Commission Members:
Tracy Rude, LPN, Chair
Mary Baroni, PhD, RN, Vice-Chair
Lois Hoell, MS, MBA, RN, Secretary/Treasurer
Adam Canary, LPN
Jeannie Eylar, MSN, RN
Ella B. Guilford, MSN, M.Ed., BSN, RN
Edie Higby, Public Member
Dawn Morrell, RN
Helen Myrick, Public Member
Sharon Ness, RN
Donna L. Poole MSN, ARNP, PMHCNS-BC
Tiffany Randich, RN, LPN
Laurie Soine PhD, ARNP
Yvonne Strader, RN
Cass Tang, Public Member

Assistant Attorney General:
Gail S. Yu, Assistant Attorney General

Staff:
Paula R. Meyer, MSN, RN, FRE, Executive Director
Kathy Anderson, Director, Finance
Chris Archuleta, Director, Operations (Excused)
Gerianne Babbo, Ed.D, MN, RN, Director, Education
Shad Bell, Assistant Director, Operations
Amber Bielaski, MPH, Assistant Director, Licensing
Debbie Carlson, MSN, RN, CPM, Director, Practice
Teresa Corrado, LPN, CPM, Assistant Director, Discipline – Case Management
John Furman, PhD, MSN, CIC, COHN-S, Assistant Director, Discipline – Washington Health Professional Services (WHPS)
Mary Sue Gorski, PhD, RN, Director, Advanced Practice, Research and Policy
Karl Hoehn, JD, FRE, Assistant Director, Discipline – Legal
Grant Hulteen, Assistant Director, Discipline – Investigations
Alana Llacuna, Administrative Assistant
Kathy Moisio, PhD, RN, Director, Nursing Assistant Programs
Tori Lane, Nursing Practice Administrative Assistant
Brandon Williams, Performance and Policy Analyst
Catherine Woodard, Director, Discipline
If you have questions regarding the agenda, please call the Nursing Care Quality Assurance Commission (NCQAC) office at 360-236-4713. Agenda items may be presented in a different order. If you wish to attend the meeting for a single item, contact our office at the number listed above and request a specific time scheduled for that item. If you have limited English language expertise call 360-236-4713 before January 3, 2020.

This meeting is accessible to persons with disabilities. Special aids and services can be made available upon advance request. Advance request for special aids and services must be made no later than January 3, 2020. If you need assistance with special needs and services, please leave a message with your request at 1-800-525-0127 or, if calling from outside Washington State, call 360-236-4052. TDD may also be accessed by calling the TDD relay service at 711. If you need assistance due to a speech disability, Speech-to-Speech provides human voicers for people with difficulty being understood. The Washington State Speech to Speech toll free access number is 1-877-833-6341.

This meeting will be digitally recorded to assist in the production of accurate minutes. All recordings are public record. The minutes of this meeting will be posted on our website after they have been approved at the March 13, 2020 NCQAC meeting. For a copy of the actual recording, please contact the Public Disclosure Records Center (PDRC) at PDRC@doh.wa.gov.

If attending remotely, please mute your connection in order to minimize background noise during the meeting.

**Smoking and vaping are prohibited at this meeting.**

I. 8:30 AM Opening – Tracy Rude, Chair – DISCUSSION/ACTION

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

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

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

A. Approval of Minutes
   1. NCQAC Business Meeting
      a. November 8, 2019
   2. Advanced Practice Sub-committee
      a. September 18, 2019
      b. October 16, 2019
   3. Discipline Sub-committee
      a. October 15, 2019
      b. November 19, 2019
   4. Consistent Standards of Practice Sub-committee
      a. October 15, 2019
   5. Licensing Sub-Committee
      a. October 25, 2019
B. Out of State Travel Reports

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

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

A. Nursing Program Approval Panel (NPAP)
   1. November 2019
   2. December 2019

B. Nursing Assistant Program Approval Panel (NAPAP) – Nov. 12 and Dec. 9, 2019
   1. November 2019
   2. December 2019

V. 9:00 AM – 9:30 AM Chair Report – Tracy Rude – DISCUSSION/ACTION

A. Nurse Licensure Compact meeting with Washington State Nurses Association
   1. WSNA Nurse Licensure Compact – Questions
   2. Uptake by state 112019
   3. ICNLCA rules 010119
   4. Discipline caseload_2014

B. Nominating Committee Report – Kathy Moisio

C. NCQAC member recruitment

VI. 9:30 AM – 9:45 AM Executive Director Report – Paula Meyer – DISCUSSION/ACTION

A. Budget Report – Lois Hoell, Kathy Anderson
   1. Budget Status Report October 2019
   2. Nursing Budget Status Report October 2019

B. Performance Measures Report
   1. NCQAC
   2. Legal
   3. WHPS
   4. NAPAP
   5. NPAP

C. Rules Update - Brandon Williams
   1. Rules Report
   2. Rules Report Additional Documentation

9:45 AM – 10:00 AM Break
VII. 10:00 AM – 11:30 AM Sub-committee Report – DISCUSSION/ACTION

A. Advanced Practice – Laurie Soine, Chair
   1. CMS regulations requiring physician signature and face to face meeting for ordering medical equipment – update

B. Consistent Standards of Practice – Tiffany Randich, Chair
   1. Frequently Asked Questions – Registered Nurse Scope of Practice: Asthma Management, K-12 Settings (Draft)
   2. Frequently Asked Questions – Licensed Practical Nurse Scope of Practice: Asthma Management in Schools, K-12 Settings (Draft)
   3. Advisory Opinion from the American Lung Association, Seattle Headquarters, Asthma Management in School Settings Committee (September 8, 2000) – Request to Rescind
   4. Frequently Asked Questions – Registered Nurse Scope of Practice: Diabetes Management in Schools, K-12 Settings (Draft)
   5. Frequently Asked Questions – Licensed Practical Nurse Scope of Practice: Diabetes Management in Schools, K-12 Settings (Draft)

C. Discipline – Adam Canary, Chair
   1. Procedure Revision- W42 Washington Health Professional Services (WHPS) Drug and Alcohol Testing
   2. Procedure Revision- W44 WHPS Unauthorized Substance Use
   3. Procedure Revision- W32 WHPS Program Non-Compliance and Discharge Criteria
   4. Procedure Revision- A27.12 Attachment A RN and LPN Sanction Standards

D. Licensing – Jeannie Eylar, Chair

E. Research – Dr. Mary Baroni, Chair

11:30 AM – 1:00 PM Lunch

VIII. 12:00 PM – 1:00 PM Education Session

International Center for Regulatory Scholarship (ICRS) – Dr. Maryann Alexander, National Council of State Boards of Nursing (NCSBN)

The NCSBN developed the ICRS to address the growing needs for education for nursing regulatory bodies and its members. The NCSBN had the Institute of Regulatory Excellence that evolved to become the ICRS. The ICRS includes course work for leadership, legislative/policy and research tracts. Dr. Alexander presents the program and how NCQAC members and staff can participate.

