We asked, and you told us! Thank you to all who completed the DNA Membership survey and DNA Needs Assessment survey. Based on your feedback, DNA has adjusted our strategic plan to meet your needs. Here are few changes that will occur in the coming months:

• improve website ease of use and activate online sign up forms for activities, programs, and volunteer opportunities;
• improve communication about DNA activities, legislative platform, and volunteer opportunities;
• strengthen collaboration with specialty and student nurses associations; and
• engage stakeholders in advocacy and educational opportunities.

As we keep moving forward, your feedback on our progress is important. Please be sure to take a few minutes to complete any future surveys to let us know how we are doing.

Thank you to all who participated in this year’s Delaware Today Magazine Top Nurse! The gala is scheduled for May 17th at the Bella Vita at Cavaliers Country in Newark. DNA appreciates the support of the Delaware Today Magazine in recognizing professional nursing in our state while educating the public about different aspects of the profession. We look forward to seeing you there!
language on the box of our breakfast cereal, to the safety features of the car we drove to work in, and so on throughout our entire day – our lives are minutely regulated and governed by law or regulation.

This is, of course, especially true of our practice as nurses. In this issue, we will explore several legal issues that affect nurses. We begin with Sanitome Memorial Hospital’s Lilia Kulmaczewski, RN, MHIA, CPHIQ, on the acculturation of cyber security in the hospital setting. Next is an article by Jeffrey Willey, PhD, RN, CNS, CLNC, CNE, who is the chair of the Department of Nursing at Salisbury University, on the topic of legalities of student nurse precepting.

Following is an article by Donna Casey, DNP, MA, RN, NE-BC, FABC, and the former Chief Nursing Officer of Christiana Care Health Services, on the ethics dilemma “right to try” laws create for nurses. Next is an article by Pamela Zakofoose, EdD, MSN, RN, NE-BC, CNE, FANE and David Mangler, MS, RN. Pam is the president of the Delaware Board of Nursing and David is the Director the Delaware Division of Professional Regulation and they provide an update on legal issues pertaining to licensure and the Board. I submitted the final article, which is about the importance of nursing advocacy and specific legislative goals of the DNA in the near-term.

As stated so eloquently by guest editor Dianetta Runser, MSN, RN in the previous issue of the DNA Reporter, nurses represent vulnerable populations through advocacy and must often provide a voice to those marginalized and stigmatized by inequalities within the healthcare system. Thus it is incumbent upon all nurses to familiarize themselves with “legal issues” affecting the profession so we can strive towards excellent, respected, and most importantly – effective advocacy for our profession and for patients and clients.

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Arthur L. Davis Publishing does a great job of contacting advertisers, who support the publication of our newsletter. Without Arthur L. Davis Publishing and advertising support, DNA would not be able to provide the newsletter to all the nurses in Delaware.

DNA needs you! The Delaware Nurses Association works for the nursing profession as a whole in Delaware. Without the financial and volunteer support of our members, our work would not be possible. Even if you cannot give your time, your membership dollars work for you and your profession both at the state and national levels. The DNA works hard to bring the voice of nursing to Legislative Hall, advocate for the profession on regulatory committees, protect the nurse practice act, and provide educational programs that support your required continuing nursing education.

At the national level, the American Nurses Association lobbies, advocates and educates about the nursing profession to national legislators/regulators, supports programs that support your required continuing nursing education. It is the policy of DNA Reporter not to provide content, style, clarity, grammar and spelling. While student submissions are greatly sought and appreciated, The DNA Reporter reserves the right to reject any advertisement. Responsibility for errors in advertising is limited to corrections in the next issue or refund of price of advertisement.

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Visit www.denurses.org to join or call (302) 733-5880.

http://www.denurses.org
**President’s Message**

Leslie Verucci, MSN, RN, APRN-BC

Glad we are done with the crazy winter we had and we now have some warm and nice days to spend outside. Let’s give a warm welcome to Gary Alderson, RN, Esq., our new DNA President-Elect. Gary brings a wealth of knowledge to the role and is a great asset to the organization. He will provide us with some well needed legalese on upcoming bills happening at both a state and national level.

We as a board discussed ways to improve the organization and promote growth. We met early in the year as a group and developed our 2018-2020 Strategic Priorities, mission statement and vision statement.

Our Mission Statement is to improve healthcare in Delaware by the advancement of nursing and our vision is to shape the future of healthcare and promotion of innovative nursing practice.

Our new priorities include:

1. Membership Growth and Engagement
2. Professional Development
3. Advocacy
4. Programs
5. Strategic Partnerships
6. Association Vitality

We will be looking for ways to enhance and promote these areas which will include increasing our online community and meetings. Offering more low cost or free continuing education methods to our members and increase participation in the Professional Development Committee. We want to provide educational opportunities for all our members taking into consideration their diverse areas of practice. We also hope to develop and strengthen our collaboration with other specialty organizations in the area and engage stakeholders in advocacy and educational programs. We are also looking at facilitating opportunities to support the Licensed Practical Nurses in the State of Delaware.

With Gary at our helm we are especially looking forward to increasing and improving our legislative involvement and communication with our Senators and Representatives to foster safe patient care and support of the profession of nursing.

