Nursing Care Quality Assurance Commission (NCQAC)
Regular Meeting Agenda
November 18, 2016
Ramada Olympia
4520 Martin Way East
Olympia, WA 98516

Commission Members:	Charlotte Foster, BSN, MHA, RN, Chair Donna L. Poole MSN, ARNP, PMHCNS-BC, Vice-Chair Lois Hoell, MS, MBA, RN, Secretary/Treasurer Mary Baroni, PhD, RN (via GoToWebinar) Adam Canary, LPN Stephen J. Henderson, JD, MA, Public Member Suellyn M. Masek, MSN, RN, CNOR Helen Myrick, Public Member Tiffany Randich, LPN Tracy Rude, LPN Renee Ruiz, Public Member Laurie Soine PhD, ARNP Teri Trillo, MSN, RN, CNE Vacant, RN
Excused:	Jeannie Eylar, MSN, RN
Assistant Attorney General:	Gail S. Yu, Assistant Attorney General
Staff:	Paula R. Meyer, MSN, RN, FRE, Executive Director Bobbi Allison, Administrative Assistant Chris Archuleta, Administrative Assistant Mary Dale, Discipline Manager John Furman, PhD, MSN, CIC, COHN-S, Director, Washington Health Professional Services (WHPS) Mary Sue Gorski, PhD, RN, Nursing Education Research and Policy Analyst Barbara Gumprecht, MSN, RN Nursing Education Consultant Karl Hoehn, Legal Manager Kathy Moisio, PhD, RN, Nursing Education Consultant Garr Nielsen, Chief Investigator Carole Reynolds, MPH, Policy and Performance Analyst Mindy Schaffner, PhD, MSN-CNS, RN, Associate Director, Nursing Education, Licensing & Research Catherine Woodard, Associate Director, Discipline
Excused:	Kathy Anderson, Financial Manager Debbie Carlson, MSN, RN, Associate Director, Nursing Practice Teresa Corrado, LPN, Licensing Manager

If you have questions regarding the agenda, please call the NCQAC office at 360-236-4713. Items may be taken out of order. If you wish to attend the meeting for a single item, contact our office at the number listed above and request a specific time scheduled for that item.

This meeting is accessible to persons with disabilities. Special aids and services can be made available upon advance request. Advance request for special aids and services must be made no later than November 10, 2016. If you need assistance with special needs and services, please leave a message with that request at 1-800-525-0127 or, if calling from outside Washington State, call (360) 236-4052. If you have limited English language expertise, call 360-236-4713 before November 10, 2016. TDD may also be accessed by calling the TDD relay service at 711. If you need assistance due to a speech disability, Speech-to-Speech provides human voicers for people with difficulty being understood. The Washington State Speech to Speech toll free access number is 1-877-833-6341.

This meeting will be digitally recorded to assist in the production of accurate minutes. All recordings are public record. The minutes of this meeting will be posted on our website after they have been approved at the January 13, 2017 NCQAC meeting. For a copy of the actual recording, please contact the Public Disclosure Records Center (PDRC) at PDRC@doh.wa.gov
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Smoking is prohibited at this meeting.

I. 8:30 AM Opening – Charlotte Foster, Chair – DISCUSSION/ACTION

II. Call to Order

A. Introductions
B. Order of the Agenda
C. Correspondence
D. Announcements: NCSBN committee appointments
1. Dr. Mindy Schaffner: Nursing Education Outcomes and Metrics
2. Paula Meyer: Leadership Succession Committee

III. 8:40 AM Consent Agenda – DISCUSSION/ACTION

Consent Agenda items are considered routine and are approved with one single motion

A. Approval of Minutes
1. NCQAC Business Meeting
    a. September 9, 2016
2. Advanced Practice Sub-committee
    a. August 17, 2016
    b. September 21, 2016
3. Discipline Sub-committee
    a. July 26, 2016
    b. August 23, 2016
4. Consistent Standards of Practice Sub-committee
    a. September 6, 2016
    b. October 4, 2016

B. Out of State Travel Reports
1. Association of Occupational Health Professionals (AOHP), Myrtle Beach, SC, September 6-9, John Furman

2. Council of Licensure, Enforcement, and Regulation (CLEAR), Portland OR, September 14-16, John Furman, Kathy Moisio
3. Citizens Advocacy Center (CAC), September 18-19, 2016, Portland OR – Renee Ruiz, Mindy Schaffner
4. Federation of Associations of Regulatory Boards (FARB), September 29 – October 2, Sarah Bendersky, Tim Talkington
5. Regulation 2030, October 2-3, 2016, Chicago, IL, Paula Meyer
6. International Nurse Society on Addictions, October 5-8, Las Vegas NV, Melissa Fraser
7. NCSBN Scientific Symposium, October 6, Chicago, IL, Lois Hoell, Mindy Schaffner
8. National Association of Drug Diversion Investigations (NADDI), October 11 – 14, Louisville, KY, Dana Malone

IV. 8:45 AM – 9:00 AM NCQAC Panel Decisions – DISCUSSION

The NCQAC delegates the authority as provided by law for certain decision to a panel of at least three members. A member of the NCQAC must chair panels. Pro tem members of NCQAC may serve as panel members. The following minutes are provided for information.

A. Nursing Program Approval Panel (NPAP)
B. Nursing Assistant Program Approval Panel (NAPAP)

V. 9:00 AM – 9:15 AM Chair Report – Charlotte Foster – DISCUSSION/ACTION

A. Governor's announcement on Action on Opioid Overdoses
B. Legislative Task Force – appointment of members to include Donna Poole as the chair
C. Gene Pingle transition and vacancy recruitment
D. Discipline Sub-committee Chair appointment

VI. 9:15 AM – 9:45 AM Executive Director Report – Paula Meyer – DISCUSSION/ACTION

A. Budget Report
B. Performance Measures Report
1. NCQAC
2. Legal
3. WHPS

C. TEMS and board pay
D. Jurisprudence examination update and request to modify deadline on Strategic Plan
E. Rules Update – Carole Reynolds
F. Legislation update
1. FBI Criminal Background Checks/Rap Back
2. Repeal of RCW 18.79.380 Licensed practical nurse/nontraditional registered nurse program – Obtaining required clinical experience.
3. Proposal to convert Health Professions Account (Fund O2G) from an appropriated to a non-appropriated account.

9:45 AM – 10:00 AM Break

VII. 10:00 AM – 11:30 AM Sub-committee Report – DISCUSSION/ACTION

A. Advanced Practice – Laurie Soine, Chair

1. Procedure F06.01 Advanced Registered Nurse Practitioner: Pain Management Specialist – Commission-Approved Credentialing Entities (Revision)
2. Exploring Options for ARNPs: Clinical Practice Requirements and "Advanced Registered Nurse Practitioner-Retired" Recognition Designation
3. Guidelines for Licensed Midwives who use Birth Assistants: Washington State Department of Health Midwifery Program

B. Consistent Standards of Practice – Tiffany Randich, Chair

1. Advisory Opinion: Dispensing Medication for Prophylactic and Therapeutic Treatment of Communicable Diseases and Reproductive Health by Public Health Nurses
2. Medication Management by Physical Therapists, Occupational Therapists, and Speech Language Therapists

C. Discipline – Vacant, Chair

1. Procedure A49 WHPS Referral Contracts

D. Licensing – Lois Hoell

1. Licensing and Continuing Competency Audits Update

VIII. 11:30 AM – 1:00 PM Lunch – Happy 2nd Anniversary to Legal and WHPS

Two years ago, the WHPS program and the Legal Services transferred to work in the NCQAC.

IX. 12:00 PM – 1:00 PM Education Session – Workplace Aggression and Nurses' Well-Being: the Role of Work-Family Supportive Supervisors, Nanette Yragui, Washington State Labor and Industries

Nanette Yragui is an Occupational Health Research Psychologist at the SHARP Program (Safety & Health Assessment & Research for Prevention) in the Washington Department of Labor & Industries. She is a graduate of Portland State University with a Ph.D. in Systems Science: Psychology. She conducts workplace violence research in healthcare settings. Her research interests in occupational health psychology include: workplace violence and aggression; workplace incivility; positive psychology including social support and helping behavior in teams; and the application of action research methods toward developing and testing the effectiveness of interventions. The SHARP research team examined patient violence and coworker incivility. Ms. Yragui will provide a presentation on patient violence and coworker incivility related to work stress when supervisors provided a resource of support for employees.

X. 1:00 PM – 1:15 PM Open Microphone

Open microphone is for public presentation of issues to the NCQAC. If the public has issues regarding disciplinary cases, please call 360-236-4713.

XI. 1:15 PM –2:15 PM Prescription Monitoring Program – Chris Baumgartner - DISCUSSION/ACTION

Mr. Baumgartner updates the NCQAC on the three year Prescription Drug Overdose Prevention grant from the Centers for Disease Control, the Governor's Opioid Overdose initiatives, and medical marijuana.

2:15 PM – 2:30 PM BREAK

XII. 2:30 PM – 3:00 PM Washington Health Professional Services (WHPS) Program Audit – Dr. Nancy Darbro, Paula Meyer, Catherine Woodard, John Furman – DISCUSSION/ACTION

In August, 2016, Dr. Nancy Darbro completed a post implementation audit of the WHPS program. Dr. Darbro completed the initial audit prior to the NCQAC adopting new procedures and approving the program. The NCQAC may consider actions necessary for full compliance as needed.

XIII. 3:00 PM – 3:30 PM Legal Services and WHPS – Karl Hoehn and Dr. John Furman – DISCUSSION/ACTION

Mr. Hoehn and Dr. Furman provide brief comments on the past 2 years since Legal Services and the WHPS Program joined the NCQAC.

XIV. 3:30 PM – 4:00 PM Education Report – DISCUSSION/ACTION

- **A. Environmental Scan – Lois Hoell**
- **B. Scientific Symposium – Lois Hoell & Dr. Mindy Schaffner**
- **C. Solution Summit – Dr. Mindy Schaffner**
- **D. Update on Direct Transfer Agreement (DTA) – Dr. Mary Baroni**

XV. 4:00 PM New Business

XVI. 4:15 PM Meeting Evaluation

XVII. 4:30 PM Closing

Nursing Care Quality Assurance Commission (NCQAC)
Regular Meeting Agenda
September 9, 2016
Ramada Olympia
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DRAFT

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Lois Hoell, MS, MBA, RN, Secretary/Treasurer
Adam Canary, LPN
Jeannie Eylar, MSN, RN
Stephen J. Henderson, JD, MA, Public Member
Suellyn M. Masek, MSN, RN, CNOR
Tiffany Randich, LPN
Tracy Rude, LPN
Renee Ruiz, Public Member
Laurie Soine PhD, ARNP

Excused:
Mary Baroni, PhD, RN
Helen Myrick, Public Member
Gene Pingle, BSN, RN-BC, CEN, CPEN
Teri Trillo, MSN, RN, CNE

Assistant Attorney General:
Gail Yu, Assistant Attorney General

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Barbara Gumprecht, MSN, RN Nursing Education Consultant
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I. 8:30 AM Opening – Charlotte Foster, Chair – Meeting was called to order at 8:30 AM

II. Call to Order

A. Introductions
B. Order of the Agenda
C. Correspondence
D. Announcements

III. 8:40 AM - 8:45 AM Consent Agenda

Consent Agenda items are considered routine and are approved with one single motion

A. Approval of Minutes

1. NCQAC Business Meeting, July 8, 2016
2. Advanced Practice Sub-committee (May and June meetings cancelled)
    a. April 20, 2016
    b. July 20, 2016
3. Discipline Sub-committee
    a. May 24, 2016 Minutes
4. Consistent Standards of Practice Sub-committee
    a. July 5, 2016
    b. August 2, 2016
5. Licensing Sub-committee
    a. February 26, 2016
    b. April 22, 2016
    c. May 26, 2016
    d. June 24, 2016

B. Out of State Travel Reports

1. NCSBN Annual Meeting, Chicago, August 17-19, 2016;
    a. Charlotte Foster, Paula Meyer, Suellyn Masek, Margaret Kelly, Lois Hoell, Tracy Rude, Mary Sue Gorski, Mary Dale, Mindy Schaffner, Margaret Holm

Ms. Hoell requested the June 24, 2016 Licensing Sub-committee minutes be removed from the consent agenda to correct a scrivener's error: Item IV. Jurisprudence Exam, first bullet – change from "NCSBN does not support" to "NCSBN supports individual state JP exams."

MOTION: Moved by Ms. Hoell with a second from Ms. Rude to adopt the consent agenda with the correction to the June 24 Licensing Sub-committee minutes. **Motion carried.**

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IV. 8:45 AM – 9:00 AM NCQAC Panel Decisions

The NCQAC delegates the authority as provided by law for certain decision to a panel of at least three members. A member of the NCQAC must chair panels. Pro tem members of NCQAC may serve as panel members. The following reports were provided for information.

A. Nursing Program Approval Panel (NPAP)
B. Nursing Assistant Program Approval Panel (NAPAP)

V. 9:00 AM – 9:30 AM Chair Report – Charlotte Foster

A. Board/Commission Leadership Meeting, July 21

Ms. Foster provided an overview of the meeting topics and presentations from the July 21st meeting. Ms. Foster suggested that the topic of dealing with high conflict people be added to the lunch education topics list.

B. Unintentional deaths related to opioid use – Laurie Soine

Dr. Soine asked Ms. Meyer to give the update regarding a recent meeting to discuss Governor Inslee's directive to reduce the number of unintentional deaths related to opioid use and the forming of a task force to focus on the issue. Ms. Meyer reported the necessity to include nurse practitioners as primary care providers and prescribers. Washington State Medical Association and the Washington Hospital Association have a task force to address opioid deaths. Ms. Meyer recommended adding representatives from ARNP United and Robin Fleming from the Office of Superintendent of Public Instruction as task force members.

C. NCQAC Annual Evaluation results and recommendations – Lois Hoell, Jeannie Eylar

Ms. Hoell introduced recommendations from the committee: Lois Hoell, Jeannie Eylar, and Margaret Kelly. The committee's recommendations address the issues brought up at the May and July business meetings. The NCQAC staff will take recommendations and apply to next year's survey.

D. Sub-committee appointment(s)

Ms. Foster assigned newly appointed LPN member Adam Canary to the Discipline Sub-committee. Tracy Rude acts as his mentor.

VI. 9:30 AM – 10:15 AM Executive Director Report – Paula Meyer

A. Budget Report

Ms. Anderson provided an update of the financial status of the NCQAC half way through the biennium.

- Revenues are holding steady and account balance holding at $2.8M.

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- The NCQAC is underspent by 12%, due in part to the increase in number of discipline cases settling, reduced use of Attorneys Generals and resulting decrease in number of hearings.
- Will be filling a few vacant positions soon.
- Held fee meeting by webinar on 9/8/16 – only 5 attendees
- Indirect rates dropped in June due to balancing of rates at the end of the fiscal year.

B. Performance Measures Report

1. NCQAC
2. WHPS
3. Legal

C. Delegation for presiding officer for Brief Adjudicative Hearings

MOTION: Moved by Dr. Soine with a second from Ms. Poole that the NCQAC designate Marlee O'Neill, Supervising Staff Attorney of the Office of Legal Services, Department of Health, as the appropriate designee to perform all necessary duties as presiding officer for any referred Brief Adjudicative Proceeding related to decisions affecting nursing and nursing assistant education programs. **Motion carried.**

D. Location of January 2017 meeting – using Department of Health, Point Plaza East, Room 152/153

Ms. Meyer reported the results of the dress rehearsal test of PPE Room 152/153 held on August 24, 2016, where the room's IT and wi fi capabilities were pushed. Staff recommends the room is capable of hosting the January 13, 2017 business meeting. Ms. Yu reminded the NCQAC staff to file the 2017 regular meeting schedule with the code reviser office, due in November.

MOTION: Moved by Ms. Hoell with a second from Ms. Randich to schedule the January 13, 2017 NCQAC meeting in Point Plaza East, Room 152/153. Scheduling future meetings in this room depends on the evaluation of services at the end of the meeting. **Motion carried.**

E. Location of 2017meetings

Ms. Meyer introduced the proposed regular meeting schedule for 2017 and the plan to use GoToWebinar as a tool to increase public participation. Test the GoToWebinar possibility at the November meeting. Discussion ensued regarding the use of webinars and different meeting locations options.

MOTION: Moved by Ms. Eylar with a second from Mr. Henderson to adopt the dates and locations of the 2017 Nursing Commission meetings as the following:

- January 13 – Olympia, Point Plaza East, Room 152/153 and webinar
- March 10 – Olympia, Point Plaza East, Room 152/153 and webinar
- May 11, 12 Seattle area, include a one day workshop on Substance Use Disorder
- July 13, 14 – Olympia, Point Plaza East, Room 152/153, include one day strategic planning workshop and Webinar
- September 8 – Spokane area and webinar
- November 10 – Olympia, Point Plaza East, Room 152/153 and webinar

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After further discussion, the motion was amended to add a second date to the September meeting in Spokane to include a one day workshop on a topic TBD:

- September 7, 8 – Spokane area, include one day workshop on topic TBD and webinar.

AMENDED MOTION: Moved by Ms. Eylar with a second from Ms. Poole to adopt the current motion with amendment. **Motion carried.**

F. Commission/pro tem computers, IT issues

At the June 24, 2016 meeting with DOH IT, issues that were identified by the NCQAC were brought to the table for discussion. Mr. Lee and Mr. Archuleta presented the outcomes and resolutions to many of the issues. One significant outcome presented was the introduction of Outlook Web Access (OWA) which allows NCQAC members to access their DOH emails from any device with an internet connection. Mr. Lee also presented an overview of the evolution of the relationship between the NCQAC and DOH IT department and the level of commitment provided by his staff to the NCQAC.

G. Strategic Plan

Ms. Reynolds provided an update on the NCQAC status with regards to meeting deadlines on the strategic plan. The NCQAC is close to missing a couple deadlines. Ms. Reynolds requested language be amended and extensions to identified deadlines on the strategic plan.

MOTION: Moved by Mr. Henderson with a second from Ms. Poole to adopt the proposed amendments to the Strategic Plan. **Motion carried.**

10:15 AM - 10:30 AM Break

VII. 10:30 AM – 11:10 AM Sub-committee Report

A. Advanced Practice – Laurie Soine, Chair
B. Consistent Standards of Practice – Tiffany Randich, Chair
C. Discipline – Gene Pingle, Chair (Ms. Rude provided reports)

1. Sanction Standards for Continuing Competency - Procedure A27.11

Ms. Dale introduced an amendment to the sanction standards procedure A27 that addresses continuing competency. Failure to meet continuing competency rules will result in indefinite suspension until successfully completing a refresher course. A Limited Education Authorization may be approved to allow the respondent to take the refresher course. The sub-committee recommends a fine of $5,000

MOTION: Moved by Ms. Rude with a second from the sub-committee that the sanction for violation of the Continuing Competency rules is suspension until successfully completing a refresher course. A Limited Education Authorization may be approved to allow the respondent to complete the refresher course. A fine of $5,000 will be imposed. **Motion carried.**

2. Electronic/Digital Signatures for Disciplinary Actions – Procedure A54.01

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MOTION: Moved by Ms. Rude with a second from the sub-committee that Procedure A54 Electronic/Digital Signatures for Disciplinary Action be approved. **Motion carried.**

D. Licensing – Jeannie Eylar, Chair

1. Temporary practice permit/NCSBN recommendations

After review of NCSBN recommendations related to temporary practice permits, the licensing sub-committee recommends that temporary practice permits' effective time should be reduced or eliminated.

MOTION: Moved by Ms. Eylar with a second from the sub-committee that the NCQAC decrease the effective time for RN and LPN temporary practice permits from 6 months with the possibility of a 6 month extension to the effective time of one month with the possibility of a one month extension. In addition, the NCQAC to open all applicable NCQAC rules that need to be updated to reflect this change. **Motion carried.**

11:30 AM – 1:00 PM Lunch

12:00 PM – 1:00 PM Education Session - Trends in Long-Term Care – Presenter, Lauri St. Ours, Director of Governmental and Legislative Affairs, Washington Health Care Authority

VIII. 1:00 PM – 1:15 PM Open Microphone

None

IX. 1:15 PM – 1:45 PM Washington Center for Nursing, Diversity Efforts – Dr. Suzanne Sikma

Dr. Sikma, with the assistance of graduate students, Fanice Okinoma and Molly Elbrier, provided a report on research dedicated to diversity in the WA state nursing population. Dr. Sikma is the contract manager for the Academic Progression in Nursing for the Center for Nursing.

X. 1:45 PM – 2:15 PM Veterans to Baccalaureate in Nursing Science (VBSN) program – Dr. Gerianne Babbo, Dr. Minerva Holk, and Dr. Mary Garguile

These former UW doctoral students developed a baccalaureate nursing program recognizing skills and competencies of people exiting their military careers wishing to attain a career in nursing. Drs. Babbo, Holk, and Garguile presented their progress in the development and implementation of the program.

2:15 PM– 2:30 PM BREAK

XI. 11:10 AM – 11:20 AM Public Disclosure of Lists and Labels – Karl Hoehn (Item moved to earlier in the agenda)

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According to Procedure J04.08, the NCQAC annually reviews the list entities recognized as professional associations and educational organizations. These entities may request the list of addresses of nurses and receive the list if they are recognized as a professional association or educational organization. The NCQAC recently revised the procedure and a panel now reviews the requests. Recommendation to delegate to a panel the review of the list of entities recognized by the NCQAC was considered.

MOTION: Moved by Ms. Rude with a second from Ms. Hoell and Ms. Poole that the NCQAC delegate to a panel the annual review and approval of recognized educational organizations and professional associations, per Procedure J04.09. **Motion carried with one dissent.**

XII. 2:30 PM – 3:15 PM Education Report - DISCUSSION/ACTION
A. TEAMS Project - Dr. Kathy Moisio and panel

Dr. Moisio presented the work being done with the TEAMS (**T**ogether, **E**ating Better, **A**ctively Living, **M**onitoring Health, and **S**elf-managing Risk) project in alignment with the NCQAC newly adopted education innovation rule. Dr. Moisio introduced Dr. Mott, retired orthopedic surgeon who championed the TEAMS project and is looking into expanding the project. The NCQAC also heard testimony from several participants in the program. The presentations impressed NCQAC with the program and discussed ways to move it forward. Dr. Moisio explained that funding is the missing piece to expansion and moving forward.

B. NCQAC Procedure for Use of Data - Dr. Mary Sue Gorski

Dr. Gorski presented the procedure requested by the NCQAC from the Data and Quality Task Force at the July Business Meeting. The procedure improves access and utilization of available data to inform policy decision, evidence based regulatory practice, and research.

MOTION: Moved by Dr. Soine with a second from Ms. Randich that the Data and Quality Assurance Procedure R.01.01 be approved. **Motion carried.**

C. Nursing Education Program Reporting Form – Dr. Mindy Schaffner

Dr. Schaffner introduced the nursing education program reporting form that is required under the new rules, specifically WAC 246.840.513, that will take effect September 16, 2016. The school of nursing program is required to complete the form.

MOTION: Moved by Ms. Hoell with a second from Mr. Henderson that the NCQAC Incident Report Form be approved. **Motion carried.**

XIII. 3:15 PM – 3:45 PM Rules Review – Carole Reynolds

Ms. Reynolds provided an update on the status of the three sets of rules that are currently open.

Ms. Reynolds announced the hearing for the Fee Rules will be held on November 30, 2016 at 1:00 PM at the Department of Health. The Secretary of Health sets the fees so the NCQAC does not hold the hearing.

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A. Demographic Data/Minimum Data Set

Ms. Reynolds explained the Demographic Data/Minimum Data Set rules are a new set of rules that would provide demographic data on the Washington State nursing population to assist in policy decisions, assist Washington Center for Nursing, and help nursing programs make decisions based on need. The rules would make the data collection a licensing requirement.

B. Substance Abuse, Mandatory Reporting

Ms. Reynolds announced she will send out a clean copy of the rules for easier reading. If approved, these WACs are supported by the RCWs and can support the newly adopted NCQAC procedures for the Washington Health Professional Services program.

C. Nursing Assistants

Ms. Reynolds explained that nursing assistants' current practice is largely defined by where they work and what they do and not by their credentials. These rules would clarify their practice and to not limit their practice to specific tasks, but based on what they are trained and competent to do. Additionally, the nursing assistant education rules need to be updated.

All three sets of rules are scheduled for hearings at the January 2017 business meeting.

XIV. 3:45 PM – 3:45 PM New Business

XV. 3:45 PM – 3:57 PM Meeting Evaluation

Pros	Cons
Lunch education session and afternoon research presentations	Meeting location – Drive to Olympia
Food was good	Breakfast too light – need something heartier
Venue – Ramada Olympia	PowerPoint issues
Staff support	Dirty dishes not cleared after lunch
Computer/ IT update and solutions	
Meeting location – Olympia	
No major technical issues	
Charlotte as Chair	
TEAMS presentation	
Meeting flow	
Amount of work accomplished	
Robust discussions	

XVI. 3:57 PM Closing

Meeting adjourned at 3:57 PM

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Charlotte Foster, BSN, MHA, RN	Lois Hoell, MS, MBA, RN
Chair	Secretary/Treasurer

Nursing Care Quality Assurance Commission (NCQAC)
Advanced Practice Sub-committee Minutes
August 17, 2016 7:00 PM to 8:00 PM
111 Israel Rd SE, Tumwater, WA 98501

Committee Members Present:	Laurie Soine, PhD, ARNP, **Chair** Heather Bradford, CNM, ARNP, FACNM Heather Schoonover, MN, ARNP, PHCNS-BC Donna Poole, MSN, ARNP, PMHCNS-BC Dan Simonson, CRNA, MHPA
Staff:	Debbie Carlson, MSN, RN, Associate Director – Nursing Practice Jean Wheat, Nurse Practice Administrative Assistant

I. 7:05 PM Opening – Laurie Soine, Chair

II. Call to Order
- The public disclosure statement was read.
- Introductions made.
- Announcements: None
- Minutes of the July 20, 2016 Advanced Practice Sub-committee were recommended to the NCQAC for approval as submitted.

III. Nursing Scope of Practice-Discussion re: Expansion During Disasters
- Debbie Carlson did an overview. All subcommittee members were encouraged to read attached documents. No action needed by the Sub-committee.

IV. Birth Assistant Sunrise Report
- This report was presented by Kathy Weed at the July 20, 2016 meeting. Heather Bradford reviewed the document. Debbie Carlson gave an overview on the background: a new credential proposed called a Birthing Assistant, which was ultimately declined by the DOH. Rather the DOH commissioned an Advisory Opinion. Heather Bradford had no concerns with this Advisory Opinion. Sub-committee was not asked for formal support and had no further comments.

V. Medical Marijuana Authorizing Guideline Group
- Seeking a Pro Tem or Commission Member willing to represent the Nursing Commission on this multi-disciplinary workforce creating guidelines and education. Donna Poole volunteered, Debbie Carlson to find out how and when they meet.

VI. Epidemiology Center Death Certificate Guidelines (Draft) Public Meeting
- Debbie Carlson went to one meeting at Vital Statistics. The draft guidelines language lacked language regarding utilizing ARNP’s. Debbie Carlson edited the document to include ARNPs along with MD and PA as providers allowed to complete death certificates. The changes were submitted to the agency.

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VII. Retired Active Status for RN's and LPN's

- Laurie Soine gave an overview of the retired active status for RN's and LPN's
- Sub-Committee all agreed to explore a retired status for ARNP's in the State.

VIII. Advisory Opinion Workshops

- Dispensing Medications by Health Departments
- Compounding Medications
- Nursing Delegation in Schools (Revisions): Glucagon Administration
- Advanced Registered Nurses Performed Medical Acupuncture

- Debbie Carlson announced Advisory Opinion Workshops.

IX. Review resumes for the Expert Witness Panel - No applications

X. Agenda Items for the Next ARNP Sub-Committee meeting on September 21, 2016

XI. Open microphone -

- Margaret McMahon supports the effort of the Subcommittee to explore a retired active status for ARNPs
- Nancy Lawton made a comment regarding acupuncture and pain management. She inquired about the proposed fee schedule. Debbie Carlson will check in to it.
- Nancy Lawton asked if the RCW support the Advisory Opinion that ARNP are eligible to sign Death Certificates – Debbie Carlson will check into it.
- Melissa Johnson looking for the proposed fee schedule.

XII. Adjournment – 7:45 PM

DRAFT

Nursing Care Quality Assurance Commission (NCQAC)
Advanced Practice Sub-committee Minutes
September 21, 2016 7:00 PM to 8:00 PM
111 Israel Rd SE, Tumwater, WA 98501

Committee Members Present: Laurie Soine, PhD, ARNP, **Chair**
Heather Bradford, CNM, ARNP, FACNM
Heather Schoonover, MN, ARNP, PHCNS-BC
Donna Poole, MSN, ARNP, PMHCNS-BC
Dan Simonson, CRNA, MHPA

Staff: Debbie Carlson, MSN, RN, Associate Director – Nursing Practice
Jean Wheat, Nurse Practice Administrative Assistant

I. 7:03 PM Opening – Laurie Soine, Chair

II. Call to Order
- The public disclosure statement was read.
- Roll Call.
- Introductions and Announcements: None

III. Standing Agenda Items
- Announcements/September business meeting highlights – Full day meeting in Olympia.
- Minutes of the August 17, 2016 Advanced Practice Sub-committee were recommended to the NCQAC for approval as submitted.
- Review resumes for the Expert Witness Panel (ongoing) – None.

IV. Old Business
- Medical Marijuana Authorizing Guideline Group Update. Donna Poole will serve as NCQAC liaison to this group.
- Retired Active Status update. All members remain interested in exploring this topic. All agreed that maintaining the ability to refer to themselves as an ARNP or Nurse Practitioner (both protected titles in this state) following retirement is important. Debbie reviewed document that she had created that highlighted retired active options by national certifying bodies. Next steps each sub-committee member is to go to their certifying body to see what options they would give an individual. Debbie to invite Mary Sue Gorski to next sub-committee meeting to present her experience.

V. New Business
- None.

DRAFT

VI. Ending Items

- Open Microphone (as time permits) - None
- Review of Actions
- Date of Next Meeting – October 19, 2016
- Adjournment – 7:40 PM

Nursing Care Quality Assurance Commission (NCQAC)
Discipline Sub-committee Minutes
July 26, 2016 3:30 pm to 5:30 pm
Webinar
111 Israel Rd SE, Tumwater, WA 98501

DRAFT

Committee Members:
Gene Pingle, BSN, RN-BC, CEN, CPEN, Chair
Jeannie Eylar, MSN, RN
Lois Hoell, MS, MBA, RN **(Excused)**
Tracy Rude, LPN
Renee Ruiz, Public Member
Suellyn Masek, MSN, RN, CNOR, ad hoc

Staff:
Mary Dale, Discipline Manager
Catherine Woodard, Associate Director of Discipline
Karl Hoehn, Legal Manager
John Furman, Director WHPS
Shari Kincy, Administrative Assistant
Debbie Carlson, Practice Manager, ad hoc

I. 3:41 pm Opening — Gene Pingle, Chair

- Call to order – Gene gave the digital recording announcement
- Roll call

II. May 2016 Minutes – Gene

Gene asked that his credentials be changed, Mary stated she would make that change. The minutes were approved to go forward to the September Business meeting.

III. Nurse Licensure Compact – Tracy, Jeannie

The Commission continues to work to pass RapBack legislation.
Tracy attended a stakeholder meetings. There was a good turn-out but not many comments.

IV. RapBack Update – Catherine

Catherine reported on the work done with state legislators. Paula Meyer, Catherine, and Jeannie met with a representative from Eastern Washington. Privacy issues have some

legislators concerned. HSQA and DOH would like to partner with NCQAC to get this legislation passed, with NCQAC as the pilot.

V. Remediation of Boundary Violations - Mary

Mary discussed this document from National Council's Case Management Conference that was forwarded by Suellyn Masek. The document was developed by the Louisiana Board of Nursing. The subcommittee agreed the information would be helpful to the commission while reviewing discipline cases, as it includes just culture and has a logical structure.

Decision: The Committee assigned Mary to make changes to the document to put it in the context of the sanction standard WAC. It will be placed on the September meeting agenda.

VI. Investigation Report - Catherine

A revised chart was sent; the one in the packet was incorrect. Cases have been increasing; they have gone from 20 to 40 per investigator. The decision has been made to hire another investigator. Catherine will post the job opening in a few days.

VII. Legal Reports – Karl

The statistics in the packet are the same as the July NCQAC business meeting. The average number of cases increased per attorney. Karl is watching the trends in both investigation and legal, especially the ARNP cases, as they are a much higher work impact.

VIII. Electronic Signatures for Disciplinary Actions - Mary

Mary reviewed the draft procedure. It is based on the electronic signature procedure for administrative documents. Each document to be signed electronically must be approved by the signer.

Decision: The committee asked for a revision to include a copy of the final document be sent to the signer. They agreed to present this to the full Commission at the September business meeting.

IX. Implementing CORE Best Practices – Mary

Mary presented an outline of information that would be placed on the Website. Karl suggested placing some "soft touches" to the language explaining the disciplinary processes. This will show nurses that the Commission understands the stress and show empathy when a nurse is placed under discipline. He also suggested that there be links to the Health Law Judges website, as well as the WHPS page. There should be some information on how to make a complaint report. This will be brought back to the subcommittee before it goes live.

X. Work Plan – Gene

Performance Measures – Quarterly/August

Newsletter – Due in October; Karl will write

Nurse Licensure Compact – On going

Investigator/Legal Reports – Done

CMT Statistics – August

DRAFT

ER Program Review – September
RapBack – On going
CORE – On going
Communication Resolution Practices – Future
Determine effectiveness - Future

XI. Closing – 4:55
Mary asked for approval for a motion that adds Continuing Competency to the Sanction Standards.
Decision: The Committee agreed to have this presented at the September Business meeting.

DRAFT

Nursing Care Quality Assurance Commission (NCQAC)
Discipline Sub-committee Minutes
August 23, 2016 3:30 pm to 5:30 pm
Webinar
111 Israel Rd SE, Tumwater, WA 98501

DRAFT

Committee Members:
Gene Pingle, BSN, RN-BC, CEN, CPEN, Chair
Jeannie Eylar, MSN, RN **(absent)**
Lois Hoell, MS, MBA, RN
Tracy Rude, LPN
Renee Ruiz, Public Member
Suellyn Masek, MSN, RN, CNOR, ad hoc

Adam Canary, LPN **(guest)**

Staff:
Mary Dale, Discipline Manager
Catherine Woodard, Associate Director of Discipline
Karl Hoehn, Legal Manager
John Furman, Director WHPS
Shari Kincy, Administrative Assistant
Debbie Carlson, Practice Manager, ad hoc
Rozanne McCarty, Administrative Assistant

I. 3:36 pm Opening — Gene Pingle, Chair

- Call to order – Gene gave the digital recording announcement
- Roll call

II. July 2016 Minutes – Gene

The minutes were approved with no changes. They will be placed in the November Business Meeting packet.

III. Nurse Licensure Compact – Tracy, Jeannie

The Commission continues to work to pass RapBack legislation.

IV. RapBack Update – Catherine

Catherine reported on the work with the legislators. She and Paula have been meeting with several legislators throughout the state.
Catherine, Paula and Adam Canary met with Representative Johnson in Eastern Washington. The bill has a prime sponsor in both the House and the Senate. Legislative sheets will be ready by November 9 and filed by December 8.

V. **Performance Measures - Tracy**

Tracy went over the numbers. We are still down an investigator and the case load is still going up. The Sanction Schedule numbers come from mitigating and aggravating circumstances. There has been ongoing training for the legal group to correct the numbers. Task backs are reflected in the numbers under the investigations.

VI. **Case Management Statistics - Mary**

There hasn't been much of a shift in the different complaint categories. Complaints have increased by 32% in the last year.

VII. **Closing First DUI – Karl/Catherine**

Karl asked the committee where they stand on the first DUI. Mary reminded the committee that the first DUI is usually closed as a single occurrence, but they can open the case if they choose. The concern is that some first DUI's have very high blood alcohol levels. Often, the blood alcohol level is not included in the report to the commission.
John will look to see if there are any statistics on first DUIs.

VIII. **Substance Abuse Referral Contracts (SARC) – Karl/Catherine**

This policy has the SARC template attached. Because of this, any changes to the SARC language must go to the Commission for approval.
The question is, can the attorney just make the change?
Gene agreed that changes to the language should just be done as needed. He asked if this needs to go to the Commission.
Karl suggested that if they want to remove the template that would need to go to the Commission.
The Committee asked that Karl to a mock-up of what it would look like if the just labeled the template as "for reference" or something to that effect and that he bring it back to the committee in September.

IX. **Work Plan – Gene**

Performance Measures – Quarterly
Newsletter – Due in October – In progress
Nurse Licensure Compact – On going
Investigator/Legal Reports – Done
CMT Statistics – Done
ER Program Review – September
RapBack – On going
CORE – On going
Communication Resolution Practices – Future
Determine effectiveness - Future

X. **Closing –** 4:30

Tracy will speak for the Discipline Sub-Committee at the September Business meeting in Gene's absence

DRAFT

Nursing Care Quality Assurance Commission (NCQAC)
Consistent Standards of Practice Sub-committee Minutes
September 6, 2016 12:00 PM to 1:00 PM

Committee Members: **Tiffany Randich, LPN, Chair**

Absent: Tracy Rude, LPN
Charlotte Foster, BSN, MHA, RN, Ad Hoc
Laura Dotlich (Yockey), RN, Pro Tem
Helen H Myrick, Public Member

Staff: Deborah Carlson, MSN, RN, Associate Director - Nursing Practice
Jean Wheat, Nursing Practice Administrative Assistant

DRAFT

I. 12:10 PM Opening – Tiffany Randich, Chair
- Call to order and roll call
- Introductions
- Announcements/Hot Topics - None

II. Review/approval of the August 2, 2016 Minutes
- Draft reviewed with consensus to send to the NCQAC Business Meeting in September for review and approval.

III. Old Business
- None.

IV. New Business
- Debbie Carlson went over the summary regarding Physical Therapy Board, Occupational Therapy Board, and Speech & Hearing Board-Scope of Practice of Physical, Occupational, and Speech Therapists-Medication Management in Home Care Settings. Agreed to bring back at the next meeting.
- Debbie Carlson went over the summary regarding Licensed Practical Nurses in Acute Care and Long-Term Care Settings. Agreed to bring back at the next meeting.

V. Closing
- Adjourned at 12:36 pm. Next meeting scheduled for October 4, 2016.

Nursing Care Quality Assurance Commission (NCQAC)
Consistent Standards of Practice Sub-committee Minutes
October 4, 2016 12:00 PM to 1:00 PM

Committee Members: **Tiffany Randich, LPN, Chair**
Tracy Rude, LPN

Absent: Charlotte Foster, BSN, MHA, RN, Ad Hoc
Laura Dotlich (Yockey), RN, Pro Tem
Helen H Myrick, Public Member

Staff: Deborah Carlson, MSN, RN, Associate Director - Nursing Practice
Jean Wheat, Nursing Practice Administrative Assistant

DRAFT

I. 12:00 PM Opening – Tiffany Randich, Chair

Call to order
- Introduction
- Public Disclosure Statement
- Roll Call

II. Standing Agenda Items
- Announcements/Hot Topics/Business Meeting Highlights – Nursing education rules approved
- Review of September 6, 2016 draft minutes – Draft approved

III. Old Business
- Physical Therapy Board, Occupational Therapy Board, and Speech & Hearing Board-Scope of Practice of Physical, Occupational, and Speech Therapists-Medication Management in Home Care Settings – Discussed issue of physical therapists, occupational therapists and speech and hearing therapists filling medication organizers and other medication management activities. No further action recommended.
- Licensed Practical Nurses in Acute Care and Long-Term Care Settings – Debbie Carlson will convene two separate workgroups to work on LPN issues in acute care and long-term care settings including the possibility of developing an advisory opinion

IV. New Business
- Advisory Opinion Draft for Dispensing Medications – Reviewed with a consensus to send draft document to the next Nursing Care Quality Assurance Commission meeting November 18, 2016 for consideration.

V. Ending Items

- Open microphone (as time permits): No comments from the public
- Review of actions
- Date of next meeting – November 1, 2016
- Adjourned at 12:31 PM.

