

DISTRICT OF COLUMBIA

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NURSE

REGULATION EDUCATION PRACTICE



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District of Columbia
Vincent C. Gray, Mayor



**CE: Physical Assessment Update
Communication Skills for CNAs**

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DISTRICT of COLUMBIA NURSE

Edition 38

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Address Change? Name Change? Question?

In order to continue uninterrupted delivery of this magazine, please notify the Board of any change to your name or address. Thank you.

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

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

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

Message from the Chair

I hope you have been enjoying your summer, and staying cool. Although you may not have seen the Board as often, due to our full-board meetings convening every other month, the Board has been hard at work. I am pleased to tell you that the implementation of our subcommittees (Discipline, Practice/Legislative, Regulation, and Education) has been very successful, as you will see below. The subcommittees are comprised of three board members, one of which is the committee chairperson, and at least one staff member. These smaller meetings have enabled board members to lend their expertise on the committee where it is best utilized. The full board reviews the subcommittee's recommendations and are better able to focus of the key issues brought before it by the subcommittee. This change in structure has increased the board's productivity.

The **Discipline Committee** [chaired by Mary Ellen Husted] has been given the authority to make disciplinary decisions on behalf of the Board. Since its inception, the Discipline Committee has had met with nurses for a number of reasons --- they have been suspended by the board and asking to have their license reinstated, they have a disciplinary action pending before the Board and as part of the disciplinary process they have asked for a settlement conference with the Board, in lieu of a hearing. The Committee has also reviewed a number of criminal background checks (see page 9) The Board is fortunate to have the Committee on Impaired Nurses as a resource. A number of persons are referred to COIN to determine whether or not the persons need to be monitored due to substance abuse and/or mental illness. The Discipline Committee has been authorized by the Board to make final discipline decisions, or refer to the full board, if they deem necessary for broader

input from the full Board. In the back of DC Nurse you will see both public and private board disciplinary actions in each issue.

Our **Practice/Legislative Committee** [chaired by Simmy Randhawa] drafted four advisory opinions to date, including suprapubic catheter replacement, staple removal, ear lavage, and Isoflurane for Status Asthmaticus. The drafts will be considered by the full-Board at the September Board meeting. The committee will also submit a new format for these opinions, for board approval. Once approved the advisory opinions will be on our website. In addition to considering practice issues this Committee has been charged with responding to legislation impacting the practice of nursing. We have reviewed and prepared comments regarding the Patient Protection Act (see Pro and Con opinions on page 14) and drafted recommendation for the Medispa and Telemedicine draft legislation and comments regarding the Prescription Drug Monitoring bill.

The **Regulation Committee** [chaired by Winslow Woodland] continues to review public comments regarding the Nursing Assistive Personnel Omnibus Regulations from hospitals, dialysis centers, the disability provider community, and assisted living providers. Omnibus regulations include proposed Dialysis Technician, Medication Aide, and Certified Nursing Assistant/Patient Care Technician Regulations. The Committee has completed reviewing all of the comments. The full-board has reviewed our recommendations regarding the Dialysis Technician and Medication Aide regulations.

At the next full-Board meeting in September, Committee's recommended amendments to the Certified Nursing Assistant/Patient Care Technician regulations will be discussed. This has



Mary Ellen R. Husted, RN, BSN, OCN

been a huge undertaking and we are grateful to all who have helped.

The **Education Committee** [chaired by Toni Eason] met with two continuing education providers who are interested in creating continuing education courses based on the Board's suggested topics. We have also met with the nursing education community to discuss proposed major changes to Nursing School regulations. Input at this time is extremely helpful as it reduces extra work when the regulations are out for public comment. We have also reviewed comments to the RN regulations and made revisions as appropriate. And we have provided the Regulation Committee with recommendations for revising the training requirements in the Nursing Assistive Personnel regulations. During this time, the committee has also addressed complaints from consumers regarding nursing schools and has reviewed Adult Protective Services mandatory curriculum.

We could not have accomplished all of this without the wonderful support of our Board of Nursing staff and the encouragement we have received from our public members who join us at our meetings and take time to provide written comments regarding our proposed regulations. Our work is not done, and we will need this continued support.

Thank you so much and we look forward to seeing you at our open sessions. ■

Mary Ellen R. Husted, RN, BSN, OCN
Chairperson, DC Board of Nursing

LPN Continuing Education Audit

The LPN CE audit concluded December 31, 2012. Any nurse who was not compliant with the negotiated settlement agreement was not able to renew their license until the settlement agreement was fulfilled.

LPNs Negotiated Settlement Agreement: \$500, Ethics Course, 18 hours of continuing education required to be submitted prior to licensure renewal.

RN Continuing Education Audit

The RN CE audit has been concluded. Negotiated settlement agreements will be sent to those nurses selected for the audit, but did not meet CE compliance or did not respond. Non-compliance with the negotiated settlement will mean that registered nurses, and APRNs will not be able to renew their license in 2014.

RNs Negotiated Settlement Agreement: \$500, Ethics Course, 24 hours of continuing education required to be submitted prior to licensure renewal.

Trained Medication Employee (TME) Recertification

TMEs please be reminded that your certification will expire October 30, 2013

To renew online: Go to the HPLA website at www.hpla.doh.dc.gov

(Web browser must be Internet Explorer or Firefox)

Requirements for re-certification: Submit completed application along with application fee

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

Verification of continued adequacy of performance: Skills check list signed by supervising nurse

Evidence of continued competency: Successful completion of twelve (12) hours of board approved in-service training.

Do not submit this information until you receive a letter from the DC Board of Nursing requesting that it be submitted.



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

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

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

Location:
2nd Floor Board Room
899 North Capitol St NE
Washington, D.C. 20002

Transportation:
Closest Metro station is Union Station.

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

September 4, 2013

November 6, 2013

***Please note new schedule**

HOME HEALTH AIDES Update

Thus far, we have approved approximately 6,000 HHA applications with approximately 3,000 pending. All applications submitted have been entered into our licensure system. HHA waiver applications should either be “Active” or “Pending.” HHA exam applications should either read “Active” or “Pending Exam.”

WHAT DOES “PENDING” MEAN?

It means that the application has been submitted and it is in the queue to be reviewed for approval of certification. As noted above we have approximately 3,000 pending review and approval.

WHY IS IT TAKING SO LONG?

We have received approximately 10,000 HHA applications in less than a year. Staff are still responsible for

processing and approving other licensure categories that come under the auspices of the Board of Nursing (RN, APRN, LPN, TME) as well as Nurse Staffing Agencies. Additionally we have just completed our LPN Renewal period and are making plans for the TME Renewal (pg 5).

SOME OF THE APPLICATIONS THAT I HAVE SUBMITTED HAVE BEEN APPROVED WHILE OTHERS HAVE NOT AND THEY WERE SUBMITTED AT THE SAME TIME. WHY ARE THEY ALL NOT APPROVED AT THE SAME TIME?

Applications are delayed for many reasons such as discrepancies or inconsistencies in the information provided or due to a positive criminal background check. Discrepancies and inconsistencies may be due to the fact that the information provided by the applicant is not the same as the information provided by the employer, such as HHA training program and dates of employment. Or the school the applicant attended may not be an approved HHA program.

Reviewing of positive CBCs takes a considerable amount of time. The initial FBI or State CBC reports provided to staff only indicate that the CBC is positive; the reason for the positive CBC is not provided. It may be positive as a result of an arrest or a conviction or it may be positive due to a bad check or immigration issues (see graph on pg 9). Although the incident may have occurred a number of years ago, when we receive a positive CBC we don't know the disposition until we obtain access to the full CBC report. Applicants with arrests or convictions occurring more than seven years ago may be approved for certification. The deciding factor is the seriousness of the crime. All positive

CBCs are reviewed and considered on a case-by-case basis.

It takes a considerable amount of time to review these reports and determine whether or not we can approve the applications. In some instances, staff may need to contact the applicant asking that they submit records from the court to determine their current disposition and to have a better understanding regarding the seriousness of the reported crime. In addition to speaking with the applicant, staff may also be in contact with their probation officer or others who can better help staff determine the applicant's ability to practice safely.

