Approved March 2, 1992
Date She

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Carol H. Sader at
Chairperson

_____ a.m./p.m. on February 13, , 1992 in room 423-S of the Capitol.

All members were present except:

Representative Carmody, excused.

Committee staff present:

Bill Wolff, Research
Norman Furse, Revisor
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Katherine Pyle, representing AARP
Alice Nida, Kansas Department on Aging
Rosemary Harris, Outreach/Older Citizens Information
Sharon Spencer, Interested Citizen
Marilyn Bradt, Kansans for Improvement of Nursing Homes
George Vega, Acting Commissioner, Mental Health/Retardation Services Department of SRS
Yo Bestgen, Kansas Association of Rehabilitation Facilities
Terri Roberts, Kansas State Nurses Association
Diana Jarvis, Eye Institute of St. Francis Hospital
Sharon Arnold, interested mother
Pat Johnson, Executive Director, State Board of Nursing
Elizabeth Taylor, Licensed Practical Nurses
Karen Testa, Parent/children's advocate
Sue Denger, Kansas Organization of Nurse Executives, Wichita, Ks.
Steve Preston, practicing Registered Nurse Anesthetist
Gina McDonald, Executive Director of Kansas Association of Centers for Independent Living

Chairperson Sader called the meeting to order and greeted all those present and welcomed the nurses on their day at the Capitol. Chair drew attention to the agenda, and noted hearings would continue on **HB 2844** that were not completed yesterday.Chair requested all conferees make their remarks as concise as possible since there are many scheduled again today, and several members will need to be excused by 2:45 again for a Joint Committee meeting. She requested conferees limit their remarks to 3 minutes or less. Chair also suggested that those members who are required to leave early do so. She would appreciate it if all other members stay. Hearings will be continued until 3:00.

HEARINGS CONTINUED ON HB 2844.

Katherine Pyle, member of Capital City Task Force of Kansas AARP gave hand-out to members, (Attachment No. 1). She stated support for **HB 2844.** She noted that one unintended consequence of the 300% cap is that, according to federal regulations, a couple's assets must be calculated in a way that subverts the intent of the Kansas division of assets law. As a result many cases have arisen in which the lion's share of the couple's income must be spent on nursing home costs, while the other spouse tries to make do in the community on next to no income. Another unintended consequence is that those who cannot receive Medicaid support because of ineligibility can nolonger live in the community, and cannot afford nursing home costs, so what are they to do? This is an intolerable situation she said. Ms. Pyle asked members to eliminate the cap.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S Statehouse, at 1:30 a.m./p.m. on February 13, 1992

HEARINGS CONTINUED ON HB 2844.

Alice Nida, Kansas Dept. on Aging (Attachment No. 2) noted that ironically, the cap has increased the cost of caring for older Kansans. In the short run, **HB 2844** would save money, but in the long run, the state would have to pick up additional costs of $290,449, but could pick that up again from estate recovery. The Department supports this estate recovery system. She stated the SRS Task Force recommended the federal government change its rules, but Department on Aging believes that will only prevent Kansas and other states who have chosen to have a medicaid cap from allowing a spousal impoverishment deduction prior to determining eligibility. By approving **HB 2844,** Kansas has the option to choose the medically needy Medicaid category and allow spousal impoverishment protections again. The Department on Aging supports the shift to community-based programs, increased health care information, and estate recovery. We do not support keeping the most medically vulnerable older Kansans from needed health care. We pledge to continue to work together with SRS and Health and Environment to build a better long-term care system. She answered numerous questions.

Rosemary Harris, Outreach/Older Citizens Information (no hand-out offered), noted she does not have pages of statistics, her comments deal with the more personal side. She deals with people on one-on-one situations in their homes. She see 10-12 individuals alla the time. She expressed concerns for restrictions eliminating people from eligibility for care in adult care homes; community based services. Some are non-eligible for a Medicaid card, they can't get a spousal impoverished card, what can they do.

At this point Chairperson Sader referred to staff for clarification on a point made by Ms. Harris. Mr. Wolff stated the 300% cap applies to nursing home reimbursement of eligibility for coverage in a nursing home but does not affect eligibility for other medicaid services that might include pharmaceuticals, home/community based services, those kinds of things.

Chair suggested Ms. Harris might wish to impart that information to those individuals that she sees regularly. It may help them a little. Chair noted, this is not to speak to the merits or demerits of **HB 2844**, it is just a clarification.

Sharon Spencer spoke on behalf of her parents, not residing in a nursing home in Derby, Kansas. It appears all their financial planning has been negated by legislation this past September. They split their assets last June, prior to the father's failing health in order to protect some of their limited resources for his extended care. The imposed cap was to force a reduction in the cost of nursing home care, but instead she believes, it forces nursing homes to provide substandard care or forces those with no resources who fall just above the cap to move into facilities or housing not fully equipped to take care of the health needs of these individuals. As a result of stricter government restrictions, many nursing homes have ben closed because of poor quality care. This has been caused because, on the one hand, regulations say standards must be met, on the other, they say expenses must be reduced. An impossible situation results. She stated her parents are moving back into a small apartment in order to reduce their cost of living and try to protect their limited income as long as they can. My father is a proud man, she said, and he won't remain in the nursing home and be kicked out when his resources are gone. She urged Committee to eliminate the eligibility cap. (See Attachment No. 3).

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 a.m./p.m. on February 13, 1992

HEARINGS CONTINUED ON HB 2844.

Marilyn Bradt, Kansans for Improvement of Nursing Homes, Inc. gave hand-out (Attachment No. 4). She noted **HB 2844** will stem the tide of nursing home care costs. In the short run, it will save money. In the long run, we can look at better ways of trying to keep older individuals in their own homes longer. KINH is in full support of diverting from nursing home care anyone who can be safely cared for at home. We support the pre-admission screening bill which will help identify the services that will enable these people to stay in their own homes. We support an estate recovery program, as proposed in the SRS budget, to recover the state's Medicaid costs. KINH did not support the income cap during the 1991 session. We believe the results of it have been disastrous for a great number of individuals. She urged Committee to reverse that decision by supporting **HB 2844.**

Chair indicated there was written testimony provided by persons who could not appear in person today, and she urged members to read over this testimony.

HEARINGS CLOSED ON HB 2844.

Chair directed staff to give a briefing on **HB 2882.**

Mr. Wolff gave a detailed explanation on both practice acts, **HB 2882, HB 2883.**

HEARINGS BEGAN ON HB 2882.

Chair again requested all conferees please confine their testimony to three minutes or less because of time restrictions.

George Vega, Acting Commissioner of Mental Health/Retardation, Dept. of SRS offered hand-out (Attachment No. 5). He presented a recommendation to amend **HB 2882** that has been agreed to by representatives from Mental Health/Retardation Services and the Board of Nursing in discussions they all have held over the last few weeks. To add "o" would allow nursing procedures to be performed by staff of community agencies licensed by SRS pursuant to rules and regulations developed by the Board of Nursing and SRS. This would allow administration of simple medication to be done for individuals with disabilities who require that assistance. This proposed amendment will assure quality control in medication administration (or other nursing procedure could be done for a specific client by a specific staff person; clear up confusion over what can and cannot be done in community adult programs licensed by SRS; make it more probable that adults with disabilities can live in the community and not be isolated simply because they require help with administering medications. He answered questions.

Yo Bestgen, Ks. Rehabilitation Facilities stated support for **HB 2882.** and the amendment she proposed, (See Attachment No. 6). She noted they would request one change in the language, i.e., "performance of services to persons served by". She detailed rationale and answered questions.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 ~~a.m.~~/p.m. on February 13, 1992

HEARINGS CONTINUED ON HB 2883.

Terri Roberts, Kansas Nurses Association, (Attachment No. 7), stated that new language proposed under "Acts which are not prohibited" was the result of a long, cooperative effort by a number of state-wide nursing organizations and the Board of Nursing. The definition of supervision arrived at, is "Provision of guidance by a qualified nurse for the accomplishment of a nursing task/activity with initial direction of the task/activity and periodic inspection of the same. Total nursing care of an individual remains the responsibility and accountability of the nurse. She stated the proposed language, "independent nursing judgment" permits/authorizes the licensed nurse to make the decision whether or not to delegate a particular activity. This decision does not rest with an employer of any other individual, but with the licensed nurse. She drew attention to a copy of the nursing delegation issues in Kansas,, part of a paper provided with her hand-out.

Diana Jarvis, Administrator, Ks. Eye Institute of St. Francis Hospital gave hand-out, (Attachment No. 8). She requested, on behalf of many individuals, that the ophalmic tech on her staff be allowed to administer dilation drops (UNDER THE SUPERVISION) of the charge RN in the department. She gave rationale, then requested an amendment to **HB 2882** as follows: new (j) to add language, "The administration, under the supervision of a registered nurse or licensed practical nurse, of topical dilation medications to patients per orders of the attending ophthalmologist or optometrist." She answered questions.

Susan Arnold, concerned and interested parent of a child with severely multiple handicapped condition, gave hand-out (Attachment No. 9). Family and friends and school personnel have helped administer medical management/ostomy management for her child since he began early intervention at the age of three. She noted how vital the medical management is to his well-being. She believes simple instruction and training of daily care nursing tasks can be successfully taught to care providers. She would trust those persons, given training, to provide the tube feeding/general basic ostomy management to be administered to her son. Restrictive practices and expenses are an unnecessary deterrent to participation and performance in regular school activities.

Pat Johnson, Kansas State Board of Nursing offered hand-out, (Attachment No. 10). She stated **HB 2882** has been developed with a number of nursing organizations along with the Board of Nursing. **HB 2882** will provide language to allow nurses to delegate nursing practices. Education will be needed, so that nurses understand this change in the law. There is no anticipated negative effect from this recommendation and it would hopefully allow for greater flexibility/utilization of nonlicensed staff. The proposed change recommended by the Department of SRS needs to be carefully worked out so the mentally retarded can be taken care of properly. She cited some practical situations that present the need for this change in the law. She urged support. Ms. Johnson answered questions, i.e., "o" seems to help because "n" as proposed not broad enough.

Elizabeth Taylor, Federation of Licensed Practical Nurses, gave hand-out, (Attachment No. 11). She noted the task of those who have worked so hard on agreed language before Committee today. Their group supports the language in the current bill. She cautioned expansion of that language because the general position of the Kansas Licensed Practical Nurses on delegating further nursing procedures to non-nursing personnel, is against such delegation. They are concerned that not all individuals will be provided the same level of nursing care without the direct supervision by a licensed professional or practical nurse.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S Statehouse, at 1:30 a.m./p.m. on February 13, 1992

HEARINGS CONTINUED ON HB 2882

Karen Testa, parent of a 19 year old severly multiple disabled son, offered hand-out (Attachment No. 12). She gave background on her son's physical and medical needs; that a restriction in the provision of care will complicate her son's life, and it will cost much more to have these needs met. Now, because of current rules, a trained direct caregiver can nolonger administer medications to her son and his peers. The Shelter Living, where he resides, has to hire nurses and licensed practical nurses for this procedure. She has cared for him herself, and now is training the nurses and others to administer the medications. Her son and his peers are suffering while this transition is taking place. She stated she would rather see the high costs go for upgrading the salaries of the direct care providers with experience and be applied to a better ratio of workers per clients.

Sue Denger, Ks. Organization of Nurse Executives noted support for the proposed amendment (n) which states that no provision of this law shall be construed as prohibiting; "(n) performance of a nursing task by a person when that task is delegated by a licensed nurse, within the reasonable exercise of independent nursing judgment and is performed with reasonable skill and safety by that person under the supervision of a registered professional nurse, or a licensed practical nurse." She called attention to a Resolution on Delegation in her hand-out (Attachment No. 13). She urged passage of **HB 2882.**

Gina McDonald, Ks. Association of Centers for Independent Living, noted concerns with (n) because it could adversly impact self-directed services. Health maintenance services are defined as including a list of medically assisted services. She detailed the list, noting (n) states those activities must be delegated by a licensed nurse and performed, under the supervision of a registered or licensed practical nurse. If we cannot add that language, or delete entirely the letter (n) proposed the Ks. Independent Living Centers must oppose the bill. She answered questions, i.e. the amendment (o) is fine. (see Attachment No. 14).

Chair requested those conferees who might return tomorrow, please do. Those who cannot please leave their printed testimony and it will be considered by Committee members.

Kay Hale, Kansas Hospital Association provided written testimony, (Attachment No. 15).

Mr. Steve Preston, Registered Nurse Anesthetist could not return because of a surgery schedule. Chair invited him to make a brief comment.

HEARINGS BEGAN ON HB 2883.

Mr. Steve Preston, Chair of Government Relations Committee, Ks. Association of Nurse Anesthetists offered hand-out (Attachment No. 16). He stated support for changes made by the State Board of Nursing which allow a registered nurse anesthetist enrolled in a refresher course to be granted temporary authorization to practice for not more than 180 days. They do oppose, however, fee increases. He detailed each of these and stated concerns. They oppose the change on page 3, line 5, the word "initial" being changed to "first licensing exam", and he indicated there is a need to be recruiting new graduates not dissuading them, since nurse anesthetists are the sole providers of anesthesia in 110 of 132 hospitals in the state. He answered questions.

Chairperson Sader stated on Monday, hearings would be completed on both **HB 2882 and HB 2883.**

She thanked all for their contribution today and for their patience.

Meeting adjourned at 3:06 p.m.

K. Pyle

TESTIMONY FOR THE PUBLIC HEALTH AND WELFARE COMMITTEE, KANSAS HOUSE OF REPRESENTATIVES, CONCERNING HB 2844

Topeka, Kansas, February 11, 1992

Madame Chairperson and Members of the Committee:

I am Katherine Pyle, a member of the Capital City Task Force of Kansas AARP.

I am pleased to testify in favor of House Bill 2844, eliminating the cap on Medicaid assistance to nursing home residents at 300% of the poverty level. The members of Kansas AARP recognize that the intent of this cap was to slow the ever-increasing drain on SRS funds that results from state aid to elderly nursing home residents whose income has fallen below the cost of their nursing home. We sympathize with the intention. However, as I am sure this Committee has learned in the five months since the cap was instituted, its effect upon a number of our elderly citizens has been catastrophic.

One unintended consequence of the cap is that, according to federal regulations, a couple's assets must be calculated in a way that subverts the intent of the Kansas division of assets law. As a result, a number of cases have arisen in which the lion's share of a couple's income must be spent on nursing home costs for one spouse while the other, almost always the wife, tries to make do in the community on next to no income at all.