IX. 1:00 PM – 1:15 PM Open Microphone

Open microphone is for public presentation of issues to the NCQAC. If the public has issues regarding disciplinary cases, please call 360-236-4713.
X. 1:15 PM – 1:45 PM Education Report – Dr. Gerianne Babbo, Dr. Kathy Moisio – DISCUSSION/ACTION

A. Dean/Directors Nursing Programs
B. Update-Implementation HB 2158
C. NPAP Workshop
D. Nursing Assistants – Strategic Plan Progress Update

1:45 PM – 2:00 PM BREAK

XI. 2:00 PM – 2:30 PM Washington Center for Nursing – Sofia Aragon – DISCUSSION/ACTION

Ms. Aragon, executive director, Washington Center for Nursing, updates the NCQAC on the work of the Center. RCW 18.79.202 describes the collection of a $5 surcharge on licenses to be granted to a Central Nursing Resource Center. The Department of Health, with the consultation of the NCQAC, administers the grant through a contract.

XII. 3:00 – 3:45 PM Legislative Process – Gail Yu – DISCUSSION/ACTION

Ms. Yu presents the legislative process from introduction of a bill through implementation of a new law.

XIII. 3:45 PM – 4:15 PM HSQA Performance Measurement - Kristin Peterson – DISCUSSION/ACTION

According to the Performance Agreement with Health Systems Quality Assurance, Ms. Peterson presents to the NCQAC every January meeting. Ms. Peterson updates the NCQAC on performance measures, comparison with HSQA and other boards and commissions.

XIV. 4:15 PM – 4:45 PM Legislative Panel – Dr. Mary Baroni – DISCUSSION/ACTION

At the November meeting, the NCQAC agreed the Legislative Panel will study and make recommendations on any legislation related to apprenticeship programs and nursing education. Dr. Baroni, chair of the legislative panel, presents the issues and recommendations from the panel.

XV. 4:45 PM Meeting Evaluation

XVI. 5:00 PM Closing
Nursing Care Quality Assurance Commission (NCQAC)
Meeting Agenda
November 8, 2019
8:30 AM- 5:00 PM
CenterPoint Conference Center
Mt. Rainier Room
20809 72nd Ave S, Kent, WA 98032

Commission Members:
- Tracy Rude, LPN, Chair
- Mary Baroni, PhD, RN, Vice-Chair
- Lois Hoell, MS, MBA, RN, Secretary/Treasurer
- Adam Canary, LPN
- Jeannie Eylar, MSN, RN (Excused)
- Ella B. Guilford, MSN, M.Ed., BSN, RN
- Edie Higby, Public Member
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- John Furman, PhD, MSN, CIC, COHN-S, Assistant Director, Discipline – Washington Health Professional Services (WHPS)
- Mary Sue Gorski, PhD, RN, Director, Advanced Practice, Research and Policy (Excused)
- Karl Hoehn, JD, FRE, Assistant Director, Discipline – Legal Grant Hulteen, Assistant Director, Discipline – Investigations
- Kathy Moisio, PhD, RN, Director, Nursing Assistant Programs
- Debbie Sullivan, Administrative Assistant
- Tori Lane, Nursing Practice Administrative Assistant
- Brandon Williams, Performance and Policy Analyst
- Catherine Woodard, Director, Discipline
This meeting will be digitally recorded to assist in the production of accurate minutes. All recordings are public record. The minutes of this meeting will be posted on our website after they have been approved at the January 10, 2020 NCQAC meeting. For a copy of the actual recording, please contact the Public Disclosure Records Center (PDRC) at PDRC@doh.wa.gov.

I. Opening – Tracy Rude, Chair – DISCUSSION/ACTION

II. Call to Order

A. Introductions
   Mr. Archuleta introduced Brandon Williams as the new policy and management analyst and Amber Bielaski as new licensing manager. Mr. Hoehn introduced staff attorney, Anthony Vaupel.

B. Order of the Agenda
   No Education report today.

C. Correspondence

D. Announcements
   Mr. Hulteen announced the hiring of new investigation staff that joined the NCQAC: Becky Thompson, Carol Neva, Erin Bush, Nicole Foster, and Robert Brown.

III. Consent Agenda – DISCUSSION/ACTION

A. Approval of Minutes
   1. NCQAC Business Meeting, September 12-13, 2019
   2. Advanced Practice Sub-committee
      a. August 21, 2019
   3. Discipline Sub-committee
      a. January 22, 2019
      b. February 12, 2019
      c. February 26, 2019
   4. Consistent Standards of Practice Sub-committee
      a. August 6, 2019
   5. Licensing Sub-Committee
      a. August 23, 2019
   6. Research Sub-committee
      a. May 20, 2019

B. Out of state travel reports
   1. British Columbia College of Professional Nursing, September 17, 2019; Lois Hoell, Dr. Gerianne Babbo, Shana Johnny, Amber Zawislak-Bielaski, Paula Meyer
   2. Council on Licensing, Enforcement and Regulation (CLEAR), September 18 – 21, 2019, Minneapolis, MN; Chris Archuleta, Grant Hulteen, Trevor Crosswaite
   3. Tri-Regulator meeting, September 26-27, 2019, Frisco TX; Paula Meyer
   4. National Council of State Boards of Nursing (NCSBN) Policy and Legislative Summit, October 2-4, 2019, Atlanta, GA; Tracy Rude
   5. FARBP Regulatory Law Seminar, October 3-6, 2019, St Louis, MO; Karl Hoehn and Tim Talkington
   6. International Nurses Society on Addictions, October 9-12, 2019, Baltimore, MD; Melissa Fraser, Lori Linenberger
IV. NCQAC Panel Decisions – DISCUSSION

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

A. Nursing Program Approval Panel (NPAP)
   1. NPAP-A -- September 19 and October 17, 2019
   2. NPAP-B -- September 5 and October 3, 2019

B. Nursing Assistant Program Approval Panel (NAPAP)
   1. September 9, 2019
   2. October 14, 2019

V. Chair Report – Tracy Rude – DISCUSSION/ACTION

A. Board/Commission Leadership Meeting – Tracy Rude, Mary Baroni, Lois Hoell, Catherine Woodard, Paula Meyer
   Ms. Rude provided an update on HELMS data base. Health Systems Quality Assurance (HSQA) will be licensing 16 medical behavior health facilities, requiring peer support certification.

B. Nominations Committee members appointments
   Ms. Rude appointed Ms. Randrich, Ms. Guillford and Ms. Strader to the Nominations committee. Dr. Moisio is the staff person for the committee.

VI. Executive Director Report – Paula Meyer – DISCUSSION/ACTION

A. Budget Report – Lois Hoell, Kathy Anderson
   1. NCQAC Budget Status Report
      Ms. Meyer reviewed the current budget documents. The fees will be monitored and assessed every year to assure adequate operating funds.
   2. NCQAC 19-21 Biennial Budget Status Report
      Ms. Meyer reviewed the report:
      - Six percent increase in Nurse Practitioners
      - Large number of endorsement applicants
      - Not many changes to the number of retired active status nurses
      - Ms. Hoell reviewed the data and announced there will be a final report in January.

B. Performance Measures Report
1. NCQAC Performance Measures
Ms. Meyer reviewed trends in licensing, noting the increase in endorsement applicants. Ms. Tang asked if there was a correlation between the number of endorsement applicants to the increase in number of case loads. There was no answer for this question at this meeting.

