

# **NURSE**

**REGULATION EDUCATION PRACTICE**



Board of Nursing Chair  
**Cathy Borris-Hale, RN, MHA, BSN,**  
and DOH Director  
**LaQuandra S. Nesbitt, MD, MPH**

- Home Health Aide (HHA) Recertification
- Trained Medication Employee (TME) Recertification



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# DISTRICT of COLUMBIA NURSE

Edition 43

**DIRECTOR, DEPARTMENT OF HEALTH**  
LAQUANDRA S. NESBITT, MD, MPH

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Washington, DC 20002  
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Phone: (202) 724-4900  
Fax: (202) 724-8677  
Web site: <http://doh.dc.gov/bon>

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Address Change? Name Change? Question?

In order to continue uninterrupted delivery of this magazine, please notify the Board of Nursing of any change 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. **IN THE KNOW** includes your opinion on the issues, and our answers to your questions. E-mail your letters to [hpla.doh@dc.gov](mailto:hpla.doh@dc.gov). (Lengthy letters may be excerpted.)



# Message from the Chair

Cathy Borris-Hale, RN,  
MHA, BSN

## Thank You for Supporting Our Service on the Board

We would like to recognize the work of our Board members and the employers who allow them to serve.

**Simmy Randhawa DNP, MBA, MS, RN, NE-BC**

Agency: Children’s National Health System  
Supervisor: Linda Talley MS, RN, NE-BC  
Position: Director - Clinical Information Systems and Professional Development

**Toni A. Eason, DNP, MS, PHCNS, COHN-S, RN-BC**

Agency: US Immigration and Customs Enforcement  
Supervisor: Stuart Ewing  
Position: Fitness For Duty Program Manager, Marriage is a Fitness for Duty program for a law enforcement agency.

**Margaret A. Green, LPN**

Agency: Unity Health Care  
Supervisor: Patricia Williams, RN, MS  
Position: Staff Nurse - DC Department of Corrections

**Rev. Mary E. Ivey, D-Min**

Position: Licensed and ordained minister who has pastored a church in the District of Columbia. Dr. Ivey is an Assistant Chaplain at Reagan National Airport, and Founder and President of both Maine Avenue Ministries and the National Association of Minority Political Families, USA, Inc.

**Vera Waltman Mayer, JD**

Position: An attorney; and retired Coordinator of the DC Coalition on Long Term Care and Senior Advocate at Iona Senior Services. Currently, Ms. Waltman Mayer works with the Coalition in a campaign to develop a nursing assistant training program in the DC public high school system.

**Ottamissiah Moore, BS, LPN, WCC, CLNI, GC, CHPLN**

Agency: Right at Home of DC  
Supervisor: Melanie Lamar Hancock  
Position: Community Liaison; responsible for planning and coordination of home care services and participating in community programs.

**Chioma Nwachukwu, DNP, PHCNS-BC, RN**

Agency: Medstar Washington Hospital Center  
Supervisor: Caren Lewis, MHA, RN  
Position: Nursing Director, Third Floor Perioperative Services

**Mamie Preston, BSN, RN**

Agency: World Bank Groups  
Supervisor: Dr. Jules Duval, Sr. Medical Officer; Rebecca Michelle Jahandari, Head Nurse  
Position: Travel Medicine Nurse Consultant Occupational Health

**Winslow B. Woodland, RN, MSN**

Agency: District of Columbia Department on Disability Services, Developmental Disabilities Administration  
Supervisor: Laura Nuss, Director  
Position: Program Manager for a team of 80 Service Coordinators, 10 Supervisory Service Coordinators whose responsibility is to ensure the needs and wants are met within the service delivery system. ■

**THANKS TO  
MARY ELLEN R. HUSTED, RN, BSN, OCN**

The Board would like to publicly offer our thanks to outgoing Board Member Mary Ellen Husted for her many years of dedicated service to the Board of Nursing.

Mary Ellen served as Board Chair and Vice Chair. The Board benefited from her knowledge, efficiency, and professionalism. She will be missed!



## Government of the District of Columbia Department of Health



Office of the Director

Dear District of Columbia Nurses,



I am pleased to offer you greetings and warm regards on behalf of the entire District of Columbia Department of Health and our exemplary Board of Nursing. I am grateful to Mayor Muriel Bowser for entrusting me with directing the department at such a critical time in public health. I look forward to working closely with you and the Board of Nursing in creating a Fresh Start for Washington, DC.

I speak for countless District residents in thanking you for the extraordinary care you provide to our patients and families. Nurses are a force to be reckoned with – not only because of the role you play in providing care, but because collectively, you represent the single largest healthcare profession. Your contributions provide a reliable perspective in understanding and establishing policies and practices that safeguard the health and wellness of District residents. I appreciate your efforts in ensuring that Washington DC leads the nation in the provision of safe, quality, and compassionate care.

As I continue in my role as Director, I look forward to actively engaging and collaborating with District of Columbia nurses in our mutual effort to improve the health and wellness of our city. As such, I invite you to join me in engaging in a broad public health conversation focusing on the following overarching themes:

- Creating a paradigm shift to focus on population health
- Addressing social determinants of health and achieving health equity
- Closing the chasm between public health and clinical medicine
- Strengthening the District's access to health data
- Implementing evidence-based/promising practices and outcomes-oriented programs and policies

I look forward to collaborating with you and other community leaders in achieving our collective vision of healthier lifestyles and wellness for all communities in our city.

Sincerely,

LaQuandra S. Nesbitt, MD, MPH  
Director

## Code of Ethics for Nurses

By Felicia Stokes, BSN, JD, Nurse Consultant/Discipline, DC Board of Nursing

The American Nurses Association (ANA) has designated 2015 “The Year of Ethics.” In December 2014, a Gallup poll of Americans revealed that nurses have the highest honesty and ethical standards. Eighty percent (80%) of Americans said that nurses have high ethical standards compared to other professions including bankers, advertisers and congressional representatives. Historically, nurses have topped the list every year since the first year of inclusion in 1999.

This year the ANA released a new revised Code of Ethics for nurses. Ethics addresses issues about morality in human behavior, choices, actions, and character. This new Code provides a road map for nurses who not only practice at the bedside, but in other settings. We, as nurses, are faced with ethical dilemmas on a daily basis. The revised Code provides not only a theoretical model of ethics, but a practical application for nurses’ daily use, including interpretative statements.

The revised Code provides guidance to many questions:

- Do I have a duty to myself as a nurse?
- Am I still a “nurse” after I leave my shift?
- Do I still have to take care of a patient if I do not agree with their healthcare decision?
- Can I accept a gift from a patient?
- Should I join a professional organization?
- Can I photograph a “selfie” with my patient?

In the District of Columbia, the ANA Code of Ethics is considered the standard of care for nurses. Specifically defined in 17 DC Municipal Regulations Chapter 54, §5416.1 & Chapter 55, §5516.1, “A [registered/practical] nurse shall adhere to the standards set forth in the ‘Code of Ethics for Nurses’ as published by the American Nurses Association, as they may be amended or republished from time to time.” Every licensed nurse in the District should be familiar with the revised Code of Ethics and know how to use the guide for carrying out the ethical obligations of the nursing profession.

### Links to ANA Code of Ethics:

- <http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics-For-Nurses.html>
- <http://www.nursesbooks.org/Main-Menu/Ethics/Code-of-Ethics.aspx>
- <http://www.nursingworld.org/codeofethics>

American Nurses Association. *Code of Ethics for Nurses with Interpretive Statements*. Silver Spring, MD: American Nurses Association; 2015.