A second unintended consequence is that a number of individuals whose income barely exceeds 300% of the poverty level cannot receive Medicaid support, cannot afford the full cost of a nursing home, and can no longer live in the community. I am sure you have heard of as many of these cases as we have. The most recent one we learned about is a 92-year-old widow, blind and childless, whose social security income plus a World War I pension from her husband places her income just $20 over the cap, substantially below the cost of her nursing home. The nursing home cannot subsidize her residence indefinitely; she cannot take care of herself in the community; and she has no family who might come to her aid. What is she supposed to do?

I am sure that you agree with me that it is simply unconscionable, at the end of their lives, to place law-abiding elderly citizens, who have worked and paid taxes all their lives, in such an intolerable situation. Kansas AARP urges eliminating that cap by passing House Bill 2844 as soon as possible.

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attm #1.

Testimony on HB 2844

by the
Kansas Department on Aging

before the
House Public Health & Welfare Committee

February 12, 1992

Chairman Sader and members of the committee, the Kansas Department on Aging testifies today in favor of HB 2844. The medicaid cap issue has generated lots of interest and concern among older Kansans. The Kansas State Advisory Council on Aging made it their major concern in 1992. The Council's annual report said: "Legislative expansion of the Senior Care Act program statewide and repeal of the 300 percent cap are the highest priorities of the State Advisory Council." We concur.

I want to discuss three aspects of the issue: the alternatives to institutional care, the cost of the cap, and division of assets.

Alternatives to Nursing Home Care

Expansion of in-home services is not an adequate solution for people who have been eliminated from the medicaid program by the 300% cap. In the first place, the cap saves money for the medicaid program, which has an income requirement that effectively denies in-home services to people with incomes higher than the 300% cap. Nor does the Senior Care Act provide an alternative for people who are above the cap. Only three areas of the state are served by the Act this year and three more perhaps next year. Even if all people above the cap could rely instead on in-home services, these services are not available statewide. We support Kansas placing more emphasis on community based care.

We cannot assume that people needing nursing home care can be served in the community. The cap arbitrarily eliminates eligibility for nursing home care without regard to medical need. Kansas has essentially deinstitutionalized these people without providing an alternative. We once did the same thing to mental health patients in our hospitals.

Fiscal Impact

Ironically, the cap has increased the cost of caring for older Kansans. In the short run, HB 2844 would save the state money, because we humanely covered the cost of care with state funds for those people who qualified for medicaid before September 1, 1991. Our estimate is that HB 2844 would save the state $345,850 in the short run. A copy of our fiscal impact estimate is attached.

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Att #2
1-4

In the long run, the state would have to pick up an additional cost of $290,449 in current dollars at current costs. The state would recover most of that from estates, if recovery mechanisms are instituted as proposed in SB 607. The governor's budget estimates recovery in the first year of $201,000. We support estate recovery.

Division of Assets

SRS announced last summer that division of assets could not be an option for people with incomes above the cap. HB 2844 solves this problem by moving us back to June 1991 eligibility standards. The medically needy program in effect in June did not restrict our access to federal spousal impoverishment protections.

The SRS Task Force recommended that the federal government change their rules. Kansas can solve this problem without Congressional action. Federal law only prevents Kansas and other states who have chosen to have medicaid caps from allowing spousal impoverishment deduction prior to determining eligibility. By approving HB 2844, Kansas has the option to chose the medically needy Medicaid category and allow spousal impoverishment protections again.

The division of resources is still theoretically available to couples who are denied medicaid because of income in excess of the 300% cap. The income test will always deny eligibility to the ill spouse. In the real world, the at-home spouse will have to spend whatever it takes to privately pay for the ill spouse.

Most spouses are forced to choose to spend all they have on nursing home care and go without, or to bring the ill spouse home and try to keep people at home who really need nursing home care.

Conclusion

We have visited with SRS on this issue and we understand the issues that brought about the changes in September, 1991. We support the shift to community based programs, increased health care information and estate recovery. We do not support keeping the most medically vulnerable older Kansans from needed health care. We pledge to continue to work together with SRS and Health & Envirionment to build a better long term care system.

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Fiscal Impact SB 548 & HB 2844

Savings from Medicaid Coverage of Grandfathered Residents

Annual Cost -- $800,000[1]

SGF if cap removed -- $800,000 (.41)[2] = $328,000

Net savings -- $800,000 (.59)[3] = $472,000

Cost of Medicaid Coverage for New Admissions Over Cap

Average cost per person -- $800,000 / 445[4] = $1,798 or $150/month

Number of rejected admissions per year -- (23)[5] (12) (.884)[6] = 244

State share of medicaid coverage -- (244) (.41) ($150) (8.4 months)[7] = $126,050

Net savings from removing cap -- $472,000 - $126,050 = $345,850

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[1]Estimate by SRS in testimony before the Joint Committee on Administrative Rules and Regulations, September 1991

[2]The state share of medicaid is 41%.

[3]The federal share of medicaid is 59%.

[4]SRS testified in September, 1991 that 445 persons were covered by the grandfather provision.

[5]SRS testified on January 21, 1992 that 23 people were denied nursing home facility coverage in September, 1991. If the number increased to 86 people per month, the state would break even.

[6]Assumes the passage of Sub. HB 2566. SRS estimates that 11.6% of persons entering nursing homes will be diverted.

[7]The SRS fiscal impact statement on HB 2566 estimated that people admitted to nursing homes stayed for an average of 8.4 months.

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Additional Comments:

The impact of the cap on individuals and spouses is far larger than the impact on SRS. The $150 average expenditure for grandfathered residents makes up the difference between income and the medicaid rate of reimbursement. People who are not grandfathered residents must make up the difference between income and the private rate.

Long Range Impact:

As people who were grandfathered died, the savings from removing the cap would decrease. The state cost would eventually be $290,449 (($1,798)(445)(.884)(.41)), assuming no increase in the number of residents and no inflation in the cost of nursing home care above the inflation in income sources and the passage of Sub. HB 2566.

State costs would be recovered by SRS as recovery is implemented as recommended by the Governor and the SRS Task Force. The Governor's budget assumes that $201,000 will be recovered in FY '93. More recovery is expected in future years.

Removing the cap would also avoid increased public expenditures for spouses who are impoverished by the inability to divide income and qualify for medical assistance.

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2-13-92
att #2
4-4

February 12, 1992

TESTIMONY PRESENTED TO THE

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

By Sharon Kay Spencer

RE: House Bill #2844 "Relating to Persons Eligible for Coverage of Adult Care Home Costs"

Representative Sader and members of the House Public Health and Welfare Committee, thank you for the opportunity to present my views of the complex Medicaid Eligibility rules and specifically to address the issue of the cap imposed last September to qualify for Medicaid assistance.

My parents, Ward and Moetta James now reside in Westview Nursing Home in Derby, Kansas. Dad, who is almost 88, worked hard all his life in a blue collar job, raised three children and managed to put away some money in savings prior to retirement. He is now legally blind and recovering from bladder surgery and radiation treatments for prostate cancer. Mom, age 79, suffered a stroke last May which left her partially paralyzed and in a wheelchair. They split their assets last June, prior to Dad's health failing, in an attempt to protect some of their limited resources for his extended care. It now appears that all their planning has been negated by legislation passed last September.

The cap was imposed, as I understand it, to force a reduction in the cost of nursing home care. Instead, I believe it forces nursing homes to provide sub-standard care or forces persons with no resources who fall above the cap to move into facilities or housing not equipped to take care of their health care needs.

Stricter government regulations have been imposed to assure appropriate nursing home care is being provided. As a result, nursing homes in Kansas and nationwide have been closed because of poor quality care. I am not suggesting this is wrong; however, when on one hand our government requires certain standards be met and on the other hand it says expenses must be reduced, a difficult, if not impossible situation is created.

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attm #3

Nursing home care costs are on the rise. That is a fact. It is also a fact that more people are living longer and needing that care, It is expensive to provide 24-hour care by qualified nursing staff, three meals per day, personal care needs, exercise, therapy and activities. Not to mention the miriad of paperwork and recordkeeping required. It is hard, demanding and sometimes thankless work, provided by dedicated, caring individuals who also deserve a living wage for their services.

My parents are more fortunate than many. They are receiving excellent care and have some resources remaining. Their combined income is presently $1,501 per month ($1,257 is Dad's; $244, Mom's). However, within less than one year, all their resources will be gone because their care now costs close to $4,000 per month with therapy and medications. According to articles published in the December 1991 issue of Active Aging (enclosed) they will not qualify for Medicaid assistance because the change in the laws last September does not allow for division of assets if their combined income exceeds $1,221 per month. (I understand that the amount is now $1,266 per month).

As a result, Dad has decided he is moving he and Mom back into an apartment to reduce their cost of living and protect their limited income as long as he can. He's a proud man and says he won't remain in the nursing home and be kicked out when his limited resources are gone. He's already dropped Mom twice in an attempt to prove he is capable of taking care of her.

It would be a shame to place my parents and many others like them who have made positive contributions to our communities for many years into what could be potentially life-threatening situations because an arbitrary lid was placed on the cost of their care. On behalf of our increasing aging population, I ask that you reconsider the legislation placing a cap of $1,266 on Medicaid eligibility and reinstate the allowance for division of assets.

PH+W
2-13-92
Attm. #3

Planning to maximize Medicaid eligibility

It has been said that only the Internal Revenue Code rivals the rules for Medicaid eligibility in terms of sheer complexity. On top of that, Medicaid planning also necessarily overlaps with complex estate planning and tax principles. Thus, seeking appropriate counsel in this area normally requires the services of an attorney well versed in all three areas.

This month's column is devoted to the basic approaches to Medicaid planning. Although Medicaid coverage extends beyond nursing home care, it is this benefit that will be the focus of this column.

Statistics tell us there is a 40 percent chance an adult over the age of 65 will at some point in his or her life reside in a nursing home. The average nursing home stay in Kansas is about 4.5 years. Kansas monthly nursing home costs now average close to $2,000. It does not take a mathematical wizard to determine that the cumulative cost of nursing home care can often exceed $100,000.

As Medicaid is a "need based" program, unlike Medicare, an individual must be of limited resources before qualifying. There are certain exempt resources that are not counted. These, basically, are a home and contiguous acreage, a car, personal effects, prepaid burial, prepaid funeral, a $1,500 life insurance policy and $2,000 of other resources.

For married couples, in addition to

It's a Matter of Law

By Timothy P. O'Sullivan

exempt resources, the law allows the well spouse to keep one-half of the non-exempt resources (determined at the time the infirm spouse goes into the nursing home), with minimum of approximately $14,000 and a maximum of approximately $67,000.

This is the so-called "division of assets" protection available to married couples. In addition to division of assets protection, the well spouse is allowed to retain income of approximately $850.00 per month (plus, in limited circumstances, housing allowances), even if this means that a portion of the infirm spouse's income must be set aside for the well spouse to bring his or her income up to such minimum income level.

The 1991 Kansas legislature enacted a final significant qualification impediment. For new individuals otherwise qualifying for Medicaid on or after September 1, 1991, if such individual has more than $1,221 of income, he or she is ineligible. This arbitrary and capricious provision renders individuals ineligible, even through there are few, if any nursing homes in Kansas whose monthly charges do not exceed this rate. Hopefully, the 1992 Legislature will rectify this inequity.

For single or married individuals meeting the resource and income qualifications, all income (including social security, pensions and annuity income) of the nursing home resident must go to the nursing home. Medicaid will then pay to the nursing home the difference between such income and the applicable Medicaid reimbursement rate.

Medicaid planning may involve four areas: gifting, maximizing exemptions, estate planning, and sometimes a divorce or separate maintenance action.

One can gift away non-exempt resources to get down to qualifying resource levels. One obvious drawback to this strategy is that the gifted property is no longer within the donor's control. A second problem is that for every $1,500 transfer, the donor is disqualified for Medicaid one month, up to a maximum of 30 months. Finally, there is no certainty that Medicaid, being a state option program, will be available to provide for nursing home care when and if the need arises.

One possible approach addressing these problems is for children to whom property has been gifted, under no pre-arrangement with the donor, to create an irrevocable trust. Distribution from the trust to the donor could then be made supplemental to governmental resources during his or her lifetime.

A second area of Medicaid planning is maximizing resource exemptions through the conversion of non-exempt property into exempt property. Examples are paying off mortgages on a personal residence, making improvements in the residence, purchase of a car or trading for one having a higher value, and purchase of furniture and personal effects. For reasons too complicated to discuss here, spouses wishing to take advantage of the division of assets law often should not convert non-exempt resources into exempt resources before the infirm spouse goes into the nursing home.

The third principal planning area is estate planning. Consideration should be given to living trusts, durable powers of attorney (which are good during incapacity) for property management and health care, and living wills. Proper usage of these estate planning tools normally avoids the necessity of a court-appointed guardian or conservator during in-

Continued on next page

Medicaid

continued from page 1

"It's a shame...she served the community well for many years...that she has to be penalized," her nephew said.

State officials say that there are many cases similar to Mary's across the state.

Donna Whiteman, secretary of Social and Rehabilitative Services, appearing at a special legislative hearing in September, recommended that the cap be left in place until the 1992 legislative session to allow SRS time to analyze the impact of the new guidelines.

Several senior advocacy groups, including the Silver Haired Legislature, have vowed to lobby the legislature for a change in the eligibility guidelines and re-instatement of division of assets. Seniors are encouraged to contact their legislator before the session and during the 1992 legislative session to encourage legislation to change the 1991 ruling.

Legislature to look at Medicaid eligibility rules

A legislative priority for most senior lobbyists for the 1992 session of the Kansas Legislature will be changing income requirements for nursing home residents to qualify for Medicaid and re-instating division of assets.

Division of assets, passed by the state in 1988 and the federal government in 1989, allows a husband and wife to protect a portion of their combined income and resources when one of them requires long-term care. The intent is to allow the well spouse to maintain certain income and assets and help the spouse needing long-term care qualify for Medicaid benefits to help pay for that care.

The new rule, passed in an appropriations bill intended to cut Social and Rehabilitative Services spending for nursing homes, raised the Medicaid eligibility to an income level of ~~$1,1221~~ per month and does not allow for division of assets if their joint income exceeds $1,221 monthly.

The effect of this ruling has been felt statewide, with many people facing tough decisions on providing care with inadequate resources.

To illustrate the effect, consider the case of a Wichita woman we will call Mary.

Mary, 94, is a retired teacher who never married. Her only remaining family are some nieces and nephews, all of whom live out of state. Her mind is vague, she really doesn't know any of her friends and family, she is incontinent and needs constant care. Mary has been in a Wichita nursing home as a private pay patient for the last six years, with the bills for her care, now at approximately $2,100 per month covered by her pension and proceeds from the sale of her home, totaling $1,250 per month. A burial plan is her only other asset.

