DISTRICT OF COLUMBIA

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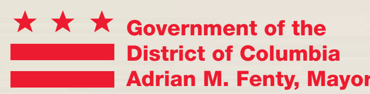
JANUARY 2009

NURSE

REGULATION EDUCATION PRACTICE

DR. RUTH LUBIC, DELORES L. FARR AND THE NURSE-MIDWIVES OF THE FAMILY HEALTH AND BIRTH CENTER



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Edition 21

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Celebrating Diversity in Nursing!

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On the Cover: Student Intern Chioma Nwachukwu, Nurse-Midwives Ebony Roebuck, Lisa Uncles, Lisa Ross, and Pediatric Nurse Practitioner Marcia Jackson-Hooper; seated are Ruth Lubic and Delores L. Farr of the Family Health and Birth Center in northeast D.C.

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.)

Farewell From Outgoing Board Member Deborah Thomas

I have served on the Board of Nursing since 2003. This level of advocacy has been rewarding and enlightening. It brings with it the understanding of your role as a professional nurse ultimately. I was on the board at a time when rapid changes were happening. I was involved in that evolution, and I was able to put my mark on the process. So it doesn't matter if I am done; I left my imprint.

Deborah Thomas, RN, BSN, CDE

This was an experience that leaves you knowing how important nurse empowerment and control of your practice is. It has to resonate from you with knowingness on all levels. We must be our own best advocate. Each nurse licensed in D.C. needs to know and understand the process, because what is decided here can alter your practice, how you are educated, and whether you and your family get professional nursing care.

So I have given my five years, what about you? This has been the best advocacy of all, and I, the mentor of all mentors, was mentored by the best. I thank the present members and past who helped me to serve the nurses and citizens of this city. I also would like to thank Karen Scipio Skinner and the staff of the D.C. Board of Nursing for such wonderful support.

Deborah Thomas,
RN, BSN, CDE

Welcome New Board Member Rachael Mitzner

The D.C. Board of Nursing welcomes a new board member, E. Rachael Mitzner, BSN, MS, RN. Originally from the New York area, Mrs. Mitzner received a Bachelor of Science in Nursing from the University of Bridgeport in 1969 and a Master of Science in Health Education from Southern Connecticut State University in 1994.

During the last 39 years, Mrs. Mitzner has worked in several different areas of nursing education. She began her career as an instructor in a hospital-based diploma program in Bridgeport, Connecticut. As a member of the Curriculum Committee and chair of the Education Committee, she worked to change a three-year system-based diploma curriculum to a two-year nursing-based curriculum which became associated with a university and allowed students to obtain an associate degree.

While pursuing her master's degree, Mrs. Mitzner worked in home care and long-term care as a nursing educator. She then became certified by the state of Connecticut and worked for the Bridgeport Board of Education as a school-nurse teacher in an inner-city high school for eight years.

In 1995, Mrs. Mitzner moved to Florida, where she held a variety of jobs both in long-term care and education. She worked as an instructor in an evening LPN program at Pinellas Technical Education Center. She was assistant director and then a director of nursing in a long-term care facility. She worked for Harborside Heathcare as the educational director of their Florida facilities and also for Rue Educational Publishers, writing and editing study materials for the Excelsior College Nursing Programs. While working for Rue, she rewrote and directed a video and wrote an accompanying workbook to prepare students for the Excelsior College Clinical testing. She also wrote a curriculum and taught weekend preparation classes for updating clinical skills for the practicum required for the LPN to RN program at Excelsior College.

E. Rachael Mitzner, BSN, MS, RN

In 2003, Mrs. Mitzner relocated to the D.C. area to marry her high school sweetheart. Since coming to Washington, D.C., Mrs. Mitzner has been working at Comprehensive Health Academy School of Practical Nursing. Her love of nursing and teaching has consistently led her back to educational settings. She is looking forward to serving on the Board of Nursing.

"I have always enjoyed making an impact on health care givers from CNA [certified nursing assistant] to RN," Mrs. Mitzner says. "If I can teach students at all levels to be mindful caregivers and prepare people who are not only qualified academically but are also caring, I have made a contribution to health care and to society. Serving on the Board gives me another opportunity to give back to the health care community. "

Board of Nursing Update

Board Actions: SEPTEMBER, OCTOBER, NOVEMBER

E. Rachael Mitzner, BSN, MS, RN, was welcomed as the newest Board of Nursing member.

Amy Filmore Nassar was elected vice-chair of the Board.

EDUCATION

Board members reviewed the accreditation status of all Practical Nurse and Professional Nursing Programs. [See page 10 for revised accreditation status.]

APRN

The American Nurses Credentialing Center and the American Psychiatric Nurses Association requested support from the Board regarding their plans to combine the Adult Psych Mental Health (PMH) CNS and the Adult PMH NP certification exams into one exam and eliminate the existing ANCC Adult PMH CNS and Adult PMH NP certification exams. The board supported the combining of the examinations.

CODE OF ETHICS FOR THE RECRUITMENT OF FOREIGN EDUCATED NURSES

The Board of Nursing endorsed "Voluntary Code of Ethical Conduct for the Recruitment of Foreign Educated Nurses to the United States." [See page 18] Dr. JoAnne Joyner represented the board as a member of the task force that created the code.

D.C. MEDICAL RESERVE CORPS

Beverly Pritchett, Senior Deputy Director for the Health Emergency Preparedness and Response Administration (HEPRA), the Medical Reserve Corps (MRC).

In preparation for the inaugural events, Ms. Pritchett met with the Board to ask for their assistance in recruiting District-licensed physicians and nurses to support the Inauguration Day festivities. The activities include staffing First Aid Stations and Roving Medical Units along the parade route and Inaugural grounds. DOH also provides emergency medical support at the inaugural balls and galas. Briefings and training is provided prior to the inauguration to help orient volunteers regarding their duties and responsibilities. Ms. Pritchett reminded members that persons signing up will be expected to participate as Corps members beyond the time of the inauguration events. [Story of the work of the corps will appear in the next edition of D.C. NURSE.]

REGULATIONS

As the board completes work on its revisions of the RN and LPN regulations, NCSBN convened a **NCSBN Uniform Core Licensure meeting**. The goal of the meeting was to address the following goals:

- *Assess individual member-board progress with the NCSBN Delegate Assembly-adopted UCLRs*
- *Become familiar with the external environment that is driving licensure uniformity and portability*
- *Identify other licensure variances that detract from the goals related to UCLRs*
- *Develop a consensus approach toward adopting UCLRs by boards of nursing.*

Board members agreed to await the outcome of this meeting prior to finalizing the revisions of the regulations.

Members of the public are invited to attend...

BOARD OF NURSING MEETINGS

Date: First Wednesday of the month

Time: 1:00 p.m. (Time subject to change)

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

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

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

January 7, 2009
February 4, 2009
March 4, 2009
April 1, 2009
May 6, 2009
June 3, 2009
July 1, 2009

♦ ♦ ♦

ATTEND BOARD MEETINGS

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

If you are interested in receiving the Board's Open Session Agenda, send your request to hpla@doh.dc.gov.

Regulation

IN THE KNOW

Your Questions, Your Opinions

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

NSAs and In-Home Care

Q Can a Nurse Staffing Agency licensed in the District send a nurse to an individual's home?

A Yes, they can. The law defines the client of the nurse staffing agency as follows:

Client – a health care facility or agency, or an individual, which enters into an agreement or a contract with a nurse staffing agency for the provision or referral of nursing personnel, Home Health Aides or Personal Care Aides. This allows you to enter into a contract with an individual to provide them with nursing personnel.

Substance Abuse/Mental Health

Q Can individuals under investigation be required to undergo evaluation for chemical dependency, physical and/or mental health related problems when "probable cause" exists?

A D.C. Official Code § 3-1205.14(b)(1) provides: "A board may require a health professional to submit to a mental or physical examination whenever it has probable cause to believe the health professional is impaired due to the reasons specified in subsection (a)(5) (Is professionally or mentally incompetent or physically incapable), (6) (Is addicted to, or habitually abuses, any narcotic or controlled substance as defined by Unit A of Chapter 9 of Title 48), and (7) (Provides or attempts to provide professional services while under the influence of alcohol or while using any narcotic or controlled substance, as defined by Unit A of Chapter 9 of Title 48, or other drug in excess of therapeutic amounts or without valid medical indication) of this section. The examination shall be conducted by one or more health professionals designated by the Board, and he, she, or they shall report their findings concerning the nature and extent of the impairment, if any, to the Board and to the health professional who was examined."