Riffkin, R. Americans rate nurses highest on honesty, ethical standards. Retrieved from <http://www.gallup.com/poll/180260/americans-rate-nurses-highest-honesty-ethical-standards.aspx> ■

## LETTER FROM A COIN PARTICIPANT

There's a saying in 12-step recovery rooms that "it takes what it takes" - referring to the idea that some people suffering from addiction get treatment and remain sober early in the process, while for others it may take some time, continued suffering, and devastating consequences. I used to say to myself, "If I had only stopped this sooner, then I wouldn't have had so many bad things happen, ruined friendships, lost jobs" and the list goes on. My reason in sharing this piece of my journey is that it took me awhile - about six years - of dealing with various sorts of addictive behaviors (alcohol, illegal and prescription drugs, nicotine, and a few others along the way), along with some pretty serious consequences, before sobriety became more important than the feeling of needing that fictional escape from reality that many of us addicts refer to as the primary reason for continuing our addictions.

As to how I was referred to COIN,\* it was the end result of an increasing addiction to drugs and alcohol and the point at which my personal and professional lives were colliding, a collision I was attempting to avoid at all costs because I didn't want to be one of "those" nurses. For whatever reason, it took placing my professional career in jeopardy before I really took the idea of sobriety seriously and that was my "turning point." And for that, I will be forever grateful.

I vividly remember my first meeting with COIN. I had referred myself because I wanted to do so before my previous facility did. That first meeting was intimidating, scary, and I had this sinking feeling in my gut that I would never be able to be involved in patient care again. I had crossed the line too many times. It was time to face the consequences of my actions and own-up to the fact that I could not provide safe patient care and risk jeopardizing someone else's life as a result of my own issues with addiction.

While those emotions were vividly staring me in the face, I found the COIN members to be welcoming and gave me hope and encouragement. In due time-I could return to clinical nursing if that was my goal, provided that I worked a solid recovery program, followed my contract regarding random drug screenings, 12-step meeting attendance and several other items necessary to ensure that I was indeed working a solid program of sobriety and remaining drug and alcohol free. The program is intense, yet reasonable, understanding that while COIN's goal is to provide assistance to nurses with addiction and other mental health disorders so they can potentially return to practice, their ultimate responsibility is to ensure that patients are receiving care from a professional who is safe and competent to have this responsibility.

Last month, I celebrated four years of sobriety and, while I owe that to many supportive people, COIN was the catalyst that set the path to recovery that I desperately needed. For me-most importantly-COIN was there to hold me accountable and provide support when needed. That sinking feeling that I had when I first met with the Committee members was replaced last year, at my last meeting, with a feeling of sincere gratitude and deep personal feeling of accomplishment. I could, once again, return to serving patients entrusted in my care. And today, I do just that.

-Anonymous

\* Committee on Impaired Nurses: contact COIN at [concheeta.wright@dc.gov](mailto:concheeta.wright@dc.gov) or (202) 724-8870.

# 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 less our resources will have to be used to address duplicate questions.

### 1ST TIME RENEWAL & CE BROKER

**Q**: Can you clarify the continuing education requirements for RNs? I received my DC license in August 2014. Do I have a full calendar year as a new licensee to complete my CEUs? I tried to verify this on the DOH website, but the CEU link would not give info without me creating an account with CE Broker. Is this what you recommend all nurses use to monitor their CEU compliance?

**A**: Continuing education (CE) is not required for first time renewals. We do recommend registering with CE Broker as an option for tracking CEs. If audited, we can check your CE record and you will not be required to submit additional documentation. To create an account with CE Broker, go to [www.cebroke.com](http://www.cebroke.com). For questions about the application process or updating courses, please contact the CE Broker support center via email at [support@cebroke.com](mailto:support@cebroke.com), or by calling toll free, 877-434-6323.

### RN TEMPORARY LICENSE

**Q**: Is there a Temporary License for a nurses?

### **A**: TEMPORARY LICENSURE STATUS:

A temporary status may be issued for a time period not to exceed ninety (90) days. This status shall not be extended. An applicant for licensure by endorsement with evidence of (1) an unencumbered license from another jurisdiction and (2) having completed a criminal background check, may ask to receive a temporary license to practice nursing.

### NPs/APRNs AND MEDICATION DELEGATION

**Q**: I'm researching Maryland, District, and Virginia regulations that address whether nurse practitioners can or cannot delegate medication administration to unlicensed clinical personnel; and, if so, what are the parameters?

**A**: We do not currently regulate medication aides, with the exception of Trained Medication Employees who administer medication to persons in homes for the disabled and in assisted living facilities. The Board has drafted Medication Aide-Certified (MAC) regulations which will allow nurses to delegate medication

administration to the MAC.

**Q**: The clinical assistants are not medication aides. They are medical assistants (MAs) similar to those in a physician's office. Currently in Maryland, Virginia, and the District physician offices, MAs can administer select medications through physician delegation. I'm researching the regulations to understand whether nurse practitioners can delegate any medication administration to the medical assistants, whom are unlicensed.

**A**: Medical assistants are not regulated in DC. If a nurse practitioner (NP) hires a medical assistant in their office and wants to delegate that responsibility to a medical assistant, they can. The NP then becomes responsible for the MA's actions. NPs can't delegate this responsibility to a medical assistant in settings such as hospitals or nursing homes because DC law does not allow unlicensed persons to administer medications in those settings. ■



# NAP NEWS!

## Nursing Assistive Personnel Q&A

### HHA COURSE COMPLETION CERTIFICATES

**Q:** When hiring Home Health Aides, are agencies required to ask HHAs to provide a Course Completion Certificate?

**A:** Home Health Aides who were working prior to and during our Home Health Aide certification waiver process submitted their original course completion certificate to the Board of Nursing when applying for certification. Their education was verified prior to the Board issuance of the Certification/License, therefore, collection of course completion certificates upon hire is not necessary when the Home Health Aide is certified by the Board of Nursing. You may verify that certification at the DOH website: <https://app.hpla.doh.dc.gov/Weblookup/>. Please note that the website verification is considered "primary verification."

### HHA ENDORSEMENT

**Q:** I have an HHA certificate and I have been working as an HHA for a year. Can I apply for certification by endorsement or will I need to take the Board exam?

**A:** You may apply for HHA certification only if you have been working as an HHA in another jurisdiction and have been registered in that state as an HHA. If not, you may receive certification only by passing the HHA examination. If your HHA training occurred more than 24 months ago, you will have to complete another HHA training program. If it is less than 24 months ago, you may submit the HHA examination application: <http://doh.dc.gov/node/323082>

### TME RECERTIFICATION

**Q:** I thought Trained Medication Aides (TMEs) could continue working,

but they would have to work within their scope, and only administer medications and treatments to the people that they were specifically supporting in a single residence. However, a nurse has informed me that she had been told that TMEs will not be able to renew their certification because the new med tech program was ready to roll out. Is that true?

**A:** TMEs will continue to be able to administer medications, and they will be able to be recertified. But once the Medication Aides are trained and certified, TMEs will no longer be trained.

### TME TRAINING

**Q:** When will the new med tech program actually start? Another program is having problems finding staff certified as TMEs, and they are thinking of having their nursing director take the course to become a trainer. Is that course still being offered and, if so, will it be worth attending if this is to be phased out soon?

**A:** If a facility needs TMEs, the nursing director should take the training. While the Board has completed a draft of the regulations, the regulations cannot be implemented until promulgated. Unfortunately, we cannot give you a definitive timeline.

### MED TECH TRANSITION

**Q:** There is anxiety about the new med tech program being launched without sufficient time to get people trained to provide the services that are needed.

**A:** We will work with the community to make the transition as seamless as possible. TMEs can continue to work as TMEs. Health care facilities will need to gear themselves up to offer the training, if they wish. We are encouraging our training programs to offer the training as well. We welcome feedback from the community

regarding this transition. We are continuing to receive about 20 TME applications a month.

### TME CLARIFICATION

**Q:** We are looking for some clarification regarding the upcoming renewal for the TMEs, and reciprocity from Maryland or Virginia to the District for the TME certification.

**A:** See details regarding TME renewals on page 13. We will continue to accept applications from Medication Aides in Maryland and Virginia as long as we continue to accept initial/new TME applications.