This fall, her conservator, a nephew who lives in Georgia, was in Wichita and was looking into applying for Medicaid, as his aunt's resources were running low. He found that her income is $39 per month over the Medicaid eligibility cap, so she will not qualify for Medicaid assistance. Her monthly income falls nearly $1,000 short of the cost for her care at a nursing home.

About the only recourse that her family can take is to try to find someplace that will accept Mary on the basis of what she can pay.

Continued on page 20

Aging is a good process
Story on page 4

Beat the winter blahs
Story on page 6

A New Year's verse
Vagaries on page 8

Hypothermia poses risks
Story on page 14

Attm #3
pg #4
PH/W
2-13-92

KINH Kansans for Improvement of Nursing Homes, Inc.

913 Tennessee, suite 2 Lawrence, Kansas 66044 (913) 842-3088

TESTIMONY PRESENTED TO
THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE
CONCERNING HB 2844

February 12, 1992

Madam Chairperson and Members of the House Public Health and Welfare Committee:

The Kansas Legislature has become increasingly and understandably disturbed by the growth in the Medicaid budget for nursing homes over the past several years. At the same time legislators have been reaching a common mind in understanding that not only is in-home care generally less costly than nursing home care, it is also the kind of care nearly everyone would prefer. The question is how to reach the goal of limiting expenditures for nursing home care and diverting state dollars to home care and services.

The 1991 session of the Legislature, with the intent of containing the cost of the nursing home budget and in so doing beginning to redirect Medicaid dollars from nursing homes to in-home care services, set a limit at 300% of the Supplemental Security Income (now $1,266) as the amount of monthly income a person could have and still receive Medicaid nursing home assistance.

Knowing that to do so would severely affect people who were already served by the Medicaid program in nursing homes, the Legislature "grandfathered" the approximately 445 people in nursing homes who were Medicaid eligible before the effective date of the legislation, September 1, 1991.

Unfortunately the result has been to disrupt the lives of a number of persons already in nursing homes and to prevent some people who can't be adequately cared for at home from receiving the nursing home care they need.

While that group of 445 "grandfathered" nursing home residents were protected, it did not protect those who were still private pay residents on September 1st, but, since that time, have depleted all their resources and need Medicaid assistance if they are to be able to remain in the nursing home. Nor is there any way of accommodating people whose functional disabilities have progressed beyond the point that home care is suitable, yet who haven't the means to pay the full cost of nursing home care.

In yet another category of persons adversely affected, a quirk of federal regulation does not permit spouses to divide their income under the Federal Spousal Impoverishment Act as envisioned and intended by the act.

Instead of simply keeping those individuals out of nursing homes who could be cared for in other ways, this legislative action has worked in some instances to penalize people who have no other choice. What is more, it is questionable that it has saved money. The 445 persons whom the state has permitted to remain in the Medicaid program are being paid for with all state funds, instead of splitting the cost with the federal government as would be the case if they were still Medicaid eligible.

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2-13-92
Attm. #4
pg 1-2

We have been told that there are some who could afford to pay the cost of nursing home care but have sheltered their income through trusts or gifts or whatever ways estate attorneys can devise. If that is a problem, address your solution to the ways in which it is possible to shelter income inappropriately. Do not punish those who have little to shelter and who haven't the means to pay for basic survival care.

With regard to the Division of Assets, we have understood that it is not, for the most part, those couples having either substantial assets or income who are availing themselves of the Division of Assets legislation. It is those whose resources, if not divided, will leave the community spouse without sufficient income to live in decency.

Poor is not a given dollar amount. Poor is when you don't have enough money to survive at the most basic level. That is the population the medically needy nursing home program is intended to address -- those persons who are impoverished beyond their capacity to survive if they pay for the nursing home care they have been determined through assessment to need.

Those adversely affected are among the most frail and vulnerable segments of society.

In the short run, the income cap does not appear to be saving a significant amount of money. Even if there prove to be long-term savings, that will have been achieved through solving one problem by creating another in cutting off access to nursing home care to people who cannot be cared for other ways.

A more appropriate way to limit nursing home expenditures is to see that needed home care services are in place in the community and to help connect people and services; to divert into those services everyone who can benefit by them; and when the state has assisted with nursing home costs under the Division of Assets, assure that as much as possible of its expenditure be recovered from the estate, upon the death of both spouses.

KINH is in full support of diverting from nursing home care anyone who can be safely cared for at home. We support the pre-admission screening bill which will help people to identify the services that will enable them to remain in their own homes. We support an estate recovery program as proposed in the SRS budget to recover the state's Medicaid costs.

KINH did not support the income cap established by the Legislature in the 1991 session. We believe the results have been disastrous for a number of individuals. We urge you to reverse that decision by supporting HB 2844.

Marilyn Bradt
Legislative Coordinator

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Attmt #4
2-13-92
2-2

G. Vega
SRS.

Kansas Department of Social and Rehabilitation Services

Testimony Presented to the
House Committe on Public Health and Welfare
Regarding House Bill 2882
Board of Nursing and Medication Administration

February 13, 1992

Presented by:

George D. Vega, Acting Commissioner
Mental Health and Retardation Services
Department of Social and Rehabilitation Serivces
Telephone (913) 296-3773

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Attm #5

pg-1-3

Thank you for allowing me to present to you today on HB 2882. This bill includes a list of nursing tasks which may lawfully be performed by persons who are not nurses. Along with this testimony, I have prepared a proposed amendment that would add one more item to this list.

This additional item, which would be in Section 1, item "o", has been agreed to by representatives of MH&RS and the Board of Nursing in discussions over the last few weeks.

This item "o" would allow nursing procedures to be performed by staff of community agencies licensed by SRS pursuant to rules and regulations developed by the Board of Nursing and SRS. MH&RS is particularly interested in seeing this proposed amendment become law so that simple medication administration may be done for persons with disabilities who require that assistance.

It is not uncommon for some persons with disabilities not to know when to take their medication or to be unable to count out the proper number of pills specified on the prescription label. This bill will allow staff of community agencies to administer those medications pursuant to regulations developed by the Board of Nursing and SRS.

The law already allows for staff of school districts to administer medications for students with disabilities. The amendment SRS proposes would extend that possibility for those students who graduate from school and move on to adult services in the community. Indeed, the language proposed for this amendment parallels the language used for schools in items "k" and "l" in the current law.

SRS favors this proposed amendment because it believes that it will:

1. assure quality control in medication administration (or any other nursing procedure) because a licensed nurse would control what specific nursing procedure could be done for a specific client by a specific staff person. A nurse would not be required to delegate if the nurse did not feel sure that the procedure could be safely performed;

2. clear up confusion over what can and cannot be done in community adult programs licensed by SRS; and

3. most importantly, make it more probable that adults with disabilities can live in the community (and not be cut off from that possibility because of the help they require for the medications they take).

I will be happy to respond to any questions the committee may have.

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attm #5

SRS AND BOARD OF NURSING

PROPOSED AMENDMENT TO
HOUSE BILL NO. 2882

(o) performance, in entities licensed by social and rehabilitation services pursuant to K.S.A. 75-3307b or K.S.A. 39-1501, of selected nursing procedures, as specified by rules and regulations of the board and social and rehabilitation services, necessary to accomplish activities of daily living and which are routinely performed by the individual or individual's family in the home setting.

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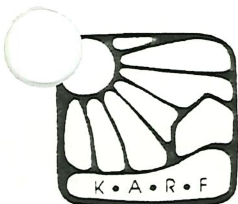
3-3



Kansas Association of Rehabilitation Facilities
Jayhawk Tower • 700 Jackson • Suite 212 • Topeka, Kansas 66603-3731
(913) 235-5103 • Fax (913) 235-0020

TO: Representative Carol Sader, Chair
House Public Health & Welfare

FROM: Kansas Association of Rehabilitation Facilities

RE: HB 2882

DATE: Feb. 13, 1992

My name is Yo Bestgen, Executive Director of the Kansas Association of Rehabilitation Facilities. I represent forty-one community providers serving children and adults with mental retardation and developmental disabilities.

The KARF supports the amendment to HB 2882 offered by Mental Health and Retardation Services and the Board of Nursing. We would, however, request one change in language:

> "performance, ~~in~~ **of services to persons served by** entities licensed by social and rehabilitation services pursuant to K.S.A. 75-3307b or K.S.A. 39-1501, of selected nursing procedures, as specified by rules and regulations of the board and social and rehabilitation services, necessary to accomplish activities of daily living and which are routinely performed by the individual or individual's family in the home setting."

The amendment as offered above would allow nursing procedures to be performed by staff of community agencies serving people with disabilities in community settings.

Community providers serve special education graduates who are now moving into adult services. There already is in law the ability for staff of school districts to administer medications and to perform other nursing procedures. This amendment would allow that same level of service as the student moves into adult services.

We would request your support of the amendment as offered by Mental Health and Retardation Services and request that you add the language as written above.

Thank you.

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attm #6

KSNA

the voice of Nursing in Kansas

FOR MORE INFORMATION CONTACT:

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February 13, 1992

H.B. 2882 BOARD OF NURSING; ACTS WHICH ARE NOT PROHIBITED

Chairperson Sader, and members of the House Public Health and Welfare Committee my name is Terri Roberts R.N. and I am a registered nurse in the state of Kansas and the Executive Director of the Kansas State Nurses' Association. Thank you for the opportunity to speak.

The new (n) language being proposed under **Acts Which Are Not Prohibited** in the current nurse practice act is something that I am proud to announce has been the result of combined efforts from a number of statewide nursing organizations over the past 18 months. In conjunction with the Board of Nursing, several other nursing organizations participated at round table discussions and eventually on a task force to develop the language before you today. The issue of nursing delegation is being discussed by our respective national organizations and decision making models as well as guidelines and frameworks are being developed to assist nurses in the variety of settings they work. One of the issues that the respective groups agreed upon was the definition of supervision, that being the one used in the 1987 position statement on activities of unlicensed persons developed by the National Council of State Boards of Nursing. That definition is as follows:

"Provision of guidance by a qualified nurse for the accomplishment of a nursing task or activity with initial direction of the task or activity and periodic inspection of the actual act of accomplishing the task or activity. Total nursing care of an individual remains, responsibility and accountability of the nurse."

Two other issues that KSNA discussed at length with the various specialty nursing groups was whose responsibility it was to make the decision to delegate and the policy question of whether LPN's could delegate within their scope of practice. We believe strongly that the word independent nursing judgment in the proposed language permits and authorizes the licensed nurse to make the decision whether or not to delegate a particular activity. This decision does not rest with an employer or any other individual, but with the licensed nurse. The policy question regarding delegation by LPN's was agreed upon in the

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Michele Hinds, M.N., R.N.—*President* • Terri Roberts, J.D., R.N.—*Executive Director*

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affirmative, recognizing that their scope of practice is limited to those tasks and responsibilities that are based on acceptable educational preparation within the framework of supportive and restorative care.

I have also attached a copy of nursing delegation issues in Kansas which was a background paper that I prepared about 18 months ago on this issue to assist individuals in historical perspective and direction in preparation for what were here today to do. I have attached a copy of that background paper for your reference.

Thank you for the opportunity to present today and I look forward to working with the Board of Nursing on this new statute.

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Testimony 1992

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2-13-92
Attm #7

pg 2-8

KANSAS STATE NURSES ASSOCIATION

NURSING DELEGATION ISSUES IN KANSAS

Background Paper

Prepared by Terri Roberts R.N., J.D.

This paper has been prepared to provide readers with a historical overview of actions and position papers developed by various regulatory bodies, including the Kansas Legislature, as well as professional nursing organizations that address issues of nursing delegation.

Nurse Practice Act Exemptions

In 1975 there were two exemptions added to the Kansas Nurse Practice Act (herein after referred to as N.P.A.) within the section entitled "Acts Which Are Not Prohibited" (K.S.A. 65-1124) and they were as follows:

> 65-1124. Acts which are not prohibited. No provisions of this law shall be construed as prohibiting:
>
> (h) auxilliary patient care services performed in medical care facilities, adult care homes or elsewhere by persons under the direction of a person licensed to practice medicine and surgery or a person licensed to practice dentistry or the supervision of a registered professional nurse or a licensed practical nurse;
>
> (i) the administration of medications to residents of adult care homes or to patients in hospital-based long-term care units by an unlicensed person who has been certified as having satisfactorily completed a training program in medication administration approved by the secretary of health and environment and has completed the program on continuing education adopted by the secretary, or by an unlicensed person while engaged in and as a part of such training program in medication administration;.

The legislative history surrounding the enactment of K.S.A. 65-1124 (h) and (i) provides some guidance to the interpretation of what may or may not be "auxillary patient care services". Clearly the administration of medications is not included in this definition, the fact that another exemption was created in (i) indicates that this was not the legislative intent, therefore (h) was added to the list of exemptions. The language that was proposed in a 1974 Interim Proposal (No. 69 Revision of the Nurse Practice Act) was "minor nursing services" and "duties necessary for the support of nursing services." This recommendation was not adopted and the language "auxillary patient care services" was enacted instead. By definition the Practice of Nursing (K.S.A. 65-1113 (d)) means

PHWS
2-13-92
Attm #7
pg 3-8

the process in which substantial specialized knowledge derived from the biological, physical, and behavioral sciences is applied to: the care, diagnosis, treatment, counsel and health teaching of persons who are experiencing changes in the normal health processes or who require assistance in the maintenance of health or the prevention or management of illness, injury or infirmity; administration, supervision or teaching of the process as defined in this section; and the execution of the medical regimen as prescribed by a person licensed to practice medicine and surgery or a person licensed to practice dentistry.

In 1987 there were two more exceptions added to the Kansas N.P.A., (k) and (l), that addressed a specific client population, students enrolled in the school setting.

(k) performance in the school setting of selected nursing procedures, as specified by rules and regulations of the board, necessary for handicapped students; or

(l) performance in the school setting of selected nursing procedures, as specified by rules and regulations of the board, necessary to accomplish activites of daily living and which are routinely performed by the student or student's family in the home setting.

In 1986 clarification on the school nurse's role in instructing and supervising unlicensed school personnel was sought by a local school district from the Kansas State Board of Nursing (KSBN). The KSBN determined that the Kansas N.P.A. allowed only for registered nurses to provide health services in schools. At that time an interagency task force was convened by the Kansas State Department of Education to study the implications for schools districts. As a result K.S.A. 65-1124 (k) & (l) were added to the exemptions clause of the N.P.A. These changes enabled registered nurses to train and delegate the performance of "selected" nursing procedures to non-nursing personnel in the school setting. Regulations implementing these new exemptions became permanent February 13, 1989. (Attachment #1) Significant and lengthy interdisciplinary discussion and debate preceeded these amendments to the N.P.A. The exemptions were added in the spirit of compromise for this specific client population with predictable and chronic problems. Delegation in these instances was clearly permissive, not mandatory by the Registered Nurse and the accountability for such delegation was assumed by each licensee responsible for the delegated nursing task (K.A.R. 65-15-102).

