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DISTRICT OF COLUMBIA NURSE

REGULATION EDUCATION PRACTICE

Ethical and Legal Practice Issues
Explored at Board Leadership Symposium

- **New Designation for Expired Licenses**
- **Meet the New Board Members**
- **LPN Licensure Renewal**
- **Diversion Programs for Impaired Nurse Professionals**

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DISTRICT of COLUMBIA NURSE

Edition 46

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Address Change? Name Change? Question?
Please notify the Board of Nursing of any changes to your name or address. Thank you.

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

Circulation includes over 37,000 licensed nurses, nursing home administrators, nurse staffing agencies and nursing assistive personnel in the District of Columbia.

Feel free to e-mail your "Letters to the Editor" for our quarterly column. The IN THE KNOW and NAP Q&A columns include 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.)

Cathy Borris-Hale, RN, MHA, BSN

Message from the Chair

This past August, I had the honor to once again represent the District of Columbia Board of Nursing at the National Council of State Boards of Nursing (NCSBN) Annual Meeting in the spectacular city of Chicago, Illinois. Also in attendance were LPN Board Member Ottamissiah Moore, and our Executive Director, Karen Scipio-Skinner. This year, there were 59 member boards represented by delegates.

The work of the NCSBN goes beyond overseeing the National Council Licensure Exam for nurses (NCLEX) but provides education, services and research through collaborative leadership to promote evidence—based regulatory excellence for patient safety and public protection. Founded in 1978, NCSBN brings nursing boards together to act and address matters of national interest. The Council's membership is made of the Boards of Nursing in the 50 states, the District of Columbia, and four U.S. territories – American Samoa, Guam, Northern Mariana Islands and the Virgin Islands. These boards regulate more than 4.5 million licensed nurses.

The 2016 annual NCSBN meeting provided a forum for nursing regulators from all over the world to meet, network and discuss important regulatory and healthcare concerns. Some of the significant actions approved by the member Boards this year included:

- Approved the Strategic Initiative for the years 2017 – 2019.

- Approved amendments to the NCSBN Bylaws

- Adopted the 2017 NCLEX-PN Test Plan

- Approved the Association of New Brunswick Licensed Practical Nurses, the Licensed Practical Nurses Registration Board of Prince Edward Island and the College of Registered Psychiatric Nurses of British Columbia as associate members of NCSBN

- Elected new members of the NCSBN Board of Directors and Leadership Succession Committee, including our very own Karen Scipio-Skinner, MSN, RN, executive director, District of Columbia Board of Nursing, who was reelected as director-at-large.

The theme for the annual meeting, "Leading Transformation: Architects of Nursing Regulation" resonated with all the participants. One of the keynote speakers, Dr. Malcolm Sparrow, Professor of the Practice of Public Management at The John F. Kennedy School of Government, Harvard University, presented a thought-provoking presentation on risk-based regulation which moves resources away from "technical compliance" with laws and moves towards a focus on conduct that represents real risks to public welfare. The presentation asked the question, "What are the implications of adopting a harm-reduction framework and what does it mean to be a 'Risk-Based Regulator'?"

More often than not the concept of regulation is the notion of public authority through a system of regulations and laws in which the regulator ensures technical compliance. According to Sparrow (2011), such approaches are seen as reactive and focused more on enforcement, and may miss risks because they are seen as being outside of their circle of influence and results in what many regulators are accused of—being slow to respond.

A risk-based approach to regulation will focus on those risks that hamper the delivery of public value rather than expending resources on ensuring compliance to laws where no real harm is done. This approach fits with the "Just Culture" philosophy that this board embraced several years ago and it provides a framework or rather a regulatory style that focuses on decreasing or reducing harm rather than promoting good. Sparrow makes the point that not everything that is illegal is harmful, and many things that are legal can cause harm (Sparrow, 2008).

While I found this presentation most informative and took extensive notes to share with my colleagues, it was the presentation by Mt. Everest Summiteer and Cancer Survivor Alan Hobson that was most memorable. Everyone in the auditorium was spellbound and hung on to every word as he described his 10 grueling self-guided and self-organized expeditions. He raised over half a million dollars to finance his childhood dream to

reach the summit. Three years later he faced his greatest challenge when he found himself diagnosed with an aggressive cancer and a life expectancy of less than a year. After receiving an adult blood stem transplant from his brother for leukemia he is now considered to be medically cured. He credited his survival to the numerous nurses who cared for him.

There he stood, the man who once stood on top of the world some 29,035 feet above sea level now stood center stage to thank all the nurses who cared for him and saved his life. It is true that in the course of our day-to-day lives we frequently see our work as just doing what we were educated to do.

Nurses save and improve lives as frontline members of the health care team. They independently assess and monitor patients, and, using a holistic approach, determine what each patient needs to attain and maintain his or her health. Nurses provide care and, if needed, alert other health care professionals to assist. Nurses assess whether care is successful and when not, they work with their colleagues to create a different course of action.

So while we (on the Board) struggle and sometimes claw our way through regulations—I urge you to remember and celebrate the fact that you do save lives each and every day. You care for and honor your patients' hopes and dreams and, more importantly, their health. To your patients, their families and us (here on the Board), you are our heroes.

Be good to yourself!

Cathy Borris-Hale, RN, MHA
Chairperson
DC Board of Nursing

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Sparrow, M. (2008). The Character of Harms. London: Cambridge University Press.

Sparrow, M. (2011). The Regulatory Craft: Controlling Risks, Solving Problems, and Managing Compliance. Washington DC: Brookings Institution Press

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Welcome New Board Members

Board Member Winslow B. Woodland, RN, MSN; Mayor Muriel Bowser, and Board Members Layo George, BSN, RN, and Laverne Plater, BSN, RN-BC.

Layo George, BSN, RN

WHEN WERE YOU APPOINTED TO THE BOARD?

I was appointed to the Board of Nursing on July 6, 2016.

CAN YOU TELL US (BRIEFLY) ABOUT YOUR BACKGROUND?

I consider myself a Washingtonian. I was born in Nigeria, lived in Italy during middle school years and moved to DC during high school years and never left. I went to Dunbar High School! My husband and I live in DC with our sweet dog Summer!

WHAT UNIQUE PERSPECTIVE DO YOU BRING TO THE BOARD?

My career path as a nurse has been very unconventional. Most of my experiences have been in public health, primary care, advocacy, and community health in the city. I have the joy of knowing that part of DC's health care system very well. Primary Health and Community Health are becoming more and more important. I am looking forward to representing that sector of our health system on the board.

WHAT BOARD-RELATED ISSUES INTEREST YOU THE MOST?

All the issues on the board interest me. If I have to pick one, I would say working on recommendations regarding emerging practice issues. Health Care System is evolving; nursing capacity and work has to continue to evolve as well.

WHAT WOULD YOU TELL SOMEONE THINKING ABOUT APPLYING TO SERVE ON THE BOARD?

Do it!

ANY MESSAGE YOU WOULD LIKE TO CONVEY TO LICENSEES?

Put your patients first and you won't have to worry about your license.

BOARD OF NURSING MEETINGS

Members of the public are invited to attend...

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

Time:
9:00 a.m – 11:00 a.m.

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

Transportation:
Closest Metro station is Union Station. (Red Line)

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

Meetings scheduled:
January 4, 2017
March 1, 2017
May 3, 2017
July 5, 2017
October, 4, 2017

Laverne Plater, BSN, RN-BC

WHEN WERE YOU APPOINTED TO THE BOARD?

I was appointed to the Board of Nursing in July 2016.

WHY AND HOW DID YOU GET INVOLVED WITH THE BOARD? WHAT SPARKED YOUR INTEREST IN SERVICE AS A BOARD MEMBER?

I considered joining the board for many years, and finally pursued getting involved with the Board of Nursing!

CAN YOU TELL US (BRIEFLY) ABOUT YOUR BACKGROUND? WHAT UNIQUE PERSPECTIVE DO YOU BRING TO THE BOARD?

I have been a past and am present District of Columbia Nurses Association board and cabinet member as well a past Chief Shop Stewart. I am currently, a Nursing Consultant for the Department of Behavioral Health. I have received many nominations, awards, and certificates in my career. I had the privilege of being highlighted on Channel 4 Morning Person Show.

I do believe I have a unique perspective that has largely been shaped by the varying nursing roles and job responsibilities I've had over the years. My nursing career path has transitioned from my start as a nursing assistant. Next, I began working as a clinical nurse in various specialty areas. This led me to nursing leadership roles such as shift supervisor and nurse manager. Now as a nurse educator and consultant I am able to use all of these skills and my understanding of the everyday challenges of nursing to help others to view things in multiple dimensions.

In my current role, as Nurse Consultant at the Department of Behavioral Health (St. Elizabeths Hospital), one of my duties is to coordinate clinical experiences for various nursing schools. Working with the students is so rewarding and refreshing! I hope to impact and instill in new nurses the importance of staying current and updating credentials throughout your career.

IS THERE ANY ASPECT OF YOUR SERVICE AS A BOARD MEMBER THUS FAR THAT HAS SURPRISED YOU (OR HAS THE EXPERIENCE BEEN WHAT YOU EXPECTED IT TO BE)?