Nurse Staffing Agency Renewals To Begin January 5, 2009

Renewal of **NURSE STAFFING AGENCY LICENSES** will begin **January 5, 2009**. Nurse Staffing Agency Licenses will be renewed a year from date of issuance. Licenses that expire on February 28, 2009, will be able to renew their licenses beginning January 5, 2009.

The renewal fee: $500.00

You will be asked to update changes in the following information:

- ☐ Demographics including: Business name, web site, telephone number, e-mail address
- ☐ Contact Person
- ☐ Supervising Registered Nurse
- ☐ Owner/Operator of Nurse Staffing Agency
- ☐ Registered Agent (if applicable)
- ☐ Attorney-in-Fact or General Agent (if applicable)

Significant Policy and Procedure revisions

Complaints involving nurses licensed and practicing in D.C.

Criminal Background Checks

Q If I'm reading the draft revisions to the RN regs correctly, and if these regs are approved, is it true that the Criminal Background Check (CBC) and subsequent periodic checks apply ONLY to new applicants? Everyone else is grandfathered? (It's sad that this item even needs

to be considered. I'm not asking because I think it's a bad idea, but because the answer may have financial implications for our operation.)

A The intent is to require all initial applicants to have CBCs. We will eventually require all applicants to have a CBC. It is unfortunate that we have to do this, but it is necessary.

Q **For one of our nursing students, a Criminal Background Check report revealed a 2005 misdemeanor for Trespass. Disposition: Guilty. Fine: $607. Sentence: two days jail, three years probation, eight-hour theft course. The student would like to know if the sentence will stop her from taking the NCLEX. If there is any chance of that happening, she would like to change her major.**

A We would need to review her court records so that we will have more information regarding the circumstances of the case. You will also need to make sure the clinical sites will allow her to do her clinicals. Our concern is that, given the fact that she received a sentence, she may have been charged with more than trespassing. We, therefore, need to review the details of the case.

Follow up comment from questioner: **I contacted the student. She stated that she does not know if she has the copies of the court order. The case was either dropped or expunged. She will try to reach one of her family members to fax copies of the court order. No clinical site will allow her to attend clinical rotation if informed with the result. Last year, the**

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EOE/AA/M/F/D/V Drug-Free Workplace

hospital accepted two students/cases, but for this semester, we don't have any clinical unit at the hospital that will match her course requirements. My concern is: from students' comments, if the director of nursing will allow her to continue, it is our responsibility to be sure that she will be allowed to take NCLEX. If not, we will be responsible for the years and money she will pay (tuition/expenses).

A Our position is that it is the student's responsibility to determine whether or not he or she can be licensed based upon their CBC, not the school. We receive calls frequently from students about their ability to be licensed due to their criminal record. The student needs to contact the jurisdiction in which they plan to work. Boards have varying requirements.

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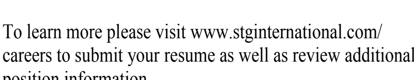
RNs L & D (Days/Nights) - Oak Harbor, WA
RN Practitioner- Locations: CA & TN
RN Manager- Rockwood, TN
RN Case Manager- San Diego, CA
Nurse Coordinator II- Washington, DC



To learn more please visit www.stginternational.com/careers to submit your resume as well as review additional position information.

STG is an EEO employer that offers a competitive compensation and excellent benefit package.

Practicing Abroad

Q I moved to the Congo, Africa, in September of 2006, where I am now volunteering feeding 100 malnourished children, but not using my licenses. My RN license is currently Paid Inactive, and my Nurse Practitioner license is expired.

1. **How long can I keep these two licenses as Paid Inactive and expired before I need to go back to work or do CEUs? (Can I continue not working for another 10 years and then return to work right away?)**
2. **Do I need CEUs? If so, how many and by when?**
3. **Do I owe money? I paid for these two licenses to be Paid Inactive and expired in August 2006.**
4. **At what point will I need to take a "refresher" course to work as an FNP again?**

A

1. A license can be in "Paid Inactive" status indefinitely.
2. To reinstate your APRN license, you will need to submit the required number of contact hours.
3. You will not be required to pay a fee until you reinstate your license.
4. You will need to contact your accrediting body to determine what you need to do to maintain your FNP certification.

Clinical Placements

Q I have a question about student clinical placements. We have a nurse practitioner student who needs to do a short clinical placement here at the university. He doesn't have a D.C. RN license but has a license in Virginia and Vermont. Is he permitted to do a clinical experience supervised by a physician and one of the nurse practitioner faculty without a D.C. license? He would probably be here for about three weeks.

A Yes, he can. The Board of Nursing's regulations state, "A student who is fulfilling educational requirements under § 103(c) of the Act, D.C. Official Code § 3-1201.03(c), may be authorized to engage in the supervised practice of registered nursing without a District of Columbia license."

Are APRNs RNs?

Q I received a call from one of our nurses, and she stated that because she is an APRN, she will not get a D.C. RN license – I guess because she will only get the highest license from the board? I just want to get clarification on this. When we staff her as an RN at our hospitals...they are going to want to see her RN license.

A Each nurse in the District receives either an LPN, RN or APRN license, no mor than one license. You cannot be issued an APRN license if you are not also licensed as an RN. You can staff her as an RN, but she will liable at the level of an APRN.

HIV Positive

Q Should a nursing student disclose his or her HIV status to a patient?

A There should be no reason for a nursing student to disclose his/her HIV status to a patient. I was the co-author of a policy for the State of Maryland Board of Nursing

(years ago); our charge was to develop an evidence-based protocol for how the Board would address HIV or HBV positive nurses in the workplace. It became clear after evaluating the many documents created by CDC [Centers for Disease Control] and others that nurses do not present any undue threat to patients in the performance of their practice. There may be issues for specialty areas (e.g. RN first assistant who may have their hands in someone's body cavity holding a suture needle).

Of course, nearly ALL of our nursing education programs have likely had students with HIV infection; we just never knew about it. The students often don't know their status. I had two of my colleagues from school who were diagnosed with AIDS in the 1980s. One was diagnosed in our final semester, and we worked with the college and hospital on exactly these issues before she was able to complete her clinicals and take the Boards. She worked as an RN for a couple of years before she died from her disease; she was a great nurse!

My greatest recommendation is that the nursing education program release that personal information ONLY to persons who would need to know it (very few would actually need that information), and be careful about accidental disclosure. As for the student, he or she should be advised to have a medical review from an HIV specialist (hopefully an APRN who is credentialed by the HIV/AIDS Nursing Certification Board) to assure that the student is not in a situation that would threaten his/her health (also, few and far between if usual precautions are taken). I would recommend the following resources: the Association of Nurses in AIDS Care (ANAC) and the HIV/AIDS Nursing Certification Board (HANCB).

Answer provided by R. Kevin Mallinson, Ph.D., RN, AACRN; PI, Nurses SOAR! Global HIV/AIDS Nursing Capacity Building Program; assistant professor, Department of Nursing; Georgetown University.

DC Board Begins Nurses Online Verification

Scheduled to begin January 12, 2009

The National Council of State Board of Nursing's Nursys® (www.nursys.com) computer system contains personal, licensure, education, verification and discipline information supplied as regular updates by boards of nursing in the U.S. and its territories. Nursys provides licensure verification and discipline status instantly, allowing for faster informed employment decisions. All boards of nursing, including non-licensure participating boards of nursing, have access to information within Nursys and are able to enter and edit discipline information. Nursys provides centralized license information to boards of nursing, which in turn, use this data to verify applicant license information, enter and review disciplinary actions and send electronic communications between boards of nursing for information requests. NCSBN also provides public access to Nursys for the purposes of licensure verification. Nursys verifies license and discipline status, including discipline against the privilege of working in a Nurse Licensure Compact (NLC) party state.

When a licensed nurse applies for licensure in another state, verification of existing or previous licenses may be required. A nurse can use Nursys to request verification of licensure from a Nursys licensure participating board. For example, the DC Board of Nursing licensure participates in Nursys; therefore, licensed nurses in DC can use Nursys for verifying licensure verification to another board of nursing by visiting www.nursys.com. If the nurse needs to request license verification from a nonlicensure participating board, the nurse should contact the board of nursing where she/he holds license.

Verification can be requested by completing an online Nursys verification request application (there is a $30.00 fee). Once verification has been processed, the verification information is available to all boards of nursing for 90 days. Multiple applications can be fulfilled by the same verification request and fee, as long as it is accessed by the board of nursing within the 90-day period. Nursys license verification is made available to boards of nursing immediately upon completion of the online verification process, which expedites the endorsement process for nurses. Employers can verify multiple licenses including all NLC party states within minutes.

