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KANSAS STATE NURSES ASSOCIATION

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Kansas State Nurses Association Opposes SB 453

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Dear Chairman Hildebrand and Committee,

Kansas State Nurses Association (KSNA) is the largest nursing association in Kansas, and we are constituent members of the American Nurses Association (ANA) which is the largest in the country representing over 3 million RNs. We are a not-for-profit association in Kansas and advocate on the state and federal level for RNs and improved healthcare of all Kansans and our country. We are a bipartisan association and do not donate to any PACs in Kansas. We meet daily with our RN members, other Kansas organizations, and our fellow directors of nursing associations throughout our country to discuss pertinent issues and to share information which allows us to get a larger perspective to advocate on healthcare issues in our state. Ultimately, we can provide new, inventive, and modern approaches to what all our consumers need and have rights.

KSNA opposes SB 453 since this will directly impact the quality of care for residents and patients, especially in long-term care. Our rationale is simple, decreased educational requirements and lack of certification affects staffing retention, best practices, quality outcomes, reduces education standards, and affect the confidence of a CNA with their education. Additionally, this bill does not fit within the Scope of Practice of an LPN in Kansas and puts the RN license at risk of investigation and loss of license.

In the years prior to COVID-19, we have data that supports three points: that long-term care industry was already in trouble, we were going to need better staffing solutions immediately, and the certification of a Nurse Aide and Medication Aide should not be under the Kansas Department of Aging and Disability (KDADS) since it is a conflict of interest with lack of knowledge or understanding of healthcare providers. None of us could have predicted COVID-19, but corporations and associations that represent the industry, not direct care staff, continue to put forward bad bills to benefit their owners, mostly corporate owned, instead of the staff and Kansans receiving care. Additionally, direct care nurses and the Kansas Board of Nursing Board (KSBN) have not been involved in this, or any other, bill that will directly impact them and their patients, despite multiple attempts by our association. Collaboration with the appropriate regulatory agencies and RNs are absolutely necessary to help shape the current and future needs in healthcare.

We must continue to operate and practice under the current educator requirement set forth in the Kansas Nurse Practice Act and definitions of Scopes of Practice for an LPN and RN: According to state and federal standards, each course instructor must be a registered nurse with a current Kansas license and have a minimum of two years' licensed nursing experience. Additionally, all nurse aide instructors must have completed a course in teaching adults or a professional continuing education offering on supervision or adult education, or shall have experience in teaching adults or supervising nurse aides and have and completed at least seven hours of professional continuing education offerings on person-centered care in an adult care home or a long-term care unit of a hospital not more than one year before becoming an instructor of the nurse aide training course and each year while serving as an instructor. By nature of the Scope of Practice (SOP)d++++ LPNs assignments require assignment or delegation by and performance under the supervision, orders, or direction of an RN, Physician, Dentist, or other person authorized by State law to provide supervision. K.S.A. 654-1113(D)(2) allows for task (assigned pieces of work) and responsibilities from (D) (1), based on acceptable education, in the area of supportive or restorative care.

LPNS are valuable to what we do in nursing. LPNs perform many basic care skills to our patients, but the more advanced skills are the reasonability of the RNs. LPNs provide what is often referred to as "essential care", which means that they provide basic nursing care. Some of those tasks include monitoring patient vital signs, maintaining health records, providing basic care (bathing, feeding), simple wound care, insertion of catheters, reinforcement of education that was already provided by the RN to the patient, and reassessment of patient's condition. The LPNs assessment is a focused appraisal of and individual's status and situation at hand, contributing to the assessment, analysis, and development of a comprehensive plan of care by the RN. The LPN supports ongoing data collection and decides who to inform. Likewise, it is beyond the SOP for an LPN to assign or delegate to an RN in accordance with Kansas Nurse Practice Act. An RN signature cannot be required if the RN has not created the program or provided supervised course instruction.

The educational ratio of 1:10 and 50 percent simulation comes for the language from the Kansas Board of Nursing for an RN, not the CNA. The educational requirements for a CNA cannot be compared to that of an RN. In the Kansas Nurse Practice Act 60-1-204 and 60-2-105 there is clear definition of how the 50% clinical use of simulation is applied for the BSN program. There is not clear research that the use of mannequin simulation meets the necessary clinical portion of the CNA education. There is research regarding the use of a highly technical program, that does not involve a mannequin, that may look promising. But, until there is good research involving the use of a mannequin (as a “dummy” was shared by Scott Bruner during the Bethel Committee Meeting as the means of simulation learning for the CNA), we cannot support any learning other than the hands-on clinical education needed for the CNA.

There is no evidence that this bill will incentivize an RN to return to bedside care or that it will increase the number of CNA students. From conversations with fellow RNs, including those who have worked in long-term care and now are CNA instructors), they will not return to long-term business employment if this bill is passed. We are also curious if this industry has an overabundance of LPNs that makes this bill logical to put forward. If this were the case, then staffing would be a null issue.

We have strong concerns that the Kansas Department of Aging and Disability (KDADS) is responsible for the CNA and CMA. We would propose the Department of Health and Environment (KDHE) or the Kansas Board of Nursing would provide better regulation. Currently, there isn’t any state in our country allowing for a department similar for KDADS to have oversight over a healthcare provider with most states having the CNA and CMA under their state health agencies and boards of nursing. KDADS has shown that they lack the knowledge, appropriate regulation of a healthcare provider as demonstrated by the Temporary Nurse Aide under HB 2477 where there continues to be unanswered questions, no data, or current regulation of this position to protect the public. KSNA continues to ask for this information, but it has still gone unanswered since the TNA was under the old Executive Orders before HB 2477 was passed.