In 1989 another exemption was added to the N.P.A. that dealt with another very specific client population, functionally disabled adults. This was amended by the 1990 legislature to include "functionally disabled individuals."

(m) performance of attendant care services directed by or on behalf of an individual in need of in-home care as the terms " attendant care services" and "individual in need of in-home care" are defined...

(a) Attendant care services means those basic and ancillary services which enable an individual in need of in-home care to live in the individual's home and community rather than in an institution and to carry out functions of daily living, self-care and mobility.

...(d) "Health maintenance activities" include, but are not limited to, catheter irrigation;; administration of medications, enemas and suppositories; and wound care, if such activities in the opinion of the attending physician or licensed professional nurse may be performed by the individual if the individual were physically capable, and the procedure may be safely performed in the home.

Attempts to create another exemption for "home health" clients needing nursing services failed.

Professional Nursing Organization Activities

In 1981 & 1982 the Kansas State Nurses' Association conducted statewide forums to gather input on the development of a position statement on the use of unlicensed personnel. A formal position paper was adopted in September of 1983 that identifies specific guidelines for the Use of Unlicensed Personnel by Registered Nurses. (Attachment #2) This paper has specific language related to "delegation" and provides both direction and information to Registered Nurses seeking guidance on this issue in their daily practice.

In 1987 the National Council of State Board of Nursing adopted a statement entitled "Position Statement on Nursing Activities of Unlicensed Persons" and in 1990 they adopted a "Concept Paper on Delegation".

In 1989 the Tri-Council for Nursing issued a Statement on "Assistive Care Personnel". (Attachment #3)

The last formal action by the Kansas State Board of Nursing related to unlawful delegation was a letter addressed to the Commissioner of Education (Kansas) that demanded a response related to the unauthorized practice of nursing by unlicensed individuals in Kansas School Districts. (Attachment #4) This letter was the precipitating factor in the interdisciplinary task force that resulted in the N.P.A. exemptions (k) & (l).

Since 1985 there have been no formal disciplinary proceedings against a licensee for the inappropriate delegation of professional nursing under the "unprofessional conduct" regulation. (K.A.R. 60-3-110 (6)).

Article 15.--PERFORMANCE OF
SELECTED NURSING PROCEDURES IN
SCHOOL SETTINGS

60-15-101. Definitions. (a) Each licensed registered professional nurse in the school setting shall be responsible for the nature and quality of all nursing care that a pupil is given under the direction of the nurse in the school setting. Assessment of the nursing needs of a pupil, the plan of nursing action, implementation of the plan, and evaluation are essential components of professional nursing practice and are the responsibility of the licensed registered professional nurse.

(b) When used in this article, the following definitions shall apply:

(1) "Unlicensed persons" includes, but is not limited to the following school personnel: teachers, secretaries, administrators, and paraprofessionals.

(2) "Delegation" means authorizing an unlicensed person to perform selected nursing tasks in the school setting under the direction of a licensed registered professional nurse.

(3) "Activities of daily living" means basic caretaking or specialized caretaking.

(4) "Basic caretaking" means bathing, dressing, grooming, routine dental, hair and skin care, preparation of food for oral feeding, exercise excluding occupational therapy and physical therapy procedures, toileting including diapering and toilet training, handwashing, transfer and ambulation.

(5) "Specialized caretaking" means catherization, ostomy care, preparation of food and tube feedings, care of damaged skin integrity, administering medications and performing other procedures requiring nursing judgment.

(6) "Handicapped student" means a person who is enrolled in any accredited public or non-public school education program who requires nursing procedures during regular school attendance hours. Handicapped student also includes exceptional children as defined in K.S.A. 1987 Supp. 72-962.

(7) "Nursing judgment" means the exercise of knowledge and discretion derived from the biological physical and behavioral sciences.

(8) "School setting" means any accredited public or non-public school environment during regular school attendance hours.

(9) "Supervision" means that the licensed registered professional nurse shall oversee the delegated task.

(10) "Medication" means any drug required by the Federal or State Food, Drug and Cosmetic Act to bear on its label the legend "caution: Federal law prohibits dispensing without prescription."

(c) In fulfilling the responsibilities for nursing care each school nurse shall:

(1) Serve as a health advocate for pupils;

(2) counsel and teach individuals, families and groups about health, illness and promote health maintenance;

(3) serve as a health consultant and as a resource to teachers and administrators serving pupils having health services needs during school attendance hours; and

(4) utilize theories, skills of communication and the teaching-learning process to increase the health, knowledge and functioning of the multidisciplinary education evaluation team as the strengths and weakness of pupils are assessed. The recommendations for appropriate educational placement shall be made from the team evaluation.

(d) The full utilization of the services of a licensed registered professional nurse may be supplemented by the delegation and supervision of selected nursing tasks to unlicensed personnel. (Authorized by K.S.A. 65-1229; implementing K.S.A. 65-1113 and K.S.A. 1987 Supp. 65-1124; effective, T-89-23, May 27, 1988; amended, T-60-9-12-88, Sept. 12, 1988; amended Feb. 13, 1989.)

60-15-102. Delegation Procedures. Delegation of nursing tasks to a designated unlicensed person in the school setting shall comply with the following recommendations:

(a) Each licensed registered professional nurse shall assess the pupil's nursing care needs and formulate a written nursing plan of care before delegating any nursing task to an unlicensed person.

(b) The selected nursing task to be delegated shall be one that a reasonable and prudent licensed registered professional nurse determines to be within the scope of sound nursing judgment and which can be performed properly and safely by an unlicensed person.

(c) Activities of daily living, defined in K.A.R. 60-15-101 (b) as basic caretaking may be performed without delegation. Activities of daily living, defined as specialized caretaking in K.A.R. 60-15-101 (b) shall be assessed and delegated as appropriate.

(d) The selected nursing task shall not require the designated unlicensed person to exercise nursing judgment or intervention except in emergency situations.

(e) The designated unlicensed person to whom the nursing task is delegated shall be adequately identified by name in writing for each delegated task.

(f) The licensed registered professional nurse shall orient and instruct in the performance of the nursing task. Return demonstration of the competency necessary to perform the delegated task shall be documented in writing. The designated unlicensed person shall co-sign the documentation indicating the person's concurrence with this competency evaluation.

(g) The licensed registered professional nurse shall be accountable and responsible for the delegated nursing task. The licensed registered professional nurse shall:

(1) Participate in periodic and joint evaluations of the services rendered; and

(2) record and monitor recorded services.

(h) The licensed registered professional nurse shall adequately supervise the performance of the delegated nursing task in accordance with the requirements of K.A.R. 60-15-103 of this regulation. (Authorized by K.S.A. 65-1129; implementing K.S.A. 1987 Supp. 65-1124; effective, T-89-23, May 27, 1988, amended, T-60-9-12-88 Sept. 12, 1988; amended Feb. 13, 1989.)

60-15-103. Supervision of Delegated Tasks. All nursing tasks delegated to a designated unlicensed person in the school setting shall be supervised in accordance with the following conditions:

(a) The degree of supervision required shall be determined by the licensed registered professional nurse after an assessment of appropriate factors including:

(1) The health status and stability of the pupil;

(2) the complexity of the task to be delegated;

(3) The training and competency of the designated unlicensed person to whom the task is to be delegated; and

(4) the proximity and availability of the licensed registered professional nurse to the designated unlicensed person when the selected nursing task will be performed.

(b) The delegating licensed registered professional nurse may designate whether the nursing task is one which may be supervised by a licensed practical nurse.

(c) Each delegating licensed registered professional nurse shall designate an alternate supervising registered professional nurse or licensed practical nurse. The delegating nurse or designated alternate shall be readily available either in person or by telecommunication. (Authorized by K.S.A. 65-1129; implementing K.S.A. 1987 Supp. 65-1124; effective, T-89-23, May 27, 1988 amended,

PHTW 2-13-92

Attm #7

T-69-9-12-88, Sept. 12, 1988, amended Feb. 13, 1989.)

60-15-104. Administration of Medications in the School Setting. The administration of medications shall be delegated only in accordance with this regulation.

(a) A licensed registered professional nurse may delegate the administration of medications to unlicensed persons if:

(1) The administration of the initial dose of a medication has been previously administered to the pupil;

(2) the administration does not require calculation of any medication dosage. Measuring a prescribed amount of liquid medication or breaking a tablet for administration is not calculation of medication dosage.

(b) The following acts shall not be delegated to unlicensed persons:

(1) The administration of medications by intravenous or intramuscular injection route;

(2) the administration of medications through intermittent positive pressure breathing machines; or

(3) the administration of medications through a tube inserted into a cavity of the body with the exception of medications administered through feeding tubes. (Authorized by K.S.A. 1987 Supp. 65-1124; effective, T-89-23, May 27, 1988; amended, T-60-9-12-88, Sept. 12, 1988; amended Feb. 13, 1989.)

DR. LOIS RICH SCIBETTA
Executive Administrator
Kansas State Board of Nursing

Doc. No. 007326

KSNA
the voice of Nursing in Kansas

KSNA Position Statement on the Use of Unlicensed Personnel

The legal definition of Nursing in Kansas clearly states that the registered nurse uses substantial specialized knowledge of the biological, physical, and behavioral sciences in deriving a nursing diagnosis and in developing and implementing a plan of care. In this process, the registered nurse exercises nursing knowledge, judgment and skill.

Some tasks required in implementing a plan of care may be delegated by the registered nurse to unlicensed personnel. The registered nurse uses professional judgment to decide which tasks can be delegated and to whom. Legally, the registered nurse is responsible and accountable for the unlicensed person's performance of that task and the consequences of that action.

Since registered nurses are responsible for the acts of unlicensed personnel in performing delegated tasks, registered nurses need to be in control of the activities which are delegated to the unlicensed personnel. Legal accountability alone is not the only motivating factor in determining delegation of tasks to unlicensed personnel. Registered nurses have a responsibility to the public as well as to their profession to deliver a high quality of health care. Thus, in order to assist registered nurses to adhere to the professional standards of practice within the scope of the Nurse Practice Act, the following are guidelines delineating the contributions that unlicensed personnel may make in the delivery of nursing care.

Guidelines for the Use of Unlicensed Personnel:

1. The registered nurse has the responsibility to verify the preparation and ability of unlicensed personnel to perform a specific task prior to its delegation in each situation.

2. Unlicensed personnel may assist in the collection and reporting of data including, but not limited to:

a. vital signs, height, weight, intake and output, clinitest and hematest results.

b. changes from baseline data established by the registered nurse.

c. unsafe environmental situations.

d. significant patient/client or family comments.

e. behaviors related to the plan of care.

3. Unlicensed personnel may contribute to the implementation of the plan of care in situations where the activity does not jeopardize the patient client's welfare by assisting with activities including but not limited to:

a. personal hygiene and elimination.

b. ambulation, positioning, turning.

c. socialization activities.

d. the provision of call lights, night lights or side rails.

e. non-invasive treatments.

f. feeding, cutting up food or placing meal trays.

g. transportation of patients clients.

4. Some aspects of the nursing process cannot be delegated to unlicensed personnel including the following:

a. Any assessment which requires professional nursing judgment or intervention, cannot be delegated to unlicensed personnel. Examples may include vital signs in an intensive care unit, digital examinations or initial nursing assessment.

b. Deriving the nursing diagnosis and establishing the nursing goals require nursing knowledge and judgment that cannot be delegated to unlicensed personnel.

c. The plan of nursing care must include setting priorities and prescribing nursing approaches to achieve the goals derived from the nursing diagnosis. As such, it must be developed by the registered nurse, and cannot be delegated to unlicensed personnel.

d. Specific tasks involved in the implementation of the plan of care which require nursing judgment may be delegated to unlicensed personnel only after the nursing judgment has been made in each situation. Examples may include such delegated tasks as medications, enemas until clear or suctioning.

e. It is the registered nurse's responsibility to insure that patient client participation is addressed in the plan of care. The responsibility for this cannot be delegated although other members of the health care team may participate in implementing this aspect of the plan of care.

f. The evaluation of the patient's client progress or lack of progress toward goal achievement determines revisions in the plan of care, requires professional nursing judgment and, therefore, cannot be delegated to unlicensed personnel.

Approved by KSNA Board of Directors September 10, 1983.

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Kansas State Nurses' Association • 700 S.W. Jackson, Suite 601 • Topeka, Kansas 66603-3731 • (913) 233-8638
Constituent of The American Nurses Association
Joan Strevel[illegible], M.N., R.N., C.—*President* • Terri Roberts, J.D., R.N.—*Executive Director*

pg 6-8 Attm #7

Tri Council for Nursing

American Association of Colleges of Nursing
One DuPont Circle – Suite 530
Washington, D.C. 20036
202-463-6930
FAX 202-785-8320

American Nurses' Association, Inc.
2420 Pershing Road
Kansas City, Missouri 64108
816-474-5720
FAX 816-471-4903 KC
FAX 202-842-4375 DC

American Organization of Nurse Executives
840 North Lake Shore Drive
Chicago, Illinois 60611
312-280-5213
FAX 312-280-5995

National League for Nursing
350 Hudson Street
New York, New York 10014
212-989-9393
FAX 212-989-3710

Statement on Assistive Personnel to the Registered Nurse

Nursing is an essential component of health care, and the consumer of health care needs to be assured of the availability, accessibility, and quality of nursing care. It is in the spirit of this responsibility that this statement related to the use of assistive personnel has been developed. Historically, unlicensed personnel have assisted registered nurses in the delivery of patient care. However, in recent years, with economic demands driving the delivery system, there have been increasing concerns about the role of assistive personnel. It is extremely important to use assistants in a manner that assures appropriate delegation or assignment of nursing functions and adequate direction and supervision of individuals to whom nursing activities are delegated.

Patient care is delivered today by a staff mix of Registered Nurses (RN), Licensed Practical/Vocational Nurses (LPN), and unlicensed personnel in assistive roles. The term "assistive personnel" is used to recognize the trained/unlicensed health care worker who is employed within the continuum of acute hospital care to home health, ambulatory and long term care. Two categories of assistive personnel are generally recognized: the patient care assistant to whom the RN delegates or assigns aspects of nursing care and who functions under the supervision of the Registered Nurse, and the unit assistant who supports the nursing care system through a variety of non-nursing activities.

