Approved: 2-16-95
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on February 9, 1995 in Room 313-S of the Capitol.

All members were present except:

Committee staff present:
Bill Wolff, Legislative Research Department
Norman Furse, Revisor of Statutes
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Chip Wheelen, Kansas Medical Society
Patsy Johnson, Executive Administrator, Kansas State Board of Nursing
Carolyn Middendorf, President, Kansas State Nurses Association
Kyle G. Smith, Asst. Attorney General, Kansas Bureau of Investigation
Joan Sevy, Kansas Organization of Nurse Executives

Others attending: See attached list

Introduction of bills

Chip Wheelen, KMS, requested introduction of a bill that would delete the sunset date that provides liability protection in the Charitable Health Care Provider Program. Senator Ramirez made a motion the Committee recommend introduction of the proposed legislation, seconded by Senator Langworthy. The motion carried.

The Chair requested introduction of a bill relating to accessible parking for persons with disabilities. Senator Langworthy made a motion the Committee recommend introduction of the proposed legislation, seconded by Senator Harrington. The motion carried.

The Chair requested introduction of a bill relating to the establishment of a health care community cooperation council. Senator Langworthy made a motion the Committee recommend introduction of the proposed legislation, seconded by Senator Hardenburger. The motion carried.

Hearing on SB 151 - Licensure of nurses and mental health technicians; information from KBI

Patsy Johnson, KSBN, gave an overview of **SB 151** and noted that most of the changes are updates to the Nurse Practice Act, and in particular authority by the Board over delegation of medications by rules and regulations. (Attachment 1)

During Committee discussion it was suggested language be developed in statute to clarify delegation of medications rather than relying on rules and regulations. Ms. Johnson noted the Board did discuss such language with a variety of opinions expressed. Most of the disciplinary cases result in a staff nurse on the floor of a long term or acute care facility who teaches and directs an unlicensed person to give insulin injections which then results in a reaction to patients if such shots are given inappropriately. The other area of complaint involves smaller facilities where they are being pressured by administrators to take unlicensed people and teach them how to administer medications. It was also pointed out that the budget for the Board of Nursing is approximately $800,000.00, and concern was expressed by a member regarding the fiscal impact of conducting disciplinary hearings.

Carolyn Middendorf, KSNA, addressed the Committee and outlined the changes that would effect the licensees and operations of the Board of Nursing as noted in her written testimony. (Attachment 2) Ms. Middendorf noted that the problem of administrators or facilities that ask nurses to use unlicensed personnel to administer tasks needs to be addressed.

Kyle G. Smith, KBI, appeared before the Committee with a proposed amendment to **SB 151** regarding limited access to criminal justice information by the board as outlined in his written testimony. Mr. Smith noted there would also be a potential fiscal impact if a record check is taken on every applicant. (Attachment 3)

Joan Sevy, Kansas Organization of Nurse Executives, appeared in opposition to the bill because of language that allows the Kansas State Board of Nursing to develop rules and regulations for delegation of nursing tasks. She felt that the current law has not been given sufficient opportunity to work and recommends that the Board of Nursing convene a group of nursing leaders from various health care delivery sites and representation from other providers in the community for further discussion and consensus building. A balloon of the bill was distributed showing the recommended changes. (Attachment 4)

Because of limited time for discussion the Chair announced that the hearing on **SB 151** would continue when the bill is worked in Committee.

The meeting was adjourned at 11:00 a.m.

The next meeting is scheduled for February 14, 1995.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2-9-95

NAME	REPRESENTING
Dorothy Zaak	Ks. State Board of Nursing
Janet Jacobs	KSBN
Diane Colgan	KSBN
Mali Zifari	Neosho County Comm. College
Vivian Rowan	Neosho County Community College
Rosemarie Vernon	Pearson County Community College
Joan LaRue	Neosho Co Comm College – Mary Greeley School of Nsg
(Carol Rosenberger)	Bethel College
Crystal Fitzpatrick	Bethel College
Michelle Peterson	Ks. Governmental Consulting
Teresa Masten	Emporia State University
Sheryl Wade	Neosho County Community College
Samantha Reinbach	Bethel College
Leona Maupin	Neosho County Community College
Kerri Dean Kruse	Bethel College
Sandy Strand	KINH
Liz Smith	Dodge City Community College
Stephen Childers	Dodge City Community College
Terri Roberts	KSNA

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2-9-95

NAME	REPRESENTING
Lu Ann Nauman	Kansas School Nurses Organization
Joann Souerbrei	Kansas State Nurses Association + ARNP
Sheila J Joon	~~Kansas State~~ KSNA
LINDA Lukenski	KS Home Care Assoc.
Lesleigh Enochs	Ks. School Nurses Organization
Cindy Schmida	Ks. School Nurses Organization
Jindre Clapp	KSNA + ARNP
Donnett Streeter	KSNA + ARNA
martha Hodgesmith	KARF
Justina D. Neufeld	self / KSNA
Mary Mangas	self / KSNA
Orly Schwabauer	KSNA
Judy Shields	Baker School of Nursing
Pam Staeebaumer	" " " "
Pam Manning	" " "
Mary VanPetten	" " "
Rebecca Staab	Wichita State University, CNS
M. Therese Casey	Ks. Wesleyan Univ, Salina (ARNP)
Rita Knapp	Wichita State University

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2-9-95

NAME	REPRESENTING
Heather Hull	Wichita State Univ
Evelyn Wasserberg	Fort Scott Community College
Shelley Patterson	Butler CCC
Rachel Herrenbruck	Butler County CC
Skaggs Team	Butler Co. Comm. Coll.
Alan Peck	BAKER UNIVERSITY
Dennis Dolle	Dodge City Community College
Debbie Zlab	Dodge City Community College
Brenda Salazar	Neosho Co. Comm. College
Misty Gervais	Neosho Co Comm College
Cindy McCall	Neosho Co. Com. College
Joe Glass	Labette Community College Parsons
Sheila Gilbert	Labette Comm. College Nursing Dept. Parsons
Brenda Beadle	Labette Comm. College Pg Parsons, KS
Nancy Mahan	Butler CCC.
Cynthia Dennis	Butler County Comm. College
Louise Waters	Baker University, School of Nursing
Andrea Parris	Bakers Univ, School of Nursing
Beth Rosas	Baker Univ. School of Nursing

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2-9-95

NAME	REPRESENTING
Kathy Smith	Baker Univ. School of Nursing
Jennifer Snow	Baker Univ. School of Nursing
Theresa A. Magee	Dodge City Comm. College
Debbie Plummer	DCCC
Shawna L. Reedy	DCCC
Amy M. Thiessnard	Dodge City Community College
Adena A. VanderVelde	SRS
Kay Stone	Avila College
Rebecca Septon	Avila College
Carla Schultz	Avila College
Mary McFarlane	Avila College
O.J. Robinson	Avila College
Jeannine Hisler	Avila College
Lori A. Nordlohne	AVILA College
Kelly Larsen Rogers	Avila College
Cindy Garner	Avila College
Nikki Schmiedeler	Avila College
Julie Worthington	NCCC / Cloud County College
Tracy Summers	NCCC / Cloud County College

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2-9-95

NAME	REPRESENTING
NATASHA DECKERT	BETHEL COLLEGE NURSING STUDENT
Verda Deckert	Bethel College of Kansas
[illegible]	Kansas University - Med Center
CHRIS WRIGHT	UNIVERSITY OF KANSAS - NURSING
Sandi Stancart	USD #290 - Ottawa KS
Rebecca J Swora	Reno County HD + ACNM Chapter 16 Region 5
Nancy Halloway	Ks Board of Nursing
Patricia A Maben	KDHE
Jo Ann Thomas	Ks Board of Nursing
Jean McClasky	Ks Board of Nursing
Barbara McPherson	Ks Board of Nursing
Krista Saltzman	Baker Univ. School of Nursing
Teresa L. Peterson	Baker Univ Nursing Student
Marilyn Bradt	KSBN
Aneatha Martin	KSBN
[illegible]	KSBN
James A. McClinton	KSBN
[illegible]	KSBN
Faith Ball, RN	GPNA

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2-9-95

NAME	REPRESENTING
Tim Buchanan	Sterling House
STEVEN VICK	STERLING HOUSE
Cheri Stuber	SRS
Rhonda Gilpin	Labette Comm Nsg / Parsons
Myron Dunavan	LTC Ombudsman
CAROLEE STEPHENS	REGIONAL LTC OMBUDSMAN KS DEPT. ON AGING
Jan Reeder	KSNA Nrsg / Wichita State Univ
Mary McHugh	KSNA Nsg / WSU
Earlene Stoner	~~KSNA~~ Reno Co. Health Dept.

Kansas State Board of Nursing

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900 S.W. Jackson, Rm. 551
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Patsy L. Johnson, R.N., M.N.
Executive Administrator
913-296-5752

To: The Honorable Senator Sandy Praeger, Chairperson
and Members of the Public Health & Welfare Committee

From: Patsy L. Johnson, M.N., R.N., A.R.N.P.
Executive Administrator
Kansas State Board of Nursing

Date: February 9, 1994

Re: SB 151

Thank you for allowing me to testify on SB 151 for the Board of Nursing.

