overview of the project concerning the Patient Care Technician (PCT) position and the duties currently being carried out by PCTs.



For more information about a nursing education program, call or visit:

dl.odu.edu/ODU-Nursing

1-800-483-2781



Dr. Bonita Jenkins

Board staff member Nurse Specialist Dr. Bonita Jenkins, serves as the principal investigator (PI) of project. Co-PI of the project is former Board of Nursing



Dr. JoAnne Joyner

chairperson, Dr. JoAnne Joyner, who is an Adjunct Professor at Trinity
University. Research will be gathered from acute care institutions that employ Nursing Assistive Personnel in our region until late in 2012.

Contact Dr. Bonita Jenkins if your facility is interested in participating in this study at email address bonita.jenkins@dc.gov.

NCLEX MYTHS

National Council Licensure Examination

MYTH: If a candidate receives a "Select all that apply" (multiple response) item and answers incorrectly, the computer will continue to give the candidate those types of questions until it determines the candidate can proficiently answer them.

Fact: With computerized adaptive testing, each candidate's test is assembled interactively as the individual takes the exam. When the candidate answers an item, the computer recalculates the

candidate's ability estimate based on all the responses including the most recent response. Next, the item bank is searched to find an item in the appropriate test plan category that best matches the candidate's ability (i.e., difficulty level). This could be any type of item, standard or alternate. The item selected is only based on the test plan content area and difficulty level, not item type. This process is repeated each time an item is administered, creating an examination tailored to the individual's ability while fulfilling

the NCLEX test plan requirements. The examination continues in this way until a pass or fail decision can be made. There is no established percentage of items with alternate formats that will be administered to candidates. The NCLEX is computer adaptive and items are based on the candidate's ability. There are alternate item types in all areas of the test plan, across all difficulty levels. As with standard multiplechoice items, alternate items are scored either right or wrong. ■

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ON GUARD

Protect Your License—Read and Understand your Nurse Practice Act

By Janet Boivin, RN

Examples of serious violations of the Nurse Practice Act (NPA) include being impaired by drugs or alcohol while working; stealing from a patient/client, including medications; providing treatment or care that should be provided only by a physician or APRN; falsifying records; and boundary issues, including abusing a patient physically or sexually.

Nurses study and work hard to obtain their nursing education and licensure, says Kathy Apple, RN, MS, FAAN, CEO of the National Council of State Boards of Nursing, based in Chicago. They also need to be aware of whether they are acting in ways that can put their licenses at risk. Apple says nurses can take the following steps to protect their licenses:

READ AND UNDERSTAND YOUR STATE'S NPA.

Licensure is a privilege, not a right, and with it comes obligations and responsibilities that are spelled out in NPAs, Apple says. Each state has its own NPA that spells out the rules and regulations governing how nurses practice. The basic legal concept in all NPAs is that nurses must be competent in the area in which they are practicing. Whether you are competent to practice is your responsibility in relation to maintaining your license in good standing, not your employer's, Apple says.

For example, if you have applied to a hospital as a med/surg nurse, but the hospital wants to hire you in pediatrics, it is your responsibility to tell the recruiter you are not competent in this area. The hospital can then make the appropriate arrangements, whether training you in the specialty area or hiring you in a different unit, Apple says.

KNOW THE PROFESSIONAL STANDARDS OF CARE FOR YOUR

PARTICULAR NURSING SPECIALTY OR HEALTHCARE WORK SETTING.

Specialty nursing associations develop standards of practice and care for their areas of expertise. If you are a psychiatric mental health nurse, for example, you need to know the standards of care for mental health nursing, Apple says.

ALWAYS QUESTION ASSIGNMENTS YOU BELIEVE ARE NOT WITHIN YOUR SCOPE OF PRACTICE.

A nursing license gives you authorization to practice within a defined scope. If a physician asks you to do something you have not done before and you believe is not within your scope of practice, you must say no. You can find out by asking your direct supervisor, Apple says. "You need to ask the question," she says.

KNOW WHAT TO DO IF SOMEONE FILES A COMPLAINT AGAINST YOU AS A NURSE.

While licensure and nursing regulation were established to protect the public from harm, nurses who have been accused of violating their NPAs for any reason have certain rights, Apple says. Every state has an administrative procedures act that guides the conduct of a state's regulatory agency when processing a complaint. If you have a complaint filed against you, you should contact your state board of nursing and ask about your rights in the process. Some of those rights usually include the right to see the complaint and know who has filed a complaint against you, the right to legal representation, the right to a hearing in front of the board and the right of appeal. You can protect your license by understanding the complaint process and knowing what those rights include.

UNDERSTAND THE DISEASE OF ADDICTION AND HOW TO RECOGNIZE IT IN YOURSELF AND CO-WORKERS.

Among the most frequent complaints

boards of nursing receive against nurses are those related to drug and alcohol addiction, Apple says. Nurses need to recognize the symptoms of addiction and its enabling behaviors so they can tell if they are working with a nurse who is impaired. For example, agreeing to sign off to wastage of a narcotic that you did not witness is putting your license at risk and is possibly illegal, Apple says. Many states have mandatory reporting laws requiring nurses to report unsafe or incompetent behavior in other nurses, Apple says.