The Board is fortunate to have the Committee on Impaired Nurses (COIN) as a referral resource. Persons with arrests or convictions such as DWIs/DUIs or with drug trafficking are referred to COIN by the Board to determine whether or not they are safe to practice.

IS IT TOO LATE FOR PERSONS MISSING THE HHA WAIVER DEADLINE TO APPLY?

It is too late for persons to apply for HHA certification by waiver of examination but the Board has agreed to allow persons practicing as HHAs to take the HHA examination. They will need to submit an application for HHA certification by examination and provide evidence of having completed a board approved HHA training program. They will not be able to work as an HHA until they pass the examination and are approved for certification.

*CHECK WWW.HPLA.DOH.DC.GOV --- Licensee search to determine the status of a HHA application. ■

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Midwives Speak to Board

Whitney Pinger, Certified Nurse Midwife, and Nicole Jolley, Certified Professional Midwife, appeared before the Board to ask for their support in regulating the practice of Direct Entry Midwives in the District. Currently, certified nurse midwives are regulated but others practicing in the District as midwives are not.



CNMC Request: Isoflurane Therapy in PICU

Krista Cato, RN, and Jeannette M. Mitchell, RN Children's National Medical Center appeared before the Board to request the utilization of Isoflurane therapy for life threatening asthma in Children's Pediatric Intensive Care Unit (PICU) by RNs.

IN THE KNOW

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

FEE FOR LICENSE IN THE MIDDLE OF 2-YEAR CYCLE

Q: I am starting my application process for a DC RN license. All licenses expire on June 30th of even numbered years, if I apply this year does this mean the \$230 fee will only be good for one year for me?

A: You are correct. You will be licensed for one year. All RN licenses expire June 30, 2014.

HHAs

Agency: I have some names of aides that [our agency] wants to turn in to the Board of Nursing. What is the process? Who do we submit the information to?

Board: You can find the complaint form online at <http://doh.dc.gov/node/145702>. Have we certified the persons named in the complaint?

Agency: Yes, two of them are certified—both terminated. One for fraud, and one for attempting to commit fraud.

Board: Have they been reported to Medicaid or the OIG for Medicaid fraud (if that is what it is)? If not, we can forward the complaint.

Agency: We have paid back the money to Medicaid, but we have not notified the other agencies. I am going to write these up and send them to you because it was my understanding that we must submit the names of any employee that has been terminated, even if it is not fraud-involved. Is that correct? Please advise because I don't want to overwhelm the stressed system unnecessarily.

Board: You are correct. If a person licensed or certified by a health care board

is terminated for a practice related issue you are required to report the termination to the appropriate board.

We are working with other agencies to assure that the appropriate agencies such as, the Office of the Inspector General, Medicaid, Health Regulations Administration, receive information sent to us regarding complaints, when appropriate.

CBCs

Q: If an applicant walks into the DC Board of Nursing with his fingerprints or has completed the MorphoTrust process in DC, can his or her license be issued the same day?

A: No, they will not be licensed the same day. MorphoTrust has to have time to send us the results.

Q: Are licenses issued after the fingerprint results are back or after DC Board of Nursing has received them?

A: All applications are initially received by our processing unit. Once the fee, all required documents and notification that a CBC has been completed, the application is submitted to Board staff for review and approval.

Q: If MorphoTrust is done, how long does it take for fingerprints to be cleared?

A: In most cases it takes MorphoTrust 24-48 hours to provide us with the results of the criminal background check. If the prints are unreadable or if the state requires additional documentation prior to processing the fingerprints, the time period will be longer.

Q: Once the license packet is received with fingerprints, which department does it go to initially?

A: All applications are initially received by our processing unit. Once the completed application and required documents, and CBC results are received, the application is submitted to Board staff for review and approval.

Q: Typically how long does it take for a license to be issued?

A: We recommend having applicants submit their application at least 2 weeks prior to their expected start date.

Q: If an applicant marked "yes" for any felonies/criminal history, is there an additional waiting period on this?

A: Yes. We need to review the arrest/conviction record.

Q: Can a clinician get a permanent license with fingerprints pending?

A: A permanent license is not issued until the results of the fingerprinting are received.

Q: If a clinician resides outside of DC and they opt for the fingerprints to be done with the MorphoTrust, does that take more time? Or would it be faster to complete this portion of the license in DC for quicker processing?

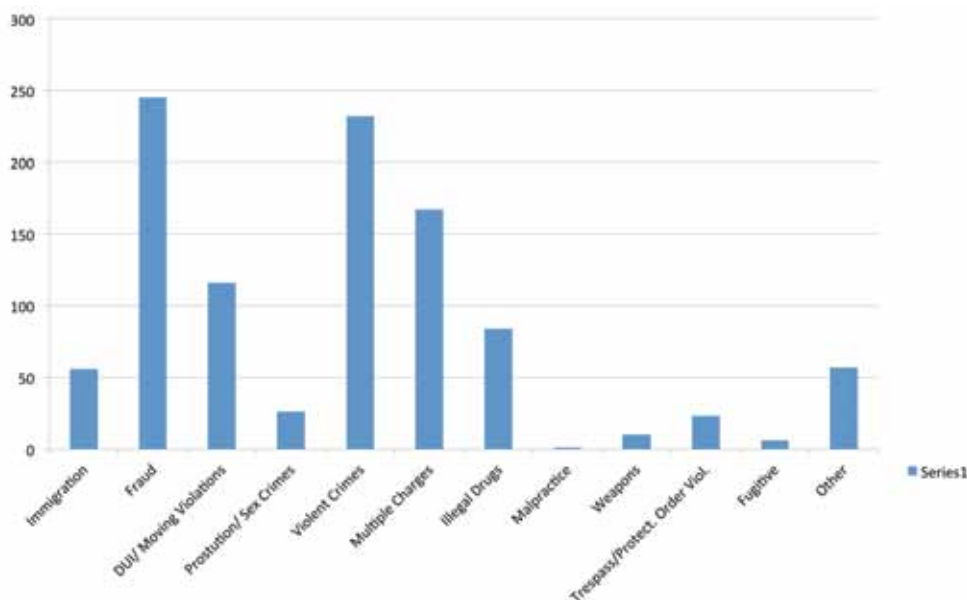
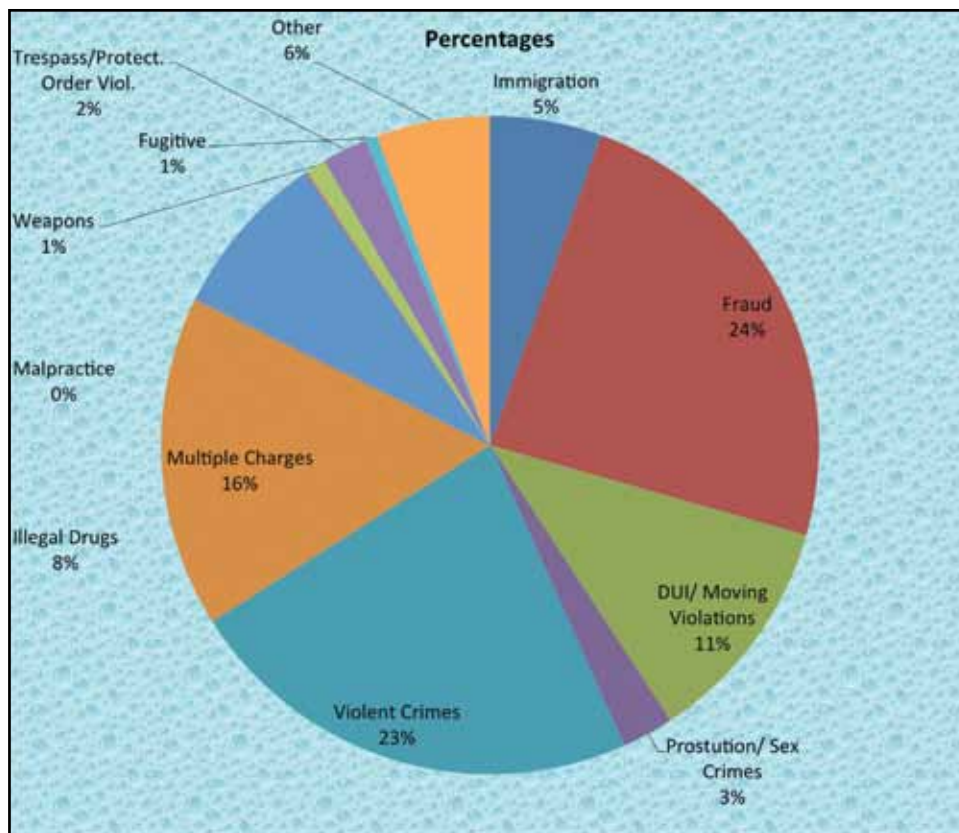
A: Background checks for DC must be done via MorphoTrust. Applications will not be considered