We are asking our members to consider becoming more involved in helping us reach these goals. If there is one area that you are interested in we can use your help whether it be ideas or active participation. We need the knowledge that Delaware Nursing brings and share with all of our colleagues. Consider becoming more involved with your State Nursing Organization. Feel free to call the Office at 302-733-5880 with any questions or thoughts you may have.
Their attention on health care. The electronic medical record became more sophisticated in their prevention of credit card information. As these entities have retailers and financial institutions in order to access millions of patient records belonging to the UCLA Health procedures and returned to a paper process while hackers had encrypted the electronic medical record (para 1). Hollywood Presbyterian Medical Center paid access to it until a ransom is paid to unlock it” (2017, January 17). Following the ransomware attack Indiana hospital pays 55k to unlock data. Retrieved from https://digitalguardian.com/blog/following-ransomware-attack-indiana-hospital-pays-55k-to-unlock-data

In 2016, Hollywood Presbyterian Medical Center was one of the first hospitals to be involved in a ransom ware attack. The Department of Homeland Security defines ransom ware as “a type of malicious software that infects a computer and restricts users’ access to it until a ransom is paid to unlock it” (2017, para 1). Hollywood Presbyterian Medical Center paid the ransom in cyber currency, called bit coins in order to return the system back to functionality. The hackers had encrypted the electronic medical record so that it could not be used. The hospital cancelled procedures and returned to a paper process while trying to recover from the attack. In July of that year, hackers may have accessed as many as 4-5 million patient records belonging to the UCLA Health System’s computer network (Winton, 2016).

Cyber criminals traditionally have targeted retailers and financial institutions in order to access credit card information. As these entities have become more sophisticated in their prevention of cyber-attacks, cyber criminals have begun to focus their attention on health care. The electronic medical record is a repository of information that is used by health care providers, insurers, and regulators. It contains the patient’s medical history, and their financial, personal, and billing information. To cyber criminals, this is a treasure trove of information that lasts forever. Credit card data is time limited because once the password is changed it is no longer used by the cyber-criminal. Because of the amount of data and its longevity, health care information has become a prime target.

Cyber criminals have a cadre of tools at their disposal and are not only skilled hackers. Once they have accessed a patient’s information, they can sell it repeatedly on the ‘dark web’ or they can use it to steal someone’s medical identity. They can alter information within the electronic medical record or they can tamper with electronic medical devices. Stealing a patient’s social security number or billing information is serious. However, changing the course of a patient’s care by distorting information programmed on a ventilator, insulin pump, or pacemaker is an entirely different matter and has dire consequences. The Federal Drug Administration (FDA) realized the danger and published guidance in 2016 to health care and manufacturers that they implement comprehensive cyber security risk management programs and documentation because of the cyber security risks and vulnerabilities (FDA, 2016).

Many question how electronic data systems are at risk. Firewalls, encryption, and antivirus are available in most organizations to deter cyber-attacks. With the enactment and emphasis on the Health Insurance Portability and Accountability Act (HIPAA), hospitals have worked diligently to increase staff’s awareness to the confidentiality of patient information whether it is written, oral, or electronic. It has become an important part of annual education offered by health care organizations. Many health care institutions employ privacy officers who educate and implement policies and procedures regarding privacy. Unfortunately, cyber-security has not fared as well. Federal incentive plans have encouraged healthcare institutions to build electronic data systems but have not emphasized to the same extent the need for cyber security. One of the reasons may be that cyber-security has traditionally been considered the responsibility of the information technology (IT) staff. Recent cyber-attacks have shown that technological protections cannot by themselves secure the information stored on networks and applications. Cyber-security cannot be assigned to IT because many workers within the healthcare environment use the electronic systems to document patient care, perform billing, abstract and code, or simply use it to communicate with each other. Users must share the responsibility to protect the data and work collaboratively with IT to prevent it from being compromised. The dilemma faced in the health care arena today, is how to embed this responsibility into the culture.

Cyber security education must be a priority if the culture is to change. Fire walls, encryptions, and antivirus applications are just one aspect of cyber-security defense programs. Locking computers when not in use; avoiding bogus websites, using strong passwords, verifying strange looking emails, and not downloading applications like ‘Drop box’ need to be incorporated into everyday work life. These practices will decrease vulnerability and enhance defenses to such an attack. Additionally, it must not be forgotten that daily work activities such as faxing and releasing paperwork improperly also offers a potential opportunity for cyber-criminals to access patient data.

From a leadership perspective, resources are necessary to fight this ongoing battle with cybercriminals whether it is to purchase needed software, hire staff to put in the needed patches, purchase cyber-insurance, establish a vendor management process, or employ a cyber-security officer. Cyber security must be considered an important budget item. An incident response plan must be developed and tested regularly much like an emergency disaster management plan so that everyone is prepared when an attack occurs.

Last but not least, health care must stay ever vigilant in training to implement the recommendations from cyber experts. Some of their recommendations are as follows; continuously educate staff, back up data, update software, conduct vulnerability and penetration tests, patch systems and always test your plans. These measures cannot guarantee that a cyber-attack will never happen, but it may reduce the damage from such an event.

References


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Make a positive contribution to the nursing profession by engaging in DNA activities.

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DNA Committees
• Professional Development Committee—provides DNA educational activities
• Continuing Education Committee—approves programs for nursing contact hours

Join Committee Participation:
• Legislative Committee
• Communication Committee—coordinates articles for publication in the DNA Reporter
• Nominating Committee
• RN Volunteer Program—supports nurses to maintain their license through volunteer practice hours
• Nurse Peer Support Program—helps nurses stay engaged in the recovery process
• DNA Awards Program

To get involved, email Sarah Carmody with your name, phone number, preferred email, and the committee(s) of interest. Email: sarah@demurses.org
Legal Implications for Student Nurses and Preceptors

Dr. Jeffrey Willey is the Chair for the Department of Nursing at Salisbury University in Salisbury, Maryland. He received his BS in Nursing from Salisbury State University, MSN from University of Delaware, and PhD in Nursing from University of Phoenix. Prior to serving as Chair of the Department, he held the position of Director of Graduate and Second Degree Programs.