UNDERSTAND THE CONCEPT OF PROFESSIONAL BOUNDARIES.

Boundary violations occur when nurses have inappropriate involvement in a patient's personal relationships. Boundary violations can be extremely complex, ambiguous and difficult to evaluate. Nurses should be aware of their feelings and behaviors toward their patients and always act in the best interest of patients.

ENSURE THAT YOUR STATE BOARD OF NURSING HAS YOUR CURRENT ADDRESS.

Apple says that sometimes nurses do not renew their licenses, either by choice or by oversight. If the state board of nursing does not have your correct address, then you will not receive notification of licensure renewal. Nurses who fail to renew and continue to practice are committing a serious violation in most states.

PERIODICALLY CHECK YOUR STATE BOARD OF NURSING'S WEBSITE.

Most state boards of nursing have websites where nurses can keep current on changes to NPAs, Apple says.

DC Board website: www.hpla.doh.dc.gov. For more information, visit the National Council of State Boards of Nursing online at www.ncsbn.org.

Janet Boivin, RN, is a freelance writer. © 2011 Gannett Healthcare Group. All Rights Reserved. ■

Continuing Education Update

LEGAL ASPECTS OF DOCUMENTATION

The Board of Nursing sponsored a continuing education program at the Washington Center for Aging Services on the "Legal Aspects of Documentation." According to speaker Izu I. Ahaghotu, RN, Esq., in a court of law, there are four elements involved in proving malpractice. To stand up in court, all four elements in a malpractice case must be present. However, if only the first two elements of the following are present, the nurse may be called before the Board of Nursing.

Four Elements in Malpractice:

- Duty to the patient (Your duty to the patient according to a reasonable prudent standard—your peers in this area of practice nationwide).
- Breach of Duty
- Causation (The patient was injured and, but for the defendant's actions, the plaintiff's injury would not have occurred)
- Damages (The patient suffered a loss, such as needing additional medical treatment or more medication)

Documentation: Your documentation represents you. Do not write with sloppy penmanship. Be mindful of spelling, grammar and penmanship. "In one malpractice case, a nurse's handwriting was so illegible, they thought she was impaired. She was not," Ms. Ahaghotu said. Here are some more tips from Ms. Ahaghotu:

- Read the entire chart. Do you have the right chart?
- Talk to the patient.
- Do not document BEFORE you have completed a task. Document AFTER.
 Something could happen to interfere



L. to R.: Mary Sklencar, Mark Donatelli, Missy Moore and Izu I. Ahaghotu, Esq.

with your ability to give the care you have charted. Charting care that has not been completed is considered fraud.

- Documentation should reflect the individual patient status, i.e. patient needs, problems, limitations, etc.
- Show continuity of care, interventions made, and responses from patient.
- The SOAP format is a great guide (S
 = subjective data, O = objective data,
 A = assessment, P = plan).
- Read your note after you write it.
- If you make a mistake in writing, put a line through it and write— "mistaken entry". After you have put a line through the mistaken entry, sign your signature.
- Do NOT write "error"! A lawyer could interpret "error" as a confession that you made a mistake in your actions, rather than just an

- error in documentation. Never use white out!
- Ask yourself: Would your facility's legal team, a survey team, or a client's attorney find documentation that is clear, concise, timely and complete?
- Do not alter a patient's record—this is a criminal offense.

Nurse Practice Act: Ms. Ahaghotu urged attendees to read the DC Nurse Practice Act (in the Health Occupations Revision Act—HORA). "It is very, very important for you to read. It is your responsibility to know it." The DC Nurse Practice Act can be accessed online at http://www.hpla.doh.dc.gov/hpla/lib/hpla/nursing/nurse_practice_act.pdf.

Continued on page 18

Continued from page 17

Malpractice Trends: According to Ms. Ahaghotu, "The frequency of claims involving RNs, for malpractice or disciplinary defense, are highest in adult med-surg, followed closely by gerontology. Claims are most frequently concerning allegations related to treatment and care management, followed by medication administration, then by assessment. DC is a federal territory, and therefore conduct is subject to federal law and the implications associated with a federal crime."

Malpractice Insurance: "You need to have malpractice insurance. You have to have it. At a cost of ninety dollars a year, malpractice insurance can provide coverage up to a million dollars. It covers disciplinary defense charges." When a malpractice case is brought, lawyers will go after the facility and the nurse. If the case is lost, the hospital has a right to come after the nurse's assets. In addition, clients are more likely to settle out of court if you have malpractice insurance, Ms. Ahaghotu said. A case is more likely to be taken to criminal court if the patient was from a prominent family, or if the family is very angry, or if the nurse's actions against the patient were clearly, extremely willful. You will be held accountable, she said.

Ms. Ahaghotu established her law firm in 2005 and dedicates a portion of her practice to providing disciplinary defense before the DC and Maryland boards of nursing. She also practices as a hospice nurse on a per diem basis.