Host: Association of Occupational health Professionals (AOHP)
National Conference
September 6-9, 2016
Myrtle Beach, South Carolina

Submitted by: Dr. John Furman

PURPOSE:

The Association of Occupational Health Professionals in Healthcare (AOHP) is a national association with nearly 1,000 members who serve as leaders in championing the vital role of occupational health professionals in healthcare today. Through active involvement at local, state and national levels, AOHP has become the defining authority and leading advocate for occupational health and safety in healthcare, representing tens of thousands of healthcare workers throughout the nation. AOHP promotes the health, safety and well-being of healthcare workers through: advocacy; occupational health education and networking opportunities; health and safety advancement through best practice and research; and partnering with other invested stakeholders.

As a keynote speaker I presented to over 600 attendees from across the nation and around the world on Substance Use Disorder among Health Professionals, a summary is as follows:

The presentation will discuss: 1) substance use disorders (SUD) as medical conditions driven by biological traits and change over time. SUD is presented as a chronic illness with remissions and exacerbations akin to diabetes, heart disease and asthma. Addressing SUD as a medical condition removes stigma. An individual with SUD has a natural, predictable disease course that is responsive to treatment, allowing for recovery; 2) substance abuse rates across specialties and risk factors unique to health professionals, focusing on medication access, attitudes toward drugs and drug use, work stress and role strain, and lack of education about SUD. Common signs of substance abuse and impairment will be presented, along with the importance of clear drug use policies and procedures; 3) common regulatory requirements for reporting unprofessional conduct to the licensing authority and the investigative /disciplinary process. This includes entry into monitoring through the voluntary and in lieu of discipline routes; and 4) regulatory monitoring program models and monitoring program requirements, including an overview of the National Council of State Boards of Nursing Substance Use Disorder Monitoring Program Guidelines.

Additional Activities:

In addition to providing a keynote presentation I attended many educational sessions including, but not limited to:

- <u>Workplace Violence Prevention Training Programs in Healthcare</u> – To assist healthcare facilities to obtain a comprehensive workplace violence training program.

- Promoting Positive Events in Nursing: Models and Evidence – Findings from an ongoing research program investigating positive experiences in nursing.
- Essential Function Testing: Retention and Health Status – Testing to ensure safe job placement and reduced injury for healthcare professionals.
- The Occupational Health Nurse and Employee Assistance Programs – The benefits of having EAP counselors integrated with occupational health services.
- Driving Employee Health and Safety through Big Data Analytics – with the advancement of electronic medical records systems and technology, the occupational health professional is in a key position to stimulate change through the use of data analytics.

RECOMMENDATION:

The Annual AOHP conference is the preeminent educational meeting for healthcare organizations in the areas of patient and employee safety.   The Annual AOHP Conference assists in promoting safety through currency with pertinent changes in the field of occupational and environmental health in healthcare. Alternative to Discipline Monitoring Programs are an integral component of an overall safety structure within and among organizational and regulatory models. I recommend that WHPS continue to associate with AOHP and participate in its activities.

Respectfully,

John Furman PhD, MSN, COHN-S

TITLE OF EVENT:

National Certified Investigator & Inspector Training (NCIT) Basic,
A CLEAR* Learning Program

*(CLEAR stands for: Council of Licensure, Enforcement, & Regulation)

DATE(S):

September 12 – 14, 2016 (Mon-Wed)

LOCATION:

Portland Marriott, Portland, Oregon

PARTICIPANTS:

- GENERAL: Investigators from across the nation
- FROM NCQAC: Kathy Moisio

PURPOSE: The purpose of this training was to provide a basic foundation of investigative knowledge and understanding for attendees in order to qualify for national certification. The topics were comprehensive in nature and addressed the following areas:

- Professional conduct
- Principles of Administrative Law
- Investigative Process
- Investigator Safety
- Principles of Evidence
- Evidence Collection, Tagging, and Storage
- Interviewing Techniques
- Overview of Inspections
- Report Writing
- Testifying in Administrative and Criminal Proceedings

OUTCOME: The class format was interactive and included discussion and role-play (regarding interviews, for example) as formative evaluation measures. The summative evaluation for the class consisted of a certification examination at the end of the 3-days. The NCQAC attendee passed the certification exam and has submitted the application for certification. The most important outcome, however, is the application of learning to investigations undertaken within the NCQAC's Education Unit. The learning from this class was directly applicable to this work.

RECOMMENDATION: This training is recommended for anyone taking on an investigator role. It dovetails nicely with and reinforces the concepts of the Investigator Training provided by the state (CORE and Advanced) and provides national certification, which can add support to the legitimacy of the investigators' work through the provision of a formal credential. One note: Because this is a national training, it provides a broad focus and the attendee must consider Washington's specific laws and rules in relation to what is learned.

CLEAR Conference
September 14 – 17, 2016
Portland, OR

John Furman

PURPOSE: Participants from across North America and around the world attend as members of the regulatory community. Conference content focuses on four areas of inquiry: compliance and discipline; testing and examination issues; entry to practice issues; and administration, legislation and policy. Best practices, expertise and research on the pressing issues for the regulatory community were presented.

OUTCOME: Highlighted sessions attended include:

- Regulatory Models from Around the World: Explore the core functions of regulation and discuss the differences among the models.
- Public Awareness: In an age of communication overload, regulators must find new ways to engage and inform the public about who we are and what we do.
- Managing Risk: Explore how various risk management principles apply to the regulatory organization.
- Legal Defensibility: Review of areas where legal risk may exist with an eye toward standard setting methodologies.
- Orders and Costs: Today's regulatory environment and the expectation for transparency create a challenge for discipline committees.

RECOMMENDATION: The conference provided a high level understanding of the issues involved in professional and occupational regulation. The conference content was geared mostly to licensure (testing) and discipline issues (administrative actions and outcomes) relevant to board members, agency administrators, and enforcement staff. I thought that it was a worthwhile opportunity for board (commission) members and executive staff to network and learn about new trends/approaches regulatory issues; However did not include content directly related to Alternative to Discipline Substance Abuse Monitoring Programs and would not recommend WHPS staff attendance unless monitoring and alternative approaches was a conference theme.

Citizen Advocacy Center 2016 Annual Meeting
September 17 & 18, 2016
Portland Marriott Downtown Waterfront
Mindy Schaffner, Associate Director Education, Licensing & Research
Renee Ruiz, Public Member

PURPOSE: The main focus of this annual meeting was to bring stakeholders together to identify and discuss ways in which the health professional regulatory system can facilitate the use of telehealth technology and maximize the benefits to the public, consistent with safe, quality, affordable care.

OUTCOME: This was an excellent conferences and addressed the telepsychology and ethical practices related to telehealth; modernizing the regulatory framework for telehealth; transforming health care with connected health technology; and Telehealth Policy Trends and Consideration. Various professional groups, including NCSBN (David Benton) presented information on the various models for licensure compacts. The NCSBN model is the largest compact and has been in existence for some time. Karen a. Goldman, Attorney Advisor for the Federal Trade Commission (FTC) presented information on the role of the FTC and the benefits of competition across state lines. She reviewed a recent (September 9, 2016) court decision titled "Brief of the US and the FTC as Amici Curiae Supporting Teledoc Court of Appeals for the 5th Circuit Court."

RECOMMENDATIONS: NCQAC should continue its work on the National Nurse Licensure Compact (NLC). It was reported that nationally 50% of nurses identified telehealth work in other states. Washington nurses would benefit from NCQAC becoming part of the NLC.

Federation of Associations of Regulatory Boards (FARB)
2016 Regulatory Law Seminar
September 29 – October 2, Chicago, IL
Tim Talkington and Sarah Bendersky

PURPOSE:

The FARB Regulatory Law Seminar (RLS) brings together attorneys from around the United States to consider and discuss important issues affecting regulatory boards. The setting allows for attorneys to compare and contrast practice experiences and strategies in this unique area of the law.

OUTCOME:

The program opened with a very informative presentation concerning the ethical challenges attorneys who work in the administrative/regulatory field commonly encounter. The presenters employed a back-and-forth style, solicited anecdotes, and engaged the audience in a wide-ranging discussion identifying pitfalls for the unwary attorney.

A common thread running through a majority of the presentations was the continuing interpretations flowing out of the United States Supreme Court antitrust decision in *North Carolina Board of Dental Examiners v. FTC.* The Court's decision continues to ripple throughout the regulatory community. One of the keynote discussions on this topic was presented by Wisconsin Solicitor General Misha Tseytlin and entitled "Regulatory State of the Union." It was a real treat to have Mr. Tseytlin deliver this talk because he actually participated on the litigation team, so he was able to offer personal insights into the strategy of the case and fallout from the decision.

We filtered the discussions regarding the *North Carolina Board of Dental Examiners v. FTC* case through the lens of our Washington state experience, and identified a few potential areas of concern for NCQAC; however, NCQAC's status relative to the Department of Health (DOH) "umbrella," as well as the DOH Secretary's jurisdiction over unlicensed cases, allayed many of the concerns identified by attorneys from other states whose boards operate under a different structure.

There were several presentations notable for their applicability to issues we face in Washington. One involved a discussion of for-profit schools and the challenges this business model presents to the regulatory community. A key development has been the recent actions by the U.S. Department of Education related to accreditation and student loan funding. Another presentation focused on the coordination of administrative and criminal investigations when they occur simultaneously—information sharing, scheduling, confidentiality, and constitutional considerations. A surprisingly interesting presentation involved a discussion of electronic signatures and how they can be used to accelerate certain processes. And there was also a robust

primer on licensure compacts and how compacts can be good for the professions as well as the public, while retaining for state regulatory boards the traditional safeguards necessary to protect the public.

The 2016 FARB RLS benefited your legal staff in many ways: (1) We networked and learned from other attorneys who have similar experiences in their states; (2) The FARB RLS was presented by attorneys, for attorneys, and specifically identified important industry-wide legal issues; (3) The setting encouraged your staff to focus and brainstorm ways to improve the legal services we provide to the NCQAC.

RECOMMENDATION:

The FARB RLS presented high-caliber speakers discussing important regulatory topics. It was a very valuable experience and we highly recommend sending legal staff to attend future FARB conferences.

Regulation 2030

October 2-3, 2016

Chicago, IL

Paula R. Meyer MSN, RN, FRE

PURPOSE: National Council of State Boards of Nursing (NCSBN) hosted the Regulation 2030 event. Participants included representatives from boards of nursing around the world, American Nurses Association, Federation of State Medical Boards, Federation of State Physical Therapy Boards, and the World Health Organization/Organization of Economic Cooperation and Development (OECD). The group was charged with visioning nursing regulatory changes needed to meet a global workforce.

OUTCOME: Seven categories and twenty-five trends were evaluated using small groups. The categories included: Governance, Purpose and Processes, Licensees/Registrants, Workforce, Education, Fitness for Practice, and Technology and Information. Each small group produced a map of desired outcomes for 2030, related requirements, and relationships among requirements and deliverables. Themes for these included:

Governance	Character of the board	Nature of regulator	Accountability	Appointment process
Education	Adult learning and blended simulation	Continued competence	Accreditation of institutions	Global calibration of curriculum content
Board Purpose and Processes	Decision making	Organizational drive	Evidence based regulation	System and coordination of participants to protect the public
Licensees/Registrants	Multigenerational workforce	Workforce and education planning		
Fitness for Practice	Criminal background checks	Complaints: investigations, non-judgmental, and decision making	Entry to practice	Risk based sanctions

Technology and Information	Data production and storage	Data access	Relicensure and access by smartphone devices	

RECOMMENDATION: Once the maps are completed and distributed, use them for the 2017-2019 NCQAC strategic plan to formulate next steps and areas for coordination. Use the directions in meetings with Department of Health related to Operating Agreement and service level agreements.

Host: IntNSA
Annual Education Conference
October 5-8th 2016
Las Vegas NV

Submitted by: Melissa Fraser

PURPOSE:

The International Nurses Society on Addictions (IntNSA) is a professional specialty organization founded in 1975 for nurses committed to the prevention, intervention, treatment, and management of addictive disorders including alcohol and other drug dependencies, nicotine dependencies, eating disorders, dual and multiple diagnosis, and process addictions such as gambling.

This conference focuses on the requisite knowledge, skills and abilities for any nurse who cares for persons with substance use, abuse and addictions. Providing patient centered care through prevention, screening, treatment and recovery services is best brought about when interdisciplinary teams work together to accomplish effective and successful patient care outcomes. Interdisciplinary collaboration utilizes the Institute Of Medicine's core competencies of evidence-based practice, informatics, and quality assurance to promote positive lifestyle changes. Attendees will increase their skills and knowledge base for collaborative practice with healthcare colleagues to further patient centered care for those with substance use disorders.

The mission of IntNSA is to advance excellence in nursing care for the prevention and treatment of addictions for diverse populations across all practice settings through advocacy, collaboration, education, research, and policy development.

Learning objectives:

1. Advance knowledge of substance use disorder and its impact on health professionals, the healthcare industry and, public safety.

2. Provide practical and evidence based guidelines for evaluating, treating and managing healthcare professionals with substance use disorder.

3. Collaborate with healthcare based occupational health professionals and state monitoring programs regarding best practices and research needs.

OUTCOME:

Activities and presentations attended:

- Are we missing the boat on Chronic Pain? : Presented by Dr. Mel Pohl from the Las Vegas Recovery Center. He discussed the fundamentals of pain, addressing opioid use and substance abuse, and alternative therapies.

- Effect of Anxiety on Treatment & Relapse after Opiate Detox: Presented by Dr. Janet Hutchison. She discussed anxiety in relation to withdrawal and substance abuse. The medications that will help in the short term to support the early recovering persons and alternative therapies.
- Substance Use Disorder among Licensed Health Care Professionals: Presented by John Paul Moses RN. He presented on signs and symptoms to be aware of in the health care field that could signify abuse or diversion.
- Impact of Opioid Dependence Epidemic a global perspective; This was a panel presentation discussing opioid dependency and impact on different countries and treatment options provided by boards, regulatory agencies and providers.
- Substance Use among Nurses and Nursing Students: A Joint Position Statement: Presented by Stephen Strobbe PhD and Melanie Crowley. They discussed/compared the moral and criminal model with Bio-psycho-spiritual model of SUD treatment. Discussed side effects associated with injectable vs pill form. Also identified the different disciplines used with nurses and nursing students with SUD.
- Injectable Naltrexone: A Retrospective Study of its Acceptance and Efficacy in a Community Setting: Presented by Brianne Fitzgerald from the Gavin foundation. Discussed use of naltrexone as a tool in treatment for alcohol and opioids. She shared outcomes over a 2 yr period.
- Effect of CES on Anxiety Following Opiate & Alcohol Detox:Presented by Janet Hutchison. Discussed anxiety within SUD and early recovery. She shared her results in a study utilizing inpatient clients who used CES for 15 days while in a structured setting.
- The nurse's role in Alcohol screening and brief intervention among women of child bearing age: Presented by Ann Mitchell. Reviewed statistics of Fetal Alcohol Syndrome (FAS) and need for education on drinking while pregnant. Presented information on how to diagnose FAS and all the misleading information on the internet. Reviewed all current brief intervention tools.
- Weighing Risks and Benefits of Opioid Use for Individuals with Pain and Substance Use Disorders: Nursing Has a Plan: presented by Deborah Matteliano. She discussed the risks and benefits of opioids in regards to people with SUD, the problems associate with long term use, and the importance of appropriate screening when a patient is receiving opioids for chronic pain.
- Opioid use, misuse, and the impacts it has on a safety sensitive workplace: Presented by Eileen Maloney-White. She Discussed misuse of opioids I the workplace, how to work with other medical staff to have successful client outcomes and what to look for when predicting long term success.

RECOMMENDATION:

The Annual InsTNA conference is focused on addiction. It addresses all aspects related to substance use disorders that nurses have to deal with to include use within the profession. This year's conference was attended by 229 Health care practitioners.

The networking opportunities and forums available at InsTNA are invaluable and not available at any other conference or educational meeting. We highly recommend that the Nursing Commission has an annual presence at the conference.

2016 NCSBN Scientific Symposium
October 6, 2016
Swissotel, Chicago Illinois
Mindy Schaffner, Associate Director Education, Licensing & Research

PURPOSE: The NCSBN Symposium brings together researchers, policymakers, and stakeholders to present and discuss national and international research that increases the body of evidence for regulatory decision-making.

OUTCOME: I attended the following presentation:

1. The Jennifer K. Hayden Keynote Address: Framing the Message and Using Data to Inform Policy
2. Findings from the First National Nursing Education Research Network (NNERN) Survey
3. Impact of Preceptor-Facilitated Pre-Licensure Clinical Experiences Across the US
4. A Practical Framework for Measuring Higher-Order Cognitive Constructs: An Application to Measuring Nursing Clinical Judgement
5. The Development of Clinical Reasoning in Pre-Licensure and RN to BSN Nursing Students.
6. Exploring Relationships between Practicing Registered Nurses Pharmacology Knowledge and Medication Error Occurrence
7. NCSBN and the Forum of State Nursing Workforce Centers – 2015 National RN and LPN Sample Survey Review
8. Supply and Mobility of the Nurse Practitioner Workforce.

RECOMMENDATIONS:

1. NCQAC should reassess the messages conveyed on its website and determine if the messages clearly reflect the policy decision and policy information intended for public review. Messages are key to good policy-making. Dr. Budden presented a review of the NCSBN messages from the NCSBN website regarding the Nurse Licensure Compact and provided some very helpful communication messages that could be made. NCQAC would benefit from applying these same principles to our public-policy messaging.
2. NCQAC education and research staff should become involved with the National Nursing Education Research Network.
3. Data suggest that the use of preceptors in pre-licensure clinical experiences needs more research. As more and more distance-learning programs are developed, the use of preceptors becomes key to the successful education in clinical and practice experiences of nursing students. New nursing education rules put in place establish specific requirements for the student's precepted experiences. Faculty role in student learning by use of preceptors needs to be clearly defined and understood.
4. Faculty need to be provided with resources and educational opportunities to develop and implement teaching strategies to increase higher-order cognition and clinical reasoning skills.
5. Data suggests that there is a difference in clinical reasoning skills between pre-licensure and RN to BSN nursing students at the end of their educational preparation. More

research in this area needs to be done as more and more ADN/Diploma nurses are pursing BSN education. The question remains: Does a RN to BSN nursing program students show similar results in clinical reasoning skills as the nurse prepared at the pre-licensure BSN level? Data on the characteristics of the nursing programs and students was not presented. The researchers plan to do more analysis of this data.

6. More research is needed on medication errors, the nurse's pharmacology knowledge, and level of nursing education.
7. NCQAC needs to continue its work on the MDS data collection. We are one of few states that do not collect this data. Lack of this data negatively impacts NCQAC and other stakeholders to make sound policy decisions.
8. The nurse practitioner workforce is increasing across the US. However, there is still great variation on level of authority and practice in individual states. This also impacts how NPs are educated in various states.

TITLE: 2016 NCSBN Scientific Symposium

October 6, 2016

Chicago, Il

Lois E. Hoell, Participant

PURPOSE:

To hear from researchers, policy-makers and stakeholders as they present and discuss national and international research that increases the body of evidence for regulatory decision-making.

OUTCOMES:

The keynote speaker challenged the participants to be more actively involved in terms of support for national policy and research for nursing. She urged NCSBN to review their website and develop more active language.

The presentations on regulation provided new information on substance use disorder in terms of compliance and recovery. The program and many ideas were in line with the WHPS program. A presentation on gender differences and discipline by Boards of Nursing was particularly interesting. The study was focused on the concept of bias and discrimination of males in nursing. In short, the study found no evidence of bias or discrimination in discipline of males versus females. The take-away is the development of sanction standards and fair and equal application is a positive strategy to avoid bias or discrimination. The presentation on criminal convictions in nursing was a complementary program to the gender study.

Exposure to the research provides a valuable addition to the work of the commission as we evaluate our processes.

RECOMMENDATIONS:

I recommend that NCQAC continue to support member attendance at this event as it provides access to the most recent research and resources.

Thank you for the opportunity to attend.

Host: National Association of Drug Diversion Investigators (NADDI)
27th Annual Educational Training Conference
October 10-14, 2016
Louisville, Kentucky

Submitted by: Dana Malone, NCQAC Investigator

PURPOSE:

The National Association of Drug Diversion Investigators, or NADDI, is a non-profit membership organization that works to develop and implement solutions to the problem of prescription drug diversion. NADDI advocates for the responsible use of prescription drugs by people who need them, and at the same time, works with law enforcement and state regulatory agencies to pursue those involved in related criminal activity.

NADDI's primary focus is training and education for our members, which include law enforcement personnel, regulatory agents, health professionals, health care fraud investigators, advocacy and treatment professionals and the pharmaceutical industry.

Learning objectives:

- Participants will recognize the basics of pharmaceutical diversion, the "who's, what's, why's and how's of the investigatory process.
- Participants will develop a network of subject matter experts.
- Participants will obtain knowledge of available of drug diversion identification and prevention resources.
- Participants will describe current drugs of abuse and the testing methods for particular drugs.
- Participants will network and exchange information with colleagues from other Healthcare Regulatory Boards and Commissions throughout the country.

OUTCOME:

Activities and presentations attended:

32 Hours of conference presentations in the following areas by subject matter experts and national speakers:

- Prescription Drug Abuse and Addiction Trending in Our Communities Towards Heroin, by Lisa McElhaney, NADDI President.
- Current Pharmaceutical Drugs-Abuse Trends, by Marc Gonzalez, PharmD.
- Doctor Shoppers & Forged Prescriptions, by Dan Zsido, Pinellas County Sheriff's Office, Florida.
- Collaborative For Effective Prescription Opioid Problems, by The Honorable Mary Bono, member of Congress 1998-2013, and Principal of FaegreBD Consulting.

- Kentucky’s Prescription Drug Problems, by Kentucky State Representative Addia Wuchner and Van Ingram, Executive Director, Kentucky Office of Drug Control Policy.
- Comprehensive Addiction and Recovery Act (CADCA), Building Drug-Free Communities, by General Arthur T. Dean, U.S. Army, Retired, and former instructor at the U.S. Army War College.
- PHARMA’s Collaboration in a 360 Strategy City, by Kevin Webb, Director of Advocacy Relations, Mallinckrodt Pharmaceuticals.
- St. Louis, a 360 Strategy City, by Natalie Newville, Public Information Officer, ACT Missouri.
- A Distributor’s Role in Supply Chain Security, by Bruce Gundy, Director of Investigations, for AmerisourceBergen, and Dave May, Senior Director of Diversion Control and Federal Investigations for AmerisourceBergen.
- SAFE CALL NOW-ABUSE AND ADDICTION, a 24-Hour Crisis Referral Service for all Public Safety Employees, by Sean Riley, President.
- Advance Analytics-Identifying Inpatient Hospital Drug Diversion, Medical Identity Fraud, and Drug-Seeking Behavior, by various Kaiser Permanente officers.
- Drug Diversion in Hospitals-Not if But When, by Gregory S. Burger Vice President of Hospital and Systems, and Maureen Burger, RN, Chief Nursing Officer, Visante
- Health Information Solutions AWARxE/NARxCHECK by Jim Huizings, Chief Clinical Officer, Appriss
- Drug Diversion Identified, Using Behavioral Analytics to Identify Diverters and System Weakness, by Cherie Mitchell, President, HelioMetrics
- A Million Little Pieces, Drug Diversion Prevention Program, by Allison Kreft, Medical Center Protection Officer, Hennepin County Medical Center, Minneapolis, MN
- D.A.R.E. America-“Teaching students good decision-making skills to help them lead safe and healthy lives”, by Francisco Pegueros, President and CEO of D.A.R.E.
- Investigating and Prosecuting Rx Crimes, by Julie Hogan, Deputy Statewide Prosecutor, Florida.
- Pharmacy Fraud Program, Diversion of Controlled Substances, by Claire Wrisley, United HealthCare.
- Pharmacy Robberies and Burglaries-A Trending Towards Violence-The NADDI Bottle Tracing Program, by Charlie Cichon, NADDI Executive Director.
- Naloxone Overview and the Challenges in Implementing in Community Pharmacy, by Patty Daugherty, PHARMD.
- Overdose Prevention Strategies, by Lisa McElhaney, NADDI President.
- Working Diversion Cases in Your Community, by Jay Frederick, Columbus, Indiana Police Department
- The Hospital Diversion Investigator, Lorri Hall, Mayo Hospital, Florida

- Abuse Deterrent medicines-a Law Enforcement perspective, by Charlie Cichon, NADDI Executive director.

The Nursing Commission attendee actively participated in all of the above mentioned classes and presentations. Additional knowledge of the current prescription drug abuse epidemic was gained. Participants learned of new ways and methods of preventing, detecting and investigating current trends in drug diversion and substance abuse. Several case studies of 'pill mill clinics" investigations were presented.

The conference also provided attendees insight into the disease of addiction by providing personal presentations of diversion, addiction and recovery by investigators, health professionals, and family survivors of drug overdose and addiction victims.

In addition to attending the above mentioned lectures, the conference provided networking opportunities for attendees to connect with colleagues and resources within the Discipline/Investigations/ and Monitoring Program units and colleagues throughout the nation.

RECOMMENDATION:

I recommend that the Nursing Commission and Quality Assurance Commission continue supporting both WHPS and Discipline by sending representatives to both regional and national NADDI conferences. The next Pacific Northwest (PNW) Chapter Training Session is scheduled for May 7, 2017, in Portland, OR. NADDI also offers a basic Drug Diversion Investigations course at various locations throughout the year.

Washington State
Nursing Care Quality Assurance Commission
NPAP REPORT

Date: August 1, 2016 to September 30, 2016

Actions	Number	Total YTD	Instate Approved Programs	Out of State Approved Programs
Letter of Determination:			8 LPN Programs 27 ADN Programs 11 BSN Programs 18 RNB Programs 42 Post BSN Programs 8 Refresher Programs	16 RNB Programs 338 Other Programs
Intent to Withdraw Approval	1	1		
Conditional Approval		3		
Deny Approval		3		
Letter of Decision:				
Approval - Programs	14	74		
Approval – Sub Change	2	10		
Plan of Correction (POC) Required	**1**	9		
Acceptance of Submitted Documents or POC	13	43		
Additional Documents or Actions Required	25	89		
Deferred Action	12	41		
Removal of Conditional Approval		3		
Complaints:				
Open		2		
Closed		2		
Complaint Investigation Reviewed:				
Action Required		2		
No Action Required		1		
Licensing Exemption Request:				
Exemption Request Approved		2		
Exemption Request Denied		2		

Other:

- Reviewed NPAP Procedure
  Reviewed Reporting Document

Washington State
Nursing Care Quality Assurance Commission
NAPAP REPORT
Date: 8/2/16 to 9/30/16

Actions	Number	Total YTD	Approved Programs
Letter of Determination:			14 Healthcare Assistants 9 Medical Assistants 4 Medication Assistant Endorsement 169 Traditional Programs
Intent to Withdraw Approval		9	
Conditional Approval		16	
Deny Approval	1	4	
Letter of Decision:			
Approval - Programs	2	11	
Approval – Substantive Change		9	
Plan of Correction (POC) Required		80	
Approval / Denial of Instructor	3	5	Approved
Acceptance of Submitted Documents or POC	2	13	
Additional Documents or Actions Required	4	17	
Deferred Action		4	
Removal of Conditional Approval		3	
Complaints:			
Open	2	4	
Closed		4	
Complaint Investigation Reviewed:			
Action Required		3	
No Action Required		2	

Other:

- **Status of Nursing Assistant Rules**
- **Panel Procedure**

JAY INSLEE
Governor

STATE OF WASHINGTON
OFFICE OF THE GOVERNOR
P.O. Box 40002 • Olympia, Washington 98504-0002 • (360) 902-4111 • www.governor.wa.gov

EXECUTIVE ORDER 16-09

Addressing the Opioid Use Public Health Crisis

WHEREAS, in 2015, each day an average of two Washingtonians died from opioid overdose, and heroin overdose deaths have more than doubled between 2010 and 2015;

WHEREAS, the opioid epidemic continues to affect communities, devastate families, and overwhelm law enforcement, health care, and social service providers;

WHEREAS, medically prescribed opioids intended to treat chronic pain have contributed to the epidemic, and though a first-in-the-nation set of Washington state guidelines for use of opioids to treat chronic pain has helped reduce the amount of opioids prescribed, more must be done to effectively implement these guidelines and offer effective treatment options for patients with chronic pain;

WHEREAS, opioid use disorder is a devastating and life-threatening chronic medical condition, and we need to improve access to treatments that support recovery and lifesaving medications to reverse overdoses;

WHEREAS, as individuals, communities, and governments, we must assist people struggling with opioid use disorder and reduce its associated stigma, using evidence-based interventions like our innovative syringe exchange program;

WHEREAS, we have developed a Statewide Opioid Response Plan that is highly consistent with the recent Center for Disease Control (CDC) Guidelines for Prescribing Opioids for Chronic Pain, the Surgeon General's call to end the opioid crisis, and a compact relating to opioid use that governors around the nation have signed; and

WHEREAS, it is imperative that we act in a comprehensive manner to address this public health crisis.

NOW THEREFORE, I, Jay Inslee, Governor of the state of Washington, direct that state agencies under my authority work with local public health, Tribal governments, and other partners across the state, to implement the state opioid response plan with an immediate focus on the following highest priority actions. These agencies must submit a progress report by December 31, 2016, in advance of next legislative session. The Office of Financial Management, which is leading and coordinating comprehensive behavioral health planning, shall evaluate, in the course of its work, the potential budget-related matters raised in this order.

Goal 1: Prevent inappropriate opioid prescribing and reduce opioid misuse and abuse.

1. The state Agency Medical Directors Group (AMDG) shall work with the Bree Collaborative (a health care improvement partnership), Tribal governments, boards and

commissions, professional associations, health care systems, insurers, teaching institutions, and others to consider amendments to the state pain guidelines and other training and policy materials, consistent with the 2015 AMDG and the 2016 CDC opioid guidelines, to reduce unnecessary prescribing for acute pain conditions for the general population, especially adolescents.

2. The Department of Health (DOH) and Department of Social and Health Services (DSHS), in partnership with my office and other agencies, including the Office of the Superintendent of Public Instruction, schools, and public and private partners, shall develop a communications strategy geared toward preventing opioid misuse in communities, particularly among youth, to raise awareness about the risks of opioid use and focus on reducing the stigma of opioid use disorder. This communication strategy shall promote safe home storage and appropriate prescription pain medication disposal to prevent misuse. Agencies shall also work with partners to consider and present options on how to best prevent misuse, including potential solutions like drug take-back programs.

3. The Health Care Authority (HCA) and Department of Labor and Industries (LNI), in collaboration with the Bree Collaborative, shall explore innovative methods and tools to deliver evidence-based alternatives and other promising practices, such as physical, occupational and cognitive behavioral therapy, to reduce overreliance on opioids while improving access to care and health outcomes with regard to the treatment of pain. HCA shall work with the University of Washington (UW) and other providers to utilize and make tele-mentoring prescriber education programs, such as UW TelePain, a fiscally sustainable telehealth service. These agencies will also establish support programs for providers, like an opioid prescribing consultation hotline.

4. To reduce the supply of illegal opioids, I have requested, and the Attorney General has agreed to partner with the Washington State Patrol and Washington Association of Prosecuting Attorneys, to convene local, state, and federal law enforcement agencies and community partners to develop and recommend strategies.

Goal 2: Treat individuals with opioid use disorder and link them to support services, including housing.

1. My office and HCA will work with health plans to support and implement behavioral health integration strategies in primary care, to include effective screening for opioid use disorder and increased management of medication-assisted and other needed treatments, like recovery support services. These strategies shall be implemented in a culturally appropriate and accessible manner, especially among historically marginalized communities such as American Indian and Alaska Native populations.

2. State agencies shall work with partner agencies and the health care community to expand availability of evidence-based medication-assisted treatment to:

    a. Identify policy gaps and barriers, in communities and the criminal justice system, that limit availability and utilization of medication-assisted treatment, including naloxone for overdose reversal.

b. Consider the spoke and hub, nurse care manager, and similar center of excellence models that closely align with Behavioral Health Organizations and Accountable Communities of Health systems so that regional differences can be addressed and treatments may be delivered on a regional and population basis.

c. Ensure availability of rapid, low-barrier access to treatment medications for people with opioid use disorder, especially pregnant women, intravenous drug users, and those who are homeless.

d. Work with the UW Alcohol and Drug Abuse Institute (UW/ADAI) to pilot and evaluate low barrier models that provide rapid access to and stabilization on buprenorphine.

e. Explore new and existing funding sources to increase capacity in syringe service and other evidence-based programs.

3. The Department of Corrections, in collaboration with DSHS and HCA, shall improve processes to identify offenders with opioid use disorder and develop evidence-based interventions to ensure offenders will receive timely and effective treatment in the community upon release, concentrating immediately in regions that have achieved behavioral health and physical health integration.

4. At my request, the Insurance Commissioner has agreed to work with state health care purchasing agencies, private insurers, and providers, to determine if access issues exist and explore and recommend solutions on how insurance payment mechanisms, formularies, and other administrative processes can ensure appropriate availability of medication-assisted services and evidence-based services for treatment of pain and overdoses. State health care purchasers shall assess whether current payment and coverage decisions support these treatments consistent with evidence-based practices and implement, as soon as feasible, value-based purchasing methods to improve results.

Goal 3: Intervene in opioid overdoses to prevent death.

1. DSHS and DOH will work with the UW/ADAI and other partners, including local public health officials, to educate heroin and/or prescription opioid users and those who may witness an overdose, on how to recognize and respond to an overdose. State and local data systems will be enhanced to document opioid overdose occurrence and response.

2. State agency health care purchasers shall ensure that covered individuals with opioid use disorder receive overdose education and access to naloxone.

3. Agency Medical Directors shall work with partners, including the CDC, to consider a centralized naloxone procurement process in order to reduce the cost of naloxone and increase its availability for first responders and families and friends of heroin users. Agency Medical Directors shall report recommended solutions when practicable.

Goal 4: Use data and information to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions.

1. DOH, the Agency Medical Directors Group, the Bree Collaborative, and UW shall collaborate with providers and other partners to develop statewide measures to monitor

prescribing practices and access to high quality and necessary pain care, focusing on metrics with a statewide and regional view. Using these measures, DOH will identify regional variations in prescribing practices and encourage health systems and insurers to use these measures to identify and intervene with health care providers who engage in unsafe prescribing practices.

2. State agency health care purchasers, with assistance from DOH, shall identify persons at high risk for prescription opioid overdose and intervene when appropriate with outreach efforts to provide necessary medical care, including treatment of pain and/or opioid use disorder.

3. DOH shall collaborate with partners to explore policies and processes to enhance functionality and increase the use of the Prescription Drug Monitoring Program among health care providers.

4. DOH will work with HCA and LNI to explore methods to notify health care providers of opioid overdose events. These methods should include how the Emergency Department Information Exchange electronic health information system used by hospitals might use prescription drug monitoring program data to identify health care providers who recently prescribed opioids to an overdose victim and notify them of that overdose event.

This Executive Order shall take effect immediately.

Signed and sealed with the official seal of the state of Washington, on this 7th day of October 2016, at Olympia, Washington.

By:

/s/
____
Jay Inslee
Governor

BY THE GOVERNOR:

/s/
____
Secretary of State

NURSING BUDGET STATUS REPORT – AUGUST 2016

EXPENDITURES:

This report covers the fourteen month period of July 1, 2015 through August 31, 2016 with ten months remaining in the biennium. The Nursing Commission budget is underspent by 12%. We committed to underspend during this biennium while we completed a fee study.

All categories within our direct budget are underspent. The Attorney General's services continue to be significantly underspent, which is a trend that has continued over the past few years. This expenditure has generated the majority of our underspending, along with some staff savings. There has been an Investigator position vacant for quite some time that is being filled due to increased workload, along with another temporary investigator position being filled for a year in anticipation of possible upcoming retirements.

The FBI Background Check unit continues to be overspent, due to an audit that changed the way their work is handled. The Public Disclosure unit is slightly overspent and we are uncertain if this will continue. Overall, the total Service Unit budget is substantially underspent, which has helped keep our revenue balance/reserve intact as we move forward with the fee adjustments.

Starting on July 1, 2016, the new indirect rate for FY17 is being charged. It is 15.4% for the agency (a 0.8% increase from FY 16) and 11.5% for HSQA (a 0.5% decrease from FY16) for a net overall increase of 0.3% over FY16. This will not have a significant impact on our reserve balance.

REVENUES:

The Nursing Commission continues to have a revenue balance of $2.8 million, otherwise known as a reserve. Due to the anticipated high volumes of revenue the past few months and lower direct and indirect expenditures, we have not dipped into our reserves as much as we had anticipated. Based on past trends, we do expect our revenue collections to decline this fall. The Commission's overall budget is very healthy, and I do not anticipate any upcoming issues.

The Nursing Commission has begun the rules process to adjust fees accordingly. The fee rule hearing is currently scheduled for November 30, 2016. We anticipate the fee adjustments to be in place no later than July 1, 2017. With the upcoming fee adjustments, the Commission's budget should remain in good shape for quite some time.