**Q:** We have heard that the training requirements will be changing to a 100-hour course, and that current TMEs will not be able to renew without the course and that CMTs from Maryland would not get reciprocity.

**A: PHASING-OUT OF TME CERTIFICATION.** To clarify: We will be phasing out the TME certification and initiating certified medication aides (MAC). Persons who are currently working as TMEs may continue to do so, but once we begin the MAC program we will discontinue certifying "new" TME applicants. We will continue to recertify current TMEs. Persons interested in becoming MACs will have to complete the training and pass the MACE exam. The training is approximately 100 hours.

**Q:** Is there an estimated timeline for when the 100-hour training will be initiated?

**A:** It will begin once the regulations are approved. We cannot give you a specific date, but we will work with the agencies to make the transition as seamless as possible.

## Board Member Training



HRLA Board Members with training facilitator Donna H. Mooney, RN, MBA, Director of Discipline North Carolina Board of Nursing, on March 26, 2015. The training program covered five areas: Foundations of Occupational and Professional Regulation, Roles and Responsibilities of a Board Member, Administrative Rulemaking, Professional Discipline, and Assessing Competence.

## NAP NEWS!



Members of the Nursing Assistive Personnel Advisory Committee meeting with the Board to discuss NAP renewals and discipline priorities.

*The Board of Nursing welcomes the following appointees to the NAP Advisory Committee:*

Ottamissiah Moore, Board Member  
Concheeta Wright, BSN, RN  
Vanetta Cox Bonner, RN  
Patrick Anthony Elliott, Dialysis Tech  
Nicole Maria Fletcher, HHA  
Tippi Hampton, RN, BSN, MBA,  
Vicky Haynes, TME  
Gay Monatgue, RN

Chairperson  
Board Support  
Currently supervising the practice of NAPs  
Currently working in a DC dialysis center  
Currently working with a beneficiary in DC  
Currently supervising the practice of NAPs  
Currently administering medications in a DC facility  
Currently teaching or administering an NAP Program

### **ROLE OF THE NAP ADVISORY COMMITTEE**

- Provide advice regarding NAP regulatory requirements
- Identify NAP in-service/continuing education needs
- Provide input regarding NAP training programs
- Provide advice regarding NAP disciplinary sanctions

### **FOLLOWING POSITIONS AVAILABLE:**

- Certified Nursing Assistant (1):  
Patient Care Technician (1):  
Consumer Member
- Currently working in a DC LTC facility  
Currently working a DC acute care facility

**BOARD OF NURSING MEETINGS**  
*Members of the public are invited to attend...*

**Date:**

First Wednesday of every **other** month.

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

**Time:**

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

**July 1, 2015**

**Location:**

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

**September 2, 2015**

**November 4, 2015**

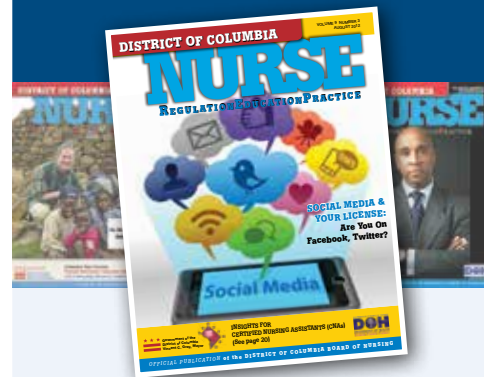
**Transportation:**

Closest Metro station is Union Station.

**January 6, 2016**

**Please note new schedule.**

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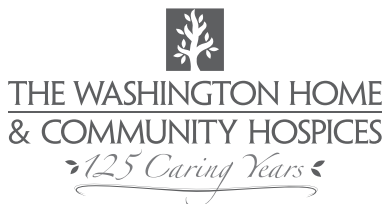
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### Manager of Care Coordination Center

The Washington Home & Community Hospices has a rich heritage for compassionate care that is deeply rooted in the District of Columbia and Maryland. Its mission is to provide exceptional care with compassion and innovation while fostering dignity and independence in those served.

We are currently seeking a Care Coordination Manager to be responsible for the overall day to day management of the intake and admission process for Community Hospices of DC and Maryland. This position ensures that communication with the referral source and/or attending physician and family is accurate and compassionate to assure admission.

To qualify, candidate must be a graduate of an NLN school, and be an RN licensed in all jurisdictions that are served by Community Hospices (Maryland and Washington, D.C). BSN is preferred. Certification in Hospice and Palliative nursing is required within one year of employment.

We offer a competitive compensation package and a friendly, professional work environment.

To learn more, please send your resume to: [recruiter@thewashingtonhome.org](mailto:recruiter@thewashingtonhome.org), or fax: (202)895-0133.

[www.TWHCHCareers.com](http://www.TWHCHCareers.com)

## Continuing Education Non-Compliance Notice for TMEs

The Board of Nursing's Continuing Education (CE) Audit for Trained Medication Employees (TMEs) began in 2013, following the renewal.

At the time that this publication went to press, we had not received a response to the Board's request from the persons listed below. Failure to comply with the Board of

Nursing's regulatory requirement will result in a fine up to \$500.00 and/or disciplinary action against your certification to practice in the District of Columbia.

Please note that if your name appears on the list of TMEs below, **YOU WILL NOT BE ABLE TO RENEW YOUR CERTIFICATION** until you:

Provide evidence of the twelve (12) hours of in-service training for 8/1/13 thru 10/31/2013 renewal cycle.

If you have any questions, contact Donna M. Harris, BSHA,MPA, Health Licensing Specialist, DC Board of Nursing via email at: [donna.harris@dc.gov](mailto:donna.harris@dc.gov).

TME637	ADOGHE, MERCY E	TME788	KINYOCK, MARIE N
TME963	AKINROLA, FUNLOLA F	TME459	KPAKA, DORIS
TME502	ALASSANI, SAIBOU	TME388	MASSAQUOI, RITA M.
TME984	AYOMPE, REGINA A	TME1045	NJOGHO, ALICE
TME920	BECKLEY, PRINCE J	TME1008	OMOLE, MERCY A
TME710	BENDER, LINDA V	TME126	PAYNE, RENEE L.
TME289	BENNETT, BEATRIZ	TME028	PRESTON, RUDOLPH
TME133	CAMPBELL, CAREY B.	TME598	ROBINSON, MELINDA
TME900	COLE, SALOME	TME232	SANKOH, HAROUN H.
TME567	COOPER, TAKEIA M	TME020	STOCKS, GARY E
TTME391	GREEN, MARIAN P.	TME983	TCHATAT, DAGOBERT
TME322	GUELADE, APPOLINAIRE D.	TME253	THOMAS, CARMALITA M.
TME571	KAMARA, MEMUNATU	TME983	TCHATAT, DAGOBERT
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TME630	KAMENI, MARIE	TME589	WALLACE, ANGELIQUE C
TME005	GURLEY, DONNA	TME588	YAMBA, YEI K
TME059	DILLON, ELIZABETH	TME493	YEBOAH, REBECCA A

# NAP NEWS!

## Home Health Aide (HHA) Recertification

HHAs please be reminded that your certification will expire October 30, 2015

### REGULATORY REQUIREMENTS FOR HHA RECERTIFICATION:

- Work a minimum of eight (8) hours during the prior twenty-four (24) months as an HHA under the supervision of a licensed nurse or other licensed health professional.
- Twelve (12) hours each year of in-service training/continuing education. (In-service/continuing education will not be audited this first renewal period.)

### COMPLIANCE AUDIT:

Prior to the renewal period, you **may be** selected for audit. If selected, you will be asked to provide the following information:

- **Verification Form:** Completed employment verification form signed by your employer, supervising nurse or licensed health professional, verifying that you have worked at least eight (8) hours within the last twenty four (24) months prior to certification renewal.

Please note: Non-compliance with these regulatory requirements **will result** in a fine and/or discipline against your certification status.