In Section 1 (a), (page 1, lines 28-30), the Board requests an exemption of the continuing nursing education requirements for license renewal for new graduates and those individuals who have reinstated or endorsed within nine months of the renewal date. This exemption has been given in the past based on regulation. After review of the regulations, it was decided that the exemption needed to be put in statute. This same exemption has been put in the Mental Health Technician Act, Section 5, (page 6, lines 35-38.)

Two additions have been added to K.S.A. 65-1120 which is the discipline section of the Nurse Practice Act. Upon the suggestion of the agency's Assistant Attorney General, a hearing fee will be assessed for each hearing procedure. The agency has various expenses when conducting a hearing including mailing, copying, recording, and hearing officer. Under current statute, K.S.A. 74-1108, (Appendix A), twenty percent of all moneys received by the Board have to go into the general fund. Since there are specific costs attributed to the hearing process, the Board would like to have all moneys received remitted to the agency's

Janette Pucci, R.N., M.S.N.
Education Specialist
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Patricia McKillip, R.N., Ph.D.
Education Specialist
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Practice
296

fee fund to defray those hearing costs, Section 2, (page 2, lines 35-37). This same language has been added to the Mental Health Technician Act, Section 6, (page 8, lines 37-39.)

The Board of Nursing has had an increasing number of applicants who have felony convictions. Currently, the agency is limited in the amount of information that can be obtained from the Kansas Bureau of Investigation. While conducting an investigation it is helpful to have access to criminal records. The Board requests information from the KBI about 10-12 times per year. New language has been added in order to receive more in depth information from the KBI, Section 2, (page 4, lines 5-19). The language is the same as found in the Healing Arts Act, K.S.A. 65-2839a (c), (Appendix B). This same provision has been added to the Mental Health Technician Act, Section 6, (page 9, lines 6-19.)

Section 4, (page 6, line 20) has been updated to allow for the mental health technician to have a temporary permit for a maximum of 120 days. This provision was missed when it was added to the Nurse Practice Act.

Three changes are proposed for K.S.A. 65-1124, acts which are not prohibited. Provisions (k) and (l), Section 3, (page 5, lines 17-23), allow nurses in schools to delegate nursing procedures to unlicensed individuals. With input from school nurses, the Board asks that "handicapped" be removed from (k) and proposes that (l) be revoke entirely. There is only a minimal difference in the meanings of (k) and (l). Since there are nursing tasks being delegated for all students, it is believed that no specific reference is needed to handicapped students.

The general provision (m), Section 3, (page 5, lines 28-33) was added in 1992 to allow nurses to delegate nursing tasks to unlicensed individuals. The Board is asking for an amendment of this exception which will give the Board rule and regulation authority over delegation. Problems which exist are:

1. Nurses do not know how to delegate,
2. There has been an increase in disciplinary actions for inappropriate delegation,
3. There is an explosion of situations where unlicensed assistive personnel are being used,
4. Employers are mandating that nurses delegate, and
5. There is an increased potential for patient harm.

Nursing administrations have utilized total patient care as the method of delivering nursing care over the last ten to fifteen years. Because of this, few schools of nursing have included content on delegation. The Board of Nursing has been directly involved over the last three years educating nurses in Kansas how to delegate and their responsibility in delegation. Diane Glynn, the Board's Nurse Practice Specialist and I have the telephone ringing continuously with questions about delegation. The lack of education with regard to the process of delegating is an obvious problem.

The number of disciplinary actions due to inappropriate delegation have grown since the law became effective in 1992 (Appendix C). A large majority of those cases involve nurses delegating to unlicensed assistive personnel the administration of medication. In 1992, there was an agreement between several groups including the Board that administration of medication could be a task. The agreement centered on the understanding that the client was stable medically with the same medications given on a routine basis. No nursing judgement was needed. The use of unlicensed personnel to administer medications is very limited with a nurse developing a plan for it. However, the limits are continually being exceeded with problems resulting.

The Board has identified a growing number of settings that unlicensed assistive personnel are being utilized. In 1992, the use of unlicensed persons was needed in home situations for the mentally retarded and handicapped. These were small group homes with around the clock use of unlicensed personnel to care for these clients. Nurses supervised the care which included medication administration. Currently there are many other settings in which

delegation is needed such as the assisted living facilities, youth and adult correctional facilities, group homes for a variety of individuals including psychiatric youths, and day cares. Hospitals are totally reorganizing with increased use of unlicensed assistive personnel. A variety of titles are used for these unlicensed individuals; however, those titles do not include the word "unlicensed" so patients and clients are unaware of the education level of those giving them care.

Although K.S.A. 65-1124 (m) specifically allows the nurse to delegate to whom, what tasks, and in what situations, employers are establishing procedures for unlicensed persons to perform nursing procedures including the administration of medications. In more and more instances, nursing judgement and continued assessment is involved. If the nurse wants to have a job, then there is a great deal of pressure from the employer to expand delegation into areas where the nurse feels it is inappropriate. The nurse turns to the Board of Nursing for information about the delegation law and direction on how to handle the situation. The nurse is put in the difficult position of losing a job or the possible loss of the nursing license.

The last but the most important issue in this discussion is patient safety. The Board received two news releases yesterday from the American Nurses Association (Appendix D and E). These news releases noted the reduction of nurses in hospitals with increased use of unlicensed assistive personnel. Quality of care and patient safety is being directly affected. An article in the latest issue of Newsweek also emphases that this a growing national problem (Appendix F).

Because of all these reasons, the Board feels that a rule and regulation provision in K.S.A. 65-1124 (m) would provide for the direction of nursing delegation. Without some change in the statutes, the Board of Nursing will continue to view the administration of medications as a nursing function and can be delegated only in very limited circumstances. The Board of Nursing took a proactive role in 1992 with regard to delegation and now takes action to address current problems.

In preparation for this statute change, the regulations which were established for delegation in the school setting, K.A.R. 60-15-101 through 60-15-104, were revised (Appendix G). Definitions are established, the procedure outlined, and supervision delineated. If delegation is properly carried out, what is outlined in K.A.R. 60-15-101 through 60-15-103 presents no restrictions on licensees or employers. If not followed, then the nurse is delegating inappropriately. The emphasis is on nurses understanding the process for delegating. The history of nurses in the school setting following these rules and regulations is positive. The Board has no intention of formulating a laundry list of what can and cannot be delegated. Each nurse in each situation has the responsibility to determine if a task should be delegated.

In K.A.R. 60-15-104, there is direct reference to administration of medications. Some medication administration procedures and types of settings are prohibited. There is an allowance for new methods in administration of medications and for possible emergency situations. Nurses are being disciplined most often for delegating medication administration and clean lines of what is allowed and prohibited will help clear the confusion.

Problems exist with nurses delegating to unlicensed assistive personnel. Nurses are being put in situations which can impact their licenses. Nurses are concerned in providing good care and recognize that patient safety is in jeopardy. Both employers and nurses need a general provision to set appropriate boundaries for expansion of delegation. Parameters for delegation of administration of medications are needed. The National Council of State Boards of Nursing has been studying this topic. In the current issue of Insight, National Council President Marcia Rachel writes, "Boards of nursing must clearly define delegation in regulation, promulgate clear rules for its use, and follow through with disciplinary action when there is evidence that the rules are violated." (Appendix H)

The Board of Nursing is aware there is opposition to rules and regulations on delegation. The health care industry is opposed for obvious reasons. While the five registered professional nurses on the Board are active Kansas State Nurses Association members, and while the American Nurses Association has announced patient care problems with the

reduction of nurses and increase of uneducated, unlicensed assistive personnel, the state nurses association continue to take an opposing position to the addition to the Nurse Practice Act. Probably the two voices that will not be heard today are from the consumer and the nurse. Unless fearing a change in current care being given for the physically or mentally handicapped, no consumer will be testifying. With only about 1,500 professional or practical nurses being represented by an association, the other 36,000 nurses licensed in Kansas will be a silent voice. The one voice speaking out in this silence is the Board of Nursing.

The Board believes that a rule and regulation provision will not restrict delegation, but decrease problems resulting from it. If rule and regulation authority is added to K.S.A. 65-1124 (m), the Board will have future meetings for input from nurses from various settings. The regulations will be broad with no laundry list of nursing procedures except in reference to administration of medications. With the dramatic changes occurring in health care, the Board is convinced a change in the statute is needed. At yesterday's meeting, the Board pledged to work with nursing and health care organizations in finding an acceptable solution.

In summary, most of the changes in SB 151 are updates to the Nurse Practice Act. Growing problems with nurses' delegating inappropriately stimulate the most controversial change.

I hope the committee will pass SB 151 favorably.

Thank you. I am available for questions.

1975, ch. 316, § 12; L. 1978, ch. 308, § 54; L. 1980, ch. 235, § 1; L. 1986, ch. 233, § 5; L. 1987, ch. 234, § 2; L. 1988, ch. 331, § 7; L. 1992, ch. 116, § 34, L. 1993, ch. 194, § 7; July 1.