Continued on page 10

CRIMINAL BACKGROUND CHECK RESULTS FOR RNs/APRNs/LPNs/TMEs

Dear Readers:

The members of the Board of Nursing staff are often asked about the results of our criminal background checks. The graphs below provide the percentages regarding the types of offenses that have been found on our applicants' records. ■



Continued from page 9

complete and eligible for review by Board staff until the CBC results are received. The fingerprinting process is quicker if they have their fingerprinting done by one of the fingerprinting venues in DC or Maryland. But, this does not mean that they will be licensed immediately after they have completed their CBC. We average 400 RN/LPN/APRN applications a month. Applicants residing outside of DC can contact MorphoTrust for directions for mailing their fingerprints for processing. If they have submitted a complete application and we receive their CBC results, they may be licensed before their start date.

NON-NURSING SUPERVISORS

Q: We had a question arise about RNs reporting to non-nursing supervisors. We have had for years nurses working out of the quality office who do data abstraction, core measure reporting etc. and who report to the Chief Medical Officer. Is this a violation of DC Municipal Regulations for RNs? I reviewed the regulation myself, but did not see any reference to that.

A: The Health Occupations Revision Act states the "Practice of Registered Nursing means... (N) Managing, supervising, and evaluating the practice of nursing;" Thus, the scope of nursing practice requires that RNs be supervised by RNs. Administrative duties can be supervised by persons who are not RNs. ■

REGISTERED NURSE SCOPE OF PRACTICE

"(17) "Practice of registered nursing" means the performance of the full scope of nursing services, with or without compensation, designed to promote and maintain health, prevent illness and injury, and provide care to all patients in all settings based on standards established or recognized by the Board of Nursing. The practice of registered nursing includes:

- "(A) Providing comprehensive nursing assessment of the health status of patients, individuals, families, and groups;
- "(B) Addressing anticipated changes in a patient's condition as well as emerging changes in a patient's health status;
- "(C) Recognizing alterations of previous physiologic patient conditions;
- "(D) Synthesizing biological, psychological, spiritual and social nursing diagnoses;
- "(E) Planning nursing interventions, and evaluating the need for different interventions and the need for communication and consultation with other health care team members;
- "(F) Collaborating with health care team members to develop an integrated client-centered health care plan as well as providing direct and indirect nursing services of a therapeutic, preventive, and restorative nature in response to an assessment of the patient's requirements;
- "(G) Developing a strategy of nursing care for integration within the patient-centered health plan that establishes nursing diagnoses, sets goals to meet identified health care needs, determines nursing interventions, and implements nursing care through the execution of independent nursing strategies and regimens requested, ordered or prescribed by authorized health care providers;
- "(H) Performing services such as:
 - "(i) Counseling;
 - "(ii) Educating for safety, comfort, and personal hygiene;
 - "(iii) Preventing disease and injury; and
 - "(iv) Promoting the health of individuals, families, and communities;
- "(I) Delegating and assigning interventions to implement a plan of care;
- "(J) Administering nursing services within a health care facility, including the delegation and supervision of direct nursing functions and the evaluation of the performance of these functions;
- "(K) Delegating and assigning nursing interventions in the implementation of a plan of care along with evaluation of the delegated interventions;
- "(L) Providing for the maintenance of safe and effective nursing care rendered directly or indirectly as well as educating and training persons in the direct nursing care of patients;
- "(M) Engaging in nursing research to improve methods of practice;
- "(N) Managing, supervising, and evaluating the practice of nursing;
- "(O) Teaching the theory and practice of nursing; and
- "(P) Participating in the development of policies, procedures, and systems to support the patient."

When a CBC Reveals Driving Under the Influence (DUI)

By Kate Driscoll Malliarakis, PhD, CNP, MAC

Last month, DC Nurse featured one of our “success” stories—a nurse who came into the Committee on Impaired Nurses (COIN) program and used the structure of the program to regain a life worth living. We love those success stories!!

The new background checks instituted by the Board of Nursing have brought the COIN many new participants. Nurses are surprised when a DUI or DWI shows up on their background check and often respond “but it’s only one DUI!!!” White and Gasperin (2007) offer the following facts about DUIs:

Between 40-70% of first-time DUI offenders have prior alcohol- or drug-related criminal offenses.

A driver would have to commit between 200 and 2000 repetitions of impaired driving violations to statistically generate one arrest.

More than 80% of DUI offenders have a significant problem in their relationship with alcohol and/or other drugs.

Reading that data, it is difficult to simply ignore a DUI or DWI. They are serious charges. COIN looks upon DUIs and drug diversion as opportunities to help you examine your relationship with drugs and alcohol, and if need be, assist you in developing a recovery program that works for you.

COIN can also assist you in assistance for your mental health issues. Sometimes, issues such as depression, anxiety, bipolar, ADHD can affect the way you are able to practice. COIN works with you and your healthcare provider to ensure that you have a safe nursing practice while grappling with mental health issues.

The goal of COIN is to preserve the nurse while protecting the public. If you have any questions, you can contact Concheeta Wright, Clinical Nurse II, Nurse Manager of COIN, (concheeta.wright@dc.gov) or call her at (202) 724-8870.

REFERENCES

White, W. & Gasperin, D. (2007). The “hard core drinking driver:” Identification, treatment and community management. *Alcoholism Treatment Quarterly*, 25(3), 113-132.

ANA Hails Iowa Court Ruling

The American Nurses Association (ANA) hailed the Iowa Supreme Court decision affirming Advanced Registered Nurse Practitioners' (ARNPs) ability to supervise a certain high-tech X-ray and imaging procedure as a victory for Iowa residents, who will benefit from having broader access and choice in obtaining important health care services.

The appeal to Iowa's highest court by three nursing organizations was spurred by an Iowa District Court judge's ruling that supervision of fluoroscopy was not "recognized by the medical...profession as proper to be performed by the registered nurse," as required by Iowa Nursing

Law. Fluoroscopy is a real-time X-ray imaging technique used to guide a variety of diagnostic and interventional procedures. The legal issue involves "scope of practice" – the range of services that nurses are educated and licensed and/or certified to provide.

"We believe the district court erred in second-guessing the department of public health and nursing board on the adequacy of ARNP training to supervise fluoroscopy," the Iowa Supreme Court wrote. "The record affirmatively shows ARNPs have been safely supervising fluoroscopy and are adequately trained to do so...[A]llowing ARNP supervision of fluoroscopy improves access to



health care for rural Iowans and helps lower costs."

The Iowa Nurses Association (INA) had initially intervened in the case along with the Iowa Association of Nurse Anesthetists on the side of the Iowa Board of Nursing, which defended its regulation against claims of illegality by the Iowa Society of Anesthesiologists and the Iowa Medical Society. ■

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Nursing Schools and Hepatitis B Discrimination

The Department of Justice, the Department of Education, and the Department of Health and Human Services sent a joint letter to the nation's medical schools, dental schools, nursing schools, and other health-related schools regarding hepatitis B discrimination. The departments expressed concern that some health-related schools may be making enrollment decisions based on an incorrect understanding of the hepatitis B virus, resulting in discrimination.

The letter updates schools on the latest recommendations from the Centers for Disease Control and Prevention (CDC). The letter also emphasizes the importance of CDC's recommendations, especially as they relate to the schools' obligation to comply with federal laws prohibiting discrimination on the basis of disability, race, color, and national origin.