2. Legal Performance Measures

3. WHPS Performance Measures

4. NA Performance Measures

C. Rules Update – Brandon Williams

Mr. Williams reviewed:
- The CR105 for prescribing opioids was adopted with no comments. Since there were no comments, the rule is effective as proposed.
- ARNP Practice hours rule draft language is ready for a hearing in January

D. Nurse Licensure Compact update

1. Status of WSNA Questions: Ms. Meyer introduced Dr. Sally Watkins, WSNA executive director. Ms. Meyer identified a list of items from WSNA considered resolved and unresolved. Currently, the issues are being identified that may be addressed with legislation during the 2020 legislative session. Dr. Watkins identified the concern that if nurses do not identify themselves the NCQAC, monitoring the workforce will be difficult.

2. Fiscal Scenarios: Ms. Meyer reviewed the report describing the potential fiscal impact related to loss of endorsement applications from nurses in compact states. A multistate license could cost more than a single state license. Also, the potential fiscal impact on HEAL-WA and the Washington Center for Nursing with reduction in their surcharge income was reviewed.

E. HELMS update

Ms. Meyer reviewed the new licensure system and discussed the Department of Health’s proposal to fund the HELMS project. Initially, the Department/Health Systems Quality Assurance (HSQA) proposed a $10 surcharge on all health professional licenses each year for four years to cover the costs of the new system. HSQA now proposes a fee increase for all health professional licenses to cover the development, implementation and ongoing costs of the new system.

F. Online Licensing update – Amber Bielaski

Ms. Bielaski and Mr. Archuleta presented an update on online applications that went live on October 15, 2019. Issues related to completing the applications related to Adobe should be resolved soon. A wide communication of the new online applications will not be completed until the issues are resolved and the on-line applications corrected.
VII. Sub-committee Reports – DISCUSSION/ACTION

A. Advanced Practice – Laurie Soine, Chair

1. Draft language ARNP practice hour’s rules change

   The Advanced Practice Subcommittee (APSC) members asked: Does the additional requirement for advanced practice clinical hours in WAC 246 840 342 (d) using the current definition of “practice hours” improve patient safety or could it impact service to the public by creating an unnecessary barrier to qualified nurse practitioners?

   On August 15, 2018, the APSC unanimously recommended opening the rules, accepting certifying bodies’ requirements for practice, and thereby removing the additional practice requirements as outlined in WAC 246-840-360 (d).

   On October 17, 2018, the APSC requested additional information to determine if rules for out of state ARNPs seeking licensure via interstate endorsement, WAC 246-840-342, should also be included in the request to remove additional practice requirements and accept certifying bodies’ requirements.

   On December 18, 2018, the APSC reviewed the data and unanimously agreed to recommend removal of WAC 246 840 342 (1) (d); (2) (g); (3); and (4). The additional practice hour requirements for interstate endorsement are redundant and may be creating barriers to practice.

   The NCQAC held rules workshops September 30, 2019, and October 9, 2019. The draft proposed rule as presented is a result of this work.

   ACTION: Dr. Soine moved to approve draft language and proceed with the filing of the CR102 to announce the revised proposed rule (WAC 246-840-342; WAC 246-840-360) and to announce the public hearing date. Seconded by APSC. Motion carried.

2. Update CMS rules, physician signature for medical supplies

   Dr. Laurie Soine continues to work on strategies to find solutions to the federal requirement for a physician face to face assessment and signing all orders for physician’s assistants and nurse practitioners for home health and medical equipment.

B. Consistent Standards of Practice – Tiffany Randich, Chair

1. Advisory Opinion: Death with Dignity (Medical Assistance in Dying): Role of the Nurse

   RCW 70.245 Washington Death with Dignity Act, enacted in 2009, allows an eligible individual with a terminal diagnosis and prognosis to legally request and obtain medications from a qualified health care practitioner (Doctor of Medicine or Doctor of Osteopathy) to end their life. WAC 246-978 Death with Dignity Requirements implements the law. (See the Washington State Department of Health Death with Dignity Act webpage for common questions and answers containing general information about the Death with Dignity Act.) The RCW and the WAC does not provide guidance for nurses involved in the care of the patient, beyond the clarification that ARNPs may not prescribe the medications to end life. WSNA requested a formal advisory opinion to clarify the role of nurses relevant to the Death with Dignity Act.

   ACTION: Ms. Randich moved to approve the Death with Dignity (Aid-in-Dying): Role of the Nurse Advisory Opinion. Seconded by CSPSC. Motion carried.
2. Advisory Opinion Revision: Delegation of Blood Glucose Monitoring to Nursing Assistants or Health Care Aides in Community-Based Settings

The NCQAC approved the existing advisory opinion in June 2017 to clarify scope of practice for RN delegation regarding delegation of blood glucose monitoring to nursing assistants and health care aides in community-based settings. The law and rule require the nursing assistant or home care aid to take the DSHS Diabetes course prior to delegation of insulin administration. The recommended revision to the document clarifies whether the RN can delegate to a nursing assistant or home care aide if the nursing assistant or home care aide is performing the blood glucose monitoring only, and not being delegated administration of insulin.

ACTION: Ms. Randich moved to approve the revision to the Delegation of Blood Glucose Monitoring to Nursing Assistants or Home Care Aides in Community-Based Settings Advisory Opinion. Second by CSPSC. Motion carried.

C. Discipline – Adam Canary, Chair

1. The Jurisprudence Module for Early Remediation and disciplinary cases.

The NCQAC recently approved the online Jurisprudence Module. The Jurisprudence Module is available on the NCSBN Learning Extension for $15.00. Because all early remediation cases and discipline cases allege a violation of nursing law, it is rational to include completion of the Jurisprudence Module as a requirement. By including the completions of the Jurisprudence module as a refresher of nursing laws, the intent is to better prepare nurses to avoid further disciplinary action in the future.

This requirement would not be applicable in permanent revocations and surrenders. Those orders end the nurse’s practice in Washington and do not impose conditions.

ACTION: Mr. Canary moved a requirement to complete the NCQAC online Jurisprudence Module be added to all Early Remediation action plans as well as all stipulations and orders that impose conditions on a nurse’s license except cases where the sanction is revocation or surrender. In cases where the credential is suspended, the Jurisprudence Module requirement shall be included as a condition of reinstatement. Seconded by Discipline Subcommittee. Motion carried.

D. Licensing – Jeannie Eylar, Chair

Ms. Eylar was not able to attend. No report from licensing committee.

E. Research – Dr. Mary Baroni, Chair

Dr. Baroni reported a change in the meeting date to the second Monday of the month from 5 pm - 6pm.

Meeting was ahead of schedule. Items XV and XVI were moved forward.
XV. Dr. Wiesman’s Directive on Social Justice, Equity, Inclusion and Diversity – Paula Meyer

DISCUSSION/ACTION

Dr. John Wiesman, Secretary of Health, Directive 19-01: Reaffirming the Department of Health’s commitment to Diversity, Inclusion, and Cultural Humility. At their leadership meeting, the NCQAC directors and assistant directors received training on the directive. The NCQAC discussed how the directive intersects with their work for nurses and nursing assistant education.