Many clinical settings are revising the staff mix needed for the delivery of patient care because of changing patient needs, the economics of reimbursement, and demand driven shortages of nursing personnel. A variety of manpower models are being explored and refined as the industry strives to balance quality and cost issues. The ultimate aim is to reallocate nursing and non-nursing activities to enable the registered nurse to focus on the patient. Specific models are best crafted at the point of delivery of care.

The nursing profession is accountable for the quality of the service it provides to the consumer. This includes the responsibility for developing nursing policies and procedures and setting the standards of practice for the nursing care of populations being served. It is further incumbent on the nursing profession to define the appropriate educational preparation and role of any group providing services within the scope of nursing practice. The State Board of Nursing is responsible for the legal regulation of nursing practice for the RN and LPN and should be responsible for the regulation of any other category of personnel who assists in the provision of direct nursing care. Professional and statutory provisions require that when the RN delegates and assigns direct nursing care activities to LPNs and assistive personnel, appropriate reporting relationships are established and the RN supervises all personnel to whom these activities have been delegated. In all situations, registered nurses and licensed practical nurses are responsible and accountable for their respective individual nursing activities. These relationships should be made explicit in workplace policies.

1/15/90

ATT[...]NT 4

KANSAS STATE BOARD OF NURSING

BOX 1098, 503 KANSAS AVENUE, SUITE 330
TOPEKA, KANSAS 66601

Telephone 913/296-4929

August 22, 1986

Dr. Harold Blackburn
Commissioner of Education
Kansas Department of Education
120 East Tenth Street
Topeka, Kansas 66612

Dear Dr. Blackburn:

The Kansas State Board of Nursing has directed me to bring to your attention a serious matter involving possible unlawful delivery of nursing services in Kansas public schools. The Board of Nursing has learned this problem arises, in part, out of the attempt by public schools to comply with the "Education of the Handicapped Act," and the Tatro decision from the United States Supreme Court. The delivery of nursing services by unqualified personnel may occur in some schools because of ignorance of the laws regulating the practice of nursing. Whatever the cause, some public schools are apparently encouraging or condoning the delivery of nursing services to handicapped or medically restricted students by unqualified personnel.

The Board of Nursing has an obligation to enforce the Nurse Practice Act. K.S.A. 65-1113 et. seq. Enforcement may require disciplinary action against school nurses who participate in or condone violation of the Nurse Practice Act. Civil injunctive action against specific schools and school personnel is an alternative enforcement measure. The advent of another school term may force the Board of Nursing to investigate and take legal action unless it receives reliable assurance that Kansas public schools are cognizant of their actions, and will take steps to avoid violation of the Nurse Practice Act. Although the Board of Nursing wishes to avoid being forced to take legal action, the Board cannot shirk its responsibility to enforce the Nurse Practice Act.

The Board is aware that several interested parties are studying and evaluating these school nursing issues, i.e. Kansas State Nurses' Association, Department of Health and Environment, Topeka Public Schools and the Kansas School Nurse Organization. Nevertheless, the Board has no conduit with the state public schools which could provide the assurance necessary to alleviate Board concern about the coming school year. As a result, the Board has concluded the State Department of Education may be the appropriate agency to disseminate Board of Nursing concerns and provide assurance to the Board of Nursing.

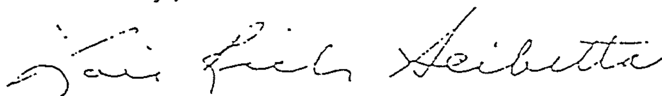
PH&W
2-13-92
Attm #7
pg 7-8

The Board of Nursing also believes the State Department of Education may be in the best position to establish or host a multi-disciplinary task force. The task force or study forum could assimilate the views and concerns of the many parties who are effected by this issue, and make recommendations for avoiding unlawful delivery of nursing services in public schools. Although the Board of Nursing is interested in participating in a forum which would study and recommend alternatives, the Board's obligation to enforce the Nurse Practice Act prevents the Board from establishing or hosting such a program. The issues raised by the facts may have a broader impact on the administration of schools, than on the practice of nursing.

In summary, the Board of Nursing would appreciate a response from the State Department of Education addressing the following matters: Is the State Department of Education prepared to communicate the concerns of the Board of Nursing to Kansas public schools and certified school nurses. Can the State Board of Education provide any assurance to the Board of Nursing that Kansas public schools will avoid or cease unlawful delivery of nursing services. Will the State Department of Education take steps to organize a forum for study of the issues, with an objective to recommend a long term solution for this continuing problem.

The Board will sincerely appreciate your cooperation in addressing this issue of mutual concern. Please feel free to contact me if you have any questions regarding this matter.

Sincerely,



Lois Rich Scibetta, Ph.D., R.N.
Executive Administrator

LRS/amm

CC: Stephen Carlow, Assistant Attorney General
O. Patricia Diamond, R.N., President, K.S.B.N.
Dr. Elaine Harvey, K.S.B.N.
Joan Olden Brake, R.N., K.S.B.N.
Joyce Markendorf, R.N., Dept. of Health and Environment

Article 15.--PERFORMANCE OF SELECTED NURSING PROCEDURES IN SCHOOL SETTINGS

60-15-101. Definitions. (a) Each licensed registered professional nurse in the school setting shall be responsible for the nature and quality of all nursing care that a pupil is given under the direction of the nurse in the school setting. Assessment of the nursing needs of a pupil, the plan of nursing action, implementation of the plan, and evaluation are essential components of professional nursing practice and are the responsibility of the licensed registered professional nurse.

(b) When used in this article, the following definitions shall apply:

(1) "Unlicensed persons" includes, but is not limited to the following school personnel: teachers, secretaries, administrators, and paraprofessionals.

(2) "Delegation" means authorizing an unlicensed person to perform selected nursing tasks in the school setting under the direction of a licensed registered professional nurse.

(3) "Activities of daily living" means basic caretaking or specialized caretaking.

(4) "Basic caretaking" means bathing, dressing, grooming, routine dental, hair and skin care, preparation of food for oral feeding, exercise excluding occupational therapy and physical therapy procedures, toileting including diapering and toilet training, handwashing, transfer and ambulation.

(5) "Specialized caretaking" means catherization, ostomy care, preparation of food and tube feedings, care of damaged skin integrity, administering medications and performing other procedures requiring nursing judgment.

(6) "Handicapped student" means a person who is enrolled in any accredited public or non-public school education program who requires nursing procedures during regular school attendance hours. Handicapped student also includes exceptional children as defined in K.S.A. 1987 Supp. 72-962.

(7) "Nursing judgment" means the exercise of knowledge and discretion derived from the biological physical and behavioral sciences.

(8) "School setting" means any accredited public or non-public school environment during regular school attendance hours.

(9) "Supervision" means that the licensed registered professional nurse shall oversee the delegated task.

(10) "Medication" means any drug required by the Federal or State Food, Drug and Cosmetic Act to bear on its label the legend "caution: Federal law prohibits dispensing without prescription."

(c) In fulfilling the responsibilities for nursing care each school nurse shall:

(1) Serve as a health advocate for pupils;

(2) counsel and teach individuals, families and groups about health, illness and promote health maintenance;

(3) serve as a health consultant and as a resource to teachers and administrators serving pupils having health services needs during school attendance hours; and

(4) utilize theories, skills of communication and the teaching-learning process to increase the health, knowledge and functioning of the multidisciplinary education evaluation team as the strengths and weakness of pupils are assessed. The recommendations for appropriate educational placement shall be made from the team evaluation.

(d) The full utilization of the services of a licensed registered professional nurse may be supplemented by the delegation and supervision of selected nursing tasks to unlicensed personnel. (Authorized by K.S.A. 65-1229; implementing K.S.A. 65-1113 and K.S.A. 1987 Supp. 65-1124; effective, T-89-23, May 27, 1988; amended, T-60-9-12-88, Sept. 12, 1988; amended Feb. 13, 1989.)

PH&W
2-13-92
attm #7
pg 8

> (a) Attendant care services means those basic and ancillary services which enable an individual in need of in-home care to live in the individual's home and community rather than in an institution and to carry out functions of daily living, self-care and mobility.
>
> ...(d) "Health maintenance activities" include, but are not limited to, catheter irrigation;; administration of medications, enemas and suppositories; and wound care, if such activities in the opinion of the attending physician or licensed professional nurse may be performed by the individual if the individual were physically capable, and the procedure may be safely performed in the home.

Attempts to create another exemption for "home health" clients needing nursing services failed.

Professional Nursing Organization Activities

In 1981 & 1982 the Kansas State Nurses' Association conducted statewide forums to gather input on the development of a position statement on the use of unlicensed personnel. A formal position paper was adopted in September of 1983 that identifies specific guidelines for the Use of Unlicensed Personnel by Registered Nurses. (Attachment #2) This paper has specific language related to "delegation" and provides both direction and information to Registered Nurses seeking guidance on this issue in their daily practice.

In 1987 the National Council of State Board of Nursing adopted a statement entitled "Position Statement on Nursing Activities of Unlicensed Persons" and in 1990 they adopted a "Concept Paper on Delegation".

In 1989 the Tri-Council for Nursing issued a Statement on "Assistive Care Personnel". (Attachment #3)

The last formal action by the Kansas State Board of Nursing related to unlawful delegation was a letter addressed to the Commissioner of Education (Kansas) that demanded a response related to the unauthorized practice of nursing by unlicensed individuals in Kansas School Districts. (Attachment #4) This letter was the precipitating factor in the interdisciplinary task force that resulted in the N.P.A. exemptions (k) & (l).

Since 1985 there have been no formal disciplinary proceedings against a licensee for the inappropriate delegation of professional nursing under the "unprofessional conduct" regulation. (K.A.R. 60-3-110 (6)).

THE KANSAS EYE INSTITUTE

Continental Medical Building • Suite 300 • 631 S.W. Horne Street • Topeka, Kansas 66606 • 913-295-5360

February 13, 1992

Representative Carol Sader
Chairperson
House Public Health & Welfare Committee
Capitol Building
Topeka, KS 666612

Re: HB 2882

Dear Representative Sader:

The Kansas Eye Institute is a Department of St. Francis Hospital and Medical Center and provides patient testing per physician orders and laser equipment for physicians' use. Much of what we do requires dilation of patients' eyes in accordance with physicians' orders. Under the present Nurse Practice Act, these dilation drops are considered medications and must be administered by registered nursing personnel. In many physician offices these drops are administered by ophthalmic techs under the supervision of the ophthalmologist or optometrist I am requesting that the ophthalmic techs on my staff be allowed to administer these dilation drops UNDER THE SUPERVISION of the charge RN in the Department. These techs have passed the American Academy of Ophthalmology's course for ophthalmic medical assistants and have had prior experience in private ophthalmologists' offices.

I am requesting that a new section be added after (i) such as: (new J) " The administration, under the supervision of a registered nurse or licensed pratical nurse, of topical dilation medications to patients per orders of the attending Ophthalmologist or Optometrist."

This change will allow the qualified techs to verify the medication with the charge RN prior to administration without causing the RN to leave the patient she is working with to personally administer dilation drops to another patient.

Thank you for your consideration of this request for a new section on administering dilation drops.

Sincerely,

Diana Jarvis

Diana Jarvis, Administrator
Kansas Eye Institute
631 Horne #300
Topeka, KS 66606
(913) 295-5360

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attm# 8

HOUSE BILL No. 2882

By Committee on Public Health and Welfare

2-6

8 AN ACT concerning the board of nursing; amending K.S.A. 1991
9 Supp. 65-1124 and repealing the existing sections.
10
11 *Be it enacted by the Legislature of the State of Kansas:*
12 Section 1. K.S.A. 1991 Supp. 65-1124 is hereby amended to read
13 as follows: 65-1124. No provisions of this law shall be construed as
14 prohibiting:
15 (a) Gratuitous nursing by friends or members of the family;
16 (b) the incidental care of the sick by domestic servants or persons
17 primarily employed as housekeepers;
18 (c) caring for the sick in accordance with tenets and practices of
19 any church or religious denomination which teaches reliance upon
20 spiritual means through prayer for healing;
21 (d) nursing assistance in the case of an emergency;
22 (e) the practice of nursing by students enrolled in accredited
23 schools of professional or practical nursing nor nursing by graduates
24 of such schools or courses pending the results of the first licensing
25 examination scheduled by the board following such graduation;
26 (f) the practice of nursing in this state by legally qualified nurses
27 of any of the other states as long as the engagement of any such
28 nurse requires the nurse to accompany and care for a patient tem-
29 porarily residing in this state during the period of one such en-
30 gagement not to exceed six months in length, and as long as such
31 nurses do not represent or hold themselves out as nurses licensed
32 to practice in this state;
33 (g) the practice by any nurse who is employed by the United
34 States government or any bureau, division or agency thereof, while
35 in the discharge of official duties;
36 (h) auxiliary patient care services performed in medical care fa-
37 cilities, adult care homes or elsewhere by persons under the direction
38 of a person licensed to practice medicine and surgery or a person
39 licensed to practice dentistry or the supervision of a registered pro-
40 fessional nurse or a licensed practical nurse;
41 (i) the administration of medications to residents of adult care
42 homes or to patients in hospital-based long-term care units, including
43 state operated institutions for the mentally retarded, by an unlicensed

Attach #8 2-13-92 pg 2-2 p4

Insert new (j)

1 person who has been certified as having satisfactorily completed a
2 training program in medication administration approved by the sec-
3 retary of health and environment and has completed the program
4 on continuing education adopted by the secretary, or by an unli-
5 censed person while engaged in and as a part of such training pro-
6 gram in medication administration;
7 (j) the practice of mental health technology by licensed mental
8 health technicians as authorized under the mental health technicians'
9 licensure act;
10 (k) performance in the school setting of selected nursing pro-
11 cedures, as specified by rules and regulations of the board, necessary
12 for handicapped students;
13 (l) performance in the school setting of selected nursing proce-
14 dures, as specified by rules and regulations of the board, necessary
15 to accomplish activities of daily living and which are routinely per-
16 formed by the student or student's family in the home setting; ~~or~~
17 (m) performance of attendant care services directed by or on
18 behalf of an individual in need of in-home care as the terms "at-
19 tendant care services" and "individual in need of in-home care" are
20 defined under K.S.A. ~~1989~~ *1991* Supp. 65-6201 and amendments
21 thereto~~.~~; *or*
22 *(n) performance of a nursing task by a person when that task*
23 *is delegated by a licensed nurse, within the reasonable exercise of*
24 *independent nursing judgment, and is performed with reasonable*
25 *skill and safety by that person under the supervision of a registered*
26 *professional nurse or a licensed practical nurse.*
27 Sec. 2. K.S.A. 1991 Supp. 65-1124 is hereby repealed.
28 Sec. 3. This act shall take effect and be in force from and after
29 its publication in the statute book.