NURSING BUDGET STATUS REPORT

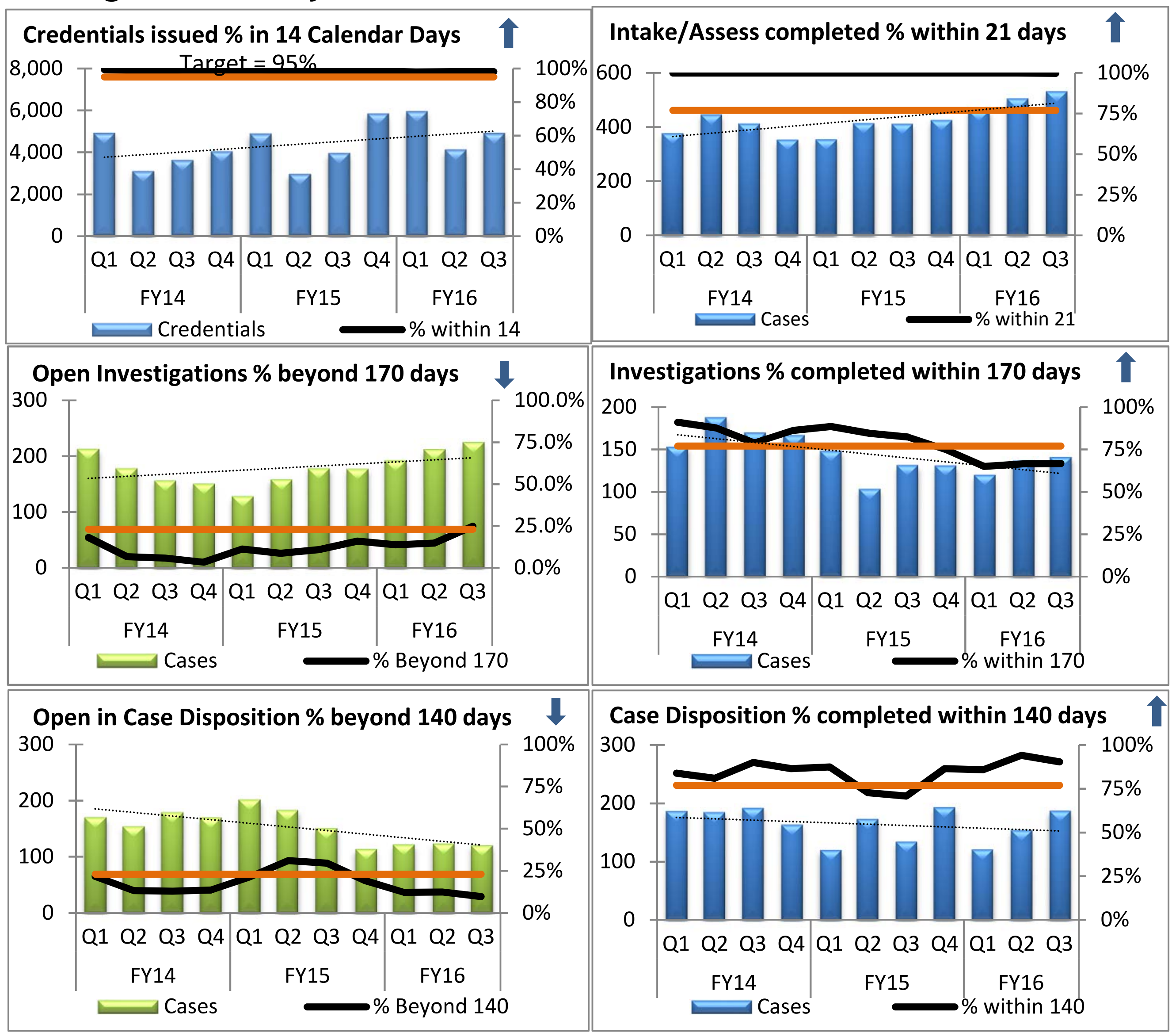
As of August 31, 2016 (14 months)

EXPENDITURES TYPES	BUDGET/ALLOTMENT TO-DATE	EXPENDITURES TO-DATE	VARIANCE TO-DATE	% SPENT TO-DATE
DIRECT EXPENDITURES:				
FTEs	57.53	54.02	3.51	93.90%
Staff Salaries & Benefits	$5,644,644	$5,420,255	$224,389	96.02%
Commission Salaries	$277,084	$231,812	$45,272	83.66%
Goods & Services	$562,290	$451,118	$111,172	80.23%
Rent	$350,868	$329,489	$21,379	93.91%
Attorney General (AG)	$889,098	$552,954	$336,144	62.19%
Travel	$235,736	$195,715	$40,021	83.02%
Equipment	$36,339	$36,178	$161	99.56%
IT Support & Software Licenses	$118,510	$91,938	$26,572	77.58%
TOTAL DIRECT	**$8,114,569**	**$7,309,459**	**$805,110**	90.08%
SERVICE UNITS:				
FBI Background Checks	$266,994	$289,239	($22,245)	108.33%
Office of Professional Standards	$254,947	$207,761	$47,186	81.49%
Adjudication Clerk	$137,621	$135,464	$2,157	98.43%
HP Investigations	$52,375	$23,091	$29,284	44.09%
Legal Services	$24,866	$15,816	$9,050	63.60%
Tort Claims	$706	$706	$0	100.00%
Call Center	$81,849	$78,928	$2,921	96.43%
Public Disclosure	$127,191	$137,910	($10,719)	108.43%
Revenue Reconciliation	$117,929	$91,082	$26,847	77.23%
Online Healthcare Provider Lic	$413,529	$235,393	$178,136	56.92%
Suicide Assessment Study	$28,297	$25,558	$2,739	90.32%
TOTAL SERVICE UNITS	**$1,506,304**	**$1,240,948**	**$265,356**	82.38%
INDIRECT CHARGES:				
Agency Indirects (15.4%)	$1,463,523	$1,193,289	$270,234	81.54%
HSQA Division Indirects (11.5%)	$1,072,407	$897,069	$175,338	83.65%
TOTAL INDIRECTS (26.9%)	**$2,535,930**	**$2,090,358**	**$445,572**	82.43%
GRAND TOTAL	**$12,156,803**	**$10,640,765**	**$1,516,038**	87.53%

NURSING REVENUE

BEGINNING REVENUE BALANCE	$2,971,006
15-17 REVENUE TO-DATE	$10,508,364
15-17 EXPENDITURES TO-DATE	$10,640,765
ENDING REVENUE BALANCE	**$2,838,605**

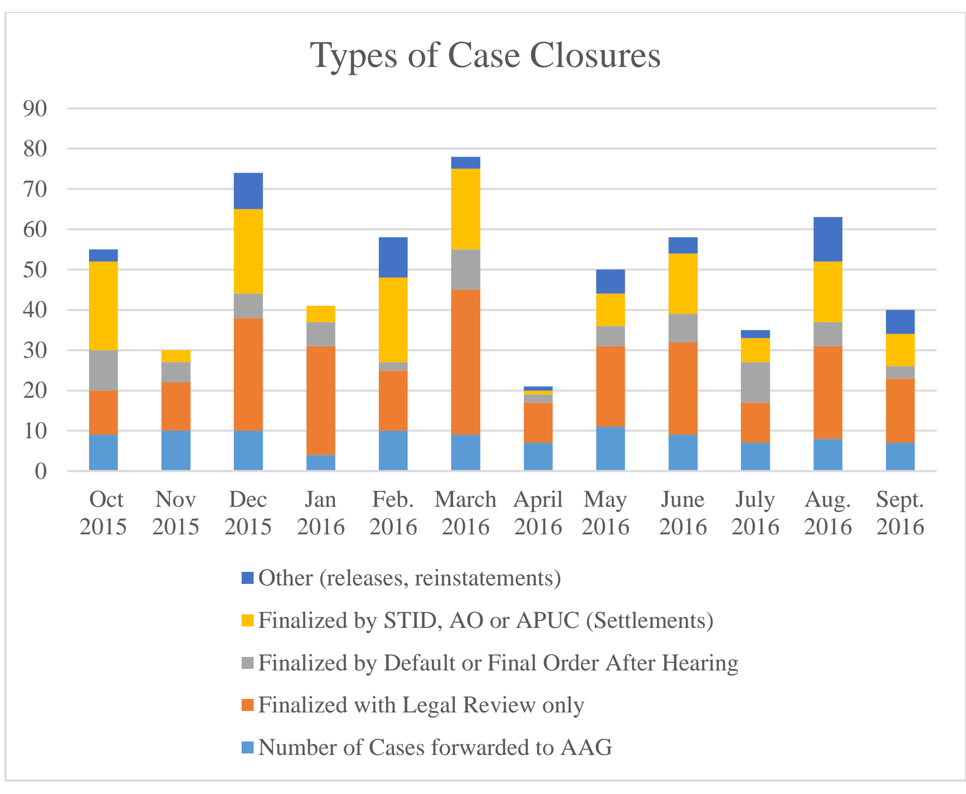
Nursing Care Quality Assurance Commission

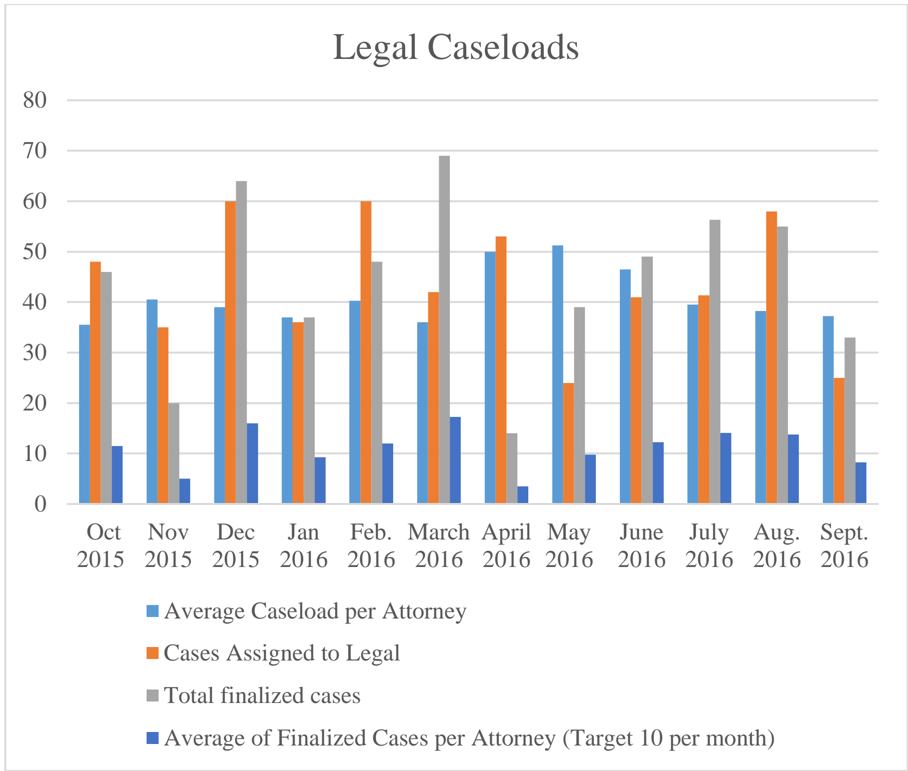


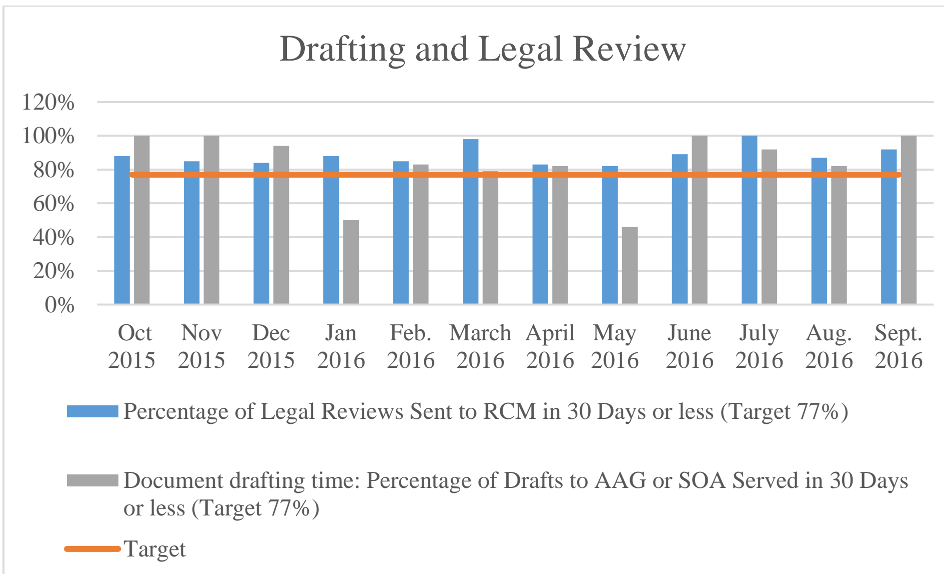
Legal Performance Measures

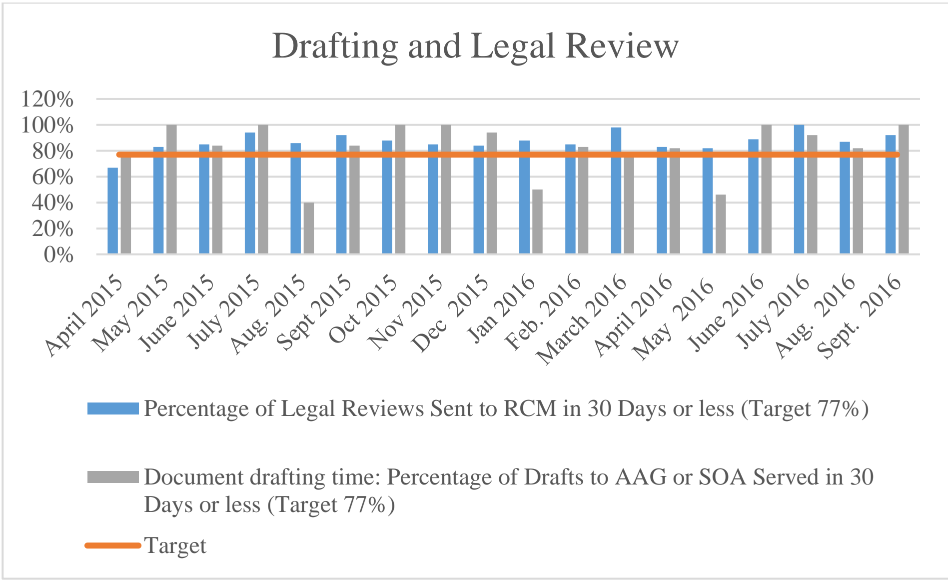
Type of Measure	Month	Jan 2016	Feb. 2016	March 2016	April 2016	May 2016	June 2016	July 2016	Aug. 2016	Sept. 2016
	Average Caseload per Attorney	37	40.25	36	50	51.25	46.5	39.5	38.25	37.25
	Cases Assigned to Legal	36	60	42	53	24	41	41.33	58	25
	Total finalized cases	37	48	69	14	39	49	56.33	55	33
Caseload / Case Volume	Average of Finalized Cases per Attorney (Target 10 per month)	9.25	12	17.25	3.5	9.75	12.25	14.08	13.75	8.25
	Percentage of Legal Reviews Sent to RCM in 30 Days or less (Target 77%)	88%	85%	98%	83%	82%	89%	100%	87%	92%
	Document drafting time: Percentage of Drafts to AAG or SOA Served in 30 Days or less (Target 77%)	50%	83%	79%	82%	46%	100%	92%	82%	100%
Performance	Percentage of Cases involving an ARNP	7%	10%	13%	14%	13%	13%	16%	17%	17%
	Number of Cases forwarded to AAG	4	10	9	7	11	9	7	8	7
	Finalized with Legal Review only	27	15	36	10	20	23	10	23	16
	Finalized by Default or Final Order After Hearing	6	2	10	2	5	7	10	6	3
	Finalized by STID, AO or APUC (Settlements)	4	21	20	1	8	15	6	15	8
Work Type and Complexity	Other (releases, reinstatements)	0	10	3	1	6	4	2	11	6

Legal Performance Measures





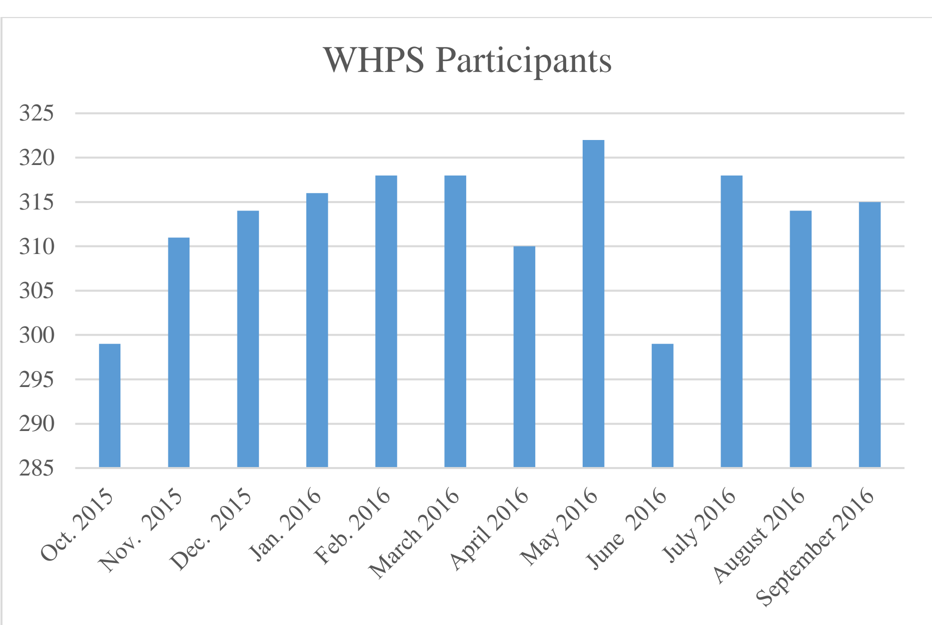


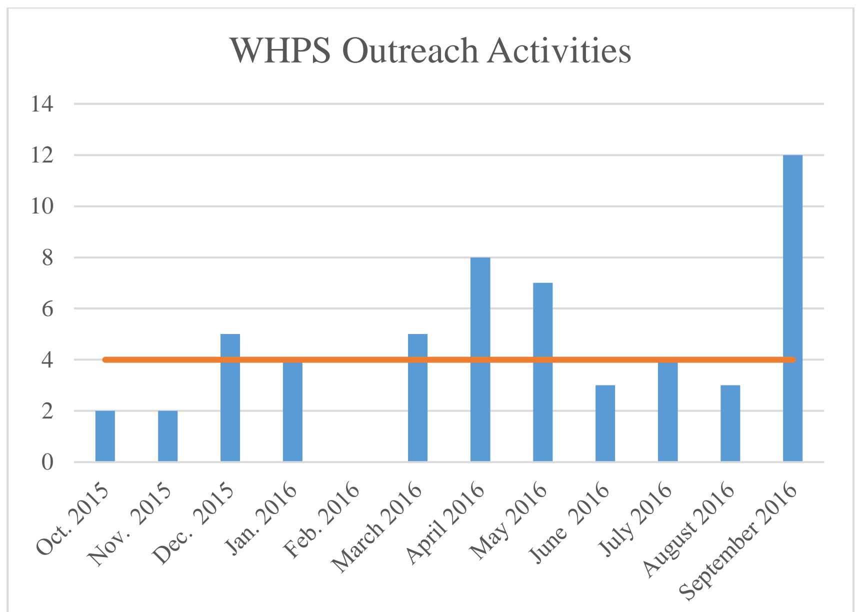


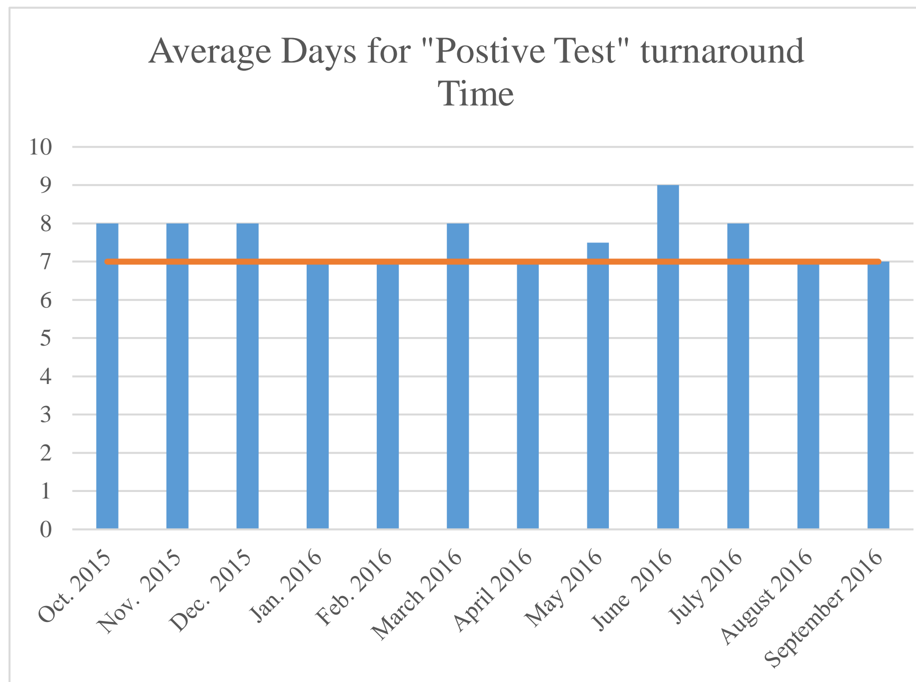
WHPS Performance Measures

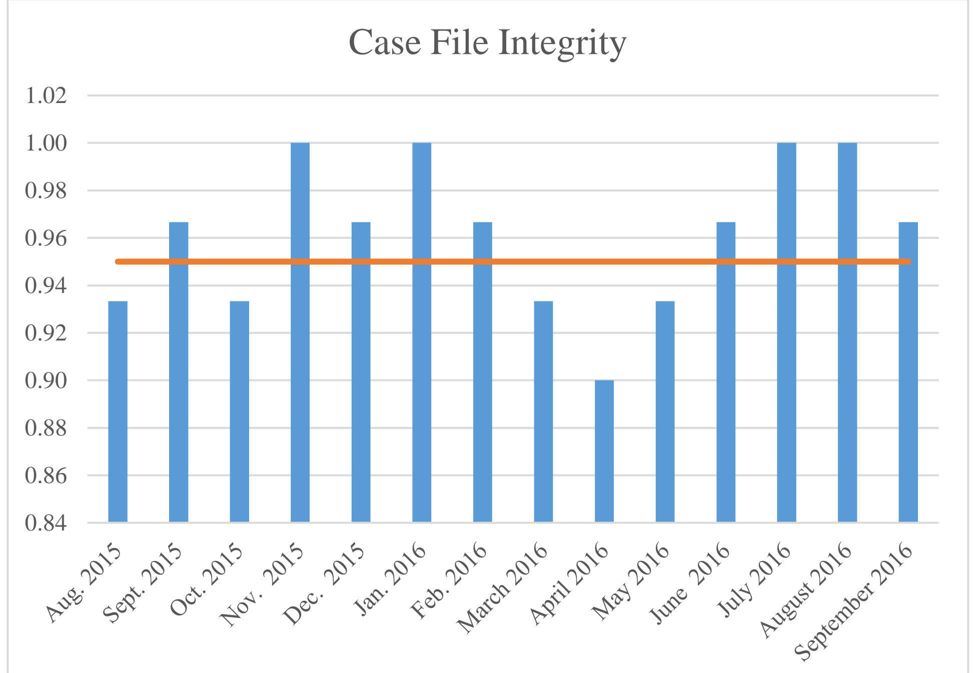
	Oct. 2015	Nov. 2015	Dec. 2015	Jan. 2016	Feb. 2016	March 2016	April 2016	May 2016	June 2016	July 2016	August 2016	September 2016	Target
Program Participation Numbers	299	311	314	316	318	318	310	322	299	318	314	315	
Average Days from Intake to Case Disposition	42	32	34	35	52	39	45	46	44	30	35	43	45
Average Days from Enrollment to Treatment Entry	1	0	1	0	2	0	1	0	0	0	0	0	14
Average Days Positive Drug Test Turn-Around Time	8	8	8	7	7	8	7	7.5	9	8	7	7	7
Positive Drug Tests Addressed Within Next Business Day	31/31	17/17	28/28	30/30	23/24	24/24	20/20	33/33	28/28	42/42	35/35	27/27	95
Average Days from Significant Contract Non-Compliance to Discipline Notification	N/A	3	N/A	1	2	3	2	3	2	2	2	1	2
Late Monthly Reports	23	21	19	21	14	17	18	16	25.00	19.00	22	19	30
Employment rate	65	68	62	65	75	74	75	73	75.00	73.00	73	76	75
Case File Integrity**	28/30 (93%)	30/30 (100%)	29/30 (97%)	30/30 (100%)	29/30 (97%)	28/30 (93%)	27/30 (90%)	28/30 (93%)	29/30 (97%)	30/30 (100%)	30/30 (100%)	29/30 (97%)	95%
Number of missed tests	0	0	2	2	3	2	1	0	4.00	4.00	1	4	5
Number of outreach activities	2	2	5	4	0	5	8	7	3.00	4.00	3	12	4

WHPS Performance Measures









DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE

Title:	Commission Pay	**Number:**	H04.03
Reference:	RCW 43.03.265 RCW 43.03.050 RCW 43.03.060		
Contact:	Paula R. Meyer, MSN, RN, FRE, Executive Director Washington State Nursing Care Quality Assurance Commission (NCQAC)		
Effective Date:	January 8, 2016		
Supersedes:	H04.01 – February 25, 2013 H04.02 – October 19, 2015	Date Reviewed:	March 2016
Approved:			
	Paula R. Meyer, MSN, RN, FRE **Executive Director** **NCQAC**		

PURPOSE:

NCQAC members are compensated for performing duties consistent with their statutory responsibilities. This policy does not apply to travel reimbursement.

PROCEDURE:

A. **NCQAC worksheet/pay sheets are due to the Administrative Assistant 3 by the 10th of the following month**.
(Example: September pay sheets are due by October 10th). This allows five (5) days for processing and forwarding to payroll by the 15th of each month.

B. **Travel Expense Management (TEMS) are due to the Administrative Assistant 3 by the 10th of the following month**. (Example: September travel expenses are due October 10th). This allows ten (10) working days for processing and forwarding to accounting for processing by the 25th of each month. Accounting has ten (10) working days to review, approve and forward to the Office of Financial Management (OFM) for payout.

C. **The maximum compensation per day is $250.**
In accordance with statute, compensation will not exceed $250 per day regardless of the length of time involved for that day, including travel time. All forms for NCQAC compensation must be submitted to the NCQAC office no later than the tenth of the month.

D. **Less than eight hour days will be prorated.**
NCQAC members receive compensation at the prorated hourly rate of $31.25 for less than eight hours in a single day.

E. **Examples of compensated activities.**
The following activities are indicative of typical duties for which NCQAC members will receive compensation:
1. NCQAC business as appointed
2. Attendance at NCQAC and business meetings
3. Travel time to and from required meetings will be compensated up to a maximum of $250.00 per day.
4. Reading NCQAC meeting packets in preparation for meetings
5. Telephone calls to and from staff, and participation in telephone conferences
6. Reviewing case files and preparing for presentation(s) of the case
   a. Reviewing journal articles directly related to a case*.
   b. Reviewing case summaries for Interim Review Panel (IRP).
   c. Settlement conferences.
   d. Reviewing or editing Stipulation to Informal Disposition (STID), Agreed Orders, etc.
7. Hearings not held during NCQAC meetings
8. Administrative activities performed by the NCQAC Chair
9. Site visits*
10. Public speaking engagements*
11. Legislative hearings*
12. New NCQAC member orientation*

** Requires pre-approval by the Executive Director or their designee. See Section F of this procedure.*

F. **Some activities require pre-approval by the Executive Director.**
Some duties, while beneficial to the public and community, may not be statutorily prescribed and may not be eligible for compensation by the program. NCQAC members should submit requests for compensation for these additional activities in advance. The Executive Director will work with the NCQAC Chair to decide on appropriate compensation. This may include a review of the budget, adequate representation by other members, the strategic plan, and prioritizing requests.

Examples:
1. Site visits
2. Public speaking engagements
3. Legislative hearings
4. New NCQAC Member orientation
5. Reviewing journals or articles directly related to a disciplinary case
6. NCQAC Member out-of-state travel. Out-of-state travel requires approval from the full NCQAC, or the Executive Director in consultation with the Chair, and is subject to approval to the travel reservations being completed.
   a. Travel time to and from the meeting will be compensated
   b. If the meeting is less than eight hours, compensation will be pro-rated according to the time posted on meeting agenda(s).

G. Not all activities are eligible for compensation.

Some activities should be done on the NCQAC member's own time and will not be reimbursed. Members are encouraged to seek clarification from the executive director prior to engaging in activities not specifically stated in statute.

Examples:
1. Continuing education courses
2. Travel time to and from official business if the member, by choice, deviated from the most efficient method
3. Performing duties on behalf of the NCQAC without informing the executive director
4. Performing duties on behalf of the NCQAC that have, or appear to have, a conflict of interest with the NCQAC's official duties
5. Attendance at meetings of specific ad hoc committees if not officially appointed
6. Study time involving reading journals or articles, not directly related to case reviews
7. Pre-payment of anticipated costs or business to be performed at a future date

H. Pro-Tem Members are compensated according to their scope.

Programs will compensate pro-tem NCQAC members for duties stated in their appointment letter. Duties outside of their appointment scope may not be compensated.

I. If a NCQAC Member is a state employee or an employee of a municipality, a choice of payer must be made.

A public official must be paid from a single payer source. Therefore, if a NCQAC Member is an elected official or an employee of a state agency, school or a municipal government, the NCQAQC Member must choose their payer source, or take leave from their payer source in order to be paid as a NCQAC Member. Individual NCQAC Members affected by this must communicate their choice for payment to the Executive Director within a month of their appointment.

Nursing Care Quality Assurance Commission
July 1, 2015 – June 30, 2017 Strategic Plan
November 2016

LICENSING

DRAFT

ID	GOAL	OBJECTIVES	RESPONSI-BILITY	RESOURCES	DEADLINES	PROGRESS
L 1	Implement national Minimum Data Sets and begin data analysis	1. Complete legal analysis to require completion of MDS as part of renewal process. 2. Work with NCSBN on data collection tool. 3. Educate licensees on data collection. 4. Begin data collection.	Licensing Manager Assistant Director of Education	ILRS Staff and online implementation committee NCSBN NCQAC staff	12/31/15 6/30/16 12/31/16 6/30/17	**Completed on time** **Completed on time**
L 2	License renewal every 2 years – LPN, RN and ARNP (and continuing competency audit cycle).	1. Stakeholder work has been done with continuing competency workshops. 2. Complete legal review and analysis 3. Develop plan including fee study 4. Rules process with workshops, drafting, review and approval	Licensing Manager	NCQAC Staff, (revenue/budget review) HSQA rules staff ILRS, AAG office.	06/30/16 7/31/17	**Completed on time**
L 3	Create "retired active" category for ARNPs.	1. Rules change required	Licensing Manager	National Certifying bodies	Begin rules process 1/31/18	

			ARNP Consultant	NCQAC Staff, (revenue review) HSQA rules staff ILRS, AAG office		
L 4	WA nursing Juris Prudence exam with relicensing.	Evaluate options to assure licensed nurses maintain currency with the RCW's and WAC's to include fiscal impact.		NCQAC members and staff, HSQA/OLS Revenue (costs to maintain on-line examination) LMS? AGG office?	12/31/16	The staff would like to have until March 31, 2016 to complete this task.

DRAFT

NEW SECTION

WAC 246-840-015 Requirement to submit demographic data. Collecting and supplying demographic data for the nursing profession in Washington state is essential to answering the fundamental questions on supply, demand, and distribution of the nursing workforce. The nursing care quality assurance commission provides a cost-effective approach collect and analyze the data to accomplish the data collection and analysis required under RCW 18.79.202.

(1) Applicants must complete all demographic data elements and attest to the completion of the data elements as part of their initial application for:

(a) Licensed practical nurse as defined under WAC 246-840-010(22); or

(b) Registered nurse as defined under WAC 246-840-010(33).

(2) All licensees must complete all demographic data and attest to the completion of the demographic data to renew their license for:

(a) Licensed practical nurse as defined under WAC 246-840-010(22); or

(b) Registered nurse as defined under WAC 246-840-010(33).

(3) Advanced practice nurses do not have to complete an additional demographic data. The demographic data is collected on their RN license.

AMENDATORY SECTION (Amending WSR 16-08-042, filed 3/30/16, effective 4/30/16)

WAC 246-840-010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Advanced clinical practice" means practicing at an advanced level of nursing in a clinical setting performing direct patient care.

(2) "Advanced nursing practice" means the delivery of nursing care at an advanced level of independent nursing practice that maximizes the use of graduate educational preparation, and in-depth nursing knowledge and expertise in such roles as autonomous clinical practitioner, professional and clinical leader, expert practitioner, and researcher.

(3) "Advanced registered nurse practitioner (ARNP)" is a registered nurse (RN) as defined in RCW 18.79.050, 18.79.240, 18.79.250, and 18.79.400 who has obtained formal graduate education and national specialty certification through a commission approved certifying body in one or more of the designations described in WAC 246-840-302, and who is licensed as an ARNP as described in WAC 246-840-300. The designations include the following:

(a) Nurse practitioner (NP);

(b) Certified nurse midwife (CNM);

(c) Certified registered nurse anesthetist (CRNA); and

(d) Clinical nurse specialist (CNS).

(4) "Associate degree registered nursing education program" means a nursing education program which, upon successful completion of course work, that includes general education and core nursing courses that provide a sound theoretical base combining clinical experiences with theory, nursing principles, critical thinking, and interactive skills, awards an associate degree in nursing (ADN) to prepare its graduates for initial licensure and entry level practice as an RN.

(5) "Bachelor of science degree registered nursing education program" means a nursing education program which, upon successful completion of course work taught in an associate degree nursing education program, as defined in subsection ((~~(28)~~)) (36) of this section, plus additional courses physical and social sciences, nursing research, public and community health, nursing management, care coordination, and the humanities, awards a bachelor of science in nursing (BSN) degree, to prepare its graduates for a broader scope of practice, enhances professional development, and provides the nurse with an understanding of the cultural, political, economic, and social issues that affect patients and influence health care delivery.

(6) "Certifying body" means a nongovernmental agency using predetermined standards of nursing practice to validate an individual nurse's qualifications, knowledge, and practice in a defined functional or clinical area of nursing.

(7) "Client" means the recipient of care provided by nurses or nursing assistants which, depending on the setting, could also be called a resident or patient.

(8) "Client advocate" means a licensed nurse who actively supports client's rights and choices, including the client's right to receive safe, high quality care, and who facilitates the client's ability to exercise those rights and choices by providing the client with adequate information about their care and options.

((~~(8)~~)) (9) "Commission" means the Washington state nursing care quality assurance commission.

((~~(9)~~)) (10) "Competency" means demonstrated knowledge, skill and ability in the practice of nursing.

((~~(10)~~)) (11) "Conditional approval" is the approval given a nursing education program that has not met the requirements of the law and the rules of the commission. Conditions are specified that must be met within a designated time to rectify the deficiency.

((~~(11)~~)) (12) "Dedicated education unit" means a clinical learning experience within a health care facility, as part of the curriculum of a nursing education program.

((~~(12)~~)) (13) "Delegation" means the ((~~licensed nurse transfers the performance of selected nursing tasks to competent~~)) transfer of responsibility for the performance of a selected nursing task from a licensed nurse authorized to perform the task to competent nursing assistants or other unlicensed person individuals in selected situations; this responsibility is one that is outside of the nursing assistant's or other unlicensed person's standard competencies. The nurse delegating the task is responsible and accountable for the nursing care of the client. The nurse delegating the task supervises the performance of the unlicensed person. Nurses must follow the delegation process following the RCW 18.79.260. Delegation in community and in-home care settings is defined by WAC 246-840-910 through 246-840-970.

((~~(13)~~)) (14) "Direction" means communicating an order or a plan of care to a nurse, nursing assistant, or other unlicensed person. Direction may be given verbally or in writing.

(15) "Distance education" or "distance learning" means instruction offered by any means where the student and faculty are in separate physical locations. Teaching methods may be synchronous, where the teacher and student communicate at the same time, or asynchronous, where the student and teacher communicate at different times, and shall facilitate and evaluate learning in compliance with nursing education rules.

((~~(14)~~)) (16) "Full approval" of a nursing education program is the approval signifying that a nursing program meets the requirements of the law and the rules of the commission.

((~~(15)~~)) (17) "Good cause" as used in WAC 246-840-860 for extension of a nurse technician registration means that the nurse technician has had undue hardship such as difficulty scheduling the examination through no fault of their own; receipt of the examination results after thirty days after the nurse technician's date of graduation; or an unexpected family crisis which caused him or her to delay sitting for the examination. Failure of the examination is not "good cause."

((~~(16)~~)) (18) "Good standing" as applied to a nursing technician, means the nursing technician is enrolled in a registered nursing program approved by the commission and is successfully meeting all program requirements.

((~~(17)~~)) (19) "Health care professional" means the same as "health care provider" as defined in RCW 70.02.010(18).

((~~(18)~~)) (20) "Home care aide-certified" means any person certified under chapter 18.88B RCW.

(21) "Home state" is defined as where the nursing education program has legal domicile.

((~~(19)~~)) (22) "Hospital" means a facility licensed under chapter 70.41 or 72.23 RCW.

(23) "Host state" is defined as the state jurisdiction outside the home state where a student participates in clinical experiences or didactic courses.

((~~(20)~~)) (24) "Immediately available" as applied to nursing technicians, means that an RN who has agreed to act as supervisor is on the premises and is within audible range and available for immediate response as needed which may include the use of two-way communication devices which allow conversation between the nursing technician and an RN who has agreed to act as supervisor.

(a) In a hospital setting, the RN who has agreed to act as supervisor is on the same patient care unit as the nursing technician and the patient has been assessed by the RN prior to the delegation of duties to the nursing technician.

(b) In a nursing home or clinic setting, an RN who has agreed to act as supervisor is in the same building and on the same floor as the nursing technician and the patient has been assessed by the RN prior to the delegation of duties to the nursing technician.

((~~(21)~~)) (25) "In-home or hospice" means a facility regulated under chapter 70.127 RCW.

(26) "Initial approval" of nursing education program is the approval status conferred by the commission to a new nursing program based on its proposal prior to the graduation of its first class.

((~~(22)~~)) (27) "Key party" means as defined in WAC 246-16-020.

(28) "Licensed practical nurse (LPN)" is a nurse licensed as defined in RCW 18.79.030(3), with a scope of practice defined in RCW 18.79.020 and 18.79.060.

((~~(23)~~)) (29) "Limited educational authorization" is an authorization to perform clinical training when enrolled as a student through a commission approved refresher course. This authorization does not permit practice for employment.

((~~(24)~~)) (30) "Minimum standards of competency" means the knowledge, skills, and abilities that are expected of the beginning practitioner.

((~~(25)~~)) (31) "National nursing education accreditation body" means an independent nonprofit entity, approved by the United States Department of Education as a body that evaluates and approves the quality of nursing education programs within the United States and territories.

((~~(26)~~)) (32) "Nontraditional program of nursing" means a school that has a curriculum which does not include a faculty supervised teaching and learning component in clinical settings.

((~~(27)~~)) (33) "Nursing assistant-certified" means an individual certified under chapter 18.88A RCW.

(34) "Nursing assistant-registered" means an individual registered under chapter 18.88A RCW.

(35) "Nursing education program administrator" is an individual who has the authority and responsibility for the administration of the nursing education program.

((~~(28)~~)) (36) "Nursing education program" means a division or department within a state supported educational institution or other institution of higher learning, charged with the responsibility of preparing nursing students and nurses to qualify for initial licensing or higher levels of nursing practice.

((~~(29)~~)) (37) "Nursing faculty" means an individual employed by a nursing education program who is responsible for developing, implementing, evaluating, updating, and teaching nursing education program curricula.

((~~(30)~~)) (38) "Nursing home" means any home, place, or institution which operates or maintains facilities providing convalescent or chronic care, or both, that is licensed under chapter 18.51 RCW.

(39) "Nursing technician" means a nursing student preparing for RN licensure who meets the qualifications for licensure under RCW 18.79.340 who is employed in a hospital licensed under chapter 70.41 RCW or a nursing home licensed under chapter 18.51 RCW, or clinic. The nursing student must be in a nursing educational program in the United States or its territories that is approved by the National Council Licensure Examination-RN. Approved nursing education programs do not include nontraditional schools as defined in subsection ((~~(27)~~)) (32) of this section.

((~~(31)~~)) (40) "Philosophy" means the beliefs and principles upon which a nursing education program curriculum is based.

((~~(32)~~)) (41) "Practical nursing education program" means a nursing education program which, upon successful completion of course work that includes core nursing course to provide a sound theoretical base combining clinical experiences with nursing principles, critical thinking, and interactive skills for entry level practical nursing, awards a certificate that the graduate is prepared for interdependent practice to prepare a practical nurse for interdependent practice as an LPN.

((~~(33)~~)) (42) "Registered nurse" or "RN" is a licensed nurse as defined in RCW 18.79.030(1), 18.79.040, 18.79.240, and 18.79.260.

((~~(34)~~)) (43) "Supervision" ((~~of licensed or unlicensed nursing personnel~~)) means the provision of guidance and evaluation of licensed or unlicensed nursing personnel for the accomplishment of a nursing task or activity with the initial direction of the task or activity; periodic inspection of the actual act of accomplishing the task or activity; and the authority to require corrective action.

(a) "Direct supervision" means the licensed ((~~RN~~)) nurse who provides guidance to nursing personnel and evaluation of nursing tasks is on the premises, is quickly and easily available, and has assessed the patient prior to the delegation of the duties.

(b) "Immediate supervision" means the licensed ((~~RN~~)) nurse who provides guidance to nursing personnel and evaluation of nursing tasks is on the premises, is within audible and visual range of the patient, and has assessed the patient prior to the delegation of duties.

(c) "Indirect supervision" means the licensed ((~~RN~~)) nurse who provides guidance to nursing personnel and evaluation of nursing tasks is not on the premises but has given either written or oral instructions for the care and treatment of the patient and the patient has been assessed by the registered nurse prior to the delegation of duties.

((~~(35)~~)) (44) "Traditional nursing education program" means a program that has a curriculum which includes a faculty supervised teaching and learning component in clinical settings.

NEW SECTION

WAC 246-841-300 Definitions. (1) "Client" means the recipient of care provided by the nursing assistant. Depending on the setting, a client will have the same meaning as resident or patient.

(2) "Community-based settings" means community residential programs for people with developmental disabilities, certified by the department of social and health services under chapter 71A.12 RCW; adult family homes licensed under chapter 70.128 RCW; and assisted living facilities licensed under chapter 18.20 RCW.

(3) "Competency evaluation" means the measurement of an individual's knowledge and skills related to safe, competent practice.

(4) "Delegation" means the transfer of responsibility for the performance of a selected nursing task from a licensed nurse authorized to perform the task to a competent nursing assistant in selected situations and under appropriate supervision. General delegation is further defined in WAC 246-840-010(7); delegation in community-based settings is defined under WAC 246-840-910 through 246-840-970.

(5) "Direction" means communicating a plan of care to a nursing assistant that includes assigned responsibilities within the nursing assistant's standard competencies. Direction does not require to imply that the nurse is supervising the individual in the employment context.

(6) "Home care aide-certified" means any person certified under chapter 18.88B RCW.

(7) "Key party" means immediate family members and others who would be reasonably expected to play a significant role in the health care decisions of the client, patient, or resident and includes, but is not limited to, the spouse, domestic partner, sibling, parent, child, guardian, and person authorized to make health care decisions of the client, patient, or resident.