Dr. Willey has presented nationally on topics regarding graduate online course development, leadership, legal issues in nursing, and telehealth in nursing. He is also involved with other investigators through a grant working on faculty shortages within the State of Maryland through the Maryland Higher Education Commission. Dr. Willey is a member of several community college advisory boards as well as a local high school health care advisory board. He lives in Delaware and has worked at both Christiana Care Health System and Nanticoke Health Services and is a member of the Delaware Nurses Association.

Legal risks seem more evident in today’s health care environment than ever before. As nursing becomes more involved in assessing, diagnosing, planning, implantation, and evaluation efforts, the profession takes on more legal risks (Nurses Legal Handbook, 2004). One area that is always a discussion point concerns preceptor designation (Ashley, 2004). Who is at risk for liability for student nurses when serving as a preceptor?

Student Nurses

The answer is not always a direct path, as with most litigation concerns. One very important point is that student nurses are personally responsible for their own negligent acts. Student nurses are responsible for providing care to their patients, and students are held to the same standards as a licensed professional nurse when performing the duties of a nurse (Pozgar, 2016). In this respect, students must understand their knowledge and ability levels and communicate with their preceptor or faculty member if they are not comfortable in performing the tasks or procedures required. If the student had been delegated a task or procedure in which they are not knowledgeable or qualified, then it is his or her responsibility to communicate this and not perform the delegated tasks. Not taking these steps, puts the student, preceptor, or faculty member at risk for legal liability.

Organizational Liability

Because student nurses are held to the standards in place for licensed professional nurses, students are viewed as an agent of the facility for liability purposes. As such, the facility is held liable for their acts based on respondent superior, which is a “well-established United States (US) law declaring that a master is subject to liability for the torts of his servants committed while acting in the scope of employment” (Tazbir, Martin, Cain, K., Priest, C. S., & Hook, S. A. (2014). p. 387). This law includes every individual employed by an organization, inclusive of students.

Preceptor Liability

As organizations are held liable for nursing students, so too are nursing preceptors. Although students are not practicing under a preceptor’s license, the preceptor would be held liable for an outcome wherein a task had been delegated to the student. Nurses are held to a competent standard and are responsible for their patients or clients at all points of the nursing process. As a preceptor, it is important to communicate with the nursing student (and faculty member) to determine the level of responsibility that the student is able to assume. Students are not allowed to perform invasive procedures without the direct supervision of a preceptor or faculty member. In addition to communication efforts, it is always imperative to determine what the agency/employer scope of practice is for students as well as the Nurse Practice Act for the state in which they are practicing.

Precautions

Although the liability for taking on nursing students may seem daunting, remember that liability for nursing students is not common. Taking precautions, as with any health care profession, will decrease the probability of legal liability. Remember that all nurses started out in the same position – being a student nurse. It is important to provide preceptorships to engage the student nurse in practice environments for exposure and understanding the profession in which they are getting ready to embark.

Communication

The first precaution is communication. Talk with the student to gain a better understanding of where they are in regard to preparation of tasks and procedures. Speak with the student’s faculty member to gauge and determine needs to better prepare the student for their journey into the profession. Before beginning any task or procedure, review the details and ask the student if he or she feels comfortable performing the delegated task or procedure. Perform a “dry-run” to review the process or task and give a constructive review and build the confidence of the student. Ask the student to review how it is to be accomplished by watching the preceptor perform the first run and then handing it over the next time to the student. Good communication between the preceptor, faculty, and the student can assist in minimizing any legal liability.

Documentation

Documentation is also a main precaution that is used to prevent legal liability concerns. Assuring proper documentation by the student, as well as the preceptor is vital in following protocol and ensuring that tasks and procedures are correctly charted. Charting in real-time enables the student and preceptor to chart what is being completed at the moment it is being done. Once again, it is important that the preceptor is with the student to assist with proper documentation. Even with the student documenting, a student’s assessment often does not take the place of the preceptor’s documentation. The student’s assessment and documentation are often in addition to and not in place of the employee’s assessment and documentation. Preceptors and faculty should review the student’s documentation to check for completeness and accuracy and give appropriate feedback to the student for any revisions or corrective actions as needed. If revisions or corrective actions are needed to the documentation, this too should be documented to properly correct any incorrect charting and provide evidence that it was corrected.

Students are provided with liability insurance from the schools in which they attend just as are nurses in health care organizations. Even with this provided insurance, it is always advisable to maintain individual professional liability insurance. Following these recommendations will assist preceptors and students to understand the legal liability risk associated with the relationship between preceptor and student. Risk is always present in health care, but by taking precautions and simply communicating, the legal liability risk of precepting nursing students can be minimized. Realizing and minimizing the legal liability risk is vital to providing the preceptor-student relationship that is instrumental in the student educational experience.

References

To participate in clinical trials (Zettler & Greely, 2014). Fear of negative confused efficacy studies and decreased availability of appropriate patients on supply of investigational agents for clinical trials, diluted clinical trials or subvert the clinical trials process assuring access to the active agent. The process for investigational treatments to become Food and Drug Administration (FDA) approved and available to the public is long (FDA, 2018). Desperate patients who have failed other treatments may be looking to slow the progression of their disease and delay death (Lowes, 2017). Do patients have a right to try investigational treatments as a last-ditch effort, and what are the ethical implications of administering potentially harmful medications?

There are multiple pathways for terminally ill patients to obtain investigational medications. The intent of these pathways is to enable dying patients to receive investigational treatments outside of clinical trials and prior to FDA approval (Zettler & Greely, 2014). Right to Try legislation and compassionate use are the common routes. Right to Try legislation empowers patients to bypass the FDA and go directly to drug manufacturers and currently it exists in 36 states.