House Committee on Public Health & Welfare   Thursday, February 13, 1992

House Bill 2882

Committee Members:

My comments today are directed to the House Committee on Public Health & Welfare to share with you information about the needs of the developmentally disabled population, and our insights through our personal experiences.

We are a family residing in Topeka over the past 17 years. We have a son, age 11, who is a child with a severely multiply handicapped condition. Our child has always lived at home, and we, as parents, are his primary care providers. There are no immediate family members residing in Shawnee County. Our son requires total care. His level of function is far behind his chronological age. He is non-ambulatory, non-verbal, has a severe hearing loss, and he is an ostomate with a gastrostomy tube for feeding, and an ostomy for a renal condition. The feeding tube was inserted in infancy, and he had ostomy surgery before age 2. He continues with both at this time.

Daily personal care includes tube feedings four times daily. Ostomy management requires drainage frequently throughout the day, and appliance changes every three days or as needed. The changes are usually done at home.

Over the past 11 years, other care providers include grandparents, aunts, uncles, friends, day care providers, and respite care providers.

There are many daily living activities we can do, and basically, we try to function just like anyone else. Our child's daily schedule includes full-day school attendance, and participating in an after-school program. Our child also received care by a licensed day care provider for nine years. Our child has attended school since age three. He has been in early intervention, preschool, and is presently attending a local public school included in the regular classroom with children his age.

Medical mangement, availability of providers, and adequate medical care are important needs of the person with a developmental disability. And, I do respect the medical community. However, I believe the level of care for the tube feeding and general, basic ostomy management can be administered by competent, trained personnel of community providers under the supevision/direction of a registered professional physician or nurse, a licensed practical nurse, or technician. Simple nursing tasks can be successfully administered when the care provider receives proper instruction and carries out the necessary tasks as instructed. I am comfortable with another person providing care for my child as long as the care provider is knowledgeable and comfortable with what they are doing.

Any course of instruction should be comprehensive in nature so as to include adequate instruction of daily use and care in actual care tasks as well as supplemental information about the task, equipment, and other conditions of the situation. It is inherent the instruction also includes consideration about the individual's general health condition.

Restrictive practices and expenses are an unnecessary deterrent to participation and performance in school activities including field trips, community day care programs and activities, community based instruction, community based programs, and community living.

Any action you can consider to alleviate unnecessary restrictive practices and expenses, and maintain adequate medical management of persons in need of daily care, will further the improvement of quality inclusive living for persons with developmental disabilities.

Respectfully submitted,

SUSAN ARNOLD

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2-13-92
attm #9

Kansas State Board of Nursing

Landon State Office Building
900 S.W. Jackson, Rm. 551
Topeka, Kansas 66612-1256
913-296-4929

Patsy L. Johnson, R.N., M.N.
Executive Administrator
913-296-3068

TO: The Honorable Representative Carol Sader, Chairperson and Members of the Public Health & Welfare Committee

FROM: Patsy L. Johnson, R.N., M.N.

DATE: February 13, 1992

RE: HB 2882

HB 2882 is presented to replace HB 2530.

The change proposed in HB 2882 is in K.S.A. 65-1124, acts which are not prohibited. A number of nursing organizations have worked with the Board to develop the addition to this statute which will allow registered professional and practical nurses to delegate nursing tasks. These nursing tasks would not require any nursing decisions while performing them. The nurse who is delegating has full responsibility to determine what, when, and whom the task may be delegated. Of course the person would have to be competent to perform the delegated task. These individuals would be under the supervision of a registered professional nurse or a licensed practical nurse. As used by the Board of Nursing, supervision is defined by the National Council of State Boards in a 1990 concept paper on delegation as, "Provision of guidance by a qualified nurse for the accomplishment of a nursing task or activity with initial direction of the task or activity and periodic inspection of the actual act of accomplishing the task or activity. Total nursing care of an individual remains the responsibility and accountability of the nurse." I have included the position paper.

Some practical situations that present the need for this change in the law to allow nurses to delegate nursing procedures include the use of nurse technicians who are often student nurses. The students have completed a portion of their nursing education and are employed by a facility. After assessing competency, nursing management would like these technicians to be able to do catheterizations, sterile dressing changes, nasogastric tube feedings, and other similar types of procedures.

Another situation often discussed is the use of emergency medical service (EMS) personnel in emergency rooms in hospitals. While physicians may delegate under Healing Arts, K.S.A. 65-2872(g), nurses have been restricted to the delegation of auxiliary patient care services. With expansion of nurses'

PH&W
2-13-92
attm #10
pg 1-5

Janette Pucci, R.N., M.S.N.
Education Specialist
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Diane Glynn, R.N., J.D.
Practice Specialist
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Patricia McKillip, R.N., M.N.
Education Specialist
296-3782

delegation privileges, selected nursing procedures could be delegated to nonlicensed personnel who are EMS technicians.

I have discussed nursing delegation with representatives from other Boards of Nursing where delegation is permitted. There seems to be a minimal number of problems. If problems do arise, we have regulation K.A.R. 60-3-110(a)(6). Disciplinary action can be taken for unprofessional conduct, "assigning or delegating unqualified persons to perform functions of licensed nurses contrary to the Kansas Nurse Practice Act or to the detriment of patient safety."

The new provision would add flexibility through a safe process to provide progressive nursing care. During this time of a technology explosion and with an increasing patient acuity level in all areas of nursing, licensed nurses are hard pressed to provide all the nursing care that is needed. The best educated should be providing the more complex care which requires decision making, while the more routine tasks can be taught and delegated to either other licensed or nonlicensed individuals. A nurse should have the option to assess situations and delegate appropriately. Changing the law to allow the nurse expanded delegation allows for use of nonlicensed personnel by the registered professional or practical nurse while not jeopardizing patient safety.

When opening a statute, there seems to always be the potential for changes to be suggested by other individuals or groups. The Department of Social Rehabilitation Services will be presenting a balloon to HB 2882. In order to move mentally retarded patients out of institutional care to community based residential homes, they need nonlicensed persons to be able to administer medications without violating the Nurse Practice Act. While the Board of Nursing takes no position on whether community based residential homes are a better place for mentally retarded individuals than institutional care, the Board is very concerned over the safety of these persons when their caretakers may have little or no nursing knowledge. While many mentally retarded individuals have no physical deformities, there are many who do, thus increasing nursing needs. While we are proposing greater delegation as part of this bill change, how much supervision will there be available for these nonlicensed persons in the residential settings? Most of the mentally retarded must rely on others totally. Our laws must be in place to protect and provide these helpless people safe care.

The Board of Nursing wants to be flexible and look for alternatives which can meet the needs of the community in the most costly fashion. The Board feels the best solution would be that anyone working in community based residential homes and performing nursing tasks including administerion of medications should be at least minimally educated as a medication aide and have on-going supervision by a professional registered or practical nurse. There is a wide range in the amount of nursing care some individuals might need. In some situations, the person taking care of the

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attm #10
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mentally retarded might have to be a certified medication aide or even a LPN or a LMHT, while in others a nonlicensed person with less education could easily handle the situation.

Over the past few days, there has been a great deal of communication between the Board of Nursing and the Department of Social Rehabilitation Services to develop new language in the Nurse Practice Act to provide for extended nursing care of the mentally retarded in community based homes by nonlicensed personnel. While the total plan is not completed, the Board of Nursing is willing to continue working with SRS until a system is developed to provide safe, competent nursing care. The proposed language that will be presented by SRS will hopefully provide us the means to complete our goals.

In summary, the Board of Nursing believes there is a definite need for nurses to be able to delegate nursing practice. Education will be needed so nurses understand this change in the law. There is no anticipated negative effect from this bill and would hopefully allow for greater flexibility and utilization of nonlicensed staff. The proposed change that will be added by SRS needs to be carefully worked out so the mentally retarded can be taken care of properly.

The Board hopes you will consider passage of HB 2882.

Thank you. I will be glad to answer your questions.

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Concept Paper on Delegation

Purpose

The purpose of the National Council formulating this concept paper is to provide to Member Boards a conceptual basis for delegation from a regulatory perspective. It is the position of the National Council that licensed nurses, in accordance with board of nursing requirements, determine the appropriateness of delegating acts from their scopes of practice. Each person involved in the delegation process is accountable for his/her own actions in this process. There is potential liability if competent, safe care is not the outcome of the delegation.

Premises

1. Performance of non-nurse delegated and non-nurse supervised nursing activities by unlicensed persons constitutes practicing nursing without a license and is not in the interest of the health, safety, and welfare of the public.
2. Pieces of care cannot be provided in isolation by unlicensed persons functioning independently of the nurse if the health, safety, and welfare of the public is to be assured.
3. Boards of nursing need to work to assure evidence of adequate nurse involvement where nursing services are being provided and delegated.
4. Boards should promulgate clear rules for delegation in all settings where nursing care is delivered.
5. Boards need to clearly define delegation in regulation.
6. A limited supply of nurses must not be used as an excuse for inappropriate delegation to unlicensed persons.
7. Regulations regarding the delegation of nursing functions must be linked to the disciplinary process.
8. Boards need to pursue criminal prosecution when there is clear evidence that unlicensed persons are performing nursing activities not delegated by nurses.

Premises 1-8 from 1987 "Position Statement on Nursing Activities of Unlicensed Persons."

9. While tasks and procedures may be delegated, the functions of assessment, evaluation and nursing judgement should not be delegated.
10. While non-nurses may suggest which nursing acts may be delegated, it is the licensed nurse who ultimately decides the appropriateness of delegation.
11. The unlicensed person cannot redelegate a delegated act.
12. Boards of nursing must develop clear rules on determination of competence of persons to perform delegated nursing tasks or procedures, the level of supervision necessary, and which acts may be delegated.

Definitions

Delegation
Transferring to a competent individual authority to perform a selected nursing task in a selected situation.

Delegator
The person making the delegation.

Delegate
The person receiving the delegation.

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2-13-92
Attm #10

Supervision

"Provision of guidance by a qualified nurse for the accomplishment of a nursing task or activity with initial direction of the task or activity and periodic inspection of the actual act of accomplishing the task or activity. Total nursing care of an individual remains the responsibility and accountability of the nurse." 1987 "Position Statement on Activities of Unlicensed Persons."

Liability

As used in this paper, the term is limited to the regulatory accountability of a licensee to the licensing agency. Other types of liability (i.e. civil liability) are beyond the scope of this paper.

Background

In 1987, the Nursing Practice and Standards (NP&S) Committee developed a "Statement on the Nursing Activities of Unlicensed Persons." (1987 Statement) The Statement presented an overview of the following: 1) use of unlicensed persons to deliver nursing care since the early 1900s; 2) a rationale for board of nursing involvement in the oversight of activities of unlicensed persons; 3) documentation on the frequency and nature of the use of unlicensed persons; 4) operational definitions of key terms used in describing the frequency and nature of the use of unlicensed persons; and 5) conclusions for Member Board consideration in the state-by-state discussion of the frequency and nature of the use of unlicensed persons. The position statement was adopted by the August 1987 Delegate Assembly and has received wide acclaim, distribution and discussion by the nursing and health care community.

In 1989, the Nursing Practice and Education Committee identified a need for further study of this topic and developed this statement on delegation.

Regulatory Perspective - A Framework for Managerial Policies

Nursing is defined in a statutory mandate which requires an individual to have a license to practice. Two nurse roles (RN/LPN) exist and, though there is a legal relationship between the two, each is held accountable for carrying out its role. RNs may delegate professional nursing acts to LPNs and unlicensed persons. LPNs may, in some jurisdictions, delegate acts within the scope of the practice of practical nursing to unlicensed persons. The statutory mandate may also set forth requirements for supervision when nursing acts are delegated. Boards of nursing should provide guidance regarding which acts may or may not be delegated by the nurse. Direction must be provided by boards of nursing regarding supervision, including the proximity of the supervising nurse to the delegate. The nurse who delegates an act to another assumes responsibility for the supervision of the act, whether the nurse is physically present or not.

Nurses traditionally carry out the role of nurse in an employment context and act as agents of the employer. The relationship is complex and is usually carried out in a setting in which the employer controls the nature of both the work of the nurse and the circumstances of the nurse role enactment. The licensed nurse is responsible to the employer for employment activities. The licensed nurse is accountable to the board of nursing for nursing practice.

Though employers vary greatly in approaches to nursing care delivery, there are issues for the nurse that are common to all management styles. Those issues center on four common areas of concern:

1. Who determines the degree of allocation of resources, both human and fiscal?
2. Where does the focus of decision-making related to allocation of resources rest?
3. What level of supervision is required by the employer for the enacting of the role of nurse?
4. What control does the nurse have in determining the nature of the work and the setting/conditions of the work?

Employers of nurses are equally concerned about these issues, but primarily from a management context. It is understandable that there are different approaches by employers and nurses themselves related to these four major concerns and the overall issue of delegation and supervision. Numerous scenarios may develop as a result of different perspectives on delegation and supervision. The employer as the hiring agent is primarily responsible for allocation of all resources. Therefore, policies requiring working in any setting based on organizational need is something that appears reasonable in a managerial context. From a regulatory context, however, assignment to a

practice area without current competence creates concern about client safety and welfare that is even more critical. The managerial understanding is that the nurse is hired to carry out a specific role on behalf of the employer and that the employer has the authority to assign the nurse as desired. The regulatory perspective holds the nurse accountable for all nursing actions. The licensed nurse has a responsibility not to accept an assignment which the nurse is unable to perform safety. It is important to distinguish the uncomfortable situation where a nurse is expected to work in an unfamiliar setting within the nurse's usual area of practice from the unsafe situation where a nurse is expected to work in a new setting, outside the nurse's usual area of practice, without adequate orientation, education and supervision.

The regulatory perspective should serve as a framework for managerial policies related to the employment and utilization of nurses. Employers may attempt to require nurses to delegate, especially when faced with staffing problems. This is inappropriate when the nurse is not willing to delegate. While employers and administrators may suggest which nursing acts should be delegated and to whom the delegation may be made, it is the nurse who ultimately decides and who is accountable for deciding whether the delegation occurs. If the nurse decides that the delegation may not appropriately or safely take place, then the nurse should not engage in such delegation. In fact, if the nurse decides that delegation may not appropriately or safely take place, but nevertheless delegates, he/she may be disciplined by the board of nursing.

Acceptable Use of the Authority to Delegate

The decision to delegate should be based on the following:

- Determination of the task, procedure or function that is to be delegated.
- Staff available.
- Assessment of the client needs.
- Assessment of the potential delegate's competency.
- Consideration of the level of supervision available and a determination of the level and method of supervision required to assure safe performance.