## Trained Medication Employee (TME) Recertification

TMEs please be reminded that your certification will expire October 30, 2015

### REGULATORY REQUIREMENTS FOR TME RECERTIFICATION:

- Supervisory registered nurse's verification of the TME's continued adequacy of performance.
- Twelve (12) hours of in-service training in pharmacology or medication administration.

Prior to the renewal period, you **may be** selected for audit. If selected, you will be asked to provide the following information:

- **Verification Form:** Completed verification form signed by your supervising nurse verifying continued adequacy of performance.
- **In-service:** Successful completion of twelve (12) hours of board approved in-service training in pharmacology or medication administration.

Please note: Non-compliance with these regulatory requirements **will result** in a fine and/or discipline against your certification status.

### Step-By-Step Online Renewal Process for HHAs and TMEs

To renew online:

**Step 1:** Go to the HRLA website at [www.hpla.doh.dc.gov](http://www.hpla.doh.dc.gov)

**Step 2:** Click on Online License Renewal

**Step 3:** Scroll down to bottom of page and log in: Enter your Social Security Number and Last Name (as it appears on your certificate)

**Step 4:** Once you log on the screen will display your address and other personal information [Please update your email address and other information, if needed].

**Step 5:** Establish a User ID and Password. Follow the step-by-step instructions.

**Step 6:** To pay renewal fee, enter the credit card information for your VISA or MASTER CARD number.

**Step 7:** After 24 hours you will be able to verify the renewal of your certification at [www.hpla.doh.dc.gov/weblookup](http://www.hpla.doh.dc.gov/weblookup)

Don't have access to a computer? Send a request for paper application to:

TME or HHA Recertification; 899 North Capitol St, NE; Washington, DC 20002

## NAP NEWS!

### Continuing Education Update:

## *CNAs Discuss Real-life Scenarios to Discover Best Practices*



CNAs discuss challenging work situations, discover best practices, learn about the disciplinary consequences of abuse and neglect, and about when to ask for help.

### **ABUSE AND NEGLECT**

Abuse – any willful or reckless act or omission that causes, or is likely to cause or contribute to, **physical or emotional injury, death, or financial exploitation of a client.**

Neglect – any act or omission which causes or is likely to cause or contribute to, or which caused or is likely to have caused or contributed to the injury, death, or financial exploitation of a consumer.

- **Verbal abuse** is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance, regardless of their age, ability to comprehend or disability.
- **Physical abuse** includes hitting, slapping, pinching and kicking; it also includes controlling behavior through corporal punishment.
- **Sexual abuse** includes but is not limited to sexual harassment, sexual coercion or sexual assault.
- **Mental abuse** includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation.
- **Misappropriation of resident property** means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.

### **TRUE INCIDENTS SHARED BY DOH INVESTIGATOR MARY SKLENCAR, RN**

#### **A Great CNA May Have Caused Harm Unintentionally**

A CNA was giving a bath to a blind demented lady. The CNA left to get clothes. She stopped on the way, to chat, then heard the housekeeper scream. The resident had drunk the liquid soap that was left in a cup near the bath. Then the resident threw up, aspirated and drowned. The CNA was convicted of criminal charges and incarcerated.

#### **A Great CNA May Be Found to be Innocent of the Charges**

A CNA was accused of abuse because a resident was burned in the shower. Upon further investigation, it was found that the valve in the shower had not been changed in three years. The temperature fluctuated because the shower had not been maintained properly. The CNA was found to be not at fault.

**Seeking the Truth:** DOH investigators are not “out to get” a CNA in any given event. The investigators want to find the facts and reveal the truth.

The Board of Nursing co-sponsored a CE program with the Health Regulation and Licensing Administration's Compliance and Investigations Unit to highlight best practices for Certified Nursing Assistants (CNAs). The program was facilitated by

Mary Sklencar, RN, of the Compliance Unit, and organized by Board of Nursing Member Ottamissiah "Missy" Moore. CNAs were divided into groups, and each group was given a selection of hypothetical long-term care scenarios to discuss. Participants had to determine if abuse or neglect had taken place and, if so, what punishment should be imposed upon the CNA.



Several themes emerged during the session:

- That treating residents in a gentle and dignified manner is paramount;
- That personal stress and heavy workloads do not absolve CNAs from acting in a professional manner; and
- CNAs should reach out to their fellow team members to get help and give help.
- A CNA's actions and tone of voice should reflect a CNA's professionalism, not their mood or be based on the nature of their interactions with supervisors, residents or residents' family members.

Ms. Sklencar distributed handouts with scenarios she created illustrating abuse and neglect of residents. Each attendee was asked to imagine that they were the CNA in each hypothetical scenario, and answer the following questions:

- Did you abuse the resident?
- Did you neglect the resident?
- Were you insubordinate?
- What was left undone?
- What facility policies were violated?

## WHAT IS ABUSE OR NEGLECT?

### Abrupt Departure

As you are feeding Mrs. Washington, your cell phone rings. It is your child's school. You answer the phone. The school nurse



tells you that your child has a fever. You immediately go to the charge nurse and tell her you have to leave and tend to your sick child.

**FEEDBACK:** "Is this abuse or neglect?" Ms. Sklencar asked participants. "It is neglect. You left. To walk away equals neglect."

### Irate Family Member

Mr. Orange's wife is yelling at you. "What's wrong with you? Don't you understand English?" she asks. You say to Mrs. Orange, "Please don't curse at me. There were several emergencies today and I am doing the best I can. If you don't like the way I care for your husband, maybe you should find another place to put him." Mrs. Orange then storms out of the room to complain to the charge nurse that you have been rude and abusive towards her and her husband.

**FEEDBACK:** Ms. Sklencar told the CNAs that those type of comments are unacceptable. "I would suspend the CNA for saying 'If you don't like it, get out.'"

### Personal Conversation

As you are cleaning up Mr. Brown, you tell Cindy CNA that your child is having trouble in school. You think it doesn't matter what you talk about because Mr. Brown is very demented.

*Continued on page 16*

Continued from page 15

**FEEDBACK:** Do not talk about your personal life. Conversations about your personal life are not appropriate, and they could hurt you in the long run, professionally. Ms. Sklencar told attendees:

“Any personal information the resident hears they will use later. If a resident feels slighted or abused, your past relationship may not matter. They are not your family.”

## Hot Tea

It is a cold morning and you get a nice hot cup of tea. You go to the unit for duty. The charge nurse tells you to take Mrs. Jones to dialysis. They have called twice already. Mrs. Jones is very confused. She mostly just sits in the geri chair and sleeps. You still have your tea. “I’m not throwing this away. It was \$1.25 and it’s still hot,” you say to yourself. You place the tea cup between Mrs. Jones’s legs so it won’t spill. You start wheeling Mrs. Jones down the hallway to the elevator to dialysis. Mrs. Jones starts to flail her arms and scream. The tea has spilled on her legs, and you lift her skirt and see that her thighs are beginning to blister. You rush back to the unit and show the charge nurse. She immediately puts cool cloths on the thighs. Mrs. Jones is still crying and screaming. The charge nurse comes in with the unit manager and the Director of Nursing (DON). The DON tells you to write a statement and leave.

**FEEDBACK:** “This really happened. They terminated the CNA,” Ms. Sklencar told attendees. “Was this abuse? No, because it was not willful (on purpose). However, this was neglect. The CNA failed to protect the resident.”

## Late for Lunch

When Mr. Peanut’s wife arrives to pick him up for his 95<sup>th</sup> birthday party, he is still in bed. The charge nurse yells at you to get him showered NOW—even though this is your lunch hour. You ask the family to leave the room after you argue with his

cousin, Cashew. You take Mr. Peanut into the shower and scrub him good, mumbling to yourself, “If you want him clean, I’ll give you clean.”

When they all leave, Mrs. Peanut says, “It is so embarrassing that we will be late meeting our guests at Olive Garden, you lazy CNA!” Days later, the DON tells you that you are suspended pending an abuse investigation.