Speaker Mark Donatelli is an investigator for the DC Health Professional Licensing Administration. "Please be sure that the MAR [medication administration record] is complete," Mr. Donatelli said. He told participants about a case in which an employer notified the Board that it terminated an RN for failing to properly document the administration and wasting of fentanyl in its post-anesthesia



Division and he has conducted investigations for all of the major boards including Nursing, Medicine, Dentistry, Podiatry, Psychology, Pharmacy, Social Work, Optometry, and Physical Therapy.

Clarity: Speaker Mary Sklencar, RN,

made it abundantly clear that your documentation must be abundantly clear: "Your documentation should be clear 250 years from now, like the Egyptian hieroglyphs. It must make sense. If what we write does not communicate, then we have failed in our professional and legal responsibilities," said Ms. Sklencar, who is a member of the HPLA Compliance and Quality Assurance Unit.

Completeness: Ms. Sklencar says that families often complain that residents in LTC facilities did not get all the attention they were due. Often, however, the staff did provide complete care, but they did not document all that they did for the resident. Your care plan should include all interventions. Be sure to put something in the record.

care unit: "The RN removed fentanyl on six different occasions and failed to document the administration and/ or wasting of fentanyl on six different occasions." Mr. Donatelli noted the possible violations of the Health Occupations Revision Act associated with this case. "We established that there were documentation errors, however we did not establish that she was taking the drug."

Documentation Tips: Use proper medical abbreviations (not your own); accurately date-and-time stamp the entry; fill out all required sections (do not take shortcuts); never replace or discard an original record.

Mr. Donatelli is currently the Senior Investigator for the HPLA Enforcement

Conform to Policies: "Cultural diversity is wonderful," Ms. Sklencar said, however, your documentation should not reflect your own individual or your cultural style. It should conform to the policies and procedures of your facility.

When indicating the patient or resident's name, please put their first name first, and last name last. Do not switch the names. "And when you sign your name, please do not include all the flourishes, ruffles and curlicues," Ms. Sklencar said. "Don't sign it that way in the record."

Profusion of Pronouns: Do not get lost in pronouns. If you are documentating and it is littered with "he did this", "she said that," "he said this" and "she did that," is the person reading it going to be able to tell who you are talking about? Be clear, write legibly and spell correctly. Do not write "Ability" when you mean "Abilify", Ms. Sklencar said. Do not make up your own abbreviations: "What is 'BBB'? Bed, Bath and Beyond?"

No Fighting: Do not use the documentation as a method of airing your grievances; do not give an opinion, fight or lay blame in your documentation.

Be precise: Do not write: "The wound was large"; specify size, color, etc., record the date, time and content of phone calls; do not chart a symptom without charting an intervention.

Ms. Sklencar has been teaching, coaching and working with surveyors and providers for almost 20 years through the DOH Health Regulation and Licensing Administration. Ms. Sklencar's duties include investigating incidents and complaints generated from the Long Term Care community.



Shadowing Nurses in Sierra Leone

Photos & Captions by Olivia Pessima, RN, MBA, MS

April 2011 marked the 50th year of independence for Sierra Leone, a country located on the gold coast of Western Africa. I took a break from vacationing to experience a day in the life of a nurse in Sierra Leone. Initially, I visited the University of Sierra Leone's Faculty College of Nursing, where I spoke to an administrator, but I was unable to gain access to a class or the clinical area. Fortunately, I was able to make a connection at

Connaught Hospital in Freetown, where I shadowed members of the nursing staff. Special thanks to Matrons Massaquoi and Momoh for allowing me to visit and shadow a few of the nurses on the surgical ward.



University of Sierra Leone's Faculty College of Nursing, College of Medicine, and Allied Health Sciences, in Freetown, Sierra Leone







Nurse with surgical ward inpatient attempting to initiate an intravenous catheter.





Registered nurse standing in front of patient's bed under mosquito netting. Seen here in a mounted position, mosquito netting is used as a preventive measure in reducing the acquisition of malaria. During times in which patients are resting or asleep, the netting is lowered and covers the full body of the patient.



Staff nurse completing documentation.



Clinical nursing student assessing the pulse of an inpatient on the surgical ward.

Public health nurse completing documentation upon transfer to the surgical ward.











Nursing students, in uniform, conversing on the surgical nursing ward.



Monthly census data for January to July (year-to-date of photo). Notes admissions, deaths, and discharges.



Supplies (gloves and safety needles) used in clinical practice.



Far left: Illustrations posted showing uniforms of the ward head nurse (green belt) and ward charge nurse (red belt). Graduate nurses (gray uniform) have completed all coursework, however are anticipating testing eligibility to enter the nursing field. Nursing ancillary staff wear green or pink.

At left: Nursing staff member pictured with two graduate nurses in the office of the head matrons at Connaught Hospital.

View of the mountains from Sussex beach.