For more information, e-mail NursysS@ncsbn.org, call 312.525.3780 or visit www.nursys.com.

Practical Nursing Programs

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

PROGRAM	CURRENT QUARTER 07/01/2008 - 09/30/2008 #Sitting	% Passing	YEAR TO DATE 01/01/2008 - 09/30/2008 # Sitting	% Passing	APPROVAL STATUS
Capital Health Institute	37	72.97	49	77.55	Conditional*
Comprehensive Health Academy	32	87.50	105	87.62	Full*
JC Inc.	14	85.71	72	65.28	Withdrawn
Radians College (formerly HMI)	21	80.95	74	78.38	Full
University of the District of Columbia	49	69.39	127	79.53	Full
VMT Academy of Practical Nursing	34	58.82	121	66.12	Conditional*

Professional Nursing Schools

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

SCHOOL	CURRENT QUARTER 07/01/2008 - 09/30/2008 # Sitting	% Passing	YEAR TO DATE 01/01/2008 - 09/30/2008 # Sitting	% Passing	APPROVAL STATUS
Catholic University of America	55	67.27	63	71.43	Full
Georgetown University	43	97.67	81	95.06	Full
Howard University	62	80.65	67	82.09	Conditional
Radians College	7	100.00	38	71.05	Conditional*
University of the District of Columbia	11	81.82	17	88.24	Full

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

The National Council of State Boards of Nursing (NCSBN) now provides the new "RN Test Plan" online at www.ncsbn.org. In the Test Plan, provisions are made for examinations reflecting entry-level nursing practice as identified in an empirical analysis of activities of newly licensed nurses. The activities identified in these studies are analyzed in relation to the frequency of their performance, their impact on maintaining client safety, and the settings where they were performed. These analyses guide the development of a framework for entry-level nurse performance that incorporates specific client needs, concepts and processes fundamental to the practice of nursing.

National Council of State Boards of Nursing seeks Volunteers. Development of the NCLEX-RN ® and NCLEX-PN® licensing examinations utilizes contributions from hundreds of nurse educators, clinicians and managers who work with entry level nurses. Volunteers are selected for three types of panels:

- Item Writing – Item writers create the items that are used for the NCLEX examination.
- Item Review – Item reviewers examine the items that are created by item writers.
- Panel of Judges – The panel of judges recommends potential NCLEX passing standards to the NCSBN Board of Directors.

If you are interested, please apply:
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Building Bridges with International Nursing Students and International Nurses

Souzan Druy, MPH, BSN

Interview with Souzan M. Hawala-Druy, MPH, BSN

by Nancy Kofie

Assimilation vs. Acculturation

Assimilation is when a person is completely converted to a new culture; one group is absorbed into another. This is accomplished by forcing the newcomer to change. **Acculturation** is the modification of a person's culture, behavior, beliefs, and values by borrowing from or adapting from the dominant culture (U.S. culture). This is done by choice.

Souzan M. Hawala-Druy, MPH, BSN, recently shared her insights with D.C. NURSE regarding the challenges which face international students, and some issues that can arise in the work environment when immigrant nurses are a part of the diversity mix. Currently, the Coordinator of Clinical Resources and Management at Howard University-Division of Nursing, Mrs. Druy also has taught a graduate course at the university on cultural diversity and social issues for students in the Family Nurse Practitioners Program.

Originally from Egypt, Mrs. Druy worked for six years as instructor at the Institute of Nursing, Ministry of Health, Alexandria, Egypt, and served as head nurse (supervising 12 nurses of nine nationalities) at King Faisal Specialist Hospital and Research Center, Riyadh, Saudi Arabia, for 18 years. A consultant for hospitals and nursing schools in the D.C. metropolitan area, Mrs. Druy offers great insights into the art of cross cultural understanding. In addition to her work at Howard University, Mrs. Druy lectures at area hospitals on the topic of culture clashes and how to facilitate better communication between international and American-born staff.

"I lived with Americans for 18 years [in Saudi Arabia], so I never felt the culture shock as much as some other people [who have immigrated to the U.S.]. Eighty-five percent of the staff and physicians, everybody are Americans," she says. "I saw Americans fighting with themselves, between white and black, with Filipinos from America. I knew the culture, how to differentiate between the ones from the South [and the North]…" For most people who immigrate to America, however, studying and working in an American cultural environment is totally new, and there are challenges.

Top Concerns of International Students and Nurses

Priority No. 1 for most international students is to **acculturate**, to blend in with Americans, and to **master the English language**. In addition to that, they worry about:

First Impressions: Students hope to make a good first impression with their professors and feel it will set the tone for the semester. When a professor asks the question, "What did you say?" this can make the student feel hesitant to speak out again, fearful that she or he made a bad first impression that will last the whole semester. Mrs. Druy says that a foreign-born nurse can feel like an outsider even if they have been here a while, and "every comment can hurt your feelings more than if you were born here and raised here. Our sensitivity is higher. When you move from your [home country] environment, you lose some of your self-esteem and self-confidence."

Communication and Self Esteem: International students can be deflated by critiques. If you cannot understand what a foreign-born student or colleague is saying, do not make a funny face and say, "What are you talking about?" This is the worse

thing you can do, Mrs. Druy says. The speaker may then lose self-confidence, then lose their train of thought, and that can lead to a momentary further loss of pronunciation and grammar. They will go on to make bigger mistakes because of the lack of confidence. Let the ESL (English-as-Second-Language) speaker know that you are not questioning their I.Q. Instead, you can say, "I know you understand English; I know you know how to communicate, but maybe sometimes the stress is making it difficult for you." You may ask "what did you say?", but do not use body language that indicates you are putting him or her down. "When you build up their self esteem, they will do much better."

Class Discussion: Instructors in other countries often lecture without class discussion, and students are often expected to sit silently. Students are not required to have read the material prior to class. Mrs. Druy says, "The professors back home give it to them on a silver plate, they give the summary of a summary of a summary." In the U.S., the student is expected to have read the material prior to class and to participate in active class discussions.

Exams: "Sometimes in the [nursing] exam," she says, "students will ask 'What is broccoli? What is sprouts?' They ask these questions because they are not used to those vegetables." There is an effort underway to delete such distracter words from the NCLEX exam (National Council Licensure Examination), Mrs. Druy says. It takes time and experience to learn all of the foods, culture, rules and expectations in the U.S.

Time Management: International students must sometimes adjust to this country's fast pace. In some cultures, it is rude to end a conversation quickly. If an international student is running late, he or she may find it nearly impossible to violate standards of etiquette if someone is engaging them in conversation. "They feel shy to tell you 'You know what, I have to go because I have an appointment.' They do not want to hurt the feelings of a friend or colleague," Mrs. Druy says. So, many international students must learn new standards for time management. [Mrs. Druy says, even now, she cannot bring herself to interrupt an elderly neighbor who is chatting, even if Mrs. Druy has something cooking on the stove that might burn.]

Rollercoaster: Immigrating to another country can have a rollercoaster affect on a person's life. The new comer may feel like an outsider, and every comment with a hint of negativity can feel devastating. The international person may feel that the pace of life in the U.S. is too fast or that Americans are too materialistic. Various family members in their home country may be pressuring the person to send money home. He or she may also find themselves in a higher or lower social class than they were in back home.

Juggling Tasks: According to Mrs. Druy, in their home countries, many students did not do so much shuffling of duties or multitasking as when they come to the U.S. Like U.S.-born students, international students may juggle school, parenthood and jobs. Back when they were still home, in their home country, they probably did not have these other additional responsibilities. They were just a student.

What it Means to Be a Nurse: In some cultures overseas, Mrs. Druy said, nursing care does not include establishing a personal rapport through small talk as in U.S. nursing practice. Also, in some other cultures, nurses are more similar to physicians—there is more hierarchy between the patient and practitioner—"you, the patient, are to do what I tell you to do." Mrs. Druy adds that in some countries, it is a stigma to be a nurse—being a nurse is viewed as being the lowest job you can do! You are taking care of someone's body, and in some countries, nurses traditionally did not have to be educated in science or math. "In the old days," she says, "it used to be like physicians would be like gods" and the nurses were more like health aides. Here and now in the U.S., "the nurse has to be responsible just as the physician is responsible."