74-1108. Board of Nursing fee fund. The executive administrator of the board of nursing shall remit all moneys received by the board from fees, charges or penalties, other than moneys received under K.S.A. 1986 Supp. 74-1109, to the state treasurer at least monthly. Upon receipt of any such remittance the state treasurer shall deposit the entire amount thereof in the state treasury. Twenty percent of each such deposit shall be credited to the state general fund and the balance shall be credited to the board of nursing fee fund. All expenditures from such fund shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the president of the board or by a person or persons designated by the president.

History: L. 1973, ch. 309, § 26; L. 1983, ch. 206, § 13; L. 1986, ch. 286, § 1; July 1.

74-1109. Fees for institutes, conferences and other educational programs offered by board; education conference fund. The board of nursing is hereby authorized to fix, charge and collect fees for institutes, conferences and other educational programs offered by the board under subsection (c)(*4) of K.S.A. 74-1106 and amendments thereto. The fees shall be fixed in order to recover the cost to the board for providing such programs. The executive administrator of the board shall remit all moneys received by the board from fees collected under this section to the state treasurer at least monthly. Upon receipt of any such remittance the state treasurer shall deposit the entire amount thereof in the state treasury, and such deposit shall be credited to the education conference fund which is hereby created. All expenditures from such fund shall be for the operating expenditures of providing such programs and shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the president of the board or by a person designated by the president.

History: L. 1986, ch. 286, § 2; July 1.

74-1110. Administrative fines. The board of nursing, in addition to any other penalty prescribed by law, may assess a civil fine, after proper notice and an opportunity to be heard, against any person granted a license, certificate of qualification or authorization to practice by the board of nursing for a violation of a law or rule and regulation applicable to the practice for which such person has been granted a license, certificate of qualification or authorization by the board in an amount not to exceed $1,000 for the first violation, $2,000 for the second violation and $3,000 for the third violation and for each subsequent violation. All fines assessed and collected under this section shall be remitted promptly to the state treasurer. Upon receipt thereof, the state treasurer shall deposit the entire amount in the treasury and credit it to the state general fund.

History: L. 1992, ch. 151, § 6; April 30.

74-1111. Attorney; appointment; salary; duties. (a) The attorney general shall appoint, with the approval of the board of nursing, an assistant attorney general who shall carry out the duties under subsection (b). The attorney shall receive an annual salary fixed by the attorney general with the approval of the board of nursing. The salary shall be paid from moneys appropriated to the board of nursing in the board of nursing fee fund.

(b) The assistant attorney general appointed under subsection (a) shall represent the board of nursing in any proceedings or litigation that may arise in the discharge of the duties of the board of nursing and shall perform such other duties of a legal nature as may be directed by the board of nursing.

History: L. 1993, ch. 194, § 19; July 1.

ch. 313, § 118; L. 1986, ch. 229, § 43; July 1.

Research and Practice Aids:
Physicians and Surgeons ⇐ 11 et seq.
C.J.S. Physicians, Surgeons and Other Health-Care Providers § 35.

Law Review and Bar Journal References:
"Malpractice '87: Status and Solutions," M. Martin Halley, M.D., J.D., 88, No. 9, Kan.Med. 261, 263, 264 (1987).

CASE ANNOTATIONS

1. Findings of board supported by substantial evidence; district court may not substitute its judgment for that of the board; revocation of license upheld. Kansas State Board of Healing Arts v. Foote, 200 K. 447, 451, 436 P.2d 828.

2. "Suspension" and "revocation" differentiated; board may suspend, for temporary period, and later revoke license permanently. Kansas State Board of Healing Arts v. Seasholtz, 210 K. 694, 696, 504 P.2d 576 (1972).

3. Cited in opinion holding that 17-2708 of professional corporation law does not authorize medical practice by general corporation. Early Detection Center, Inc. v. Wilson, 248 K. 869, 877, 811 P.2d 860 (1991).

65-2839.

History: L. 1957, ch. 343, § 39; L. 1976, ch. 273, § 17; Repealed, L. 1984, ch. 238, § 17; July 1, 1984; Repealed, L. 1984, ch. 313, § 157; July 1, 1985.

65-2839a. Investigations and proceedings conducted by board; access to evidence; subpoenas; access to criminal history; confidentiality of information. (a) In connection with any investigation by the board, the board or its duly authorized agents or employees shall at all reasonable times have access to, for the purpose of examination, and the right to copy any document, report, record or other physical evidence of any person being investigated, or any document, report, record or other evidence maintained by and in possession of any clinic, office of a practitioner of the healing arts, laboratory, pharmacy, medical care facility or other public or private agency if such document, report, record or evidence relates to medical competence, unprofessional conduct or the mental or physical ability of a licensee safely to practice the healing arts.

(b) For the purpose of all investigations and proceedings conducted by the board:

(1) The board may issue subpoenas compelling the attendance and testimony of witnesses or the production for examination or copying of documents or any other physical evidence if such evidence relates to medical competence, unprofessional conduct or the mental or physical ability of a licensee safely to practice the healing arts. Within five days after the service of the subpoena on any person requiring the production of any evidence in the person's possession or under the person's control, such person may petition the board to revoke, limit or modify the subpoena. The board shall revoke, limit or modify such subpoena if in its opinion the evidence required does not relate to practices which may be grounds for disciplinary action, is not relevant to the charge which is the subject matter of the proceeding or investigation, or does not describe with sufficient particularity the physical evidence which is required to be produced. Any member of the board, or any agent designated by the board, may administer oaths or affirmations, examine witnesses and receive such evidence.

(2) Any person appearing before the board shall have the right to be represented by counsel.

(3) The district court, upon application by the board or by the person subpoenaed, shall have jurisdiction to issue an order:

(A) Requiring such person to appear before the board or the boards duly authorized agent to produce evidence relating to the matter under investigation; or

(B) revoking, limiting or modifying the subpoena if in the court's opinion the evidence demanded does not relate to practices which may be grounds for disciplinary action, is not relevant to the charge which is the subject matter of the hearing or investigation or does not describe with sufficient particularity the evidence which is required to be produced.

(c) The board may receive from the Kansas bureau of investigation or other criminal justice agencies such criminal history record information (including arrest and nonconviction data), criminal intelligence information and information relating to criminal and background investigations as necessary for the purpose of determining initial and continuing qualifications of licensees and registrants of and applicants for licensure and registration by the board. Disclosure or use of any such information received by the board or of any record containing such information, for any purpose other than that provided by this subsection is a class A misdemeanor and shall constitute grounds for removal from office, termination of employment or denial, revocation or suspension of any license or registration issued under this act. Nothing in this subsection shall be construed to make unlawful the disclosure of any such information by the board in a hearing held pursuant to this act.

1-8

KANSAS STATE BOARD OF NURSING

CASES ON INAPPROPRIATE DELEGATION

(BY CALENDAR YEAR)

PRIOR TO HAVING DELEGATION AUTHORITY

1989	7	
1990	5	
1991	2	
1992	2	(January through June)

AFTER DELEGATION AUTHORITY GIVEN IN STATUTE

1992	10	(July through December)
1993	17	
1994	18	
1995	2	(To date)

American Nurses Association
600 Maryland Avenue SW
Suite 100 West
Washington, DC 20024-2571
TEL 202 651 7000
FAX 202 651 7001

NEWS RELEASE

EMBARGOED UNTIL:
9:30 a.m. (EST)
February 7, 1995

CONTACT: Sara Foer (202) 651-7023
Joan Meehan (202) 651-7020
Lisa Wyatt (202) 651-7019

LOSS OF NURSING JOBS IS DIMINISHING THE SAFETY OF CARE PATIENTS RECEIVE, NEW SURVEY FINDS

WASHINGTON, DC -- A reduction of registered nurses (RNs) in hospitals is causing unsafe conditions for some patients and massive increases in the workload of the remaining RNs, according to many respondents of a new survey of 1,835 registered nurses conducted for the American Nurses Association (ANA).

The survey found more errors occurring in hospitals including medication errors; more accidents, such as patient falls and fractures; and numerous unnecessary patient inconveniences.

Cutting nursing budgets is a prime target of many hospitals to boost the bottom line. This is occurring despite record double-digit profits for the hospital industry for five straight years (Modern Healthcare, August 8, 1994).

"But these cutbacks are often achieved at the bedside of sick patients where they are being cared for by too few overworked registered nurses and this is degrading patient care and safety," Geri Marullo, MS, RN, executive director of ANA, said.

MORE...

ANA
AMERICAN NURSES ASSOCIATION

"It is ironic that the same industry that raced to end the nursing shortage a few years ago because of its devastating effect on sick patients, is now willing to substitute safe and quality nursing care for the goal of dramatic profit margins," Marullo added. "We, with the American people will hold those who choose this unsafe and dangerous policy publicly accountable."

More than two-thirds (68.4%) of the 1,835 respondents said that the number of RN's employed in their facilities had been cut back (whether by layoffs or attrition) in the past 12 months. No other staff or service area was named nearly as often as this. Seventy percent of the respondents to that question said that their employers were cutting back on RN staffing by leaving vacated positions unfilled. Sixty-six percent said that their employers had instituted overall reductions in staff, or had announced plans to do so.