Approximately 800,000 to 1.4 million people in the United States have hepatitis B. Asians, Native Hawaiians, and Pacific Islanders make up roughly 4.5 percent of the U.S. population, but represent 50 percent of the persons with hepatitis B in the United States. The letter cites to a March 2013 settlement agreement that the Justice Department reached with a medical school and a school of osteopathic medicine resolving allegations that the schools violated the Americans with Disabilities Act by excluding previously-accepted applicants with hepatitis B from their programs.

The updated CDC recommendations dispel many myths associated with hepatitis B and provide guidance to health-related schools on managing students with the virus. Among other recommendations, the CDC recommends that chronic hepatitis B virus

infection, in itself, should not preclude the study or practice of medicine, surgery, dentistry, or allied health professions.

The Departments of Justice, Education, and Health and Human Services share responsibility for protecting the rights of students and applicants with disabilities, including those with hepatitis B, in schools of higher education by enforcing titles II and III of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. The Departments of Justice, Education, and Health and Human Services also enforce Title VI of the Civil Rights Act, which prohibits discrimination on the basis of race, color, or national origin in programs and activities receiving federal financial assistance, including those of health-related schools. ■

NCSBN launches a mobile site

The National Council of State Boards of Nursing Inc. (NCSBN) announces the launch of its new mobile website, m.ncsbn.org, to optimize the experience of smartphone and tablet users.

NCSBN's website hosts more than 4.5 million visits a year; 12 percent of all visits are with a mobile device. This represents 192 percent increase in such visits over the last year. Regardless of the platform used, NCSBN is committed to providing the best possible website visitor experience and that goal moved the organization to accommodate the needs of mobile users with this new site.

NCSBN's mobile website is specifically designed to increase accessibility to users on the go with an easy to browse and simple layout,

which utilizes mobile user experience design best practices. With an eye toward maximizing the mobile user experience, m.ncsbn.org features the most popular content from the site, including NCLEX Exams, Nurse Licensure Compact, nurse license verification and board of nursing contact details.

In the future geo-location services will also be available. Ultimately, a single site that will be responsive to both desktop and mobile screen sizes will be developed, eliminating the need for a separate mobile version.

Founded March 15, 1978, as an independent not-for-profit organization, NCSBN was created to lessen the burdens of state governments and bring together boards of nursing (BONs) to

act and counsel together on matters of common interest. NCSBN's membership is comprised of the BONs in the 50 states, the District of Columbia, and four U.S. territories — American Samoa, Guam, Northern Mariana Islands and the Virgin Islands. There are also 12 associate members that are either nursing regulatory bodies or empowered regulatory authorities from other countries or territories.

NCSBN Member Boards protect the public by ensuring that safe and competent nursing care is provided by licensed nurses. These BONs regulate more than 3 million licensed nurses, the second largest group of licensed professionals in the U.S.

The Patient Protection Act of 2013 (B20-101)

The introduction this year of the "Patient Protection Act" has resulted in heated debates in the District's health care community. Below you will find "Pro and Con" positions regarding this legislation. Where do you stand? Your feedback is welcomed send to hpla.doh@dc.gov

By Judy Alba MA, CAPA, RN



PRO

"I think this bill is today's version of the eight-hour day—something that we will see business resist but, on the other hand, makes good sense and leads to quality care"—Phil Mendelson on February 5, 2013, introducing the Patient Protection Bill of 2013 in the District of Columbia City Council.

With the sponsorship of the Chairman of the City Council, and nine other members, DC nurses from across the city under the umbrella organization National Nurses United (NNU), which represents over 4,000 registered nurses in the District, have introduced The Patient Protection Act of 2013. With a few differences, this bill was modeled after California's law of 1999, to address a persistent patient safety crisis that exists in DC's hospitals. As it is reported yearly by the Hospital Consumer Assessment of Healthcare and Systems, District of Columbia hospitals fall below the

national average on most indicators for patient satisfaction, and patient safety.

Fundamentally, the bill seeks to establish minimum ratios that are safe for each specialty unit in hospitals at all times (including meal break times). The bill also institutes unit-based committees composed of 50% direct care RNs, which would serve to correct staffing according to patient acuity. These committees can provide the flexibility that is needed for the 20% of unpredictability that commonly exists in hospitals with regards to patient acuity (Porter

O'Grady & Malloch, 2011). In addition, the bill bans mandatory overtime, which many hospitals use to fill their staffing shortages, in excess of what is safe. It also provides for whistle blowing protection for hospital nurses that expose patient safety violations.

What makes this bill controversial, and also has provoked the reaction of the American Hospital Association to spend millions of dollars to lobby against this kind of legislation around the country, is the regulatory aspect of the bill with a strong reinforcing safeguard: It includes

a \$25,000.00 fine for each day that a violation occurs. In fact, the same day the Patient Protection Act was introduced, Councilwoman Mary Cheh presented a different version of the bill which also calls for the establishment of staffing committees, but includes no consequences for violations. NNU representatives call it “the do nothing bill,” as it basically maintains the status quo. In practice, hospitals continually violate their own staffing policies and District regulations in the absence of enforcement legislation.

Since this same legislation took effect in California in 2003, numerous studies have been conducted that give mounting evidence of the close link that exists between patient outcomes and nurse-to-patient ratios. It has been documented, for example, that improving nurse workloads and staffing can prevent 30 day readmissions for heart failure, acute myocardial infarction, and pneumonia (McHugh & Ma, 2013); or that higher nurse staffing levels protect postoperative cardiac surgery patients from unplanned readmissions to the intensive care unit or the operating room, as well as from in-hospital mortality (Diya, Van den Heede, Sermeus & Lesaffre, 2012). Other studies find that for every additional patient assigned to an RN there is a 7% increase in the risk of hospital acquired pneumonia, a 53% increase in respiratory failure, a 17% increase in medical complications (Kane, Shamliyan, Mueller, Duval & Wilt,

2007); Nurse-to-patient ratios are directly related with urinary tract infections and surgical site infection (Cimiotti, Aiken, Sloane & Wu, 2012).

Understaffing, and unsafe workloads, are the most important causes of nurse burnout and dissatisfaction among nurses (Van den Heede, et al, 2013; Aiken et al, 2010). Chronic RN understaffing, and eroding patient safety was expressed by the majority of District of Columbia nurses in a survey conducted by NNU in 2012. Eighty seven percent of the 857 nurses that answered the survey responded that mandatory RN-to-patient ratios are a necessary measure to improve the situation. Focused group discussions of RNs conducted by NNU in 2012, and testimonies expressed at the City Council, have revealed that hospitals frequently do not follow their own staffing policies and matrixes. The opinion of the nurses, and that of some experts is that in the absence of mandatory ratios legislation, hospital corporations are not inclined to maintain minimum safe staffing, as their priority is mainly focused on saving labor costs (Aiken, Clarke & Sloan, 2001).

Mounting evidence of the past 10 years strongly suggest that RN-to-patient ratios is a cost effective solution for hospitals and could produce billions in reduced patient care costs on a number of different fronts, such as fewer complications, less litigation, shorter patient hospitalization stays, fewer readmissions, less nurse

turnover, less need for temporary and traveling nurses. Investment in additional nursing care hours better prepares patients for discharge, which results in less readmissions (Weiss, Yakushua & Bobay, 2011). Adding 133,000 RNs to acute-care hospitals nationally would result in an estimated \$6.1 billion in reduced patient care costs, and an additional \$231 million per year when nurses help patients to recover more quickly reducing hospitalization days (Dall, Chen, Seifert, Maddox & Hogan, 2009). Reducing the high RN turnover rate, estimated at 18.5 percent nationally (Washington DC’s is 20 percent), could save about \$20 billion every year based on a 2007 inflation-adjusted turnover cost of \$82,000 to \$88,000 per RN (Jones, 2008).