Nurses should avoid delegating practice pervasive functions of assessment, evaluation and nursing judgment. Sometimes there is a differentiation made between the terms "delegation" and "assignment." Delegation involves giving to someone else a task from the delegator's practice. Assignment involves giving to someone else a task within his/her own practice. Based upon this differentiation, the RN would assign acts to other RNs who have the same scope of practice. The RN would delegate to others, e.g, LPNs and unlicensed persons, acts which are within the scope of professional nursing practice. Similarly, the LPN would assign acts within the scope of practice of practical nursing to other LPNs. However, the LPN would, if allowed under the State Nurse Practice Act, delegate practical nursing acts to unlicensed persons.

Licensure Accountability

Every nurse is accountable as an individual for practicing according to the statutory mandate in the nurse's jurisdiction of practice. The delegating nurse is accountable for assessing the situation and is responsible for the decision to delegate. Monitoring, outcome evaluation and follow-up are necessary supervisory activities that follow delegation. The delegator is accountable for the act delegated, and may incur liability if found to be negligent in the process of delegating and supervising.

The delegate is accountable for accepting the delegation and for his/her own actions in carrying out the act. If licensed, this person may incur liability if he/she deviates from safe practice through no fault of the delegating nurse.

Boards of nursing may review situations where a delegating nurse made an acceptable delegation to a competent delegate who erred in the performance of the delegated act. Clearly, the delegate is accountable for his/her actions in performing the delegated act. The delegator would be expected to provide supervisory follow-up such as intervention on behalf of the client and corrective action. The delegator would be accountable for the delegation and supervision provided.

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Conclusion

From a regulatory perspective, the nurse is held accountable for both acts directly carried out and acts delegated. This regulatory perspective should serve as the framework for managerial policies related to the employment and utilization of nurses. Where nurse practice acts permit, RNs and LPNs may delegate certain acts within their respective practices. They may be involved in either delegation or assignment, depending upon interpretation of the definitions of these terms. Both the delegating nurse and delegate are accountable for their own actions in the delegation process. Furthermore, the delegating nurse has a responsibility to determine that the delegate is indeed competent to perform the delegated act. Finally, the delegating nurse must provide appropriate supervision. The nurse must be the person who ultimately decides when and under what circumstances delegation is to occur. Non-nursing and managerial persons must not coerce the nurse into compromising client safety by requiring the nurse to delegate. While tasks and procedures may be delegated, the nurse should not delegate practice pervasive functions of assessment, evaluation and nursing judgement.

KANSAS FEDERATION OF LICENSED PRACTICAL NURSES, INC.
Affiliated with NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES, INC.
933 Kansas Avenue Topeka, KS 66612. 913-354-1605

TESTIMONY PRESENTED ON HOUSE BILL 2882 AND HB 2883

presented by Elizabeth E. Taylor
Legislative Consultant for KFLPN
February 13, 1992

House Public Health & Welfare Committee
Honorable Representative Carol Sader, Chair

HB 2882 - DELEGATION The policy decisions expressed in HB 2882 are ones which have been negotiated by the Kansas State Board of Nursing on which sit three LPN members. The KSBN has reviewed this topic during the past several months with all interested parties and all have agreed to the position you have presented before you in HB 2882. KFLPN has been a part of that negotiation and **we do support the language of HB 2882.**

CAUTION ON EXPANSION OF DELEGATION LANGUAGE Because the language of HB 2882 has been agreed upon after considerable review by the interested nursing parties. The general position of the KFLPN on delegating further nursing procedures to non-nursing personnel strictly prohibits such delegation. Our concern is that not all Kansans will be provided with the same level of nursing care when further delineation of services exists without direct supervision by a licensed professional or practical nurse.

HB 2883 - FEE INCREASE POTENTIAL KFLPN has always wanted to be sure it supported its fair share of the cost of licensure of LPNs. However, the Kansas State Board of Nursing has indicated that its current balance of funds is high and that no increase is needed at this time. With existing high balances we are not sure of the need for HB 2883. Until such time as a fee increase is needed, **we oppose any increase in the maximum cap for nursing licensure fees.**

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attmt #11

Karen Testa

Testimony to Public Health and Welfare Committee
Room 423-S
February 13, 1992

I am Karen Testa, a parent of a 19-year old severely multiple disabled son. I come before the Public Health and Welfare Committee today to appeal and encourage on his behalf and his peers your support for a proposed statute amendment to House Bill 2882. This proposal briefly states that unlicensed persons be trained by licensed medically trained individuals and then be certified to administer medicine and medical procedures to individuals unable to do so for themselves amd periodically be supervised or reviewed by practicing nursing personnel.

I would like to briefly share with you an example of how without this bill and amendment my son's life and three of his peers are being made more complicated and costing all of us more.

Ross, until 2 1/2 weeks ago, has always lived at home with his family. I have always taken care of him and given his medications to him at home or hired and trained others to help me. Even when he has been in the hospital I have trained the nurse; or if they are not comfortable working with him, I have cared for him. Two and one-half (2 1/2) weeks ago Ross moved into an apartment with another young man and next to two other young men in a pilot Supportive Living Program administered by Shelter Living, Inc. for the more severely disabled.

Now because of the present rules the trained direct care person can no longer give Ross and his peers their medicines, and Shelter Living has had to hire nurses and LPN's to administer the medicines. This has not made Ross' adjustment living away from home any easier. Most of Ross' medicines are given at meal times, and he does better taking his medicines and eating and drinking if he has individuals who are relaxed and trained to feed and work with individuals who are disabled. Because the nurses and LPN's are so new and just being trained, this is not going real well. While administering medications is important, they can be administered at the same time as food and liquid by the direct care provider. I know the nurses are trying and they care for Ross, but it is quite visible at this time that having LPN's and nurses giving Ross his medicine is not giving Ross a more quality life-style and is making his adjustment traumatic for him and more slower. What we have is a direct care person and myself training nurses and LPN's which is costly for all. All of Ross' medicines administered both for his seizures and asthma are very elementary, and the training is like what doctors teach parents of young children to do and it would be easy to train the direct care person. I would rather see the high cost for nurses go to upgrade the salary of the direct care individual with experience and be applied to a good ratio of workers per clients.

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2-13-92
attm #12

pg 1-2

This bill and amendment would bring Kansas standards of services up to other states' services for the profound/severe development disabled individuals and make it so more could live supportably in the community in quality cost effective programs.

Thank you.

Karen Testa
Parent/Advocate
Vice-President of Topeka GAP, Inc.
Vice-President of Shelter Living, Inc.
3610 S.E. 28th Street
Topeka, KS 66605
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2-13-92
Attm. #12
Pg 2/2.

KONE

Kansas Organization of Nurse Executives
P. O. Box 2308
Topeka, KS 66601

Testimony

presented to the

House Public Health and Welfare Committee

by the

Kansas Organization of Nurse Executives

February 13, 1992

Good afternoon. My name is Sue Denger. I am employed as Vice President of Nursing at St. Francis Regional Medical Center in Wichita. I am a registered professional nurse who has practiced nursing in six different states for over 35 years, including nearly 23 years as chief nursing executive in four institutions in four different states.

On behalf of the Kansas Organization of Nurse Executives (KONE), I want to thank you for this opportunity to address H.B. 2882. KONE represents over 250 nurse executives and nurse managers across the state of Kansas. This organization supports adding the new paragraph (n) to K.S.A. 65-114 which states that no provision of this law shall be construed as prohibiting:

> "(n) performance of a nursing task by a person when that task is delegated by a licensed nurse, within the reasonable exercise of independent nursing judgement and is performed with reasonable skill and safety by that person under the supervision of a registered professional nurse or a licensed practical nurse."

On November 8, 1991, I had the privilege of representing KONE at a consensus building task force convened by the Kansas State Board of Nursing. The task force was comprised of representatives from the Kansas Hospital Association, two long-term care associations, and three major nursing organizations. All parties present agreed that the language in new paragraph (n) will allow health care providers to effectively use unlicensed personnel to perform nursing tasks when delegated by a licensed nurse. This language also provides a mechanism for protecting the public from unsafe delegation practices.

Also, during the consensus building task force meeting the participants agreed upon the meaning of certain concepts and words within paragraph (n). Attached to this testimony is a resolution adopted by the KONE membership at the annual meeting on November 13, 1991, which spells out the agreed upon concepts and

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attm #13

definitions. I refer you to items 10, 11 and 12. Item 10 indicates "delegation is defined as transferring to a competent individual, authority to perform a selected nursing task in a selected situation." Item 11 states, "supervision is defined as provision of guidance by a qualified nurse for the accomplishment of a nursing task or activity with initial direction of the task or activity and periodic inspection of the actual act of accomplishing the task or activity." Item 12 defines independent judgement as "the nurse having the ultimate authority to decide what and to whom to delegate activities provided such authority is carried out within the guidelines of the agency."

In closing we encourage your favorable consideration of H.B. 2882. I want to thank you for the opportunity to address the Committee on this vital issue. I'll be happy to answer any questions.

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2-13-92
Attm. #13
pg 2-4

Kansas Organization of Nurse Executives
Resolution on Delegation

1. Whereas, The Kansas Organization of Nurse Executives (KONE) is the major healthcare organization in Kansas addressing nurse executive and nurse manager practice;

2. Whereas, Nursing is practiced in a variety of settings - acute care, skilled care, outpatient, office, school, nursing home, home health;

3. Whereas, The Nurse Executive in the acute care setting is accountable for defining nursing practice in the agency;

4. Whereas, KONE recognizes nursing is a process consisting of assessment, care planning, implementation of care, and evaluation of care;

5. Whereas, The registered nurse cannot delegate assessment, planning, and evaluation;

6. Whereas, Almost all activities of implementation can be delegated, depending on individual nurse judgment and use of a decision making grid that considers potential for harm, complexity of task, problem solving and innovation necessary, predictability of outcome, and level of interaction required with the patient;

7. Whereas, The Nurse Executive is accountable for providing for education to the skill level necessary;

8. Whereas, Registered professional nurse decides what tasks can be delegated and develop guidelines or protocols for delegation;

9. Whereas, Licensed Practical Nurses (LPN) may delegate tasks to other LPNs or unlicensed personnel on a shift-by-shift basis and based on guidelines or protocols developed by registered nurses;

10. Whereas, Delegation is defined as transferring to a competent individual, authority to perform a selected nursing task in a selected situation*;

11. Whereas, Supervision is defined as provision of guidance by a qualified nurse for the accomplishment of a nursing task/activity with initial direction of the task/activity and periodic inspection of the actual act of accomplishing the task/activity*;

12. Whereas, Independent judgment is defined as the nurse having the ultimate authority to decide what and to whom to delegate activities provided such authority is carried out within the guidelines of the agency;

13. Whereas, There is necessity to have language in the Nurse Practice Act that provides maximum flexibility for nursing practice, therefore be it

1. Resolved, That KONE support the addition of clarifying language to the Nurse Practice Act, Section 2, K.S.A. 65-1124; be it further resolved;

2. Resolved, The language would be new item [n] which reads "the performance of a nursing task by a person when that task is delegated by a licensed nurse within the reasonable exercise of independent nursing judgment and is performed with reasonable skill and safety of that person."

* National Council of State Boards, 1990.

Approved by KONE membership at their annual meeting on November 13, 1991.

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2-13-92
Attm. #3
pg 4-4

KANSAS ASSOCIATION OF
CENTERS FOR INDEPENDENT LIVING
3258 South Topeka Blvd. ~ Topeka, Kansas 66611 ~ (913) 267-7100 (Voice/TDD)

Gina McDonald
Executive Director

Member agencies:

ILC of Southcentral Kansas
Wichita, Kansas
(316) 942-8079

Independence, Inc.
Lawrence, Kansas
(913) 841-0333

Independent Connection
Salina, Kansas
(913) 827-9383

LINK, Inc.
Hays, Kansas
(913) 625-2521

Resource Center for
Independent Living
Osage City, Kansas
(913) 528-3105

Resource Network
for the Disabled
Atchison, Kansas
(913) 367-6367

The WHOLE PERSON, Inc.
Kansas City, Missouri
(816) 361-0304

Three Rivers Independent
Living Resource Center
Wamego, Kansas
(913) 456-9915

Topeka Independent
Living Resource Center
Topeka, Kansas
(913) 267-7100

TESTIMONY TO

HOUSE COMMITTEE ON

PUBLIC HEALTH AND WELFARE

FEB. 13 1992

Thank you for the opportunity to testify today regarding H.B.2882. My name is Gina McDonald and I am the executive director for the Kansas Association of Centers for Independent Living.

KACIL recognizes the need H.B. 2882 as it relates to providing services by programs licensed by the state of Kansas, and we in no way want to infringe on the intent of this bill as it relates to those services. However, we need to express one concern.

As you may recall, H.B. 2012, passed by the 1989 legislature was designed to insure that individuals in need of in home care had the right to self direct their attendant services. I am happy to report that there are over 100 people statewide who are successfully directing their own personal assistance services.

KACIL is concerned that H.B. 2882 especially letter "n" could adversily impact self directed services. Health maintenance services are defined in statute as including "but are not limited to, catheter irrigation; administration of medications, enemas and suppositories; and wound care, if such activities, in the opinion of the attending physician or licensed practical nurse may be performed by the individual, if the individual were physically capable, and the procedure may be performed safely in the home." Letter "n" states that those activities must be delegated by a licensed nurse and " is performed with reasonable skill and saftey by that person under the supervision of a registered professional nurse or a licensed practical nurse.

KACIL is opposed to that language if it relates back to 2012. If there could be language added to clarify that this in no way impacts the statutes regarding self

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pg1-2

directed services, KACIL would be satisfied. If we can not add that language, or delete letter "n" entirely, then KACIL must oppose this bill.

KACIL does not oppose or are we concerned with the language contained in the proposed amendment which would be letter "o".

Thank you for the opportunity to testify today.

P H&W
2-13-92
attm. #14
pg 2 - 2

Donald A. Wilson
President

Testimony

presented to the

House Public Health and Welfare Committee

by the

Kansas Hospital Association

February 13, 1991

Good afternoon. Chairperson Sader and members of the committee, my name is Kay Hale. I am the Director of Education Services for the Kansas Hospital Association. I am a registered professional nurse and I provide consultation services to member hospitals on matters related to nursing education and practice. On behalf of the Association, I want to thank the committee for giving us this opportunity to comment on House Bills No. 2882 and 2883.