More than three-fourths of those respondents (78.6%) who reported reductions in RN's said that the quality of patient care had, in their estimation, been degraded as a result of those cutbacks. And nearly two-thirds of this group (64.0%) said they feel that patient safety has been affected adversely, as well.

Two factors, apparently working in tandem, were identified by the nurses as having the primary influences in the deterioration of safety and quality of care. These are that the remaining nurses are "taking care of more patients than before (53.9%) and "that there is less time to provide patient care" (53.7%).

Increased use of unlicensed assistive personnel (UAPs), which are minimally skilled workers with as little as 4 - 6 weeks of training, to provide direct patient care was reported by 44.7% of all respondents. In just over a quarter of all employing facilities (25.4%), it was reported that replacement of RN's with UAPs had been implemented or had been announced as a future course of action.

MORE...

SAFETY OF CARE/3...

One third of all survey respondents volunteered detailed descriptions of their patient safety concerns. The most frequently mentioned category of response about patient safety has to do with insufficient time to spend with patients (35.5%). Another area of concern by these nurses was the lack of time to adequately assess and monitor patients condition (19.5%).

One hundred-sixty respondents (26.2%) described various aspects of their work situations that they believe contribute to lowered safety standards for patients. An increase in the number of errors committed by nursing and non-nursing staff was reported by (17.5%) of the respondents to the patient safety question. Medication errors were reported far more frequently than other types of errors (13.7%), including late delivery of prescribed medications, administration of medication to the wrong patient, failure to remember to give medication at all (including pain medication), and so forth.

Patient impacts reported in the survey range from the minor inconvenience of a meal being delivered late, through such things as the pain and inconvenience of being "stuck" multiple times during the drawing of blood by an inexperienced assistive staffer. Other examples include recent post-op patients being left alone in the bathroom and falling, to a patient turning blue from lack of oxygen while a UAP continues to feed her, all the way to death resulting from the failure of an unlicensed assistant to report a critically low oxygen level to the RN responsible for the patient.

The most frequently reported result of reduced nursing staff is accidents, such as falls, involving patients, and fractures from those falls. Increases in falls and fractures of patients were reported by 13.6% of this subgroup of respondents. Longer waits for routine care (trips to the bathroom, baths, and so forth) were also reported, as were early re-admissions and re-injuries resulting from inadequate patient education, increased numbers of nosocomial infections and illnesses, and longer waits for lab draws, lab results, and other procedures, even under emergency conditions.

MORE...

In some instances reported by the RNs (2.3%), certain situations attributed to the reduction in RN staffing were reported to have led to death or near death of a patient. In all, 14 respondents to this question reported patient deaths, although at least three of these reports were recognizable as describing the same incident in the same hospital.

RNs who said their facilities reduced the number of RN's during the previous 12 months gave several reasons. The most frequently reported explanations for the nurse cutbacks were economic reasons (60%) including: increased profitability (43%), budget cuts and/or reduced revenues (14.3%) and to become/remain competitive (2.7%). A decrease in patient census (filled hospital beds) was the second at (58.2%) of respondents. A weak local economy was given as a reason for staffing cuts by (21.6%) of the respondents. Mergers with or acquisitions by other facilities (16.4%); loss of managed care contracts (11.2%); and reorganization, restructuring, and/or implementing a new patient care model was answered by (6.6%) of the respondents.

The executive summary of the survey, written by Decision Data Collection, Inc., contains the following statements:

"A worst-case scenario would have the RN's who have not been laid off working longer shifts, with less professional backup, having to rely upon and oversee the activities of either "float" or agency RN's who are unfamiliar with the procedures employed on the units to which they are assigned, or UAP's who are often described as poorly trained, inexperienced in patient care, and either unaware of or willing to disregard the limits of their capabilities and authority."

"In addition, the nurse-to-patient ratio may become more burdensome, with the RN having insufficient time to monitor and assess any but the most acutely ill patients. As a result, the RN moves from crisis to crisis, unable to anticipate the next impending emergency, but

MORE...

having to react instantaneously when an emergency does arise, leaving still less time for attention to the general patient population. Meanwhile, patient education suffers, and re-injuries or early re-admissions follow, due to poor at-home care."

"Physical and emotional stress take their toll on the RN. The ultimate effects on the patient can range from mere inconvenience (a cold meal) to more serious consequences, such as medication errors, injuries resulting from frustrated patients trying to do too much on their own, failure to carry out procedures ordered by doctors, more numerous nosocomial illnesses, and even deaths that are perceived as having been preventable if more RN's had been available."

"While this worst-case scenario cannot be viewed as typical even of the most understaffed facility, let alone the totality of settings in which professional nurses are employed, there is no mistaking the intensity and sincerity with which survey respondents reported these conditions as affecting their lives and those of the patients they serve."

Decision Data Collection, Inc., of McLean, Virginia, conducted the survey which was self-administered, in which any ANA member who received the September 1994 issue of The American Nurse had the opportunity to take part by completing the questionnaire and returning it for analysis. Approximately 210,000 copies of The American Nurse are distributed monthly, of these, 1,835 were analyzed and included in the survey analysis. Because the survey was available to all ANA members, rather than a pre-selected sample, there is no formula that can be applied to determine that "the results of this survey are accurate within plus or minus X percent."

Responses were received from all 50 states and the District of Columbia in rough proportion to the population distribution of the United States. Nearly three-fourths (73.4%) of the

survey respondents are employed in hospitals. Two-thirds (64.7%) described themselves as staff nurses. Thirteen percent hold supervisory positions and 6.3% described their positions as administrative in nature. In total, 9.0% reported having personally experienced a lay off this year. More than half were employed by non-profit facilities (58.3%), government-operated facilities (23.6%), for-profit facilities (19.8%), with 14.4% being described as being affiliated with an HMO.

The American Nurses Association has also published a consumer brochure to assist consumers in choosing an appropriate and safe hospital. Included in the document is a "pre-hospitalization" checklist of questions to ask about a hospital before considering admission there. To obtain a single copy of "Every Patient Deserves a Nurse" call 1-800-637-0323 and request item #NP-92.

A full copy of The Report of Survey Results: the 1994 ANA Layoffs Survey is available for free to credentialed members of the news media by calling Jeanine Williams at the American Nurses Association, at (202) 651-7022.

All others may obtain a copy by sending a check for $10.00 payable to : [The American Nurses Association], c/o Communications Department, 600 Maryland Avenue, SW, Washington, DC 20024.

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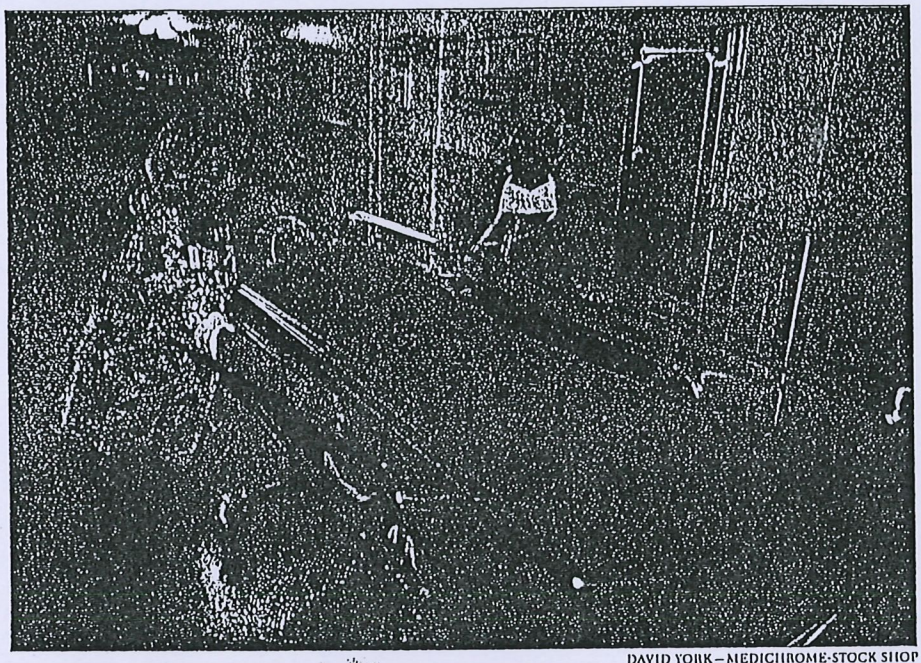
g:\releases.95\survey

Intensive Care on a Budget

Health: Do patients suffer when hospitals replace registered nurses with unskilled assistants?



DAVID YORK—MEDICHROME-STOCK SHOP

Life on the edge: *Nurses say layoffs are a hazard, but the evidence is murky*

As an intensive-care nurse, Barbara Grady knows the buzz of a bedside alarm like the ring of a telephone. When it sounds, she straightens a ventilator hose or fixes an IV line, often easing someone back from the edge of death. Grady used to work one-on-one with her patients, but she now often handles two or more. When she can't respond to an alarm and there's not another nurse nearby, she summons one of the unlicensed nurse's aides her Boston hospital has hired. Not long ago, Grady recalls, an aide responded to an alarm in her unit and noticed only that there was a little blood on the patient's bed. Seconds later the alarm sounded again, and Grady rushed over to find that the patient's arterial line was detached, and her sheets were drenched with blood. The aide, though well-meaning, hadn't known to check the line.