Compassionate use regulations were established by the FDA to provide dying patients with faster access to investigational treatments (Zettler & Greely, 2014). The FDA usually approves requests for unapproved treatments for patients with serious or terminal condition when other treatments have failed or do not exist. Compassionate use regulations enable physicians to request the FDA to approve use of investigational treatments for dying patients. The physician obtains informed consent for compassionate use (Zettler & Greely, 2014).

Right to Try laws and compassionate use regulations enable patients to obtain treatments that have completed phase 1 clinical trials. Phase 1 clinical trials evaluate safety, but not efficacy. The main purpose of phase 1 clinical trials is to determine the highest dose that can be safely given without causing serious side effects. Phase II clinical trials determine if the investigational treatment is effective (American Cancer Society, 2017). In phase II and III clinical trials – some patients receive the standard therapy plus the experimental treatment while the control group receives standard therapy/treatment/treatments and-side-effects/clinical-trials/what-you-need-to-know/phases-of-clinical-trials.html. Patients using the Right to Try or compassionate use loopholes, subvert the clinical trials process assuring access to the active agent. Drug developers and manufacturers are reluctant to provide access to the investigational treatments. Concerns include negative publicity and impact on future FDA approval from treatment failures and patient harm, impact on supply of investigational agents for clinical trials, diluted clinical trials or confused efficacy studies and decreased availability of appropriate patients to participate in clinical trials (Zettler & Greely, 2014). Fear of negative publicity on social media may have a strong motivator for manufacturers to provide investigational treatment access despite concerns (Zettler & Greely, 2014). The FDA has stringent approval processes devedled to protect the public from treatments that cause more harm than benefit. While manufacturers have the ultimate authority to permit or deny access to experimental treatments for dying patients, negative publicity from social media may impact those decisions. Approximately 90% of medications that enter phase 1 safety trials never make it to market because they don’t work or have side effects that outweigh benefit (Leuty, 2017).

Cost of medications is another concern for right to try legislation. There is no price limit for investigational treatments under Right to Try legislation. Insurance companies rarely cover investigational treatments (Lowes, 2017). Cost also affects use FDA regulations limit what manufacturers can charge. Patients who participate in clinical trials do not pay for investigational treatments or associated testing. This presents a justice concern for patients who cannot afford access to investigational treatments under right to try legislation.

Ethically, the challenge is to balance the patients need for hope and potential for benefit with the obligation to not cause harm. Multiple provisions in the American Nurses Association Code of Ethics (ANA, 2018) inform this issue. Provision 1 states that “The nurse practices with compassion and respect for the inherent dignity worth and unique attributes of every person.” Establishing a trusting relationship, considering patients’ needs and respecting their religious, spiritual, and cultural values and right to self-determination would seem to require nurses to advocate for and assist patients to obtain investigational treatments if the request is consistent with their values and the patient and family are fully informed. Provision 2 states that “The nurses’ primary commitment is to the patient...” This would also indicate the nurse would be required to advocate for access for investigational treatments for dying patients. This is somewhat conflicting as Provision 2 also identifies the patient as a population and community. There is a risk to the population of patients in need of safe and effective treatments when the clinical trials process is somehow curtailed. Dual, unapproved use and approved use Provision 3: “The nurse advocates for and protects the rights, health and safety of the patient” addresses the importance of informed consent for participation in research. This would seemingly apply for access to investigational treatments outside the research process as well. Special concern for vulnerable patients is addressed in provision 3 (ANA, 2019). Terminally ill, desperate patients would be considered vulnerable, raising the bar for assuring fully informed consent to receive investigational treatments. Zettler and Greely (2017) proposed IRB oversight as another layer of protection for informed consent processes. Provision 3 seems to indicate that investigational treatments should not be provided. Scientifically complex treatments should be proven through the rigorous clinical trials and FDA approval process (Zettler & Greely, 2014). Provision 4 states “The nurse has authority, accountability and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and to provide optimal care.” Nurses bearing primary responsibility for the nursing care provided to patients, their judgments, decisions, and actions require reflection on the provision of investigational treatments because the outcomes of investigational treatments are unknown. Creating false hope for terminally ill patients and families can be harmful when it prevents preparation for the dying process.

Nurses are likely to encounter a patient dying from a condition where research and investigational treatments are not available. Desperate patients and families are more likely to investigate options more so today, than in years past. Nurses need to be prepared to engage in discussions that support patient self-determination with information and an ethical foundation. The ANA Code of Ethics provides the ethical framework to support nurses in these discussions and deliberations in balancing ethical obligations to support self-determination and autonomy while also maintaining patient safety.

References
Dr. Zickafoose earned her BSN, MSN, and EdD degrees from the University of Delaware. Her MSN is in Nursing Education and her doctorate is in Educational Leadership with a Policy and Administration concentration. She is currently certified in Nursing Administration by the American Nurses Credentialing Center and is a Certified Nurse Educator by the National League for Nursing. Over 30 years working in education, teaching in a hospital staff development department as well as in baccalaureate and associate degree programs preparing students for both RN and LPN licensure. In 2016 she completed a fellowship program sponsored by the NCSBN and she is the only nurse in DE nationally recognized as a Fellow in Post Doctoral Education. Dr. Zickafoose has published articles in peer-reviewed journals as well as nursing education textbooks. She can be reached at pzickafo@dtcc.edu or by phone at (302)259-6620.

David Mangler is the Director of the Division of Professional Regulation, a Division under the Delaware Secretary of State. He has held this position since January of 2011. He holds a Bachelor of Science degree in Nursing from The University of Iowa and a Master of Science degree in Administrative Studies from the University of Delaware.