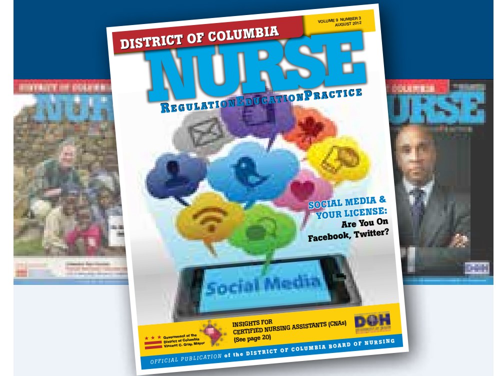
There have not been any aspects of my board service that have surprised me so far; I continue to look forward to serving on the Board. I would tell others this experience is an important part of growth and development. It has strengthened my ability to understand better the value of lifelong learning and making sure you master your subject material.

ANY MESSAGE YOU WOULD LIKE TO CONVEY TO LICENSEES?

The message I would give to others would be to be a great nurse; make sure your heart is in it, and find your passion. Is it giving, caring, teaching, nurturing, or leading? It is important to always be responsible, credible, respectful, honest, active and involved. Lastly, join a professional nursing organization and demonstrate your commitment to excellence in your practice at all times and remember to balance quality with efficiency always. Be the change you want to see in the world!!

"Nursing is an art and if it is to be made an art it requires exclusive devotion as hard a preparation, as any painter's or sculptor's work."—Florence Nightingale

Reach Recruit Retain



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LPN Licensure Renewal

April 3, 2017 – June 30, 2017

RENEWAL INFORMATION:

LPN renewal begins April 3, 2017. All LPN licenses expire June 30 of odd numbered years. Upon completion of the renewal application and payment of the renewal fee, your license will be renewed for a two-year period. Licenses not renewed by June 30, 2017 will expire and will have to be reinstated if not renewed by the late renewal period, August 30, 2017. (See page 10)

RENEWAL TIPS

DO

Renew online **sooner rather than later** by accessing the HRLA website at: **https://app.hpla.doh.dc.gov/mylicense/**

Read all screening questions carefully before answering, as incorrect or unintentional responses may result in a delay of your renewal even though the system will allow you to pay and exit the renewal program.

Provide written explanation(s) to screening questions as required.

Print out receipt after completion of your online application renewal process

DON'T

Don't wait until the last minute to renew.

Don't let your license "expire" if you plan to work in DC.

Don't disregard the Continuing Education audit notification if you are a random audit selectee.

Once you have completed your renewal:

Verify your renewal after 24 hours at **www.hpla.doh.dc.gov/weblookup**.

Allow ten (10) business days to receive the renewed license in the mail.

If your license did not renew it may have been for one or more of the following reasons:

Reason: You could not finish the online renewal process.

Remedy: Retrace your steps, and complete the process. Your renewal effort is successful once you enter payment information, press submit, and the website processes that data and produces a Renewal Payment Receipt for inspection and printing. Note: Please print as evidence of successful renewal.

Reason: Your payment was not processed.

Remedy: Please refer to above response. If payment information is entered and submit button is pressed and that button does not depress and/or no Renewal Payment Receipt is produced, payment was not processed. Retrace your steps and repeat your process.

Reason: You answered "No" to completion of Continuing Education contact hours.
Your renewal will be placed on "Hold" if you answered **"No."**

Remedy: If you answer "No" You will not have completed your CE requirements by June 30, 2017, you will be required to submit evidence of satisfactory completion of 18 contact hours of continuing education before your license will be renewed.

Reason: You owe the District Government $100 or more in fees.

Remedy: Provide evidence on official document from agency to whom you owe fees that you have either paid the fee or have an approved payment plan.

WHAT YOU NEED TO KNOW ABOUT CONTINUING EDUCATION

- It is not required for those who are first time renewals but is required for all others.
- It must be obtained from July 1, 2015 – June 30, 2017 to satisfy the CE requirement for license renewal.
- It must be consistent with your nursing position, totaling 18 Contact Hours.

Track Your CE with CE Broker

CE Broker simplifies the process of tracking your continuing education with easy reporting, digital storage for your certificates and licenses, and a credit counting CE Compliance Transcript all in one online portal. There are three subscription options.

THE BASIC ACCOUNT: This no-cost account provides licensees a no-frills way to report course completions and verify that all completed hours have been entered into the system.

THE PROFESSIONAL ACCOUNT ($29/ YR): CE Broker's most popular option is the best value for professionals with several licenses or cards to keep up with. Online Reporting—Easily report your accomplishments from your computer or phone. CE Compliance Transcript—See all of your requirements, what has been completed, and what CE still needs to be fulfilled. Course Search—Search for all the board-approved courses needed to fulfill your requirements. Plus digital certificate storage, course history backlog, helpful tips and deadline notifications.

THE CONCIERGE ACCOUNT ($99/ YR): Designed for the extra busy healthcare professional, this full reporting service option provides you with a personal reporting assistant.

For more info call **1-877-434-6323** or go to **www.CEBroker.com**.

Patricia Austin is an advanced practice community and public health nurse with more than 20 years of experience in health care delivery systems, academia and health policy development, having worked with diverse populations in both urban and rural settings.

She currently serves as chief operating officer of HSC Home Care, LLC in Washington, D.C. and HSC Health & Residential Services in Landover, Md.

At HSC Home Care, LLC we deliver state-of the-art care and services that allow patients to receive family-centered care in the comfort of their homes. We partner with patients and their families by creating an individualized care plan and teaching skills that increase quality of life and independence.

HSC Home Care, LLC is a licensed Medicare & Medicaid certified home health agency in Washington, D.C. and the only CHAP accredited pediatric home care agency in the District. HSC Home Care, LLC is one component of The HSC Health Care System, a nonprofit health care organization committed to serving people with complex health care needs and eliminating barriers to health services through expert medical care, advocacy and care coordination for over a century.

In the District of Columbia, HSC Home Care serves infants, children, teens and young adults up to age 21. Our expert staff manage the multifaceted health care needs of pediatric and young adult patients with complex medical needs and disabilities such as developmental delays, cerebral palsy and brain injuries.

Why Choose HSC Home Care? At HSC Home Care, we offer:

Quality care. Our goal is to make sure patients and their families receive quality care and services in the comfort of their homes. HSC Home Care is accredited by the Community Health Accreditation Partner (CHAP), an independent accrediting body for community-based health care organizations. CHAP accreditation demonstrates that HSC Home Care meets the highest quality standards.

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HSC Home Care, LLC

Change in Renewal Status Designation From "Expired—Renewal Eligible" to "Expired"

Beginning in 2017 the District of Columbia Health Regulation and Licensing Administration will change the renewal status designation for nursing personnel who have not renewed their license/certification prior to the end of their renewal period. Nursing personnel regulated by the Board of Nursing (which includes registered nurses, advanced practice registered nurses, licensed practical nurses, trained medication employees and home health aides) who have not been licensed/certified by the end of their renewal period will no longer receive **a status of "Renewal Eligible."** The status **will now read "Expired."**

Previously, persons renewing their license or certification would see a status of "renewal eligible" on our website for a period of 60 days beyond the renewal period. This designation indicated that while their licensure/certification had not been renewed, they were still eligible to practice. Beginning with the 2017 renewal, this designation will no longer be used. Instead, nursing personnel whose licenses/certifications have expired will no longer have a status of renewal eligible, their status will read "Expired."

The reason for changing the language is twofold: To have consistency in language for all health professional licensing boards, and to clarify the fact that the license/certification is expired.

While **nursing personnel will continue to have a 60-day "grace period"** their license/certification status will show as "expired" not "renewal eligible" on our website. What is the grace period? The law allows persons to continue to work 60 days beyond the expiration of their license, without being considered by their licensing board to be practicing without a license/certification, as long as they renew within the 60-day period after the expiration of their license/certification. The law has not changed, only the designation from renewal eligible to expired. See relevant section of the law below:

17 DCMR Chapter 40, Section 4005.5 - *"A holder of a license, certificate, or registration who fails to renew prior to the expiration date may renew the license, certificate, or registration within sixty (60) days after expiration upon paying the required late fee. Upon renewal, the holder shall be deemed to have possessed a valid license, certificate, or registration during the period between the expiration of the license, certificate, or registration and the renewal thereof."*

Licensees who do not renew prior to the expiration date may still renew within sixty days of the expiration date upon completing the application and paying a late fee.

Please note that while the Board of Nursing will not take action against a person during the "grace period," your employer has the option of requiring your license to be active in order for you to work.

NCSBN Provides Automatic License Status through Nursys e-Notify

With NCSBN's Nursys e-Notify® system (**https://www.nursys.com/EN/ENDefault.aspx**), institutions that employ nurses or maintain a registry of nurses, now have the ability to receive automatic licensure, discipline and publicly available notifications quickly, easily, securely and free of charge.

The e-Notify system alerts subscribers when modifications are made to a nurse's record, including changes to:

- License status;
- License expirations;
- License renewal; and
- Public disciplinary action/resolutions and alerts/notifications.

Nursys data is pushed directly from each participating board of nursing's database (for participating jurisdictions visit nursys.com). Nursys is live and all updates to the system are reflected immediately. Through a written agreement, participating BONs have designated Nursys as a primary source equivalent database. NCSBN posts licensure and disciplinary information in Nursys as it is submitted by individual BONs.