"Everything": As new Americans, international students are learning "everything." All college students have a lot of coursework to absorb; international students also must learn everything from how to speak during class discussions and how to allow Americans their personal space, to how to act during a traffic stop. Mrs. Druy says one of her students got out of her car during a traffic stop and approached the police officer with her license in hand, as is the proper procedure in her home country. "The police officer was shouting 'Go back to your car!' Finally, when she saw him holding his gun, she immediately went back to her car and cried."

TIPS: If you are "American Born and Raised"

- Be patient with international students/nurses, and do not be condescending.
- Do not assume that she or he already knows the rules and norms of American life.
- Do not gossip about the person behind their back; if there is a problem, begin a dialog.
- Be open to listening to the international nurse's point of view; respect their culture; however, let them know when you must enforce the dress codes or other standards which affect patient care.
- In a non-condemning way, explain your point of view and the standards of your facility. Pinpoint the problem, then approach the subject with sensitivity. If a colleague is eating food that is highly spicy and the scent remains long after the meal, or the colleague uses hygiene products that are not adequate, explain the guidelines established by your employer. Some people are wary of American deodorant products—fearing that they cause cancer.
- If you hear an "angry" voice-tone used as a person speaks a foreign language, the speaker may not actually be angry or upset. That could just be the tone used when

speaking that language. If an inappropriate voice-tone is being used on the job, explain that the tone is unacceptable because it could be misunderstood by patients.
- African-American History: Be mindful that just because a person shares your skin color doesn't mean they have the same historical worldview. Back in their home country, your colleague may have lived through political upheaval or a civil war; but the topic of the U.S. Civil War and the issue of slavery may not resonate with them as it does for Americans. The immigrant nurse is not deliberately being "cold" in regard to this topic; it is simply a reality that she has not personally been touched by slavery (nor any family members, going back generations). Each country in Africa has its own history, political situation and language; they do not all speak English, and they are not African-Americans.

TIPS: If you are an International Student or Nurse

- Understand that if you are clear in your message, your accent and minor grammar mistakes do not matter. "Patients don't care if you say 'had' or 'has' or 'have,' Mrs. Druy says. "If you are not confident about your grammar or pronunciation now, that will come in time."
- If you do not understand an American word, slang phrase or idiom—please ask a colleague.
- If you would like to reduce your accent, get a mini-cassette recorder and practice speaking English. "Practice your pronunciation," Mrs. Druy says. "Listen to your recordings. Speak clearly and build your self confidence." Yes, please do keep you accent, she says, but concentrate on speaking clearly, with self confidence.
- Observe your colleagues' voice-tone (loud or soft? urgent or relaxed?), as well as body language, way of dressing, and how they interact with patients and with nurse-colleagues. Be aware of areas that may be a problem, and consider making adaptations to American culture to minimize violating the rules of your employer.
- Making eye contact is not considered rude in the U.S.; people will expect you to look them in the eyes when you speak.
- Keep in mind that frequent touching and hugging is not always acceptable in the U.S. workplace.

Generational Differences: Computer Skills, Research, Cheating

In an added complexity, Mrs. Druy says, we must take into consideration generational differences: "When you have nursing students of an older age, they are not the same as the younger students. If you have a student who came here young—like high school—he will do much better in college [in the U.S.] than someone from the same culture that earned two degrees in their home country." Older students tend to not have computer skills. They are not used to research. Mrs. Druy says she did not have to do research for her BSN degree in Egypt, not until she came to the U.S. to do her master's: "The kids now in high school in Egypt, they do research," but not in the past. "You need to differentiate between the generations. Some older students (who did not attend high school in the U.S.) feel that it is acceptable to share test answers or information with their friends. In the U.S., however, this "help" is unacceptable. It is cheating. A younger person will understand when you are trying to communicate the rules with them, whereas an older person from the same culture may think you are putting them down. Older students will not only study together, but then also help each other during the exam, she says. They don't consider this as cheating. They see it as helping a fellow colleague.

Acculturation NOT Always Best

We asked Mrs. Druy to give us an example of a medical practice that is considered normal in the U.S., but considered unacceptable in another culture. In the U.S., she says, it is common for a husband to be encouraged to be present in the labor and delivery room when his child is born so that he will feel connected with the baby. "In some cultures, the husband should not be in the delivery room," Mrs. Druy said. "That part of the woman's body cannot be exposed even in front of her husband."

Mrs. Druy provided an example of what could be called cultural coercion: "They [the American medical staff] pushed the husband to attend the birth, and it was a very bad experience… Respect and be understanding when someone says 'I cannot do that'," Mrs. Druy says. Be sensitive to that person's culture. You should only press an issue against another person's cultural preference if the American way of doing it is a necessity for better patient care.

Drawing the Line

Where do you draw the line between being "sensitive" to foreign cultures and mandating that American standards be adhered to? Mrs. Druy says you should express concern only if the person's actions are going to negatively affect patient care. If a husband awaits the arrival of his baby in the "Waiting Room" (instead of in the delivery room), he is not harming his wife or baby by his actions.

Overcome Silence

Silence can be the biggest barrier to cross-cultural understanding. The key to overcoming misunderstanding and building bridges is to openly discuss your feelings in a calm, non-judgmental manner. Explain why you found the other person's words or actions disconcerting. Many of us have been taught the Golden Rule: "treat others as you wish to be treated." But Mrs. Druy speaks of a more enlightened rule for nursing practice. "Some people don't want to

be treated as you want to be treated," she says. "Treat people the way they would like to be treated. Now, I don't talk about cultural competency, I talk about culturally-congruent care—when you tailor the nursing care to the patient's cultural needs with individuality in mind, because of diversity even in the same culture."

There'll Be Emotions—But Be Willing to Talk About It

Yet, despite her diverse work experience and her expertise on culture clashes, even Mrs. Druy can get caught in the currents of a culture clash. Mrs. Druy told us of an instance when she didn't speak to her American-born husband for ten days. He had casually compared her son (his stepson) to his dog because of the child's affectionate, fun personality and unconditional love. Mrs. Druy says, "I could not even explain to him" why that comparison made her furious. Words of misunderstanding can have a particularly harsh sting when the two parties have grown up on different continents, in different cultures, with differing ideas about what is offensive and what is not. In Mrs. Druy's culture, one simply cannot ever compare a child to a dog.

"Sometimes something positive in your culture can mean something negative in my culture," she says. "Culture clashes can come because of misunderstanding, not because we really mean to hurt each other. Be open to discuss it, not be too shy to ask. Express how you feel, but use the right words. There will be conflicts between nurses on the same unit or two nursing students in the same classroom. One may accuse the other of not having showered that morning. Maybe [he or she] did shower, but the kind of food prepared at home—the onion, the garlic, the way they cook the food—it will come out on your body smell. Or maybe the clash will be because someone's perfume is strong."

Although feelings may be hurt when a topic is brought up, Mrs. Druy says, open discussion can lead to resolution. American-born and international nurses can learn strategies for resolving culture clashes. American-born nurses can learn more about other cultures and expand on their ability to offer culturally-congruent care to a wider variety of patient populations. The international nurse can remind her colleagues that she is from a country with a specific history and culture outside of the U.S., and she can also pinpoint the areas where she may need to adapt to American ways: "After being here in the U.S. a while," Mrs. Druy said, "the international student (or nurse) will think about it and be open to change: 'Do I need to feel upset, or do I need to do something about it?'"

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BOARD OF NURSING COMMITTEE ON IMPAIRED NURSES

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The goal of COIN is to work with nurses to preserve their health and preserve their careers, with our ultimate goal being protection of the patient.

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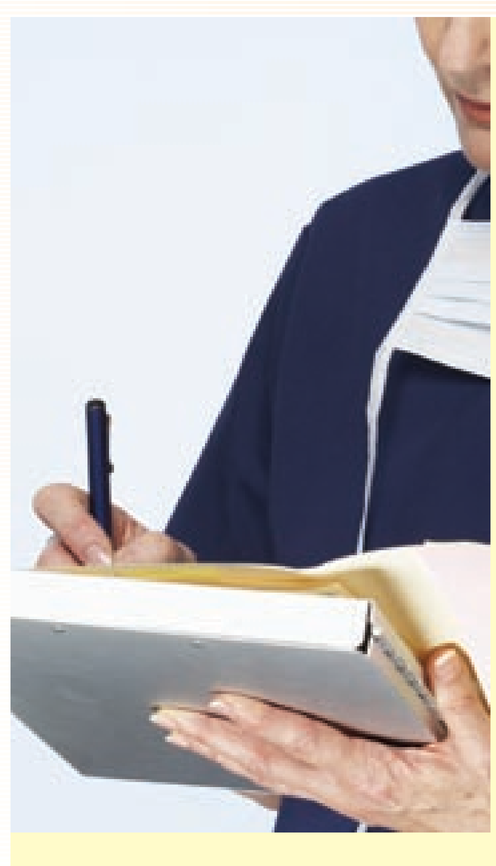
Kate Malliarakis

Chairperson



DC BOARD OF NURSING
Continuing Education Program

Defensive Documentation

Date: Wednesday, January 28, 2009
Time: 8:30 am Registration
9:00 am - 1:00 pm
Program Fee: No cost (Lunch will not be provided)
Where: United Medical Center Auditorium
(formerly Greater Southeast Community Hospital)
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PRE-REGISTRATION REQUIRED
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Please register by January 21, 2009
Seating is limited. Register early!