The choice to support The Patient Protection Act is becoming clear for most bedside care nurses and unit supervisors, even as hospital executives recite many of the same arguments that were used to oppose the California legislation. They generally cite overwhelming economic burden to hospitals, reduction of the skill mix to care for patients and subsequent reduction of the ancillary work force, as well as lack of evidence of the difference that the legislation makes in patient outcomes. The ten years since the implementation of the legislation in California, and the production of numerous studies in this same

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period (more than can be cited in this short article), have contradicted most of those arguments (Mchugh, Kelly, Sloane & Aiken, 2011; Weiss, Yakusheva & Bobay, 2011). Today there is increased certainty that the regulation is not only a common sense measure to improve oppressive workloads, but it would also reduce mortality and injury to patients.

Most acute care hospital nurses in the District of Columbia experience the frustration of not having time to care adequately for all patients assigned to them. I have been a nurse for thirty years, and like most of my experienced colleagues, can testify that our work environments have deteriorated significantly in terms of understaffing since the 1990's when most hospitals in the District changed ownership to large corporations. Very often we have to work in constant fear that our patients may suffer some kind of harm, or that our licenses to nurse patients and earn our livelihoods maybe at risk. Nurses have the right and the mandated duty to advocate for their patient's wellbeing unhindered, and un-encumbered by poor working conditions.

The struggle to pass this legislation takes advocacy for patients and for the nursing profession to a new level of activism among DC nurses. It also has the potential to transform the present patient care crisis in the District of Columbia in a matter of a few years if the bill passes.

For any information about The Patient Protection Act, and

opportunities to participate in the coming activities at the City Council please contact

healcdc@nationalnursesunited.org or call 240-235-2000.

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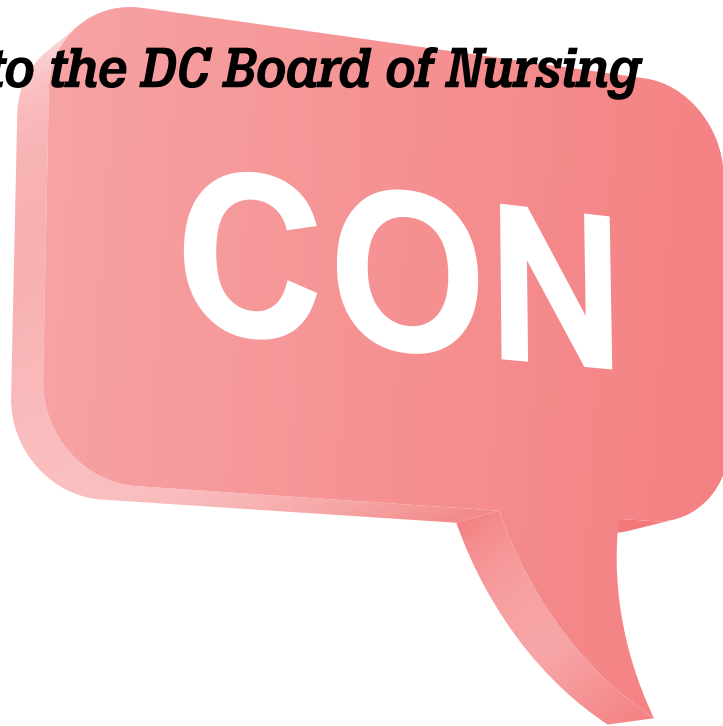
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A Letter to the DC Board of Nursing

By Delores Clair, RN, MHA, CNAAB, BC
President, DC Organization of Nurse
Executives (ONE)



We write to you today asking you to oppose B20-101, the Patient Protection Act of 2013, which would result in mandated staffing quotas at all District of Columbia hospitals. Although this legislation is being positioned as a “Standards of Care” bill, the reality is that the bill’s provisions have little to do with establishing standards to improve the care we provide our patients. As Chief Nursing Officers from across the District, we’re concerned with the unintended yet predictable consequences of this legislation. This legislation would increase patient, taxpayer and hospital costs without advancing patient safety or quality. It is a solution in search of a problem.

Scheduling staff for a hospital is unlike staffing other work places. It is extremely challenging to try to foresee or plan for the emergencies that will inevitably affect the needs of the patient population. As Chief Nursing Officers, we work with care teams at our local hospitals to determine staffing. We have to consider individual patient needs along with the training, experience and capabilities of the whole care team when scheduling shifts. Circumstances in a hospital can change at a moment’s notice and we need the flexibility to properly care for the people involved in those emergencies. This legislation would deprive local hospitals of the flexibility needed to make the best staffing decisions for our patients.

When emergencies like this year’s flu epidemic caused an influx in emergency rooms, we take advantage of our cross-trained staff of caregivers. By utilizing our entire staff rosters, we are able to care for the emergency victims and other critical care patients. If this bill were to become law, our ability to provide care would be limited.

Successful patient care comes from a team of healthcare providers. It is about doctors, advanced practice nurses, registered nurses, licensed practical nurses, nurse assistants, and others working together to provide patients with the best quality care. A rigid quota from the government would restrict us from providing patients with our staff’s highest level of expertise.

We look to nurses to use their critical thinking skills to provide patients with the best care. They know when to call on other team members and when to request more staff. Hospitals in the District provide the high quality care we do in large part because of the high quality staff we attract and retain.

Staffing is a collaborative effort that

takes place between nurse leaders, staff nurses and other members of the care team. It is a complex and dynamic process that requires intense knowledge of staff capabilities, patient care and the ongoing change in needs of the patient population. We urge you to keep staffing decisions with the people who know their hospital’s needs best: nurses and care teams at local hospitals. We would welcome the chance to speak with you about this issue. ■

Link to the DC Patient Protection Act 2013

<http://dcclims1.dccouncil.us/images/00001/20130207134956.pdf>

ANA- Nurse Staffing Plans & Ratios

<http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/State/Legislative-Agenda-Reports/State-StaffingPlansRatios>

AONE- Policy Statement on Mandated Staffing Ratios

http://www.aone.org/resources/leadership%20tools/PDFs/ps_ratios.pdf

Continuing Education Update

Physical Assessment

Assessment skills are essential to excellence in nursing practice. “If a nurse cannot assess—everything else is just following orders,” according to the Board’s Nurse Specialist for Education Bonita Jenkins, EdD, RN, CNE, who addressed the topic of physical assessment recently at a Board-sponsored continuing education program. Dr. Jenkins was joined at the podium by colleague Elizabeth Miller, DNP, RN, CCM, who is an Assistant Professor in the Department of Nursing at Bowie State University.

The speakers described assessment techniques for Integumentary, Cardiovascular, Musculoskeletal, Respiratory, Gastrointestinal, and Neurological systems; discussed the

subjective and objective data that should be obtained from the six systems; explained the normal findings for the six systems; and provided samples of appropriate documentation for the six systems.

“Assessment is extremely important in this day and time,” Dr. Jenkins said. **“A nurse is only as good as her/his assessment skills and ability to document findings.”**

Initial Observations: Your assessment should begin before you speak with the patient. Watch and observe patient’s height, stature, gait, fat distribution, level of nutrition, facial features—do you note any distress or trauma? Write what you observe. Are the patient’s word choices and ideas clear?

Avoid Writing “Normal”: Dr. Jenkins cautioned nurses against writing “normal” as part of assessment. “Nurses like to write ‘normal’ in documentation,” she said. However, your assessment should state what you have found more specifically. **“If you cannot define normal, do not document normal,”** Dr. Miller told attendees.

Copycat Syndrome: Do not document what the nurse before you wrote, just for the sake of expediency. You may be the only member of the nursing staff conducting an accurate assessment.

Frequent Flyers: Dr. Miller indicated that some patients may feign symptoms. Someone having a seizure cannot speak and is unaware of their surroundings. Be cognizant of this fact if patient tells you, “I am having a seizure.”

INTEGUMENTARY ASSESSMENT – SKIN, HAIR AND NAILS

Do a quick general survey looking head to toe, looking for obvious lesions, then start head to toe examining lesions with a penlight and gently palpating after inspection. For skin lesions, note the color, size, location, drainage, wound bed, peri-wound tissue, and treatment.

The various types of lesions and the classifications of pressure ulcers were discussed.