If you need assistance in getting started, have any questions or need additional information please send an email to Dennis Roy at **droy@ncsbn.org.**

You can also learn more about Nursys® e-Notify by viewing an introductory video at **https://www.nursys.com/Help/HelpVideoPlayer.aspx?VID=EN**

Or by visiting the Nursys website at: **https://www.nursys.com/**

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. 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 better outcomes we can expect.

RENEW OR INACTIVE STATUS?

Q: I am seeking employment opportunities within academia. I may work in a location other than the District of Columbia or Virginia—in online education. My Virginia license expires/renews in May and my DC license expires/renews in June. I live in Virginia. Should I renew my Virginia and DC licenses? Are there any reasons why I should renew the DC license if I will not be working at DC?

A: If you don't plan to work in DC you can either choose to not renew your license, in which case it will expire, or apply for inactive status. Inactive status will allow you to apply to reactivate your licensure status in the future by paying the reactivation fee, which is currently $34, and meeting the board's continuing education requirements. Your other option will be to allow your license to expire, and if you chose to work in DC again you can apply to reinstate your license. The reinstatement fee is currently $230.00.

To place your DC license in inactive status, you must pay the $145.00 licensure renewal fee. We can't place a license that is expiring in inactive status. Once placed in inactive status, your license can remain inactive indefinitely.

LGBTQ CULTURAL COMPETENCY

Q: I received a notice from the DC Office on Aging (DCOA) that they are partnering with Whitman-Walker Health to offer LGBTQ cultural competency training for service providers in the DCOA Senior Service grantee network. The memo mentions that this is a mandatory training and references the legislation signed by Mayor Bowser requiring this training for all licensed health professionals. This potentially impacts RNs and social workers but ultimately will also impact the HHAs this renewal cycle. Can you please clarify?

A: The regulations incorporating this requirement have not yet been passed. When this requirement goes into effect, health care professionals will be notified. The requirement will not begin in the middle of a renewal period.

WORKING ON BEHALF OF DC IN VIRGINIA/MARYLAND/DELAWARE

Q: Some nurses work for the District and travel to Maryland, Virginia or Delaware on behalf of the District. Some have expressed concern regarding whether they are engaged in unauthorized practice when practicing in these other states on behalf of their job. They are not licensed in these other states. I have assured them that they are covered as long as they are functioning within their job functions with the District. Please advise.

A: It depends upon the requirements of the state in which they will be providing care. Some require licensure. Some require notification, and others require issuance of a temporary license. If the nurses live in Maryland or Virginia they might want to apply for a compact license that will allow them to work in the states of Maryland, Virginia and Delaware without applying for an additional license.

NURSE PRACTITIONER (NP) LICENSE

Q: What licenses would a nurse practitioner need in order to join a private pediatric office in Washington, DC?

A: They would just have to be licensed as a nurse practitioner in DC. The Advanced Practice RN application package is online at: **http://doh.dc.gov/node/323062** .

NP CERTIFICATIONS UPDATE

Q: I am trying to renew my license online. My current advanced practice license indicates that I am licensed as a nurse practitioner (NP). This goes back to the time advanced practice nurses were originally licensed in DC. Presently, I am a Certified Clinical Specialist in Psychiatric and Mental Health Nursing and I would like my new license to reflect that status. How do I update the status? I tried to update my profile and got an error message.

A: When DC began licensing advanced practice registered nurses, Certified Clinical Specialists in Psychiatric and Mental Health Nursing were licensed as nurse practitioners. This was utilized as a generic title. We recommend waiting to update your title until the revised APRN regulations are passed. At that time we will begin licensing APRNs based upon their population foci, and evidence of your certification will need to be submitted to the Board of Nursing. We will not be able to update your profile without evidence of current certification.

NPs AND TELEMEDICINE

Q: I have been considering making online visits a part of my practice. In light of the Department of Health's Notice of Proposed Rulemaking establishing rules

Continued on page 12

Continued from page 11

on telemedicine, have NPs been excluded from providing this service? Is there any information other than what is currently being reviewed by Board of Medicine in the DC Register?

A: A Telemedicine Law which includes advanced practice registered nurses has not been introduced in DC. If you plan to provide care in another state, you need to check that state's law.

Q: I am hoping to offer virtual visits to our patients here in DC. Is there anything that prohibits that?

A: There is not a prohibition, but if you plan to maintain an ongoing relationship with the client you will need to be licensed in DC.

TELEPSYCHIATRY

Q: I'm a psychiatric nurse practitioner in Florida applying for licensure in DC to do telepsychiatry. Does DC have restrictions which would prevent an out-of-state practitioner from obtaining a Controlled Substance Registration (CSR) in DC? Will I need a physical business address in DC to obtain a CSR?

A: You are required to have an affiliation with a business located in DC in order to obtain a CSR. Pursuant to the DC Uniform Controlled Substances Law (D.C. 4-29; D.C. Code § 48.901.02 (et. seq.)) and regulations promulgated under 22 DCMR Chapter 10," …every person who manufactures, distributes, dispenses, prescribes or who conducts research with controlled substance within the District of Columbia must be registered with the D.C. Department of Health." This registration is required in addition to federal registration with the U. S. Drug Enforcement Administration (DEA).

A DC Business affiliation is required before a DC Controlled Substance Registration can be approved. The address is printed on the license as the applicant's place of business.

NAP NEWS!

Nursing Assistive Personnel Q & A

TMEs & CONTROLLED SUBSTANCES

Q: May Trained Medication Employees (TMEs) administer Section [schedule] I and II Controlled Substances only with training from a supervisory nurse?

A: TMEs cannot administer Schedule I and II drugs under any circumstances. It is prohibited by law. [Title 17 DCMR Chapter 61 online at: **http://www.dcregs.dc.gov/Gateway/RuleHome.aspx?RuleNumber=17-6100**.]

MAY TMEs ROAM?

Q: Are Trained Medication Employees (TMEs) permitted to "roam"—go from house to house to administer medications?

A: No. TMEs are required to administer medications in a timely manner and ensure that the client is not experiencing an adverse reaction. Previously, LPNs went from home to home to administer medications. Medications were not administered in a timely manner. The rationale for developing the TME program was to address these issues.

PERSONAL CARE AIDES

Q: What training is required in DC for private-pay personal care aides (i.e., non-medical caregivers) that work for agencies (i.e. not Medicaid or Medicare covered)?

A: Persons providing private duty care may be required by insurance companies to be certified. Certification is usually required for third party reimbursement. Persons working in a private setting and paid directly by the client may or may not be required to be certified. But if certified we require persons to work under the supervision of a licensed nurse.

Q: An unlicensed individual providing Personal Care Aide (PCA) services, in the Elderly & Persons with Physical Disabilities (EPD) waiver, is also interested in providing care to a participant directed services (PDS) participant. The PDS program is new to the EPD waiver and allows the beneficiary to hire, fire and train their own participant-directed worker (PDW) this is in comparison to accessing services through a Home Health Aide (HHA). In the past, it was decided that these workers would not fall under the purview of Board of Nursing. Therefore, we would not have the same requirements, one of which was requiring that the PDW complete hours of continuing education or in-service training in the area of health or nursing needs of an assigned client population. A potential PDW inquired whether the hours worked with a participant in the PDS program could "count" towards this certification requirement as an unlicensed professional.

A: The hours would not count towards certification. They would need to work at least 8 hours in a setting in which they are being supervised by a nurse.

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POETRAVEL

Diversion Programs for Impaired Nurse Professionals:

Characteristics of Participants in the District of Columbia Committee on Impaired Nurses (COIN)

By K. Malliarakis, J. Joyner, T. Walsh, M. Dengler, K. Cavallo, P. Compton
Corresponding Author: Peggy Compton, RN, PhD

INTRODUCTION

Substance use disorders, more commonly referred to as substance abuse, substance dependence, or addiction, are not uncommon in the United States (US) today, and thus are likely to be encountered in health care professionals. According to the National Survey on Drug Use and Health (NSDUH) (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014), in 2013, approximately half (52.2%) of all Americans aged 12 or older report having had at least one alcoholic drink in the past 30 days, with 6.6% meeting the criteria of alcohol use disorder. Furthermore, more than one-fifth (22.9%) of people aged 12 or older engaged in binge drinking (drinking five or more drinks on one occasion) at least once in the past 30 days, with another 6.3% reported engaging in heavy drinking (five or more drinks on five or more occasions during the past 30 days) (SAMHSA, 2014).

The use of illicit drugs is also prevalent in the US. In 2013, an estimated 9.4% (or 24.6 million) of Americans aged 12 or older had used an illicit drug in the month prior to the NSDUH. Although increasingly decriminalized, marijuana is by far the most commonly-used "illicit" drug in this country, used by 80% of those identified as illicit drug users in 2013, and representing 7.5% (19.8 million) of the population (SAMHSA, 2014). Following in prevalence is the non-medical use of prescription drugs (i.e., pain relievers, tranquilizers, stimulants, or sedatives) by 2.5% Americans (6.5 million), with the majority (4.5 million) reporting nonmedical use of prescription pain relievers. Illicit drug use is also associated with alcohol use; among youths who were heavy drinkers, 67% also were current illicit drug users, whereas among nondrinkers, the rate was only 5.6%. An estimated 8.2% of Americans (21.6 million) age 12 or older were diagnosed with a current substance use disorder in 2013, and approximately 20.3 million adults aged 18 or older had a past year substance use disorder, which translates to 8.5% of adults. Thus, at any one point in time, almost 1 out of 7 Americans (14.6%) meets the diagnostic criteria for substance use disorder (alcohol or illicit drug), making it one of the most common chronic diseases in the US (Kessler et al., 2005).