This continuing education offering has been approved by the DCBON 4 contact hours

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CONTINUING EDUCATION AUDIT TO BEGIN!

The Board of Nursing will begin auditing D.C. RN/APRN licensees for Continuing Education Compliance beginning in January 2009. If selected, you will be asked to provide evidence of meeting CE requirements by providing verification of completing 24 hours CE in any of the following options:

(1) Contact Hour Option
An applicant shall provide an original verification form signed or stamped by the program sponsor.

(2) Academic Option
An applicant shall provide proof of having completed an undergraduate or graduate course in nursing or relevant to the practice of nursing.

(3)Teaching Option
An applicant shall provide evidence of having developed or taught a course or educational offering approved by the Board or a Board-approved accrediting body. (This is not an option as the continuing education courses or educational offering is a condition of employment.)

(4) Author or Editor Option
An applicant shall provide evidence of authorship or editor of a book, chapter or published peer reviewed periodical if the periodical has been published or accepted for publication during the period for which credit is claimed.

PLEASE NOTE: Subscribers to CE Broker CE Compliance will not be required to submit documentation.

Voluntary Code of Ethical Conduct for the Recruitment of Foreign-Educated Nurses to the United States

Foreign-educated nurses (FENs) recruited to work in the United States are vulnerable to financial exploitation, unfair labor practices, and threats of deportation. A foreign nurse is often urged to sign a contract at a job fair, and then refused a copy of that contact. Foreign nurses are paid at a lower rate than their American peers and compelled to work excessive overtime, while being denied sick leave and health insurance. Some employers even retain custody of the foreign nurse's green card.

In an attempt to develop ethical standards for the recruitment of foreign-educated nurses, a task force comprised of stakeholders—unions, hospitals and health systems, and educational and licensure bodies—has published a Voluntary Code of Ethical Conduct for the Recruitment of Foreign-Educated Nurses to the United States.

What does the Code Cover? "The Code sets standards for ensuring that the rights of foreign educated nurses are protected, that the provision of clinical and cultural orientation programs for foreign-educated nurses is adequate, and that the practice of recruitment is not harmful to source countries." It calls for fair labor standards, civil rights, equal pay and occupational safety standards. The code's best practices for recruiters and employers outlines ethical conduct for an immigrant nurse's presentation and review of contacts and practical support for daily living. To review a print out of the full text of the code, go online at: **www.fairinternationalrecruitment.org**.

The D.C. Board of Nursing's past chairperson, JoAnne Joyner, Ph.D., APRN, BC, represented the Board as a member of the task force.

KEY COMPONENTS OF ETHICAL CODE

Recruitment and employment organizations that subscribe to the Code voluntarily agree to comply with specific minimum standards, as specified in Part I of the Code, and to strive to achieve the best practices, as described in Part II of the Code. Subscription to the Code also implies full cooperation with the monitoring system that will be developed by a representative Board of Directors.

Part I: Minimum Standards

Subscribers to the Code agree to:

I. Comply with the laws of any foreign country in which they operate, and comply with the laws of the United States, including relevant employment and immigration laws when operating in the United States.

II. Communicate and make representations to applicants in an honest, forthright, and accurate manner based upon available information.

III. Adhere to general principles of fair contract, immigration, and labor practices.

IV. Support FENs' transition, after arrival in the United States, into the U.S. work force so that the FENs are free to concentrate on their work.

Part II: Best Practices

I. Working jointly with local authorities in source countries to identify innovative and meaningful ways to ameliorate the impact of recruitment to local health care organizations and ensure the sustainability of qualified healthcare professionals in those communities.

II. Respecting agreements in which the FENs have contractual obligations to serve their home country health system in return for public education or scholarships provided in the source country.

III. Avoiding active overseas recruitment in those countries or areas within countries that are experiencing either a temporary health crisis during which health professionals are in dire need, or a chronic shortage of health workers.

Ageism & Nursing

by Barbara J. Hatcher,
Ph.D., MPH, RN, FAAN

"We tilt our heads back to use our bifocals. Our knees are bad, our feet flat, back out, and shoulders pulled. Sometimes, when we run to the desk to get something, we can't remember what it was we were running for by the time we get there. We are old nurses. But we still have something not found in the new nurse, something worth more than being swift; we have experience."— Kathleen MacInnis, RN, author, "To Old Friends: What if all the experienced nurses left?" American Journal of Nursing, 2003.

Under the Civil Rights Act of 1964, it is illegal to discriminate in hiring, promotion, and/or layoff. However ageism or age bias is pervasive throughout society and it is an especially important issue for nurses because the nursing workforce is aging rapidly. Also, the nursing workforce is made up primarily of women and research documents that women are affected more by ageism than men. The first director of the National Institute on Aging introduced the term *ageism* in 1969 to describe a form of bigotry directed toward those who are considered old. More recently it has been defined as a process of systematically stereotyping and discriminating against people based on age. When compared to racism and sexism, ageism has been described as the strangest. According to Rosalie Kane[1]," unlike racism, sexism, and homophobia, ageism represents a prejudice against a group that all members of the "in" group will inevitably join if they live long enough"

Ageism , she further contends, is comprised of negative stereotypes about our future selves.

According to the Wikipedia and other sources, ageism contains three inter-related mechanisms: (1) prejudicial attitudes toward older people, old age and the aging process attitudes (affective); (2) discriminatory practices against older people (behavioral); and (3) institutional policies and practices that perpetuate stereotypes about older people (cognitive). [2] According to Susan Letvak[3] and others, ageism is an ignored topic in nursing. While federal law bars age discrimination, older workers including nurses are increasingly facing age-related hurdles. Given the reality of a rapidly aging nurse workforce, the prevalence of ageist attitudes against older workers and increasing reports of age discrimination by nurses, it is important to better understand this issue.

The U.S. Context

In our youth-oriented society, being "old" is an un-cherished stage of life because it most often connotes deterioration. However, the average age of retirement is extending rapidly because of several key factors: the raising of the full or normal retirement age from 65 years of age with a notable impact on baby boomers whose full retirement age is between 66-67 years of age; increased life expectancy and overall better health; rapidly shrinking nest-egg reserves, further heightened by the country's recent economic downturn and an increased cost of living. As a result, many "boomers" are staying in the workforce longer or re-entering the work force.

More importantly, the size of the workforce between ages 30-49 will shrink by 3.5 million by 2015 and by 2015 there will be 16 million additional workers over the age of 50 than there are today. Currently, the median age of all workers is 40 and by 2012 nearly 1 in 3 workers will be 50 years of age and older and by 2020, the number of workers 55 years of age and older will increase by 80% to more than 33 million. Further, from 2005-2025, there will be no growth in the native born workforce 25-54 years of age. So the U.S. workforce is shrinking and there will be fewer potential workers to replace the baby boomers.

The Nursing Context

The nursing population is aging more rapidly than the workforce as a whole. From 1983 to 1998, the number of working nurses younger than age 30 decreased from 30% to 12%, whereas the number of people in the U.S. workforce younger than age 30 decreased only 1%.[4] The average age of RNs in the United States has increased substantially from 37.4 years in 1983, to 41.9 years in 1996; 44.5 years in 2000. The average age of the US workforce as a whole increased only two years during this same time period.[5] Currently, the average age of a nurse is 47 years old. By 2010, approximately 40% of the US nurse workforce will be over 50 years of age. [6]As stated for the US as a whole, the nursing workforce is aging and shrinking and there are fewer potential workers to replace the baby boomers.

Barbara J. Hatcher, PhD, MPH, RN, FAAN, is Director of the Center for Learning & Global Public Health at The American Public Health Association and http://www.apha.org/ Secretary General of The World Federation of Public Health Associations.