Olivia Pessima, RN, MBA, MS is an Infection Control Nurse for the Department of Defense and completed a DC Board of Nursing internship under the supervision of Karen Skinner, Executive Director for the Board. Ms. Pessima completed a Master of Science degree in Nursing and Business Leadership from The Washington Adventist University in May 2011, and is currently pursuing doctoral studies at The George Washington University. Ms. Pessima ultimately plans to direct her focus toward health policy and international health.

Tropical Medicine Expedition to Tanzania

By Erin J. Bagshaw, NP

This was an expedition led by a well-known tropical medicine specialist out of Germany named Dr. Kay Schaefer. He takes a small group of international health care providers into Africa for clinical hands on experience with tropical diseases at both the bed side and in field excursions, as well as to learn the health care resources available in Tanzania. I chose to do this expedition for a few reasons. First, since our practice provides comprehensive primary care AND travel medicine we were beginning to see more travelers return to our primary care side with tropical diseases, creating more overlap of

February 20, 2011 - We are thirteen medical providers from Germany, US, Caribbean and Japan. Everyone has varied experience and expertise. We were briefed on safety and told never to take pictures of crowds, bridges, banks or of policemen. We were advised to always travel as a group and not to leave our compound. We were to be up in just a few hours to begin our hospital rounds in Arusha. In Tanzania, although many speak English, the official language is Swahili.

February 21 - We began our day with rounds at St. Elisabeth's hospital. Approximately 30% of the hospital

is HIV positive. We learn that close to one million orphans are living with HIV. Many do not tell their families of their disease or seek testing as there is still a stigma associated with this diagnosis. For this and other reasons many patients are not seen in the clinic or the hospital until they are considered Stage 3 or 4 in their disease, this is extremely advanced. We see tuberculosis, cryptococcal meningitis, severe malaria

and dysentery.

The hospital is funded mostly by grants, much of the treatment is covered, but some patients must pay for their medications and many cannot afford treatment. Patients or their families often times bring in their own bed sheets and food as this service is not provided. Followup is difficult for the doctors and keeping the patients on the needed medications. The wards are crowded sometimes more than 10 patients per room. There is no isolation room,



Rounds in Mnazi Moja Hospital.

tuberculosis (an infection spread by respiratory droplets through the air) patients are placed by the windows. There are no masks, sinks or standard infection control measures in place.

February 22 - Today we traveled through an extremely impoverished area of Arusha. The poverty level is difficult to describe. Most Americans will never see this level of poverty. Even the internship I completed in rural Appalachia does not compare. No modern conveniences exist and one realizes very quickly why even clean water may not be found. We are rounding today on a pediatric ward. There are many of the Massai tribe here and in this area they are becoming fractured, kids living with grandparents, many single moms and severe malnutrition. The Massai are hard to describe as they vary a bit in region. The Massai will eat



Rounds in Father Babu Hospital.

needs, i.e. it is changing the questions we need to ask and the diagnoses we need to consider. Second, most health care providers in the U.S. have not had the opportunity to see these diseases and I wanted this experience. It has been my dream to travel to Africa and understand why everybody says, "It is amazing."



The Flying Medical Service.

beef or lamb but no chicken or eggs. They wear traditional clothing, and depending what region you are in still carry spears and knives to hunt and gather. We saw a 2 year old who weighed 11 pounds. We attempt to give our opinion on a 5 year old who weighs 23 pounds, most of us believe

there is an underlying disorder, but we are limited in ability to make any difference here other than discussion for we are not their treating provider and testing capability is limited. There is a pecking order for meals and who eats first in the family -husband, older men, wives and lastly children.

We visited the ICU (Intensive Care Unit),

it was eerily quiet as there are no alarms or sounds because there are no machines, no oxygen, no ventilators and still no gloves or standard infection control precautions. We see other diseases but the malnutrition at this level overshadows the experience. Today feels like we have traveled back in time.

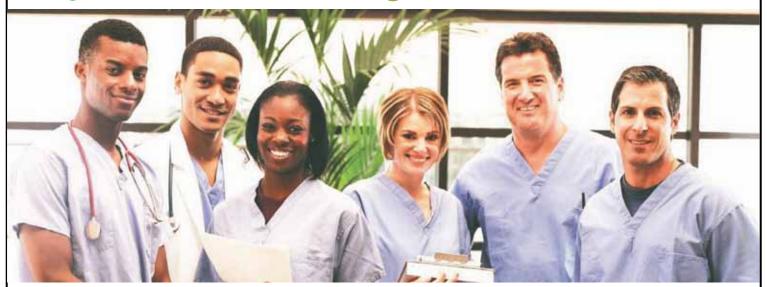
February 23 - This morning we listened to a fabulous lecture on malaria by our expedition leader and tropical medicine specialist, Dr. Kay Schaefer. There is treatment for all forms of malaria (take your prophylaxis though and you have a 90% chance of not getting it!). Treatment of malaria in children presents more challenge. Between 1 and 3 million die annually, the majority are children and live in Africa.