SUBSTANCE USE DISORDERS IN NURSES

There is little reason to suspect that rates of substance use disorders would be lower among health care providers. It is estimated that practicing nurses generally misuse drugs and alcohol at the same rate (10 to 15 percent) as the rest of the population (National Council of State Boards of Nursing, 2011), although others report rates as high as 20% (Trinkoff, Eaton, & Anthony, 1991; Trinkoff, Shou & Storr, 1999; Monroe and Kenega, 2011). Rates may in fact be higher; fear of punishment or disciplinary action by practice Boards likely limit self-report (Monroe and & Kenega, 2011), and reporting by nurse colleagues may be limited by an unwritten "Code of silence" amongst health care professionals (Dunn, 2005).

The presumption of good knowledge about the health consequences of ongoing drug or alcohol use does not protect the development of these types of disorders. In fact, there appears to be risk factors specific to the work and workplace environment which makes nurses more vulnerable to develop a substance use disorder. These stressors include role strain;

problems of daily living; enabling by peers, physician colleagues and managers; permissive attitudes towards drugs and drug use (Clark & Farnsworth, 2006); lack of formal education regarding substance use disorders; and lack of controls over access (Clark, 1988). Characteristics of the nursing work schedule, including shift rotation, long shifts (>8h), limited time off between shifts, and forced overtime increase the likelihood of substance abuse (Geiger-Brown & Trinkoff, 2010; Trinkoff & Storr, 1998a).

Access to controlled substances may increase rates of misuse in nurses (Trinkoff et al., 1999; Wright et al., 2012), enabling self-medication of pain or uncomfortable feeling states. In comparison to matched control nurses, registered nurses disciplined for a substance abuse problem are much more likely to use prescribed opioids to treat chronic pain and emotional symptoms (Bugle, 1996). Qualitative reports on physician substance abusers confirm there is self-medication usage of opioids to treat pain, emotional distress, stress and withdrawal symptoms (Merlo et al., 2013). Nurses with a substance use disorder report changing or transferring to a new work site to maintain or increase access to medications (Sullivan, Bissell, & Leffler, 1990).

There is evidence that different nursing specialties are more likely to develop substance abuse disorders than others. Nurses who were the least likely to report substance abuse during the previous year worked in general pediatrics, women's health, school and occupational health settings. Of substance misusing nurses, those working in pediatric, general practice and emergency room were more likely to use marijuana; those in oncology and administration were most likely to misuse alcohol; and psychiatric nurses most likely to smoke tobacco (Trinkoff & Storr, 1998). Critical care nurses were more likely to use cocaine (Plant et al., 1991; Collins et al., 1999). Nurse anesthesia is a specialty which appears to put nurses at particular risk for substance misuse. Although the prevalence of substance use disorders among anesthesiologists and nurse anesthetists hover at national rates (10%-15%) (Bell, McDonough, Ellison, & Fitzhaugh, 1999; Quinlan, 1996), their access to powerful opioids may put them at higher risk for relapse (Skipper et al., 2009). Boziowski and colleagues (2014) have reported a very low rate of substance misuse among nurse anesthesia students (<1% in 5 year observation) as reported by program directors. These data are limited by a low response rate (21.7%) and a tendency for schools to not reveal substance abuse amongst students.

DIVERSION PROGRAMS FOR NURSES

The significance of substance use disorder in practicing nurses extends beyond the individual nurse to the patients under his/her care, due to the potential effects of impaired nursing practice on patient safety and outcomes (Dunn, 2005). Nursing licensing boards are charged with ensuring licensed nurses provide safe and appropriate care to the public. If provided with evidence that a nurse is misusing alcohol or illicit drugs, these bodies are responsible for removing the impaired health care provider from practice, usually in a punitive manner (i.e., taking away the license).

To provide the nurses suffering from a substance abuse disorder an opportunity to receive treatment, recover, and return to work, many state boards have established alternative-to-discipline or diversion programs which will return the nursing license to those individuals who successfully complete the program. These programs are usually confidential and voluntary, and typically consist of a mutually agreed upon multi-year observation period during which time the participant must provide evidence of contract treatment engagement and completion and ongoing recovery (including random urine drug screens). As of July 2016, 41 of the 50 states have some form of diversion program in place for nurses, with Alaska, Arkansas, Connecticut, Delaware, Minnesota, Missouri, New Hampshire, North Dakota, and Rhode Island being without; Colorado's diversion program is currently under development. The majority are overseen by a nursing licensing board and intended specifically for nurses, although for some states, programs serve all licensed health professionals (Michigan, New York, Nebraska). Several of the state programs include nurses with mental illness other than substance use disorder that may be impairing practice (DC, California, Oregon, West Virginia). Most are designed to intervene with individual participants, although others are more engaged in educating employers to identify cases of substance-induced impairment (Pennsylvania, Oregon).

Continued on page 16

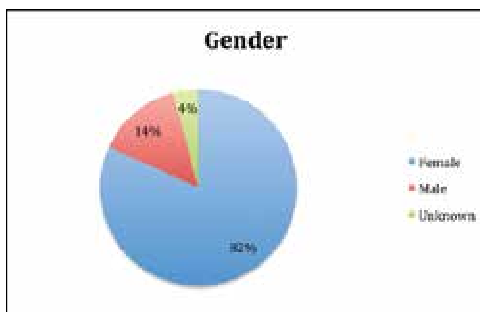

Figure 1. Gender of COIN particpants

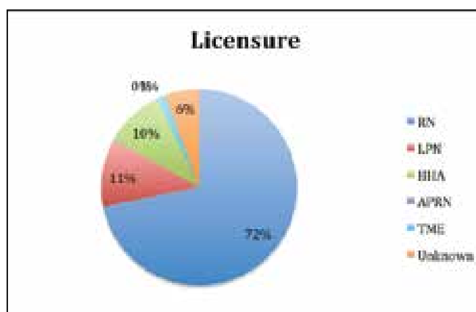

Figure 2. Type of nursing license of COIN participants RN-registered nurse, LPN – licensed practical nurse, HHA –home health assistant, APRN – advanced practice registered nurse, TME-trained medical employee

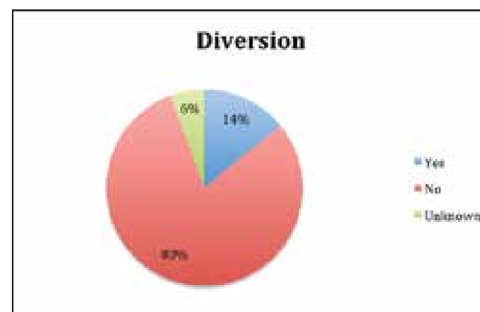

Figure 3. Rates of diversion among COIN participants

CHARACTERISTICS OF PARTICIPANTS IN DISTRICT OF COLUMBIA DIVERSION PROGRAM: COMMITTEE ON IMPAIRED NURSES (COIN)

The District of Columbia's Committee on Impaired Nurses (COIN) has been in existence since 2004, and COIN consists of a team of registered nurses with educational, administrative and substance abuse training. COIN members are all volunteers and operate under the auspices of the DCBON. Participants are received into COIN by several routes. Health care providers can be self referred to COIN or can be reported to COIN by an outside entity or agency. The BON can also refer individuals to COIN for evaluation. After the initial referral is received, the participant is interviewed by the COIN members. Following an initial evaluation by the COIN, a determination is made regarding the issue for the participant.

If a substance abuse disorder is present, a mutually agreed upon three-year contract is established with the participant, detailing expectations for successful completion and return of full nursing license. Depending on the severity of participant impairment, contract stipulations often include a formal objective psychiatric assessment, engagement in treatment program with regular counselor notes, involvement in 12-step program, random urine or breathalyzer testing, and inability to work as a nurse, depending upon the offense. Many nurses enrolled in COIN are purposefully banned from areas that have a high likelihood of exposure to controlled substances, such as the Emergency Room or the PACU, or in any clinical setting with patient contact. Participants are mandated to follow the contract, else risk expulsion from the program and eventual license revocation from the Board. However, if the participant maintains compliance and exhibits completion of the program with sobriety, recommendations from COIN to the Board will allow the participant to remain a licensed health care provider.

Over the course of the COIN program, 71 nurses at risk for losing their license voluntarily entered the program, 13 of whom were still active participants in the program. The majority (82%) were female (Fig 1) and Registered Nurses (RNs)(72%) with the remainder comprised of equal sized groups of Licensed Practical Nurses (LPNs) and Home Health Aids (HHAs) (Fig. 2). With respect reason for entry, 14% of participants were referred for suspected diversion (Fig. 3), 14% for DUI (Fig. 4), and 14% self-referred (Fig. 5). A little over one-third (36%) of participants successfully completed the program while another 14% were either expelled or discharged due to noncompliance. Almost a quarter (24%) never arrived for an initial evaluation or left before engaging in program (see Fig. 6).