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[6]The Registered Nurse Population: Findings from the 2004 National Sample Survey of Registered Nurses, 2005, US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, http://bhpr.hrsa.gov/healthworkforce/rnsurvey04/ (accessed 1 November 2008)

Myths and Realities of An Older Workforce

by Barbara J. Hatcher, Ph.D., MPH, RN, FAAN

There is disagreement about the significance of age bias. Many reliable sources believe that age bias in its most subtle forms is increasing. Negative stereotypes about people over 50 are imbedded in our culture. According to one source, employee opinion surveys indicating that 65 percent to 70 percent of older workers experience bias are contradicted by employer claims of older workers' misperceptions and exaggerations. [7] Further, employers are three times more likely than employees to believe that age bias is declining.

Research suggests that many myths about aging affect older workers, including older nurses. Older nurses are often accused of receiving higher salaries and benefits, having reduced speed and efficiency, being less flexible and adaptable, being less productive and unable to learn new technology. Employers are concerned about the cost of older workers' total compensation and training.

While chief executive officers of hospitals and other health care organizations, including public health, report substantial vacancies, few systematically consider the aging work force, and many exhibit ageism. For example, employers are concerned that older workers, including nurses want to "coast" to retirement, are rigid or set in their ways, do not mesh with younger team members, and are not technologically savvy or current with industry trends. Employers also support early retirements and layoffs that substantially impact older workers with the thought of reducing personnel costs in their organization. Few consider the impact on organizational performance.

However, research on aging documents the following:

1. Chronological age is a weak predictor of capacity for productive performance.[8]
2. Older adults have the physical and mental capabilities to perform all but the most physically demanding tasks, and they have the ability to learn new skills.[9]
3. Individuals maintain stable intellectual functioning well into their seventies and beyond.[10]
4. Performance does not decline with age.[11]
5. Many older workers are ready, willing and able, and willing to continue working longer than previous generations.[12]
6. According to the AARP, while leisurely pursuits, fun, and time with family and friends still dominate people's images of retirement, pre-retirees envision a retirement that includes at least some form of work. Fewer than half (48 percent) define retirement as a chance to stop working for pay completely."

The Business Case for Older Workers

The experience of age-friendly workplaces document the following about older workers:

- Higher return on investment through reduced turnover and replacement costs
- Safer and more effective environment by reducing negative patient outcomes
- Improved decision-making and knowledge retention by capitalizing on the wisdom of nurse experts
- Decreased on–the-job injuries and absenteeism.

Conclusion

Given the shortage of nursing, fewer younger nurses to hire, and the social and economic conditions influencing older nurses to stay on the job, it is time to eliminate age bias. If older nurses remain in the work force beyond normal retirement age, even part-time, some of the pressures facing health care facilities in terms of maintaining patient safety and quality care would be mitigated. Nurses must help organizations place a higher value on experience by increasing their understanding of the impact of losing most of its intellectual capital and institutional memory. Nurses must advocate for age-friendly workplaces such as those recognized by the AARP and promote best practices for attracting and retaining older nurses.

[7] Boomers to Bust Age Bias. Electronic Recruiting News, (22 November 2006). http://www.interbiznet.com/archives/061122.html (accessed 1 November 2008).

[8]. H Sterns, A Sterns, "Health and employment capability of older Americans," in Older and Active: How Americans Over 55 Are Contributing to Society, ed S A Bass (New Haven, Conn: Yale University Press, 1995) 117-135.

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[10] W Schaie, "Intellectual development in adulthood," in Handbook of the Psychology of Aging, ed J E Birren, K W Schaie (San Diego: Academic Press, 1990) 291-310

[11] H L Sterns, S M Miklos, "The aging worker in a changing environment: Organizational and individual issues," Journal of Vocational Behavior 47 (Dec 1, 1995) 248-268.

[12] Towers Perrin. *Perspectives of Employers, workers, and policy makers in the G7 countries on the new demographic realities.* The Journal. Winter 2007.

"IT'S A CALLING" SAY THE NURSE MIDWIVES AT THE FAMILY HEALTH AND BIRTH CENTER

Contact Numbers:

Family Health and Birth Center	**(202) 398-5520**
Healthy Babies Project, Inc.	**(202) 396-2809**
United Planning Organization	**(202) 730-0004**
Developing Families Center	**(202) 396-2007**

Center Location:
801 17th Street, NE, Washington, DC 20002-7200

The Developing Families Center (DFC) is a non-governmental not-for-profit agency consisting of the Healthy Babies Project (HBP); the United Planning Organization Early Childhood Development Center (UPO ECDC); and the Family Health and Birth Center (FHBC).

A NURSE PRACTITIONER'S PERSPECTIVE

by Amy Filmore Nassar, MSN, FNP, Nurse Practitioner and member of the D.C. Board of Nursing

In 2007, I was happily pregnant and looking for the best prenatal care in Maryland, Virginia, or District of Columbia. As a family nurse practitioner for the past 10 years, I knew that my choice of obstetric provider would strongly impact my pregnancy and birth. During my second trimester, my husband and I interviewed doulas. Doulas, professionals who provide continuous physical and emotional support during pregnancy and labor, have been shown to reduce a pregnant woman's chance of cesarean section by 50 percent. All of the doulas we interviewed recommended the midwives at Family Health and Birth Center.

At the Family Health and Birth Center (FHBC), I learned that FHBC midwives "caught" babies at Washington Hospital Center and in their birthing rooms. I also discovered that the FHBC midwives had a cesarean section rate of less than 10 percent. My pregnancy care was outstanding – low on technology and high on education. My birth was a partnership of medicine and advance practice nursing. Despite my medically indicated induction, magnesium infusion, pitocin infusion, and restriction in motion, the FHBC midwives assisted me in a wonderful birth of a healthy baby girl. The FHBC midwives provided me the opportunity to have the birth my husband and I wished for.

I now also have the job I have hoped for. After my maternity leave, I started a new position at Developing Families Center. It is wonderful to work with three organizations providing essential education, resources, and health care to pregnant and parenting women. Healthy Babies Project (HBP) provides free pregnancy tests to women of all ages and free HIV tests for men and women under the age of 24. All women who have a positive pregnancy test at HBP are referred to FHBC – located in the same building – for prenatal care. Additionally, pregnant patients at FHBC who have suffered a prior pregnancy loss, who have a chronic medical condition or social challenges such as a lack of stable housing or education are referred to HBP – located in the same building. HBP assigns a nurse case manager or family support worker to assist these pregnant women with housing, government assistance, WIC enrollment, GED class enrollment, parenting education, free crib programs, and free car seat programs. HBP provides case management until the client's baby is 2 years old. The child development center located within Developing Families Center also gives priority to applicants who have given birth with FHBC midwives.

Come visit us, work with us, volunteer with us or give birth with us. FHBC accepts most insurance and pregnant women up to 38 weeks pregnant who are not in labor. HBP accepts clients who live in Wards 5, 6, 7, and 8 who are pregnant or who have given birth in the last three months. UPO cares for children 6 weeks old to 3 years old. FHBC is looking for a full-time pediatric nurse practitioner! Send your resume to uncles.midwife@gmail.com.

D.C. NURSE:REP SPEAKS WITH CENTER MIDWIVES
by Nancy Kofie

The Vision

The D.C. Developing Families Center at 801 17th Street in northeast Washington offers a comprehensive array of services—gynecological services, the personalized care of nurse-midwifes, pregnancy care, ability to give birth with nurse midwives in a birthing room or at a hospital, case management by nurses and family support workers, day care, teen programs, and fatherhood support. Enrolled family members can take classes in obtaining a GED and job-seeking techniques. Families are provided with access to social service assistance, crisis intervention, free immunizations, education in self-care, and home visitation. The staff makes every effort to address as many aspects of family life and wellness as possible.

Establishing this center was no easy task. In 1991, Healthy Babies Project founder nurse **Delores Farr** reached out to local police officials, barber and beauty shops, and went into drug treatment centers to find those in need of care and counseling. In 1998, **Dr. Ruth Lubic**, a certified nurse midwife, founded Developing Families Center after winning a MacArthur "genius grant." It took a lot of pounding the pavement, knocking on doors, educating the community about the value of midwifery, rallying residents, coaxing expectant mothers and fathers, and the tenacity to wage a three-year campaign (of gentle persuasion) to convince the Hechinger family to donate the building in which the center is housed. "Ruth Lubic is calling again," was a refrain often sighed by the administrative staff at the Hechinger offices. When Dr. Lubic founded the Developing Families Center, Healthy Babies Project became one of the three non-profit organizations in this new center.