Across the nation, hospitals are cutting back on registered nurses—and delegating some of their chores to aides who average only two to six weeks of training. No one knows how many RNs have been lost or how the trend will affect patients. The scant available evidence comes mainly from nurses' groups that have a stake in the status quo. But health workers do seem worried. Of 1,800 who were polled recently by the American Nurses Association, 68 percent said their RN staffs had been cut in the past year, through attrition or layoffs. And two thirds of those reporting cutbacks thought the changes were jeopardizing patients. Doctors are voicing similar concern. "If I were really worried about one of my patients, I would set my alarm and go check myself," says Dr. Christopher Greeley, a pediatric resident in Nashville, Tenn. "Some of the people I'm relying on to be my eyes and ears have less training than the person running the slushy machine at 7-Eleven."

Hospital administrators say they're merely trying to adapt to a changed market. Hospital admissions have plummeted since the early 1980s, when insurers began treating inpatient care as the costly luxury it is. The shift has put many institutions out of business and forced survivors to cut expenses wherever they can. Nurses, as the largest group of hospital employees, are an obvious target for savings. The idea isn't to do away with them, administrators say, but to deploy them more efficiently—by hiring $15,000-a-year "care associates" to handle mundane tasks, such as changing linen, bathing patients and helping doctors with routine technical procedures. As Barry Horn of Berkeley's Alta Bates Medical Center explains, "I don't need to take a nurse out of commission to assist in a spinal tap. The assistance it requires is simple."

The problem, critics say, is that these aides are performing feats for which they're unqualified. State and national nurses' associations have been particularly outraged by reports that unlicensed attendants are handling catheters in cardiac patients at UCLA Medical Center and suturing surgery patients at some of California's Kaiser hospitals. "They shouldn't be doing invasive procedures," says Grady, the Boston intensive-care nurse. "Many don't even know to bring an unstable vital sign to somebody's attention." UCLA and Kaiser both acknowledge letting unlicensed aides perform these drills, but both defend the practice, saying that doctors are always on hand to supervise. "We think it's very clear that this is legal," says Frances Ridle Hoover, director of ambulatory care and cardiodiagnostic services at UCLA.

Aside from anecdotes, there is little evidence that the move away from RNs has harmed patients. A few studies have found that hospitals with low nurse-to-patient ratios have slightly elevated mortality rates. And nurses at Boston College noted in a 1994 survey that nursing staffs had been cut at several Massachusetts hospitals where patients later died in mishaps. "This should tell us that we have to be very careful," says study leader Judith Shindul-Rothschild. But there is no direct link between the cutbacks and the deaths. As Massachusetts Hospital Association spokesman Andrew Dreyfus says, any number of factors could have contributed.

The nurses' concerns are no doubt parochial in part. "One has to wonder whether this has more to do with traditional union work protection than with real concern about patient care," says Mark Speare, associate director of the UCLA Medical Center. For years, he recalls, RNs disdained many of the tasks they're now fighting to keep. Yet no one denies that nursing cuts *could* have dire effects. "Somewhere down the line," says Horn of Alta Bates, "the dollars could dry up to the point where care will be affected." Where that point lies is anyone's guess. The Institute of Medicine, a federal advisory group, may help clarify the hazards in a forthcoming study of hospital nursing trends. But if the nurses' associations expect to save the status quo, they're sure to be disappointed. The revolution is already here. The question is how happily it will play out.

'Dollars could dry up to the point where care will be affected'

GEOFFREY COWLEY *with* SUSAN MILLER *in New York and* MARY HAGER *in Washington*

1/6

DRAFTED 01/17/95

DELEGATION OF SELECTED NURSING PROCEDURES

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

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

(1) "Unlicensed person" means anyone not licensed as a nurse or mental health technician.

(2) "Delegation" means authorizing an unlicensed person to perform selected nursing tasks under the direction of a nurse.

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

(4) "Basic caretaking" means bathing, dressing, grooming, toilet training, transfer and ambulation.

(5) "Specialized caretaking" means catheterization, ostomy care, preparation of gastrostomy tube feedings, care of skin with potential for or damaged integrity, administering medications and performing other procedures requiring nursing judgment.

(6) "Anticipated health crisis" means a previously diagnosed condition which under predictable circumstances may lead to an imminent risk to an individual's health.

(7) "Task" means an assigned piece of work or duty that is part of defined nursing practice.

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

(9) "Supervision" means provision of guidance by a 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.

(10) "Medication" means any drug required by the federal or state drug and cosmetic acts to bear on its label the legend "Caution: Federal law prohibits dispensing without prescription. Experimental medications would be included.

(c) In fulfilling the responsibilities for nursing care, a nurse may:

(1) serve as an advocate for the individual receiving nursing care;

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

(3) promote health maintenance;

(4) serve as a health consultant and a resource; and

(5) utilize nursing theories, skills of communication and the teaching-learning process to increase the knowledge and functioning of the inter-disciplinary evaluation team as the strengths and weaknesses of individuals are assessed and plans for the individual's needs are developed.

(d) The full utilization of the services of a nurse may be supplemented by the delegation and supervision of selected nursing tasks to unlicensed personnel. (Authorized by K.S.A. 65-1129; implementing K.S.A. 65-1113 and K.S.A. 1989 Supp. 75-1124; effective, T-89-23, May 27, 1988; amended, T-60-9-12-88, Sept. 12, 1988; amended Feb. 13, 1989; amended Sept. 2, 1991.)

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

(a) Each nurse shall assess the individual'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 nurse determines to be within the scope of sound nursing judgment and which can be performed properly and safely by an unlicensed person.

(c) Basic caretaking as defined in K.A.R. 60-15-101(b) may be performed without delegation. Specialized caretaking as defined 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.

(e) In an anticipated health crisis identified in a nursing care plan, the unlicensed person may provide care for which instruction has been provided.

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

(g) The nurse shall orient and instruct unlicensed persons in the performance of the nursing task. The unlicensed person's 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.

(h) The nurse shall:

(1) be accountable and responsible for the delegated nursing task;

(2) participate in periodic and joint evaluations of the services rendered;

(3) record and monitor recorded services; and

(4) adequately supervise the performance of the delegated nursing task in accordance with the requirements of 60-15-103 of this regulation. (Authorized by K.S.A. 65-1129; implementing K.S.A. 1989 Supp. 65-1124; effective, T-89-23, May 27, 1988; amended, T-60-9-12-88, Sept. 12, 1988; amended Feb. 13, 1989; amended Sept. 2, 1991.)

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

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

(1) The health status and mental and physical stability of the individual receiving the nursing care;

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

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

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

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

(Authorized by K.S.A. 65-1129; implementing K.S.A. 1989 Supp. 65-1124; effective, T-89-23, May 27, 1988; amended, T-60-9-12-88, Sept. 12, 1988; amended Feb. 13, 1989; amended Sept. 2, 1991.)

60-15-104. Administration of medications. The task of administering medications shall be delegated only in accordance with K.A.R. 60-15-101 through 103.

(a) A nurse may delegate the task of administering medications to unlicensed persons if:

(1) The administration of the initial dose of a medication has been previously administered to the individual. No subsequent administration shall require medication dosage calculation. Measuring a prescribed amount of liquid medication or breaking a tablet for administration is not calculation of medication dosage;

(2) the nursing care plan requires administration by oral, subcutaneous, rectal, or other accepted routes or methods; or

(3) an anticipated health crisis requires administration by intramuscular route.

(b) Administration of medication as a task shall not be delegated to unlicensed persons when:

(1) By intravenous route;

(2) through intermittent positive pressure breathing machines;

(3) through any tube inserted into the body except through an established feeding tube directly inserted into the abdomen;

(4) in acute care facilities where on-going nursing assessment and judgement is required; or

(5) otherwise controlled by law.

(Authorized by K.S.A. 1989 Supp. 65-1124; effective, T-89-23, May 27, 1988; amended T-60-9-12-88, Sept. 12, 1988; amended Feb. 13, 1989; amended Sept. 2, 1991.)

ional Council Unlicensed Assistive Personnel Letter Elicits Respons

[The following is the text of a letter written by National Council President Marcia M. Rachel to government agencies and organizations involved in the provision of care by unlicensed assistive personnel. The letter, written at the direction of National Council's 1994 Delegate Assembly, was dated August 24, 1994. Responses to the letter appear on this and the following page.]

Representatives of 55 boards of nursing recently met in Chicago for the National Council of State Boards of Nursing's Annual Meeting. At that meeting, the delegates adopted, with strong support, a motion that the National Council express its position in unequivocal terms that the inappropriate use of unlicensed personnel in lieu of licensed nurses is a detriment to the delivery of quality health care for the consumer. The National Council and all of its member boards of nursing hold as their highest goal the protection of the public health, safety, and welfare. In keeping with this commitment, the National Council urges you to consider the meaning of licensure, and the assurance of quality that it provides to patients, residents, and clients to whom nursing care is provided.