**FEEDBACK:** Ms. Sklencar said: “The CNA abused the resident by being rough.”

## Dinnertime

The busy afternoon started with a code as soon as you came on duty, and that caused a delay in the whole schedule. You finally got to do your first rounds at 5:00 pm. The residents are really angry. *Where was everybody?*

Mr. Lester tells you that you are lazy and should be fired. You take a deep breath and keep working. The dinner trays arrive and you help pass them out.

Mr. Rickets needs to be changed because he has diarrhea. His daughter is there causing a fuss. So you have to stop to clean him up.

It is now almost 7:00 pm and the kitchen is calling you for the trays. You walk into Mrs. King’s room and see that no one has fed her. She is a very slow eater and you just can’t take the time right now. You have three showers to give and still need to change Mr. Rickets again. You have to finish your work or the night shift will report you. You ponder the situation. Mrs. King looks pretty healthy and you decide that she will be okay if she misses dinner.

**FEEDBACK:** What is the element of abuse in this scenario?

## Protecting the Public

Ms. Sklencar provided attendees with an overview of DOH’s role, and spoke of how CNAs can best fulfill their duties with professionalism. The primary task of the Department of Health is to protect the public. She said DOH investigators and Board members must act to ensure that the residents of our long-term care facilities are not abused, neglected or otherwise harmed. As a CNA, take a proactive stance. Think about these potential scenarios before they occur. Know when to ask for help. Know when to control your attitude. Know when and how to communicate with residents, family members, your charge nurse and your Director of Nursing. Ultimately, the only person you can control is yourself. Practice in a professional manner, and if you have done so, do not worry about how others will portray you or what the investigators will find.



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## COMMUNICATING WITH CHARGE NURSE

There can be a clash of personalities when a CNA with many years of experience reports to a charge nurse with much less experience. Board of Nursing LPN Member Ottamissiah Moore told attendees: “You might have a new charge nurse who is as ‘green’ as the grass, but do not approach others with an attitude. Come with a Colgate smile and a good attitude.”

A CNA in the audience urged her colleagues to fully communicate with the charge nurse: “Most of the things that go on, the charge nurse doesn’t know about. Communicate with the charge nurse.”

## WHY IS SUSPENSION NECESSARY?

Federal regulations state that a CNA under investigation must be kept away from the residents.

## WHEN YOU ARE CONTACTED BY THE DEPARTMENT OF HEALTH

“If you get mail from DOH regarding a complaint, it doesn’t pay to not reply,” Ms. Sklencar told attendees. If we have used your address of record, you are still going to be liable, whether or not you have moved and did not receive the letter. If you get a call, please respond. It’s better to come forward with your side of the story. “Don’t just run to another state—we have databases and share discipline information,” Ms. Sklencar said.

## TRUTH AND CONSEQUENCES

If DOH can substantiate abuse, you will be put on the abuse registry. The DC Office of the Inspector General (OIG) can bring criminal charges, depending on the level of abuse.

PLEASE NOTE: CNA information shall remain in the registry permanently, unless the finding was made in error, the individual was found “not guilty” in a court of law, or the District is notified of the individual’s death.

## CONSEQUENCES OF ABUSE:

- You may be called before the Board of Nursing
- You may be placed on the Abuse Registry
- You may be subject to Criminal Charges

## BE PROACTIVE

**Attitude:** Be positive! It does not help to gripe and moan. It does not serve the residents. Exhibiting a bad attitude does not help the development of supportive, respectful, team spirit.

**Teamwork:** One participating CNA urged her colleagues to remember the importance of teamwork: “Family members are impatient. Everybody should work together. You must multitask. Ask a colleague for help. Teamwork is important.” Another CNA added: “Never talk back to a family member; a family member is a customer.”

Ms. Sklencar: “You need to be supportive of each other because it’s a hard job, no matter where you work.”

## BE “OKAY” WITHIN, AND FOLLOW THE PROPER PROCEDURES

Ms. Sklencar: “Be clear within yourself that what you did was the right thing to do. If you asked for help and didn’t get it, that protects you. Follow the proper procedures.” DOH also investigates the actions taken by all staff, including the supervising RN, the charge nurse, and the physicians.

## DOH RECOGNIZES THAT CNAs MUST BE PROTECTED ALSO

Compliance and Investigations Supervisor Greg Scurlock: “DOH is aware that CNAs may also be vulnerable to harm. Some residents are violent. We had one situation where a resident put a psychologist in a chokehold. Please cooperate with Investigations when you are contacted by DOH. The truth of the situation must be determined.” ■

## Metropolitan Washington's Nurse Memorials



By Toni A. Eason, DNP, MS, PHCNS, COHN-S, RN-BC  
Board Member, DC Board of Nursing

One of the many benefits associated with the District of Columbia is its ability to serve as both a literal and metaphoric nexus.

As the nation's capital, the District vividly archives our country's history and legacy. The city also embodies the diversity and unwavering hope for the future, upon which this nation was founded.

A visit to the national mall gives rise to memorials that honor President Lincoln, Dr. Martin Luther King Jr., World War II Veterans and countless other citizens and patriots.

The homage to recognized patriots throughout the Washington, DC metropolitan area brings into question: are there any memorials to honor nurses?

Three memorials were identified in the DC metropolitan area that honor the role that nursing has played in our nation's history. Those memorials include: the **Vietnam Women's Nurses Memorial**, the **Nuns of the Battlefield**, and the **Nurses Memorial at Arlington National Cemetery**.

### VIETNAM

The Vietnam Women's Nurses Memorial sits on the national mall, not far from the Lincoln Memorial. The sculpture was dedicated on November 11, 1993 and designed by Glenda Goodacre. The sculptor depicts three female nurses in battle dress caring for a wounded soldier.

The three nurses in the sculpture are appropriately named: Faith, Hope, and Charity. One nurse looks to the skies, as if in *hope* and anticipation of arrival of the helicopter which will bring the young soldier the help so desperately needed. She rests her right hand on the arm of her



nurse colleague providing care to the young soldier. She validates that she is alert and focusing on all of their well-being (The History of the Vietnam Women's Memorial, n.d.).

One nurse appears to tenderly provide care to the soldier. She comforts him and reassures him that all will be fine. She provides the *charity* that he needs at this time. She is a gracious, safe harbor in the midst of a foreign and dangerous environment. She focuses all of her attention on remaining a calming presence and providing him support and attention.

One nurse kneels, as if in prayer. She holds in her left hand the helmet of the young soldier. She gently holds the helmet, feeling connected to this young hero and her colleagues. She sincerely asks for a means of assuring the young man's health and everyone's safety. She knows that having *faith* in a good outcome is necessary to get through



this challenge. This memorial highlights the role that nursing played during the Vietnam War era.

### CIVIL WAR

The Nuns of the Battlefield is another memorial that honors the role that nursing has played in the country's history. Also known as the Civil War Nurses Memorial, the bronze was erected in 1924 by the Ladies Auxiliary to the Ancient Order of Hibernians of America by order of Congress and sculpted by Jerome Connor (Civil War Nurses, n.d.).

The bronze was dedicated on September 24, 1924 by removing an American flag which covered it. Sailors present at the dedication lifted signal flags spelling "*faith, hope and charity*" and a flock of white pigeons were released (Wikipedia, n.d.).





The Civil War Nurses Memorial is a reminder of nursing service to the country during a time of national dissent. It is located at the intersection of Rhode Island Avenue NW and M Street, NW, just east of Connecticut Avenue in Washington, DC.

The memorial is located unremarkably in a busy downtown DC corridor that is more frequently visited for its proximity to the Cathedral of Saint Matthew the Apostle. The Cathedral is famous for holding the funeral mass for President Kennedy (Lowens, n.d.). The memorial is just across the street from the Cathedral. The face of the memorial has a large bronze panel relief showing twelve nuns dressed in traditional habits. Tribute is paid through this memorial to the over six hundred nuns who nursed soldiers of both armies during the Civil War.