DISCUSSION

As described above, diversion programs for nurses with substance use disorders vary widely from state to state, thus making generalizations about participants and program outcomes impossible. In the District of Columbia, nurses arrive at the COIN program via various pathways. Those suspected of drug diversion are typically identified by employers, with the accusation usually based upon evidence of patterns of inaccurate drug accounting. Due to the criminality associated with diversion, recovery efforts and activities can be complicated for these nurse participants by legal issues. DUI arrests are another mechanism by which the criminal justice system brings nurses to COIN. Although not flagged when the arrest occurs, these charges become known to the Board of Nursing during the bi-annual license renewal process.

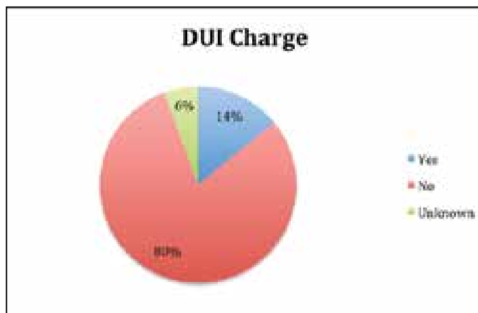

Figure 4. Rates of Driving Under the Influence (DUI) charge among COIN participants

Figure 5. Rates of self-referral to program among COIN participants

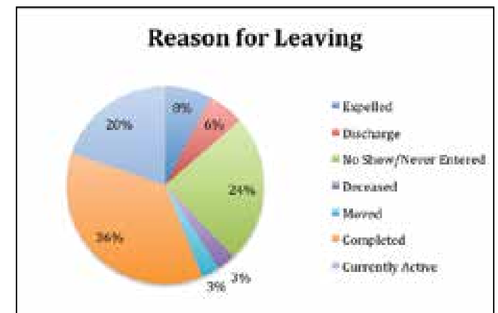

Figure 6. Reasons why COIN participants leave the program

However, just as many cases come to COIN via self-referral as do from the Board. Multiple points of entry enable broader participation of nurses needing treatment.

During the reporting period, over one-third of the participants completed the COIN program in good standing, with far fewer expelled or discharged for contract noncompliance. These rates reflect not only the effectiveness of the program, but the ability of COIN to retain participants over time. Worrisome is that many nurses who could benefit from the COIN program are not accessing these services. Almost 25% of nurses referred either never arrive for first visit or do not return following the initial visit. Further, it is estimated that there are 5500 RN's, LVNs and NPs working in DC, yet only 71 have been referred to the COIN program in the past 12 years (0.01%). Strategies to increase case identification and referral to COIN are needed to ensure that impaired professionals receive effective treatment.

CONCLUSION

Health professionals are as likely those employed in other sectors to develop and suffer from substance use disorders, although the progression and impact of these are somewhat unique due to the environment in which they practice and the vulnerable patients for whom they provide care. Alternative-to-discipline or diversion programs offered at the state level provide nurses with substance use disorders an opportunity to receive treatment, recover, and eventually return to work. Data from the DC COIN indicate that the program has been effective, but low rates of utilization suggest that many impaired nurses in the district remain unidentified and therefore undertreated.

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Continued on page 18

FREE COURSES ON PRESCRIBING OPIOIDS AND MEDICAL CANNABIS

The DC Department of Health offers free Continuing Medical Education (CME/CPE) to DC nurses, physicians, pharmacists, and physician assistants through the DC Center for Rational Prescribing (DCRx). **(Nurses in DC can use CME to satisfy nursing continuing education credits.)** The two newest modules about opioids focus on practical tools for counseling patients about opioids as well as the history of opioid promotion and prescribing. Nine CME credits are currently available, with more modules on the way. Other modules address prescribing in older adults, medical cannabis, and myths and facts about generic drugs. Please take advantage of this free CME—the District is the only jurisdiction in the country providing this service.

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Continued from page 17

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FREE COURSES ON SUBSTANCE USE DISORDER

Free for Nurses and Nursing Students

The National Council of State Boards of Nursing is providing the courses "Understanding Substance Use Disorder (SUD) in Nursing" and "Nurse Manager Guidelines for Substance Use Disorder" **free of charge for all nurses and nursing students.**

The toolkit, including brochures, posters, a book and two continuing education (CE) courses, was developed to ensure that nurses are armed with the knowledge to help identify the warning signs of SUD in patients, nurses and the general public and provide guidelines for prevention, education and intervention. In addition, the toolkit includes the "Substance Use Disorder in Nursing" resource manual, the "Substance Use Disorder in Nursing" video, prevention-focused posters for health care facilitates and two brochures, "What You Need to Know About Substance Use Disorder in Nursing" and "A Nurse Manager's Guide to Substance Use Disorder in Nursing."

All of these resources are available free of charge from **www.ncsbn.org**. Both CE courses award contact hours upon successful completion. Register for the courses at **www.learningext.com**.

CONTACT COIN

If you are a **Trained Medication Employee, Home Health Aide, Certified Nursing Assistant, LPN, RN, or APRN** whose practice is unsafe due to drug or alcohol dependence, or mental illness, please feel free to contact Concheeta Wright, Nurse Specialist II, by email at **concheeta.wright@dc.gov**. The purpose of the COIN (Committee on Impaired Nurses) is to provide an alternative to Board discipline. The Committee monitors the recovery of participants and their practice to ensure that they practice within acceptable standards of care. All information about the participants in the program is confidential.

Attention:
DC Nursing Assistant & Home Health Aide Training Programs

PLEASE BE INFORMED REGARDING UPCOMING CHANGES IN THE NURSING ASSISTANT AND HOME HEALTH AIDE EXAMINATION PROCESSES IN THE DISTRICT OF COLUMBIA BEGINNING DECEMBER 7, 2016.

GENERAL INFORMATION FOR BOTH NURSING ASSISTANTS AND HOME HEALTH AIDES:

Although the National Nurse Assistant Assessment Program (NNAAP) exam is not electronic, the registration and scheduling of the exam will be. **Pearson VUE and the Department of Health are excited to announce that effective December 7, 2016, District of Columbia nurse aide and Home Health Aide candidates will be able to register online and schedule their own examination(s).**

Online Application Registration will:

- Eliminate the transit time associated with mailing a paper application to the American Red Cross
- Decrease the time it takes to get scheduled for an exam
- Avoid delays in scheduling due to illegible or incomplete applications – i.e. deficiencies
- Support efforts to reduce paper and take advantage of technology

Please be advised that as with all changes, there may be some concern but the advantages far outweigh the perceived disadvantages. All students will need the following *2 things* before accessing the new system:

- **A valid email address.** If they don't have one now, it can be obtained free of charge from Gmail, AOL, Yahoo, MSN, etc.
- **A credit card.** This can be a debit card, a pre-paid card or other single-use card. It must be valid but may have another person's name on it – i.e. parent or significant other. This will be used to pay for their exam. In lieu of a credit card, electronic vouchers can be purchased by the training program.

TRAINING PROGRAMS:
Please share this information with your students so they have time to get what is needed.

SPECIFIC INFORMATION FOR HOME HEALTH AIDES:

A new Home Health Aide exam is being developed. In addition to the new exam itself, the ***delivery*** of the exam is also different. The Home Health Aide written exam will be taken online at a Pearson VUE Test Site. The date for the first exam and available test sites will be provided at the training session.

If a Home Health Aide candidate is required to take the Skills exam in addition to the Written exam (some HHAs will not be required because they are CNAs) the Skills exam will need to be scheduled separately and will take place at an approved test site.

HHAs can take their written examination in any Pearson Testing Center. The testing center in DC is located at:

TEST SITE
1615 L Street, NW Suite 410
Washinton, DC 20036
Metro: Red Line – Farragut North metro station is one block north of test center.

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(202) 373-0336
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If you or a colleague is in need of an Attorney to represent you before the D.C. Board of Nursing or FOR ANY OTHER LEGAL MATTER, Call a Nurse Attorney for a confidential consultation.

Please contact Izu I. Ahaghotu, RN, Esquire directly:

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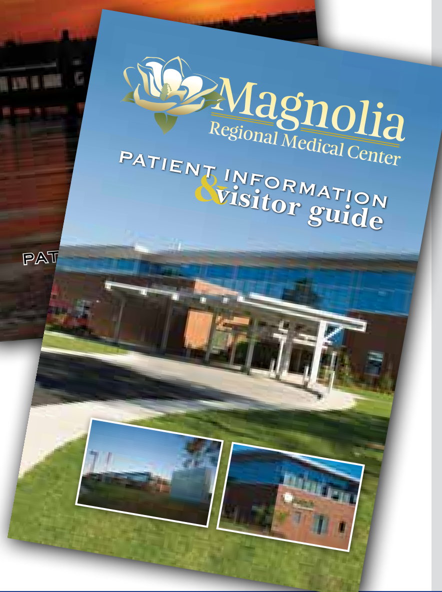

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2016 Nursing Leadership Symposium

Just Culture: Ethical and Legal Practice

DOH Director LaQuandra Nesbitt, MD, MPH

In the Summer of 2016, the Board of Nursing sponsored a symposium for nursing leaders on the topic of "Just Culture: Ethical and Legal Practice." Department of Health Director LaQuandra S. Nesbitt, MD, MPH, opened the program and affirmed DOH's commitment to health equity, health literacy and cultural competence.