We then traveled to the Meserani Snake Park in Arusha. Here we met "B.J.", the owner of the park and the clinic. He provides free anti-venom treatment. Each vial costs \$200 and

Continued on page 24



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Continued from page 23



Treatment for a Puff Adder snake bite.

for some bites, like a neurotoxic bite from a black mamba, the patient can require up to 7 vials for stabilization. There are neurotoxic and cytotoxic types of bites and treatment and symptoms vary depending on the bite. Most of the bites are from puff adders and mambas but they also have spitting cobras and pythons here. We saw a young Massai woman with a snake bite of her hand. Many Tanzanian women give birth at home. She was giving birth alone on the floor of her home (these homes are made in a traditional way with cow dung, sticks and dirt) and while she was delivering her own baby she was bitten on the hand by a snake. It is believed to be a puff adder but she did not see it as it was nighttime. The baby is about 2 days old; the Massai at times will walk for miles to be seen. They will both be okay.

February 24 - We rounded this morning at a private hospital in Arusha. For 10,000 Tanzanian shillings you can see a specialist, (\$1 USD equals 1,500 shillings). For a medical visit it is 5,000 shillings. The hospital is cleaner; there is even a "VIP" room with a TV. We still see lots of malaria, tuberculosis, pneumonia

and HIV. I still don't see much use of gloves, masks, or gowns. Everything runs very slow, the rounds, the work-up of patients, and the doctors whisper the cases which makes it very hard to hear and move through the rounds. In Tanzania in some areas it is considered more polite to speak in a quiet tone.

We then went to Tarangire National Park to view Tsetse Flies and Tsetse traps. This type of fly can carry African Trypanosomiasis, also known as "African Sleeping Sickness." Once bitten the parasite can eventually move to the brain if left untreated and cause meningoencephalitis, the appearance may mimic dementia as



Massai girl with author Erin Bagshaw.

the disease can take months to years to progress. Measures to control the flies have involved "traps." The flies are drawn to the colors dark blue and black and actual movement. These traps are impregnated to stop the fly from breeding. We did see these flies and the bite hurts.

February 25 - The Massai here hunt and gather for their food. They walk miles and miles for food, water or medical treatment. Often the young children are tending to the cattle with no adult in sight. The Massai warriors antagonize the lion,

if they kill a lion they are seen as a hero amongst the village. There are around 100 lion bites a year according to the Doctor at this hospital. The hospital has an x-ray machine and some surgical capabilities. They exist here on donation. We see cases of Brucellosis. This disease is caused by a gram negative bacillus. It is usually



An operating room.

seen as an occupational disease of those who work with cattle. However, here you see it through the ingestion of unpasteurized milk. The Massai still drink the blood and milk directly from the cow. It causes fever, lymph node involvement and severe arthritis, but complications can vary. Although the Massai are educated to boil the milk often times this does not happen. It is hard to describe the environment, it is easy to say, "Just boil it," but this tribe lives day to day dealing with getting enough food and not succumbing to animals hunting them as hyenas, lions and other animals compete for food in this region. Hyenas are particularly vicious as they hunt in packs and will go into their homes attacking them as they sleep. Medications are limited and pain control is not always available even in cases with children. This is one of my hardest days as I watch a young burn victim being treated.

We next visited the Olduvai Gorge also known as the "Cradle of Mankind". This is one of the best known archeological sites. The oldest known human footprints were found here in the 1970's and were dated to be 3.75 million years old. One of the most famous skulls, a 1.8 million year old ape skull was found in 1959 by Mary Leakey. It's a unique area as almost 2 million years ago volcanic ash was laid down in a sequential order allowing the preservation of many of these fossils.

February 26 - Today we visited the F.A.M.E (Foundation for African Medicine and Education) hospital. This is one of the most organized and functioning hospitals. It was put together by an American named "Dr. Frank," a pediatric cardiac anesthetist and his wife. He had attempted to climb Kilimanjaro years ago with his wife and developed pulmonary edema - a high altitude induced medical emergency. He was treated in Tanzania. After hearing how much they needed doctors, he and his wife sold everything and moved here to



Visiting with Hadzabe people.

establish the hospital (You can see a video of the work they are doing on You Tube by visiting their web site www.fameafrica.org). They are really making a difference and I find them the most inspiring for their passion for their work and care.

Next we visited the

last tribal medicine group known as the "Hadzabe." The tribe has only around 1,200 tribesmen left. They move in small groups still hunting and gathering for food and to live off the land. We learn how they get to water by digging holes and what they are using for herbal medicine to treat colic, fever, malaria. They speak a kind of "cluck" language. Their highest mortality rate is under the age of five, there is a high rate of miscarriage. There is a strong possibility that they will disappear sometime in the next decade.

February 27 - We make it to a government hospital that is treating

African Trypanosomiasis, or "African Sleeping Sickness." We rounded on a few patients with this disease and learn about the treatment and complications that can occur. It is a rare disease amongst short term travelers to game parks or safaris. The treatment is dependent on the stage of the disease and can be complicated.

February 28 - Zanzibar is predominantly Muslim. There are approximately 1.2 million people on this island.