"We specifically do outreach in Wards 5 and 6," they told D.C. NURSE:REP, but they will accept walk-in clients, regardless of the ward of the city they live in. According to Ms. Farr, "The purpose of joining together was to offer collaborative care. All services are free to enrolled families; our goal is to strengthen families." In 2000, the center's founder, Ruth Lubic, made her vision into a reality. The center houses three entities: The Family Health and Birth Center (FHBC), the Healthy Babies Project (HBP), and the United Planning Organization Early Childhood Development Center (UPO ECDC). FHBC provides advance practice nursing care in pediatrics, obstetrics, and gynecology. HBP provides nurse case managers and family support workers to at-risk pregnant women. These pregnant women are followed by case managers until their babies are 2 years old. UPO ECDC is a child development center for children 6 weeks old to 3 years old.

Birthing room at FHBC

DC Developing Families Center

The Midwifery Difference

The value of midwifery is in the stats.

Dr. Lubic says, "The time we spend with clients has made the difference. The midwives make it possible for the women to be expressive of their feelings. We have significantly reduced the disparities in infant mortality." D.C. used to have the highest rates of infant mortality in the country, but now the municipality which has this statistic is Memphis, Tennessee.

In the D.C. community, the center has proven that the availability of midwifery services mean more client control, and lower C-section rates, in addition to the lower rates of infant mortality. The C-section rate of FHBC patients is approximately 9 percent — much lower than the C-section rate citywide.

But what makes the center so magnificent is not the 15-room facility, but the staff. "I have the greatest admiration for these midwives," Dr. Lubic says. "It is not easy to function out of the hospital setting and in the hospital setting. For many people, there is a disconnect. They are not comfortable in both places."

Career Pathways

The nurse-midwives at the Family Health and Birth Center have come to their profession

from different career backgrounds.

Lisa Uncles, who is director of clinical services at the center, told us, "For a lot of us it is a second or third career." Ms. Uncles started her career as a chemist responsible for testing the public drinking water. She also worked as a bartender. When one of her co-workers invited her to a home birth, that experience was so profound, she decided to become a nurse-midwife. For all nurses considering a career as a nurse-midwife, Ms. Uncles offers encouragement and says, "We need you! And there is a great need for more midwives of color." Although the clients do love all of the midwives—no matter what color—having more minority midwives would help for the purposes of getting reluctant clients to come through the door.

Nurse-midwife **Lisa Ross** told us that the key to the success of the center is that the nurse-midwives each operate independent practices. "The Center brings cost-savings to the health care system," Ms. Ross says. It is "so much more fulfilling" than conventional care. "Working here is incredible," she said. "You get to watch the babies you deliver grow up" as they attend the center's child care program.

Nurse-midwife and self-described "midwife stalker" **Ebony Roebuck** is an ex-teacher who was so enamored with the profession of midwifery that she became a volunteer at the center even before she entered nursing school. "I believe so strongly in the profession—the empowerment of women. Our patients are becoming informed consumers as they are with us." And her enthusiasm is backed up by the data showing the worth of the midwifery services. Recalling a presentation the midwives did for the medical staff at Washington Hospital Center, Ms. Roebuck notes: "[Our C-section] stats spoke volumes." Because of her youthful look, Ms. Roebuck often meets clients who assume she is also a client. When they find out she is a midwife, they are pleasantly surprised.

The midwives of the center also deliver babies at Washington Hospital Center, in addition to within the warm, home-like birthing rooms at the center. No expectant mother is pressured to give birth at the center. If she would like to give birth at Washington Hospital Center she may. They also give referrals to OB/GYNs if the client would like one.

Family Health and Birth Center

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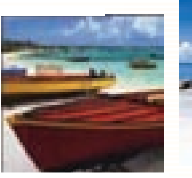

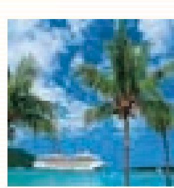

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Midwifery Rumors

Have you been thinking about a career as a nurse-midwife but have been discouraged by the rumors surrounding the profession? Perhaps you have heard midwifery is unsafe or that "you'll never get a job" or that "you'll never get malpractice insurance." All of these assertions are untrue, according to the midwives who spoke to D.C. NURSE:REP.

"Every other country [is accepting of midwifery] except for here," Ms. Roebuck told us. Traditionally, the medical establishment of the U.S. has been hostile to midwifery, but things are changing slowly but surely. Midwifery is slowly gaining more acceptance, despite the resistance. Dr. Lubic noted that the American College of Obstetricians and Gynecologists gave its endorsement to free-standing birth centers in February of 2008. "That only took 35 years," Dr. Lubic joked. When Dr. Lubic first became a midwife in 1960, few people were impressed with her choice of nursing practice, she said. Since then, she has dedicated her life to the profession (and garnered a "genius grant" from the MacArthur Foundation for her work).

When they first opened the center, Ms. Farr told us, a physician told her that having midwives deliver babies would lead to lawsuits. To which Ms. Farr replied, "Well, you might be sued, too." Since then, she says, a lot of the physicians who doubted the center have become friends as opposed to foes.

Other Staff

Amy Filmore Nassar came to the center as a patient and gave birth with the Family Health and Birth Center midwives at Washington Hospital Center. Ms. Nassar, who is vice-chair of the D.C. Board of Nursing, says in the hospital, the birth process can get out of [the patient's] control. "Midwives," she says, "empower women and their families to be more in control of their birth." Ms. Nassar is a nurse practitioner at the center.

In addition to benefiting from the expertise of nurse-midwives and nurse practitioners, the clients of the center also gain access to breastfeeding peer counselors and child development specialists. For mothers about to deliver, there is a doula on call 24 hours a day. (A doula is "a professional who provides continuous physical, emotional and informational support to the mother before, during and just after birth; or support during the postpartum period." [Source: www.dona.org]) The center also has a graduate-level intern from Catholic University: "I am at the Family Health and Birth Center in the capacity of a graduate nursing student, and Amy Nassar is my preceptor," says Washington Hospital Center nurse **Chioma Nwachukwu**. "The Developing Families Center has been an excellent site for my clinical rotation as a master's level graduate nursing student in Community and Public Health at The Catholic University of America. I am learning and seeing first-hand how this center is helping to meet the goals of Healthy People 2010 by addressing the needs of the vulnerable population of women and children in Wards 5, 6, 7, and 8. Having a wealth of inter-connected services and knowledge in one location helps to decrease the barriers to access and increases the continuity of care." *[Healthy People 2010 sets health objectives for the nation for the first decade of the new century. For more info, visit www.healthypeople.gov.]*

Nurse-midwife Ebony Roebuck with Cole, son of Healthy Babies Project Outreach Worker Timeka Murphy (who gave birth to Cole in one of Family Health & Birth Center's birthing rooms).

New Ground: Emotionally and Legislatively

The program structure is flexible, in that clients may gain access to any service offered

regardless of the particular service that initially brought them through the door. "A person can come in from any door," Ms. Farr says. "They might come in from the Birth Center. They might start from the day care and get pregnant and decide to give birth in the Birth Center." When working with the families, the staff seeks to break new ground with the fathers. At first, fathers tended to say that the center's services were "ladies stuff," but as the years have passed, more fathers have gotten involved in prenatal care and delivery. Ms. Roebuck enjoys bringing the fathers into the process: "I have the dads help me measure the belly, check the heart rate. We let dads 'catch'. Even the 'tough' dads. When they catch their babies, they are crying."

As a result of their success, the center has received many inquiries from other jurisdictions seeking to replicate their center in other cities all over the U.S., and in other countries as well. "There is a great deal of interest in replicating the [center model] from all over the country," says Dr. Lubic. "It is putting health care in its social context."

But before a center like this can be established in a jurisdiction, the nurse-midwives in that jurisdiction must be granted the means to operate independently. That autonomy came to District nurse-midwives through the District of Columbia Nurse Practice Act. Speaking with the center midwives, Board of Nursing Executive Director **Karen Scipio Skinner** noted that a major battle in changing the Nurse Practice Act was getting third-party reimbursement for Advanced Practice Registered Nurses without physician supervision. This ground-breaking practice act was enacted in D.C. in 1994. So, although many jurisdictions would like to replicate the center here in D.C., this may not happen unless there are legislative changes regarding nursing practice.