### ARLINGTON NATIONAL CEMETARY

Last, but not least, the Nurses Memorial at the Arlington National Cemetery is one of the most compelling dedications to the role that nursing has played in the United States. Section 21 of Arlington Cemetery commemorates the devoted service to country and humanity by Army, Navy, and Air Force nurses. The area is marked by the haunting white marble statue of a nurse in a uniform of her time, who stands eternal vigil over the chiseled gravestones of Army, Navy and Air Force nurses, each of whom courageously served the country and earned burial with full military honors at Arlington National Cemetery (Arlington National



Cemetery, n.d.).

Colonel Anita Newcomb McGee was a pioneering force in the creation of the monument dedicated to the memory of those heroic volunteers who nursed the injured and ill during the Spanish-American War. Colonel McGee founded the Army Nurse Corps, was President of the Society of Spanish-American War Nurses, and was the only woman with the rank of assistant surgeon of the US Army. She was solemnly laid to rest in the cemetery in 1940. Colonel McGee's dedication to the nursing profession and creation of the Army Nurse Corps continued with passing of the torch to Jane Arminda Delano (Arlington National Cemetery, n.d.). Jane Delano founded the American Red Cross Nursing Service. During the Spanish-American War, she joined the New York Chapter of the American Red Cross and served as Secretary for the enrollment of nurses. Her tireless efforts toward the education and preparation



of nurses led to her promotion to the role of Superintendent of the United States Army Nurse Corps. And, later as the President of the American Nurses Association and chair of the National Committee of the Red Cross Nursing Service (Miles, 2009). Jane Delano's tombstone humbly describes the contributions that she made to not only the nursing profession, but the world.

**Continued on page 18**

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## INDELIBLE PLACE IN HISTORY

The devotion to forging an indelible place in history of the military's nurse heroes by these two leaders and many others is awe inspiring. Of particularly powerful tribute is the alabaster nurse's statue, ever at attention, casting her enigmatic gaze over the marble tombstones of the six-hundred-and-fifty-three nurses who lie in Section 21 of Arlington National Cemetery, all having loyally served our country and humanity.

These memorials linger as silent remembrances of the valiant forebearers

of the nurse profession. These monuments stand as a constant reminder of the honorable and dedicated public service that nurses continue to deliver today. Though the discipline has evolved over time, the principles and values key to nursing present in each memorial remain evident in nursing practice, regulation, education and research.

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## Nursing News

### Preparing The Nursing Workforce For A Changing Health System:

The nursing profession is the largest

segment of the nation's health care workforce. There is consensus among experts that **nursing education should**

**be modernized to train a greater percentage of nurses at the graduate level** and provide the skills nurses

need as today's health care delivery system continues to evolve towards more team-based, data-driven, and coordinated care. What does the nursing workforce look like now and how does it need to change to meet current and future health needs in the US? What is the role of federal policy in training a 21st century nursing workforce? How does the nursing workforce fit into today's primary care workforce and the evolving health care delivery system? Board of Nursing Executive Director Karen Scipio-Skinner attended a Briefing on Graduate Nursing Education at the Russell Senate Office Building earlier this year. To read the article "Preparing The Nursing Workforce For A Changing Health System - The Role Of Graduate Nursing Education," go online at: [http://www.allhealth.org/publications/GNE-Toolkit\\_162.pdf](http://www.allhealth.org/publications/GNE-Toolkit_162.pdf) ■

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Georgetown University School of Nursing &  
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Interim Program Director of Nursing, Radians College  
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## Black Nurse of the Year

In March 2015, the Black Nurses Association of Greater Washington, DC Area, Inc. (BNA of GWDCA) honored their 2015 Black Nurse of the Year, Crystal L. Scott, MSN, RN-BC, the Geriatric Nurse Educator at Carroll Manor Nursing and Rehabilitation Center. Ms. Scott graduated from Clara Barton High School in Brooklyn, New York where she received her Licensed Practical Nursing (LPN) training and certification. She attended Howard University, earning a Bachelor of Science Degree in Nursing. Recognizing the importance of education, Ms. Scott enrolled in George Mason University earning an MSN, with honors.

Ms. Scott began her professional career as a staff RN at Howard University Hospital. She later transferred to the Washington Hospital Center and practiced in various nursing departments including high-risk obstetrics, intensive care nursery, orthopedics, cardiac transplant and oncology. In 2005, Ms. Scott was recognized as the Washington Hospital Center Nurse of the Year. As her career advanced, she held various leadership and management positions at Washington Hospital Center, including Assistant Nurse Manager and Interim Director of the Medical-Surgery Telemetry Department. The President of WHC recognized Ms. Scott

for her role in achieving milestones in the Magnet program for the hospital.

Ms. Scott excelled in various staff positions at Providence Hospital prior to her assuming the position of Geriatric Nurse Educator at Carroll Manor Nursing and Rehabilitation Center. Ms. Scott played an integral role in the implementation of an integrated Electronic Medical Record (EMR) system that resulted in Carroll Manor becoming the first long-term care facility in Washington, DC to utilize an EMR system.

She was the first RN at Carroll Manor to become board certified in gerontology. She was instrumental in and oversaw educational study sessions for RNs and LPNs obtaining national certification in gerontology. Carroll Manor was the first long-term care facility in the nation to graduate a class of LPNs certified in gerontology. She created and implemented an advanced training program for CNAs, specializing in dementia and end of life care. Ms. Scott served as Program Coordinator for the Pathway to Excellence Magnet program. In July 2014, the American Nurses Credentialing Center (ANCC)



Crystal L. Scott, MSN, RN-BC

awarded Carroll Manor the Pathway to Excellence designation, making it the fourth nursing home in the country to receive this prestigious honor. In the nursing community, she is well known for her constant professionalism and knowledge of evidence based

practice.

Ms. Scott designed a company making educational programs accessible to health care workers across the continuum, by building and enhancing competence through best practices, education, experience, theory and research. She is the President of Quality Resource Management, LLC.

Ms. Scott is also the President of the Honor Society of Nursing, Sigma Theta Tau International, Gamma Beta Chapter, Howard University. She is an active member of the Black Nurses Association of Greater Washington DC Area Inc. and serves on several committees. Ms. Scott is very active in her community and church. She participates in volunteer and outreach activities for woman, youth and older adults.

Ms. Scott is married to Paul Scott and is the proud mother of two sons, Paul and Michael, and a beautiful daughter, Victoria. ■

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# Using Web-Based Software Platforms to Improve Case Management

By Elizabeth V. Hobson-Powell, MA, MS, BSN, Edwin W. Powell, DA.Ed., M.Ed, MS, MA and Eric Conner, MA, BA

*The authors' affiliation with the United States Department of Commerce, the United States Public Health Service, Howard University College of Medicine and the District of Columbia Superior Court are provided for identification purposes only. The views expressed here are those of the authors and do not represent the official policy or position of the United States Department of Commerce, the United States Public Health Service, the United States Government, Howard University College of Medicine or the District of Columbia Superior Court.*

Healthcare disparities and the access to healthcare is a concern amongst medical professionals. With each patient encounter, nurses serve as leaders, patient advocates, facilitators and coordinators of medical care. Despite their overwhelming patient load, they are taking on collateral duties that are often carried out by social workers. These duties include but are not limited to patient counseling, home assessments and securing wraparound services. Given the many complexities associated with discharge planning, there is a need for an innovative and efficient way to provide patients with comprehensive case management.

## **ECONOMICALLY DISADVANTAGED**

The poorest ten percent of Americans are more likely to die nearly a decade earlier

than the richest ten percent according to research from the Brookings Institute (Culp-Ressler, 2014). The ability to assess a patient's social determinants is one of the best ways to determine the risk of a stroke, heart attack, cancers as well as predict the likelihood of developing asthma, COPD, and diabetes. The fact is social determinants result in poorer Americans developing a variety of chronic illnesses and succumbing to them more often than their richer peers (World Health Organization, 2015). As a result of these findings, we need to do more to reduce the potential impact that social determinants have in determining health care outcomes.