(8) "Medical assistant-certified" under chapter 18.88A RCW, means a person who holds a current certification from one of the certifying organizations in WAC 246-827-0200(2).

(9) "Medication assistant" means a nursing assistant-certified with a medication assistant endorsement issued under chapter 18.88A RCW.

(10) "Nursing assistant-certified" means an individual certified under chapter 18.88A RCW.

(11) "Nursing assistant-registered" means any person registered under chapter 18.88A RCW.

(12) "Nursing home" means any home, place or institution which operates or maintains facilities providing convalescent or chronic care, or both, that is licensed under chapter 18.51 RCW.

(13) "Supervision" means the provision of guidance and evaluation by a licensed registered nurse or licensed practical nurse for the accomplishment of a nursing task or activity with the initial direction of the task or activity; periodic inspection of the actual act of accomplishing the task or activity, and the authority to require corrective action. Supervision does not require that the nurse is supervising the individual in the employment context. Levels of supervision include:

(a) "Direct supervision" means the licensed nurse who provides guidance to nursing assistants and evaluation of delegated nursing tasks is on the premises, is quickly and immediately available, and has assessed the client prior to delegation of duties.

(b) "Immediate supervision" means the licensed nurse who provides guidance to nursing assistants and evaluation of delegated nursing tasks is on the premises, is within audible and visual range of the client, and has assessed the client prior to delegation of duties.

(c) "Indirect supervision" means the licensed nurse who provides guidance to nursing assistants and evaluation of delegated nursing tasks is not on the premises but has given either written or oral instructions for the care and treatment of the client and the client has been assessed by the nurse prior to the delegation of duties.

AMENDATORY SECTION (Amending WSR 08-06-100, filed 3/5/08, effective 4/5/08)

WAC 246-841-400 Standards of practice and competencies for nursing assistants. Competencies and standards of practice are statements of skills and knowledge, and are written as descriptions of observable, measurable behaviors. All competencies are performed under the direction and supervision of a licensed registered nurse or licensed practical nurse as required by RCW 18.88A.030. The following competencies are considered standards of practice for both nursing assistant-certified and nursing assistant-registered:

(1) **Basic technical skills.** A nursing assistant demonstrates basic technical skills which facilitate an optimal level of functioning for a client ((~~or resident~~)), recognizing individual, cultural, and religious diversity. A nursing assistant:

(a) Demonstrates proficiency in cardiopulmonary resuscitation (CPR) and can adequately perform CPR independently by maintaining current CPR certification.

(b) Takes and records vital signs.

(c) Measures and records height and weight.

(d) Measures and records fluid and food intake and output.

(e) Recognizes normal body functions, deviations from normal body functions and the importance of reporting deviations in a timely manner to a supervising nurse.

(f) Recognizes, responds to, and reports client's ((~~or resident's~~)) emotional, social, cultural, and mental health needs.

(g) Recognizes, responds to, and reports problems in client's ((~~or resident's~~)) environment to ensure safety and comfort ((~~of client~~)).

(h) Participates in care planning and nursing reporting process.

(i) Observes and reports client's pain.

(j) Demonstrates health care team member skills including time management and prioritizing work.

(2) **Personal care skills.** A nursing assistant demonstrates basic personal care skills. A nursing assistant:

(a) Assists client ((~~or resident~~)) with bathing, oral care, and skin care.

(b) Assists client ((~~or resident~~)) with grooming and dressing.

(c) Provides toileting or ostomy assistance to client ((~~or resident~~)).

(d) Assists client ((~~or resident~~)) with eating and hydration.

(e) Uses proper oral feeding techniques.

(3) **Mental health and social service needs.** A nursing assistant demonstrates the ability to identify psychosocial needs of all clients

((~~or residents~~)) based upon awareness of the developmental and age specific processes. A nursing assistant:

(a) Addresses individual behavioral needs of the client ((~~or resident~~)).

(b) Knows the developmental tasks associated with the developmental and age specific processes.

(c) Allows the client ((~~or resident~~)) to make personal choices, but provides and reinforces behaviors consistent with the client's ((~~or resident's~~)) dignity.

(d) Is sensitive and supportive and responds to the emotional needs of the clients ((~~or residents~~)) and their sources of emotional support.

(4) **Care of cognitively impaired ((~~residents~~)) clients.** A nursing assistant demonstrates basic care of cognitively impaired clients ((~~or residents~~)). A nursing assistant:

(a) Uses techniques for addressing the unique needs and behaviors of individuals with cognitive impairment including Alzheimer's, dementia, delirium, developmental disabilities, mental illnesses and other conditions.

(b) Communicates with cognitively impaired clients ((~~or residents~~)) in a manner appropriate to their needs.

(c) Demonstrates sensitivity to the behavior of cognitively impaired clients ((~~or residents~~)).

(d) Appropriately responds to the behavior of cognitively impaired clients ((~~or residents~~)).

(5) **Basic restorative services.** The nursing assistant incorporates principles and skills in providing restorative care. A nursing assistant:

(a) Demonstrates knowledge and skill in using assistive devices in ambulation, transferring, eating, and dressing.

(b) Demonstrates knowledge and skill in the maintenance of range of motion.

(c) Demonstrates proper techniques for turning and positioning a client ((~~or resident~~)) in a bed and chair.

(d) Demonstrates proper techniques for transferring and ambulating client ((~~or resident~~)).

(e) Demonstrates knowledge about methods for meeting the elimination needs of clients ((~~or residents~~)) including, but not limited to, bowel and bladder training.

(f) Demonstrates knowledge and skill for the use and care of prosthetic devices by client ((~~or resident~~)).

(g) Uses basic restorative services by training the client ((~~or resident~~)) in self-care according to the client's ((~~or resident's~~)) capabilities.

(h) Uses appropriate body mechanics when working with client.

(6) **Client ((~~or resident~~)) rights and promotion of independence.** A nursing assistant demonstrates behavior which maintains and respects ((~~client or resident~~)) rights and promotes independence of all clients, regardless of factors such as, but not limited to: Race, creed, color, national origin, sex, veteran status, religion, life-style, gender identity, sexual ((~~preference,~~)) orientation, sensory mental or physical disability, disease process, or ability to pay. A nursing assistant:

(a) Recognizes ((~~that~~)) the client ((~~or resident~~)) has the right to participate in decisions about his or her care.

(b) Recognizes and respects ((~~clients' or residents'~~)) client need for privacy and confidentiality.

(c) Promotes and respects the client ((~~or resident~~)) right to make personal choices to accommodate their needs.

(d) Reports client ((~~or resident~~)) concerns.

(e) Provides assistance to client ((~~or resident~~)) in getting to and participating in activities.

(f) Respects the property of client ((~~or resident~~)), key party, and employer and does not take equipment, material, property or medications for his, her, or other's use or benefit. A nursing assistant may not solicit, accept, or borrow money, material, or property from client ((~~or resident~~)), key party, or employer for his, her, or other's use or benefit.

(g) Promotes client ((~~or resident~~)) right to be free from abuse, mistreatment, and neglect.

(h) Intervenes appropriately on the client's ((~~or resident's~~)) behalf when abuse, mistreatment or neglect is observed.

(i) Complies with mandatory reporting requirements by reporting to the department of health and the department of social and health services instances of neglect, abuse, exploitation or abandonment.

(j) Participates in the plan of care with regard to the use of restraints in accordance with current professional standards.

(k) Understands advance directives and do-not-resuscitate orders, and the nursing assistant's role implementing them.

(7) **Communication and interpersonal skills.** A nursing assistant uses communication and interpersonal skills effectively to function as a member of the nursing team. A nursing assistant:

(a) Reads, writes, speaks, and understands English at the level necessary for performing duties of the nursing assistant.

(b) Listens and responds to verbal and nonverbal communication in an appropriate manner.

(c) Recognizes how his or her own behavior influences ((~~client's or resident's~~)) clients' behavior and uses resources for obtaining assistance in understanding the client's ((~~or resident's~~)) behavior.

(d) Adjusts his or her own behavior to accommodate client's ((~~or resident's~~)) physical or mental limitations.

(e) Uses terminology accepted in the health care setting to record and report observations and pertinent information.

(f) ((~~Appropriately~~)) Records and reports observations, actions, and information accurately and in a timely manner.

(g) Is able to explain policies and procedures before and during care of the client ((~~or resident~~)).

(h) Interacts appropriately with the client's family.

(8) **Infection control.** A nursing assistant uses standard and transmission-based precautions to prevent the spread of microorganisms. A nursing assistant:

(a) Uses principles of medical asepsis and demonstrates infection control techniques and standard and transmission-based precautions.

(b) Explains how disease causing microorganisms are spread.

(c) Is knowledgeable regarding transmission of bloodborne pathogens.

(d) Demonstrates knowledge of cleaning agents and methods which destroy microorganisms on surfaces.

(9) **Safety and emergency procedures.** A nursing assistant demonstrates the ability to identify and implement safety and emergency procedures. A nursing assistant:

(a) Provides an environment with adequate ventilation, warmth, light, and quiet.

(b) Promotes a clean, orderly, and safe environment including equipment for a client ((~~or resident~~)).

(c) Identifies and utilizes measures for accident prevention.

(d) Demonstrates principles of good body mechanics for self and client ((~~or resident~~)), using the safest and most efficient methods to lift and move clients((~~, residents,~~)) or heavy items.

(e) Demonstrates proper use of protective devices in care of clients ((~~or residents~~)).

(f) Demonstrates knowledge of and follows fire and disaster procedures.

(g) Identifies and demonstrates principles of health and sanitation in food service.

(h) Demonstrates the proper use and storage of cleaning agents and other potentially hazardous materials.

(10) **Rules and regulations knowledge.** A nursing assistant demonstrates knowledge of and can explain the practical implications of the laws and regulations which affect nursing assistant practice including, but not limited to:

(a) Mandatory reporting procedures related to client ((~~or resident~~)) abuse, neglect, abandonment, and exploitation.

(b) Scope of practice.

(c) Workers right to know.

(d) The Uniform Disciplinary Act.

(11) **Standards of behavior for nursing assistants.** The nursing assistant shall:

(a) Competently perform nursing tasks and functions as delegated by the nurse.

(b) Demonstrate honesty and integrity.

(c) Perform nursing tasks based on his or her education and training and the direction of the supervising nurse.

(d) Accept accountability for his or her behavior and actions while assisting the nurse and providing care.

(e) Assist in observing clients and identifying client needs.

(f) Communicate progress toward completing directed nursing tasks, as well as any changes in a client's status.

(g) Seek clarification if unsure of expectations.

(h) Function as a member of the health care team, contributing to the implementation of an integrated health care plan.

(i) Protect confidential client information.

(12) **Nursing assistants must work within their scope of practice under the supervision of a licensed nurse regardless of setting.**

(a) The supervising nurse determines the level of supervision necessary.

(b) Indirect supervision is the minimum level allowed. Indirect supervision means the licensed RN who provides guidance to nursing personnel and evaluation of nursing tasks is not on the premises but has given either written or oral instructions for the care and treatment of the patient after assessing the patient and prior to the direction of care.

(c) The supervising nurse must:

(i) Document the directed tasks in the client's plan of care;

(ii) Provide avenues for the nursing personnel to communicate with the supervising nurse as needed for the care and treatment of the patient;

(iii) Provide monitoring and supervision throughout care and treatment in accordance with the directed plans as incorporated into the plan of care;

(iv) Adjust directed plans as needed based on assessment.

(d) A nursing assistant may consent or refuse to consent to perform a directed nursing care task by communicating this decision to the supervising nurse. The nursing assistant is responsible for his or her own actions with the decision to consent or refuse to consent and the performance of the directed nursing care task.

(13) Nursing assistants may not perform any of the following duties:

(a) Tasks that involve severing or piercing the skin;

(b) Sterile procedures;

(c) Central line maintenance; or

(d) Acts that require nursing judgment.

(14) A nursing assistant may not perform any task that they have not been trained to perform and had their competency verified.

(15) Nursing assistant-certifieds working as long-term care workers are subject to the requirements or the Uniform Disciplinary Act in RCW 18.130.180 and must abide by the standards of practice in this chapter.

AMENDATORY SECTION (Amending WSR 09-06-006, filed 2/18/09, effective 3/21/09)

WAC 246-841-405 Nursing assistant delegation in community-based settings. ((~~Provision for delegation of certain tasks.~~)) (1) Nursing assistants perform tasks delegated by a registered nurse for patients in community-based care settings or in-home care settings each as defined in RCW 18.79.260 (3)(e).

(2) Before performing any delegated task:

(a) Nursing assistants-registered must show the certificate of completion of both the basic caregiver training and core delegation training from the department of social and health services to the registered nurse delegator.

(b) Nursing assistants-certified must show the certificate of completion of the core delegation training from the department of social and health services to the registered nurse delegator.

(c) All nursing assistants must comply with all applicable requirements of the nursing care quality assurance commission in WAC 246-840-910 through 246-840-970.

(d) All nursing assistants, registered and certified, who may be completing insulin injections must give a certificate of completion of diabetic training from the department of social and health services to the registered nurse delegator.

(e) All nursing assistants must meet any additional training requirements identified by the nursing care quality assurance commission. Any exceptions to additional training requirements must comply with RCW 18.79.260 (3)(e)(v).

(3) Delegated nursing care tasks described in this section are:

(a) Only for the specific patient receiving delegation;

(b) Only with the patient's consent; and

(c) In compliance with all applicable requirements in WAC 246-840-910 through 246-840-970.

(4) A nursing assistant may consent or refuse to consent to perform a delegated nursing care task. The nursing assistant is responsi-

ble for their own actions with the decision to consent or refuse to consent and the performance of the delegated nursing care task.

(5) Nursing assistants shall not accept delegation of, or perform, the following nursing care tasks:

(a) Administration of medication by injection, with the exception of insulin injections;

(b) Sterile procedures;

(c) Central line maintenance;

(d) Acts that require nursing judgment.

NEW SECTION

WAC 246-841-408 General delegation to nursing assistants in health care settings. (1) Licensed registered nurses and licensed practical nurses may delegate activities to a nursing assistant-registered or nursing assistant-certified in any setting where nursing care occurs. The nurse may not delegate acts that involve puncturing the skin, medication administration except as provided in WAC 246-841-405, sterile procedures, central line maintenance or acts that require nursing judgment. The delegating nurse shall be responsible for:

(a) Assessing the client prior to the delegation of tasks;

(b) Maintaining the overall accountability for the patient;

(c) Delegating only those tasks that are within the licensed registered nurse's or licensed practical nurse's scope of practice;

(d) Evaluating the appropriateness of the delegation;

(e) Communicating the delegated tasks to the nursing assistant and verifying the nursing assistant is competent to perform the delegated task;

(f) Determining the level and frequency of supervision required (direct, immediate, or indirect);

(g) Documenting the delegated tasks in the client's plan of care;

(h) Providing avenues for the nursing personnel to communicate with the supervising nurse as needed for the care and treatment of the patient;

(i) Providing monitoring and supervision throughout care and treatment in accordance with the plans as incorporated into the plan of care;

(j) Adjusting delegated plans as needed based on assessment.

(2) The nursing assistant shall be responsible for:

(a) Accepting activities based on his or her own competence level;

(b) Maintaining competency for delegated responsibility;

(c) Maintaining accountability for performing the delegated activity; and

(d) Communicating acceptance or refusal to accept a directed or delegated nursing task to the supervising or delegating nurse.

AMENDATORY SECTION (Amending WSR 11-16-042, filed 7/27/11, effective 8/27/11)

WAC 246-841-530 Alternative program—Purpose. The commission intends to establish criteria for an alternative program for home care aid-certified and medical assistant-certified that will provide continued opportunity for recruitment and career advancement in nursing, recognize relevant training, and maintain a single standard for competency.

The alternative program is intended to provide twenty-four hours of additional training, including clinical training, on topics not addressed in the specified training for certification as a home care aide or medical assistant((~~,~~)) that will meet the requirements necessary to take the nursing assistant-certified competency evaluation.

Successful completion of an approved alternative program may allow the home care aide-certified and medical assistant-certified to meet requirements to complete a competency evaluation. Successful completion of the competency evaluation may allow an applicant who is a home care aide-certified or medical assistant-certified to become a nursing assistant-certified. ((~~The nursing assistant-certified credential may then qualify an individual for entry into a nursing program.~~))

AMENDATORY SECTION (Amending WSR 13-15-012, filed 7/8/13, effective 7/8/13)

WAC 246-841-586 ((~~Applicability.~~)) Purpose. WAC 246-841-587 through 246-841-595 apply to the endorsement of a nursing assistant-certified as a medication assistant. A nursing assistant-certified with a medication assistant endorsement administers medications and nursing commission-approved treatments to residents in nursing homes, under the direct supervision of a designated registered nurse.

Nothing in these rules requires a nursing home to employ a nursing assistant-certified with a medication assistant endorsement. A medication assistant's employer may limit or restrict the range of functions permitted in these rules but may not expand those functions.

WAC 246-841-587 through 246-841-595 also apply to the approval of education and training programs and competency evaluations for medication assistants.

A medication assistant is responsible and accountable for his or her specific functions.

AMENDATORY SECTION (Amending WSR 13-15-012, filed 7/8/13, effective 7/8/13)

WAC 246-841-588 Application requirements. (1) **Initial applicant requirements:** Applicants for an initial medication assistant endorsement must meet the following requirements:

(a) Be certified as a nursing assistant-certified, with a certification in good standing, under chapter 18.88A RCW;

(b) Successfully complete a nursing commission-approved medication assistant education and training program, as described in WAC 246-841-590 (6) and (7) within the immediate year prior to the date of application;

(c) Complete at least one thousand hours of work experience in a nursing home as a nursing assistant-certified within the immediate year prior to the date of application and before starting the medication assistant training program; and

(d) After completing the requirements in (a) through (c) of this subsection, pass the nursing commission-approved medication assistant competency evaluation. Each applicant must successfully complete a written competency evaluation. The competency evaluation must measure an individual's knowledge and skills related to the safe, competent performance as a medication assistant. The evaluation assesses the competency specification required in the core curriculum as listed in WAC 246-841-590(6).

(2) **Application requirements:**

(a) To obtain an initial medication assistant endorsement credential, the nursing assistant-certified must submit to the department:

(i) An application on forms approved by the secretary.

(ii) The applicable fees under WAC 246-841-990.

(iii) Proof of completion of a nursing commission approved medication assistant:

(A) Education and training program under WAC 246-841-590 (6) and (7); and

(B) Competency evaluation under subsection (1) of this section; and

(iv) Employer documentation of work experience as required in subsection (1)(c) of this section.

(b) An applicant who is currently credentialed as a medication assistant in another state or jurisdiction may qualify for a medication assistant endorsement credential under this chapter. An applicant must submit to the department:

(i) An application on forms approved by the secretary;

(ii) Written verification directly from the state or jurisdiction in which the applicant is credentialed, attesting that the applicant holds a credential substantially equivalent to the medication assistant endorsement credential in Washington in good standing, and is not subject to charges or disciplinary action;

(iii) Verification of completion of the required education that is substantially equivalent to the education requirements as described in WAC 246-841-590 (6) and (7);

(iv) Employer documentation of work experience as required in subsection (1)(c) of this section; and

(v) The applicable fees under WAC 246-841-990.

(3) **Renewal requirements:** To renew a medication assistant endorsement credential, the medication assistant must have a current nursing assistant-certified credential in good standing, and meet the requirements of WAC 246-12-030.

(4) **Continuing competency requirements:** A medication assistant shall meet the following requirements on an annual basis to coincide with renewal of their nursing assistant-certified credentials:

(a) Employer documentation of successful completion of two hundred fifty hours of employment as a medication assistant in a nursing home setting under the direct supervision of a registered nurse;

(b) Documentation of eight hours of continuing education specific to medications, medication administration, and performance of selected patient treatments. Continuing education hours must be obtained through a nursing commission-approved medication education and training program as described in WAC 246-841-590 (6) and (7), continuing education programs approved by a professional association, or staff development programs offered in a nursing home. The education hours must directly relate to the medication assistant's role of medication administration and the performance of selected patient treatments.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 246-841-410	Purpose of the review and approval of nursing assistant-certified training programs.
WAC 246-841-420	Requirements for approval of nursing assistant-certified training programs.
WAC 246-841-430	Denial or withdrawal of approval for nursing assistant-certified training programs.
WAC 246-841-440	How does a nursing assistant training program whose approval has been withdrawn become reinstated?
WAC 246-841-450	Appeal rights of a nursing assistant-certified training program when the commission has denied or withdrawn approval.
WAC 246-841-460	Closure of an approved nursing assistant-certified training program.
WAC 246-841-470	Program directors and instructors in approved nursing assistant-certified training programs.
WAC 246-841-490	Core curriculum in approved nursing assistant-certified training programs.
WAC 246-841-500	Physical resources required for approved nursing assistant-certified training programs.
WAC 246-841-510	Administrative procedures for approved nursing assistant-certified training programs.
WAC 246-841-535	Alternative program—Definitions.
WAC 246-841-545	Home care aide-certified alternative program requirements.
WAC 246-841-550	Medical assistant-certified alternative program requirements.
WAC 246-841-555	Responsibilities of the program director in alternative programs.

WAC 246-841-560 Alternative program application for approval, denial, or withdrawal.

WAC 246-841-570 Recordkeeping and administrative procedures for approved alternative programs.

WAC 246-841-573 Closure of an alternative program.

WAC 246-841-587 Definitions.

WAC 246-841-590 Requirements for approval of education and training programs.

WAC 246-841-591 Commission review and investigation.

WAC 246-841-592 Commission action for violations.

WAC 246-841-593 Reinstatement of approval.

WAC 246-841-594 Appeal rights.

WAC 246-841-595 Medication assistant endorsement program renewal.

Chapter 246-842 WAC
((~~NURSING ASSISTANTS—NURSING HOMES—~~))NURSING ASSISTANTS TRAINING PROGRAMS

NEW SECTION

WAC 246-842-090 Definitions. (1) "Background check" means a Washington state patrol check or other government background check.

(2) "Client" means the recipient of care provided by the nursing assistant. Depending on the setting, client will have the same meaning as resident or patient.

(3) "Clinical" means the portion of the program where the students practice with clients the skills that they are learning in the classroom and skills lab. The clinical sessions are held at a facility that provides care.

(4) "Competency evaluation" in medication assistant means the measurement of an individual's knowledge and skills related to the safe, competent performance of tasks.

(5) "Home care aide-certified" means any person certified under chapter 18.88B RCW.

(6) "Medical assistant-certified" under chapter 18.88A RCW, means a person who holds a current certification from one of the certifying organizations in WAC 246-827-0200(2).

(7) "Medication assistant" means a nursing assistant-certified with a medication assistant endorsement issued under chapter 18.88A RCW.

(8) "Nursing assistant-certified" means any person certified under chapter 18.88A RCW.

(9) "Nursing assistant-registered" means any person registered under chapter 18.88A RCW.

(10) "Nursing home" means a nursing home licensed under chapter 18.51 RCW.

(11) "Owner" means a natural person or business entity that has ultimate management control or beneficial interests in a training program that must be approved by the commission under chapter 18.88A or 18.88B RCW.

(12) "Skills laboratory" or "skills lab" means a classroom space that is set up to resemble a care setting to allow students to practice skills.

AMENDATORY SECTION (Amending WSR 91-07-049, filed 3/18/91, effective 4/18/91)

WAC 246-842-180 Students (trainees) in approved training programs. (1) Students ((~~shall~~)) must register with the department within three days of hire at a ((~~health care facility~~)) nursing home.

(2) Students ((~~shall~~)) must wear name tags which clearly identify them as students or trainees at all times in interactions with patients, clients, and families.

(3) Students or trainees cannot represent themselves as nursing assistants until the registration or certification is issued by the department.

NEW SECTION

WAC 246-842-400 Purpose of the review and approval of nursing assistant-certified training programs. The nursing care quality assurance commission (commission) approves nursing assistant-certified training programs. The commission reviews and approves training programs to:

(1) Assure preparation for safe practice as a nursing assistant-certified by requiring nursing assistant-certified programs meet minimum standards.

(2) Provide guidance for development of new nursing assistant-certified training programs.

(3) Facilitate career mobility of nursing assistants-certified into nursing educational programs toward higher levels of nursing.

(4) Facilitate career mobility of certified home care aides and medical assistants into nursing assistant alternative "bridge" training programs.

(5) Identify training standards and achieved competencies of nursing assistants-certified in the state of Washington.

NEW SECTION

WAC 246-842-410 Requirements for approval of nursing assistant-certified and nursing assistant alternative "bridge" training programs. (1) To qualify as a nursing assistant-certified training program, an institution or facility must submit a completed application packet provided by the department of health at least ninety days prior to the anticipated start date. The packet will include forms and instructions to submit the following:

(a) Program objectives which include learner outcomes that describe what the students will be able to do as observable, measurable outcomes of their learning.

(b) Curriculum content outline which describes teaching and learning activities and all learning materials used throughout the program.

(c) Qualifications of program director and additional instructional staff.

(d) Contractual agreements related to providing this training. For any program that uses another facility to provide clinical training, this includes an affiliation agreement between the training program and the facility. The affiliation agreement must describe how the program will provide clinical experience in the facility. The agreement must specify the rights and responsibilities of both parties, students, and clients.

(e) Sample lesson plan for one unit that includes:

(i) Program objectives which include learner outcomes that describe what the students will be able to do as observable, measurable outcomes of their learning;

(ii) A description of teaching and learning activities that demonstrate the educational approach used;

(iii) A list or description of all supporting materials including, but not limited to, textbooks, workbooks, videos, and handouts;

(iv) Evaluation methods and standards used to measure student achievement of stated learning objectives;

(v) A timeline for implementing the lesson plan.

(f) Skills checklists for the classroom, clinical, and mock skills testing portion of the program. The skills checklists must include, at a minimum, all skills that are included in the state's skills competency exam.

(g) Description of classroom facilities.

(h) Declaration of compliance with administrative guidelines signed by the program director.

(i) Verification that the program director and staff meet the requirements of WAC 246-842-420.

(j) Official verification that the nursing assistant-certified training program or school is approved to operate in the state of Washington by:

(i) The state board for community and technical colleges;

(ii) The superintendent of public instruction;

(iii) The workforce training and education coordinating board; or

(iv) The department of social and health services per C.F.R. 483.151(a)(3)(b)(iii)(2) and C.F.R. 483.151(a)(3)(b)(iii)(3).

(k) A curriculum verification form.

(2) Programs may not operate until they are approved.

(3) Submit to on-site survey of the training program.

(4) Comply with any changes in training standards and guidelines in order to maintain approval status.

(5) Notify the commission of any program changes and receive approval prior to implementation, including:

(a) Changes in ownership;

(b) Changes in program director;

(c) Changes in instructional staff;

(d) Changes in curriculum;

(e) Changes in program hours;

(f) Changes in program locations; or

(g) Changes in clinical facilities.

NEW SECTION

WAC 246-842-420 Program directors and instructors in approved nursing assistant-certified training programs and alternative "bridge" nursing assistant training programs. (1) The program director must hold an active Washington state registered nursing license (RN) in good standing. All health care licenses held by the program director shall be free of discipline for at least the last three years. The program director shall not have any findings entered against him or her that limits his or her ability to work with vulnerable adults.

(2) The program director must complete a training course on adult instruction and have demonstrated that he or she has one year full-

time equivalency teaching adults. All program directors must provide proof of completion of a course in adult instruction at the time of program renewal.

(a) Acceptable experience does not include patient teaching.

(b) The training course on adult instruction must provide instruction in:

(i) Understanding the adult learner;

(ii) Techniques for teaching adults;

(iii) Classroom methods for teaching adults;

(iv) Audio visual techniques for teaching adults; and

(v) A program director directing a program with exclusively high school students may use training courses on teaching high school students.

(3) The program director will have a minimum of three years of experience as an RN, of which at least one year will be in direct patient care. The experience must be full-time or the equivalent. A program director who will direct exclusively high school students may use experience teaching high school students to meet the requirement.

(4) The program director must meet the requirements for instructional staff under subsection (7)(a) through (c) of this section if the program director will also be acting as an instructor.

(5) Program director responsibilities:

(a) Develop and implement a curriculum, which meets at a minimum the requirements of this chapter. The program director is responsible for all classroom and clinical training content and instruction.

(b) Assure compliance with and assume responsibility for meeting the requirements of WAC 246-842-400 through 246-842-470.

(c) Assure that all student clinical experience is directly supervised. Direct supervision means that an approved program director or instructor is on-site observing students performing tasks.

(d) Assure that the clinical instructor has no concurrent duties during the time he or she is instructing students.

(e) Create and maintain an environment conducive to teaching and learning.

(f) In conjunction with the program owner, select all instructors involved in the course, including clinical instructors and guest lecturers.

(g) Supervise and evaluate all instructors involved in the course, including clinical instructors and guest lecturers.

(h) Assure that students are not asked or permitted to perform any clinical skill with patients or clients until first demonstrating the skill satisfactorily to an instructor in a lab setting and having successfully completed the related didactic classroom information.

(i) Assure that students have attained requisite knowledge and skills before verifying completion of the course.

(j) Assure that students receive a verification of completion when requirements of the course have been satisfactorily met.

(k) Submit verification of student completion and eligibility to test on approved commission forms.

(l) Prior to enrollment, assure that the admissions process includes:

(i) Disclosure of the background check requirements for the program;

(ii) Disclosure of immunization and health or other physical requirements for the program;

(iii) Disclosure of requirements to complete the program; and

(iv) Complete and accurate information about the program.

(6) The program director, working with the owner, may select instructional staff to assist in the teaching of the course.

(a) Instructional staff must teach in their area of expertise.

(b) Instructional staff must:

(i) Have a minimum of one year full-time equivalency of experience within the past three years in direct patient care. The direct patient care must include holistic care of patients and include hands on physical care; or

(ii) Have a minimum of three years full-time equivalency in the last ten years in a role that requires direct patient care. The direct patient care must include holistic care of patients and hands on physical care.

(c) Instructional staff must complete a training course on adult instruction or have demonstrated that he or she has two thousand hours of experience teaching adults. An instructor who will teach exclusively high school students may use experience teaching high school students to meet the requirement.

(i) Acceptable experience does not include patient teaching.

(ii) The training course on adult instruction must provide instruction in:

(A) Understanding the adult learner;

(B) Techniques for teaching adults;

(C) Classroom methods for teaching adults;

(D) Audio visual techniques for teaching adults; and

(E) An instructor who will teach exclusively high school students may use training courses on teaching high school students.

(d) All instructional staff must hold an active Washington state license to practice as a registered or licensed practical nurse, free of discipline for at least the last three years. Instructional staff shall not have any findings entered against them that limits their ability to work with vulnerable adults.

(e) Instructional staff may assist the program director in development of curricula, teaching modalities, and evaluation. The instructor will be under the supervision of the program director at all times. The program director maintains responsibility for the curricula, teaching, and evaluation.

(f) A guest lecturer who is an individual with expertise in a specific course unit may be used in the classroom setting for teaching without commission approval, following the program director's review of the currency of content.

(i) The guest lecturer must have a minimum one year full-time equivalency of experience in his or her professional field; or be approved by an outside organization to teach the content.

(ii) The guest lecturer, where applicable, must hold a license, certificate or registration in good standing in their field of expertise.

(iii) Guest lecturers do not replace approved instructors, and an approved instructor must be in the classroom when a guest lecturer is teaching; the approved instructor maintains responsibility for the content.

NEW SECTION

WAC 246-842-430 Program owners of approved nursing assistant, nursing assistant alternative "bridge" programs, and medication assistant training programs. (1) The program owner or designated administrator in approved training programs must notify the commission in advance of any changes listed in WAC 246-842-410 before they are made and receive approval prior to implementing the changes.

(2) The program owner or designated administrator is responsible for assuring that programs have adequate fiscal, personnel, and physical resources to operate.

(3) The program owner or designated administrator shall assure that all information submitted to the nursing commission is accurate and complete.

(4) The program owner or designated administrator shall maintain employee files for all program directors, instructors, and guest lecturers that meet the requirements of WAC 246-842-420. The program owner or designated administrator shall assure that required files are complete and accurate, and maintained.

(5) The program owner or designated administrator shall coordinate the hiring of instructors in conjunction with the program director, and shall assure that all staff are licensed.

(6) The program owner or designated administrator will assure that a background check is completed on all instructional staff and students before the beginning of clinical education.

(7) The program owner or designated administrator shall complete an annual report in collaboration with the program director as required by the nursing commission. The survey must be completed on the forms required by the commission.

NEW SECTION

WAC 246-842-440 Core curriculum in approved nursing assistant-certified training programs. (1) The curriculum must be competency based. It must be composed of learning objectives and activities that will lead to knowledge and skills required for the graduate to demonstrate mastery of the core competencies as provided in WAC 246-841-400.

(2) There must be a minimum of one hundred forty program hours. These must include at a minimum:

(a) Fifty-five hours of classroom time.

(b) Sixteen hours of skills lab time, with at least ten hours occurring prior to students experiencing clinical hours.

(c) Sixty-four hours of clinical time. The clinical setting must allow the students to apply the knowledge and skills required in the curriculum to achieve competency.

(d) Five hours of mock skills practice and testing in a skills lab setting to be completed after students complete their clinical time.

(e) Training to orient the student to the health care facility and facility policies and procedures are not to be included in the minimum hours above.

(f) Programs must assure that students meet the seven hours AIDS education requirements in chapter 246-12 WAC, Part 8 before beginning clinical time.

(3) Each unit of the core curriculum will have:

(a) Behavioral objectives, which are statements of specific observable actions and behaviors that the learner is to perform or exhibit.

(b) An outline of information the learner will need to know in order to meet the objectives.

(c) Learning activities such as lecture, discussion, readings, or film and clinical practice designed to enable the student to achieve the stated objectives.

(4) Classroom, lab and clinical teaching shall be aligned to integrate knowledge with manual skills.

(a) Students must wear name tags clearly identifying them as students when interacting with patients, clients, and families.

(b) An identified instructor(s) will supervise clinical teaching or learning at all times. At no time will the ratio of students to instructor exceed ten students to one instructor in the skills laboratory or clinical setting.

(5) The curriculum must include evaluation processes to assess mastery of competencies. Students shall not perform any skill in clinical with clients until first demonstrating the skill satisfactorily to an instructor in the skills lab setting.

(6) Training programs shall utilize a textbook that has been published within the previous five years or submit documentation that the textbook is still current.

NEW SECTION

WAC 246-842-450 Physical resources required for approved nursing assistant-certified training programs. The program shall provide:

(1) Classroom facilities which include adequate space, lighting, comfort, cleanliness, and privacy for effective teaching and learning.

(2) Adequate classroom resources, such as white board or other writing device, audio visual materials, written materials, and other teaching materials.

(3) Adequate equipment and supplies for teaching and practicing curriculum skills and procedures.

NEW SECTION

WAC 246-842-460 Administrative procedures for approved nursing assistant-certified training programs. (1) The program must establish and maintain a file for each student enrolled. The file must include:

(a) Dates attended;

(b) Test results;

(c) Skills evaluation checklists including date(s) that skills were evaluated, and the name and signature of instructor(s) for:

(i) Preclinical skills lab;

(ii) The clinical experience; and

(iii) Postclinical mock skills lab testing.

(d) Documentation of successful completion of the course, or documentation of the course outcome.

(2) Each student file must be maintained by the program for a period of five years, or as required by other approving organizations, and copies of documents made available to students who request them.

(3) Verification of successful completion of the course of training will be provided to the commission on forms provided by the commission.

(4) For those programs based in a health care facility, verification of program completion and the application for state testing will not be withheld from a student who has successfully met the requirements of the program. Successful completion will be determined by the training program director separately from other employer issues.

(5) Programs must maintain employee files that contain at a minimum:

(a) An initial instructor application for the staff member as submitted to the commission. (Guest lecturer applications do not need to be approved by the commission.)

(b) Proof that the staff member meets the requirements of WAC 246-842-420 as of the time of hire.

(c) Proof that the professional license has been verified upon hire and at least annually.

(d) Any information about complaints or corrective action for the particular staff member that are relevant to the nursing assistant or medication assistant training program.

(e) Employee files must be kept for three years after the staff member leaves the program.

(6) Programs must keep a record for each class run that shows all instructional staff, including guest lecturers, who taught the class.

(7) Programs must keep records for each calendar year of:

(a) The number of students that enrolled in the program;

(b) The number of students that started the program;

(c) The number of students that completed the program;

(d) The number of students that failed the program;

(e) The number of students that completed the program with a cohort other than the cohort they started with; and

(f) The number of students that took the certification exam.

NEW SECTION

WAC 246-842-470 Renewal of nursing assistant training programs and alternative "bridge" nursing assistant training programs. (1) All approved nursing assistant programs and alternative "bridge" nursing assistant training programs must participate in the renewal process every two years as requested by the commission.

(2) Approved programs must submit renewal documents at least ninety days in advance of the expiration date of the current program.

(3) Failure to renew shall result in automatic withdrawal of approval of the program.

NEW SECTION

WAC 246-842-500 Alternative program—Purpose. The commission intends to establish criteria for an alternative program for home care aide-certified and medical assistant-certified that will provide continued opportunity for recruitment and career advancement in nursing, recognize relevant training, and maintain a single standard for competency.

The alternative program will provide twenty-four hours of additional training, including clinical training, on topics not addressed in the specified training for certification as a home care aide or medical assistant, and will meet the requirements necessary to take the nursing assistant-certified competency evaluation.

Successful completion of an approved alternative program shall allow the home care aide-certified and medical assistant-certified to meet requirements to complete a competency evaluation. Successful completion of the competency evaluation may allow an applicant who is a home care aide-certified or medical assistant-certified to become a nursing assistant-certified. The nursing assistant-certified credential may then qualify an individual for entry into a nursing program.

NEW SECTION

WAC 246-842-510 Home care aide-certified alternative program requirements. (1) The commission may approve alternative programs for individuals credentialed as home care aides-certified to successfully complete in order to qualify to take the nursing assistant-certified competency evaluation.

(2) An alternative program shall:

(a) Meet the requirements of WAC 246-842-400 through 246-842-430 and 246-842-450 through 246-840-500.

(b) The curriculum content shall include:

(i) Observing and reporting client pain;

(ii) Demonstrates health care team member skills including time management and prioritizing work;

(iii) Demonstrates knowledge about methods for meeting the elimination needs of clients including, but not limited to, bowel and bladder training;

(iv) Uses appropriate body mechanics when working with client;

(v) Understands advance directives and do-not-resuscitate orders, and the nursing assistant's role implementing them;

(vi) Measuring vital signs, height and weight, fluid and food intake and output;

(vii) Developmental tasks associated with developmental and age specific processes;

(viii) Use and care of prosthetic devices;

(ix) Provision of adequate ventilation, warmth, light, and quiet for the client;

(x) Principles of good body mechanics for self and clients to lift and move clients or heavy items;

(xi) Achieving competence in reading, writing, speaking and understanding English at the level necessary to:

(A) Use terminology accepted in health care settings; and
(B) Accurately record and report observations, actions and information in a timely manner.
(xii) The scope of practice of nursing assistant-certified;
(xiii) The workers right to know law; and
(xiv) The Uniform Disciplinary Act, including RCW 18.130.180.

NEW SECTION

WAC 246-842-520 Medical assistant-certified alternative program requirements. The commission may approve alternative programs for individual medical assistant-certified to successfully complete in order to qualify to take the nursing assistant-certified competency evaluation.

(1) An alternative program shall meet the requirements of WAC 246-842-400 through 246-842-430 and 246-842-450 through 246-840-500.
(2) The curriculum content shall include:
(a) Observing and reporting client pain;
(b) Demonstrates health care team member skills including time management and prioritizing work;
(c) Demonstrates knowledge about methods for meeting the elimination needs of clients including, but not limited to, bowel and bladder training;
(d) Uses appropriate body mechanics when working with client;
(e) Understands advance directives and do-not-resuscitate orders, and the nursing assistant's role implementing them;
(f) Measurement of fluid and food intake and output;
(g) Participation in planning and nursing reporting process;
(h) Bathing, oral care, and skin care;
(i) Personal care tasks, appropriate to chronological age and developmental stage of clients;
(j) Grooming and dressing;
(k) Toileting;
(l) Eating and hydration, including:
(i) Techniques to prevent choking and aspiration.
(ii) Health and sanitation in food services.
(iii) Basic restorative services.
(iv) Use of assistive devices in ambulation, transferring, eating and dressing.
(v) Range of motion.
(vi) Turning and positioning.
(vii) Transferring and ambulating.
(viii) Use and care of prosthetic devices.
(ix) Client rights and promotion of independence.
(x) Assistance in getting to and joining in activities appropriate to chronological age of client.
(xi) Respect for client's property.
(xii) Use of restraints and acknowledgment of agency policies that may apply to restraints.
(xiii) An environment with adequate ventilation, warmth, light, and quiet.
(xiv) Rules and regulations, including:
(A) The scope of practice, nursing assistant-certified.
(B) The workers right to know law.