David served on active duty in the U.S. Navy for 25 years. Assignments included positions on the staffs of the Navy Inspector General and the Navy Medical Inspector General as well as progressive leadership positions throughout his military career. He has also had over 20 years of quality improvement and regulatory compliance experience and has served on regulatory Boards in the State of Delaware both as a public and a professional member. David was the Delaware Director of Nursing before joining Geisinger Health System in 2011. Just prior to returning to the Division of Professional Regulation he was the Director of Geisinger Health System’s ProvenCare® Program and Clinical Improvement Strategies.

The Delaware Board of Nursing (DBON) is among 29 states who enacted the enhanced nurse licensure compact (eNLC) legislation. This is an improvement to the current NLC that DE has been a member of since 2000. The primary purpose of the new eNLC is patient safety through implementation of uniform licensure requirements. The eNLC requires both state and federal criminal background checks, and it does not allow nurses with a felony criminal conviction or a misdemeanor related to the practice of nursing to hold a license. It also requires new applicants to have a Social Security number, and it does not allow nurses with a felony criminal conviction or a misdemeanor related to the practice of nursing to hold a license. The eNLC also requires both state and federal criminal background checks, and it does not allow nurses with a felony criminal conviction or a misdemeanor related to the practice of nursing to hold a license.

For Delaware licensed nurses, there were no major changes, and those who hold a multistate license will maintain that license. In former NLC compact states nurses were grandfathered to hold the multistate license and to renew it in the state of residence. If a nurse moves to a new compact state, the nurse will need to obtain a multistate license in the new primary state of residence using the new eNLC uniform licensure requirements. The Division of Professional Regulation was prepared and ready for the change by the January deadline. There was a rules and regulations hearing in January to update Advanced Practice Registered Nurse (APRN) language throughout the rules. In addition, the requirement for the “maiden name” on DE nursing licenses was eliminated. The 2017 audit of RN licensees revealed a few nurses had not completed this requirement. The Board followed the disciplinary process for nurses who did not meet the CE and/or practice hour requirements related to their practice of nursing. In the future, the Board may impose monetary fines for audit failure. The Delaware Professionals Health Monitoring Program (DPHMP) is available to assist nurses and other health care professionals with substance use disorders.

The Delaware Board of Nursing for almost five years. Her clinical expertise is in critical care. For over 25 years she has worked in nursing education, teaching in a hospital staff development department as well as in baccalaureate and associate degree programs preparing students for both RN and LPN licensure. In 2016 she completed a fellowship program sponsored by the NCSBN and she is the only nurse in DE nationally recognized as a Fellow in Post Doctoral Education. Dr. Zickafoose has published articles in peer-reviewed journals as well as nursing education textbooks. She can be reached at pzickafo@dtcc.edu or by phone at (302)259-6620.

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This article is a call to political action for all nurses. There are so many critical issues to address in our nation and state, thus it has never been more important for nurses to step up and speak out as the voices of reason, credibility and civility for the good of our profession, patients, and clients. According to the Gallup Poll results on honesty and ethics survey for 15 years running, the public considers nurses members of the most trusted profession (American Nurses Association [ANA], 2017a). In fact, the ANA stated that when nurses speak, politicians listen. The Delaware Nurses Association (DNA) provides that single voice for the almost 8,000 registered nurses licensed in our state.

Nurses must be heard whenever new statutes or regulations, or changes to existing statutes or regulations affecting our profession are conceived, debated, passed, and implemented. Nurses must be involved in the oversight of these regulations or statutes in order to initiate change in those laws and regulations when necessary. It is important, however, that nurses’ influence is not diluted, and for that reason, efforts should be focused on just a few key issues for maximum impact. Therefore, I have identified two issues to discuss for the current session of the Delaware legislature; first, to amend the Nurse Practice Act to remove “permanently revoke” and second, to clarify the criminal law for assaulting a nurse.

Delaware regulates 41 professions and occupations, ranging from physicians and nurses to adult entertainment operators (Del. Code Ann., Title 24 (2018)). All but one of those regulated occupations address license revocation, but only one – nursing – has permanent revocation as its sole option for revocation. The Board of Nursing and the Superior Court interpret this statutory language to mean that regardless of future circumstances, including a pardon from the Governor, a nurse whose license was once revoked can never again hold a license. That interpretation is currently on appeal to the Delaware Supreme Court. Regardless, the law must be changed to clarify that it was never the intention of our legislature to treat nurses differently from other professions and vocations. The statutes for the other 15 regulated “healing arts” vocations and professions use only the word “revoke;” meaning that the Boards for those other 15 vocations have a degree of latitude and discretion not given to our Board of Nursing (Del. Code Ann., Title 24, §§ 516(a)(5), 711(e)(6), 1129(a)(8), 1731(a), 2017(e), 2115(a)(7), 2536(a)(5), 2616(a)(9), 3011(h), 3516(a)(7), 3716(a)(7), 3811(b)(6), 3916(f), 5218(a)(5), and 5315(f), (2018)).

The Board of Nursing is a highly dedicated group of professional and lay members who take their responsibility to protect the public very seriously. Removal of the word “permanently” before “revoke” in the statute would give the Board the same discretion afforded their peers on those other boards to view an applicant seeking reversal of revocation on her or his individual merits on a case-by-case basis.