The use of unlicensed personnel has increased dramatically over the past decade and is projected to continue to grow. The Bureau of Labor Statistics predicts that by the year 2000, the number of home health aides will increase by 80 percent and nursing assistant positions by 33 percent. Although unlicensed persons can be trained to perform a variety of nursing tasks, a nurse's supervision of each unlicensed person who performs nursing tasks is essential to both coordination and safety of patient care.

In a 1990 position on delegation, the National Council defined acceptable delegation by nurses to others, including unlicensed personnel. Essential premises of that paper included: (1) that quality nursing 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; and (2) that a limited [or costly] supply of licensed nurses must not be used as an excuse for inappropriate delegation to unlicensed persons.

Delegation is an appropriate means, and a useful tool, to maximize the contributions of various members of the health care team to the well-being of the patient/client/resident when performed according to well-reasoned principles. The National Council's delegation paper sought to set out such principles. First, nurses should avoid delegating the practice-pervasive functions of assessment, evaluation, and nursing judgment. Second, the delegating nurse assumes responsibility for determining that the delegate is indeed competent to perform the delegated act and provides appropriate supervision. Third, boards of nursing must clearly define delegation in regulation, promulgate clear rules for its use, and follow through with disciplinary action when there is evidence that the rules are violated.

Underlying all of the above principles relative to delegation is a central tenet of professional regulation: that a license is a mechanism to assure the public of the competence of the licensee to practice safely and effectively. The process leading to licensure is therefore rigorous, including requirements for education (didactic and clinical) and examination. Such assurance cannot be replicated by training programs typically provided to unlicensed personnel. Nor can the accountability of unlicensed personnel match the accountability of the licensed nurse. The licensee is accountable not only to the employer, but also to the state authorities issuing the license. The licensee stands to lose not only his or her job, but also license, should the care provided not meet the standards for safety and effectiveness.

The National Council urges all who participate in the provision of health care to the public to consider and endorse the value of a license as an essential mechanism to assure the delivery of quality nursing care for the consumer.

Department of Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

I am responding to [National Council's] letter urging us to safeguard public health and safety through prohibiting the use of unlicensed individuals instead of licensed nurses.

I would like to assure you that public health and safety is our paramount concern in setting standards for individuals and institutions that furnish care to Medicare and Medicaid beneficiaries. In establishing standards, we give heavy weight to the value of licensure. Nevertheless, there may be situations under which we are compelled (e.g., for statutory reasons) to permit unlicensed personnel to perform services that some might prefer to have performed by licensed nurses. Thus, while we will always strive to set the most appropriate rules and requirements, I cannot promise that we will always require the use of licensed nurses instead of other personnel.

Thomas Hoyer
Acting Director
Office of Coverage and Eligibility Policy
Bureau of Policy Development

1-20

Insight: Newsletter on Nurse Aides & Assistive Personnel

American Association of Colleges of Nursing
One Dupont Circle, NW, Suite 530
Washington, DC 20036

American Association of Colleges of Nursing

September 12, 1994

AACN and other members of the Tri-Council for Nursing have had extensive discussions on the growing use of unlicensed personnel for the delivery of nursing care.

As you may be aware, in 1990 the Tri-Council did develop and adopt a position statement on personnel who are serving in roles that are assistive to the professional nurse. The position statement still stands the test of time and is pertinent to the issues you have raised in your letter.

AACN is aware of the need to assure the appropriate oversight and monitoring of nursing care delivery. Moreover, in keeping with the position statement, the AACN supports the view that it is incumbent upon the nursing profession to define the appropriate educational preparation for individuals delivering nursing care and that professional nurses retain the ultimate responsibility for tasks delegated to unlicensed personnel.

We applaud [National Council's] efforts to raise awareness of concerns for public health, safety, and welfare that could be generated through the inappropriate use of unlicensed personnel. AACN also maintains as one of its primary goals the assurance of public safety through the preparation of highly skilled and knowledgeable professional nurses. To that end, we will continue to discuss this issue.

Geraldine Polly Bednash, PhD, RN, FAAN
Executive Director

American Medical Association
515 North State Street
Chicago, Illinois 60610

American Medical Association
Physicians dedicated to the health of America

September 27, 1994

The American Medical Association (AMA) shares [National Council's] concerns about maintaining the quality of patient care in all settings, especially during the rapid changes that are occurring in the health care system. The AMA has long recognized that nurses are very important in maintaining the quality of medical care, and I know [National Council's] efforts will continue in the future.

The AMA continues to be a supporter of enhanced education for nurses and also for other personnel as a method of improving the quality of patient care. At the present time AMA supports all levels of nursing education, including the education of licensed practical nurses (LPN) who meet a vital need of patients for basic bedside care. I applaud the initiatives of the nursing profession in preparing and licensing LPNs who can appropriately work to answer the needs of health care reform for a multiskilled, economic, nursing workforce.

The complexity of patient care demands the full cooperation of the health care team, including physicians and nurses working together to ensure the safety of our patients. In these times of increasing cost consciousness, the system seems to be demanding that both our professions work to conserve resources and mentor and supervise unlicensed personnel that assist both physicians and nurses in the delivery of patient care at less cost. Physicians accept the responsibility of delegating to other health care workers, many of whom we help to educate. It is this sense of responsibility and collaboration that promotes the welfare of the patients we all serve. Whether money is truly saved is another matter, but nurses and physicians will need to be especially vigilant as more unlicensed helpers are having direct contact with patients.

James S. Todd, MD
Executive Vice President

1-21

Appendix D

American Nurses Association
600 Maryland Avenue SW
Suite 100 West
Washington, DC 20024-2571
TEL 202 651 7000
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NEWS RELEASE

EMBARGOED UNTIL:
9:30 a.m. (EST)
February 7, 1995

CONTACT: Sara Foer 202/651-7023
Joan Meehan 202/651-7020
Lisa Wyatt 202/651-7019

AMERICAN NURSES ASSOCIATION SAYS QUALITY OF CARE IS BEING SACRIFICED FOR PROFITS IN MANY HOSPITALS

Nationwide Survey of RNs Finds More Aides, More Errors

WASHINGTON, DC, February 7, 1995 -- The American Nurses Association (ANA) held a press conference today to alert the public to an alarming trend where hospitals implement cost-cutting schemes that reduce the number of registered nurses (RNs) caring for patients, and growing evidence that quality and safety of patient care are being jeopardized as a result. ANA is mounting a public awareness campaign to inform consumers about staff changes in hospitals and about the link between RN care and positive outcomes for patients.

ANA released findings from a survey of 1,835 nurses nationwide that point to a reduction in RNs in hospitals causing unsafe conditions for some patients and massive workloads for the RNs who remain. More than 2/3 of the respondents said the number of RNs employed in their facilities had been cut back (whether by layoffs or attrition) in the past 12 months. Increased use of unlicensed assistive personnel, minimally skilled workers with as little as 4-6 weeks of training, to provide direct patient care, was reported by 44% of respondents.

Because of the reduction of RNs and the increased workloads of those who remain, increases in the number of errors reported by nursing and non-nursing staff were reported by 17.5% of respondents to the patient safety question. Medication errors were reported far more frequently than other types of errors. Increases in patient falls and fractures, longer waits for routine care, and earlier readmission and re-injuries resulting from inadequate patient education were also reported.

MORE...

ANA
AMERICAN NURSES ASSOCIATION

ANA SAYS QUALITY OF CARE/2...

Hospitals continue to target RNs for layoffs. According to Modern Healthcare's 1994 national survey of hospitals, 27% planned to layoff nurses in the next year - an increase from 19% in 1993. For example, just recently in Washington, D.C., Georgetown University Hospital and Howard University Hospital have announced layoffs of RNs.

"Patients in hospitals are very sick and vulnerable. They and their families expect professional care for the high prices they pay," said ANA President Virginia Trotter Betts, JD, MSN, RN. "When only an untrained technician comes when you or your loved one is in crisis or pain, do you get a rebate? NO! So we must ask where and to whom is your health care dollar going when it is not going for quality, safe care!" Betts declared.

ANA also released preliminary findings from a study conducted by Lewin-VHI, Inc. of Fairfax, Virginia, to identify patient outcome indicators linked to nursing care, such as nosocomial (related to hospitalization) infections, decubitus ulcers (bed sores), medication errors, patient injury rate, and patient satisfaction, for inclusion in report cards that would provide information to consumers about quality of care in health care facilities.

ANA also highlighted its public education brochure, "Every Patient Deserves a Nurse." The brochure includes checklists for consumers to use to evaluate a hospital's nursing staff.

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KSNA
the voice of Nursing in Kansas

KSNA & You
A Powerful Match

FOR MORE INFORMATION CONTACT:
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Executive Director
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(913) 233-8638
February 9, 1995

SB 151 NURSE PRACTICE ACT CHANGES

Senator Praeger and members of the Senate Public Health and Welfare Committee, my name is Carolyn Middendorf MN, RN, and I am the current president of the Kansas State Nurses Association.

As you know, S.B. 151 makes a number of changes to the Kansas Nurse Practice Act, affecting licensees of the Board of Nursing, and operations at the Board of Nursing. For purposes of simplicity, I will speak to the changes in the act in the order in which they appear in the bill.