Dr. Nesbitt noted that the principles of Just Culture compel us not only to identify medical errors, but to create systems that decrease those errors. Dr. Nesbitt also acknowledged the Board of Nursing's wide-ranging responsibilities in regulating professionals with varying areas of practice. The Board regulates individuals with a broad range of duties, skills and educational levels—from Nursing Assistive Personnel (NAPs), who may have had as little as 12 weeks of training, to advanced practice registered nurses who have 8 years of academic preparation or more. Maximizing the talents of our licensees is important, she noted, as is creating a career pathway to guide NAPs to BSN degrees.

Dr. Nesbitt also spoke about the urgent need for facilities in the District to contact the Board and report individuals with unsafe practice in order to safeguard the public. She noted the outstanding work of the Committee on Impaired Nurses (COIN), which provides an opportunity for individuals to self-report, but this does not absolve facilities' duty to report impaired practitioners, she said.

DOH's mission is to protect the health and safety of the public, and the mission of the Health Regulation and Licensing Administration (HRLA) includes fostering excellence in the health professions. HRLA Senior Deputy Director Sharon Williams Lewis, DHA, RN-BC, CPM, told attendees: "As nursing leaders, I truly respect the knowledge you have." She noted that nursing leaders are accountable for reporting unsafe practice and to take administrative measures within District facilities to reduce medical errors. "Let's challenge ourselves to think about policies and procedures, equipment, staffing, and coverage during change of shift."

SOCIALIZATION OF THE NEW NURSE

HRLA Senior Deputy Director Sharon Lewis, DHA, RN-BC, CPM

Speaker Sarah Vittone, MSN, MA, RN, spoke about "Professional Identity Formation: A Challenge for Nursing Organizations." When a new nurse arrives on the unit, she is socialized into a group of colleagues. Why is socialization important? Because nurses want to fit in. When a nurse is supported in developing a professional identity, as a professional with high standards, she or he will not be vulnerable to the influence of colleagues who cut corners and make remarks such as: "Just do it this way. We have been doing it this way forever."

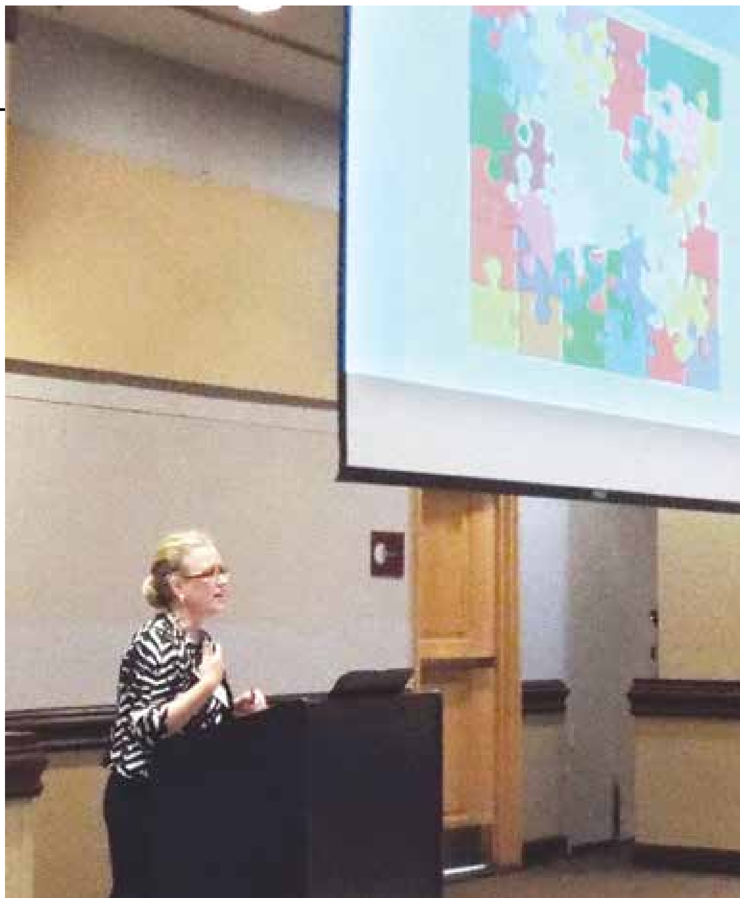
Nursing students must be supported by educators and later as nurses by their supervisors, to maintain a high level of professionalism and ethics despite any negative influences from peers. The development of the nurse is impacted by how strongly she or he is supported in her or his resolve.

Ms. Vittone noted that new nurses tend to follow all of the rules and make decisions intentionally. Those standards can be eroded if colleagues ostracize the nurse who is "too good." Ms. Vittone, an Assistant Professor at Georgetown University, and Primary Consultant at Pellegrino Center for Clinical Bioethics at MedStar Georgetown University Hospital, said she seeks to raise the confidence of her nursing students, so their practice will not be swayed by peers.

FEEL THE CONFIDENCE

As a professor, she tries to ensure that her students develop a firm sense of self. She has her students give her a handshake. She requires a firm handshake and tells students to "feel the confidence."

"We should be role-modeling responsibility and authority. Are we helping the new nurses to become advocates? Don't do something against your own set of values." In addition to her handshake test, as part of her students' training, Ms. Vittone has someone enter the room with the student and make an



Speaker Sarah Vittone, MSN, MA, RN

inappropriate comment, to see if the student (or nurses present) will speak up. Will anyone take the offending individual aside and say 'I feel uncomfortable with that comment' or 'That is inappropriate, even if the patient is asleep'?" The ultimate goal is to create powerful nurses, she said.

THAT IS NOT MY PRACTICE

Micro ethics are the little comments made throughout the day, such as "oh, you don't need two gloves for that." We must empower the nurse so she or he can maintain their high ethics. Ms. Vittone told attendees, "I made my students say 'That is not my practice', so they will be prepared for ethical challenges.

WHAT NURSING LEADERS CAN DO

"The nurse who follows all of the rules may be the socially awkward nurse who does not fit in with her peers," Ms. Vittone said. "Other nurses may target her as being 'too good' or say 'she's trying too hard'." But how long is the good nurse going to stay? The so called "goodie-goodie" nurses provide quality care. Does the nurse who follows all the rules feel embraced as a nurse? Does nursing leadership address micro-ethic problems in unit?

"What is the piece that organizations bring to new staff to allow them to fit in?" How can we ensure that socialization into the existing group does not adversely affect a nurse's practice?

STRATEGIES FOR NURSING LEADERS

- **Increase Professional Socialization (Validate)**
  Institute an informal "chat and chew" time, a safe place where nurses can discuss their practice concerns and ethical dilemmas is an effective tool for change.
- **Address Microethical Problems in the Unit**
  Little things happen through the day. A colleague may say, "Oh you don't need two gloves for that." The nurse should feel empowered to say "That is not my practice."
- **Manage First-year Experiences**
- **Rehearse Empowerment**
- **Reduce Incivility**
- **Compensate and reward for expertise, certification.**

A SAFE PLACE TO SPEAK OUT

Many individuals do not report errors or lapses in safe practice. They deliberately turn a blind eye to the situation. Perhaps medications are given off schedule, or a nurse records in the record before the meds are given. Few people want to be the one person who deviates from how things are done.

The cycle of "not seeing" can be broken if nurses are supported and encouraged to speak out. Nursing students need support from their professors in the academic setting, nurses need support from their supervisors in the workplace. Supervisors should create a safe space, such as a "chat and chew" where nurses can discuss micro ethics and errors on the unit. These discussions should take place beyond the required routine in-service program.

RETALIATION

Nurses who turn a blind eye to errors and unsafe practice may be doing so for fear of retaliation. Nurses should be encouraged to speak up, even if they see a minor mistake. The facility and the work environment should support nurses with high ethical standards, not work against those standards.

Nursing leadership must impress upon each nurse that their license belongs to them, not the other people trying to chip away at their ethical standards: "Only you hold your license, not your colleagues, not your spouse. No one holds your license but you."

ORIGINS OF PROFESSIONAL ETHICS

- Personal values
- Schooling about ethics
- What you learn over time in the workplace
- Insights gained from Continuing Education.

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A NURSE-ATTORNEY'S PERSPECTIVE

Speaker Nurse Attorney Izu I. Ahaghotu, RN, JD

"Nursing was my first love," speaker Izu I. Ahaghotu, RN, JD, told attendees. Ms. Ahaghotu now practices as an attorney, and represents nurses before the Board of Nursing. Ms. Ahaghotu said her job is to bridge the gap between an individual nurse and the Board of Nursing.

UNINTENTIONAL ERROR VS. RECKLESS MISTAKE

Ms. Ahaghotu said that 90 percent of errors that nurses make are honest mistakes; only ten percent occur because a nurse is being intentionally reckless. When she determines that the nurse has exhibited reckless behavior, she is honest with them, she says, and is not hesitant to say: "Maybe this is not the profession for you."