The unspeakable depravity of former Lewes pediatrician Earl Bradley a few years ago created a horrible situation. In response, Delaware now has a provision in all healthcare practice acts except for pharmacists, dieticians, nutritionists, and nursing home administrators for mandatory and permanent license revocation for any licensee convicted of a felony sexual offense (Del. Code Ann., Title 24 §§516(a)(7), 711(e)(7), 1129(a)(8), 1731(a), 2017(e), 2115(a)(7), 2616(a)(9), 3011(h), 3716(a)(7), 3916(f), and 5315(2)(a)(8)). That provision was also added to the Nurse Practice Act (Del. Code Ann., Title 24 § 1922(a) (2018), and would not be affected by removing the word “permanent” from the statute elsewhere.

The enactment of the “Bradley provision” provided the perfect opportunity for “permanent” revocation to be amended to simple revocation, but nursing was not at the table to make that request. Nurses and DNA in particular, should be vigilant to never again allow such an opportunity for positive change to the laws affecting nurses to pass us by.

The second issue for the DNA to address with the legislature is the changes regarding assault upon a nurse. According to Campbell (2017), there has been a 110% increase in the number of violent incidents reported against healthcare workers in the past decade. According to the ANA (2017b), one in four nurses was assaulted at work, and the likelihood of healthcare workers being exposed to violence is higher than for prison guards or police officers.

Currently, one who assualts an EMT, LPN, RN, paramedic, or physician in Delaware while such person is performing "a work-related duty" is guilty of a class D felony, whereas, if the assault were “while such person is rendering emergency care,” the assailant would be guilty of a class B felony (Del. Code. Ann., Title 11 §§612(a)(4), 613(a)(2)(b) (2018)). The differences between those felony classes is the sentencing. The sentence for assaulting a nurse who is “on-duty” (class D felony) is from zero to eight years of incarceration in state prison. Whereas, the sentence for assaulting a nurse while that same nurse was “rendering emergency care” (class B felony) is “not less than two years up to 25 years” of incarceration (Del. Code. Ann., Title 11 §§620(b)(1), 2017(c). A reasonable interpretation of “rendering emergency care,” which is presently codified as a higher-level felony than assault upon the same nurse in a clinical or occupational setting, means outside one of those settings, such as in a bystander or Good Samaritan role. The law should reflect that assault upon a nurse, in any setting, is a very serious offense. Thus, any assault upon a nurse should be codified as a serious class B felony and punished accordingly.

DNA intends to work hard towards passage of these two legislative changes and welcomes – and needs – the involvement of nurses in the political and legislative process right here in Delaware.

References:


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- Post-Bachelor's to D.N.P. – 80 credits for doctorate and eligibility for Family Nurse Practitioner certification
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What makes life worth living? How do we cope with serious illness? Nurses have a unique perspective on these questions. In touch with life, death, pain, and joy on a daily basis: nurses experience the most intense extremes of our existence and yet – they continue to devote their lives to providing dignity to anyone in need of care.

With the support of the American Nurses Foundation, award-winning filmmaker Carolyn Jones has brought these insights to life in Defining HOPE, a feature-length documentary that tells the story of patients with life-threatening illnesses, and the nurses who share their journey.

**The significance of hope**

The Foundation has supported the documentary to raise public awareness on the impact of nursing, and the light that nurses can bring to the darkest of times. Through exploring what matters most at the fragile junctures in life, the film follows patients making choices about how they want to live, how much medical technology they can accept, what they hope for – and how that hope evolves when life is threatened.

**Learn from the movie**

The feature was released on November 1, 2017, in honor of National Hospice and Palliative Care Month, with a special showing in Washington, D.C., on November 2. To fully showcase the nursing excellence in the documentary, the Foundation has invested in educational resources to accompany the work.

Our study guide highlights 16 brief vignettes, covering a range of topics, and profound talking points. Explore the guide with your clinician(s) or students, to promote vital dialogue on how nurses can work together and continue to keep hope alive.

Through the film and the use of the American Nurses Foundation’s guide, viewers will be able to:

1. Discuss key factors that affect patient and family decision making about end-of-life care.

2. Distinguish between hospice and palliative care.

3. Compare and contrast the terms sympathy and empathy.

4. Discuss internal conflicts that people may encounter when making decisions about whether to pursue aggressive treatment for life threatening illnesses.

5. Describe the role of the nurse in palliative care/hospice settings.

6. Discuss how family members play a significant role in decision making surrounding care choices.

For additional information, visit [https://www.nursingworld.org/foundation/programs/defining-hope](https://www.nursingworld.org/foundation/programs/defining-hope)

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**Why are Nurses Suing the EPA?**

How is it that our shampoo can contain carcinogens and our floor cleaner reproductive toxins?

For over a decade nurses have been working with a wide range of partners, including other health professionals, environmentalists, and health-affected groups, to up-date the nation's chemical safety policy. Written in 1976, the Toxic Substance Control Act was an ineffectual safety net for people and the environment from exposures to toxic chemicals in our air, water, food, and products. It did not require companies to do any sort of pre-market testing of their products for toxicity or potential harm.

Worse, it established that any chemicals that were already in the market place (some 80,000 chemicals) were "generally regarded as safe" without any evidence about their safety or harm to confirm this assumption. This was a way in which "grandfather" a host of toxic chemicals and thus grandfathered a host of toxic chemicals and thus allowed companies to do any sort of pre-market testing of their products for toxicity or potential harm.

For additional information, visit [https://www.nursingworld.org/foundation/programs/defining-hope](https://www.nursingworld.org/foundation/programs/defining-hope)
When Nurses Speak, Washington Listens

The American Nurses Association strives to represent nurses on Capitol Hill, provide support for state nurses associations as they advance their own advocacy agendas, and help federal agencies and elected officials propose and enforce new laws that will advance the nursing profession. ANA serves to amplify nurses’ voices as policies are conceived, debated, and implemented. We create long-lasting relationships with nurses and their representatives, working to establish a health system where care is accessible, of high quality, and recognizes the nursing profession as an integral component.