Nurses who run the Kizimkazi/Dimbani Health Center.

We were awoken this morning by the Muslim prayer in the distance. We went to visit the largest hospital in Zanzibar. It is government run and now having seen private, non-profit and government hospitals, it is clear that the government hospital is not as well organized or efficient. The female doctor in charge is young and impressive. We rounded through some very crowded wards, sometimes 25 people to a room. We see typhoid and many issues of overlapping dysentery and HIV. There is one ventilator for the entire island, let me repeat that one! We completed our rounds and went to see the Spice Farm. Zanzibar is known for their spices such as curry, nutmeg and cinnamon. We tour through and learned what spices treat certain conditions.

March 1 - Today we visited a Muslim school of almost 900 children. They scream for us as if we are celebrities. We ask why and we are told they were hoping the Mazungos (white people) were bringing them pens. Yes, just simple pens to write. We are introduced as "doktores" and unfortunately we are here looking

Continued from page 25

for schistosomiasis, a water born parasite. This school has a high rate of infection. There is a stream nearby and the children bathe and urinate in the water there perpetuating the cycle. In order for this parasite to live it must have a fresh water (slow moving) stream, snails and a human. The snail is the host until the human arrives, then it penetrates human skin and eventually makes it way to the liver. It matures here into adult worms and eventually migrates to other areas including the bladder. Symptoms can vary based on the infection from rash, fever, diarrhea to blood in the urine. Screening for blood in the urine is the first step in looking for the disease in these children.



Boys submitting urine samples for testing.

March 2 - This morning we returned to the government hospital in Zanzibar for dermatology rounds. We see many cases of tinea, also known as fungus. Fungus is common around the world but likely more prominent here due to the weather/heat, lack of resources and other infections.

March 3 - Today we had a lecture on lymphatic filariasis, some know this disease as elephantitis. There are three species of this worm.

Transmission occurs via the bite of a mosquito to the human and it moves into the lymphatic system causing lymphoedema, here usually in a limb such as a leg. We drive south of the island to the Kizimkazi/Dimbani Health Center. Here two nurses

run this center and they concentrate on treatment for this disease as well as leprosy. We see both types of patients and I am so impressed on their assessment, documentation and treatment records of cases.

March 4 - Africa is a contrast in so many ways. Between the most amazing landscapes I have ever seen to the poverty and disease to the resilience of the people and joy of the children in the smallest of things. I leave Africa with the hope of returning one day; my clinical knowledge of tropical medicine improved but even better my soul more fulfilled. Africa is truly amazing.

About the Author: ERIN J.
BAGSHAW, NP is the owner of
Northwest Nurse Practitioner
Associates, the first primary care Nurse
Practitioner practice in Washington,
DC. Their practice currently cares
for approximately 4,000 patients as
their primary care provider and they
are also certified in travel health. If
you would like to read more about
the expedition or their practice you
can check out their web site www.
NWNursePractitioners.com.



Continuing Education Update

WOUND CARE

Article and Photos by Nancy Kofie

At a wound care conference sponsored by the Board of Nursing, speaker Diane Krasner, PhD, RN, CWCN, CWS, MAPWCA, FAAN, began her talk on Skin Changes at Life's End (SCALE) by acknowledging that some wounds/pressure ulcers are not healable, due to the dying process and the body's shunting of blood to vital organs: "You can do everything right," Dr. Krasner said, "but some wounds may be unhealable due to co-morbidities."

Three Pathways: Dr. Krasner delineated three major pathways for wound care:



Left to right: RN Cindy Sylvia with Dr. Diane L. Krasner

(1) Aggressive, (2) Maintenance, and (3) Palliative. Look at every case individually, Dr. Krasner said. "Patient centered concerns should be addressed—including pain and activities of daily living. The family of patient may be confused as to why you chose a particular level of treatment. Communicate to the family that you are addressing the pain. Dr. Krasner shared the SCALE project's statement #5: "Expectations around the patient's end of life goals and concerns should be communicated among the members of the interprofessional team and the patient's circle of care."

"For pressure ulcers, it is important to determine if the ulcer may be (i) healable within an individual's life expectancy, (ii) maintained, or (iii) non-healable or palliative. If you are offering palliative care, do not send the patient for debridement every week. Debridement could bring more pain. Focus on symptom management. Aggressive modalities for symptom management reduce pain.

Show the Family: "The family needs to understand that the wound is present and what we are doing about it," Dr. Krasner said. "Invite families in to see the wounds," she said. After one resident passed away, her daughter complained "They hid the wound from me. When they did wound care they put me out [of the room]." Show the family.

Each Case is Different: Dr. Krasner told attendees: "A comprehensive, individualized plan of care should not only address the patient's skin changes and co-morbidities, but any patient concerns that impact quality of life including psychological and emotional issues." SCALE statement #7 says, in part: "A total skin assessment should be performed regularly and document all areas of concern consistent with the wishes and condition of the patient. Pay special attention to bony prominences and skin areas with underlying cartilage."