Ms. Meyer reviewed the directive. NCQAC Unit was the first to implement directive. Mr. Bell and Mr. Archuleta reviewed how they used a microagression clip taken from The Seattle Times campaign as an introduction to Dr. Wiseman’s directive for the licensing and operations unit. The purpose of the clip was to gather reactions, consultation and reflection to design a solution on how they can move forward. There is an ongoing process for DOH to move forward and improve on working towards meeting the directive. The NCQAC expressed interest in receiving more information on the directive at their July 2020 workshop.

XVI. Meeting Locations - Paula Meyer - DISCUSSION/ACTION

The NCQAC determined the location for meetings through 2020. Due to the success of the Spokane meeting in September, NCQAC members reconsidered the location of upcoming meetings. Mr. Archuleta gave an update to Department of Health’s current construction at the Town Center 2 and Point Plaza East buildings. The Department of Health has a promised delivery date of January 1, 2020, for a new conference center in the Town Center 2 location. The January 10, 2020, and March 13, 2020, meetings are reserved in Point Plaza East and Town Center 2 (new conference room on 1st floor) but could be held in the new conference center if it is completed.

ACTION: Ms. Myrick moved that the January and March regular meeting be held at the DOH location. Seconded by Ms. Poole. Dr. Soine opposed. Motion carried.

July meeting location confirmed for two days at Lacey Community Center.

The NCQAC discussed the cost and location of the September meeting in Spokane. A meeting in Spokane maintains connection with student participation and is cost effective. The NCQAC was also discussed the importance of the NCQAC presence in eastern WA.

ACTION: Ms. Tang moved to have the September meeting in Spokane and November meeting to be held in Kent. Second by Dr. Soine. Motion carried.

VIII. Education Session

Dr. Kathleen Haerling, Associate Professor, University of Washington.
Presentation: Using Simulation to Assess Clinical Judgment.

The objectives of this presentation were to 1) Define simulation and clinical judgment; 2) Identify opportunities for using simulation to assess clinical judgment; 3) Discuss the quality (reliability and validity) of simulation-based assessment data; and 4) Describe how
the National Council of State Boards of Nursing Clinical Judgment Measurement Model can help guide the design of simulation-based assessments of clinical judgment. The presentation focused on the current use of observation-based simulation participant performance assessment and opportunities for improving scenario design, assessment procedures, and data interpretation.

IX. Open Microphone
Open microphone is for public presentation of issues to the NCQAC. No individuals signed up for the presentation.

X. Prescription Monitoring Program and Drug Take Back Program- Sasha de Leon, Drug Systems Director, and Carly Bartz-Overman, Safe Medication Return Program Manager – DISCUSSION/ACTION
Ms. de Leon and Ms. Bartz-Overman provided brief updates on the Prescription Monitoring Program and Safe Medication Return Program.

XI. Apprenticeship in Nursing Education – Tracy Rude, Mary Baroni, Lois Hoell, Paula Meyer - DISCUSSION/ACTION
At the March 2019 NCQAC meeting, Dr. Barbara Trehearne, Dr. Sarah Bear and Ms. Helen Kuebel presented on apprenticeship in nursing education. Ms. Rude, Dr. Baroni, Ms. Hoell and Ms. Meyer participated in a meeting with representatives from WSNA and the Washington Center for Nursing on this topic.

Dr. Baroni announced Senate Bill 5236 from the 2019 session encouraged apprenticeship in nursing education but did not pass. Dr. Baroni entertained the idea of changing the term ‘apprenticeship’ causing strong reactions from nurses.

Mr. Jody Robins, an employee of the Department of Labor and Industries, advocated for the topic and spoke on his experiences of apprenticeship and touched on exploitation of nursing education in the past.

Ms. Meyer clarified the question of preserving the integrity of nursing education in an academic model. The NCQAC members did not agree with replacing current nursing education model with apprenticeship.

Ms. Rude posed the question: Can the NCQAC support apprenticeship in the Nurse Tech program?

ACTION: Ms. Tang requested to table the topic. No one seconded. Motion was not recognized by group. Ms. Hoell called point of order.

ACTION: Ms. Myrick moved assigning the topic to the legislative panel and bring recommendations back to the January meeting. Seconded by Dr. Baroni. Motion Carried.

XII. Education Report
There was no education report this meeting.
XIII. Long Term Care Budget Proviso, Interim Report – Kathy Moisio - DISCUSSION/ACTION

The 2019 legislature passed a budget proviso requiring the NCQAC to continue its work on the staffing in long term care settings. Dr. Moisio presented a draft interim report due to the legislature on November 15, 2019. The NCQAC reviewed the draft document.

MOTION: Ms. Myrick moved to approve the Long-Term Care Workforce Development Interim Report. Second by Dr. Soine. Motion carried.

XIV. Strategic Plan – Paula Meyer - DISCUSSION/ACTION

Draft plans with objectives were presented at the September NCQAC meeting for comment. The draft plans were presented.

A. NCQAC Strategic Plan Final Draft
Ms. Meyer reviewed the strategic plans:
- Academic progression of LPN education initiative
- Nursing assistants initiative: Ms. Rude requested a change to the language of “80%” in the first sentence.
- WHPS initiative: no questions
- Communication

B. Communications Charter Final Draft
Charter draft was presented and more information to follow at the January meeting.

Ms. Meyer will appoint 2 pro tem graduate students, one with expertise in communication and one with the technological base in communication to assist.

MOTION: Ms. Hoell moved to adopt strategic plans. Ms. Tang seconded. Motion carried.

XVII. Meeting Evaluation

XVIII. Meeting adjourned at 4:30PM.
Nursing Care Quality Assurance Commission (NCQAC)
Advanced Practice Sub-committee Minutes
September 18, 2019    7:00 pm to 8:00 pm

Sub-Committee: Laurie Soine, PhD, ARNP, Chair
Members Present: Donna Poole, MSN, ARNP, PMHCNS-BC
Kathleen Errico, PhD, ARNP, Pro Tem
Lindsey Frank, CD, OB-RNC, ARNP, CNM

Sub-Committee: Joanna Starratt, MSN, ARNP, CRNA
Members Absent:

Staff: Mary Sue Gorski, PhD, RN, Director Research and Advanced Practice
Tori Lane, Nursing Practice Administrative Assistant

I. 7:00 PM Opening – Laurie Soine, Chair
Call to order
- Introduction
- Public Disclosure Statement
- Roll Call

II. Standing Agenda Items
- Announcements/Hot Topic/NCQAC Business Meeting Updates
  o Laurie went over the September Business meeting and discussed the dinner that
  was held on Thursday evening with Washington State University faculty and
  members from NWONE.
- Draft Minutes for August 21, 2019
  o Consensus reached to take the minutes to the November 8th Nursing
    Commission business meeting for approval.

III. Old Business
- Updates on the response to CMS and HCA about Home Health Services signatures
  o Mary Sue will follow up with Mike Ellsworth reinforcing the message with the
    Washington State congressional delegation of the impact of the CMS rule change
    for patients to get the medical care that they need. Laurie requested striving for
    monthly meetings with the Health Care Authority primarily to keep this on their
    radar.
  o Mary Sue- In terms of the state and working with the HCA, we will continue to
    await a response to our August letter proposing suggestions to mitigate the effect
    of new rule.
- Update on CR101 for practice requirement change for licensure endorsement and
  renewal.
  o Stakeholder meetings with regards to the rules that are open to evaluate the
    practice hour requirements for renewal for an ARNP license. The first stakeholder
meeting is on Monday, September 30th from 5-6pm and the second is Wednesday, October 9th from 12-1pm. The commission will be able to gather stakeholder feedback about removing the practice requirements for the renewal of ARNP license in the state.