KSNA cannot support the portion of the bill that would allow for 40 hours of training, with no certification, to provide direct skilled care to our seniors. KSNA would assert that SB 453 has every intention to expand the Temporary Nurse Aide (TNA) under HB 2477, without any certification requirement, to provide skilled care to our patients and seniors. Any mention of Activities of Daily Living (ADLs) is skilled care. ADLs include the transfer of an individual from a bed to a chair, which can include operating a Hoyer Lift. We know on the 8-hour unsupervised training courses (and 50 multiple choice unsupervised exam) where they watch videos and read PDF documents that contains everything that a CNA performs, including operation of a Hoyer Lift as we looked at the training being used. KDADS needs to begin to track information and have good data now while HB 2477 is law. But we’re not aware that there is any tracking for data currently in place. Our seniors are at extreme high risk and “warm bodies” is putting them in greater and greater situations of serious injury.

In SB 453 it allows a physician, physician assist, and other professions that is under the Board of Healing Arts (BOHA) to provide diagnosis and consultation for long-term care businesses. It leaves out the Advanced Practice Nurse (APRN) who has a specific Scope of Practice that could be allowed, also. We are curious why this language to include an APRN has been left out.

According to the United States Census Bureau from 2010 to 2019, there has been a 30.1 to 60% growth of adults over the age of 65 in Kansas in our more urban areas. By 2030 almost 77 million people in our country will be over the age of 65. This increase in older adults in our country may see more demands for healthcare, in-home caregiving, and assisted living facilities. That number will continue to incline. The possible good news for Kansas is areas in our country with warm weather tend to attract our aging population. Kansas has several rural counties that will start to see a decline of our older adults.

Detailed information and statistics on population aging of our adult population are critical for understanding the impact to inform policy changes and programs. At the biological level, aging leads to growing risks of disease in physical and mental capacity, a growing risk of disease and death. Common conditions in older age include hearing loss, cataracts, back and neck pain, osteoarthritis, chronic obstructive pulmonary disease, diabetes, depression, and dementia. As people age, they are more like to see a combination of diseases. We will see geriatric syndromes including frailty, urinary incontinence, falls, delirium and pressure ulcers. Physical and social environments should provide our older adults an environment to enable them to do what is important to them, despite losses in capacity. The availability of safe and accessible and supportive environments is important to recovery, adaptation, and physiological growth. Public health officials and society need to address these because it affects whether good policies are developed as well as the opportunities for older people to experience healthy again. SB 453 does not meet these needs now or in the future and will only provide poor quality outcomes.

Because KSNA represents our RNs and advocates for quality healthcare, we thought it was important to share proposed solutions in addition to opposing HB 453.

KSNA proposes the following short- and long-term solutions:

- Increase the number of education requirement hours for a CNA from 90 to 110 to include acute care education.
- RN direct supervision and instruction for a CNA but allow for LPN substitution to teach direct skill-based care that fall under the definition of ADL's (activities of daily living).
- Make available a list of CNA instruction programs for the entire state of Kansas to help assist an individual in seeking CNA schools.
- Move CNA certification from KDADS back to KDHE.
- Offer clinical time within a hospital and long-term care business.
- No use of simulation until there is adequate research to support. Type of simulation should also be defined.
- Work with the Kansas Board of Nursing to see where in the Registered Nurse program a student could become certified as a nurse aide to increase the CNA workforce that has the appropriate level of education and knowledge of multiple sciences and ADL skill-based care.
- Consultation with the Kansas Board of Nursing, Nurse Educators to include RN CNA Educators, KDHE and KDADS to change educational requirements and experience for an RN to allow for more RN CAN Educators.
- Require CNA certification for long-term care Administrators so they can assist to provide skilled care to residents in long-term care when short staffed.

- Paid education for CNAs who commit through a signed contract to work for a long-term care business for one, maybe two, years.
- Paid CNA education for addition staff who work in long-term care so they can provide skilled care when needed.
- Develop a consistent mentorship program in respective areas of healthcare to offer the emotional support and increased teaching opportunities in to retain staff.
- Allow for nurses to have a seat at the table for all decisions that directly impact the outcomes of patients.
- Appoint a direct care RN to all hospital and long-term care boards so they best represent the needs of staff and patients.
- Company-paid geriatric education every 6 months to stay current on healthcare for our seniors. This would include the same requirements for administrators of long-term or skilled facilities.
- Allow for a staff member who does not provide skilled care and is more comparable to what has been referred to as a "candy striper". This would allow the employee to do checks on all residents in long-term care for safety, get water, push a wheelchair but not allow for any transfers, and assisting with resident activities. Any witnessed concerns can be directed to the nursing staff. Uniform or badge is required to identify this individual is not allowed to provide skilled care. This position would not be allowed to have "certified", "nurse", or "aide", in their title.
- A task force created by KDHE, that works toward additional concrete solutions including, but not limited to, the need for RN educators to meet staffing requirements. Additional Task Force members should include those who advocate for our older adults, adults with disabilities, nurses, all regulatory agencies, and more.

KSNA thanks your time and attention. We appreciate your ongoing support of all nurses in Kansas.

Best regards,

KANSAS STATE NURSES ASSOCIATION BOARD OF DIRECTORS

Kelly K Sommers

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