Registered nurses represent the largest segment of health professionals, with more than 3.6 million nationwide. Nurses not only represent an incredible force by sheer numbers, but policymakers rely upon their expertise as they work to improve our nation’s health system. For 16 years, nurses have outranked all other professions in Gallup’s annual honesty and ethics survey and are viewed as the most trusted profession.

Throughout the year, we will feature examples of ANA members advocating for patients and the communities they serve. Each quarter will have a dedicated theme, building from local to more global examples, but overlap with other quarterly themes will occur.

Nurses are advocates every day, so examples are endless and no illustration is too small. Please consider sharing your story and being recognized by ANA and your colleagues.

Send either a brief written description (under 150 words) OR a video (less than a minute) capturing your experience: actions, any challenges / barriers as well as strategies and any words of wisdom or tips for colleagues. If providing in writing, please include a high-resolution picture.

Questions or submissions should be directed to Janet Haehler, janet.haehler@ana.org, at ANA.

GET ENGAGED: #BedsideAndBeyond

Each quarter will have a dedicated theme, building from local to more global examples, but overlap will occur.

Q1: Nurses advocating locally (January – March)

Highlighting efforts at the bedside or in the community both for individual and/or groups of patients and/or nurses. Some examples: patient-focused practice changes/process improvements; workplace safety policies addressing issues such as staffing, workplace violence, safe patient handling and mobility; and representing the interests of patients, consumers and/or the profession while serving on a committee, council or board.

Q2: Nurses influencing elected officials and other key decision makers (April – June)

Highlighting efforts to impact change with key decision makers that are local, state or federal. Could be employer specific, immediate community/county, state legislative/regulatory, or federal. Individual influence as well as participation in a coalition.

Q3: Nurses get out the vote! (July - September)

With the approach of election day, emphasis will shift to political examples. Highlighting nurses leveraging their position as most trusted profession to impact policy change and 2018 campaigns. Will feature nurses who participated in a campaign, currently in or running for an elected or appointed position, and/or have a productive relationship with their elected official.

Q4: Global Impact and Making every year a year of advocacy (October – December)

Continue highlighting nurses who have had an impact within their community, state, or at the federal level, while also expanding to experiences beyond the US borders. Considering 2019 and future policy issues relevant to the nursing profession, will include an analysis of the November election results as well as insight on potential impact of political advocacy, and tips and words of wisdom on how to make every year a year of advocacy at any level in any role and setting.

To learn more about ANA advocacy efforts and what you can do to help, visit: http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/

Why are Nurses Suing the EPA? continued from page 9

some toxicological evidence: over 80,000 chemicals and in the marketplace. Think about how many years and decades we may see preventable health effects from toxic chemicals that have not been reviewed by us just haven't gotten to them yet.

As a nurse, whose mantra is “evidence-based practice,” I find it difficult to help individuals and communities navigate the necessary purchasing decisions required to live, work, learn, and play because of the lack of information about so many of the chemicals that make up our everyday products. Because we don’t require complete labeling for the vast majority of products, we can’t even do our own independent research to make informed decisions regarding the ingredients. When nurses started working on the revamping of the old chemical law, we had 3 elements that our coalition members agreed upon: 1) We need basic health and safety information on all chemicals in the marketplace. 2) We must be able to protect the most vulnerable of our population, including the fetus, infants, and children, from the effects of toxic chemicals, and 3) The EPA must have the power to ban chemicals that create the greatest risk of harm.

Our new chemical safety law, which has a very long name and honors the original Senator who sponsored the bill, is called the Frank R. Lautenberg Chemical Safety Act for the 21st Century. Once signed into law in 2016, the EPA was mandated to issue guidance documents for how they were going to review the chemicals under the updated regulation. Unfortunately, the EPA is now under a different and admittedly anti-regulatory administration. The new guidelines, issued in June 2017, reflect this bias. Instead of looking at all possible uses of a chemical in the marketplace and commerce, the new guidelines allow the EPA to pick and choose which uses they will consider when determining if the chemical poses an unreasonable health risk. Considering the case of lead, lead can be found as a contaminant in air, water, food, toys, and even in lipstick. If they only look at one or two of these sources, the EPA may be missing important exposure sources that could underestimate the health risks and allow a toxic chemical to be used in products that would otherwise be deemed unsafe.

At the issuance of the new guidelines, nurses joined a number of other organizations in suing the EPA for placing the public at an unreasonable health risk. The new guidelines fly in the face of our attempts to protect the public’s health,” asserts Katie Hufnigg, Executive Director of the Alliance of Nurses for Healthy Environments. Three separate suits were filed in District Courts around the country. It is anticipated that the judges in the courts will consolidate the cases and there will be one case heard. To follow the court case and other information about chemical safety and chemical policy, you can go to www.saferchemicalshappyfamilies.org.

To join in free monthly national calls with other nurses who are concerned about chemicals and public health policy, go to the website of the Alliance of Nurses for Healthy Environments: https://envirn.org/policy-advocacy/

With so many policy changes occurring – in healthcare, the environment, and other important areas – it is sometimes difficult to keep up. We welcome you to join our calls and just listen, if you like, to hear from nurses who are engaged in helping to protect human and environmental health. We also, especially, invite you to get involved and join a growing number of nurses who are concerned about potentially toxic chemicals in our everyday lives.