IV. New Business
- None

V. Ending Items
- Open Microphone
  - Lousie- Urged the NCQAC and sub-committee to continue to work closely with ARNP United and other stakeholder groups in the effort to alter the effects of this new rule. She expressed concerns that a divided effort may splinter our influence. She asked that ARNP United and AANP be included in our efforts and that coordination of efforts should be prioritized.
- Review of Actions
- Subcommittee Meeting Feedback
  - Ran out of time for formal feedback.
- Date of Next Meeting – October 16, 2019
- Adjournment – 7:40 PM
I. 7:00 PM Opening – Laurie Soine, Chair
Call to order
- Introduction
- Public Disclosure Statement
- Roll Call

II. Standing Agenda Items
- Announcements/Hot Topic/NCQAC Business Meeting Updates
- National Council State Boards of Nursing Knowledge Network Update
- Approve Draft Minutes for September 18, 2019
  - Minutes taken back for editorial review for the open microphone section and to be reviewed again in November.

III. Old Business
- Updates on CMS rules
  - Mary Sue and Laurie reported on a follow up conversation with Mike Ellsworth, who provided recommendations, to revise the original document. Mary Sue and staff are working on the document to be able to bring it to the sub-committee in November.
  - Review stakeholder feedback about practice hours rules change
    - Mary Sue and Tori reviewed stakeholders meetings including attendance and how many were in favor or opposed. Majority of stakeholder feedback was positive or in favor for the practice hours rules change. For those who opposed pointed out that while there is no evidence to support that practice hours protect the public or there is likewise no evidence that they do not. Next steps is to draft rule change language and bring before the NCQAC to adopt this new language CR-102. The draft practice rule language will go as a motion to the November 8th Commission Meeting.
- Review of Significant Analysis and SBEIS drafted by Commission Staff
IV. New Business
   - None

V. Ending Items
   - Open Microphone
     - Melissa Johnson- WANA had their board meeting and fall conference last weekend and they support the elimination of the clinical hours and support the draft rule language moving forward.
     - Louise Kaplan- Suggested we consider how we will operationalize the new practice rules- they go into effect in February how will we deal with ARNPs who renew in January? She also announced that she would be joining Tracy Kline in going to DC next week in her ongoing efforts to work with AANP and alerting our congressional delegation as to the effects of the new CMS rule.
   - Review of Actions
   - Subcommittee Meeting Feedback
     - Ran out of time for formal feedback.
   - Date of Next Meeting – November 20, 2019
   - Adjournment – 7:40 PM
I. 3:30 PM Opening – Adam
   o 3:32 Call to order – Digital recording announcement
   o Roll call

II. Commission Meeting Review September 12/13, 2019 – Adam
   o The commission approved procedures W39 (Professional Peer Support Groups) and A25 (Case Disposition Panels).
   o The commission approved the August 13, 2019 DSC minutes on the consent agenda.

III. Performance Measures – Catherine, Grant, Karl, and John
   o Grant reported on investigation performance measures and how new investigators affect them.
   o Grant reported a consistent number of complaints open at CMT.
   o Karl reported on legal performance measures, new attorney hires, and the anticipated changes. Drafting time is down on reports. 10% of cases are ARNPs.
Lois and Cass asked about the baseline target and if it is the same as HSQA. Karl explained our target is 77% and it is our own. Legal strives for 30 days but has 130 days in case disposition. They regularly meet that performance measure.

Karl said it will take around six months for new staff attorneys to be operational, but admitted it can take up to a year if an attorney lacks specific training.

John reported on WHPS performance measures, including outreach efforts in July and August 2019. Staff took vacation during summer months, which is why outreach efforts were a bit lower. They still met the goal of four per month.

The total number of WHPS participants reported for June 2019 (284) is inaccurate; it is more likely 301-304. Intake was not added to the totals. July 2019 numbers were okay as intake was included. August 2019 lists 281 but really should have been 300-301 as intake was not included.

John explained the use of CBD products is acceptable as long as nurses don’t test positive for THC. John said there is a small amount of alcohol in near beer (.05%) and it is possible to test positive on a PEth test.

Cass would like to see a spreadsheet listing all the outreach programs that includes a column with the dates of site visits. Cass also requested a bar chart for trends. John said that increased outreach is part of the WHPS strategic plan and they will be able to show progress after the commission adopts the plan and they focus more work in this area.

IV. Early Remediation (ER) annual report – Margaret Holm

- Margaret reported on the ER program data.
- Margaret discussed challenges to the data and subcommittee members agreed that the data should tell a story and the collection of data needs to be restructured. Should at least be capturing recidivism. What is the recourse when a nurse’s work is insufficient?
- Discussion followed regarding the origin of Early Remediation. Karl referenced 264-840-851 WAC. Is the program still effective? There is agreement to study the program in more depth to make recommendations. Perhaps a subcommittee workgroup to consider the health of the program and suggested revisions?

V. A.34.06 Early Remediation procedure review – Karl, Grant, Margaret

- Discussion regarding the procedure and looking at old complaints as an accumulated issue. That behavior may still qualify for ER. Many cases are closed below threshold at CMT, so what prompts entry into ER? (Editor’s note: The commission has adjusted thresholds twice since the ER program was created, which results in fewer cases eligible for ER.)
- Lois and Margaret discussed nurses in therapeutic settings being addressed in ER. Could be a mix of both ER and facility issues.
- Margaret expressed concern that her preliminary interview may interfere with and investigator’s interview should the case go back to investigations. Grant said no.
- Helen thinks there should be a definition for ‘willful.’ Grant suggested ‘willful intent.’
VI. Jurisprudence Module (JP) – Shana Johnny and Margaret Holm

- Margaret discussed the JP Model and requested that it be included as coursework in disciplinary cases. Lois believes it should be in our sanction standards.
- Sharon said many stakeholders are interested in it, and questioned the cost.
- Karl reminded the subcommittee that this is also under discussion with the continuing competency workgroup.
- Margaret pointed out that it covers all the work of the commission, including WHPS.
- Karl explained the matter needs to go before the commission to go into sanction standards. The DSC agreed to make the motion at the November commission meeting.

VII. Review of Case Management Team (CMT) and Case Disposition Panel (CDP) closure codes – Helen and Karl

- Karl discussed he is on an HSQA workgroup looking at all the closure codes and thinning them out prior to HELMS. HSQA is interested in looking into this issue. Codes are not set in law; the same ones have been used forever. Wants to keep HSQA in the loop as it may affect business practices.
- Lois was concerned about the code ‘issued in error.” Karl said this is rarely used.
- Teresa agreed being consistent with other professions in HSQA is important, but pointed out that NCQAC could lead the way.
- Sharon asked if the codes are inclusive.
- Staff will continue to work with HSQA on this matter and report back to the DSC.