(C) The Uniform Disciplinary Act, including RCW 18.130.180.

NEW SECTION

WAC 246-842-600 Medication assistant endorsement purpose. (1) WAC 246-841-587 through 246-841-595 apply to the endorsement of a nursing assistant-certified as a medication assistant. A nursing assistant-certified with a medication assistant endorsement administers medications and nursing commission-approved treatments to residents in nursing homes, under the direct supervision of a designated registered nurse.

(2) Nothing in these rules requires a nursing home to employ a nursing assistant-certified with a medication assistant endorsement. A medication assistant's employer may limit or restrict the range of functions permitted in these rules but may not expand those functions.

(3) A medication assistant is responsible and accountable for his or her specific functions.

NEW SECTION

WAC 246-842-610 Requirements for approval of education and training programs. (1) A medication assistant endorsement education and training program must:

(a) Be a nursing commission-approved nursing assistant-certified training program in good standing; or

(b) Be a nursing commission-approved nursing educational program in good standing; and

(c) Have a program director and instructional staff who each hold an active, Washington state registered nursing license in good standing, free from any license discipline for at least three years. Program directors and instructional staff shall not have any findings entered against them that limits their ability to work with vulnerable adults.

(2) To apply, the program must submit a completed application packet and application forms provided by the department of health to the nursing commission. The packet must include:

(a) Program objectives;

(b) Curriculum outline and content as detailed in subsection (6) of this section;

(c) Written contractual agreements related to the provision of the training. For any program that uses another facility for the clinical practicum, this includes an affiliation agreement between the training program and the facility. "Clinical practicum" means clinical experience under the supervision of a qualified registered nurse instructor. The affiliation agreement must describe how the program will provide clinical experience in the facility. The agreement must specify the rights and responsibilities of students, residents, clinical facility, and school;

(d) Sample lesson plan for one unit;

(e) Skills checklists for student skills lab performance and clinical performance during the practicum with dates of skills testing and signature of the instructor;

(f) Description of classroom, skills lab, and clinical practicum facilities;

(g) Declaration of compliance with administrative guidelines signed by the program director;

(h) Verification that the program director has completed a course on adult instruction and has one year of full-time equivalent experience in the past three years teaching adults. Acceptable experience does not include patient teaching. A program director working exclusively in post-secondary educational setting is exempt from this requirement; and

(i) Verification that the medication assistant training program or school is approved to operate in the state of Washington by the state board for community and technical colleges; the superintendent of public instruction; the workforce training and education coordinating board; or the department of social and health services.

(3) Failure to submit a complete application packet within forty-five days will result in closure of the application.

(4) The program director or designee shall:

(a) Allow and cooperate with on-site surveys and investigations of the training programs, as requested by the nursing commission.

(b) Comply with any changes in training standards and guidelines in order to maintain approved status.

(c) Notify the nursing commission and any other approving agency of anticipated changes in overall curriculum plan or curriculum content prior to implementation such as changes in program hours, clinical practice facilities, program name or ownership, legal status, and credit status impacting the program's ability to sustain itself financially; approval must be received from the nursing commission prior to implementation.

(d) Notify the nursing commission and any other approving agency of changes in program director or instructors, ensuring that program directors and instructors meet the requirements in this section; and

(5) Core curriculum competency requirements.

(a) The program curriculum must include training on the specific tasks that a medication assistant may perform as well as training on identifying tasks that may not be performed by a medication assistant as listed in WAC 246-841-589.

(b) The program curriculum must include the complete medication assistant-certified model curriculum adopted by the National Council of State Boards of Nursing. The education and training program may add to the required curriculum as stated in these rules but may not delete any content from the required curriculum.

(c) The curriculum must include a minimum of sixty hours of didactic training which must include work in a skills lab or simulation facility.

(6) Clinical practicum. The curriculum will include a minimum of forty hours of supervised and progressive clinical practicum in the administration of medications to residents in a nursing home. At no time will the ratio of students to instructor be allowed to exceed ten students to one instructor during clinical practicum.

(7) Students must demonstrate achievement of curriculum objectives, including competency in all curricular aspects of medication administration, in order to complete the course successfully.

(8) The program director must attest to the student's successful completion of the course on forms or electronic methods established by the commission.

NEW SECTION

WAC 246-842-620 Medication assistant endorsement program renewal. (1) Programs must submit a renewal application on the forms provided by the commission and be approved by the commission every two years. The renewal application is due ninety days before the two-year anniversary of the date approval was originally granted.

(2) Commission approval is automatically terminated if the program does not renew.

(3) The commission may deny the renewal application or grant renewal with provisional status if the program fails to substantially meet the standards contained in the law and this chapter or has pending a statement of deficiencies, plan of correction, intent to withdraw approval, or withdrawal of approval.

(4) If a program application renewal is not completed within ninety days of its receipt, the commission may close the application renewal.

NEW SECTION

WAC 246-842-700 Closure of an approved training program. (1) When an approved nursing assistant-certified training program, alternative "bridge" nursing assistant training program, or medication assistant endorsement training program closes, it shall notify the commission in writing.

(2) The nursing assistant, nursing assistant alternative "bridge," or medication assistant training program may continue until the last class enrolled is graduated if:

(a) The nursing assistant program continues to meet the standards for approval, WAC 246-841-400 through 246-842-720 until all of the enrolled students have completed the program;

(b) The date of closure is the date on the certificate of the last graduate; and

(c) The governing institution notifies the commission in writing of the closing date.

NEW SECTION

WAC 246-842-710 Commission review and investigation. The nursing commission may conduct a review or investigation of a nursing assistant-certified training program, alternative "bridge" nursing assistant training program, or medication assistant endorsement training program, and/or conduct a site visit of the training facility to evaluate:

(1) Complaints or information relating to potential violations of the rules.

(2) Whether the program or program staff have provided false or misleading information to students or the public concerning the nursing assistant education and training program or the medication assistant education and training program.

(3) Whether the program has failed to secure or retain adequate staff to provide quality supervision and teaching.

(4) Whether the program has failed to notify students when there has been a change in the program's current approval status.

(5) Whether the program has failed to provide students with information in written format that is accurate, fair and complete.

(6) Whether the program has failed to provide accurate and complete information on the state approved nursing assistant certification exam.

(7) Factors that may be contributing to program pass rates below eighty percent for first time test takers.

NEW SECTION

WAC 246-842-720 Denial of approval. (1) Commission approval is automatically withdrawn for programs that do not renew.

(2) The commission may deny approval of an additional program to an existing program if the existing program is not in good standing.

(3) The commission may deny approval of a new program if the program owner or director has owned or directed any program in the last year that has been issued a statement of deficiencies, been on conditional approval, or has had program approval withdrawn.

NEW SECTION

WAC 246-842-730 Pass rate standards for approved programs. (1) First time test takers are individuals who have:

(a) Completed an approved (or conditionally approved) program; and

(b) Taken the written (or oral) examination and the skills examination one time, whether or not both examinations were completed on the same day.

(2) The pass rate standard for approved (and conditionally approved) programs is eighty percent of first time test takers.

(3) Pass rates for programs will be calculated annually for the previous calendar year as follows: The total number of first time test takers who passed both examinations, divided by the total number of first time test takers.

NEW SECTION

WAC 246-842-735 Required pass rates. (1) If a nursing assistant education and training program:

(a) Fails to maintain an average passing rate of eighty percent of first time test takers for two consecutive years, the commission may require the program to assess the problem and submit a plan of correction.

(b) Fails to maintain an average passing rate of eighty percent of first time test takers for three consecutive years, the commission may require the program to complete an assessment of possible problem areas within six months, and the commission may conduct an evaluation visit. The commission may offer technical assistance.

(c) Fails to maintain an average passing rate of eighty percent of first time test takers for four out of five consecutive years, the commission may place the program on conditional approval and require an evaluation visit.

(d) Fails to maintain an annual average passing rate of eighty percent of first time test takers for five consecutive years, the nursing commission may withdraw program approval.

(2) If a medication assistant education and training program:

(a) Fails to maintain an average annual passing rate of eighty percent of first time test takers for two consecutive years, the nursing commission will require the program to assess the problem and submit a plan of correction.

(b) Fails to maintain an annual average passing rate of eighty percent of first time test takers for three out of four consecutive years, the nursing commission may withdraw program approval.

NEW SECTION

WAC 246-842-740 Commission action for violations. (1) When the nursing commission determines that a nursing assistant education and training program or medication assistant education and training program fails to meet the requirements in this chapter, the nursing commission may issue a statement of deficiencies, place the program on conditional approval, or withdraw approval from an existing program or deny approval of a new program.

(2) Statement of deficiencies:

(a) Within ten calendar days of notification of the cited deficiencies, the program must prepare, sign, date, and provide to the commission a detailed written plan of correction. Such plan of correction will provide notification to the commission of the date by which the program will complete the correction of cited deficiencies. The commission will review the program's plan of correction to determine if it is acceptable. A plan of correction must:

(i) Address how corrective action will be accomplished;

(ii) Address what measures will be put into place or systematic changes made to assure that the deficient practice will not recur;

(iii) Indicate how the program plans to monitor its performance to assure that solutions are sustained;

(iv) Give the name and title of the person who is responsible for assuring the implementation of the plan of correction;

(v) Give the day by which the correction will be made.

(b) The commission will verify that the plan has been implemented.

(3) Conditional approval:

(a) The commission may place a program on conditional approval if it determines that a program fails to substantially meet the standards contained in chapter 18.88A RCW and this chapter.

(b) Within ten days of being placed on conditional approval, the program shall submit a plan of correction detailing how it will come into compliance with the requirements of this chapter. The commission shall set a deadline for compliance with this chapter.

(4) Withdrawal of approval. The commission may withdraw approval from a program if it determines that the program fails to substantially meet the standards contained in the law and this chapter.

(a) When the commission withdraws approval, the program shall submit a plan for enrolled students to complete their educational program.

(b) The withdrawal of approval may include conditions that must be met prior to the program's petition for reinstatement.

(5) Denial of approval. The commission may deny approval to a program if it determines that the program fails to substantially meet the standards contained in the law and this chapter.

(6) The commission's action to place a program on conditional approval, to withdraw approval, or deny approval is final twenty days after service if not appealed, or upon the issuance of an order affirming the action after an adjudicative proceeding.

NEW SECTION

WAC 246-842-750 Reinstatement of approval. (1) The nursing commission shall consider reinstatement of a nursing assistant education and training program or medication assistant education and training program upon submission of satisfactory evidence that the program meets the requirements as contained in these rules, and any additional conditions imposed in the withdrawal.

(2) Upon review of the program's request for reinstatement and review of evidence submitted, the commission may grant reinstatement with full or conditional approval, or may deny reinstatement to the program.

(3) A program that is automatically terminated for failure to renew may be immediately reinstated upon meeting all requirements for a new program.

NEW SECTION

WAC 246-842-760 Appeal rights. When the commission places a program on conditional approval, withdraws approval, or denies approval, the program has the right to an adjudicative proceeding to appeal the nursing commission's decision according to the provisions of chapters 18.88A and 34.05 RCW, the Administrative Procedure Act, Parts IV and V.

NEW SECTION

WAC 246-842-770 Grandfathering and time period for changes. (1) Currently approved programs that do not have a curriculum that meets the requirements of this chapter must have a new curriculum approved and in place by October 1, 2018. Failure to have an approved curriculum in compliance with this chapter in place by October 1, 2018, will result in a withdrawal of approval.

(2) Except as otherwise provided, approved programs must have all changes needed for compliance with these rules approved and implemented by July 1, 2017.

(3) Instructional staff who were approved prior to the implementation of these rules may be deemed to meet the educational and experience requirement listed in WAC 246-842-420 at the program(s) for which approval was granted. To teach in a different program, an instructor must meet current requirements.

(4) Program directors who were approved prior to the implementation of these rules may be deemed to meet the educational and work experience requirement listed in WAC 246-842-420 at the program(s) for which approval was granted, except that program directors must have completed the adult education course as required in WAC 246-842-420. To direct in a different program, a program director must meet current requirements.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 246-842-100	Standards of practice and competencies of nursing assistants.
WAC 246-842-110	Purpose of review and approval of nursing assistant training programs.
WAC 246-842-120	Requirements for nursing assistant training program approval.
WAC 246-842-130	Denial of approval or withdrawal of approval for programs for which the board is the approving authority.
WAC 246-842-140	Reinstatement of approval.
WAC 246-842-150	Appeal of board decisions.
WAC 246-842-160	Closing of an approved nursing assistant training program.
WAC 246-842-170	Program directors and instructors in approved training programs.
WAC 246-842-190	Core curriculum in approved training programs.
WAC 246-842-200	Physical resources for approved education programs.
WAC 246-842-210	Administrative procedures for approved nursing assistant training programs.

AMENDATORY SECTION (Amending WSR 00-01-186, filed 12/22/99, effective 1/22/00)

WAC 246-840-730 Mandatory reporting. ((~~Mandatory reporting assists the nursing care quality assurance commission (nursing commission) in protecting the public health and safety through the discovery of unsafe or substandard nursing practice or conduct. These rules are intended to define the information that is to be reported and the obligation of nurses and others to report.~~

~~The nursing commission does not intend every minor nursing error to be reported or that mandatory reporting serve as a substitute for employer-based disciplinary action.~~

~~**Who must make reports and what must be reported to the nursing commission?**~~

~~(1) Any person, including, but not limited to, registered nurses, practical nurses, advanced registered nurse practitioners, health care facilities and governmental agencies shall always report the following, except as provided for in subsections (2) and (3) of this section:~~

~~(a) Information that a nurse may not be able to practice with reasonable skill and safety as a result of a mental or physical condition;~~

~~(b) Information regarding a conviction, determination or finding, including employer-based disciplinary action, that a nurse has committed an act that would constitute unprofessional conduct, as defined in RCW 18.130.180, including violations of chapter 246-840 WAC, including, but not limited to:~~

~~(i) Conviction of any crime or plea of guilty, including crimes against persons as defined in chapter 43.830 RCW [RCW 43.43.830], and crimes involving the personal property of a patient, whether or not the crime relates to the practice of nursing;~~

~~(ii) Conduct which leads to dismissal from employment for cause related to unsafe nursing practice or conduct in violation of the standards of nursing;~~

~~(iii) Conduct which reasonably appears to be a contributing factor to the death of a patient;~~

~~(iv) Conduct which reasonably appears to be a contributing factor to the harm of a patient that requires medical intervention;~~

~~(v) Conduct which reasonably appears to violate accepted standards of nursing practice and reasonably appears to create a risk of physical and/or emotional harm to a patient;~~

~~(vi) Conduct involving a pattern of repeated acts or omissions of a similar nature in violation of the standards of nursing that reasonably appears to create a risk to a patient;~~

~~(vii) Drug trafficking;~~

~~(viii) Conduct involving the misuse of alcohol, controlled substances or legend drugs, whether or not prescribed to the nurse, where such conduct is related to nursing practice or violates any other drug or alcohol-related nursing commission law;~~

~~(ix) Conduct involving sexual contact with a patient under RCW 18.130.180(24) or other sexual misconduct in violation of nursing commission law under WAC 246-840-740;~~

~~(x) Conduct involving patient abuse, including physical, verbal and emotional;~~

~~(xi) Conduct indicating unfitness to practice nursing or that would diminish the nursing profession in the eyes of the public;~~

~~(xii) Conduct involving fraud related to nursing practice;~~

~~(xiii) Conduct involving practicing beyond the scope of the nurse's license;~~

~~(xiv) Nursing practice, or offering to practice, without a valid nursing permit or license, including practice on a license lapsed for nonpayment of fees;~~

~~(xv) Violation of a disciplinary sanction imposed on a nurse's license by the nursing commission.~~

~~(2) Persons who work in federally funded substance abuse treatment programs are exempt from these mandatory reporting requirements to the extent necessary to comply with 42 C.F.R. Part 2.~~

~~(3) Persons who work in approved substance abuse monitoring programs under RCW 18.130.175 are exempt from these mandatory reporting rules to the extent required to comply with RCW 18.130.175(3) and WAC 246-840-780(3).~~

~~**How is a report made to the nursing commission?**~~

~~(4) In providing reports to the nursing commission, a person may call the nursing commission office for technical assistance in submitting a report. Reports are to be submitted in writing and include the name of the nurse, licensure identification, if available, the name of the facility, the names of any patients involved, a brief summary of the specific concern which is the basis for the report, and the name, address and telephone number of the individual submitting the report.~~

~~(5) Failure of any licensed nurse to comply with these reporting requirements may constitute grounds for discipline under chapter 18.130 RCW.~~

~~**What are the criteria for whistleblower protection?**~~

~~(6) Whistleblower criteria is defined in chapter 246-15 WAC and RCW 43.70.075.~~)) The uniform mandatory reporting rules are found in WAC 246-16-200 through 246-16-270.

AMENDATORY SECTION (Amending WSR 97-13-100, filed 6/18/97, effective 7/19/97)

WAC 246-840-750 Philosophy governing voluntary substance abuse monitoring programs. The nursing care quality assurance commission (commission) recognizes the need to establish a means of ((~~proactively~~)) providing early recognition and treatment options for licensed practical nurses or registered nurses whose competency may be impaired due to the abuse of drugs or alcohol. The commission intends that such nurses be treated and their treatment monitored so that they can return to or continue to practice their profession in a way, which safeguards the public. ((~~To accomplish this the commission shall approve voluntary substance abuse monitoring programs and shall~~)) The Washington health professional services (WHPS) program is the commission's approved substance abuse monitoring program under RCW 18.130.175. The commission may refer licensed practical nurses or registered nurses ((~~impaired by substance abuse to approved programs as an alternative to instituting disciplinary proceedings as defined in~~)) to WHPS as either an alternative to or in connection with disciplinary actions under RCW 18.130.160.

AMENDATORY SECTION (Amending WSR 08-11-019, filed 5/12/08, effective 6/12/08)

WAC 246-840-760 Definitions of terms used in WAC 246-840-750 through 246-840-780. ((~~(1) "Approved substance abuse monitoring program" or "approved monitoring program" is a program the commission has determined meets the requirements of the law and the criteria established by the commission in WAC 246-840-770. The program enters into a contract with nurses who have substance abuse problems regarding the required components of the nurse's recovery activity and oversees the nurse's compliance with these requirements. Substance abuse monitoring programs do not provide evaluation or treatment to participating nurses.~~

~~(2) "Contract" is a comprehensive, structured agreement between the recovering nurse and the approved monitoring program wherein the nurse consents to comply with the monitoring program and its required components of the nurse's recovery activity.~~

~~(3) "Approved treatment facility" is a facility approved by the division of alcohol and substance abuse, department of social and health services according to chapter 70.96A RCW or RCW 69.54.030 to provide concentrated alcoholism or drug treatment if located within Washington state. Drug and alcohol treatment programs located out-of-state must be equivalent to the standards required for approval under chapter 70.96A RCW or RCW 69.54.030.~~

~~(4) "Substance abuse" means the impairment of a nurse's professional services by an addiction to, a dependency on, or the use of alcohol, legend drugs, or controlled substances.~~

~~(5) "Aftercare" is that period of time after intensive substance abuse treatment that provides the nurse and the nurse's family with group or individual counseling sessions, discussions with other families, ongoing contact and participation in self-help groups and ongoing continued support of treatment program staff.~~

~~(6) "Nurse support group" is a group of nurses meeting regularly to support the recovery of its members from substance abuse issues. The group provides a confidential setting with a trained and experienced nurse facilitator in which nurses may safely discuss drug diversion, licensure issues, return to work and other professional issues related to recovery.~~

~~(7) "Twelve-step groups" are groups such as alcoholics anonymous, narcotics anonymous, and related organizations based on a philosophy of anonymity, belief in a power outside of oneself, peer group association, and self-help.~~

~~(8) "Random drug screens" are laboratory tests to detect the presence of drugs of abuse in body fluids which are performed at irregular intervals not known in advance by the person to be tested.~~)) (1) "Approved treatment facility" is a facility certified by the division of behavioral health and recovery (DBHR) department of social and health services, according to chapters 388-877 through 388-877B WAC and meeting the defined standards. Drug and alcohol treatment programs located out-of-state must meet equivalent licensing standards.

(2) "Continuing care" means the phase of treatment following acute treatment. Common elements of continuing care include relapse prevention and self-help group participation.

(3) "Monitoring contract" is a comprehensive, structured agreement between the recovering nurse and WHPS defining the requirements of the nurse's program participation.

(4) "Peer support group" is a professionally facilitated support group designed to support recovery and re-entry into practice.

(5) "Random drug screens" means laboratory tests to detect the presence of drugs of abuse in body fluids and other biologic specimens which are performed at irregular intervals not known in advance by the person to be tested.

(6) "Self-help groups" means groups or fellowships providing support for people with substance use disorder to support their sobriety and recovery.

(7) "Substance abuse" or "substance use disorder" means a chronic progressive illness which involves the use of alcohol and/or other drugs to a degree that it interferes in the functional life of the registrant/licensee, as manifested by health, family, job (professional services), legal, financial, or emotional problems.

(8) "Referral contract" is a formal agreement between the commission and the nurse to comply with the requirements of the WHPS program in lieu of discipline.

(9) "Washington health professional services (WHPS)" is the approved substance abuse monitoring program as described in RCW 18.130.175 used by the commission that meets criteria established by the commission. WHPS does not provide evaluation or treatment services.

AMENDATORY SECTION (Amending WSR 97-13-100, filed 6/18/97, effective 7/19/97)

WAC 246-840-770 Approval of substance abuse monitoring programs. ((~~The commission will approve the monitoring program(s) which will participate in the commission's substance abuse monitoring program. A monitoring program approved by the commission may be contracted with an entity outside the department but within the state, out-of-state, or a separate structure within the department.~~

~~(1) The approved monitoring program will not provide evaluation or treatment to the participating nurses.~~

~~(2) The approved monitoring program staff must have the qualifications and knowledge of both substance abuse and the practice of nursing as defined in this chapter to be able to evaluate:~~

~~(a) Clinical laboratories;~~

~~(b) Laboratory results;~~

~~(c) Providers of substance abuse treatment, both individuals and facilities;~~

~~(d) Nurses' support groups;~~

~~(e) The nursing work environment; and~~

~~(f) The ability of the nurse to practice with reasonable skill and safety.~~

~~(3) The approved monitoring program will enter into a contract with the nurse and the commission to oversee the nurse's compliance with the requirements of the program.~~

~~(4) The approved monitoring program may make exceptions to individual components of the contract on an individual basis.~~

~~(5) The approved monitoring program staff will determine, on an individual basis, whether a nurse will be prohibited from engaging in the practice of nursing for a period of time and restrictions, if any, or the nurse's access to controlled substances in the work place.~~

~~(6) The approved monitoring program shall maintain records on participants.~~

~~(7) The approved monitoring program will be responsible for providing feedback to the nurse as to the acceptability of treatment progress.~~

~~(8) The approved monitoring program shall report to the commission any nurse who fails to comply with the requirement of the monitoring program.~~

~~(9) The approved monitoring program shall provide the commission with a statistical report on the program, including progress of participants, at least annually.~~

~~(10) The approved monitoring program shall receive from the commission guidelines~~)) The commission uses WHPS as the approved monitoring program.

(1) WHPS will:

(a) Employ staff with the qualifications and knowledge of both substance abuse and the practice of nursing as defined in this chapter to be able to evaluate:

(i) Clinical laboratories;

(ii) Laboratory results;

(iii) Providers of substance abuse treatment, both individuals and facilities;

(iv) Peer support groups;

(v) The nursing work environment; and

(vi) The ability of the nurse to practice with reasonable skill and safety.

(b) Enter into a monitoring contract with the nurse to oversee the nurse's required recovery activities. Exceptions may be made to individual components of the contract as needed.

(c) Determine, on an individual basis, whether a nurse will be prohibited from engaging in the practice of nursing for a period of time and restrictions, if any, on the nurse's access to controlled substances in the workplace.

(d) Maintain case records on participating nurses.

(e) Report to the commission any nurse who fails to comply with the requirements of the monitoring program as defined by the commission.

(f) Provide the commission with an annual statistical report.

(2) The commission approves WHPS's procedures on treatment, monitoring, and limitations on the practice of nursing for those participating in the program.

AMENDATORY SECTION (Amending WSR 97-13-100, filed 6/18/97, effective 7/19/97)

WAC 246-840-780 Participants entering the approved substance abuse monitoring program must agree to the following conditions. ((~~(1)(a) The nurse shall undergo a complete physical and psychosocial evaluation before entering the approved monitoring program. This evaluation will be performed by health care professional(s) with expertise in chemical dependency. The person(s) performing the evaluation shall not also be the provider of the recommended treatment.~~

~~(b) The nurse shall enter into a contract with the commission and the approved substance abuse monitoring program to comply with the requirements of the program which shall include, but not be limited to:~~

~~(i) The nurse will undergo intensive substance abuse treatment in an approved treatment facility.~~

~~(ii) The nurse will agree to remain free of all mind-altering substances including alcohol except for medications prescribed by an authorized prescriber, as defined in RCW 69.41.030 and 69.50.101.~~

~~(iii) The nurse must complete the prescribed aftercare, which may include individual and/or group psychotherapy.~~

~~(iv) The nurse must cause the treatment counselor(s) to provide reports to the approved monitoring program at specified intervals. Reports shall include treatment prognosis and goals.~~

~~(v) The nurse will submit to random drug screening as specified by the approved monitoring program.~~

~~(vi) The nurse will attend nurses' support groups facilitated by a nurse and/or twelve-step group meetings as specified by the contract.~~

~~(vii) The nurse will comply with specified employment conditions and restrictions as defined by the contract.~~

~~(viii) The nurse shall sign a waiver allowing the approved monitoring program to release information to the commission if the nurse does not comply with the requirements of this contract.~~

~~(c) The nurse is responsible for paying the costs of the physical and psychosocial evaluation, substance abuse treatment, and random drug screens.~~

~~(d) The nurse may be subject to disciplinary action under RCW 18.130.160 if the nurse does not participate in the approved monitoring program, does not comply with specified employment restrictions, or does not successfully complete the program.~~

~~(2) A nurse who is not being investigated by the commission or subject to current disciplinary action or currently being monitored by the commission for substance abuse may voluntarily participate in the approved substance abuse monitoring program without being referred by the commission.~~

~~(a) The nurse shall undergo a complete physical and psychosocial evaluation before entering the approved monitoring program. This evaluation will be performed by health care professional(s) with expertise in chemical dependency. The person(s) performing the evaluation shall not also be the provider of the recommended treatment.~~

~~(b) The nurse shall enter into a contract with the approved substance abuse monitoring program to comply with the requirements of the program which shall include, but not be limited to:~~

~~(i) The nurse will undergo intensive substance abuse treatment in an approved treatment facility.~~

~~(ii) The nurse will agree to remain free of all mind-altering substances including alcohol except for medications prescribed by an authorized prescriber as defined in RCW 69.41.030 and 69.50.101.~~

~~(iii) The nurse must complete the prescribed aftercare program of the intensive treatment facility, which may include individual and/or group psychotherapy.~~

~~(iv) The nurse must cause the treatment counselor(s) to provide reports to the approved monitoring program at specified intervals. Reports shall include treatment prognosis and goals.~~

~~(v) The nurse will submit to random drug screening as specified by the approved monitoring program.~~

~~(vi) The nurse will attend nurses' support groups facilitated by a nurse and/or twelve-step group meetings as specified by the contract.~~

~~(vii) The nurse will comply with employment conditions and restrictions as defined by the contract.~~

~~(viii) The nurse shall sign a waiver allowing the approved monitoring program to release information to the commission if the nurse does not comply with the requirements of this contract.~~

~~(c) The nurse is responsible for paying the costs of the physical and psychosocial evaluation, substance abuse treatment and random drug screens.~~

~~(3) The treatment and pretreatment records of license holders referred to or voluntarily participating in approved monitoring programs shall be confidential, shall be exempt from RCW 42.17.250 through 42.17.450, and shall not be subject to discovery by subpoena or admissible as evidence except for monitoring records reported to the disciplinary authority for cause as defined in subsections (1) and (2) of this section. Records held by the commission under this section shall be exempt from RCW 42.17.250 through 42.17.450 and shall not be subject to discovery by subpoena except by the license holder.~~)) (1) To participate in the substance abuse monitoring program, the nurse must:

(a) Undergo a complete substance use disorder evaluation. This evaluation will be performed by health care professional(s) with expertise in chemical dependency.

(b) Enter into a monitoring contract with WHPS which includes, but is not limited to, the following terms, which require the nurse to:

(i) Undergo any recommended level of treatment in an approved treatment facility, including continuing care;

(ii) Abstain from all mind-altering substances including alcohol and cannabis except for medications prescribed by an authorized prescriber, as defined in RCW 69.41.030 and 69.50.101;

(iii) Cause the treatment counselor(s) to provide reports to the approved monitoring program at specified intervals;

(iv) Attend peer support group and/or self-help group meetings as specified by WHPS;

(v) Complete random or for-cause drug screening as specified by WHPS;

(vi) Comply with specified employment conditions and restrictions as defined by the monitoring contract;

(vii) Agree in writing to allow WHPS to release information to the commission if the nurse does not comply with any contract requirements or is unable to practice with reasonable skill and safety;

(viii) Pay the costs of any required evaluations, substance abuse treatment, peer support group, random drug screens, and other personal expenses incurred in relation to the monitoring program;

(ix) Sign any requested release of information authorizations.

(2) When referred to WHPS in lieu of discipline, the nurse must enter into a referral contract with the commission. The commission may take disciplinary action against the nurse's license under RCW 18.130.160 based on any violation by the nurse of the referral contract.

(3) A nurse may voluntarily participate in WHPS in accordance with RCW 18.130.175(2) without first being referred to WHPS by the commission.

BILL REQUEST - CODE REVISER'S OFFICE

BILL REQ. #: Z-0139.1/17

ATTY/TYPIST: AL:akl

BRIEF DESCRIPTION: Concerning the health professions account.

AN ACT Relating to the health professions account; and amending RCW 43.70.320.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 43.70.320 and 2015 c 70 s 39 are each amended to read as follows:

(1) ((~~There is created in the state treasury an account to be known as~~)) The health professions account is hereby established in the custody of the state treasurer. All fees received by the department for health professions licenses, registration, certifications, renewals, or examinations and the civil penalties assessed and collected by the department ((~~under RCW 18.130.190 shall be forwarded to the state treasurer who shall credit such moneys to~~)) must be deposited in the health professions account. Only the secretary or the secretary's designee may authorize expenditures from the account. The account is subject to the allotment procedures under chapter 43.88 RCW, but an appropriation is not required for disbursements from the account.

(2) All expenses incurred in carrying out the health professions licensing activities of the department and implementing and administering the medical marijuana authorization database established in RCW 69.51A.230 shall be paid from the account ((~~as~~

~~authorized by legislative appropriation, except as provided in subsection (4) of this section~~)). Any ((~~residue~~)) residual funds in the account shall be accumulated and shall not revert to the general fund at the end of the biennium.

(3) The secretary shall ((~~biennially prepare~~)) annually submit a ((~~budget request based on the anticipated costs of administering the health professions licensing activities of the department which shall include the estimated income from health professions fees~~)) report to the governor and legislature by December 31st each year that includes:

(a) An executive summary;

(b) Cumulative revenue, including estimates versus actuals; and

(c) Expenditures versus revenue and projected fund balances for each health profession.

(4) The secretary shall, at the request of a board or commission as applicable, ((~~spend unappropriated~~)) allocate funds ((~~in~~)) from the health professions account ((~~that are allocated~~)) to the requesting board or commission to meet unanticipated costs of that board or commission ((~~when revenues exceed more than fifteen percent over the department's estimated six-year spending projections for the requesting board or commission. Unanticipated costs shall be limited to spending as authorized in subsection (3) of this section for anticipated costs~~)).

(5) Funds may be allocated solely at the secretary's discretion:

(a) For changes to approved biennial allotment amounts greater than either one million dollars or fifteen percent of the board's or commission's fund reserve;

(b) If the total reserve for the health professions account falls below the minimum reserve required by the office of financial management.

--- END ---

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE

Title:	Advanced Registered Nurse Practitioner: Pain Management Specialist – Commission-Approved Credentialing Entities	**Number:**	F06.01TBD
Reference:	Chapter 18.79 RCW Nursing Care Chapter 246-840 WAC Practical and Registered Nursing		
Contact:	Paula R. Meyer, MSN, RN, FRE, Executive Director, NCQAC		
Effective Date:	May 13, 2016TBD		
Supersedes:	Not applicable		
Approved:	**Charlotte Foster, BNS, MHA, RNMargaret Kelly, Chair** **Washington State Nursing Care Quality Assurance Commission**		

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PURPOSE STATEMENT:
The mission of the NCQAC is to protect the public. The purpose of this policy is to identify commission-approved credentialing entities for an advanced registered nurse practitioners (ARNP) who practices as a pain management specialist to recognize competence in the specialty area of practice.

Background

The Pain Management Specialist Rules (WAC 246-840-493) outline the requirement for an ARNP pain management specialist. An ARNP pain management specialist must meet one or more of the following qualifications:

1. A minimum of three years of clinical experience in a chronic pain management care setting
2. Credentialed in pain management by a Washington State NCQAC-approved national professional association, pain association, or other credentialing entity
3. Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years
4. At least thirty percent of the ARNP's practice is the direct provision of pain management care or is in a multidisciplinary pain clinic.

POLICY:

An ARNP must practice within their scope of practice defined by the Washington State laws and regulations, the ARNP's national credentialing body, individual scope of practice, and competencies. The NCQAC recommends ARNPs contacting their credentialing body for

questions related to scope of practice as a pain management specialist. The NCQAC approves the following entities to meet one of the required qualifications for an ARNP pain management specialist:

1. American Society for Pain Management Nursing® Advanced Practice Pain Management Nurse
    a. Hold an advanced practice registered nurse (APRN) license or advanced practice nursing position
    b. Possess current entry-level American Nurses Credentialing Center Pain Management Nursing Certification (RN-BC)
    c. Hold a Master's, Post-Master's, or Doctorate degree as a Nurse Practitioner, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist, or Certified Nurse Midwife
    d. Work completed to meet eligibility criteria must get completed after achieving APRN status

2. National Board of Certification and Recertification for Nurse Anesthetists Nonsurgical Pain Management (NSPM) Credential Program
    a. Unrestricted licensure as an a registered nurse (RN) and/or APRN
    b. Current full certification as a nurse anesthetist
    c. Two years of nurse anesthesia clinical experience by the time of NSPM application
    d. Actively engaged in nurse anesthesia clinical practice
    e. Meet educational requirements within the immediate four years prior to the application date
    f. Demonstrate clinical competence

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3. Academy of Integrative Pain Management (AIPM) – American Academy of Pain Management (AAPM)
    a. Licensed as an advanced practice registered nurse in good standing
    b. Two years of clinical experience accumulated after residency
    c. Master's or doctoral degree in a relevant medical field
    d. Completed fifty hours of continuing medical education related to pain management within the last two years
    ~~f.~~e. Be currently practicing in a clinical setting

The NCQAC does not maintain documentation of pain management certificates or identify an ARNP as a pain management specialist.

SBAR – Exploring Options for ARNPs in Retirement

October 21, 2016

Situation:

It is not legal for a Nurse Practitioner (NP) or ARNP in Washington State to call themselves as such, in retirement.

Background:

- Both the title of ARNP and Nurse Practitioner (NP) are protected in Washington State, requiring an active license for use.
- Currently ARNPs in Washington State must meet four requirements for renewal of their license (WAC 246-840-360)
    - (a)Hold an active Washington State RN license
    - (b)Current certification from a certifying body as identified in WAC 246-840-302
    - (c)Obtain 30 contact hours of CE during the renewal period and
    - (d)Attest to practicing at least 250 hours in advanced clinical practice for each ARNP designation within the two-year licensing renewal cycle
- ARNPs must renew their national certification every five years
- The American Nurse Credentialing Center – ANCC (largest NP certifying body) recently revised their renewal options and no longer requires practice hours to maintain certification. This for the first time allows the option that ARNPs in Washington State may maintain their national certification without active practice.
- Physicians in Washington State do not have a practice requirement.
- As such, physicians in Washington State have the option of maintaining their medical license, in retirement, if they so choose, by obtaining CE hours.
- The impact upon the ARNP and NP profession, when senior members are not allowed to maintain their identity as such throughout their lives, is likely significant.

Assessment:

The fact that ARNPs in Washington are stripped of their self-identified title of NP or ARNP in retirement, due to lack of practice hours, is inconsistent with current ANCC certification requirements and our physician colleagues in Washington State.

Plan:

Propose that the AP Subcommittee, in an attempt to remain consistent with ANCC renewal requirements and parity with our physician colleagues, consider opening the ARNP rules and remove subsection "c" from WAC 246-840-360. Thereby eliminating the 250 hrs in advanced clinical practice for each ARNP designation currently required for ARNP License Renewal. This option would allow ARNPs in Washington State who choose to maintain an active RN license (meeting continuing competency requirements), maintain national board certification, and obtain 30 CE hours to maintain their license and identity as an ARNP or Nurse Practitioner into retirement.

And

Propose the creation an "ARNP-Retired" designation for ARNPs in Washington State who, in their retirement, do to wish to maintain an active ARNP license.

FYI: ANCC Retirement Option:

Benefits
The Retired Certified Nurse Recognition grants adapted use of certification credentials to include the addition of – Retired. For example: RN-BC—Retired or FNP-BC—Retired. The retired credential may only be used on business cards, a curriculum vitae or resume. The credential may not be used on patient charts or records, professional name badges, or after a signature.

Retired certified nurses who qualify also receive a congratulations letter, wall certificate and a complimentary coffee mug with the ANCC logo.

Eligibility
To quality for retired recognition, you must:

- *Be retired from nursing with no plans to return to active nursing practice*
- *Hold a current, unrestricted RN license at the time of retirement*
- *Be certified in good standing with ANCC*
- *Submit an application up to one year after the expiration of your latest ANCC certification renewal date.*

If you wish to re-certify after obtaining retired status, you must meet all current certification eligibility requirements at that time. The retired credential may not be used for any licensing requirements for advanced practice nurses.

Apply Now!
Download Retired Certified Nurse Application [pdf]

Fee
This is a one-time (not annual) fee.

Regular/Nonmember	*$100*
American Nurses Association Members	*$ 75*

Department of Health

Midwifery Program

Advisory Opinion

The Washington State Department of Health Midwifery Program issues this advisory opinion in accordance with WAC 246-834. An advisory opinion adopted by the Secretary of Health is an official opinion about safe midwifery practice. The opinion is not legally binding and does not have the force and effect of a duly promulgated regulation or a declaratory ruling by the Secretary.

Title:	Guidelines for Licensed Midwives Who Use Birth Assistants	**Number:**	**3.1**
Reference:	RCW 18.50, WAC 246-834		
Contact:	Kathy Weed, Program Manager 360-236-4883, kathy.weed@doh.wa.gov		
Effective Date:	September 13, 2016		
Supersedes:	NA		
Approved:	Washington State Department of Health Midwifery Program		

Purpose Statement

According to Washington law, a licensed midwife (LM) may render medical aid for a fee or compensation to a woman during prenatal, intrapartum, and postpartum stages or to her newborn up to two weeks of age.

The purpose of this guideline is to prevent licensed midwives from aiding and abetting the unlicensed practice of midwifery. This guideline was created because of the absence of formal rules identifying appropriate duties and activities for a licensed midwife in contrast with an unlicensed, unpermitted birth assistant. These guidelines address normal, non-emergent midwifery care.

Definitions for Terms Used In This Document

Assess: evaluate or estimate the true nature, ability or quality of.

Assist: to give help.

Birth assistant: any unlicensed, unpermitted individual who attends births with a

licensed midwife and acts as a compensated assistant. This definition does not include midwifery students enrolled in a state approved program, an individual such as a father or family member participating in a birth event, or any other duly licensed individual who works at a birth.

Compensated: means some form of payment by a licensed midwife or any other individual and may include non-monetary items.