MITIGATE THE DAMAGES

Nurses who have made an honest mistake should be honest and admit the mistake. Supervisors should create a work environment that is amenable to this conversation. Nurses work in an ever-changing environment. There are constant budgetary, regulatory, technological, and political changes which affect nursing practice. In this environment, errors do occur.

Some individuals fail to acknowledge nursing errors because they don't want to cause embarrassment for themselves or others, they fear a lawsuit, or fear the Board of Nursing. If individual nurses and their institutions acknowledge mistakes, that acknowledgment can facilitate expedited actions to mitigate the damage and to properly document the error and the corrective actions. If the Board becomes aware of the incident at a later date, the Board members will want to see that something was done to address the situation that caused the mistake.

WHY DO NURSES REMAIN SILENT WHEN ERRORS OCCUR?

"I don't want to be fired."
"I don't want to tell on the other nurse."
"I fear there will be retaliation."
"I don't want to get blackballed."
"I don't want to lose my license."

Leadership is needed so that nurses feel empowered to see and to address issues in a direct manner, instead of being afraid of the consequences of taking action. Symposium attendee Kate Malliarakis, who is Chairperson of the Committee on Impaired Nurses (COIN), noted that there is currently "a culture of turning your head, so you don't have to see."

IMAGE OF PERFECTION

The image that nurses have is one of perfection, Ms. Ahaghotu said, but that is a standard no human can meet. Nurses want to live up to that perfect image and may not want to report errors because they have failed to live up to the perfect image, but "it is okay to make a mistake. We are constantly trying to be what the public wants us to be: caring, competent, careful, and pure. We no longer wear white, but the perception is still the same." Ms. Ahaghotu urged nurse supervisors to tell nurses, "If you make a mistake, come to me."

"Have discussions with your nurses," she said. "As nursing leaders, you must create an environment that does not demand the total fulfillment of perfection. Nurses should be encouraged to report a mistake. They should feel that they can come to their supervisor, because eventually someone will find out [and the person who uncovers the mistake may be a Department of Health surveyor or an accreditor]."

Ms. Ahaghotu told attendees about the day when her own nursing ethics were tested. She described her day working at a Long Term Care facility: "I had forty patients. The other nurse told me 'you can't document as you go.' That day, I was there from 7:00 am to 9:00

pm. I did everything right—but I didn't go back." She only worked there one day because she said she knew it would have been just a matter of time before she began to cut corners.

THE ADMINISTRATION MUST PROMOTE JUST CULTURE

High ethics and identifying/discussing the occurrence of errors are key elements for making Just Culture work in the workplace. One attendee asked if Just Culture can work at the unit level, if it is not a policy of the facility. "That is difficult," Ms. Ahaghotu said. Just Culture starts from the top."

FEAR FACTOR

Are nurses afraid to report an error to supervisors? Are nursing supervisors afraid to report the termination of a nurse to the Board? There are many factors that feed the fear of reporting:

- Patient Lawsuits
- Board Actions
- Staff Retaliation

However, failure to disclose can only make the situation worse. Bringing the situation out into the open will allow you to look for root cause of an error.

Speaker Van Brathwaite, LLM, JD, BA

DUTY TO REPORT

Board of Nursing Attorney Advisor Van Brathwaite, LLM, JD, BA, directed attendees to a very important regulation—the Duty to Report: **"DC Official Code § 44-508 requires a facility to report to the Board the occurrence of: clinical privileges being reduced, suspended, revoked or not renewed; employment being involuntarily terminated or restricted, or voluntarily terminated or restricted while involuntary action is being contemplated, because of professional incompetence, mental or physical impairment, or unprofessional or unethical conduct."**

Facilities should contact the Board if the nurse has unsafe practice. Is the RN unsafe? Facilities should report if the unsafe practice could pose harm to patients. (Lesser issues, such as tardiness and rudeness to family members are not grounds for contacting the Board.) If you ask that a nurse not to come back to your facility due to unsafe nursing practice, the Board must be informed.

"The number-one role of Board is to protect the public," Mr. Brathwaite said, but the Board cannot do its job if it is not informed about those who pose a threat to the safety of vulnerable patients and residents.

SEXUAL ASSAULT

According to Mr. Brathwaite, some heinous news of unsafe practice only comes to the Board by happenstance: "In January 2015, a nurse sexually assaulted patients, but the Board was not informed and Board members did not find out until October 2015, when the story was covered on a television newscast," he said. The facility should have informed the Board months before. (see page 30.)

TIMELINES & FINES

"We are working on revising the regulations [to encourage facilities to report unsafe practice to health professional licensing boards]," Mr. Brathwaite said. "We are proposing that if the facility does not report [unsafe practice] in *up to 10 days*, the fine will be *up to* $10,000. It is hoped that this change will make it more likely that a facility will report to the Board. "If you think that fine is stiff," he said, "consider that the State of Virginia imposes fines up to $25,000, and that Florida imposes fines up to $250,000 when facilities fail to report."

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THE FACILITY HAS CONTACTED THE BOARD—WHAT HAPPENS NEXT?

Order to Answer (OTA): After the Board receives a complaint or report of unsafe practice, the Board sends an Order to Answer (OTA) to the nurse in question. The OTA delineates the allegations and asks the nurse for a response to the allegations.

Sanction Review: The Board of Nursing has a Sanction Review Committee comprised of the Board's investigator; attorney; and nurse specialist and/or executive director. The Committee reviews the nurse's response along with the complaint received. The explanation provided by the nurse may lead the committee to the conclusion that the incident need not be pursued further and the case may be closed. If the explanation is not sufficient or if the nurse does not respond, the committee may recommend disciplinary sanctions or refer to the Board. The committee reports to the Board.

Notice of Intent to Discipline (NOI): If the Board determines that it is warranted and a valid complaint, they may either invite the licensee to appear before the Board, or issue a Notice of Intent to Discipline (NOI) to the Office of the Attorney General.

Hearing: The accused may request a meeting with the Board to establish a consent order, in lieu of a hearing, or request a hearing; if the nurse does not respond, the Board will make determination regarding the disciplinary action based on the information provided.

Appeals: After the finding of facts, the Board issues an Order. The licensee has 30 days to go to DC Court of Appeals to appeal the decision.

Final Order: Board issues a final decision.

Reconsideration: The nurse may ask the Board for reconsideration of the case.

Settlement: Settlement conference may be scheduled with the respondent, their attorney, and Board.

A Negotiated Settlement Agreement is established if they agree to comply with the agreement.

COURAGE

Having the courage to say "That is not my practice" is an essential piece of the puzzle, according to speaker Karen McCamant, MSN, RN, ACNS-BC, Director of Excellence in Nursing Practice and Education at Sibley Memorial Hospital.

Speaker Karen McCamant, MSN, RN, ACNS-BC (left) and Board Chair Cathy Borris-Hale, RN, MHA, BSN.

IMPORTANCE OF ETHICS

Why is ethical judgment important to nursing? "Nursing is a knowledge profession, not a cookbook," speaker Karen McCant told attendees. Since we can't possibly have a procedure for every scenario, ethics guide nurses as they practice.

DRUG DIVERSION

In the last year, Ms. McCamant's facility discovered cases of drug diversion and responded appropriately. In response to drug diversion at Sibley, the nursing leadership reported six nurses to the Board of Nursing for medication diversion. In Open Session of a Board meeting in 2015, Ms. McCamant said, "Board Executive Director Karen Skinner graciously commended Sibley for our surveillance processes, diligence and integrity in reporting."

Ms. McCamant notes that when a nurse makes a sudden departure—a resignation without notice—this precipitous resignation should raise red flags for possible drug diversion. "Please let the Board know if a nurse suddenly resigns."

ENABLERS

"Nurses are often enablers," she said. "As a profession, we must understand that enabling problematic behaviors in our colleagues is not the compassionate approach. The best interest of our patients must always be at the heart of any decision to report a nurse to the Board." Ms. McCamant noted that when reporting to the Board, language should be clear and uncluttered by adjectives. You should

HOW TO CONTACT THE BOARD OF NURSING

There are several ways that you can contact the Board of Nursing:

- Print out the DOH Complaint Form at **http://doh.dc.gov/node/991552** and fill it out and email to **dc.bon@dc.gov** or mail it to the DC Board 899 North Capitol Street, NE, Washington DC 20002
- Call the Board at **(202) 724-8800**
- Call the COIN program at **(202) 724-8870**

WHAT TO REPORT TO THE BOARD

Report a Nurse to the Board:

- If the nurse's actions are unsafe practice or put patients/residents in danger.

Do not report the Nurse to the Board:

- If a nurse was fired because she was late for work.
- If a nurse was fired because she or he was rude to a family member.

THE BOARD OF NURSING'S GOAL

Board Vice Chairperson Chioma Nwachukwu urged nursing leaders to keep the Board informed about unsafe practice. "Our mission is not to take away the nurse's license. The Board may require the nurse take classes with coursework which addresses the weak areas in their practice. The Board's goal is to protect the public, not destroy the nurse."

DC Board Vice Chair Chioma Nwachukwu, DNP, PHNCNS-BC, RN

not say there is "compelling" evidence or "significant" amounts, as the words do not provide any precise information.