VIII. Work Plan – Adam

- Review status of items on the work plan.
  - Updates on work plan.

IX. Evaluation – All

- Lois: Very productive on many topics and enjoyed people involved in discussion
- Sharon: Likes what Margaret said and enjoyed the discussion.
- Tiffany: Great meeting. Agree with two others regarding interactions and opinions. Also the JP going in the right direction.
- Dawn: Appreciated the pre-meeting reading. Agrees with streamlining closure codes.
- Cass: Thanked everyone. Glad to contribute. Appreciate the feedback. Suggestion in agenda to put “action/discussion” items.
- Barb: Glad we got the meeting back online. Good discussion
- Helen: Enjoyed topics. Enjoys ER work as it is near and dear to her but the program is under-utilized. In addition, the closure codes is very important to address. Great meeting, looking forward to outcomes.
- Teresa: Incredible meeting, good collaboration, and look forward to contributing and streamlining.


John: As usual, productive
Karl: Echoed everyone’s comments and it’s a pleasure.
Margaret: Thanked the commission for letting her present today. Appreciated the discussion on the JP model and looks forward to seeing where it goes.
Grant: Went really well. Good topics. Thanks everyone.
Adam: Thanked staff and is looking forward to making positive change.

X. Closing
Meeting adjourned 5:07pm.
Nursing Care Quality Assurance Commission (NCQAC)
Discipline Sub-committee MINUTES
November 19, 2019    3:30 pm to 5:45 pm

Join our GoToMeeting from your computer, tablet or smartphone
https://global.gotomeeting.com/join/297633269

You can also dial in using your phone
United States: +1 (646) 749-3122
Access Code: 297-633-269

Committee Members:
Adam Canary, LPN, Chair – arrived late due to work-related matter
Lois Hoell, MS, MBA, RN
Sharon Ness, RN
Tiffany Randich, LPN – filled in for Adam until he arrived on the call
Tracy Rude, LPN ad hoc
Dawn Morrell, RN, BSN, CCRN
Cass Tang, Public Member

Staff:
Catherine Woodard, Director, Discipline
Karl Hoehn, Assistant Director, Discipline - Legal
Grant Hulteen, Assistant Director, Discipline - Investigations
John Furman, Assistant Director, Discipline - WHPS
Teresa Corrado, LPN, CPM, Assistant Director, Discipline - Case Management
Helen Budde, Case Manager
Barb Elsner, HSC

Public member:
Debra Strom, RN, Peace Health Home Health Quality Facilitator
I. 3:30 PM Opening – Adam
   - Call to order – Digital recording announcement
   - Roll call
   - Adam was delayed for a work-related matter. Tiffany covered for the first part of the meeting until Adam could join.

II. October 15, 2019 DSC minutes – Adam
   - Minutes approved.
   - Cass asked for the minutes to be in black ink and not italicized.

III. Commission Meeting Review November 8, 2019 – Adam, et al
   - Lois commented on the large discussion about apprenticeship. Mentioned that NCQAC leadership was going to meet with the Oregon Board but Oregon cancelled the meeting. Nothing rescheduled yet.
   - Tiffany appreciated the familiarization to Consistent Standards of Practice session held the evening before the commission meeting. The intent was to review processes and responsibilities. Good opportunity for review and many attended.
   - Lois noted that the commission approved the strategic plan. The long term care budget proviso is moving right along.

IV. Performance Measures – Catherine, Grant, Karl, and John
   - Grant corrected the percentages from the original Investigations report that went into the packet.
   - Karl noted that now with six staff attorneys working, they are quickly coming up to speed. He is anticipating the job posting soon for the third staff attorney.
   - Several commission member said they are enjoying working with Tony and Seana.
   - John said there was nothing outstanding on the WHPS compliance report. Lois noted a greater number of nurses and John noted there are a few more than usual because the holidays are coming. The non-compliance cases trend upwards this time of year.
   - Tiffany asked how WHPS tracks the prescription timelines for approvals; John said the dates are included on the fax from the provider referencing the start and stop date of particular medications.
   - Catherine noted that Brandon will be assisting Alicia with performance reports and capturing trends. Cass requested that the reports include trending outreach efforts.

V. Original Dates of Licensure – Data from NURSYS - Teresa
   - Teresa worked with NCSBN to get the raw data on nurses’ date of initial licensure and when they endorsed into WA.
   - Lois is pleased that we could get the data, and Teresa explained that we can use the data to calculate averages and learn more about licensure and trends. For instance, Lois read an article a while ago that said nurses who have been in practice for 10-15 years tend to make more errors.
   - Catherine suggested the Research Subcommittee could take over with additional requests for information along these lines; Mary Sue offered to run this through her subcommittee.
VI. Procedure Review for Revisions

W44 Unauthorized Substance Use and W42 Drug and Alcohol Testing – Catherine

- The highlighted changes to W44 included putting a time frame around WHPS reporting unauthorized substance use to the Substance Use and Abuse Team (SUAT), and itemizing the information and documents WHPS needs to submit with the notification.
- The DSC approved the revisions to W44, recommended spelling out MRO (Medical Review Officer) and approved moving it forward to the full commission for review at the January business meeting.
- The highlighted changes to W42 only impact the monitoring interruption portion of the procedure. The revision adds language to define when a case manager can approve a monitoring interruption for a nurse in the program.
- The DSC approved the revision and approved bringing it forward to the January business meeting for full commission review.

VII. Work Plan – Adam

- Review status of items on the work plan.
- Commission members and staff discussed the work plan updates: some items removed as work is completed, some items added.
- The significant additions include a monthly review of procedures that need updating, and adding some of the work of the WHPS strategic plan.

VIII. Meeting Evaluation – All

- Cass: Efficiently run meeting. Thanked Tiffany for stepping in to run the meeting until Adam could join.
- Dawn: Great meeting. Appreciate the work. Good to read information.
- Tracy: Agrees. Appreciated the procedure review.
- Tiffany: Great work on procedure revisions. Looking forward to more.
- Sharon: Appreciates the performance measures. It’s great working with Tony and Seana on complex cases. Good to keep the procedures rolling.
- Lois: Thanks for addressing concerns related to the discipline process and refining procedures. It serves the public well.
- Catherine: Loves the balance between commission and staff.
- Karl: Good meeting: if you’re happy, I’m happy.
- Grant: Same as Karl.
- John: Ditto.
- Teresa: Agrees with Catherine.
- Helen: Meeting went well; excited about the two revised procedures.
- Barbie: Went well; thanks for your support.