Author: Barbara Sattler, RN, MPH, DNP, FAAN, Professor, University of San Francisco School of Nursing and Health Professions (bsattler@usfca.edu) and Board Member of the Alliance of Nurses for Healthy Environments (www.envirn.org)

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ANA’s Case for Evidence-Based Nursing Staffing

Essential for cost-effective, high-quality hospital-based care and patient safety

Registered nurse (RN) staffing makes a critical difference for patients and the quality of their care. ANA champions the role of direct-care nurses and nurse managers in working with their hospital leadership to define the best skill mix for each hospital unit, recognizing the role of nurses in managing each patient’s treatment plan and continuously assessed health status. Our work demonstrates that patients, nurses, and health care systems thrive with appropriate and flexible nurse staffing. For hospitals to succeed, tools and processes must support evidence-based staffing decisions driven by nurses who understand the dynamic nature of patient care.

ANA bases its advocacy on research. ANA commissioned a comprehensive evaluation of nurse staffing practices as they influence patient outcomes and health care costs. A white paper, authored by consulting firm Avalere, evaluated a range of hospital-based care issues, including: Medical and medication errors Length of stay Patient mortality Readmissions Preventable adverse events, including falls, pressure ulcers, health care-associated infections, and other complications

Nurse staffing models affect patient care, which also drives health care costs. Safe staffing affects a range of hospital-based care issues, including: Medical and medication errors Length of stay Patient mortality Readmissions Preventable adverse events, including falls, pressure ulcers, health care-associated infections, and other complications

Nurse injury, fatigue, and low retention

Findings point to the importance and cost-effectiveness of nurse staffing decisions that are based on evidence rather than traditional formulas and grids. To foster innovation and transparency in staffing models, it is essential to capture and disseminate outcomes-based best practices.

Staffing and Cost Containment

Nurse salaries and benefits are among the largest components of a hospital’s expenses and thus are an easy target when balancing budgets. However, decisions to cut labor costs are sometimes shortsighted when the long-term impacts on cost and patient care quality are not considered. Other variables to consider in addressing hospital-based care costs include:

• High-tech devices and procedures
• Prescribed drugs and other medicine
• Clinician and system practice insurance

Other variables to consider in addressing hospital-based care costs include:

• Medical and medication errors
• Length of stay
• Patient mortality
• Readmissions
• Preventable adverse events, including falls, pressure ulcers, health care-associated infections, and other complications

• Nurse injury, fatigue, and low retention.

Findings point to the importance and cost-effectiveness of nurse staffing decisions that are based on evidence rather than traditional formulas and grids. To foster innovation and transparency in staffing models, it is essential to capture and disseminate outcomes-based best practices.

Conclusion

ANA supports direct-care nurses and nurse managers in working with hospital clinical and management teams to address pressures to control costs while providing high-quality care in a safe environment. Outcomes-based staffing models require partnerships between nurses and hospital/health system leadership, including those in finance, operations, and clinical areas. Together, we can find pragmatic solutions to complex and pressing issues.

Key Findings

Best practices consider many variables when determining the appropriate care team on each hospital unit:

• Patients: Ongoing assessment of patients’ conditions, their ability to communicate, their emotional or mental states, family dynamics, and the amount of patient turnover (admission and discharges) on the unit

• Care teams: Each nurse’s experience, education, and training; technological support and requirements; and the skill mix of other care team members, including nurse aides, social workers, and transport and environmental specialists

• Information collected from a series of panels of nurse researchers, health care thought leaders, and hospital managers.

To read ANA’s first staffing white paper, visit info.nursingworld.org/staffingwp.

The NSSRN will be sent to over 100,000 registered nurses in March of 2018. Nurses will be able to fill out the survey electronically or through a paper questionnaire. It is imperative that nurses participate and send back as soon as possible.

The NSSRN will gather up-to-date information about the status of registered nurses in the U.S. These data will be used to describe the registered nurse population at both the national and state level, so policymakers can ensure an adequate supply of registered nurses locally and nationally.

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Data Collection

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The Survey Contractor

HRSA has contracted with the U.S. Census Bureau, the leading statistical federal agency in the United States. Census has assembled a team of expert survey methodologists responsible for gathering the lists of licensed RNs, constructing the national sample, and administering the survey by mail, and on the internet.

Did you know...

• Employment settings change as nurses age? The vast majority of registered nurses under 30 years old work in hospitals, but over 50 percent of registered nurses 55 years or older work in non-hospital employment settings.

• Information technology investments and upgrades

• Facility construction, renovation, and maintenance

• Information technology investments and upgrades

Some organizations advocate for legislated nurse-patient ratios, believing that strict ratios will ensure patient safety. Based on our experience with unintended consequences, ANA does not support numeric, fixed ratios. In many cases, to meet these ratios, hospital administrators have eliminated other care team positions and then shifted noncore patient care work to nurses. This leaves nurses overextended and distracted from their core responsibilities of continuously monitoring patient status and implementing clinical treatment plans.

Legislated nurse-patient ratios versus flexible, nurse-driven staffing

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National Sample Survey of Registered Nurses

2018 National Sample Survey of Registered Nurses

Nurses play a critical role in the lives of patients across the country. That is why the U.S. Department of Health and Human Services is dedicated to providing you, policy makers, and researchers with the most comprehensive data on U.S. registered nurses and nurse practitioners. To accomplish this, we need your help.

Please support and encourage participation in the 2018 National Sample Survey of Registered Nurses (NSSRN). This vital national survey is the primary source of data on the nursing workforce, the largest group of healthcare providers.

The NSSRN will gather up-to-date information about the status of registered nurses in the U.S. These data will be used to describe the registered nurse population at both the national and state level, so policymakers can ensure an adequate supply of registered nurses locally and nationally.

The Purpose of the Study

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