Elizabeth Miller, DNP, RN, CCM

SAMPLE DOCUMENTATION OF SKIN ASSESSMENT

Skin: Dark brown, soft, dry, warm, turgor resilient; no edema, odor or excess perspiration; freckling over cheeks and nose; 2 cm scar over left scapula; 4 mm round brown nevi on left thigh; no other lesions;

Hair: coarse, curly, black with few gray, male distribution pattern thinning at crown, no infestations.

Nails: smooth, hard, uniform, no clubbing or spooning, nail folds without redness, swelling or lesions.

CARDIOVASCULAR ASSESSMENT

Dr. Jenkins reviewed the anatomy of the heart and great vessels and discussed the cardiac cycle as it relates to EKG and heart sounds. She also provided a list of subjective data that should be collected, such as chest pain, cough, cardiac history, personal habits, as well as objective data through assessment.

Inspect – Neck for Jugular Vein Distention (JVD), and point of maximum impulse (PMI)

Palpate – chest wall for lesions beneath the skin and PMI, palpate peripheral arteries bilaterally, except carotids (Never palpate both carotid arteries at the same time)

Auscultate – carotid using bell of stethoscope, auscultate chest (supine, left latera) recumbent, and then sitting for rate and rhythm. Use the diaphragm, then the bell, in the order:


- Aortic
- Pulmonic
- Erb's Point
- Tricuspid
- Mitral

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Bonita Jenkins, EdD, RN, CNE

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Dr. Jenkins stated that you can remember the order of heart assessment by the saying: “All People Enjoy Time Magazine.”

SAMPLE DOCUMENTATION OF CARDIOVASCULAR ASSESSMENT

PMI not seen on precordium inspection, Regular rhythm S_1 and S_2 present, rate 86 bpm no extra or abnormal sounds heard in apex or base. No pulse deficit. No bruits. PMI palpated at 4th intercostal space L. mid-clavicular line. Carotid arteries palpable, no bruit. JVD absent at 45° angle. All peripheral pulses palpable bilaterally 3+, capillary refill < 3 sec in upper and lower extremities. No edema noted in extremities.

RESPIRATORY ASSESSMENT

Dr. Miller presented assessment of the respiratory system. She indicated, “begin by inspecting the thoracic cage—anteroposterior and lateral dimensions. Inspect the skin over the chest and back, noting the color and condition. Note the client sitting position and work involved when breathing; as well as the respiratory rate.

“Next is palpation. Palpate posterior chest wall for symmetric expansion and tactile fremitus.”

“Percussion would be next if done, in most cases, nurses do not percuss.”

“Then, auscultate, the passage of air through tracheobronchial tree creates a characteristic set of noises that are audible through the chest wall. These sounds may be modified by obstruction within respiratory passageways or by changes in lung tissue, the pleura, or chest wall.”

SAMPLE DOCUMENTATION OF RESPIRATORY ASSESSMENT

Patient sitting upright during assessment, Anteroposterior to lateral diameter is 1:2 and breathing is easy and unlabored. Color is consistent with genetic background. No lesions noted in anterior or posterior chest wall. Tactile fremitus noted to be equal bilaterally over posterior wall. Chest expansion is symmetrical. No percussion performed. Vesicular breath sounds are clear throughout periphery.

ABDOMINAL ASSESSMENT

Dr. Miller provided information on abdominal assessment. **There is a specific order for assessment of the abdomen.** It is inspection, auscultation, percussion, and palpation.

Inspect the abdomen for contour, symmetry, the position of umbilicus, the condition of the skin. In addition the

nurse should inspect for pulsation in the abdomen.

Auscultation of the abdomen begins in RLQ at ileocecal valve area because bowel sounds are normally always present there, then proceed clockwise to the RUQ, LUQ, and LLQ. Use diaphragm of stethoscope. Note character and frequency of bowel sounds. Depending on time elapsed since eating, a wide range of normal sounds can occur. Bowel sounds are high pitched, gurgling, cascading sounds, occurring irregularly anywhere from 5 to 30 times per minute; do not bother to count them. Use the bell of stethoscope to listen over aorta and renal arteries for bruit.

Percuss to assess relative density of abdominal contents, to locate organs, and to screen for abnormal fluid or masses. Dull sounds are heard over organs tympany should predominate because air in intestines rises to surface when person is supine.

Palpate surface and deep areas. Begin with light and then deep palpation. With first four fingers close together, depress skin about 1 cm. Make gentle rotary motion, sliding fingers and skin together. Then lift fingers (do not drag them) and move clockwise to next location around abdomen.

SAMPLE DOCUMENTATION OF ABDOMINAL ASSESSMENT

Skin over abdomen is consistent in color, no lesions. Noted pulsation over aorta in mid - lower abdomen. Contour is flat. Bowel sounds present with normal rate in all four quadrants. No bruit heard over aorta or renal arteries. No percussion. Light palpation revealed no tenderness.

MUSCULOSKELETAL ASSESSMENT

Dr. Jenkins presented assessment of the musculoskeletal system, which

involves the techniques of inspection and palpation only.

Inspect then Palpate, Upper extremities then lower.

ROM and test for strength at each major joint comparing side to side.

Head and neck.

Upper: shoulders, elbows, wrists, fingers.

Lower: hips, knees, ankles, toes.

Finally, Inspect and Palpate Spine: Check ROM and curvature of spine by asking to bend and touch toes.

Observe patient in motion. Gather subjective data such as occupational hazards and functional deficits.

SAMPLE DOCUMENTATION OF MUSCULOSKELETAL ASSESSMENT

Head straight and erect on neck. Active ROM to all joints with full joint movement, no pain or discomfort, No redness, swelling or deformity of joints. Bilateral strength grade 5 in upper and lower extremities, Able to oppose force in two directions in upper and lower extremities. Gait steady. Spine is straight.

NEUROLOGICAL ASSESSMENT

Dr. Miller presented neurological assessment, focusing on assessment of the 12 cranial nerves.

Consciousness: Eyes open spontaneously to name.

Motor response - Have patient squeeze your fingers and push against your hand like a gas pedal and document the response.

Verbal response.

Communication.

Cranial Nerve II, III, IV and VI - Pupil size in mm and reaction, movement right and left, any ptosis (drooping eyelid),

Cranial Nerve V - Muscle strength jaw, Sensation.

Cranial Nerve VII – facial muscle movement, droop, is the face symmetrical.

Cranial Nerves IX, X, XII - Ability to swallow, protrude tongue midline, gag reflex.

Cranial Nerve XI – Shoulder muscle strength – resistance.

Consciousness: One participant asked about declaring a patient to be unconscious. The long term care facility called 911 and the EMT personnel wanted to know if the resident was conscious or unconscious. Dr. Jenkins said that your assessment doesn't have to conform to the either/or thinking of others. "We try to make things simple, when they are not simple," Dr. Jenkins said. "There are various states of consciousness. The choices go beyond conscious and unconscious. You call the patient's name and they are not responsive. They could be unconscious, semi-conscious, in a state of slumber, somnolence, in a stupor, or unconscious." If you see the resident's eyes moving while they are unresponsive, you will probably be hesitant to automatically classify them as unconscious.

LPNs also need to know assessment. RNs do the initial head-to-toe assessment, but LPNs do focused and ongoing assessment.

Dr. Jenkins informed participants about the IOM's 2010 report which proposes that 80% of the nursing workforce have baccalaureate degrees in nursing by 2020. She stated, "I encourage you to go back to school if you do not have the bachelor's degree in nursing. Baccalaureate programs require students to complete a three -credit, 45-hours physical assessment course."

This continuing education program was held in February 2013 at United Medical Center. ■

Continuing Education Update

Communication Skills for CNAs

by Nancy Kofie

“There are 19 nursing homes in the District of Columbia, and CNAs are my pride and joy,” DOH Compliance Nurse Specialist Mary Sklencar told the **Certified Nursing Assistants (CNAs)** who attended a Board of Nursing continuing education program on mastering CNA communications skills. Ms. Sklencar is not a surveyor, but rather “I am the one that asks you questions about what happened when there is a complaint or an incident is reported. Don’t be afraid of me. Tell me the truth because I will eventually find it anyway.” CNAs must be master communicators. They must be able to communicate effectively with residents, LPNs, RNs, and with DC Department of Health investigators.