IX. Closing

- Meeting adjourned at 4:38 pm.
Nursing Care Quality Assurance Commission (NCQAC)
Consistent Standards of Practice Sub-committee Minutes
October 15, 2019    12:00 pm to 1:00 pm

Sub-Committee Members Present: Sharon Ness, RN, Acting Chair
Ella Guilford, RN
Edie Higby, Public Member
Tracy Rude, LPN, NCQAC Chair, Ad Hoc
Jamie Shirley, PhD, RN, Pro Tem

Sub-Committee Members Absent: Tiffany Randich, RN, LPN, Chair

Staff Present: Deborah Carlson, MSN, RN, Director of Nursing Practice
Shana Johnny, Nursing Practice Consultant
Tori Lane, Nursing Practice Administrative Assistant

I. 12:00 PM Opening – Sharon Ness, Acting Chair
Call to order
  • Introduction – Sharon Ness
  • Public Disclosure Statement – Sharon Ness
  • Roll Call – Deborah Carlson

II. Standing Agenda Items
  • Announcements/Hot Topic/NCQAC Business Meeting Updates
    o CSPSC Member Orientation, November 7, 2019 – Announced the special event to provide education and training to the CSPSC members. The meeting is also open to the public (in-person and by webinar) with announcement via through GovDel.
    o Washington Statewide Standing Order to Dispense Naloxone – Kathy Lofy, MD, The Washington State Health Officer, issued a state-wide standing order to dispense naloxone effective August 27, 2019. The purpose is to facilitate wide distribution of the opioid antagonist, Naloxone, so that people in Washington State can provide assistance to persons experiencing an opioid-related overdose. Anyone can get a prescription in the State of Washington from a pharmacy or other entity using this standing order. Discussion of the current commission’s Prevention and Treatment of Opioid-Related Overdoses Advisory Opinion and Prevention and Treatment of Opioid-Related Overdoses Frequently Asked Questions and need to review/revise.
    o Frequently Asked Questions: Role of Licensed Practical Nurse in Assisted Living Facilities and Adult Family Homes in Performing Pre-Admission/Resident Assessments and Staff Training – Announced
approval by the commission at the September 13, 2019 business meeting.

- Advisory Opinion Update: Registered Nurse and Licensed Practical Nurse Scope of Practice Revision – Announced approval by the commission at the September 13, 2019 business meeting.

- National Council State Boards of Nursing Knowledge Network Updates – Reviewed August 23, 2019 updates. Key highlights include Marijuana Guidelines and Registered Nurses and School Nursing/Patient Abandonment.

- Long-Term Care Workgroup and Steering Committee Update – Tracy Rude provided an update on this project. There are four workgroups: Data, Curriculum, Skilled Nursing Facility Staffing Models, and Testing. The next Steering Committee Meeting is January 24, 2020. The Workgroups meet monthly in the interim. Go to Long-Term Care Workforce Development Report - December 2018 (PDF) for more information.

- Review of Draft Minutes – Reviewed draft CSPSC August 6, 2019 – No recommended changes with agreement to send to the commission for approval.

- Sub-committee Work Plan – Reviewed work plan and status of the top three projects.

III. Old Business
- None

IV. New Business
- Advisory Opinion: Death with Dignity (Medical Assistance in Dying): Role of the Nurse (Draft) – Discussion included appreciation of consultation from Jamie Shirley, Ethicist and Pro Tem in developing the draft. Reviewed draft with no recommended changes and agreement to send to the commission for approval.

- Frequently Asked Questions (FAQs): Scope of Practice in Schools, K-12 Settings:
  - Registered Nurse Scope of Practice: Asthma Management (Draft) – Reviewed draft with no recommended changes and agreement to send to the commission for approval.
  - Licensed Practical Nurse Scope of Practice: Asthma Management (Draft) – Reviewed draft with no recommended changes and agreement to send to the commission for approval.
  - Registered Nurse Scope of Practice: Diabetes Management (Draft) – Reviewed draft with no recommended changes and agreement to send to the commission for approval.
  - Licensed Practical Nurse Scope of Practice: Diabetes Management (Draft) – Reviewed draft with no recommended changes and agreement to send to the commission for approval.

- Advisory Opinion from the American Lung Association, Seattle Headquarters, Asthma Management in School Settings Committee (September 8, 2000) – Discussed recommendations to rescind, since this document only includes FAQs, with replacement of the advisory opinion with formal FAQs.

- Advisory Opinion Revision: Delegation of Blood Glucose Monitoring to Nursing Assistants or Health Care Aides in Community-Based Settings (Draft) – Discussed changes to add a statement to clarify whether Assistive Personnel
must take the Department of Social and Health Services Diabetes Course if they are delegated to do blood glucose testing but NOT giving insulin. Reviewed draft with no recommended changes and agreement to send to the commission for approval.

V. Ending Items

- Open Microphone
- Review of Actions
  - Initiate review and revision of Prevention and Treatment of Opioid-Related Overdoses Advisory Opinion and Prevention and Treatment of Opioid-Related Overdoses Frequently Asked Questions
  - Add CSPSC August 6, 2019 draft minutes to the November 8, 2019 commission business consent agenda.
  - Add Advisory Opinion: Death with Dignity (Medical Assistance in Dying): Role of the Nurse (Draft) to the November 8, 2019 commission business meeting agenda.
  - Add the FAQs to the November 8, 2019 business meeting agenda
    - Frequently Asked Questions (FAQs): Scope of Practice in Schools, K-12 Settings:
      - Registered Nurse Scope of Practice: Asthma Management (Draft)
      - Licensed Practical Nurse Scope of Practice: Asthma Management (Draft)
      - Registered Nurse Scope of Practice: Diabetes Management (Draft)
      - Licensed Practical Nurse Scope of Practice: Diabetes Management (Draft)
  - Add request to rescind the Advisory Opinion from the American Lung Association, Seattle Headquarters, Asthma Management in School Settings Committee (September 8, 2000) Add the FAQs to the November 8, 2019 business meeting agenda
  - Add the Advisory Opinion Revision: Delegation of Blood Glucose Monitoring to Nursing Assistants or Health Care Aides in Community-Based Settings (Draft) Add the FAQs to the November 8, 2019 business meeting agenda
- Meeting Evaluation
  - No specific recommendations or comments
- Date of Next Meeting – December 3, 2019
- Adjournment: 1:00 p.m.
I. 9:30 AM Opening – Jeannie Eylar, MSN, RN, Sub-committee Chair
   - Roll Call
   - Call to Order

II. Standing Agenda Items
   - Announcements/Hot Topic/NCQAC Business Meeting Updates
     - Jeannie gave an overview of the September Business meeting, Lisa Day, a Providence Health Care Ethic Consultant from Washington State University (WSU) did the educational session. The reports from the Licensing staff were given which talked about how the staff was very busy with increased endorsements and the continued competency work that is being done. The social security procedure was also approved. Karl finished his fellowship from the Institute of Regulatory Excellence.
   - Approve Minutes for August 23, 2019
     - Consensus reached to take minutes to the November 8th business meeting for approval.

III. Old Business
   - Update on Continuing Competency Workgroup
     - Shana gave an overview of the continuing competency workgroup. She explained the current feedback from stakeholders based off of the last four meetings. Some of the feedback was, to keep current practice and continuing education hours without attestation or audit, the second would be to keep current practice and continuing education hours with the...
attestation at renewal but without the random audit, the third would be to
remove all practice and continuing education hours recognizing that the
continuing competency is the sole responsibility of the nurse. The fourth is
a disciplinary model which is the Jurisprudence Model. The fifth model
incorporates the Jurisprudence Model and Scope of Practice Tree, the sixth
model involves simulation to support continued competency.

- Update on Nurse Licensure Compact- Nothing to Report
  - Jeannie and Karl gave background on the compact, everyone is on board
    and trying to find something that is supported by everyone.