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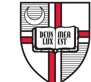

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District Ranks No. 1 for Providing Government Health Insurance

The District of Columbia Department of Health (DOH) has been cited for its success in providing health care to disadvantaged residents by the Foundation for Health Coverage Education (FHCE), a national nonprofit advocacy group. The District ranks No. 1 in the country with providing health insurance assistance to the uninsured. "People should have access to quality health care regardless of their social or economic status. In the District of Columbia, we have a long-standing commitment to providing, maintaining, and improving access to health quality health care. Providing broad equitable access to health insurance is a priority for us, so we are proud of the fact that the Department of Health has been able to provide health coverage for approximately one-third of the District's estimated 582,000 residents, many of whom would otherwise be uninsured," said Dr. Pierre Vigilance, director, D.C. Department of Health." The Foundation for Health Coverage Education cited data provided by the Kaiser Family Health Foundation (statehealthfacts.org) to identify how programs differ from state to state. The study showed that, of every state in the nation, the District provided the most generous subsidy for health care to its poor and indigent residents.

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Kudos!

Congratulations to D.C. Board of Nursing Member **Ottamissiah "Missy" Moore, LPN**. Missy has been elected President of the National Federation of Licensed Practical Nurses (NFLPN)!

Her goal is to help the organization grow and "go from good to great... What I hope to accomplish is to build membership through education and certification, LPN advocacy, student membership and mentorship, and to raise awareness of the LPN scope of practice," she says. She will serve a two-year term.

Congratulations to **Beverly Morgan, LPN**, who has been awarded a $2500 scholarship to attend the Wound Care Education Institute's (WCEI) wound care program and National Alliance of Wound Care's (NAWC) credentialing exam. The award was presented during the 2008 annual conference of the NFLPN. (For more info, go online at www.nflpn.org; www.wcei.net; or www.nawccb.org.)

Margaret Green, Beverly Morgan, Rick Garcia, Missy Moore, and Dr. Mary Ivey.

Congratulations to the following nurses for representing the District of Columbia in the NCLEX item development program: **Berle Allison Henry, RN**, Item Review Panel; **India M. Medley, PN**, Item Writing Panel; **Jacqueline Brewington, RN**, Item Review Panel; **Brenda N Millet, PN**, Item Review Panel.

Damon B. Cottrell, MS, RN, CCNS, CCRN, APRN-BC, CEN, of Washington Hospital Center, has been approved to serve as a member of the D.C. Board of Nursing's APRN Advisory Committee.

Ladan Eshkevari, RN, CRNA, MS, has been awarded the John F. Garde Doctoral Fellowship by the American Association of Nurse Anesthetists Foundation. Ms. Eshkevari is assistant director of the nurse anesthesia program and an assistant professor in the School of Nursing and Health Studies at Georgetown University. She is a Ph.D. candidate in physiology and biophysics at Georgetown. Source: *Nursing Spectrum* (www.nurse.com)

JoAnne Joyer, PhD, APRN, BC, outgoing chairperson of the D.C. Board of Nursing, is the newest member of the D.C. Board of Nursing's Committee on Impaired Nurses (COIN).

R. Kevin Mallinson, PhD, RN, assistant professor at Georgetown University School of Nursing and Health Studies, was recently selected as a Fellow of the American Academy of Nursing (FAAN). Mallinson currently serves as principal investigator on a $2.5 million grant to build nursing work force capacity in Africa related to HIV/AIDS, called Nurses SOAR! (Strengthening Our AIDS Response), which includes sites in South Africa, Lesotho and Swaziland. Source: Advance for Nurses (www.advanceweb.com)

Teresa C. Richardson, APRN, BC, of PNP Associates, LLC, (and a member of the Committee on Impaired Nurses) has been selected to serve as a Fellow in the Minority Fellowship Program (MFP) of the American Nurses Association for FY 2008-2009. The program's mission is to increase the number of rigorously educated nurses from under-represented ethnic minority groups to conduct research and assume leadership roles regarding mental health issues.

Barbara J. Hatcher, PhD, MPH, RN, FAAN, Secretary General of the World Federation of Public Health Associations was inducted into the American Academy of Nursing, as one of the 2008 new Fellows. She was nominated for this honor by two current Academy Fellows and was selected by the Academy's 15-member Fellow Selection Committee for her outstanding achievements in the nursing profession. Dr. Hatcher was formally inducted as a Fellow with 90 other nurse leaders during the Academy's Annual Awards Ceremony and Induction Banquet in Scottsdale, AZ. Dr. Hatcher is a former Chair of the District of Columbia Board of Nursing.

Barbara J. Hatcher, PhD, MPH, RN, FAAN

Board Disciplinary Actions

NAME	LICENSE #	ACTION
Adebowale Adefolaju	LPN7903	License revoked for five years
Yolanda Forte	LPN7018	License suspended for one year
Craig Smart	RN963671	License Suspended Indefinitely

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

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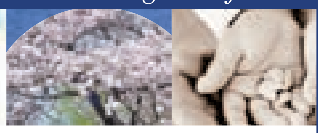

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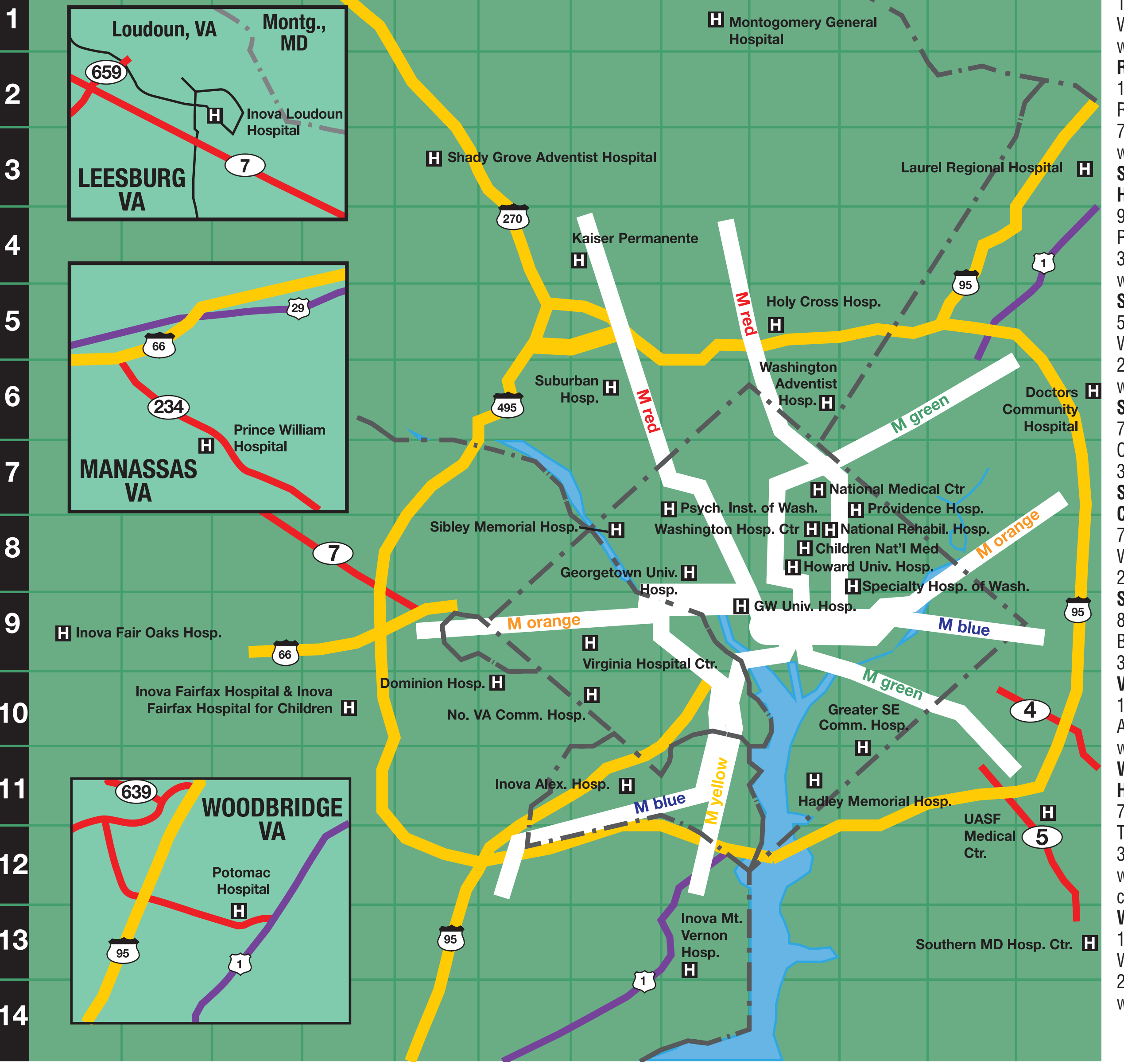

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