Addressing the social determinants of health has been highlighted by the U.S. government's Healthy People 2020 initiative, National Partnership for Action to End Health Disparities, and National Prevention and Health Promotion Strategy as being integral to improving health for all. The health care sector's efforts to address health disparities to date have been insufficient. For that reason, there is a need to develop and translate appropriate medical technologies as interventions.

Social determinants of health should be mitigated by and within community clinics, hospitals, and managed care plans serving populations with high health disparities, including racial and ethnic minorities, socioeconomically disadvantaged individuals, and medically underserved patients. In medical clinics, only fifteen percent of patients are screened

for associated socioeconomic needs, while existing case management programs struggle with high caseloads and unreliable information sources.

## **ADDRESSING CASE MANAGEMENT CONSTRAINTS**

Healthify, a web-based software platform, may be the answer to the many contemporary questions addressing social determinants of health. The potential benefits of such a technology include easier tools to help nurses and case managers improve health outcomes and reduce the disparities generated by social determinants. This platform is the first to systematically address a population's social and behavioral needs in and beyond the health care setting. The necessary support systems are built to ensure that patients are connected to appropriate services and multi-disciplinary teams have the tools to manage the risks driving poor health outcomes. During the initial triage, after signing the appropriate privacy and consent forms, patients are screened for social risk factors with a web based tool and are automatically provided information about the best resources that can address those risks—condensing a potentially lengthy screening process into five minutes.

Public health practitioners deployed in the field or on the front lines face many challenges. The July 4<sup>th</sup> celebration on the National Mall in Washington, DC is

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a crowded event and public health teams are usually deployed to mitigate medical emergencies. The crowds arrive early and leave late. With any large gathering, there is the potential for medical emergencies. Medical aid stations or tents are placed strategically around the National Mall to provide accessibility to medical care. These stations are staffed with nurses and physicians who coordinate and provide medical expertise. In order to provide effective quality medical intervention to these injured or ill patients, these nurses assess the patient's emotional, spiritual and psychological needs. During the discharge phase, it becomes apparent how social determinants impact patient outcomes and here is an example:

*Jane is a 68 year old female from Arkansas with a long history of smoking. She travelled by chartered bus to the 4<sup>th</sup> of July celebration on the National Mall, which was funded by her church. The temperature was a scorching 97 degrees with very high humidity. Jane began to exhibit the following symptoms: profuse sweating, nausea, fatigue, anxious, dizziness, cramps, coughing, shortness of breath and headache. Her friend immediately beckoned for assistance. A team of medical care rovers came to her assistance and carried her to an air conditioned medical tent.*

*Upon her arrival, she was greeted by a team of nurses dressed in military attire. A nurse took Jane's vital signs while obtaining her medical history. Another nurse began loosening her clothing. Jane's medical history revealed diabetes, anxiety and emphysema which required her to see a pulmonologist and psychologist regularly. Jane had been diagnosed with heat exhaustion and was treated with a cooling blanket, ice packs and intravenous (IV) fluids in order to lower her body temperature and was also given a bronchodilator to relieve the coughing and shortness of breath. She revealed that she could not afford her medications or schedule regular appointments with health care providers*

*as often as she would like because she has been unemployed for the past two years. During her discharge from the medical tent, the medical officer recommended that she stop smoking, follow-up with social services, a nutritionist, pulmonologist and a psychologist when she returns home.*

*Jane reported that she would be in the Washington, DC area for two weeks and wanted information about a nearby pharmacy, smoking cessation program and a pulmonologist in the area. The nurses attempted to assist her but did not have access to a list of providers within the vicinity of where Jane was staying, nor did they know of any providers who accepted Medicaid. The nurses did not have access to*

*Nurses are in the best position to holistically address social determinants root, stem, and branch. Nursing, according to the American Nurses Association, is both the "prevention of illness and injury" and "advocacy in the care of individuals, families, communities, and populations" (ANA, 2003). Few in the health care profession are as well placed to improve the health outcomes of millions of low-income Americans by helping them alleviate some of the worst effects of poverty.*

*that information but recommend that she look through a local telephone directory or do a Google search. Although Jane had been treated and released, the nurses felt that there was a breakdown in the continuity of care in that particular situation. During the debriefing session, it was determined that Jane did not receive the seamless case management necessary to access the community resources that she needed. Nor did anyone believe that she was capable of searching telephone directories or online resources independently...*

## SHARING ACCOUNTABILITY

Nurses are in the best position to holistically address social determinants root, stem, and branch. Nursing, according to the American Nurses Association, is both the "prevention of illness and injury" and "advocacy in the care of individuals, families, communities, and populations" (ANA, 2003). Few in the health care profession are as well placed to improve the health outcomes of millions of low-income Americans by helping them alleviate some of the worst effects of poverty.

Unfortunately, the lack of time is the biggest constraint to addressing the burden of social health needs. Finding the appropriate community services, developing care plans, and making referrals is a complicated, time-consuming process. While electronic health records and smart devices have allowed health care professionals to be more connected, there has not been a corresponding development between health care providers and the community-based organizations, faith-based institutions, and government benefits programs that play a pivotal role in helping alleviate the worst effects that poverty inflicts on health outcomes among the homeless, the hungry, the addicts, and others with a multitude of needs.

## CASE MANAGEMENT EFFICIENCIES

The multi-disciplinary team can use the collected patient data to see trends in health outcomes across their patient population or to access an individual patient's records for more personalized care, using the software to send out and respond to patients' messages. This is an ideal opportunity for health care providers and case managers to connect to their patients while building trust and advancing behavior change.

Healthify's platform not only greatly improves case management efficiency and long-term health outcomes, but it also

**Continued on page 26**



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allows health care providers to screen and connect with all patients and not just a fraction as before. Healthify is developing an innovative way to help flip the health care clinic to focus more on patient-centered care, helping along the national transformation of health care that is currently underway.

An automated outreach system follows up with patients between appointments via interactive SMS (texts), reminding them how to access recommended services and updating them on available services. Staff is notified when patients make contact with a referred service provider via the dashboard, allowing them to gauge how well patients are managing their social risks and to track the most effective services for them. This data can then be exported into any legacy IT system.

By capitalizing on SMS usage rates that are nearing 90% in low-income communities, this mobile intervention makes the patient's safety net more cohesive by bridging the gap between social and physical health needs. Automatic yet individualized follow-up can empower patients by making them more informed about resources they need and better prepared to access them. The result will be improved transition rates from clinic to community-based resources, which in turn has been linked to reduced emergency room readmission rates and health care system utilization.

## IMPROVING OUTCOMES

The Healthify platform has the long-term potential to improve health outcomes by building a more integrated safety net system and to prove financial value in addressing social needs to groups that are financially at risk for patients. As a result, social risks such as; poor nutrition and energy needs will be addressed more frequently, in multiple settings, and with less stigma.

Healthify represents the potential of technology to help multi-disciplinary teams bridge gaps between clinics and community resources. Because of relatively low costs, it can be scaled up quickly to improve rates of access to community-based resources for patients like Jane and to begin addressing the social determinants that have led to such tremendous health inequity between well-off and impoverished patients.

*Elizabeth Hobson-Powell is a Commander in the United States Public Health Service Commissioned Corps. Dr. Edwin W. Powell is an Educational Psychologist and Assistant Professor at Howard University College of Medicine; and Mental Health Expert with the District of Columbia Superior Court. Eric Conner is the Founder & Chief Operations Officer at Healthify.*

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# Kudos!

## **NURSE EDUCATORS TAKE ON SIGNIFICANT LEADERSHIP ROLES**

Nurses are gaining well deserved recognition for their outstanding leadership abilities. Their respect in leadership roles continues to grow in a variety of industries, and especially healthcare. As a nursing community, we should be aware and celebrate the accomplishments of two contemporary leaders in Nursing Education who are excelling in “non-traditional” nursing roles:



**Pamela V Hammond, PhD, RN**  
Dr. Pamela Hammond, former Dean of Hampton’s School of Nursing, was recently appointed “the first female president of Virginia State University.”