Ms. Sklencar brought a unique perspective to the topic of CNA communications: “I have been a CNA. I have been kicked, hit, spit at, cussed at and told that I hurt somebody.”

YOUR RESIDENT HAS A BACKSTORY

The challenge of communicating with residents is that they come with a different life experience than yours. Can a 35 year old CNA (from the US or who has immigrated to the US) communicate effectively with an 85 year old resident with dementia who was raised in the Washington, D.C., of the 1930s? Yes. But it may take strategies and mindfulness. Layered on top of the resident’s culture, personal history and personality, is the fact that they are residents in the facility because they need 24-hour care.



Mary Sklencar, RN, with DOH Compliance Supervisor Gregory Scurlock.

CULTURE/FAMILY/PERSONAL EXPERIENCES

“You come to work with a whole set of experiences,” Ms. Sklencar said. “The resident has a totally different set of experiences. When two people talk, the messages are interpreted through their experiences. Communication can be affected by the speaker’s and listener’s age, culture, country of origin, experience, anger issues, dementia, hearing abilities. The onus is on the CNA to learn how to communicate with the resident. You are the professional—the onus is on you.

THERE IS A REASON: REACTIONS TO THE PAST

People behave that way for a reason. They are not acting this way against you, CNA, as a person; they are acting based on their personal history and experience. Think about where the resident is coming from. If you are a smoker, and I tell you to stop smoking this very moment, will you? NO. There was a whole life of smoking prior to my request. There is a reason you can’t just stop. Ms. Sklencar shared a few anecdotes.

- Resident A was from an African country. She fell and broke her

hip. She would not go with EMS to hospital. Everyone stood around her shouting that she should go to the hospital. In her home country, when people come in the middle of the night, wearing uniforms, they take you and kill you.

- Resident B had been a farmer, born and bred in the USA. When he was younger, he only took a bath once a year. Now he is worried: What is going to happen to my crops if I take a bath?
- Resident C was from Asia. She would not speak with her CNA because they had not been formally introduced.
- Resident D had been the president of a university. He demanded a double portion of food! He has lost everything. He had no control

over anything, except his food. He had moved in with his brother, but then his brother died two weeks later. This is not the time to push him. Before you judge him, think of where he's coming from.

THEY NEED CARE

"When you attempt to communicate with residents, keep in mind that you are dealing with someone who is NOT WELL. You are not seeing them in their best light, for a variety of reasons," Ms. Sklencar told the CNAs. "Residents may be: angry, proud, and/or have dementia or psychological issues; the younger residents may be former or current drug users."

SET THE TONE

"When I said 'Good Morning' to you at the registration table, you said 'hello' back. I set the tone. Keep in mind that

the first thing you say to the resident in the morning sets the tone for the whole day." Be eager to acknowledge something positive about the person. Take a positive approach.

YOU'RE NOT THE RESIDENTS' BOSS

"I have noticed when a resident doesn't understand, some CNAs speak louder," Ms. Sklencar said. "Do you think that is going to help? 'Mr. Smith, it is time to get up. MR. SMITH IT'S TIME TO GET UP!!' It is a troubling trend I see—CNAs thinking they have authority over the residents." You should not be raising your voice and speaking with authority. You should be asking instead of telling. CNAs should respond cheerfully, not resentfully. Ask "How can I help you?" rather than "What do you want?" The resident is the client. Be professional. It is not personal unless you make it personal."

FIND THE WORDS THAT WORK

Words mean different things to different people, Ms. Sklencar said. "Let's run away" can mean let's get married or let's elude the police. "Nothing works all the time," Ms. Sklencar said. Use gentle experimentation to gain residents' trust.

US VERSUS THEM

Do not unknowingly create a hostile atmosphere. Don't form a little CNA social session with a co-worker, talking in hushed tones about your date last night, your child's bout with the flu, about who won the election in your home country,



CNAs participating in CE program exercise.

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or if Delores slept with John. Secret conversations turn into ammunition for the resident. You cannot tell the resident, “This is not your business. This is personal business. This doesn’t involve you.” A resident can say, “that CNA was rude to me.” Yes, residents can be paranoid. If you abruptly stop talking when a resident approaches, he may think you are talking about him. CNA success means creating an atmosphere of trust.

PROFESSIONALISM BASICS

“You chose this profession,” Ms. Sklencar reminded participants. You chose this profession, this town, this country, this facility. You must abide by the rules. When you sign your name, put

First initial, Last name, CNA (example: D. Smith, CNA). Ms. Sklencar asked attendees to sign legibly—no loopy curlicue signatures. An illegible signature could be interpreted that you are hiding something, she said.

SPEAK THEIR LANGUAGE

Is English the resident’s second language? Residents may greatly appreciate it if you say something in their native language: “When I travel, I gravitate to the persons who at least try to speak some English. If you can say a few words, it opens up a passageway of trust,” Ms. Sklencar said.

COPING WITH CONFLICT

CNAs must remain calm and keep their cool. Remember—no one can steal

your joy or make you angry except you. Don’t argue with a resident. Don’t “feel important” at the risk of the resident. If a resident is nasty, arguing, and angry, his or her goal may be just to release the anger. It is not personal. If you are having difficulty, seek help. Ask another CNA, a nurse, or a member of the housekeeping staff. Sometimes the housekeeper may be able to communicate better, in a certain situation, than you or any other health care professional in town.

PART OF THE ART

CNAs have a very difficult job. You do a wonderful job, given the task ahead of you! Continue to attend educational programs and improve yourselves. Seek to improve communications with your supervisor and co-workers, as well as residents.

“You are part of the Art of Nursing,” Ms. Sklencar said. “The goal is to get things done while keeping the resident happy.” ■



PERSPECTIVE

Residents are not your buddies; Residents are your clients. Put up the wall called Professionalism.

DO THIS

- Speak softer; if the Resident is hard of hearing, speak closer to their ear rather than yell
- Slow down and speak with clarity
- Use a Strategy rather than assume a Tone of Authority

DO NOT DO THIS

- Yell
- Talk Fast
- Speak as if You Have Authority over Resident
- Roll Your Eyes or Sigh
- Fold Your Arms across your Chest
- Put Your Hands on Your Hips
- Whisper to Co-workers
- Stop Talking Abruptly when Resident Approaches
- Speak in Another Language

Winning Strategies For Communicating

- Simplify your language
- Clarify your statements
- Validate that the Resident heard what you meant to say
- Validate who your Residents are as individuals.

Validate with Creativity (an example)

Issue:

- Resident has dementia.
- Resident is a former federal employee, and attempts to leave the building saying "I have to go to work."
- Use a creative strategy to get the desired result. Tell the resident, "There is no work today. The office is closed."

Resident Non-Compliance

- A resident cannot be "non-compliant."
- There is a Reason why the Resident is acting this way.
- Rise to the challenge. Acknowledge what is important to them.
- Acknowledging their values opens a pathway to communication.

Are You a CNA "Ugly Betty" or "Simon LeGree"?

- Shuts the Residents Out
- Becomes "deaf" when he or she doesn't want to deal with a resident
- Points at the dinner plate and yells "Here's your dinner! Eat it!"
- Alienates residents—and once words are spoken, you can't take them back.
- If you cannot say something nice, don't say anything.

Foundation of Trust

- Eye Contact: Look at person you are talking to and smile.
- Touch: When you touch a resident, let them know you are going to touch them ahead of time.
- Tone of Voice: Don't bark orders, ask "How can I help you?" or "How do you want me to help you?"
- Don't Alarm Resident: Nobody likes surprises. Don't grab for the resident because they don't know what you want.
- Reset Trust: When a resident has dementia, you have to reestablish trust every day.

Tools of the Trade

- Words
- Tone of Voice
- Gestures

ENTER THE STAGE

Before you enter your facility, know yourself: Are you angry about something? Did you get a speeding ticket? In a fight with your spouse?

When you cross the threshold, be centered. If not, any little thing will set you off.

If you enter angry, who will get the brunt of it? The resident!

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CROSSING THE THRESHOLD

- A CNA is an Actress or Actor on a Stage
- You set the tone for the whole day
- Be a Professional, focused on providing care for the client (resident)

BLOW OFF SOME STEAM

Feel you are about to verbally explode? Take 5 minutes in the bathroom.