The Kansas Hospital Association supports H.B. No. 2882. This bill adds a new exemption to the nurse practice act. Specifically, the bill adds the following new paragraph (n) to K.S.A. 65-1124 which states that no provisions of this law shall be construed as prohibiting:

> " (n) performance of a nursing task by a person when that task is delegated by a licensed nurse, within the reasonable exercise of independent nursing judgement, and is performed with reasonable skill and safety by that person under the supervision of a registered professional nurse or a licensed practical nurse."

Currently the Kansas Nurse Practice Act does not specifically address delegation. However, in response to personnel shortages in recent years many executives in hospitals have restructured their patient care delivery models to utilize nursing assistive personnel. We believe that this has been and will continue to be necessary in order to meet the health care needs of Kansans.

The delegations issue has engendered considerable discussion among nurses and health care attorneys over the past two years. Attached to this testimony is a chronology of events surrounding the legal questions which have been raised. The central point of these discussions has been, which tasks can be delegated by a licensed nurse to assistive personnel. H.B. 2882 answers this question by allowing the licensed nurse to use his or her independent nursing judgement to make that decision.

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2-13-92
Attm. #15

pg 1-8

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436 • FAX (913) 233-6955

It is important for you to know that the Kansas State Board of Nursing convened a consensus building task force to address the issues surrounding delegation. This task force was comprised of representatives from the Kansas Hospital Association, two long-term care associations, the home health industry and three major nursing organizations. All parties agreed that the language in new paragraph (n) will allow health care providers to deploy assistive personnel efficiently and effectively and to provide a mechanism for protecting the public from unsafe delegation practices.

Turning now to H.B. 2883 (Section 1). We support creating the category of inactive license and the $20.00 fee. In Section 2. we question the need to increase the fee for approval of single continuing education offerings from $25.00 to $100.00. This fee is a disincentive for organizations who are not approved as long-term continuing education providers to even seek approval of a single program offering. Further, we oppose the establishment of a fee for approval of individual courses. We believe that the license renewal fee is sufficient to cover this activity.

In closing we would like to commend the Kansas State Board of Nursing for convening the consensus building task force and listening to the perspectives of the providers from various health care settings.

Thank you for considering our comments. I would be happy to answer your questions.

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2-13-92
Attm. #15

CHRONOLOGY

JULY 1990

Two hospitals were notified by Belva Chang of the Kansas State Board of Nursing to stop utilizing unlicensed personnel (student nurse technicians) to perform nursing tasks. Tasks listed by Ms. Change included Accu-checks, insertion of levines, catheter insertion, etc. She further stated that the Board views Accu-cheks as an invasive procedure and that it requires a licensed person to execute such a procedure. She stated to representatives of both institutions that this was a violation of the Nurse Practice Act and nurse administrators could lose their licenses.

A subcommittee of the KSBN Practice Committee was appointed to study the practice of nursing students as employees of health facilities.

AUGUST 23, 1990

During the first and only subcommittee meeting, a question was posed as to whether a nurse could delegate specific tasks to unlicensed persons when the unlicensed person has demonstrated competence. Legal counsel was asked to research this question The subcommittee decided to:

1) analyze the scope of practice of other health occupations that overlap with nursing; and

2) review laws from other states governing delegation.

SEPTEMBER 12, 1990

At the September KSBN meeting, the subcommittee was disbanded and the issue was referred back to the KSBN Practice Committee.

SEPTEMBER 27, 1990

A legal opinion concerning the Scope of Nursing Practices Subject to the Board's Regulation was prepared by KHA legal counsel and mailed to KHA member hospitals. It contained the following statement: As long as a hospital's "delegation of duties" policies are consistent with generally accepted practice and harmonious with its "written delineation of responsibilities and duties of each category of nursing personnel" and its written "nursing care policies and procedures," as required by KDHE hospital regulations, the hospital will be operating within legal bounds. The one final consideration, and perhaps the most important, is that the personnel performing the delegated duties must be adequately trained so as not to present any unnecessary risks to patients' health or safety.

P H&W
2-13-92
attm #15
pg 3-8

OCTOBER 11, 1990

The Practice Committee agenda listed delegation as an agenda item. The Practice Committee examined legal issues involved with the Board's authority to regulate the delegation of nursing procedures to unlicensed personnel. Three possible resolutions were suggested by the Assistant Attorney General.

1) One suggestion was to enlarge the prohibition against delegating nursing functions to unqualified personnel specified in KAR 60-3-110(6).

2) The second option was to define the terms "auxiliary patient care services" as used in KSA 1990 Supp. 65-1124.

3) The third possibility was a statutory amendment.

The committee decided to refer this issue to the full Board and ask for direction concerning which option to pursue. KSBN staff was instructed to draft regulations for the Board's consideration if they selected that option. Observers at the meeting expressed concerns that the regulations should not include a laundry list of what could and could not be delegated.

OCTOBER 26, 1990

Representatives from KONE, KHA, KSNA, and KLN held a meeting to examine the delegation issue. A letter to the Board of Nursing was prepared and subsequently mailed to each Board member. The letter, signed by the presidents of all four organizations, set forth the following points:

1) We support that each professional registered nurse or licensed practical nurse is responsible to determine that a proper delegation has been made.

2) We do not believe that further relegation by the KSBN is needed. We believe that the authority, responsibility and mechanism for disciplining licensees by the Board is already in the Kansas Nurse Practice Act.

3) We recommend that the Board of Nursing refrain from promulgating additional regulations governing delegation.

DECEMBER 4, 1990

The Practice Committee of the Board of Nursing reviewed a draft of proposed regulations related to performance of selected nursing procedures and delegation procedures.

PH&W
attm. #15
2-13-92
pg 4-8

DECEMBER 5, 1990

During the open forum held by the Board of Nursing on December 5, testimony was presented by the following organizations:

* Kansas Hospital Association
* Kansas State Nurses' Association
* Kansas Organization of Nurse Executives
* Kansas League for Nursing
* Kansas Association of Homes for the Aging

All of these organizations supported keeping the current regulations and volunteered to educate nurses about the principles of appropriate delegation. Copies of this testimony are attached for your review.

DECEMBER 6, 1990

The Board reviewed the draft regulations prepared by staff. During discussion, the Assistant Attorney General opined that the Board is authorized by the Nurse Practice Act to promulgate the proposed regulations. The Board staff noted that current delegation practices may far exceed the legislative intent for "auxiliary patient care" specified in KSA 65-1124(h). The Board voted to table the draft regulations and requested the Attorney General's office to research the legislative intent of "auxiliary patient care."

FEBRUARY 19, 1991

The Practice Committee received legal advice from the Attorney General's Office which stated:

> "Auxiliary patient care services was not intended by the Legislature to cover administration of medications, tube feedings, suctioning catheterizations and other such specialized procedures. By authorizing nurses to delegate these functions, the Board would be authorizing what the statutes do not allow.
>
> We understand that there is confusion in the health care industry regarding the role of unlicensed persons performing nursing tasks. The role of those individuals should be determined by the Legislature. In the meantime, the Board may continue to regulate nurses and may enforce the prohibition against unlicensed nursing practice, subject to the exceptions in the nurse practice act or other statutes."

FEBRUARY 20 - 22, 1991

The Kansas State Board of Nursing considered the Attorney General's legal advice at the Board meeting and no action was taken.

P H & W
2-13-92
Attm. #15
pg 5-8

FEBRUARY 27, 1991 — KSBN staff introduced HB 2530, which authorizes the following: "the delegation of nursing procedures in medical care facilities, adult care homes or elsewhere to persons not licensed to practice nursing as supervised by a registered nurse or a licensed practical nurse pursuant to standards of delegation specified by rules and regulations of the Board."

MARCH 1, 1991 — Senator Roy Ehrlich requested the Attorney General to issue a formal opinion with regard to "interpretation of K.S.A. 65-1124(h), a provision of the exceptions clause of the Kansas Nurse Practice Act. The section provides that no provision of the Act shall be construed as prohibiting:

(h) Auxiliary patient care services performed in medical care facilities, adult care homes or elsewhere by persons under the direction of a person licensed to practice medicine and surgery or a person licensed to practice dentistry or the supervision of a registered professional nurse or a licensed practical nurse; ...

MARCH 1, 1991 — The Board of Nursing convened a special meeting via telephone conference call. The Executive Administrator explained that she had introduced HB 2530 on behalf of the Board. The Board voted to support the bill.

MARCH 1, 1991 — The Executive Administrator of the Board of Nursing discussed HB 2530 with the KSNA Board of Directors.

MARCH 3, 1991 — The Board of Nursing requested a formal Attorney General's opinion on the same portion of the Nurse Practice Act specified in Senator Ehrlich's request.

APRIL 24, 1991 — The Attorney General's Office released Opinion Number 91-45, which stated the following:

Synopsis: the practice of nursing is reserved for licensed nurses. As an exception to the licensure requirement, unlicensed persons may, in certain instances, provide auxiliary services. Auxiliary services may be performed by unlicensed persons if supervised by a licensed nurse, or directed by a medical doctor or dentist. The phrase "auxiliary patient care services" does not refer to specific tasks, and is not to be given a broad

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p96-8

definition. It refers to acts which support or assist nursing services. Any process exceeding this function of support or assistance must be performed by a licensed nurse unless otherwise authorized by law. Cited herein: K.S.A. 65-1113, 65-1114, 65-1123; K.S.A. 1990 Supp. 65-1124; K.S.A. 65-1129; 74-1106.

APRIL 24, 1991

The Executive Administrator of the Board of Nursing discussed HB 2530 with the KONE Board of Directors. The KONE Board expressed the following concerns about the bill:

1) It does not state that the registered professional nurse is responsible for using professional judgment to delegate nursing activities.

2) The resulting regulations may potentially specify which activities could and could not be delegated. The KONE Board further stated such restrictions would be counter-productive because appropriate delegation is based on the following:

    A. Potential for harm.

    B. Complexity of a nursing activity.

    C. Required problem solving and innovation.

    D. Predictability of outcome.

    E. Extent of patient interaction.

The KSBN Executive Administrator stated that she did not believe that the KSBN would move in this direction, but she could not guarantee the Board's actions.

MAY 1991

The Legislature adjourned. HB 2530 was not heard by the Public Health and Welfare Committee and is being carried over to the 1992 legislative session.

SEPTEMBER 18, 1991

KHA, KONE and KSNA presented testimony to the Board of Nursing. All of these organizations recommended the Board withdraw its support for HB 2530. And further recommended that a task force be convened to build consensus on the delegation issue.

NOVEMBER 8, 1991

The KSBN convened a consensus building task force that agreed on proposed language to authorize delegation in the nurse practice act.

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2-13-92
Attm. #15

DECEMBER 5, 1991	With the addition of a phrase concerning supervision, the KSBN adopted the language agreed upon by the consensus building task force as a substitute for HB 2530.
FEBRUARY 4, 1992	HB 2882 was introduced. Specifically, the bill adds the following new paragraph (n) to K.S.A. 65-1124 which states that no provisions of this law shall be construed as prohibiting:

> "(n) performance of a nursing task by a person when that task is delegated by a licensed nurse, within the reasonable exercise of independent nursing judgement, and is performed with reasonable skill and safety by that person under the supervision of a registered professional nurse or a licensed practical nurse."

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Attm. #15
2-13-92
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pg 8-8

S. Preston

Kansas Association of Nurse Anesthetists

Chairperson Sader, members of the House Committee on Public Health and Welfare, thank you for allowing me time to address this hearing.

I am Steve Preston, a Certified Registered Nurse Anesthetist representing the Kansas Association of Nurse Anesthetists. I am present today to testify regarding House Bill number 2883.

Regarding KSA 1991 Supp 65-1153 as amended on page 3, lines 9-17; the Kansas Association of Nurse Anesthetists strongly supports the changes made by the Kansas State Board of Nursing which will allow a Registered Nurse Anesthetist enrolled in a refresher course to be granted temporary authorization to practice nurse anesthesia for not more than 180 days. This allows the anesthetist who has not been in practice for five years prior to application to renew their skills and become part of the anesthesia work force in Kansas again.

Regarding K.S.A. 65-1118a as amended, the K.A.N.A. opposes several of the increases in fees as follows. Page 1, lines 19 and 20; Application for biennial renewal of license-professional nurse and practical nurse-increasing from $40.00 to $60.00. Page 1, line 21; Application for reinstatement of license increasing from $50.00 to $75.00. Page 1, lines 30 and 31; Application for renewal of certificate of qualification-advanced-registered nurse practitioner-increasing from $15.00 to $40.00. Page 1, line 34; Application for authorization-Registered Nurse Anesthetist-increasing from $40.00 to $60.00. Page 1, lines 37 and 38; Application for biennial renewal of authorization-Registered Nurse Anesthetist-increasing from $40.00 to $60.00. Page 1, lines 39 and 40; Application for reinstatement of authorization-Registered Nurse Anesthetist-increasing from $50.00 to $75.00. And lastly on page 1, lines 35 and 36; Application for authorization with temporary authorization-Registered Nurse Anesthetist-increasing from $75.00 to $110.00. We are wondering on this last item why Registered Nurse Anesthetists are being singled out with the highest fee for temporary authorization?

PH&W
2-13-92
attm# 16

The rationale for our opposition to these increases in fees is that at present the Kansas State Board of Nursing's fee fund balance is approximately $360.000. This is almost 50% of their budgeted expenses of $735,000. This is the largest balance ever held by the K.S.B.N.

On page 2 line 12; Approval of individual courses increasing from $0.00 to $15.00.

The rationale for the Kansas Association of Nurse Anesthetists's opposition to the above proposed increase is that at present the K.S.B.N. does not charge for this service. It stands to reason that this increase will only stimulate the K.S.B.N. to create a situation where they require approval of **more** individual courses. As advanced practice nurses, Registered Nurse Anesthetists potentially have a high usage rate of this approval process. With respect to this individual course approval fee, we are hoping that the process will not be necessary if the Legislature adopts language to give licensees greater flexibility for continuing education programs being brought into the State.

On page 3, line 5; the word **initial** has been changed to read **First** licensing examination---.

K.A.N.A, opposes this change as it further restricts graduate Nurse Anesthetists to a shorter amount of time to take their certifying examination after graduation. With the wording left as **initial**, graduates would be able to work with a temporary authorization until the second available certifying exam to study and practice to broaden their knowledge prior to taking the exam. With a wording change to **first**, the graduates would be forced to take the first available certifying examination, possibly before they felt completely ready to do so. The clinical practice of nurse anesthesia allows a graduate to learn in many ways that simply studying cannot. With the current shortage of Nurse Anesthetists in Kansas, it seems counter productive to further restrict graduate Nurse Anesthetists. We need to be recruiting new graduates not dissuading them, since Nurse Anesthetists are the sole providers of anesthesia in 110 of 132 hospitals in Kansas.

Testimony Submitted by,

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