The goals of care should be considered; SCALE Statement #9 provides a listing of 5 P's to be considered for determining appropriate intervention strategies: Prevention, Prescription, Preservation, Palliation, and Preference. Each case is



different. Dr. Krasner noted one case at her facility where the family and physician opted for above-the-knee amputation for a resident who habitually crossed her ankles and the wound created was down to the tendon; it was irritated and painful. The amputation increased her quality of life—no pain. "It was the best outcome for her."

Documentation is crucial: "Lawsuits come three, four, five years later. The only thing you have to rely on is the record." Documentation should include a wound description, measurement and wound care treatments as well as documentation of pressure redistribution devices and techniques, including support surfaces and turning schedules (Source: Legal Issues in the Care of Pressure Ulcer Patients).

Dr. Krasner is a board certified wound specialist who served as a member of the Expert Panel for the SCALE (Skin Changes At Life's End), an 18-month project with 18 panel member including physicians, nurses and legal experts. Dr. Krasner is a wound and skin care consultant and works part-time as the WOCN/Special Projects

Nurse.

Speaker and wound care "diva" Nancy Morgan, RN, BSN, MBA, WOCN, WCC, DWC, showed nurses in attendance a



Nancy Morgan, RN

Continued on page 28

Continued from page 27

photograph of a huge pile of coffee beans. "Look closely," she said. Eventually the audience members realized that one of the coffee beans was actually a small image of a man's face. Ms. Morgan used the photo to illustrate the importance of close inspection when assessing wounds. "Do detective work. Proper and accurate wound assessment will help determine wound type and etiology." Wound care greatly impacts our health care system. "In the US, more than 5 million patients have chronic wounds, and it costs \$40,000 to treat the average leg ulcer."

When documenting wound characteristics, be thorough, Ms. Morgan said, "Document what the wound looks like, as if you were explaining to a blind person." Characteristics to document:

- Note tissue type presence of eschar, slough (wet stringy, note color); granulation; epithelial tissue, muscle, tendon, bone.
- Describe surrounding tissue (periwound tissue)
- Explain wound's characteristics Drainage amount? Bleeding? Tissue destruction? Mushy like pudding? Hypergranulation? Wet? Dry? Cool or warm? Color?
- Use diagnostic tools such as the Ankle Brachial Index (ABI) to compare the systolic blood pressure of the ankle to that of the arm (brachial).
- In your documentation note patient education. Address pain level in documentation.
- Look at the wound location (document using proper anatomical location) and its shape (is it round? jagged edges? irregular shape?).

Ms. Morgan reviewed the specific characteristics of diabetic and arterial wounds,. She also provided specific charting guidance for venous ulcers, arterial

ulcers, and diabetic (neuropathic) ulcers.

Ms. Morgan, a Certified Wound Care Nurse, has an extensive background in wound care education and wound management program development.

Support Surfaces: Speaker Gail Rogers Hebert, RN, MS, WCC, CWCN, LNHA,



Gail Rogers Hebert, RN

participated in research conducted by the National Pressure Ulcer Advisory Panel (NPUAP) to formulate standardized terms and definitions for wound care. (See website www.npuap.

org). Ms. Hebert spoke about therapeutic support surfaces. She urged participants to anticipate the questions of the Joint Commission: What type of support surface are you using for your patient? Where is it documented? How does it benefit the patient? How does it redistribute pressure? Why did you pick this surface – any particular benefits over another surface? Did you change the surface based on changes in patient condition? Are surfaces addressed in the care plan? How old is the surface you are using? (if facility owns the surface) How do you assure that it is functioning properly?

Basic Wound Care:

- <u>ALWAYS</u> turn and reposition your patients.
- Lift, don't drag.
- Use maximum inflation for patient care activities.
- A loose sheet underneath patient is preferable to a fitted sheet.

Ms. Hebert has been a registered nurse for 35 years, and is a member of the Certification Committee for the National Alliance of Wound Care and a National Pressure Ulcer Advisory Panel member.

Speaker Sue Petros, RN, BSN, CWOCN, a Senior Clinical Nurse Educator with 3M



Sue Petros, RN

Health Care, reviewed skin anatomy and spoke about the levels of tissue injury (partial thickness and full-thickness wounds). She shared photographic examples of a wound base

with slough (nonviable tissue) or eschar (necrotic tissue). She reviewed the methods of cleansing and debridement (mechanical, autolysis, biologic). Ms. Petros also reviewed types of dressing—from traditional gauze and tape, to composite dressings, transparent film, acrylic dressing, hydrocolloids, foam, absorbent wound fillers (alginates), hydrogel.

Tips for cleansing:

- Cleanse wounds at each dressing change
- Cleansing doesn't require antiseptics, normal saline is effective when delivered at 8-12 psi (19g needle with 30 ml syringe)
- Chronic wound cleansers designed to deliver appropriate psi.
- Preserve the peri-wound skin integrity: cleanse surrounding skin, use non-adherent dressings, alcohol free barrier film, moisture barriers, solid barrier wafers.