If you don't, when someone tells you that you didn't get Ms. Jones a bath, you may explode!

What are some causes of Residents becoming violent?

- Dementia
- Psychiatric issues
- "Street survival" mode

You Better Tell Somebody

- Get help from the Charge nurse, Unit Manager or Director of Nursing. They can be a buffer.
- The more information you can give the charge nurse the better.
- Ask yourself "What is important to the resident? What could be the root cause of the anger?"
- You can't just start yelling; no resident likes to be berated. Get the charge nurse or remain silent momentarily. It takes two to fight.
- Accept resident where they are. You can lead a horse to water, but you can't make him drink.



CNA asks a question during CE program.

Family Members

- Be respectful and polite when speaking to Resident's family members.
- Channel discussion to the Charge nurse.
- DO NOT give them information that you are not sure of.
- Whatever you say, the family members take it as gospel.

Hard of Hearing?

If a resident is hard of hearing, do not yell. Talk closer to the ear. A visitor may mistake the situation and think you are yelling at the resident in anger. Being yelled at feels denigrating and looks to visitors like abuse.

Anticipate Problems

When you know that you will not be on duty the next day, assure your resident that he will be okay with another CNA: "Beverly will be here tomorrow. Would you let Beverly take care of you? She is really good."

Do Not

- yell
- chat in a CNA social clique
- grab the resident
- approach from behind

Solutions

Fear: A resident may be resistant to walk because they fear falling.

Solution: That resident's fear may disappear with support from two people at each side.

Words: Words not working?

Solution: Change it up. Change the words you are using. Say "prayer" instead of "chapel." A different word may get desired results!

Creative Strategies!

Problem: resident frequently falls.

Solution: Give the resident something to do.

Example: We put a bible in her lap and asked "Do you know Matthew 15?" or "Oh, Millie, What is John 3:16?" She never fell again. Keep them occupied with a newspaper, bible, baby doll. Duct taping to wheelchair is not a solution it is patient abuse.

Abuse

According to DOH Compliance Supervisor Greg Scurlock, "if you say something negative about a resident within earshot, that is abuse."

Abusive behavior is reported to the Board of Nursing for discipline.

Rule #1

You are the professional. If the resident does not understand your message, it's your fault.

Be prepared for the challenges with professionalism and a creative approach to communications!

CALM YOURSELF DOWN.

REMEMBER, STRESSED SPELLED BACKWARDS IS 'DESSERTS'!

Motive #1:

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Kudos!

Congratulations to [Ottamissiah “Missy” Moore](#) on the publication of her article “A Reflective Look at Practical Nursing” which was published last spring in a special issue of the National Black Nurses Association News entitled THE FUTURE OF NURSING.

Reprinted below with permission from the National Black Nurses Association, from the NBNA News special issue THE FUTURE OF NURSING, published in celebration of National Nurses Week, May 6-12, 2013.

A Reflective Look at Practical Nursing

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

Over 26 years ago, I stood with a group of my peers in a crisp white uniform, holding a nightingale lamp. It was my graduation from License Practical Nursing (LPN) school and my entrance into the nursing profession. Armed with my new license, a new nursing venture and a great mentor, I was preparing myself for best career of my life.

THE PAST

When I look at the history of practical nurses, some contend it began in 1897, with the programs at Massachusetts General Hospital in Boston, and New Haven Hospital in Connecticut which opened around 1873. Others believe LPN practice started with the programs established in New York. These “trained” nursing schools were Bellevue Hospital in New York City, the Ballard School in New York (1893) (Anderson, 2001, p. 17); and a training program for practical/vocational nurses developed by the American Red Cross (1892) at the Young Women’s Christian Association in New York City. After the turn of the century, LPN education and licensure became more formalized with the opening of the Thompson Practical Nursing School in Vermont in 1907 and the Household Nursing School in Boston in 1918 (White & Duncan, 2001).

World War II brought the need for additional nurses, which focused attention on the contributions of the LPN/LVN. The



“Practicals” were licensed through waivers and different States had different ways. Some required a letter of recommendation from a physician, a supervisor, etc., and the nurse had to have worked as a practical nurse for at least five years immediately prior to application. State-by-State, they were waived into nursing. Their licenses had a “W” on it and for many of them it was a stigma until they actually took the licensure exam. By 1945, 19 states and one territory had licensure laws. One state was permissive licensing.

The National Federation of License Practical Nurses (NFL PN) was organized in 1949 to provide a structure at the national level through which LPNs and LVNs (Licensed Vocational Nurses) could promote better patient care and to speak

and act on behalf of the occupational group. It is the only organization in the United States governed entirely by LP/VNs for LP/VNs. NFL PN is recognized by the other national nursing organizations as the official voice of LP/VNs.

THE PRESENT

The discussion about the “phasing out” practical nurses has been going on for more than 26 years. Although the conversation is quietly spoken, practical nurses are slowly leaving areas they have practiced in for many years. Licensed Practical/Vocational Nurses across the county are voicing their concern over several issues as discussed below.

The underutilization of practical nurses, in some states and workplaces, prohibits practical nurses to perform tasks that they have been taught, and show knowledge, skill and competency to perform. LP/VNs are being replaced by unlicensed assistive personnel. During periods of nursing shortage, LP/VNs are often recruited for positions which were originally RN jobs and assistive personnel are often recruited for jobs traditionally held by LP/VNs.

While they can assist with tasks associated with the maintenance and support of the aged, they do not and cannot replace the LP/VN at the bedside. While we may not be able to conduct comprehensive assessments of the patient, we do understand patient response, we

have been taught how to conduct general assessments and able to accurately convey patient status, care concerns and needs in a manner unknown to unlicensed assistive personnel.

LP/VN students are not receiving the education and career opportunities previously afforded the profession. Clinical experience has always been an integral part of nursing education. It prepares student nurses to be able to perform as well as have knowledge about the clinical principles in practice. Clinical practice stimulates students to use their critical thinking skills for problem solving. There is a strong demand for high-quality, cost effective clinical education experiences that facilitate student learning in the clinical setting. The clinical learning environment (CLE) is the interactive network of forces within the clinical setting that influence the students' clinical learning outcomes. We believe clinical experiences would improve the knowledge, skills and abilities of LP/VNs. We have heard about problems existing with students obtaining clinical experiences, preceptorships, and job placement. No studies have been conducted on this issue. Concerns about lack of clinical experiences for LP/VN students may be one of the barriers to the NCLE X pass rate and employment opportunities.

THE FUTURE OF PRACTICAL NURSING

It appears there are more questions than answers. The practice, the market and the education of LP/VNs is changing every single day. The questions are...

How will LP/LVN become educated?

Who will offer clinical sites to LP/LVN students?

What will the skill set of an LP/VN look like over the next 10 years?

How will practical nurses transition to another position if the market does not utilize them?

Who will precept LP/VNs new to practice?

These questions and others about the issues are endless.

Leadership in nursing must take a look at what part LP/VNs have in nursing history, bedside nursing, patient outcomes and work together to carve out a role and practice specifically for LP/VNs now and for the future. Leadership must be creative in our thinking to assist LP/VNs to transition to the role of an RN. The nightingale light of LP/VNs is still shining. Given the opportunity, LP/VNs will prove the value of practical nursing in the primary, preventive and long-term care settings. We only need to have our light shine brighter.

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Uline Atongnong	LPN1005891	Suspension Order terminated
Stephanie Thompson	NA364249	Revoked
Dominic Atabongakeng	NA807355	Summarily Suspended
Denise Bain	RN1025455	Suspended
Raymonia Foreman	LPN1007361	License Denied

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Nursing Staffing Agencies

- Aburro Staffing - Revoked
- AEF Comfort Nursing Care - Revoked
- Franka Blossom - Revoked
- Dedicated Care - Revoked
- Prime Consulting - Revoked

Non-Public Disciplinary Actions:

Referrals to COIN	9
Consent Orders	24
Requests to Withdraw	10
Requests to Surrender	3
Letters of Concern	3
License denied	1

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