Direct Supervision: A supervisor must be physically present on site and available to intervene when a birth assistant performs any clinical care task at a birth and during immediate postpartum care.

Licensed Midwife: an individual who is licensed as a midwife in Washington.

Monitor: to remind, advise or warn; observe and regulate.

Obtain: get, acquire, or secure.

Support: give assistance to; enable to function or act.

Background and Analysis

The midwife is the primary caregiver for the birthing woman and her baby. The birth assistant takes direction from the midwife and, by law, is not allowed to perform duties that require midwifery licensure.

Administering medication in Washington: several credentialed healthcare professions are authorized to administer medications under the direction or supervision of an appropriately licensed profession. For example, the medical assistant certification requires a minimum of 720 hours of training and a clinical externship of at least 160 hours; and Licensed Practical Nurse and Registered Nurse licensure both require completion of nursing education programs that are a minimum of 60 quarter credits and passage of a national examination.

Licensed midwives are permitted to administer drugs specified in their rule and statute. If a licensed midwife allows their assistant to perform an activity for which they are not licensed, it may be considered aiding and abetting the unlicensed practice of midwifery.

Recommendations

For continuity and consistency statewide for the utilization of birth assistants, the following duties are broken down on those that require licensed midwife judgement and skill and those that are appropriate for a birth assistant.

Duties that are appropriate for a licensed midwife:

- Pre-natal, intrapartum, and post-partum exams
- Assessing maternal vital signs, voiding, fluid intake, eating etcetera

- Assessing fetal heart tones
- Assessment of Apgar scores
- Assessing the newborn transition
- Assessment of fundal height and monitoring of bleeding

Duties that are appropriate for a birth assistant under direct supervision of a licensed midwife:

- Assist with intrapartum and post-partum care
- Provide labor support
- Check layout of supplies for easy access to equipment and medications
- Obtain and report fetal heart tones
- Obtain and report maternal vital signs (blood pressure, temperature, pulse, respirations)
- Ensure warmth and safety of the newborn
- Obtain, report, and record the condition of the newborn
- Check and report on maternal fundus and lochia
- Assist with immediate post-partum care
- Check and report continued activities of mother (bleeding, voiding, fluid intake and eating, maternal adjustment, physical needs etcetera)
- Monitor and support the newborn as directed by LM
- Assist the mother and newborn establish breastfeeding
- Assist with post-partum care until discharge
- Document findings in the health care records

The birth assistant may assist as instructed by and under direct supervision of the licensed midwife. However, birth assistants may not perform the following:

- Pelvic or dilation exams, intravaginal procedures
- Urinary catheterization
- Newborn exams
- Suturing
- Administration of medications
- IV placement

Conclusion

Performing assessments, administering medication, and conducting other higher level clinical functions carries a high risk of harm if not properly trained. The performance of these functions already require a healthcare credential, and should not be performed by birth assistants. A licensed midwife is ultimately responsible for assigning the duties performed by an assistant during a birth. These guidelines will help credential holders avoid aiding and abetting unlicensed practice.

If you have further questions about appropriate utilization of birth assistants please contact the Department of Health Midwifery Program at 360-236-4883.

Department of Health Nursing Care Quality Assurance Commission

Advisory Opinion

The Nursing Care Quality Assurance Commission (NCQAC) issues this advisory opinion in accordance with WAC 246-840-800. An advisory opinion adopted by the NCQAC is an official opinion about safe nursing practice. The opinion is not legally binding and does not have the force and effect of a duly promulgated regulation or a declaratory ruling by the NCQAC. Institutional policies may restrict practice further in their setting and/or require additional expectations to assure the safety of their patient and//or decrease risk.

Title:	Dispensing Medications/Devices for Prophylactic and Therapeutic Treatment of Communicable Diseases and Reproductive Health by Public Health Nurses	*Number:* NCAO TBD
References:	RCW 18.79 Nursing Care WAC 246-840 Practical and Registered Nursing RCW 70.05.070 Local Health Officer - Powers and Duties RCW 70.41.480 Findings - Intent - Authority to Prescribe Prepacked Emergency Medications-Definitions RCW 69.41 Legend Drugs - Prescription Drugs RCW 18.64 Pharmacists	
Contact:	Deborah Carlson, MSN, RN Associate Director of Nursing Practice	
Phone:	(360) 236-4725	
Email:	NursingPracticeConsultation.NCQAC@doh.wa.gov	
Effective Date:	TBD	
Supersedes:	Not Applicable	
Approved By:	Nursing Care Quality Assurance Commission	

Conclusion Statement

The Nursing Care Quality Assurance Commission concludes that a registered nurse (RN) may distribute, deliver, or dispense prescriptive medications/devices for reproductive care and prevention and treatment of communicable diseases according to a written or standing order of an authorized prescriber.

Background

The Nursing Care Quality Assurance Commission received a request to develop an advisory opinion as to whether nurses employed as public health nurses (PHNs) could dispense medications for prophylactic and therapeutic treatment of communicable diseases and reproductive health. PHNs may work in a variety of settings, such as a local health department or local health jurisdiction (LHJ). PHNs play a vital role in disease prevention and treatment including the safe delivery and dispensing of certain medications/devices for:

- Family planning (such as hormonal contraceptives, including emergency contraception, diaphragms, and over-the-counter methods such as condoms, cervical caps, contraceptive sponges); and

- Prophylactic and therapeutic treatment of communicable diseases of patients, including partner treatment (such as tuberculosis and sexually transmitted diseases).

It is a recognized and long-accepted practice for RNs in public health settings to dispense certain medications and devices to public health patients for prevention and treatment following written standing orders. PHNs often operate under standing orders. The Nursing Care Quality Assurance Commission's Standing Orders and Verbal Orders Advisory Opinion provides guidance on standing orders.

The local health officer is responsible for, and authorized to: "control and prevent the spread of any dangerous, contagious, or infectious diseases that may occur within his or her jurisdiction" and "take such measures as he or she deems necessary in order to promote the public health." RCW 70.05.070.

LHJs have established the practice of having nurses administer, deliver, and dispense medications/devices following standing orders to improve the effective and efficient delivery of quality public health services. In the public health context, it is not feasible to have a licensed provider with prescribing authority or a pharmacist at each site, in the patient's home or other outside setting, or for partner treatment, and delayed access to time sensitive treatment would hinder the control of communicable diseases and the prevention of unintended pregnancies. PHNs investigate each case, identify contacts, ensure that each case receives prescribed medication, and ensure that contacts receive appropriate prophylactic medication. The conditions in which these specially trained nurses dispense medications are usually already differentiated or have a high degree of diagnostic certainty.[1]

Several states allow RNs to dispense medication in public health settings, including California, Delaware, Georgia, Maryland, Minnesota, Missouri, North Carolina, and Oregon.

Analysis

The commission may adopt rules or issue advisory opinions in response to questions put to it by professional health associations, nursing practitioners, and consumers in this state concerning the authority of various categories of nursing practitioners to perform particular acts. RCW 18.79.110(1). The Washington state nursing law does not specifically prohibit dispensing by public health nurses. The practice of nursing includes carrying out a medical regimen. RCW 18.79.040. A RN may, at or under the general direction of a licensed physician and surgeon, dentist, osteopathic physician and surgeon, naturopathic physician, optometrist, podiatric physician and surgeon, physician assistant, osteopathic physician assistant, advanced registered nurse practitioner, or midwife acting within the scope of his or her license, administer medications, treatments, tests, and inoculations, whether or not the severing or penetrating of tissues is involved and whether or not a degree of independent judgment and skill is required. Such direction must be for acts which are within the scope of registered nursing practice. RCW 18.79.260. Registered nursing practice also includes the performance of such additional acts requiring education and training that are recognized by the medical and nursing professions as proper and recognized by the commission to be performed by registered nurses. RCW 18.79.240.

[1] Research shows that home dispensing of hormonal contraceptives by RNs may improve women's postpartum contraceptive use and should be explored as an intervention in communities where contraceptives are not easily accessible (Melnick, A., Rdesinki, R, Mario, M., Jacob-Files, E., Gipson, T., Kuyl, M., Dexter, E., and Olds, D.).

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Washington pharmacy laws define "dispensing" to mean "the interpretation of a prescription or order for a drug, biological, or device and, pursuant to that prescription or order, the proper selection, measuring, compounding, labeling, or packaging necessary to prepare that prescription or order for delivery." RCW 18.64.011(11). However, the pharmacy laws do not restrict the scope of authorized practice of any practitioner other than a pharmacist, duly licensed as such under the laws of this state. RCW 18.64.255. And the Legend Drug Act, RCW 69.41.030 does not apply to a practitioner acting within the scope of his or her license whose possession of any legend is in the usual course of business or employment. This exempts any licensed practitioner acting within the scope of his or her license from the law's prohibition of the sale, delivery, or possession of legend drugs. A licensed health practitioner with prescriptive authority may dispense medications or devices directly to a patient under his or her care. Neither the pharmacy law nor the nursing law prohibits a licensed health care practitioner with prescriptive authority from directing a RN to carry out the dispensing process following a standing order.[2]

The commission concludes that it is within the scope of practice of a properly trained registered nurse to administer, deliver, and dispense medications or devices pursuant to an appropriate standing order by a licensed provider with prescriptive authority in public health settings. These guidelines are intended to assist in the issuance and implementation of appropriate standing orders for public health registered nurses.

Recommendations

Nurses are accountable and responsible for providing safe and competent care to their patients. These guidelines provide nurses with information needed to dispense medications or devices safely. Dispensing includes the preparation and transfer of a medication for a patient, taking steps to ensure the pharmaceutical and therapeutic suitability of the medication for its intended use, and taking steps to ensure its proper use. The organization should provide the organizational supports necessary for safe dispensing (e.g. documentation systems, quality assurance and audit, nursing training and competency assessment, supports for safe transport, storage and security of medications, and policies and procedures).

Standard Operating Procedures

Standing operating procedures using the following framework for the dispensing process will improve consistency and quality of work:

1. Receive and validate the prescription or follow standing order;
2. Understand interpret the prescription or standing order;
3. Prepare and label items for use;
    a. Select stock or prepack
    b. Measure or count quality from stock containers (if not using prepack)
    c. Pack and label medication/device
4. Make a final check;

[2] RCW 69.41.030 further provides that a family planning clinic that is under contract with the health care authority may sell, deliver, possess, and dispense commercial prepackaged oral contraceptives prescribed by authorized, licensed, health care practitioners. And RCW 70.41.480 allows a practitioner with prescriptive authority to prescribe and distribute prepackaged emergency medications to patients being discharged from a hospital emergency department during times when community or outpatient hospital pharmacy services are not available within fifteen mile by road, or when in the judgment of the practitioner and consistent with hospital policies and procedures, a patient has no reasonable ability to reach the local community or outpatient pharmacy." These statutes, while specifically allowing dispensing by these clinics, do not prohibit the use of appropriate standing orders.

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5. Record the action taken; and
6. Issue medicine to the patient with clear instructions and advice.

Standing Orders
The standing order should address (at minimum):

1. Name of medication/device;
2. Strength of medication/device (as per age, weight, condition, etc.);
3. Frequency medication/device is to be taken (as per condition, etc.);
4. Exact dosage (as per age, weight, condition, etc.);
5. Quantity of medication/device;
6. Method of administration (as per age or condition, etc.);
7. Permission to refill;
8. Condition for which the medication/device would be dispensed (Example: patient with a positive gonorrhea culture);

Principles
Nurses who dispense meet the following expectations:

1. Nurses dispense medications/devices when it is in the best interest of the patient;

2. Nurses dispense medications/devices only to patients under their care following a written order or a standing order approved by a licensed prescriber with prescriptive authority;

3. Take steps to ensure pharmaceutical and therapeutic suitability:
    a. Review the order for completeness and appropriateness (e.g. drug, dosage, route, and frequency of administration);
    b. Review the patient's medication history (including over-the-counter medications) and other personal health information;
    c. Consider potential drug interactions, contraindications, allergies, therapeutic duplications, and any other potential problems (e.g. adverse reactions);
    d. Use current, evidence-based resources to support their decision making; and
    e. Consider the patient's ability to follow the medication regimen.

4. Take steps to ensure proper labeling of container prepared from stock or pre-packaged medications/devices:
    a. Label the medication/device legibly meeting the prescription labeling requirements. To every box, bottle, jar, tube or other container a label must be affixed with the following:
        i. Patient's name;
        ii. Medication/device name, dosage, route, and (where appropriate) strength;
        iii. Nature of the drug/device;
        iv. Control number
        v. Prescribing provider (provider who signed the prescription or the standing order);
        vi. Directions for use;
        vii. Quantity dispensed;
        viii. Date dispensed;

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ix. Cautionary statements and other relevant factors (if appropriate);
x. Refills authorized (if appropriate);
xi. Initials of the nurse dispensing the medication/device
xii. Name, address, and telephone number of the agency from which the medication/device is dispensed; and
xiii. Required statement, "Warning: State or federal law prohibits transfer of this drug to any person other than the person for whom it was prescribed."

b. Dispense in a child-resistant container as required by federal law unless:
   i. Authorization is received from the prescriber to dispense in a container that is not child-resistant;
   ii. Authorization is obtained from the patient or delegate of the patient to dispense in a container that is not child-resistant;
   iii. Authorization from the patient to use a regular container (non-child resistant) must be verified by signing a statement requesting a non-child resistant container;
c. Hand the medication/device directly to the patient or their delegate;
d. Provide education based on an assessment of the patient's abilities, and level of understanding regarding the medication/device, including:
   i. Purpose of medication/device
   ii. Dosage regime, expected benefits, potential side effects, storage requirements, and instructions required to achieve a therapeutic response; and
   iii. Written information about the medication/device.

<u>Applying the Principles to Practice</u>

1. Perform a patient assessment:
   a. Need for medication/device;
   b. Contraindications (including allergies or sensitivities);
   c. Medical history, medication history, and other pertinent information; and
   d. Ability to follow medication/device regimen.

2. Take action if a dispensing order does not seem to be evidence-based or does not appear to reflect the individual patient characteristics or wishes. Actions could include:
   a. Getting more information from relevant resources or from the patient;
   b. Consulting with a colleague or manager; or
   c. Consulting with the health professional who gave the order.

3. In some situations, it may be more appropriate for a pharmacist to dispense ordered medications/device. In making these decisions, use nursing judgment and consider such things as:
   a. The nurse's competence;
   b. The complexity of the dispensing request;
   c. The complexity of the patient's medication profile;
   d. Access to relevant patient information; and
   e. Access to resources to support decision-making.

4. Take all reasonable steps to identify potential drug interactions and therapeutic duplications.

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5. Affix a properly prepared label to each container or prepack of medications/device. When dispensing using blister packets, attach the label to the envelope or box. Perform a final check review checking the label against the order.

6. Whenever possible, involve pharmacist in dispensing. Pharmacists are experts in safe medication/device dispensing and can help make nurse dispensing safer (for example, by creating labels that provide a template for required information, by providing education to nurses about safe dispensing practices, by reviewing dispensing scenarios with nurse to improve resources, processes, and systems).

7. Medication/device should not be dispensed if in the RN's judgment:
   a. A patient's condition contradicts further medication/device until the nurse has consulted with an authorized prescriber;
   b. The label is inaccurate (for pre-labeled medications/devices) or errors in labeling;
   c. Medication/device is outdated, obviously contaminated, or otherwise compromised; and
   d. Medication/device is improperly stored.

Security, Storage, and Accountability
Dispensing environments must be clean and organized so that dispensing can be performed accurately and efficiently. Stock containers and prepacked medicines must be stored in an organized way and be clearly labeled to ensure safe selection. Records (including invoices or other records necessary to account for the receipt and disposition of the drugs) must be maintained for at least two years. Medications/devices must be stored following the manufacturer's recommendations. Systems must be in place to monitor for expired drugs. The organization should maintain a dispensing record for security, storage, and accountability. Records containing confidential material and should be handled accordingly. Records may be kept using a paper system or electronic record documenting the following:
- Patient's name;
- Name of medication/device (or generic name), name of manufacturer, and lot number;
- Prescriber's name;
- Strength, and dose of the drug;
- Quantity dispensed; and
- Date of dispensing.

Patient Education
The RN should provide the following information to the patient:

- Condition for which the medication/device has been prescribed
- Effects of medication/device, expected and adverse reactions;
- How, when, what, and amount of medication/device to take;
- Other factors as indicated by patient need and type of medication/device;
- Other appropriate interventions as indicated by the assessment; and
- Warning to keep the medication/device out of the reach of children.

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Documentation
Document the following in the patient's record:

- Date;
- Findings of assessment that indicate or contraindicate need for medication/device. In situations where medication/device is not dispensed, document the justification and any consultation.
- Reference to the standing order;
- Name of medication/device dispensed, strength, dose, route, frequency, and amount dispensed; and
- Signature of RN dispensing medication/device.

Conclusion

In conclusion, RNs employed by public health programs may dispense medications/devices for reproductive health and control of communicable diseases under standing orders. The nurse assumes responsibility and accountability and must have the training, knowledge, skills, and abilities, to perform the activity competently.

References

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Dispensing Medications, College of Registered Nurses of British Columbia: https://www.crnbc.ca/Standards/PracticeStandards/Pages/dispensing.aspx

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Summary of Issue

Medication Management in the Home Care Setting by Physical, Occupational, and Speech Therapists

Physical Therapy, Occupational Therapy and Speech and Hearing Boards were contacted by Kaiser Permanente about the scope of practice for PTs, OTs, and SLPs and whether these licensed individuals can provide medication management and perform vital signs in the home setting. Carole Reynolds attended the Board of Hearing and Speech Meeting on 8-19-16.

- American Physical Therapy Association Position Statement - Role of PTs in Medication Management states that PTs should be recognized in the role of medication management (e.g. screening, evaluation, collection of information, identification of adverse events/reactions, and education) in the home.
- Scope of Practice for Therapist Presentation-Quality Insights-Medicare Quality Innovation network=Quality Improvement Organization is a presentation about PTs, OTs, and SLPs – The American Speech Language and Hearing Association has a position statement that supports cross-training of basic patient care skills including routine, frequently provided, easily trainable, low risk procedures such as suctioning patients, monitoring vital signs, and transferring and position patients. Federal regulations do not restrict PT, OT, SLP from performing drug regimen reviews/assessments for potential adverse effects and drug reactions.
- American Occupational Therapy Association states that OT brings expertize to help patients translate "doctor" orders to manageable daily habits and routines-strengthen outcomes related to medication management.
- One of the concerns/issues is in these situations, it appears that the RNs are possibly directing and supervising these individuals re: to this activity and whether RNs have authority to do this and the concept of medication management.
- Home Care Association of Washington (HCAW) has drafted a "Medication Management in the Home" document and is apparently supporting using PTs, OTs, and SLTs in the home setting to perform medication management (apparently the SLTs are doing this now – going through their medications, understanding when they take them, reading them side effects, may be filling medication organizers.
- Summary from HCAW https://hcaw.wildapricot.org/forum/4195608?rid=4195608#4195608

PT, OT and SLP Scope of Practice Issue

HCAW was contacted by DOH to participate in a meeting on July 21st dealing with a letter from Kaiser Permanente Home Health to the Physical Therapy (PT) Board. The PT Board responded by writing a statement that limits the role of the PT regarding medication management. There were great concerns from the home health community that this would limit the ability of PTs to perform their current. Donna Goodwin developed draft guidelines for the PT Board to consider at their August 5th meeting in Bellingham WA. The OT and SLP boards were going to take our concerns into consideration at their next board meetings. Here is a summary of the PT Boards response from an HCAW attendee:-The Board was emphatic that their response was in direct relation to the Kaiser letter and not a global statement about a therapist's scope of practice with medication reconciliation.-They made it clear that they did not want to

specify any specifics to a therapist's scope of practice with medication reconciliation and stated that PTWA, the APTA, and CMS have given us room for interpretation. They were impressed with Donna's summary of Med Rec for Home Health and suggested that HCAW consider sending the Board a formal request to include these guidelines for DOH approval. They were however, pretty specific in saying that they did not want to set apart a specific area of focus (i.e. Home

- Speech-Language Pathology-Minimum Standards of Practice
  http://app.leg.wa.gov/WAC/default.aspx?cite=246-828-105
  This was referenced as to scope of practice allowing review of medications: (1) Case history, including: (c) Review of pertinent medical, pharmacological, social, and educational status.
- There was discussion of nursing delegation rules that limit NAs from administering medications except for community-based and in-home care settings under delegation – The NCQAC does have a statement about RNs or LPNs filling medication organizers. It is very old (2002) and is on our list for review and revision.
  - Medication Organizer Device, Letter from Secretary of Health (PDF)
  - Medication Organizer Device (PDF)

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE

Title:	Washington Health Professional Services Referral Contracts	**Number:**	A49.03
Reference:	RCW 18.130.170; RCW 18.130.180		
Contact:	Mary Dale, Discipline Manager		
Effective Date:			
Supersedes:	September 13, 2013, January 11, 2013		
Approved:			
	Charlotte Foster, BSN, MHA, RN, Chair **Washington State Nursing Care Quality Assurance Commission**		

PURPOSE STATEMENT: The purpose of this procedure is to set up guidelines for management of cases in which the respondent admits to a substance abuse issue and agrees to enter the Washington Health Professional Services Program (WHPS). After review by the Commission, the case may be closed as a unique closure in compliance with policy A20, Substance Abuse Orders.

PROCEDURE

1. During an investigation, the investigator determines whether unprofessional conduct may be the result of substance abuse. The investigator may send a WHPS Referral Contract (Referral Contract) to the respondent immediately if the case meets all of the following criteria:
   - The respondent admits, in writing, to misuse of controlled substances, alcohol, or other drugs.
   - The unprofessional conduct does not rise to the level of "serious misconduct" as identified in NCQAC policy A20.
   - The respondent has not been previously referred to WHPS in lieu of discipline or ordered into the program.

If the respondent has previously participated in WHPS, the file will be referred to the Substance Use and Abuse Team (SUAT) for an evaluation and a recommendation to the Commission.

2. The investigator sends a Referral Contract to the respondent for signature.
   - If the respondent signs the Referral Contract, the investigator immediately forwards the signed Referral Contract to SUAT administrative personnel, and continues with the investigation.
   - If the respondent refuses to sign the Referral Contract, the investigator completes the investigation as usual.

3. The case file is sent to SUAT administrative personnel after the investigation is completed.
   - If the respondent does not have a WHPS contract in place after 45 days, as required by the Referral Contract, the case is taken back to SUAT for recommendation to the Commission.
   - If/when the respondent signs a WHPS contract, and the investigation is complete, the case is presented to the Case Management panel for Unique Closure.
     - If approved for Unique Closure, the original Referral Contract is signed by a CMT panel member or its designee.
   - The Commission considers the case for possible discipline:
     - If the respondent refused to sign the Referral Contract, or
     - If the respondent has not signed a WHPS contract within 45 days of signing the Referral Contract.

If a respondent is in WHPS in lieu of discipline (with a Referral Contract in place) and the respondent is terminated from WHPS, within seven calendar days of receipt of the WHPS closure letter:

- SUAT administrative personnel opens a new complaint in the Integrated Licensing & Regulatory System (ILRS).
- SUAT performs an assessment/triage. Items considered during the triage include:
  - WHPS closure letter
  - Prior investigative report(s)
  - Referral Contract (if any)

SUAT administrative personnel writes a recommendation to the Commission based on the triage notes. The new complaint, including the SUAT recommendation, is given to the NCQAC Complaint Intake to continue with the regular complaint process.

WASHINGTON HEALTH PROFESSIONAL SERVICES REFERRAL CONTRACT

A complaint alleging unprofessional conduct by (Respondent), has been filed with the Nursing Care Quality Assurance Commission (Commission). The Commission has cause to believe that the alleged unprofessional conduct may be linked to substance use and/or abuse.

In consideration for Respondent signing this agreement and entering the Washington Health Professional Services Program (WHPS), the Commission agrees not to take disciplinary action against Respondent's license regarding case file number , provided that Respondent complies with all of the terms and conditions of this Washington Health Professional Services Referral Contract (Referral Contract) and successfully completes the WHPS program.

By signing this Referral Contract, Respondent acknowledges that a breach of this contract may subject Respondent to disciplinary action. Such disciplinary action may be based on the breach of this Referral Contract, the underlying facts contained in case file , or both. Respondent further acknowledges that a finding of unprofessional conduct, if proven, constitutes grounds for discipline under chapter 18.130 RCW, and that any sanction set forth in RCW 18.130.160 may be imposed. Respondent agrees to the admissibility of the evidence contained in case file .

1. Within seven (7) calendar days of Respondent signing this Referral Contract, Respondent must contact WHPS and begin the process of signing a WHPS Monitoring Contract and enrolling in the WHPS program.[1]

2. Within forty-five (45) calendar days of Respondent signing this Referral Contract, Respondent must execute a WHPS Monitoring Contract.

3. The length of the WHPS Monitoring Contract will be at the sole discretion of the WHPS program. Contracts generally have a term of five (5) years. The WHPS program's recommendation to enter into a monitoring contract and the term of the monitoring contract is not based exclusively upon a substance use evaluation.

4. Respondent agrees to comply with <u>all</u> aspects of the WHPS program which may include, but are not limited to:

   (a) undergoing intensive substance use treatment in an approved treatment facility.

   (b) remaining free of all mind-altering substances including alcohol except for medications prescribed by an authorized prescriber, as defined in RCW 69.41.030 and 69.50.101.

[1] Washington Health Professional Services
P.O. Box 47864
Olympia, WA 98504-7864
Phone: 360-236-2880 Fax: 360-664-8588
WHPS@doh.wa.gov

EXAMPLE

(c) completing the prescribed aftercare, which may include individual and/or group psychotherapy.

(d) causing the treatment counselor(s) to provide reports that include treatment prognosis and goals to the WHPS program at specified intervals.

(e) submitting to random drug screening as specified by the WHPS program.

(f) attending recovery support groups as specified by the WHPS program.

(g) complying with specified employment conditions and restrictions as defined by the WHPS Monitoring Contract to include notifying WHPS and receiving approval prior to a change in work status, shift, employment position, or place of employment.

(h) signing a waiver allowing the WHPS program to release information to the Commission if the nurse does not comply with the requirements of the WHPS Monitoring Contract or is unable to practice with reasonable skill or safety.

5. Respondent is responsible for paying all costs associated with participation in WHPS.

6. Respondent shall report to the Commission if he/she fails to comply with this Referral Contract or with his/her WHPS Monitoring Contract.

7. Respondent understands and acknowledges that failure to comply with any and all aspects of the WHPS program breaches this Referral Contract, and may subject Respondent to discipline under RCW 18.130.160, RCW 18.130.180, and WAC 246-840-780. Respondent expressly waives statutory or jurisdictional objections to disciplinary action deriving from a breach of this Referral Contract or the underlying facts contained in case file .

8. The Commission will not sign this Referral Contract or close Respondent's disciplinary case file until Respondent has signed a WHPS Monitoring Contract.

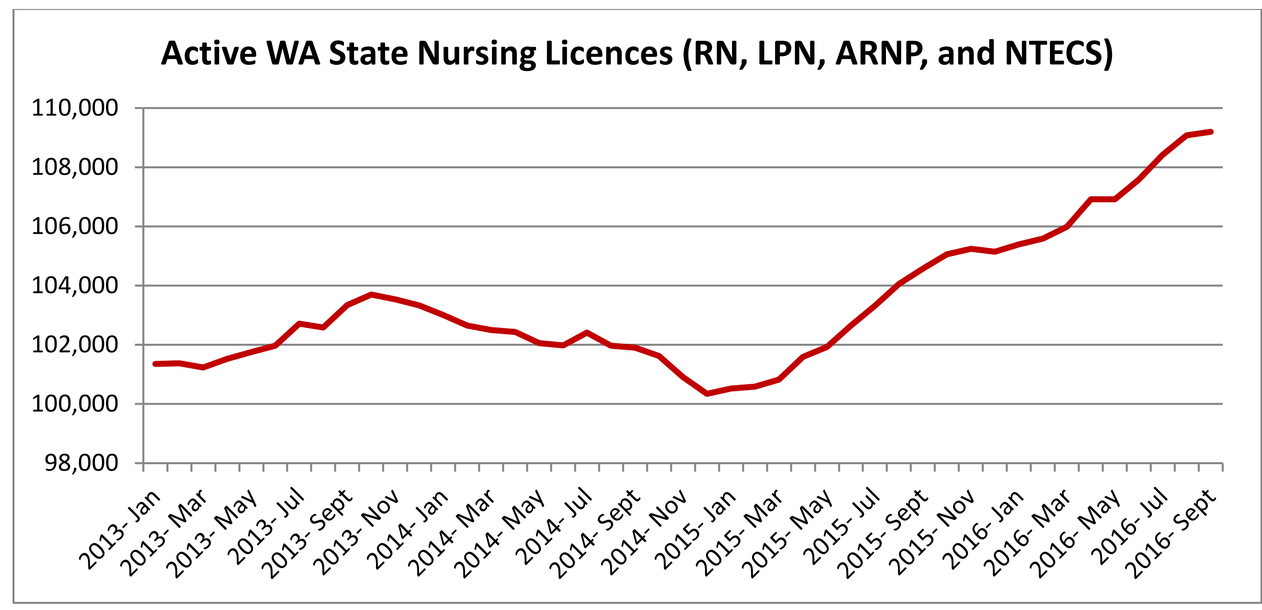
______________________________	__________________	__________________
RESPONDENT	DATE	LICENSE NUMBER
______________________________	__________________	
PANEL CHAIR	DATE	

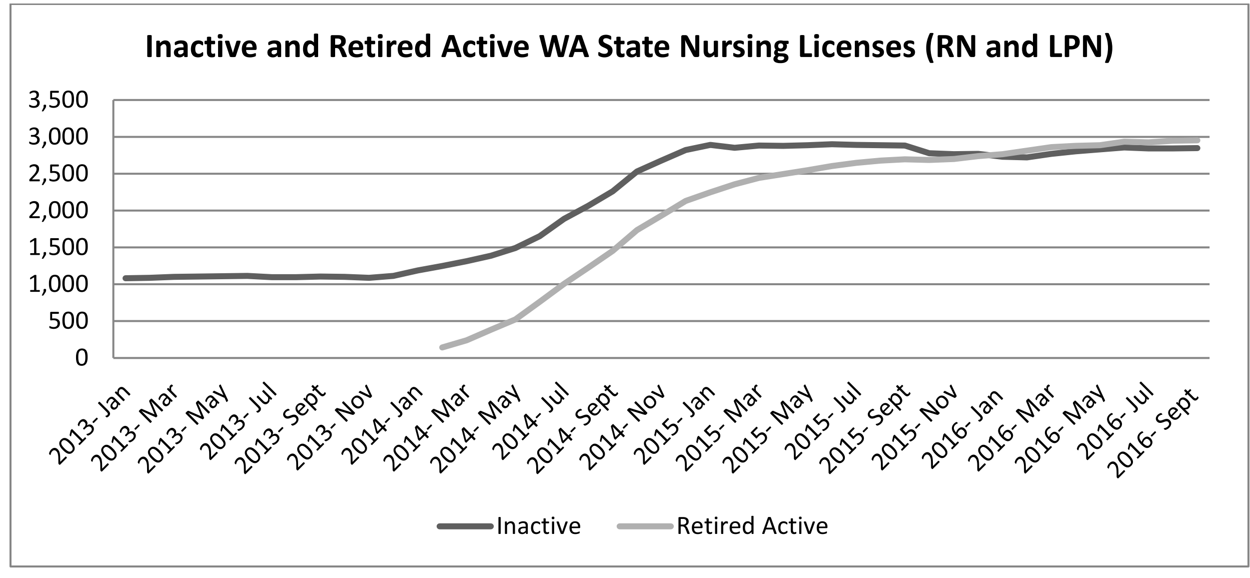
EXAMPLE

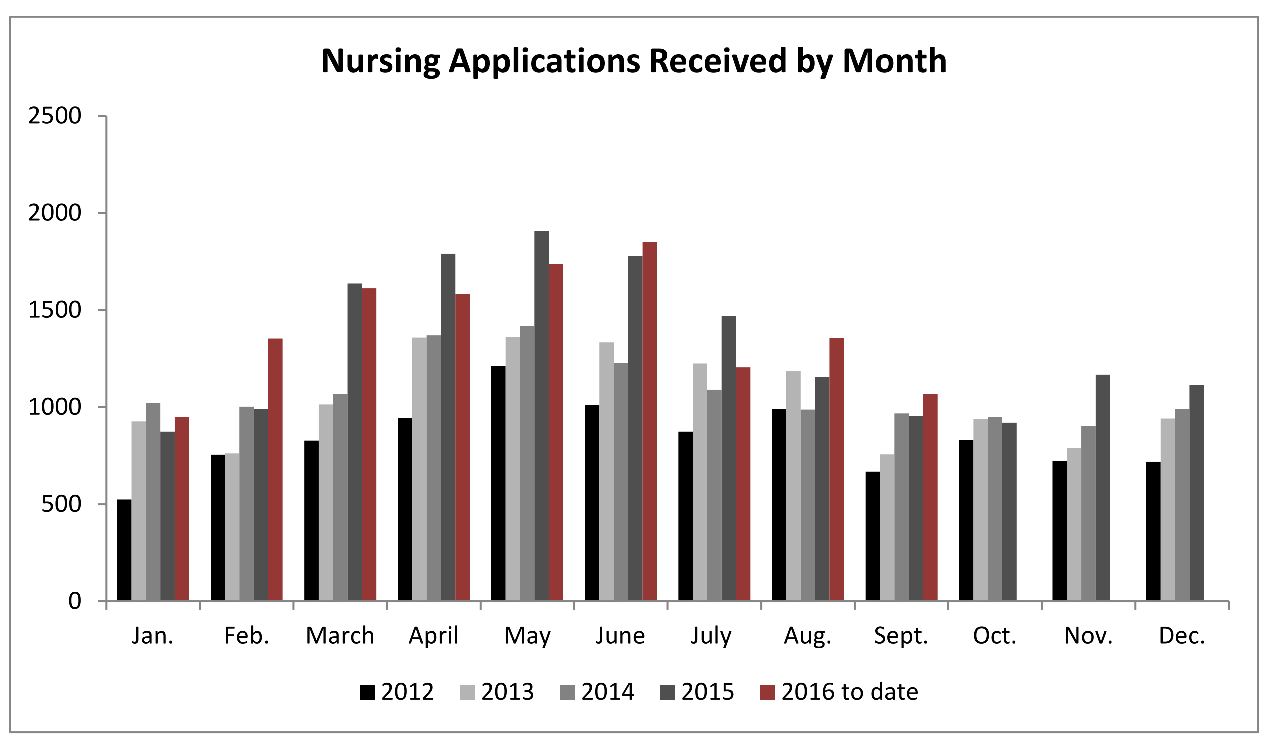
Licensing Subcommittee

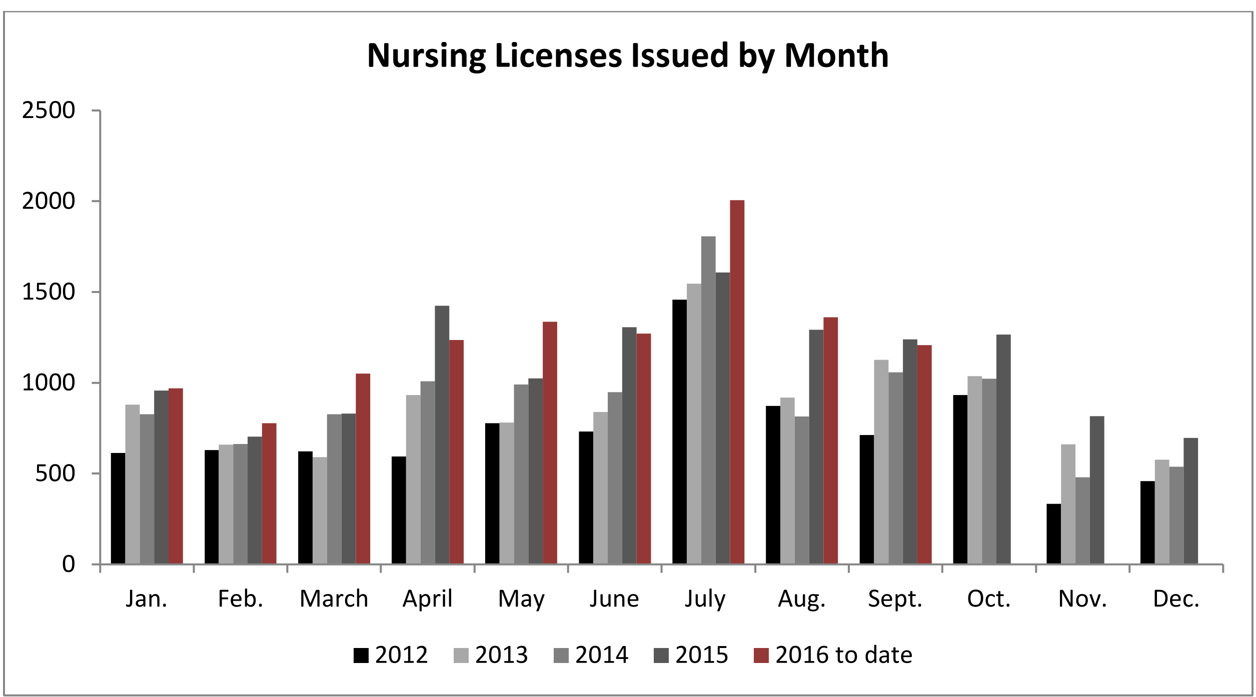
Licensing and Continuing Competency Audits Update

Current Nursing Numbers				
September 2016	Active	Inactive	Military Active	Retired Active
(AP) ARNP	6,956	62	43	
(LP) LPN	11,375	332	23	350
(NS) NTEC (Nurse Tech)	377			
(RN) RN	90,490	2,453	218	2,603