**Beverly Malone, PhD, RN, FAAN**  
Dr. Beverly Malone, CEO of the National League for Nursing (NLN); a former Dean of A &T School of Nursing; active leader in Healthcare policy and National Nursing Education Issues; a recent Inductee into the Institute of Medicine (IOM); relocation

leader of the NLN Headquarters from New York to the Watergate Complex, here in the District; and the leader orchestrating the creation of a new nursing education accreditation commission. Dr. Malone was recently awarded an Honorary Doctor of Science Degree during the 2015 Commencement Convocation of the University of the District of Columbia.

## **OTHER ACHIEVEMENTS**

**Sarah M. Roque, RN, MPH, BSN**

The Washington, DC chapter of the National Association of Hispanic Nurses (NAHN) recently installed, as its new president, Sarah M. Roque, Public Health Analyst for the District’s Fire and Emergency Medical Services (F&EMS). The National Association of Hispanic Nurses is a non-profit professional association committed to the promotion of the professionalism of Hispanic nurses by providing equal access to educational, professional, and economic opportunities for Hispanic nurses, and dedicated to the improvement of the quality of health and nursing care for Hispanic consumers. Ms. Roque has more than 20 years of nursing experience. Prior to joining the District’s Fire and EMS Department, she was the Director of Clinical Services for Maxim Healthcare Services in Washington, DC.

**Ottamissiah Moore, BS, LPN, WCC, CLNI, GC, CHPLN**

The National Council of State Boards of Nursing (NCSBN) has appointed Ms. “Missy” Moore to their Expert Panel for Delegation Guidelines. NCSBN is developing evidence-based guidelines in efforts to provide support to practicing nurses, health care organizations, boards of nursing, etc. when making decisions and performing best practices surrounding the delegation process involving registered nurses, licensed practical nurses, nursing assistive personnel, and unlicensed assistive personnel. ■

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## **REPORT MEASLES**

The District of Columbia requests that physicians, physician assistants, and nurse practitioners report cases of measles to the Department of Health (DOH). To report data, please use the Government of the District of Columbia Department of Health Communicable Disease Report Form and fax the form to DOH at (202) 442-8060. For additional information please call (202) 442-8141 during normal business hours. Thank you for your hard work and commitment toward keeping District residents safe and healthy. ■

# Mayor's Office of Talent and Appointments

The Mayor's Office of Talent and Appointments has an online application process for residents interested in applying to **serve on one of the District's Boards and Commissions**. Please encourage your colleagues and networks to apply to serve on a board or commission.

How To Apply to serve on a DC Board or Commission:

- Go to <http://mota.dc.gov/>
- Hover over "Join a Board or Commission"
- Click "Join a Board or Commission"
- Find your board or commission of interest and apply or apply through the general "ASSESSMENT: Join a District of Columbia Board or Commission."
- Fill out the required fields and submit your application

The Mayor's Office of Talent and Appointments assists the Mayor by making recommendations for outstanding community leaders to serve as appointed leadership staff or members to boards and commissions. The MOTA team recruits energetic, committed and forward-thinking individuals committed to helping the District of Columbia make a fresh start. Learn more at: <http://mota.dc.gov/>.

Applications will be sent to the appropriate staffer for review and applicants will be contacted in a timely manner. ■



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# DOH Awarded National Accreditation Status

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The District of Columbia Department of Health (DOH) has been recognized as an official accredited public health department by the Public Health Accreditation Board (PHAB). The goal of the voluntary national accreditation program is to improve and protect public health, by advancing the quality and performance of the nation's tribal, state, local, and territorial public health departments.

"We are excited to be recognized for achieving national standards that foster effectiveness and

promote continuous quality improvement," said DOH Director, Dr. LaQuandra S. Nesbitt. "The accreditation process helps ensure our programs and services are responsive to the needs of the community. With accreditation, DOH is demonstrating increased accountability and credibility to residents, surrounding jurisdictions, stakeholders and other constituents. This recent accomplishment means a lot to us and reinforces the Bowser Administration's commitment to delivering a fresh start by helping

to improve the quality of life for District residents."

The national accreditation program, is jointly supported by the Centers for Disease Control and Prevention and the Robert Wood Johnson Foundation, sets standards by which the nation's more than 3,000 governmental public health departments can continuously improve the quality of their services and performance. For more information on public health accreditation, visit [phaboard.org](http://phaboard.org). Follow DOH on Twitter at @DOHDC.



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# DISCIPLINARY ACTION

## Board Public Orders

Available at <https://app.hpla.doh.dc.gov/Weblookup>

### REVOKED

**Smith, Tambi** RN1025757 (1/7/15) - This registered nurse's license was revoked based on a voluntary surrender and actions taken by the Virginia Board of Nursing related to unsafe practice.

### SUMMARILY SUSPENDED

**Miller, Christine** RN1022319 (2/23/15) - This registered nurse's license was summarily suspended following a hearing, based on noncompliance with the DC Committee On Impaired Nurses (COIN) agreement.

### SUSPENDED

**Howland, Karin** RN1031409 (4/20/15) - This registered nurse's license was suspended based on a voluntary surrender and actions taken by the Virginia Board of Nursing related to impairment.

**McNeil, Queen** LPN1007787 (3/25/15) - This licensed practical nurse's license was suspended due to failure to complete a Board ordered Fitness to Practice examination.

**Ndi, Lilian** LPN1004581 (5/28/15) - This licensed practical nurse's license was suspended due to a failure to respond to a complaint alleging she was sleeping during her shift.

**Newton, Kwason** LPN1003588 (5/28/15) - This licensed practical nurse's license was suspended due to a failure to respond to a complaint alleging patient abuse.

### LICENSE/CERTIFICATION DENIED

**Condell, Nigel** HHA6400 (2/26/15) - This home health aide certification was denied based on a criminal felony conviction of intent to distribute a controlled dangerous substance.

**Eaton, Roneka** HHA7305 (1/7/15) - This home health aide certification was denied based on a criminal conviction of theft and failure to disclose this conviction.

**Exum, Eric** HHA5160 (2/26/15) - This home health aide certification was denied based on criminal convictions of destruction of property, assault and distribution of cocaine.

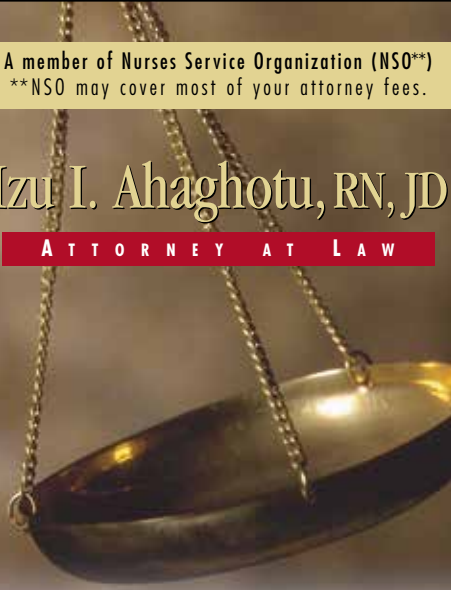
**Meador, Sherry** HHA10490 (5/28/15) - This home health aide's certification was denied based on a criminal conviction of voluntary manslaughter.

**Ross-Jones, Barbara** HHA7171 (5/11/15) - This home health aide certification was denied based on a criminal conviction for possession with the intent to distribute heroin.

### PROBATION

**Darpoh, Henrietta** LPN1007116 (5/29/15) - This licensed practical nurse's license is placed on probation concurrent with the probation placed on her by the Maryland Board of Nursing and will be terminated accordingly.

A member of Nurses Service Organization (NSO\*\*)  
\*\*NSO may cover most of your attorney fees.



**Izu I. Ahaghotu, RN, JD**  
ATTORNEY AT LAW

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:  
Office: 202.726.0001 DIRECT 202.361.6909

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