Continuing Education Exemption for New Licensees

The changes embodied in lines 27-29, which exempt the licensees newly licensed by examination (New Graduates) and RN & LPN's coming to Kansas from other states where they are licensed for essentially their first renewal period, has been the practice of the Board of Nursing since the inception of mandatory continuing education for nurses in 1978. While this practice has been in rules and regulations, this statute provides the necessary statutory authorization to the Board. This issue came to the attention of the Board of Nursing as they were considering requests from several licensees to complete all of their Continuing Education by independent study, due to illnesses which prevented them from physically attending programs offerred in the community. One of the licensees was immunosuppressed and could not be in large public crowds. The Board is taking a serious look at making provisions for licensees to take **all** their continuing education by independent study on an individual basis. Currently, out of the thirty hours of required CE (every two years), only twelve (12) hours can be accumulated from independent study. Only nurses licensed by the Kansas Board of Nursing, but residing in foreign countries are permitted to submit all of their CE by independent study. The quality of independent study has increased significantly over the past 17 years.

Senate Public Health & Welfare
Date: 2-9-95
Attachment No. 2

KSNA supports the statutory amendment being proposed that would provide the statutory authorization for the exemptions and the Board of Nursings attempt to address the issue of independent study in rules and regulations.

Board Proceedings: Retention by the Agency of 100% of Monies Collected

KSNA supports the Boards request to retain 100% of the monies collected by the agency for costs associated with licensees who have been formally disciplined. The Board just this month implemented a 20% fee increase for RN's and LPN's renewal fees, from forty dollars ($40) to fifty dollars ($50), which should generate and additional $50,000 to the agency in their FY 1995 budget. These fee increases were needed to support the agencies role in investigating and disciplining licensees.

We believe that licensees who violate the Nurse Practice Act should bear a share of this financial cost to the agency. We support the proposed amendment. The Board of Nursing has not routinely and systematically charged disciplined licensees for these costs, currently permited by this statute. We support the Boards immediate implementation of this section in all disciplinary proceedings where applicable, the agency will be able to keep 80% of the collected monies (20% to the state under current statute), and if this bill passes, then 100% of the monies collected after July 1 will be credited to the agency fee fund. These monies should increse the length of time between the most recent license renewal fee increase and the next fee increase.

KBI and Criminal Justice Information

KSNA supports the request by the Board for statutory authority to gain access to KBI information on licensees. It seems logical that two agencies designed to "PROTECT THE PUBLIC" should work in concert by sharing relevant information. The KBI is funded with state tax dollars and should be strongly encouraged to work cooperatively with the Board when information they posses may assist the agency in determining the appropriateness of licensing applicants and/or disciplining licensees.

School Setting and Delegation Exception to the Nurse Practice Act
School Setting Issue
Current (k) and (l) in the exception clause of the Nurse Practice Act were added in 1989 to provide latitude to school nurses to delegate to unlicensed persons "selected nursing procedures". This

was necessary to due to volume of functionally disabled children who were being mainstreamed. The language proposed, while appears to be a substantive, is really a recognition that any student can have such services performed on their behalf, pursuant to delegation by a nurse. The language proposed simplifies the statute, making the language applicable to all students, instead of having two seperate sections, one for handicapped and describing a specific set of criteria when delegation can occur. The two exemptions are covered in one set of regulations now. KSNA supports the changes proposed in (k) and (l).

Delegation

The Kansas State Nurses Association continues to support the statutory language of delegation, in which nurses have the professional responsibility to delegate appropriately. KSNA does not support the inclusion of the phrase "pursuant to a process of delegation as defined by rules and regulations of the board," in relationship to delegation of nursing activities. We believe it is unnecessary for guidelines to be written, because it would require exhaustive listing to cover the situations. Further, a situation may be interpreted differently a second time, with other circumstances in place. Without supporting data, we do not believe the Board of Nursing has sufficient reason to detail regulations that remove the options the professional registered nurse might use in delegation. We will continue to work with the Board, the hospital industry, the rehabilitation facilities, and others to clarify this section so that the statutory construction of this provision is clearly understood. We are concerned that the Board of Nursing's interpretation, for which nurses may and are being disciplined may be different than what was intended when the original exception was passed in 1992 (House bill 2882). We urge to the Board to work with all the parties involved to come to some resolution of this issue, so that licensees feel comfortable exercising independent judgement with fear of reprisal for the agency.

Thank you for the opportunity to speak. As President of KSNA I would also like to publically thank Senator Prager and the Committee Secretary JoAnn Bunten for graciously expediting the accomidations for todays hearing. I'm confident the nurses in the audience are appreciative of this wonderful opportunity to see how important legislation can be to their practice.

Thank you for the opportunity to speak to you today.

KANSAS BUREAU OF INVESTIGATION
DIVISION OF THE OFFICE OF ATTORNEY GENERAL
STATE OF KANSAS

LARRY WELCH
DIRECTOR

CARLA J. STOVALL
ATTORNEY GENERAL

KYLE G. SMITH, ASSISTANT ATTORNEY GENERAL
KANSAS BUREAU OF INVESTIGATION
BEFORE THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE
FEBRUARY 9, 1995

Madam Chairperson and Members of the Committee:

My name is Kyle Smith. I appear today on behalf of the Kansas Bureau of Investigation (KBI) with a proposed amendment to SB 151. Our concerns deal with paragraphs authorizing the board to have access to criminal justice information located on page 4, lines 5-18, and page 6, lines 6-19. It is my understanding that the language used was lifted from language used by the Board of Healing Arts, which lifted it from the Racing Commission statutes.

However, what may be appropriate in a highly regulated and sensitive activity of granting a racing license might not be appropriate or even legal for a normal occupation license such as nursing or a mental health technician.

The first question deals with the language authorizing the board to receive arrest, non-conviction data and criminal intelligence information for purposes of determining initial and continuing qualifications of licensees and applicants. Due to its limited probative value such data is usually not available for licensing purposes. In fact, Title VII of the Civil Rights Act prohibits consideration of even conviction data unless there is a specific showing that such a conviction bears a reasonable relationship to the qualifications for the position. Arrest and non-conviction data is only provided to criminal justice agencies and for investigative purposes. Other disclosure is, in fact, a crime. See K.S.A. 22-4707(d). Currently, any licensing board

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may enter into a non-disclosure agreement and run record checks with the KBI and obtain conviction only data. In fact, we have such an agreement with the Board.

Criteria for licensure as a nurse or mental health technician and for disciplinary action does not contain and probably could not legally contain a criteria regarding of having never been arrested. If non-conviction data cannot be the basis of any disciplinary action. There would seem little reason to make this information available.

We have prepared a balloon striking the non-conviction data references.

There may be need to distinguish whether this information is needed for application for licensing or disciplinary action or both, whether SB 151 states that the information is to be available for initial and continuing qualifications. As stated previously, under current law, the Board of Nursing can enter into a non-disclosure agreement, and I believe in the past has, to run record checks on applicants. If they wish to make this mandatory, we certainly would have no objection, however, I presume there are statutes dealing with qualifications or initial licensure of nurses and mental health technicians. We need to make certain that criminal convictions, e.g. felonies and drug and alcohol misdemeanors, are statutorily provided as a basis for denial of such licenses. Further, a fee charge would need to be authorized. If this information is wanted for disciplinary actions only, then the amendment would seem sufficient.

A secondary decision that needs to be made by the legislature is whether they wish to include federal records. The KBI maintains criminal history record information only as regards to Kansas. Therefore, if a person has a conviction in another state or in the federal system, that information would not be available through record checks of the KBI. The FBI will only run record checks if a state statute mandates that the records be run through the FBI record system.

Yet another consideration is that there are two levels of background checks. The first

generally thought of as a "name/date of birth" check, is conducted on teletype through the computers. These checks connect applicants to individuals with records who have the same name, date of birth, social security number, height, weight, etc. The second procedure involves submission of fingerprint cards, which, of course, provides a more certain way of confirming that the person subject to the record check is, in fact, the person who has the criminal record. However, the fingerprint system does entail six to eight weeks before the records are obtained from the FBI and a higher fee. The degree of certainty required dictates the procedure.

Another issue that may be present in this question is whether the Board of Nursing would have access to a criminal investigative file of the KBI or another criminal justice agency regarding a licensee. For instance, if a licensee were arrested and criminally charged for stealing narcotics, the release of those investigative files is currently left to the discretion of the law enforcement agency. As a policy, the KBI (as do most law enforcement agencies) has always made our investigative files available to administrative agencies after the criminal investigation and prosecution are completed. Therefore, language specifying that they may have access to such information (again after it is no longer needed for criminal prosecution), is left in our amended version.

I would be happy to stand for questions.

SB 151

standard of care to a degree which constitutes ordinary negligence, as determined by the board; or

(3) a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice nursing.

(f) Criminal justice information. The board may receive from the Kansas bureau of investigation or other criminal justice agencies such criminal history record information ~~(including arrest and nonconviction data), criminal intelligence information~~ and information relating to criminal ~~and background~~ investigations as necessary for the purpose of determining initial and continuing qualifications of licensees and registrants of and applicants for licensure and registration by the board. ~~Disclosure or use of any such information received by the board or of any record containing such information, for any purpose other than that provided by this subsection is a class A misdemeanor and shall constitute grounds for removal from office, termination of employment or dental, revocation or suspension of any license or registration issued under this act. Nothing in this subsection shall be construed to make unlawful the disclosure of any such information by the board in a hearing held pursuant to this act.