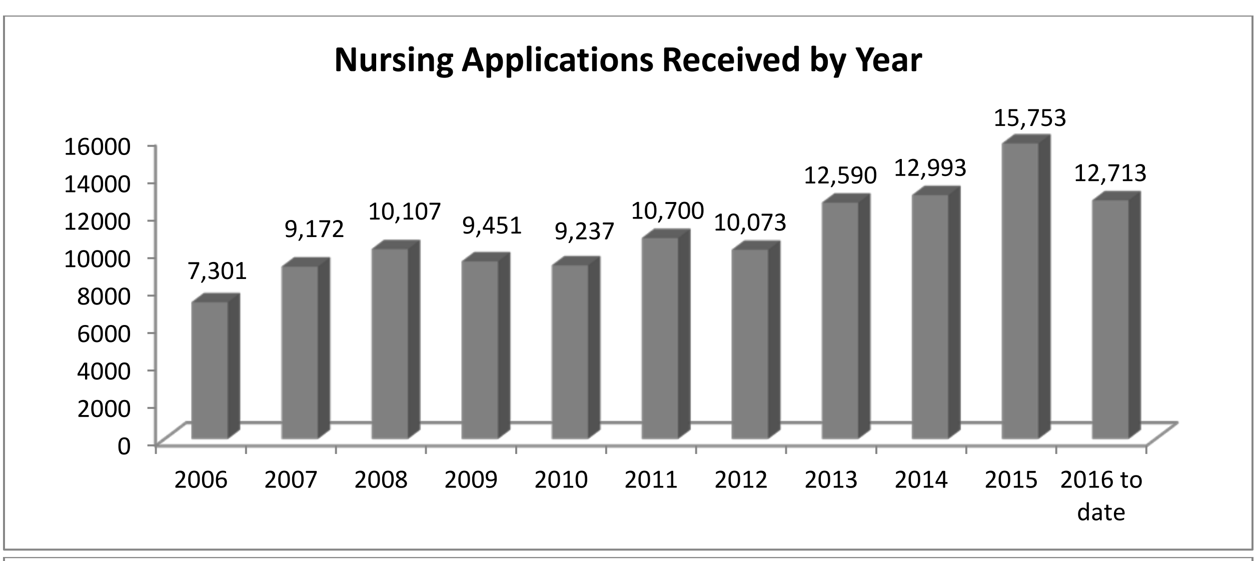


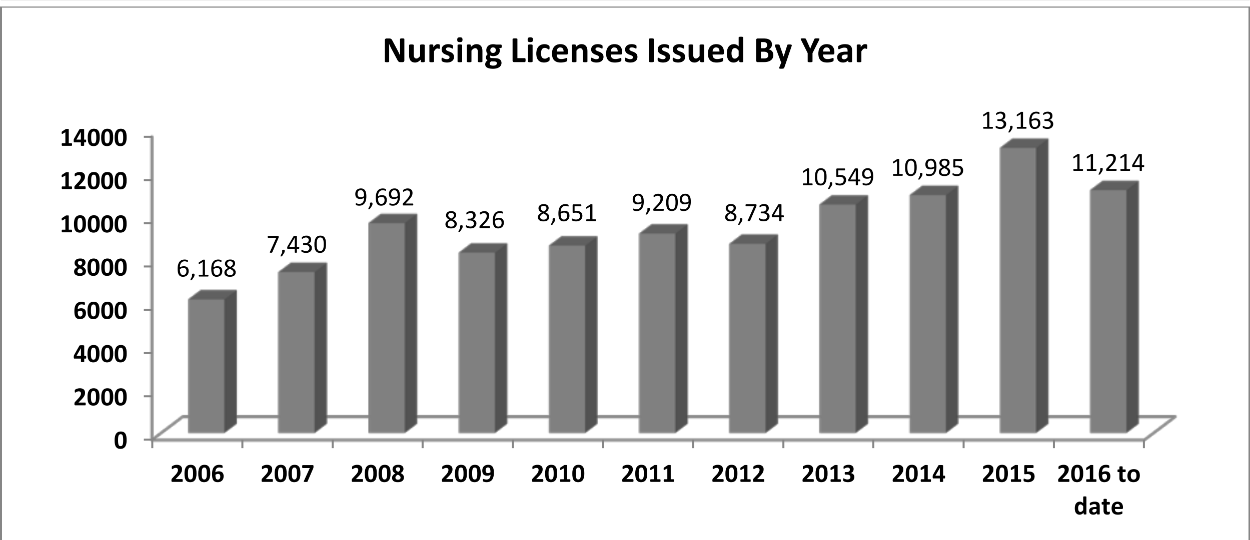


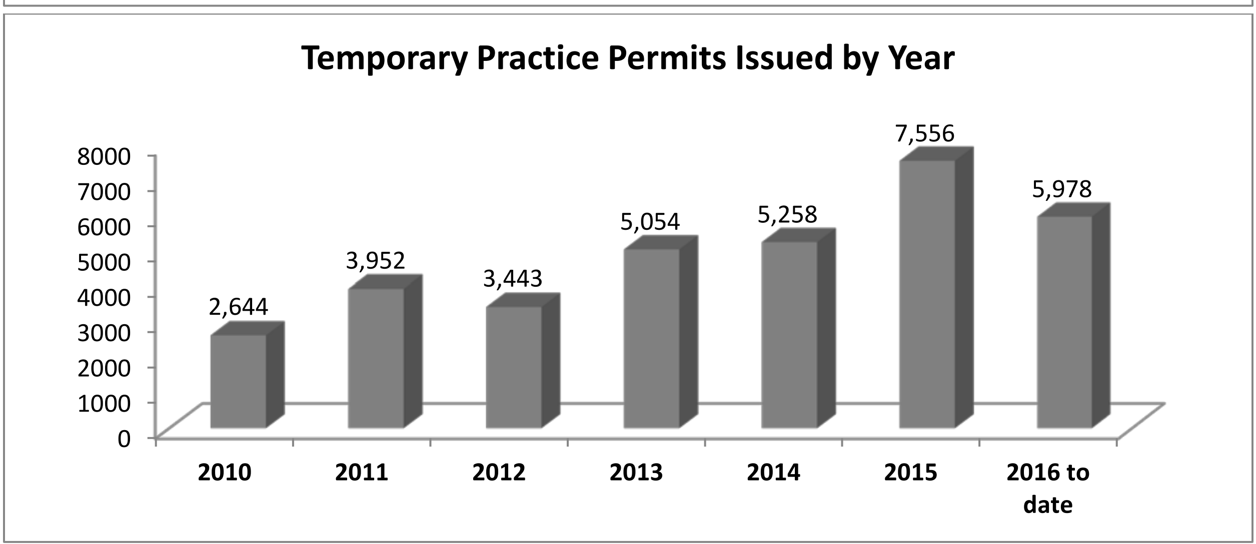


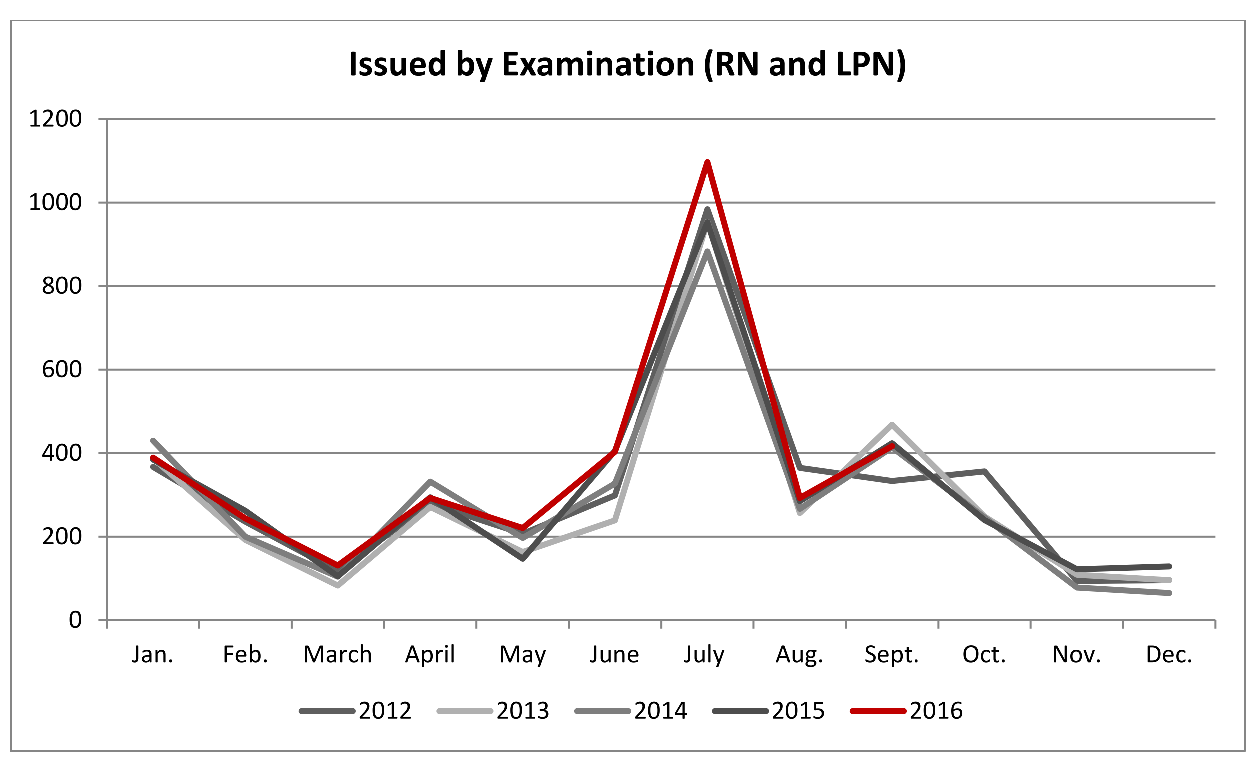


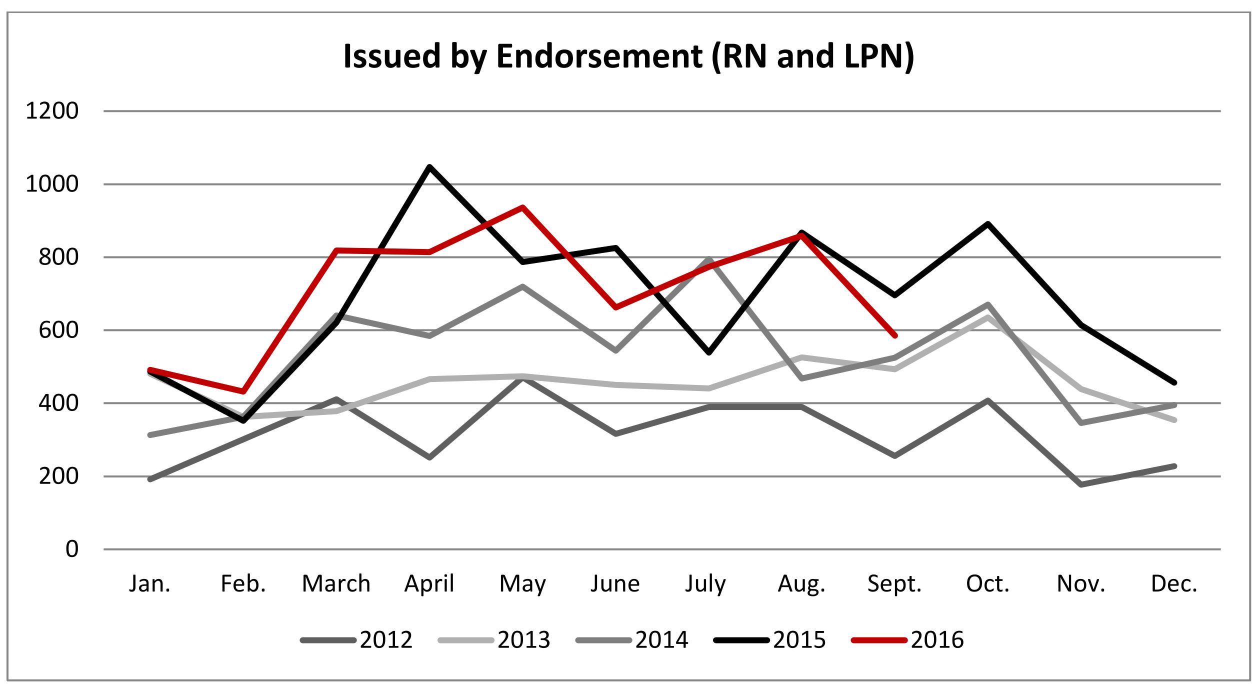
NCQAC has received a total of 12,713 nursing application and issued 11,214 nursing licenses in 2016. (By September 2015, the yearly totals had been 12,555 applications and 10,385 licenses issued. 2015 had proved to hold the highest numbers ever recorded for NCQAC and current trend is showing 2016 will surpass those statistics.)


Nursing Applications Received by Year
16000
14000
12000
10000
8000
6000
4000
2000
0
7,301
9,172
10,107
9,451
9,237
10,700
10,073
12,590
12,993
15,753
12,713
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016 to date


Nursing Licenses Issued By Year
14000
12000
10000
8000
6000
4000
2000
0
6,168
7,430
9,692
8,326
8,651
9,209
8,734
10,549
10,985
13,163
11,214
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016 to date


Temporary Practice Permits Issued by Year
8000
7000
6000
5000
4000
3000
2000
1000
0
2,644
3,952
3,443
5,054
5,258
7,556
5,978
2010
2011
2012
2013
2014
2015
2016 to date





Licensure by Method: Of the total 11,214 nursing licenses issued in 2016 to date, 56.8% have been endorsement licenses, 31.1% exam licenses, 6.8% ARNP licenses, and 5.3% reactivation licenses.

Continuing Competency Update

	2014	2015	2016 to date
531/45 Audits Completed	917	1,034	175
531/45 Failed Audits	96	156	19
531/45 Reactivation Audits			90
177/15 Reactivation Audits Completed		277	393
177/15 Failed Reactivation Audits		274	276
177/15 Renewal Audits Completed		166	292
177/15 Failed Renewal Audits		26	79
Total Audits	**1,013**	**1,900**	**1,048**

There are currently 795 pending 177/15 reactivation audits to be completed within the next year. NCQAC has observed a low response rate in 2015 (50.3%) from reactivation audits, possibly due to the license staying in active status after failure to comply. We implemented a new process in 2016 allowing us to change statuses to “Active Not Renewable” for non-compliant reactivation audits and this has slightly increased response rate (57.6%). Late renewal audits and random audits have a much higher response rate at 89.2% since the auditing process began in 2014. Late renewal and random audits are changed to “inactive” status if failure to comply with NCQAC audit letter.

Medical Marijuana Program 101

Susan Reynolds, Program Operations Manager

Program Requirements

- **On April 24, 2015, Gov. Inslee signed 2SSB 5052, the Cannabis Patient Protection Act . It directs the Department of Health to complete tasks that include:**
  - Establish a Patient Authorization Database
  - Establish a Medical Marijuana Consultant Certification
  - Establish Medical Marijuana Product Standards

DOH Goals

- Protect Access for Patients with Qualifying Conditions
- Ensure Safe, Quality Tested and Accurately Labeled Products for Patients

Authorization Database

1. Establish a voluntary, confidential medical marijuana authorization database with a third-party vendor.
2. Create a process for producing recognition cards for qualifying patients and designated providers.

Recognition Cards

Benefits of Recognition Card

- **Increases purchase and possession limits:**
  - May purchase up to three times the current limits at licensed retail store with a medical marijuana endorsement
  - May possess six plants and eight ounces of useable marijuana (*healthcare practitioner may authorize additional plants to a maximum of 15*)
- **Purchase High THC products**
- **Tax-free purchases at retail stores with a medical marijuana endorsement**
- **Provides arrest protection**
- **Required for participation in cooperatives**

Marijuana Product Purchases

	High THC Compliant	High CBD Compliant	General Use Compliant	Any Product Available for Sale in a Retail Store with a Medical Endorsement
Patients and Designated Providers with Recognition Card*	✓	✓	✓	✓
Any Adult Consumer		✓	✓	✓

*All purchases made by a recognition card holder are sales tax free at 3 times the recreational purchase limits. High CBD products are sales tax free to anyone. Cards can be obtained in medically endorsed stores on July 1, 2016.

Consultant Certification Program

1. **Define curriculum and select vendors to provide training or education programs.**
2. **Develop an application and renewal process for consultant certificate holders.**
3. **Specify the services that consultants may provide at medically endorsed stores.**

Consultant Services Parameters

- **Can Do:**
  - Assist with product selection
  - Describe risks and benefits of administration methods
  - Advise on safe handling and storage of products
  - Provide Instruction on proper use
- **Can't Do:**
  - Diagnose any conditions
  - Recommend modification or elimination of any treatment not involving medical use of marijuana

Product Standards

For products that may be sold or donated to patients at a medically endorsed retail store, DOH must determine:

- THC and CBD concentrations/ratios
- Labeling requirements
- Testing for pesticides, mold, fungus, solvents, etc.
- Safe handling requirements
- Employee training requirements

Product Logos

How the Rules Address the SB 5052 Requirements

The Rules Do:

- Create voluntary standards for safer and healthier products.
- Allow consumers the choice of compliant or regular products.

The Rules Do Not:

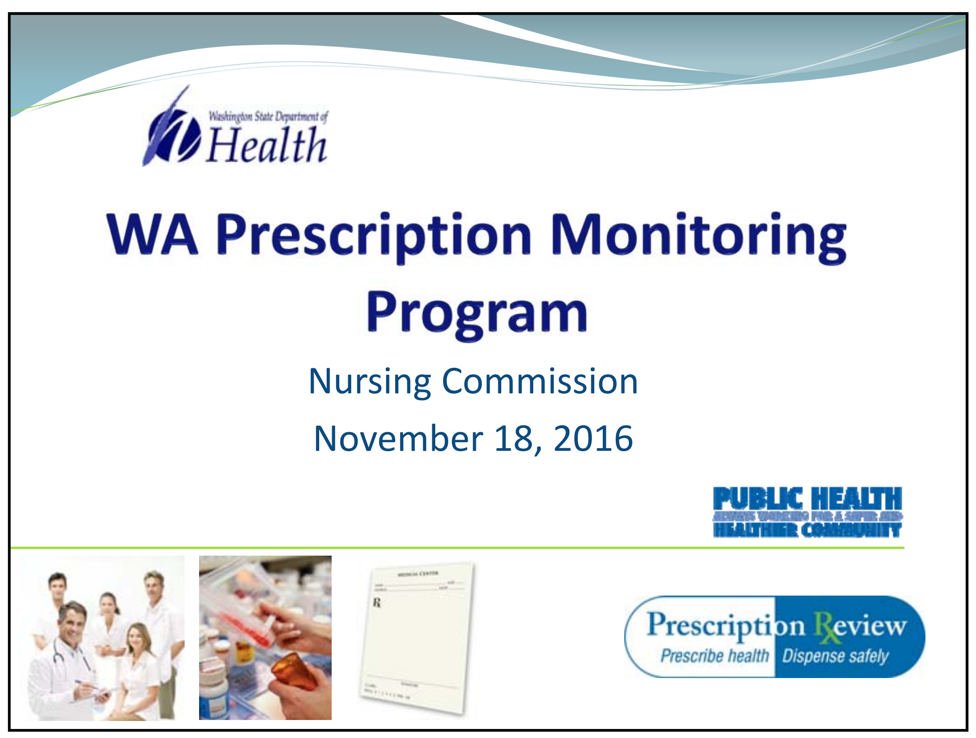
- Differentiate between "medical" and "non-medical" marijuana.
- Limit the types of products a patient with a recognition card will be able to purchase.

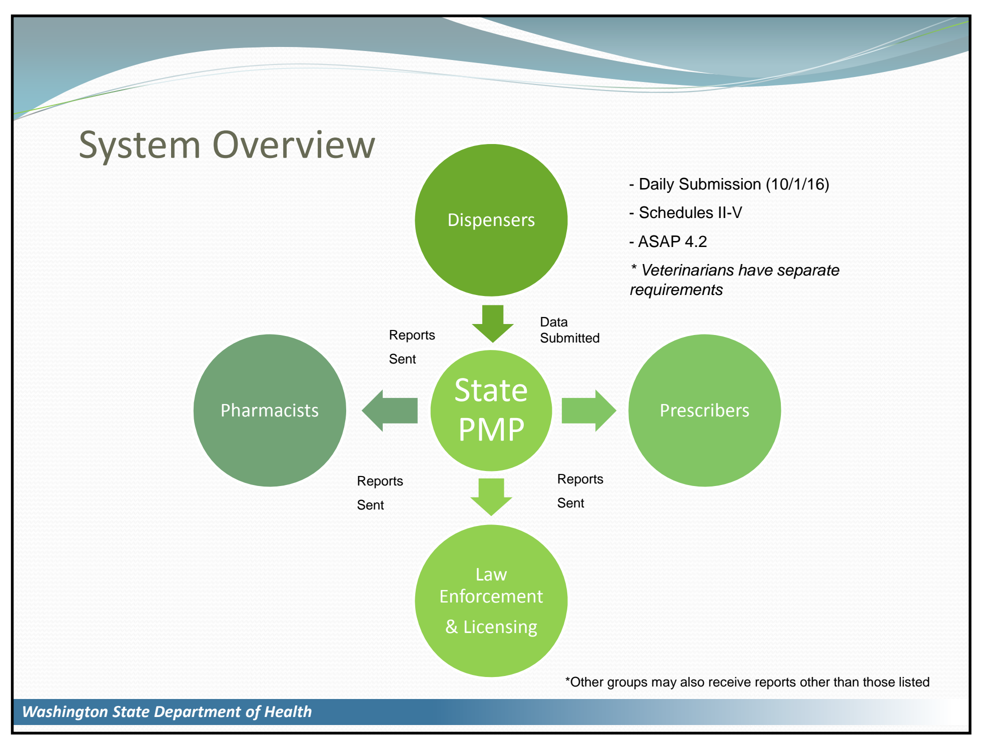
MMJAS Statistics – 10/24/2016

Active Stores with MMJ Consultants: 155
MMJ Consultants at Stores: 446

Total recognition cards issued: 13,478
Adult cards issued: 12,564
Designated Provider cards issued: 881
Minor cards issued: 33

DOH MMJ Consultant certificates issued: 665
DOH MMJ Consultant applications: 805


Washington State Department of
Health
WA Prescription Monitoring Program
Nursing Commission
November 18, 2016
PUBLIC HEALTH
Prescription Review
Prescribe health
Dispense safely

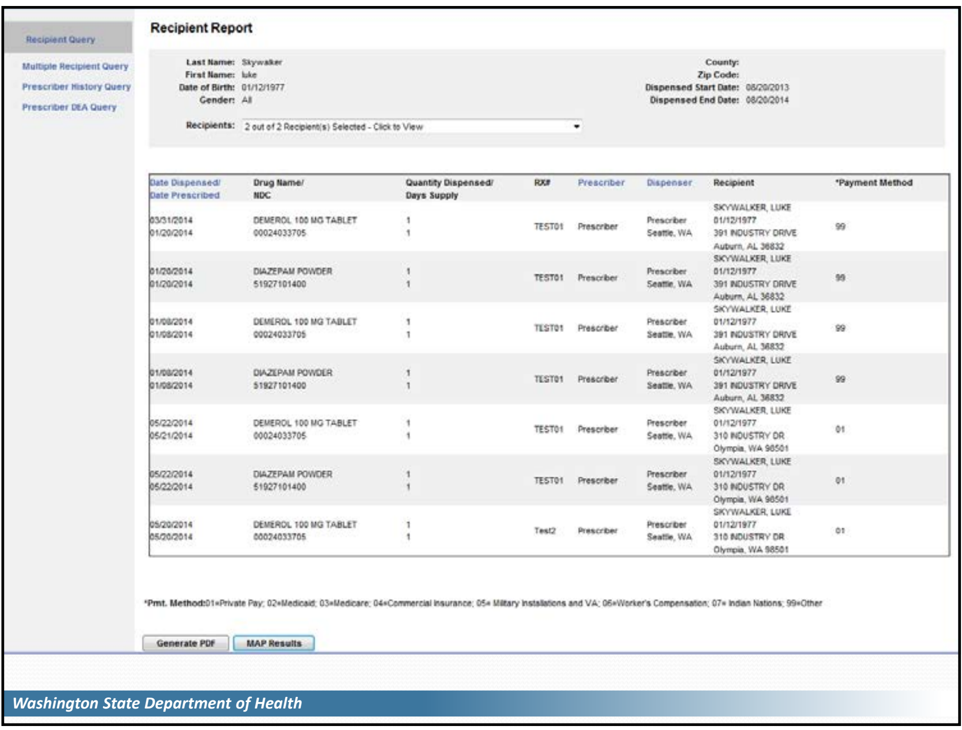

System Overview
Dispensers
- Daily Submission (10/1/16)
- Schedules II-V
- ASAP 4.2
* Veterinarians have separate requirements
Data Submitted
Reports Sent
State PMP
Pharmacists
Prescribers
Reports Sent
Reports Sent
Law Enforcement & Licensing
*Other groups may also receive reports other than those listed
Washington State Department of Health

DOH's Goals for Washington's PMP

Help Prevent Prescription Drug Overdoses!

- Give practitioners an additional tool that provides more information for making patient care decisions.
- Data can help healthcare providers recognize patterns of misuse and addiction ensuring SBIRT opportunities are not missed.
- Make sure those in need of scheduled prescription drugs receive them.
- Educate on the danger of prescription drug misuse.
- Curb the illicit use of prescription drugs.

Washington State Department of Health



Recipient Query
Multiple Recipient Query
Prescriber History Query
Prescriber DEA Query

Recipient Report

Last Name: Skywalker
First Name: luke
Date of Birth: 01/12/1977
Gender: All
County:
Zip Code:
Dispensed Start Date: 08/20/2013
Dispensed End Date: 08/20/2014

Recipients: 2 out of 2 Recipient(s) Selected - Click to View

Date Dispensed/ Date Prescribed	Drug Name/ NDC	Quantity Dispensed/ Days Supply	RX#	Prescriber	Dispenser	Recipient	*Payment Method
03/31/2014 01/20/2014	DEMEROL 100 MG TABLET 00024033705	1 1	TEST01	Prescriber	Prescriber Seattle, WA	SKYWALKER, LUKE 01/12/1977 391 INDUSTRY DRIVE Auburn, AL 36832	99
01/20/2014 01/20/2014	DIAZEPAM POWDER 51927101400	1 1	TEST01	Prescriber	Prescriber Seattle, WA	SKYWALKER, LUKE 01/12/1977 391 INDUSTRY DRIVE Auburn, AL 36832	99
01/08/2014 01/08/2014	DEMEROL 100 MG TABLET 00024033705	1 1	TEST01	Prescriber	Prescriber Seattle, WA	SKYWALKER, LUKE 01/12/1977 391 INDUSTRY DRIVE Auburn, AL 36832	99
01/08/2014 01/08/2014	DIAZEPAM POWDER 51927101400	1 1	TEST01	Prescriber	Prescriber Seattle, WA	SKYWALKER, LUKE 01/12/1977 391 INDUSTRY DRIVE Auburn, AL 36832	99
05/22/2014 05/21/2014	DEMEROL 100 MG TABLET 00024033705	1 1	TEST01	Prescriber	Prescriber Seattle, WA	SKYWALKER, LUKE 01/12/1977 310 INDUSTRY DR Olympia, WA 98501	01
05/22/2014 05/22/2014	DIAZEPAM POWDER 51927101400	1 1	TEST01	Prescriber	Prescriber Seattle, WA	SKYWALKER, LUKE 01/12/1977 310 INDUSTRY DR Olympia, WA 98501	01
05/20/2014 05/20/2014	DEMEROL 100 MG TABLET 00024033705	1 1	Test2	Prescriber	Prescriber Seattle, WA	SKYWALKER, LUKE 01/12/1977 310 INDUSTRY DR Olympia, WA 98501	01

***Pmt. Method:** 01=Private Pay; 02=Medicaid; 03=Medicare; 04=Commercial Insurance; 05= Military Installations and VA; 06=Worker's Compensation; 07= Indian Nations; 99=Other

Generate PDF | MAP Results

Washington State Department of Health

Top 6 Times to Check the PMP

1. New patients
2. When prescribing a controlled substance
3. Patient is in substance abuse treatment
4. Chronic pain patients – ensure treatment contract compliance
5. For evaluating episodic care
6. Expecting and Breastfeeding Mothers

Washington State Department of Health

2015 AMDG Guideline on Prescribing Opioids for Pain

- Updated guide from Washington State Agency Medical Director's Group
- Guide covers Prescribing Opioids:
  - In the Acute and SubAcute Phases
  - For Perioperative Pain
  - For Chronic Non-Cancer Pain
  - and many other related topics
- http://www.agencymeddirectors.wa.gov/opioiddosing.asp

Washington State Department of Health

Patient History Requests

Query By:	CY 2012	CY 2013	CY 2014	CY 2015
Prescriber	319,050	362,705	522,872 (Includes Delegate Queries)	958,246 (Includes Delegate Queries)
Pharmacist	55,308	298,174	394,016	541,802
Delegate	32,330	61,752	n/a	n/a
EDIE	-	-	26,546	2,222,446
Total Queries	406,688	722,631	943,434	3,722,494

12/31/15

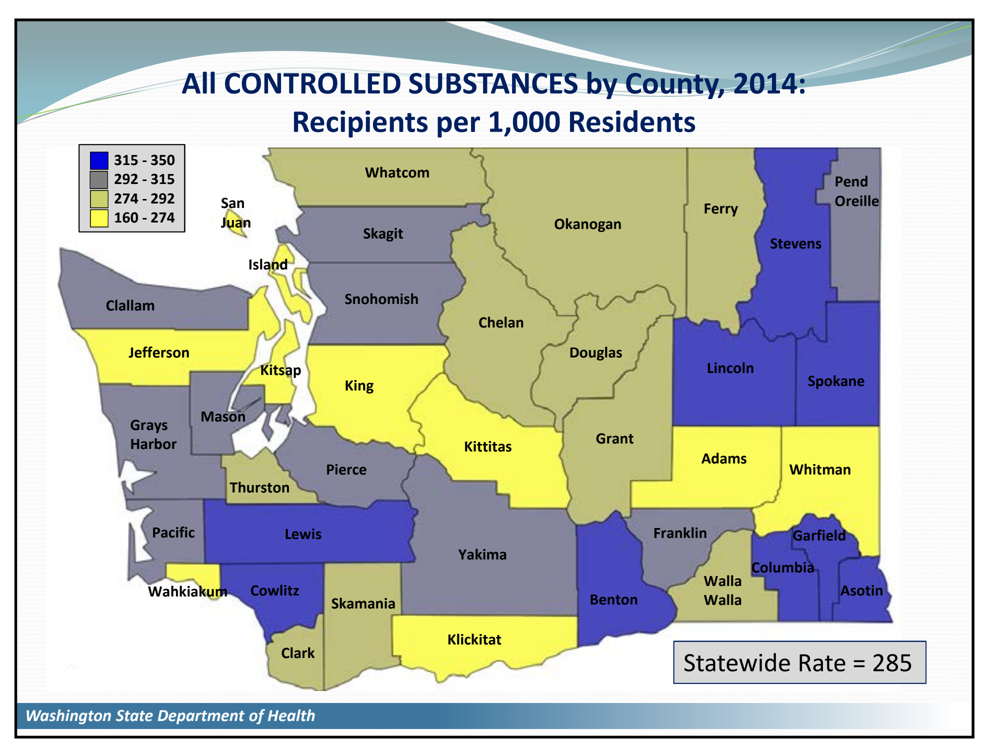
Washington State Department of Health

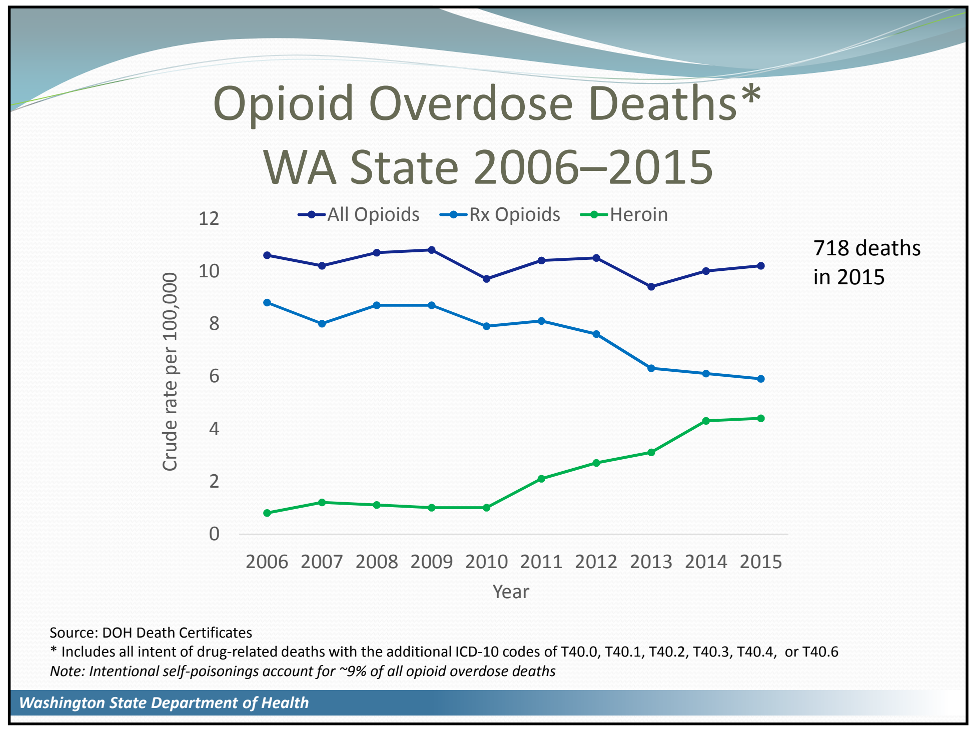
Prescriptions Dispensed '12 – '15

Rank by most recent year

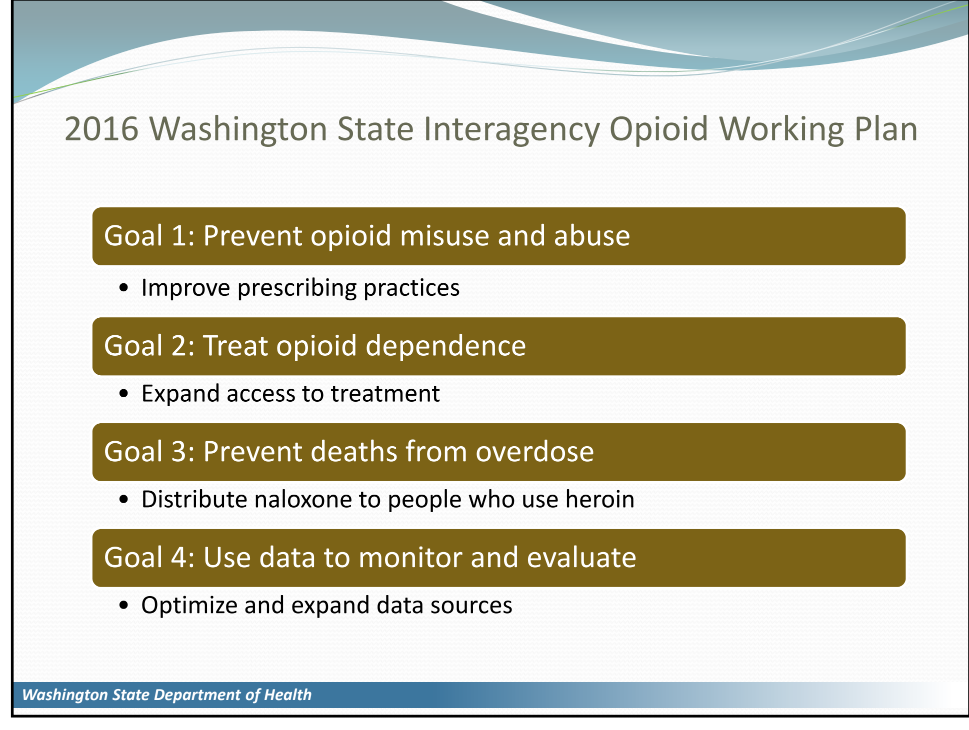
Generic Name	2012 Rx	2013 Rx	2014 Rx	2015 Rx
HYDROCODONE/ACETAMINOPHEN	3,007,054	2,814,288	2,775,054	2,465,054
OXYCODONE HCL	927,899	962,909	1,043,239	1,109,474
OXYCODONE HCL/ACETAMINOPHEN	922,408	854,344	847,054	852,840
ZOLPIDEM TARTRATE	916,823	834,515	791,303	766,708
TRAMADOL HCL	N/A	N/A	308,524	733,077
LORAZEPAM	644,306	457,689	644,463	644,157
DEXTROAMPHETAMINE/AMPHETAMINE	475,749	518,964	580,426	631,137
ALPRAZOLAM	657,064	638,556	645,435	629,653
CLONAZEPAM	529,671	518,349	528,338	523,953
METHYLPHENIDATE HCL	412,848	414,548	423,117	424,223
MORPHINE SULFATE	333,717	328,015	336,520	364,098

Washington State Department of Health





Opioid Overdose Deaths*
WA State 2006–2015
All Opioids
Rx Opioids
Heroin
718 deaths in 2015
Crude rate per 100,000
12
10
8
6
4
2
0
2006 2007 2008 2009 2010 2011 2012 2013 2014 2015
Year
Source: DOH Death Certificates
* Includes all intent of drug-related deaths with the additional ICD-10 codes of T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6
Note: Intentional self-poisonings account for ~9% of all opioid overdose deaths
Washington State Department of Health



2016 Washington State Interagency Opioid Working Plan
Goal 1: Prevent opioid misuse and abuse
• Improve prescribing practices
Goal 2: Treat opioid dependence
• Expand access to treatment
Goal 3: Prevent deaths from overdose
• Distribute naloxone to people who use heroin
Goal 4: Use data to monitor and evaluate
• Optimize and expand data sources
Washington State Department of Health

Legislation & Rules

CR 101 filed opening the chapter to allow for updates to accommodate HB 2730 and 5027

- HB 2730 – 2016
  - Adds Legend prescribers to those authorized to access PMP
  - Adds facilities (licensed by DOH) and provider groups of 5 or more as entities authorized for access (must be HIE Trading Partner)
- SB 5027 – 2015
  - Authorizes PMP access for Medical Testing Laboratories

CR 103 filed submitting amended language to the chapter:

- Reporting frequency changed from weekly (7 days) to "By the next business day"
- Adds fields to be reported to PMP including: NPI (prescriber and dispenser); Phone Number (prescriber and dispenser)
- HB 1637 – 2015
  - Adds Tribal Law Enforcement and Prosecutorial Officials to those authorized to access PMP

Washington State Department of Health

CDC Rx Drug Overdose Grant

- Grant Period: 3/1/16 to 8/31/19
- Current Budget Period: 3/1/16 to 8/31/17
- Budget Amount: $1.3 million
- Agencies Involved: DOH, LNI, HCA, & UW

Washington State Department of Health

CDC Grant Strategy Areas

1. *Enhance and Maximize PDMP*
2. *Implement Community or Insurer/Health System Interventions*
3. *Evaluate Laws, Policies, or Regulations*
4. *Rapid Response Projects (RRP)*

Washington State Department of Health

Enhance PMP Sub-Strategies

1. Integrate PDMP into EHR systems
   - Meaningful Use, Pilot EMR connections, Pharmacist delegates, Interstate data sharing
2. Reduce the PDMP data collection interval
   - Daily reporting, Data processing, Evaluate real-time
3. Expand and Continue Use of PDMP as a Surveillance System
   - County profiles, link to death records, Opioid Mapping

Washington State Department of Health

Implement Community or Insurer/Health System Interventions Sub-Strategies

1. Enhance Patient Review Restriction (PRR) capacity in Medicaid MCOs
2. Develop and apply metrics for inappropriate prescribing (WC and Medicaid)
3. Identify high-risk groups among the insured (WC and Medicaid)
4. Identify high-burden communities and counties, and provide technical assistance to prevent opioid misuse, treat those with opioid use disorder and prevent opioid overdose.

Washington State Department of Health

Evaluate Laws, Policies, or Regulations Sub-Strategies

1. Conduct evaluation of statewide pain management rules and AMDG guidelines

Rapid Response Projects (RRP) Sub-Strategies

- Our proposal is to collaborate with CDC to plan for the development of surveillance capacity of the electronic emergency medical systems (EMS) data to track opioid overdose occurrence and document law enforcement and bystander responses to overdose events.

LNI & HCA Prescribing Activities

- Analyze WC & Medicaid PDMP and claims data to identify providers with patients at risk for overdose.
- Use prescribing report cards to compare providers against their peers on opioid prescribing measures.
- Outreach to prescribing outliers based on report card analyses.
- Identify prescribers of Medicaid clients for clinical quality review
- Consult with the Medicaid Pharmacy Administrator to apply algorithms to identify needed prescriber education, targeted drug utilization review interventions and additional utilization management rules.

Washington State Department of Health

Exploring Options

- DOH is exploring options for identifying and addressing prescribing patterns as we have a responsibility and obligation to ensure patient safety and promote public health.
- As a key partner we want feedback from boards and commissions on:
  - Should proactive review be done
  - If so, what criteria should be used
  - If so, what steps should be taken after criteria are met

Washington State Department of Health

Exploration considerations…

- Boards and Commissions have only used PMP data after receiving a complaint
- DOH now has the capacity to analyze the data in-house to look for patterns that may indicate inappropriate prescribing.
- DOH also has data that can be linked to PMP data to enhance our understanding of the epidemic such an overdose deaths and hospitalizations caused by prescription drugs.
- LNI and HCA are already doing some of this type of work in their provider networks and so we'll work to stay coordinated with them if we choose to move forward.

Washington State Department of Health

What do Other States do?