Wound Care Basics:

- If the wound is infected, treat it.
- If the wound is dry, add moisture.
- If the wound is wet, absorb it.
- If wound is necrotic, debride it.
- Fill dead space with alginates, gauze,

or hydrogels.

• Protect the peri-wound skin.

Wound Assessment: Speaker Donna B.

Johnson, BSN, RN provided insights on wound assessment. "You need to know what type of wound you are assessing pressure wound, vascular

wound, venous



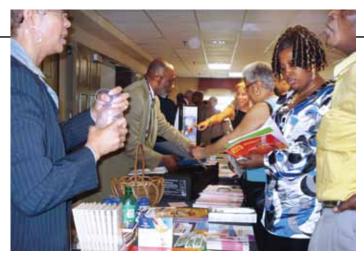
Donna B. Johnson, RN

leg wound or diabetic wound. Use your detective skills. Try to discover what caused the wound and determine how long the wound has been present. Try to ascertain what types of treatments have been used in the past." Always assess the WHOLE patient, not just the HOLE in the patient, she said.

Invest in gaining this expertise; conducting a focused wound assessment is a skill and requires training, she said.

"This refers to a collection of data that characterizes the status of the wound and the peri-wound skin," Ms. Johnson told participants. Data to document:

- anatomic location of wound
- extent of tissue loss (i.e., stage if pressure)
- characteristics of wound base
- type of tissue observed
- percentage of wound containing each type of tissue observed
- dimensions of wound in cm (length, width, depth, tunneling, undermining)



- amount and type of exudates
- odor
- · wound edges
- peri-wound skin
- presence or absence of local signs of infection, and
- wound pain.

Ms. Johnson has been an RN for over 30 years. She has been employed as a Wound, Ostomy Continence Nurse Specialist at Greater Southeast Hospital for 20 years. ■

Kudos!

Congratulations to Board member Ottamissiah "Missy" Moore, LPN, BS, WCC, CLNI, CHPLN, GC, CSD-LTC, who was been named the 2012 Black Nurse of the Year by the Black Nurses Association of the Greater Washington DC Area. Ms. Moore is the first Licensed Practical Nurse honored with this award.

Ms. Moore has been a member of the DC Board of Nursing since 2005. She has served on the 2011 PN NCLEX Item Selection Committee of the National Council of State Boards of Nursing and on the LPN Standards Committee of the Commission of Graduates of Foreign Nursing Schools, from 2007-2011. Ms. Moore has served as a Staff Development Specialist for the Washington Center for Aging Services since 2011.

Ms. Moore has been President of



Ottamissiah "Missy" Moore with her father, Elder Stanford A. Moore.

the National Federation of Licensed Practical Nurses since 2008. NFLPN has a membership of 7,000 LPNs and LPN students. Ms. Moore speaks at the national level on nursing topics such as wound care, hospice care of the aging, IV therapy and scope and regulation of practical nursing, and she has organized numerous continuing education programs for nurses in the District of Columbia.

Ms. Moore holds an LPN degree from Atlantic County Vocational School

and Bachelor of Science degree from the Medical Universities of America. Ms. Moore has verifications in wound care, IV therapy, gerontology, and hospice and staff development in Long Term Care. Ms. Moore is a Life Time Member of the National Black Nurses Association. She is also a member of the Association of Hospice and Palliative Nurses, Infusion Nursing Society, the Hookup for Black Women and National Baptist Convention.

Congratulations to Kate Malliarakis, RN, MSM, CNP who was honored with the Medical Professional Award by the Caron Foundation at its 7th Annual Washington



Kate Malliarakis

Metropolitan Area Community Service Awards Breakfast. Ms. Malliarakis was selected for "making a difference" for those suffering from the disease of addiction.

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.

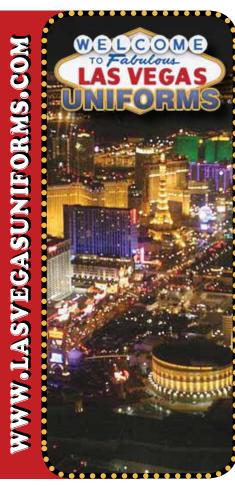
Non-Public Disciplinary Actions:

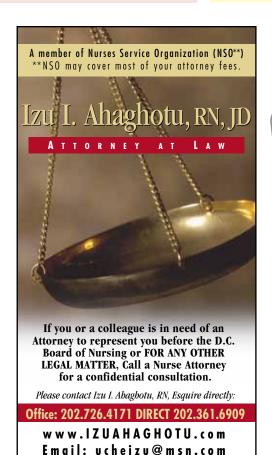
| Notices of Intent to Discipline | 5 |
|----------------------------------|---|
| Referrals to COIN | 1 |
| Consent Orders | 4 |
| Requests to Withdraw Application | 0 |
| Requests to Surrender License | 1 |
| Letters of Concern | 1 |
| Licensure Denied | 1 |
| | |

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.





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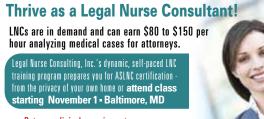
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