Sec. 3. K.S.A. 1994 Supp. 65-1124 is hereby amended to read as follows: 65-1124. No provisions of this law shall be construed as prohibiting:

(a) Gratuitous nursing by friends or members of the family;

(b) the incidental care of the sick by domestic servants or persons primarily employed as housekeepers;

(c) caring for the sick in accordance with tenets and practices of any church or religious denomination which teaches reliance upon spiritual means through prayer for healing;

(d) nursing assistance in the case of an emergency;

(e) the practice of nursing by students enrolled in accredited schools of professional or practical nursing or programs of advanced registered professional nursing approved by the board nor nursing by graduates of such schools or courses pending the results of the first licensure examination scheduled following such graduation but in no case to exceed 90 days, whichever comes first;

(f) the practice of nursing in this state by legally qualified nurses of any of the other states as long as the engagement of any such nurse requires the nurse to accompany and care for a patient temporarily residing in this state during the period of one such engagement not to exceed six months in length, and as long as such nurses do not represent or hold themselves out as nurses licensed to practice in this state;

(g) the practice by any nurse who is employed by the United States government or any bureau, division or agency thereof, while in the discharge of official duties;

Repeat on page 9.

KONE

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

February 8, 1995

Senator Praeger,
Members of the Senate
Public Health and Welfare Committee:

My name is Joan Sevy. I am a member of the Board of Directors of the Kansas Organization of Nurse Executives and Chair of the KONE Legislative Committee. I am also a practicing nurse executive at one of the hospitals in Topeka. I am here to represent the organization's opposition to proposed paragraph "m", of Section 3 of 65-1124 in Senate Bill 151. The amended language, new paragraph "m", allows the Kansas State Board of Nursing to develop rules and regulations for delegation of nursing tasks. We are not opposed and in fact, support all other proposed changes contained in this bill.

It is our belief that this amended language would permit the Kansas State Board of Nursing to attempt to legislate nursing judgement. We see the language currently contained in the statute as sufficient to address appropriate, safe delegation by reasonable, prudent nursing professionals. KONE has been involved in this issue since 1990 when we participated in discussions with the Board and other health care organizations. For your information, I have attached a chronology of those events to my testimony. The language currently in the practice act was the result of the work of these groups. It was intended to permit

delegation of nursing tasks, under the supervision of a licensed nurse. It assumes an appropriate assessment of the need to delegate and the competence of the individual to whom tasks are delegated.

At this time, it appears to KONE that the Kansas State Board of Nursing is changing its position regarding the use of rules and regulations for delegation of nursing tasks, specifically that of medication administration. This was not our understanding at the time this issue was addressed in 1992. I refer to a letter dated February 27, 1992 to Representative Sader signed by Ms. Johnson, also attached to my testimony.

It is the position of the Kansas Organization of Nurse Executives that development of rules and regulations such as those we have seen proposed by the Board is restrictive to both the professionals and the health care institutions which employ them. They attempt to legislate professional nursing judgement in a changing health care environment. Such restriction has the potential to increase the cost of health care. As an example, health care providers are redesigning their work to maximize the skills of all members of the health care team. Nurses remain accountable for the management of care, however, they may well be supervising unlicensed, but highly qualified health care personnel. Respiratory therapists for example, who are unlicensed, currently administer medication by inhalation. The proposed rules and regulations would not permit a professional nurse to delegate this

same task to that same therapist if they were working in a redesigned patient care team.

The proposed rules and regulations are based on current practices which will, and probably should change over the next years of anticipated health care reform. This is why we see them as restrictive and unnecessary. We question if the legislature really wishes to support movement in a direction which will increase the regulation of professionals and possibly health care costs.

The Kansas Organization of Nurse Executives believes that the current law has not been given sufficient opportunity to work. It is our recommendation that the Board of Nursing convene a group of nursing leaders from various health care delivery sites for further discussion and consensus building. We further recommend there be representation from other providers in the community, such as correctional facilities, child care facilities and rehabilitation facilities. Lastly, we recommend that the proposed language contained in Section 3 of KSA 65-1124 contained in new paragraph "m" be deleted, and that the language currently contained in Section 3 of KSA 65-1124 as paragraphs "l", "m" and "n" be retained until this issue can be further explored. I have attached a balloon of this bill for your review.

Thank you.

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.

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.

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.

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

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.

DE[illegible]BER 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."

KRH:amj

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

Mental Health & Retardation Services
Fifth Floor North
(913) 296-3773

February 27, 1992

The Honorable Carol H. Sader, Chairperson
House Public Health & Welfare Committee
Kansas State Representative
State Capitol, Room 115-S
Topeka, Kansas 66612

Re: HB 2882 - An ACT concerning the board of nursing; amending K.S.A. 1991 Supp. 65-1124 AND REPEALING THE EXISTING SECTIONS.

Dear Representative Sader,

The Kansas State Board of Nursing, the Division of Mental Health and Mental Retardation Services of the Kansas Department of Social and Rehabilitation Services, the Kansas State Nurses' Association and the Kansas Association of Rehabilitation Facilities support the passage of HB 2882 without amendment. The new (n) language allows the nursing profession, state agencies, community providers, and consumers of services to cooperate in the effective delivery of quality care in the least restrictive environment.

This letter reflects the understanding of the above parties that the proposed legislative change in HB 2882, which creates section (n) of K.S.A. 65-1124, codifies the responsibility of the licensed nursing professional to:

I. Within the reasonable exercise of independent nursing judgment, "delegate" the performance of a nursing task. Independent nursing judgment permits and authorizes the licensed nurse to make the decision whether or not to delegate a particular activity.

II. Exercise the responsibility of supervision. - The responsibility for supervision requires that the registered professional nurse or the licensed practical nurse delineate, educate, and supervise the nursing tasks that unlicensed personnel may perform. The signatories of this letter concur that the following definition of supervision developed by the National Council of State Boards of Nursing and printed in the 1989 Concept Paper on Delegation, is the operational definition for the use of the word supervision in this proposed statutory change.

> 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.

III. Allow the performance of a nursing task with reasonable skill and safety by a person under the supervision of a nurse. Performance of a nursing task may include the administration of medications. Education and demonstrated competency would be the basis for assuring reasonable skill and safety.

Past legislative efforts to create exceptions for the delegation and delivery of nursing services resulted in sections (k), (l), and (m) of the K.S.A. 65-1124. Review of companion regulations and statutes to those sections (see attachments 1 and 2) reflects the framework of tasks subject to delegation to unlicensed personnel. The administration of medications is specifically listed as a task that can be delegated under the existing guidelines specific to (k), (l), and (m).

In the future, as the support systems for persons with disabilities grows in the community setting, the scope of nursing tasks which may be delegated will also continue to expand. The present legislative and regulatory framework provides direction to nursing professionals in the exercise of their professional nursing judgment and guidance to others as to the scope of tasks deemed appropriate for delegation.

The signatories concur that the exception to the Nurse Practice Act conferred in Section (n) is an essential component in the implementation of public policy that supports the efforts of persons with disabilities to live in their communities.

Sincerely,

Patsy Johnson, R.N. M.S.N.
Executive Administrator,
Kansas State Board of
Nursing

George D. Vega,
Acting Commissioner,
Mental Health and
Retardation Services
Department of Social and
Rehabilitation Services

Terri Roberts, J.D. R.N.
Executive Director,
Kansas State Nurses' Association

Yolande Bestgen
Executive Director,
Kansas Association of
Rehabilitation Facilities

(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;

(i) the administration of medications to residents of adult care homes or to patients in hospital-based long-term care units, including state operated institutions for the mentally retarded, 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;

(j) the practice of mental health technology by licensed mental health technicians as authorized under the mental health technicians' licensure act;

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

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

~~(m)~~ *(l)* 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 under K.S.A. 65-6201 and amendments thereto;

~~(n)~~ *(m)* 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, *pursuant to a process for delegation as defined by rules and regulations of the board,* and is performed with reasonable skill and safety by that person under the supervision of a registered professional nurse or a licensed practical nurse; or

~~(o)~~ *(n)* the practice of nursing by ~~applicants~~ *an applicant for Kansas nurse licensure* in the supervised clinical portion of a refresher course.

Sec. 4. K.S.A. 1994 Supp. 65-4203 is hereby amended to read as follows: 65-4203. (a) Except as is hereinafter provided, an applicant for a license to practice as a mental health technician shall file with the board a written application for such license, on forms prescribed by the board, and shall submit satisfactory evidence that the applicant:

(1) Has been satisfactorily rehabilitated if the applicant has ever been convicted of a felony;

(2) possesses a high school education or its recognized equivalent;

4-13

KANSAS ORGANIZATION OF NURSE EXECUTIVES

RECOMMENDATIONS FOR AMENDING S.B. 151

Do not delete

Renumber accordingly

Delete: "pursuant to a process for delegation as defined by rules and regulations of the board"
Renumber accordingly