- From the National Training & Technical Assistance Center for PMPs…
  - 31 states have authority to send unsolicited reports to licensing entities
  - 15 are currently sending unsolicited reports
  - Example: (KY) – licensing entities set parameters/thresholds for PMP data to be reported to them. Reports are reviewed by an advisory counsel to determine if the case should be sent as a complaint

Washington State Department of Health

Example of NC Rule

SUBCHAPTER 32Y –CONTROLLED SUBSTANCE REPORTING SYSTEM

21 NCAC 32Y .0101 REPORTING CRITERIA

(a) The Department of Health and Human Services ("Department") may report to the North Carolina Medical Board ("Board") information regarding the prescribing practices of those physicians and physician assistants ("prescribers") whose prescribing:

(1) Falls within the top one percent of those prescribing 100 milligrams of morphine equivalents ("MME") per patient per day; or

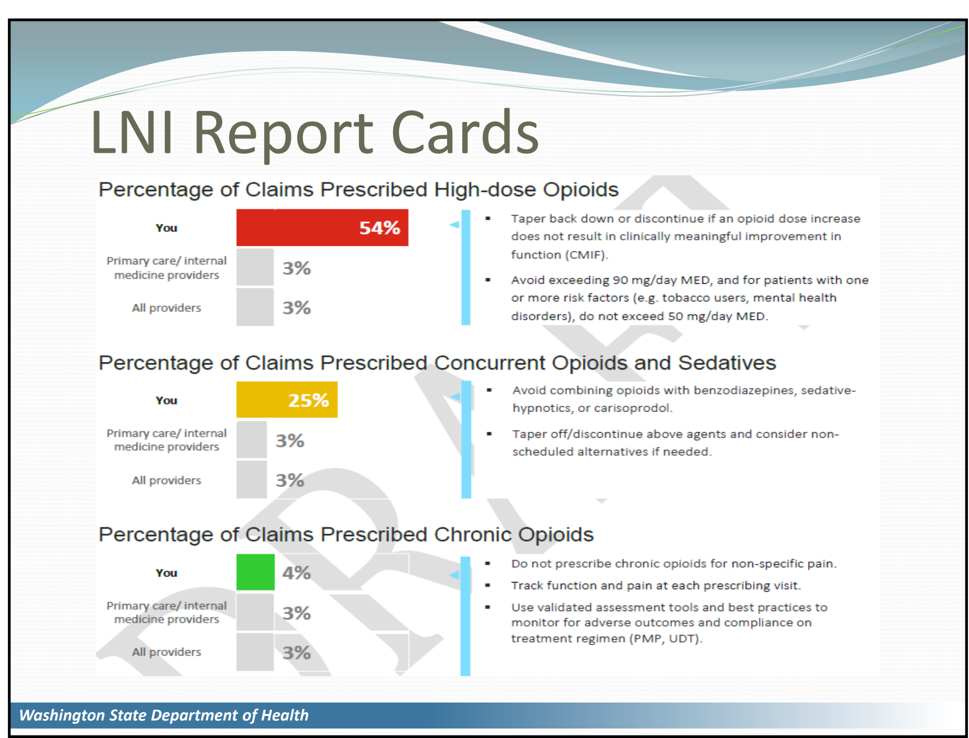
(2) Falls within the top one percent of those prescribing 100 MME's per patient per day in combination with any benzodiazepine and who are within the top one percent of all controlled substance prescribers by volume.

(b) In addition, the Department may report to the Board information regarding prescribers who have had two or more patient deaths in the preceding twelve months due to opioid poisoning.

(c) The Department may submit these reports to the Board upon request and may include the information described in N.S. Gen. Stat. § 90-113.73(b).

(d) The reports and communications between the Department and the Board shall remain confidential pursuant to 19 N.C. Gen. Stat. § 90-16 and 90-113.74.

Washington State Department of Health



Summary of Possible Options

- Regulatory Approaches
  - Set criteria and send complaints for all cases meeting any criteria
  - Set criteria and have a professional review prior to sending a complaint
- Non-regulatory Approaches
  - Send prescriber report cards to prescribers
  - Peer prescriber provides education
- Hybrid Approaches
  - Begin with report cards to prescriber but file a complaint if prescribing doesn't change
  - Begin with peer education but file a complaint if prescribing doesn't change

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Additional Resources

- http://www.pdmpexcellence.org/sites/all/pdfs/Using_PDMP_Data_Guide_Interventions_at_Risk_Prescribers.pdf
- http://www.pdmpassist.org/pdf/Report_Card_TAG_20160315_final.pdf
- http://www.pdmpassist.org/pdf/Standardized_Reports_LE_Boards_TAG_FINAL_20140626.pdf

Washington State Department of Health

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WASHINGTON STATE DEPARTMENT OF HEALTH:
NURSING CARE QUALITY ASSURANCE COMMISSION

Washington Health Professional Services (WHPS) Program

Comparison of Baseline and Second On-Site Audit Report-November 18, 2016

Nancy Darbro, PhD, CNS, RN

10/13/2016

The purpose of this contract requested by the Nursing Care Quality Assurance Commission is to audit, analyze and evaluate the Washington Health Professional Services (WHPS) program.

Comparison Results of Baseline and Second Audit & Final Recommendations:

Background

In December of 2014, an organizational restructuring brought the Washington Health Professional Services (WHPS) monitoring program under the authority of the Nursing Care Quality Assurance Commission (NCQAC). This restructuring ensured that WHPS would be solely responsible for monitoring nursing health care professionals, and no longer monitoring other health care professionals. The first on-site audit took place in June, 2015, approximately six months after the restructuring. The purpose of that audit was to review current case files for participants in the program, checking for policy compliance and timely reporting of non-compliance issues. The audit report was submitted to NCQAC Executive Director on July 17, 2015. A second function of the audit was to revise the policy and procedure manual according to the National Council of State Boards of Nursing Substance Abuse Disorder Manual and audit tool as approved by the NCQAC. The first draft form of the revised WHPS Business Practices Manual, or P & P was submitted to the NCQAC Executive Director on August, 10, 2015. A decision was made by the NCQAC Executive Director to incorporate the WHPS P & P manual into the NCQAC P & P format and numbering system. This added significant time for the NCQAC to understand and review these new WHPS sections of the P & P. There were several conference calls with the SUD taskforce to discuss the revised P & P, and these also resulted in additional significant revisions to the P & P. The final draft of the P & P was reviewed at the November 13, 2015 NCQAC meeting. The NCQAC approved the final revision and format on January 8, 2016.

The final revision of the NCQAC WHPS P & P was provided to WHPS in February, 2016. In conversation with the WHPS Director, he provided staff with the new P & P and had weekly meetings with them to review significant changes in monitoring and reporting processes. This also resulted in revisions to all of the documents utilized in WHPS for communicating and documenting compliance. The process for assimilating the new P & P into practice took some time, and was not fully operational until mid to late April, 2016. The Director reported that the most significant document revisions were made to the initial and employment contracts, the transition contract and new graduation requirements, and the documents for requesting additional evaluations. These will be discussed in more detail under each policy. The second on-site audit took place from August 22-26, 2016. At the time of the second on-site audit, staff members were still in the process of understanding and implementing the P & P revisions, since they had only been operational for four months. A more thorough understanding of the effectiveness and impact of the new P & P may require a longer period of time of implementation to adequately assess policy compliance and timely reporting.

The Director of WHPS provides supervision, clinical case consultation and is responsible for overall compliance with all monitoring and reporting activities. Case Managers consult with the Director for direction and decisions. Since one case manager retired in May, 2016, the Director was managing her case load at the time of the second

on-site review. A new case manager was hired and was scheduled to start in September, 2016.

During the 2015 on-site audit, the Operations Manager stated that she had not been able to generate the QA audits for drug screens and other reports since June, 2014, due to time constraints. It was a recommendation from that year that the Director begin to generate these QA audits to ensure consistency, to review with staff and for use as a training tool. It was not clear if these thorough QA audits are being generated. The Director does a monthly audit of 30 random files in AOS to determine that nine required reports are in place. One of the case manager associates also continues to generate a monthly statistics report that is submitted to each WHPS staff member and the interim Dir. of Operations. The Operations Manager continues to generate the monthly drug screening report and the non-compliance report for late or missing reports for each case manager. Another recommendation from last year was to provide staff trainings or meetings to allow for discussion and collaboration, to develop and support a sense trust, equality and teamwork, and to ensure consistent follow up on duties and responsibilities for the staff. NCQAC did provide a team building life coach to meet monthly with WHPS staff, since the 2015 audit, to begin this process. The office environment is more relaxed and collegial, and staff reported that there is a more supportive and collaborative environment.

The WHPS program has been using the Affinity On-line System (AOS) for many years as the 3rd party contractor for compliance monitoring. Many of the recommendations from the 2015 audit were to enhance and expand some of the reports available in the AOS system, which have not been implemented. The Director stated that when he requested these revisions from AOS, he was informed that AOS could not consider revisions in the system format until after 2016.

In 2015, a total of seventeen (17) case files, and in 2016, a total of twenty-five (25) case files were reviewed and analyzed for compliance with some or part of the policy and procedures for WHPS. There are twenty (20) policy and procedures that address core compliance monitoring issues, and five (5) other policies that address administrative, reporting and evaluation requirements.

<u>Audit Comparison and Recommendations:</u>

W01.01 Program Eligibility and Referral/Discharge Criteria:

<u>1st 2015 Recommendation 01:</u> Title this “Program Eligibility and Referral/Discharge Criteria”. Add the three criteria for mandatory referral to NCQAC under material non-compliance page, to include reporting all cases of unauthorized use. The purpose and rationale for discharging nurses needs discussion. To ensure ongoing tracking after non-compliance events, it would make sense to keep nurses under scrutiny with their monitoring contracts while disciplinary action is being considered. Staff could develop a separate document & attachment in AOS containing a summary of non-compliance, reasons for discharge and the referral memo to NCQAC, using a consistent title. Staff could also include more information in the referral memo to NCQAC; include more details on chronological facts of all relevant information, reason for entry, diagnosis,

compliance summary to include actions taken by staff in response to all prior non-compliance incidents, reason for referral, and conditions for re-entry. Relevant case notes should also specify the relevant topic in AOS, ie "referral memo to NCQAC", etc, so the chronology can be tracked more easily. Upon referral to NCQAC, nurses may remain in the WHPS monitoring program. All referrals, necessary discharges and incarceration events will be included in the monthly performance summary or audit performed by the Director to provide more transparency on how minor or low level compliance issues are addressed internally by WHPS.

2nd 2016 Recommendation 01: The requirements for reporting the first unauthorized use and expanding the referral memo to NCQAC have been implemented. Any recommended revisions for changes in the AOS reporting system were not implemented for any policies, due to the inability of AOS to revise documents. Appendix A-Material Non-Compliance now includes expanded and specific consequences for each of the 13 examples of material non-compliance. The WHPS Director indicated that the P & P revision to "agree to limit practice to one state" was not feasible as WHPS does admit nurses living out of state, often per NCQAC order, and monitors nurses who move out of state while still in WHPS. The intent of this policy was to prevent nurses in WHPS from practicing in another state without that states knowledge and approval. The WHPS Director and staff could benefit from having outside and expert assistance in understanding and implementing some of the details of the new revisions to the P & P, such as ensuring that nurses who plan to move out of state notify the board and program of that state of their pending relocation. A closer relationship and more regular interactions with a NCQAC liaison could be helpful in interpreting these details. The dissolution of the SUD committee also led to some confusion by the Director about completing the "monthly performance summary that includes all referrals, necessary discharge and incarceration events" listed in this policy and other details in 6 others. He will start generating this monthly report, which is to be reviewed and discussed monthly with the interim Associate Director of Operations.

W02.01 Admission Types:

1st 2015 Recommendation 02: The chronology of reasons for changes in admission types & number of prior admissions and contracts should be contained in a separate document in the electronic monitoring record. The Personal Information tab has a Demographic drop down box that could be used for this, since it does contain the current admission type. It would be important to ensure that all records of prior admissions and types and lengths of each contract are maintained. This could be helpful for CMs to be able to review the number and type of previous admissions and contracts on this page, and to have access to the files of these admissions. Under Voluntary admissions, add the four NCSBN criteria for denying admission.

2nd 2016 Recommendation 02: Under voluntary admissions, revisions included the NCSBN criteria for determining that if a nurse poses a significant risk, WHPs will require the nurse to report to NCQC. No case files reviewed included this issue. One revision in this policy contradicts a previous policy; 06.01, and should be reconciled. This policy states under 1. F. "If non-compliant with monitoring contract, and as agreed in contract, *will* be reported to NCQAC". The statement in policy 06.01 E. states "non-compliance

with any of the terms of the contract *may* result in referral to NCQAC, and this is the statement that is included in the initial contract. NCQAC would need to decide which statement should remain in policy.

W03.01 Confidentiality and Records Management:

Recommendation 03: None

W04.01 Intake:

1st 2015 Recommendation 04: WHPS should develop a comprehensive Case Staffing Intake form to be used consistently and attached in AOS under Documents. This would be different from the initial electronic intake form. Add to Contract Development the current practice in WHPS that each intake case is staffed in weekly CM staffing meetings. The intake history and summary is presented by CM, and length of contract, drug screen requirements, PSG and support group meeting attendance is discussed and decided by the team. Discussion also needs to include the initial type and length of treatment recommended and required, & any safety to practice issues. The current contract has a general sentence that nurses will comply with treatment. The specific type and length of treatment should be specified in the contract itself so that the nurse is clear and fully informed on specific treatment requirements. The CM should use an expanded intake form template as mentioned above for each case staffing that can be added to AOS documents, which will provide a comprehensive summary overview of all intake & psych-social history and contract requirements. This new document would contain this comprehensive information at a glance.

2nd 2016 Recommendation 04: Due to inability of AOS to revise documents, a comprehensive Case Staffing Intake form was not developed, so this cannot be amended at this time. The current revised contract still contains a general sentence that nurses will comply with treatment recommendations. After discussion with the Director on-site, the specific type of treatment required will be added to subsequent contracts.

W05.01 Substance Use Evaluation and Treatment Services:

1st 2015 Recommendation 05: Since the evaluation is the decision maker for treatment recommendations, specify type of treatment, aftercare & discharge summary to be required by WHPS and also add this to the contract. This should also be included in case notes and as a separate document attached in AOS as “treatment recommendation” so that it is easily accessible and can tracked by same subject title in case file notes. I could not find an AOS document specifying all details of treatment entry and progress. WHPS should also send an introduction letter to the identified treatment therapist, attaching the therapist report and reporting requirements. This would be similar to the process currently used for evaluation therapists.

2nd 2016 Recommendation 05: This continues to be a thorough policy, and implemented consistently. A letter to the treatment therapist was developed by WHPS. The Director will have the CM add the specific treatment requirements to each initial contract to comply with the revised P & P.

W06.01 Terms and Conditions of Contract Compliance:

<u>1st 2015 Recommendation 06:</u> Title this "Terms and Conditions of Contract Compliance". The majority of contracts in case files reviewed were for level 3 with a 5 year length. Procedure 2-Contracts by profession now address nurses only. Suggest expand list of contract conditions and restrictions to include cease practice requirement if any, specify type & length of treatment with immediate report from provider of entry into initial treatment, monthly early progress reports, and aftercare and discharge requirements. Specific compliance monitoring requirements were included. The contract should be updated to include specific the treatment requirements so that nurses have fully informed consent. Add specific requirements for initial treatment, aftercare and relapse prevention to general sentence on complying with treatment.

<u>2nd 2016 Recommendation 06</u>: The contract template was revised to include the specific requirements of compliance in the new policy, except for "obtaining prior approval for a pending relocation out of state", which may have been an oversight. This sentence needs to be added to all contracts. WHPS needs to ensure that nurses inform other state boards and programs of any pending move to and practice in that state. The specific requirements for initial treatment and aftercare were also not added to the revised contract. These will be added to the contracts after discussion with the Director.

W07.01 Case Management:

<u>1st 2015 Recommendation 07:</u> It would be helpful for verifying overall compliance on a regular basis for the staff to have an at a year glance compliance summary window available in the AOS monitoring system. They have apparently requested this from AOS with no response. It is also challenging for staff to switch frequently from window to window to access different documents, reports, and to verify compliance and determine overall status of participants. It would also be invaluable to have a summary window with a current view of the history of issues regarding drug screening compliance, a core monitoring tool that results in the most alerts & requires more staff time to address and follow up on a day to day basis. Currently, the Operations Manager generates a monthly drug screening and non-compliance report that is sent to each team and the Director. This could be a useful tool for the Director to use as a QA measure to review and clarify duties, responsibilities and ensure consistent responses to non-compliance events. The CM monitoring activities need to include the monthly attendance forms from 12 step or recovery support groups, as these are not currently required, and should be submitted monthly to WHPS. The self report submitted by the nurses in the AOS system is thorough if it is filled out completely. If all the fields were mandatory, it could provide more information.

<u>2nd 2016 Recommendation 07</u>: Staff continue to report that it would be helpful for verifying overall compliance on a regular basis to have an at a year glance compliance summary window available in the AOS monitoring system and a summary window with a current view of the history of issues regarding drug screening compliance, especially now with the increased requirements. Staff report that there is more clarity about their duties and specific responsibilities, and they believe there is more consistency in monitoring among the teams. The Operations Manager continues to generate a monthly

drug screening and non-compliance report that is sent to each team and the Director, and they use this for follow-up and to send reminders for late reports. As reported by the Director, the policy revision that states the CMs "must witness the nurse's signature on the contract in person" may not be feasible for the CMs. Although the CMs are striving to meet with all their nurses face to face at some point, this requirement may not be practical due to time and distance constraints. This policy statement may need revision in the future, even though a witnessed signature is listed in the NCSBN guidelines.

W08.01 Job/Practicum Approval:

<u>1st 2015 Recommendation 08:</u> The Employment Contract should be separated from the initial contract in all systems, so it can be mailed separately, and amendments can be specified and also mailed separately. The WSM Criteria should also be included in the employment contract, since these contracts are amended frequently. Employment Contracts should be saved as separate titles & documents in AOS. This contract could also be updated with lines to fill in beside each work restriction with dates started and revised. When the contract is amended, it should specify in a written section what is being amended, ie access restriction removed on ___date, and reason for amendment, --- ie worked for one year with no issues. It should also include those restrictions that remain in place. A new format might make this easier to accomplish.

<u>2nd 2016 Recommendation 08</u>: None. The extensive revisions to the Employment Contract were implemented and are seen by the CMs as providing more oversight for them and more accountability for the nurses and WSM. The employment contracts are saved as separate documents in AOS. The revised forms did not seem to add time constraints to the CM workload, as they had previously ensured the timely submission of new employment contracts.

W09.01 Medication Management:

<u>1st 2015 Recommendation 09:</u> This policy and procedure should be followed more closely. When participants are prescribed mood altering or potentially addictive medications for longer than 3 months, they should be notified that a medication management evaluation is required, and needs to be scheduled within 30 days. This includes those participants who are prescribed methadone and suboxone, unless an evaluation has already been done. All evaluations should specifically address safety to practice issues while on prescribed medications. NCSBN guidelines indicate that nurses should identify one prescriber, one pharmacy and one dentist. If WHPS had access to review the PMP reports, this would enhance identification of misuse or doctor shopping.

<u>2nd 2016 Recommendation 09:</u> WHPS does have referral form letters to send to prescribers of mood altering or potentially addictive medications of longer than 3 months, requesting that they send the nurse for evaluation with an addictionologist or specialist within 30 days. It was not clear if these letters were sent to the five prescribers and if the prescribers decided that their own prescription form statements covered this requirement. An on-site Clinical Director with experience in mental health, SUD treatment and pain management could facilitate quality evaluations for these

situations. WHPS did add a statement on the Prescription Information Form for the prescriber to check the PMP reports when prescribing controlled substances. If the prescriber does review the PMP report and reports any pertinent information on their forms, this would enhance identification of medication misuse or doctor shopping. The revised contract requires nurses to identify one prescriber.

W10.01 Short Term analgesic Use:

1st 2015 Recommendation 10: Consistently follow the procedures outlined in this policy for those who are prescribed analgesics for acute pain, including notification of WSM and removal from direct patient care. WHPS may need to specify that if the prescription is for a verified one day medical procedure these indicated procedures may not be required.

2nd 2016 Recommendation 10: CMs are informing WSMs and nurses to cease practice, or have no direct patient care, and not to return to work until 24 hours after last dose. Notification of WSM for no direct patient care and when to resume direct patient care was not documented in one case file.

W11.01 Unauthorized Substance Use:

1st 2015 Recommendation 11: This is an important policy and a critical monitoring tool that needs a separate document created in AOS and subject references in case file notes throughout the case file. Recommend that a written summary note be developed that would capture all chronological information in one report to include all dates, events, notifications, incidences, actions taken and responses for each unauthorized use event. This form could be titled "relapse summary", could be accessed under documents for easy access, and titled same in case notes, for easier review. Based on the definition of relapse in this policy, any use after entry into the program, after the nurse has submitted negative drug screens, should be considered unauthorized use. My understanding is that all unauthorized use is now reported to NCQAC.

2nd 2016 Recommendation 11: Based on the definition of relapse in this policy, any use after the nurse has submitted negative drug screens is now considered unauthorized use. Staff reported that a next day drug screen was not usually done because they already had a positive, and that they would retest within 1 week and prior to return to work. The next day drug screen may not a useful measurement as reported by staff, and could be deleted in the future. Report all unauthorized use to NCQAC.

W12.01 Cease Practice Requirements:

1st 2015 Recommendation 12: Title policy Cease Practice Requirements. Revisions to cease practice should include mandatory "will cease practice" instead of "may cease practice", and include "diversion of controlled substances" and "incidences of provable harm, abuse or neglect to patients"; "all cease practice requests will be included in the monthly performance non-compliance summary" so that the data could be captured and reviewed by the CM teams and Director and the NCQAC liaison.

2nd 2016 Recommendation 12: CMs notified WSM to require cease practice, if employed, for each example of positive drug screen and unauthorized use. The Director will begin to generate the non-compliance monthly summary report. One case file indicated a report of inappropriate behavior and diversion of controlled substances from work that was not reported. The WSM notified WHPS that the nurse took a patients' pain pills, was confronted immediately, returned the pills, and was terminated from work. An evaluation was required and her contract was extended one year. Report all examples of significant material non-compliance to NCQAC.

W13.01 Case Staffing:

1st 2015 Recommendation 13: These are important meetings. Recommend that all case staffing reviews be documented in a summary document that is attached in AOS as an easily accessible document and titled by subject, ie "case staffing intake", "case staffing relapse" or "case staffing medication management". All cases involving unauthorized use, relapse reports or verified workplace concerns, a pattern of missed check-ins, missed tests, dilute & abnormal specimens should also be staffed. "A summary of case staffing issues discussed and reviewed with recommendations and actions by staff will be included in the Directors monthly performance audit report".

2nd 2016 Recommendation 13: Discussing the pattern of missed check-ins, missed tests, dilute & abnormal specimens in case staffing meetings was not considered useful by staff, as these are taken care of on a day to day basis, with the more specific reporting requirements. In the future, these could be deleted from this policy. AOS was not able to amend any reports in the electronic system. The summary of case staffing issues discussed and reviewed with recommendations was not generated as the Director was initially unclear, and he will start generating this monthly report.

W14.01 Work Site Monitoring:

1st 2015 Recommendation 14: The Employment Contract should be updated to include work place restrictions listed with blank lines. This would assist in clarifying any modifications to the Employment Contract with new dates to verify change. The WSM Orientation Module has current and useful education, it is lengthy and could require time to complete. It should be utilized, with CMs to send reminders to complete it. The WSM criterion that lists qualifying and disqualifying criteria should be sent to the WSM at the same time as the Employment Contract and AOS password, or included in the employment contract, so that there is a signature to verify compliance with these criteria. The monthly report form on AOS should have a mandatory comment section for the WSM to write out a summary of current workplace performance. Also add to the WSM monthly report a checklist to verify current workplace restrictions in place or specific questions that the WSM would have to fill in, rather than checking a statement that the WSM is aware of workplace restrictions.

2nd 2016 Recommendation 14: The Employment Contracts were revised although there were no revisions to AOS documents. This policy is implemented consistently and is an important monitoring tool. For all nurses that were employed, all had current WSM and reports submitted. CMs have frequent communications and exchange of information

with WSMs and employers. It may not be feasible to ensure that WSM complete the orientation module, as CM can only encourage this. Add mandatory comment section to the WSM report if it is possible in the future.

W15.01 Peer Support Groups:

1st 2015 Recommendation 15: Add a statement to the policy that the Director of the program will verify the procedures listed in this section, and will retain the PSG applications and agreements electronically. The PSG report form on AOS should be amended to provide a mandatory comment section for the PSG facilitator to provide a summary statement of the nurses' level of participation and quality of interactions in the group. The Operations Manager reported that she generates a yearly attendance report on all clients and sends it to CMs. If more than the 6 allowed absences occur, the CMs add one week to the contract length for each week missed.

2nd 2016 Recommendation 15: None. The Director of the program does verify the procedures listed in this section, and retains the PSG applications and agreements electronically. The PSG report form on AOS is an attendance form with a checklist of level of participation, AOS could not add a mandatory comment section. The Operations Manager continues to generate a yearly attendance report on all clients and sends it to CMs. If more than the 6 allowed absences occur, the CMs add one week to the contract length for each week missed.

W16.01 Graduation:

1st 2015 Recommendation 16: Add that clients have to demonstrate compliance with all aspects of their monitoring contract for the previous two years, in addition to complying with the final year Transitional Contract. Suggest more responsibility be given to the clients for graduation requirements. Could require the nurse to submit a written request for discharge, indicating the reasons they think they are ready for discharge & plans to maintain recovery, submit letters of support for discharge from their WSM and PSG facilitator, and if applicable, their sponsor or therapist.

2nd 2016 Recommendation 16: None. The transition contract was revised to include all the new requirements for graduation. Staff members report this process provides more accountability for the nurse and information for them.

W17.01 Drug and Alcohol Testing:

1st 2015 Recommendation 17: Require either observed collections or a dry room collection at a minimum. The 2nd revision requires a hair test for four dilutes tests in 3 months, four abnormal tests in 6 months, a 2nd out of temperature test, or a substituted or adulterated specimen. The last revision was for the Director to generate a monthly non-compliance audit report capturing all instances of non-compliance with drug screens, including positives with no prescription, all missed check-ins, missed tests, dilute and abnormal specimens, out of temperature, substituted and adulterated specimens, and to review this with the Associate Director of Operations. This could ensure that protocols are consistently followed and applied, and provide the Dir. with

real time data to ensure consistent application of procedures, and provide additional training and support to staff.

2nd 2016 Recommendation 17: AOS was instructed to require observed collections or a dry room technique. Suggest that some documentation be provided by AOS that identifies which collection sites are either observed or a have dry room collection procedure. No case files had a fourth dilute/abnormal, out of temperature, substituted or adulterated specimen. During on-site discussion, the Director stated that he would begin to generate the monthly non-compliance report.

W18.01 Missed Check-ins and Tests:

1st 2015 Recommendation 18: The number of missed check-ins should have a limit of three within a 3 month period. Second and subsequent missed check-ins will have a test scheduled, for 3rd/3 months, notify WSM, and nurse, 4th/3 month refer to NCQAC. All verified missed tests will have a test scheduled, and revisions added that the 2nd missed test, rather than the 3rd missed test, is now reported to NCQAC.

2nd 2016 Recommendation 18: Monitoring activities to the revisions to this policy were followed. Two nurses were tested after a 4th missed check-in/3 months and reported to NCQAC, Three nurses were tested, WSM notified, referred for SUD evaluation and reported to NCQAC after a 2nd missed test. The non-compliance report to be generated by the Director was not generated, and during on-site discussion, he did not see this as a useful tool for monitoring of missed check-ins. The NCQAC could determine in the future if missed check-ins should remain in the monthly non-compliance report.

W19.01 Positive Drug Screen Results:

1st 2015 Recommendation 19: A positive drug screen was considered unauthorized use if there was no valid prescription and the policy for Unauthorized Use was to be followed; the only revision was to add “or if the positive is for illicit substances”. This policy was updated to delete reference to physical case files, which are no longer in use.

2nd 2016 Recommendation 19: Five case files reviewed showed positive drug screen results for which there were valid prescriptions. Of the other thirteen positive drug screen results, all were required to cease practice and eleven were reported to the NCQAC. All positive drug screen results not covered by a prescription are considered unauthorized use and to be reported to NCQAC.

W20.01 Dilute and Abnormal Urine Specimens:

1st 2015 Recommendation 20: All dilute specimens have an observed test scheduled for the next day; notify nurse, and possible increase in testing. Three abnormal specimens/6 months may require medical evaluation. Revisions added a retest on all dilute and abnormal specimens; that a 3rd dilute specimen in 3 months requires a medical evaluation. If no cause, a 4th dilute in 3 months requires WSM, hair test, face to face with CM and report to NCQC. A 3rd abnormal in 6 month requires a medical evaluation and possible increase in testing. If no cause, a 4th abnormal in 6 months

requires WSM, hair test, face to face with CM and report to NCQAC. See recommendation # 18 above for Director to generate an audit report specific to all drug screening non-compliance issues to ensure consistency and reliability in following procedure.

2nd 2016 Recommendation 20: Retesting on dilutes and abnormal specimens was implemented, one nurse had a 3rd dilute and a medical evaluation and one nurse had a 3rd abnormal and a medical evaluation, both of which found cause. No 4th dilute/3 months or 4th abnormal/6 months specimens were noted. Staff indicated that the face to face meeting with a CM after a 4th dilute or abnormal may not have a beneficial impact, as CM are in consistent phone or email communication for all dilute and abnormal specimens. Consideration could be given to delete the face to face evaluation with the CM for a 4th dilute/abnormal in the future.

Out of the last seven policies, the following five were deemed to be relevant to the on-site review and so will be addressed:

W21.01 Policy and Procedure Review:

1st 2015 Recommendation 21: Update to indicate that WHPS and NCQAC will review the policy manual on an annual basis to maintain currency with existing practice, ensure compliance with current laws and other requirements.

2nd 2016 Recommendation 21: None, This policy now lists NCQAC as the oversight agency, with the Director to now review the P & P and present revisions to NCQAC every November.

W22.01 Reporting:

1st 2015 Recommendation 22: To meet the intent of this policy, more relevant information on performance and non-compliance issues is needed. The Director will track performance measures and report results at each NCQAC meeting. The monthly performance audit to include summary and non-compliance information to be generated by the Director was added to this policy and, along with the monthly statistics and audit reports, will be reviewed and discussed monthly with the Associate Director of Operations. Again, there needs to be discussion and decisions about these reports and how they can be used to improve business operations and to evaluate the program and its effectiveness. “An annual evaluation of the program”, with extensive details to be included, was also added to this policy.

2nd 2016 Recommendation 22: The monthly AOS audit and statistics report is still being completed, but the monthly review and discussion with the Associate Director of Operations did not occur. There apparently has not been a new process implemented for how these reports are to be shared, reviewed and discussed collaboratively with the NCQAC liaison, and if this liaison is to be the interim Associate Director of Operations. There still needs to be collaboration and clarification between the Director and the liaison or the interim Associate Director of Operations about the monthly review and discussion of these reports. It was not clear when the first annual evaluation of the program will be due. This evaluation will allow NCQAC to evaluate whether WHPS is

meeting required performance measures and outcomes and to review the program effectiveness annually. Monthly reviews and the annual evaluation will ensure clear accountability and performance outcomes for WHPS. These reports will also provide QA evidence to improve business operations and evaluate actual program performance.

W24.01 Relationships with Disciplining Authorities:

1st 2015 Recommendation 24: These are all important areas of intersection between WHPs and NCQAC that can enhance communication and transparency. WHPS maintains access to a record of cases discussed with NCQAC SUAT, reasons for referral, and actions taken. The referral memo to NCQAC contains more information about non-compliance events and actions taken by WHPS prior to referral. The Director of WHPS is to provide performance measure reports at each NCQAC meeting.

2nd 2016 Recommendation 24: The policy intent of working collaboratively and exchanging appropriate information and fostering communication to enhance work processes and to better protect the public remain valid. This policy was revised to place WHPS under the authority of NCQAC, to add that WHPS maintains a written record of cases reported to NCQAC, and to expand the information included in the referral memo to NCQAC, and for the Director to provide performance measurement reports at each NCQAC meeting. It appears that all of the revisions were implemented.

W25.01: Outreach and Education

1st 2015 Recommendation 25: Include monthly and yearly goals for number of presentations by each Case Manager and Director. Also add to this section that WHPS CMs complete and file a monthly report of all outreach and educational efforts, which will be included in the monthly report noted in 13.22. The Director and all the CMs reported that they provide education and training frequently. Suggest that the Director spend more outreach time on developing on-going professional contacts and providing presentations to larger organizations and nursing employers, high level nursing administrators, supervisors and charge nurses. Education and outreach are very important functions that need to be maintained.

2nd 2016 Recommendation 25: None. A review of the revised recommendations was not accomplished, due to time constraints. The CMs reported that continuing education credit is now provided by NCQAC for these presentations, which should increase attendance.

W27.01 Program Evaluation:

1st 2015 Recommendation 27: Add the monthly performance audits and non-compliance reports to be generated by the Director to this policy. Provide more information other than program numbers in the monthly internal audit of thirty randomly selected files, and identify a liaison or committee of NCQAC to discuss and evaluate all the audits. The contents of these audits should be discussed with NCQAC so that useful and appropriate information will be included. Some of these audits can be generated from various reports in the AOS system, and could be individualized to provide more detailed information on specific compliance monitoring parameters, as well as non-

compliance reporting criteria, actions taken by staff, and mandatory non-compliance referrals to NCQAC.

2nd 2016 Recommendation 27: The Director apparently did not understand the additional requirement to provide a monthly program performance audit and program summary and non-compliance report. He continues to do a monthly internal audit for accuracy of AOS reports in thirty randomly selected files, and WHPS staff generates a monthly statistics report, yet again apparently the results of these have not been discussed and evaluated with the interim Associate Director of Operations. A process for how this and other performance reports will be reviewed needs to be implemented. The Director indicated that since the SUD taskforce was disbanded, there was no liaison or contact person with NCQAC with whom he could discuss the AOS audit, the statistics reports and the additional program performance and non-compliance summary monthly report. It is again recommended that the Director have a monthly meeting to review and discuss the internal AOS audit, the monthly statistics report, and the new monthly performance and non-compliance report with the interim Associate Director of Operations.

Report Summary and Final Recommendations:

The action of rewriting the WHPS P & P in the format of the NCQAC Policies and Procedures was a major undertaking that resulted in much more involvement and engagement by the SUD taskforce in late 2015, and ultimately the NCQAC. The WHPS policies and procedures had existed in a free standing format for many years prior to this, and the specialized subject matter required additional time and attention by NCQAC members to familiarize themselves with the language and intent of the WHPS policies, as well as the 2015 revisions. NCQAC members took responsibility for reviewing all these policies in detail, and included revisions that they believed were needed. The final draft of the NCQAC WHPS P & P was reviewed at the November, 2015 NCQAC meeting. The NCQAC authorized their final approval of the new policies in January, 2016. WHPS received the approved, revised P & P in February, 2016. These were implemented and operational by mid April, 2016, as reported by WHPS. A limitation to this audit was the short time frame available since the implementation of the new P & P. It would make sense to allow for a year of implementation of the new policies before the effectiveness of the revised policies could be fully evaluated. Another limitation was the small sample size that was reviewed. To gain a more comprehensive understanding of performance outcomes in implementing the revised P & P, more staff time to review a higher percentage of case files would be needed. In depth review of case files requires time and attention to detail. Only after a longer period of time has ensued for operational implementation of the P & P should major revisions be considered.

Acknowledgements:

The WHPS staff has undertaken a comprehensive revision of their day to day operations after receipt of the revised P & P from NCQAC. The Operations Manager stated that every single document used by WHPS was revised to some degree to meet the standards of the revised P & P. Every staff member has had to read, review and

apply the numerous and detailed revisions to their day to day monitoring activities. The fact that they had no external assistance or consultation from others was notable as revised P & P was such an important document in the major transition to moving under the auspices of NCQAC. That they assimilated and implemented the new details to such a high degree of success proves their high level of efficiency and effectiveness in monitoring activities, as well as a high level of adaptability to the new P & P.

General Recommendations:

1. If the interim Associate Director of Operations is to be the liaison with the WHPS Director, this fact should be clarified and formalized. The role of the liaison and level of participation with the Director also needs to be clarified and confirmed. The Director stated that he has had little contact with a liaison from NCQAC. One intended purpose of establishing this relationship was to provide a resource and consultant for the Director, and a link or intermediary between WHPS and the NCQAC to support transparency. A second purpose was to clarify the content and value of information with the required reports that was requested by NCQAC to provide adequate assurances of WHPS program efficiency and consistent evaluation of performance measures.

2. Regular, monthly meetings should be scheduled for face to face communication between the interim Associate Director of Operations and the WHPs Director to review and discuss significant reports and information.

3. The last audit from 2015 recommended that NCQAC identify a liaison or committee to serve as the initial point of contact and/or intermediary means of reviewing non-compliance reports and consequences and making preliminary decisions about the issues brought before them. The SUAT team at NCQAC seems to have informally evolved to serve some of this purpose. The WHPS Director and CM staff meet with this team to review and discuss the referral memos, current compliance of each nurse, and the increased monitoring requirements imposed by WHPS. All of the non-compliance memos still go to the NCQAC case management team for a final decision, and now include more background information and SUAT recommendations.

4. The WHPS Director has been scheduled to attend each NCQAC meeting on a regular basis to update and discuss the WHPS performance measures report. This has provided more “face” time in order for the WHPS Director and NCQAC members to become more familiar and engaged. It has also given NCQAC regular quality assurance updates.

5. The effectiveness of the WHPS program could still be increased with the addition of a qualified psychiatrist or psychiatric ARPN/ Clinical Director with extensive experience in mental health, SUD evaluation, treatment, and diagnosis as well as expertise in pain management and treatment. This individual could provide as needed and immediate professional feedback to staff members on clinical issues,

as well as be available to conduct required evaluations for medication management, chronic pain issues, unauthorized substance use, and for patterns of non compliance with drug screening protocols. A part time or contract position should provide the time and benefit needed. This has not occurred, apparently mostly due to financial constraints. This remains a strong recommendation.

6. WHPS staff are still not able to access and review PMP reports, but they did revise the Prescription Information Report required from all prescribers to request that they check the PMP and document this on the form. Because there were only four months of implementation, the utility of this revision could not be assessed.

Policy Recommendations:

1. Policy W01.01- Appendix A-Significant Material Non-Compliance: Revisions added expanded and specific consequences and actions required for each of the 13 examples. These included cease practice, SUD evaluations and report to NCQAC for most of the examples. A typo was noted in c. Missed drug tests; it says a 3rd missed test will be reported to NCQAC, and it should say a 2nd missed test will be reported to NCQAC. This will align it with the revision in W18.01 missed tests.

2. Conflicting policy statements were found in two policies. 02.01 Admission Types-1.F-the new revision states "if non-compliant with monitoring contract, and as agreed in contract, *will* be reported to NCQAC". 06.01 Terms and Conditions of Contract Compliance-E-original policy states "non-compliance with any of the terms of the contract *may* result in referral to NCQAC". This last policy statement is contained in the revised contract. NCQAC will need to discuss and decide which policy statement they want to retain.

3. Because the on-site review was only able to capture four months of the policy implementation, more time may be needed to determine the degree of implementation and effectiveness of any of the current revisions. There was feedback from staff that some of the revisions were burdensome and did not have an actual benefit for monitoring purposes. The following policy is one of these.

4. Policy W20.01 dilute and abnormal specimens revisions which added a "face to face meeting with the CM" upon submission of a 4th dilute in 3 months and a 4th abnormal in 6 months was reported as unnecessary as the CMs handle these issues by phone or email. After review and discussion by NCQAC, these meetings could be deleted in the future if they are determined not to have additional benefit.

Monitoring Recommendations:

The recommendations from the last audit that were specific to the internal and administrative processes of WHPS program and staff continue as the following recommendations.

1. A continuing recommendation calls for the development of more comprehensive documents in AOS to contain all information for mandatory reports and major incidents, creating more specific tracking methods and titles within the AOS system. WHPS was informed by AOS that no revisions to documents would occur until after 2016, so none of these policy revisions were implemented.

2. A continuing recommendation calls for the Director to generate the monthly program performance audit report that will include comprehensive information on program performance, tracking of specific non-compliance events, such as positive, dilute and abnormal specimens, and missed check-ins, cease practice requests, including staff responses, and monthly discussion of this report with the NCQAC liaison. This report is required in the following revised policies: 01.01, 11.01, 12.01, 13.01, 17.01, 22.01, and 27.01. These could be used as a QA measure to assist and support staff as well as to keep NCQAC informed of critical information and performance measures. The reports would also contribute to the request for more transparency and accountability in the developing relationship with NCQAC. These reports would also provide NCQAC with a baseline of ongoing P & P performance outcomes and provide guidance for any future audit needs and focus.

3. A continuing recommendation calls for the Director to create a "decision grid" or summary table to address frequent non-compliance incidents and guidelines for consequences based on the revised policy and procedures. This grid would verify the sequential and increasing consequences for first and subsequent violations and follow-up required by staff, such as dilute and abnormal specimens, missed check-ins and missed tests, and could serve as a quick reference or desk guide for staff. This could be reviewed and approved by the NCQAC liaison or NCQAC. An example of one such grid was provided to the Director during the 2015 on-site visit, with the suggestion that he develop a similar tool for the WHPS program. This could offer staff a quick review tool for the new monitoring guidelines.

Respectfully Submitted,

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