"The Board has been a resource for us regarding whether to report," she said. A facility can call Executive Director Karen Skinner to discuss an incident to gauge whether it is something that should be reported to the Board.

HAVE ETHICAL QUESTIONS? HELP IS AVAILABLE

Need help with ethical dilemmas? Contact Felicia Stokes, JD, RN. The Senior Policy Advisor for the Center for Ethics and Human Rights with the American Nurses Association, Ms. Stokes areas of expertise include bioethics, nursing ethics and substance abuse in nursing. "Nursing practice has not changed, but ethical dilemmas have," she told symposium participants. Nursing leaders with ethical questions may contact the Center for Ethics at the email address **ethics@ana.org**.

Felicia Stokes, JD, RN

TRICKLE-UP ETHICS

Ms. McCamant stated that, although Just Culture is established by a facility's organization, it is possible for high ethical practice to trickle up: "As a student, I would not work without gloves. When I left the facility, the nurses told me 'I am so glad you came here; now we wear our gloves!' Gloves were new back then."

Nursing Symposium Coordinator and Board of Nursing Education Nurse Specialist Bonita Jenkins, EdD, RN, CNE.

BLAME-FREE VS. ACCOUNTABILITY

During the program, Board of Nursing Chairperson Cathy Borris-Hale noted that Just Culture is not about being blame-free, it is about accountability. You are harming patients because you don't have the courage to report. "There are two types of nurses—new ones and those that were once new. We must give the new ones courage."

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Left to right: Chairperson of the COIN committee Kate Malliarakis, PhD, ANP-BC, MAC, FAAN; former Chairperson of DC Board JoAnne Joyner, PhD, RN; current Chairperson of Board Cathy Borris-Hale; RN, MHA, BSN; former Chair of the Board Connie Webster, PhD, at leadership symposium.

THE BOARD AS A RESOURCE

Not sure if you should refer the nurse to the Board?

Nursing supervisors should contact the Board if they need help determining if the situation warrants submitting a report to the Board.

The Board can help nursing supervisors determine if the error is an indicator of a systemic problem rather than an error caused by unsafe practice.

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JUST CULTURE PRINCIPLES

Discipline needs to be tied to the behavior of individuals and the potential risks their behavior presents more than the actual outcome of their actions.

Just Culture:

- Places focus on evaluating the behavior, not the outcome;
- Requires leadership commitment and modeling;
- Distinguishes between normal error, unintentional risk-taking behavior and intentional risk-taking behaviors;
- Fosters a learning environment that encourages reporting of all mistakes, errors, adverse events, and system weaknesses (including self-reports);
- Lends itself to continuous improvement of work processes and systems to ensure the highest level of patient and staff safety;
- Encourages the use of non-disciplinary actions whenever appropriate (including coaching, counseling, training and education); and
- Holds individuals accountable for their own performance in accordance with their job responsibilities but does not expect individuals to assume accountability for system flaws over which they had no control.
- *Encourages discussion and reporting of errors and near misses without fear of retribution. It is a culture that focuses on the behavioral choices of the practitioner, not merely the fact that an error occurred or that a bad outcome resulted from an error.*
- Recognizes that perfect performance is not something that can be sustained, and errors will occur. It recognizes that the threat of disciplinary action does NOT prevent individuals from making errors.

In a "Just Culture," there is agreement that even the most experienced and careful nurse can make a mistake that could lead to patient harm. There is recognition that nurses will make mistakes and that perfect performance is impossible.

"Just Culture" is not a "blame-free" response to all errors. It focuses on the behavioral choice of the nurse, the degree of risk-taking, and whether the nurse deliberately disregarded a substantial risk. It holds the nurse accountable who makes unsafe or reckless choices that endanger patients.

Source: The principles of Just Culture were developed by engineer/attorney David Marx, JD, president of Outcome Engineering. To read his seminal paper "Patient Safety and the 'Just Culture": A Primer For Health Care Executives", go online at: **https://psnet.ahrq.gov/resources/resource/1582** or **http://www.safer.healthcare.ucla.edu/safer/archive/ahrq/FinalPrimerDoc.pdf**

Kudos!

Erin Bagshaw

Congratulations to **Erin Bagshaw, NP**, who opened the first Nurse Practitioner primary care and travel medicine practice in Washington, DC, Northwest Nurse Practitioner Associates. Ms. Bagshaw has been invited to join the International Women's Forum, a global organization that advances leadership across careers and cultures. The International Women's Forum is the only organization of its kind in the world today, representing women leaders in diverse fields whose mission is to further dynamic leadership, leverage global access to and maximize opportunities for women in 33 countries on six continents. She is the first in her profession to be invited to join the Forum.

Congratulations to Board of Nursing Chairperson **Cathy Borris-Hale, MHA, BSN, RN**, who has been appointed to serve on the Marijuana Regulatory Guidelines Committee of the National Council of State Boards of Nursing. The charge of this committee will be to:

1. Develop model guidelines for the APRN authorization of marijuana in patient care.
2. Develop model guidelines for APRN, RN, and LPN care of patients using marijuana.
3. Develop recommendations for marijuana-specific curriculum content in APRN education programs.
4. Develop recommendations for marijuana-specific curriculum content in RN and LPN education programs.
5. Develop model guidelines for assessing safeness to practice of licensees who use marijuana.

Jonas Nguh, PhD, RN, (second from the left).

Congratulations to **Jonas Nguh, PhD, RN**, who has been elected as a Distinguished Scholar & Fellow of the National Academies of Practice (NAP). Dr. Nguh was inducted at a gala membership banquet in April 2016 in Baltimore, Maryland. Founded in 1981, NAP is an interdisciplinary, nonprofit organization, with membership, representing 14 health care professions, willing to serve as distinguished advisors to health care policy makers in Congress and elsewhere. Membership in the NAP is an honor extended to those who have excelled in their profession and are dedicated to furthering practice, scholarship and policy in support of interprofessional care.

Congratulations to Board of Nursing Education Nurse Consultant **Bonita Jenkins, EdD, RN, CNE** who has been appointed to serve on the Nursing Education Outcomes and Metrics Committee by the National Council of State Boards of Nursing. The charge of this committee will be to:

1. Establish a set of outcomes and associated metrics to recommend processes to assess nursing education programs.

- Review current literature on program approval metrics and their relevance to public safety.
- Recommend factors in addition to first time NCLEX pass rates that can be used to determine criteria for a legally defensible Board of Nursing's approval/ removal process.

Congratulations to **Board Vice Chairperson Chioma Nwachukwu, DNP, PHNCNS-BC, RN**, who has been selected to receive the American Association of Nurse Practitioners (AANP) 2017 DC Advocate Award for Excellence, which will be presented at the AANP National Conference in June 2017.

In addition, Dr. Nwachukwu was recognized her achievement locally a recent meeting of the Nurse Practitioner Association of DC (NPADC).

DISCIPLINARY ACTION

Board Public Orders
Available at https://app.hpla.doh.dc.gov/Weblookup

REVOKED

Cobbler, Ann Marie LPN1002900 (10/14/2016) – This LPN was referred to the Board due to a practice infraction and was placed on probation. Her license was later revoked based on a voluntary surrender affidavit predicated on the nurse having submitted to the Board false information in the form of an evaluation from a supervisor which the nurse knew to be false.

Gbuyiro, Adeyemi T. HHA4340 (07/27/2016) – This home health aide's certification was revoked based on a felony conviction for Second Degree Sexual Abuse of a Patient and a misdemeanor conviction for Threats to do Bodily Harm.

SUSPENDED

Hairston, Deborah CNA (06/29/2016) – This nursing aide's certification was suspended based on the allegations stemming from an incident whereby this nursing aide hit a resident in the chest and put her hands around the resident's neck after he had reached into her purse without authorization.

REPRIMAND

Mansfield, Deanna RN10324245 (11/13/2015) - This registered nurse's license was reprimanded for submitting a false test results in order to gain employment.

LICENSE/CERTIFICATION DENIED

Anderson, Tomeika (05/19/2016) – This applicant's application for certification as a home health aide was denied based on allegations that she knowingly filed a false certificate attesting to completion of 75 hours of "Home Health Instruction" when in fact UDC said no record of her attendance existed in the University's database.

Dillard, Bianca applicant (08/17/2016) – This applicant's application for certification as a home health aide was denied based on a felony conviction for grand larceny which is a crime of moral turpitude.

McLeod, Robin applicant (08/17/2016) – This applicant's application for certification as a home health aide was denied based on a conviction for theft which is a crime of moral turpitude.

Ex-Nurse Jared Kline Convicted of Sexual Assault

This past summer, former nurse Jared Kline was convicted and sentenced to approximately 4 years in prison for sexually assaulting patients in the emergency departments of George Washington University Hospital and Washington Hospital Center between 2013 and 2014.

For more see: "Ex-emergency room nurse sentenced for sexually assaulting patients" at https://www.washingtonpost.com/local/public-safety/ex-emergency-room-nurse-sentenced-for-sexually-assaulting-patients/2016/09/23/f18937d2-81cf-11e6-a52d-9a865a0ed0d4_story.html?tid=hybrid_collaborative_1_na.

Jared Kline

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