IV. New Business
- Current Challenges and Recent Accomplishments
  - Online Applications (RN, LPN, ARNP, NTEC)-
    - The timeline was to have the online applications live as of October
      15th which was met, rigorous testing was done on those, the RN and
      ARNP which went live for the first time, as well as adjustments
      made to the LPN and NTEC applications to make it easier for the
      applicant. The communication has not be sent out to GovDelivery
      but they are live in the online system. Licensing staff is
      communicating to applicants over the phone about the online
      applications. The licensing staff is hoping to get a test population,
      they have found there is other parts of the application that is
      needing to be adjusted or little bugs that need to be worked out.
      Once those are fixed, a full communication to GovDelivery will be
      sent out.
    - Website updates- Amber has been working with Jen Anderson to
      revamp the licensing webpage, they are reorganizing how it will
      look for the licensing portion of the pages, such as how they apply
      online, what is required of them prior to getting to the portal and
      any other question they may have before possibly getting stuck on
      the application.

V. Ending Items
- Open Microphone (as time permits)
- Review of Actions
- Meeting Evaluation – All
  - Helen- Very informative meeting, it is exciting to see the projects come to
    the implementation stage- the continued competency and the online
    applications.
  - Adam- I think it was a great meeting.
- Date of Next Meeting – November 22, 2019
- Adjournment: 10:32 am
NADDI National Conference  
November 12-15, 2019  
St. Pete Beach, Florida  
Attendees: Tara Serrano & Jocelyn Kabacinski

Purpose  
This conference provides an interactive and informative forum to learn effective investigative tools, strategies, and procedures for narcotic related investigations.

Some stated objectives were:
1. Identify and analyze the different trends in narcotic usage among healthcare professionals, youth, and the public.
2. Study lessons learned in the opiate epidemic across state lines.
3. Describe public health failures when investigating drug diversion investigations
4. Identify risks of health care associated infections from drug diversion
5. Analyze case studies involving the tampering of Dilaudid in healthcare facilities.

Outcome  
Subject matter experts on the different topics were informative and insightful regarding the material related to investigative work. Extremely valuable information was given regarding new drug trends and uses, including the use of over the counter medications to aid in the cover of withdrawal symptoms, what medications are often diverted to increase the strength of another drug, and overall trends of what medications are being diverted the most.

Contacts across all states and federal level were made. This is particularly helpful for diversion cases that involve tampering and/or traveling nurses. Case discussion assisted with investigative tips on different types of diversion cases, that may be new or unseen.

Recommendation  
The conference as a whole provided incredibly helpful and insightful information that is imperative for our jobs; especially with the opiate epidemic that we are facing. Each day provided new information that has been applied to my job, and increased my awareness for diversion investigations.

NCQAC Investigators should continue to participate in the NADDI Annual Conference as well as the Regional Conferences as able.
PURPOSE:

As part of the Strategic Plan for the Nursing Care Quality Assurance Commission (NCQAC), responsibility for oversight of competency evaluation for nursing assistants in Washington will transition from the Department of Social and Health Services (DSHS) to NCQAC in January 2020, through a contract amendment. The purpose of this out-of-state travel was to have key personnel from NCQAC meet directly with key personnel from the contracted vendor (Pearson VUE) for an intensive orientation to competency evaluation processes. The end goal is a smooth transition of the competency evaluation program and quality operation and oversight of the program on an ongoing basis.

OUTCOME:

The orientation addressed the following topics:

- **Review of Program Processes/Materials**: Forms and processes from the program perspective.
- **Review of Student Processes/Materials**: Forms and processes from the student perspective.
- **Review of Files and Reports**: Review of the secure file structure and reports.
- **Review of Testing Processes/Materials**: Forms and processes related to testing sites and candidate and evaluator activities.

RECOMMENDATION:

The in-person orientation was a helpful step toward supporting a smooth transition for NCQAC in terms of oversight of competency evaluation for nursing assistants. It was also helpful in terms of connecting with Pearson VUE personnel to open and establish communication channels and role expectations to support optimal experiences for testing candidates moving forward.
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<tr>
<td>Deny</td>
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<tr>
<td>Deferred</td>
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<tr>
<td>Instructor Applications:</td>
<td></td>
<td></td>
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<tr>
<td>Approve</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
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<tr>
<td>Deny</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Deferred</td>
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<td></td>
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<td></td>
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<tr>
<td>Complaints:</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>0</td>
<td>5</td>
<td>7</td>
<td>5</td>
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<td>Closed</td>
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<td>2</td>
<td>4</td>
<td>2</td>
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<tr>
<td>Complaint Investigation Reviewed:</td>
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<td>Accept Report – No Further Action</td>
<td>3</td>
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</table>
Licensing Education Exemption (Waiver) Request:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Exemption Request Approved</td>
<td>1</td>
<td>5</td>
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<tr>
<td>Exemption Request Denied</td>
<td></td>
<td>6</td>
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<tr>
<td>International Request Denied</td>
<td>2</td>
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</table>

Referred to CMT

- Does not include Dec 19, 2019 NPAP Data
Snapshot of Approved Nursing Assistant Training Programs (December 2019)

<table>
<thead>
<tr>
<th>Number of Nursing Assistant Training Programs (All Types)</th>
<th>205</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Traditional Programs</td>
<td>167</td>
</tr>
<tr>
<td>• Home Care Aide Alternative/Bridge Programs</td>
<td>22</td>
</tr>
<tr>
<td>• Medical Assistant Alternative/Bridge Programs</td>
<td>10</td>
</tr>
<tr>
<td>• Medication Assistant Certification Endorsement (MACE) Programs</td>
<td>6</td>
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</tbody>
</table>

**Trend Indicator in Program Numbers:** ___ Notable Increase  **X** Stable  ___ Notable Decrease

**Comments:** Increased sanction closures in 2018, but an increase in new program applications are off-setting sanction numbers; program numbers have ranged 180-200 total over last several years, but have grown to > 200 in recent months.
<table>
<thead>
<tr>
<th>Activity</th>
<th>NOV</th>
<th>YTD</th>
<th>Status</th>
<th>Additional in the Queue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Applications Reviewed**</td>
<td>2</td>
<td>42</td>
<td>30 Approved _1_Approved/Pending _5_Deferred ___Denied _10_Application Withdrawn or Closed</td>
<td>0</td>
</tr>
<tr>
<td>Program Substantive Change Reviewed</td>
<td>0</td>
<td>5</td>
<td>3_Approved _1_Deferred _1_Denied</td>
<td></td>
</tr>
<tr>
<td>Program Director/Instructor Applications Requiring Panel Review</td>
<td>0</td>
<td>10</td>
<td>7_Approved _3_Deferred ___Denied ____CMT Referral</td>
<td></td>
</tr>
<tr>
<td>Site Visit Summaries Reviewed</td>
<td>0</td>
<td>4</td>
<td>1_Accepted _3_Additional Documents/Actions Required ___Program Status Change _1_Deferred</td>
<td></td>
</tr>
<tr>
<td>DPOC/POC* or Other Program Conditional Requirement Reviewed</td>
<td>1</td>
<td>22</td>
<td>1_Accepted _17_Additional Documents/Actions Required _2_Deferred _2_Program Status Change</td>
<td></td>
</tr>
<tr>
<td>Complaints Reviewed</td>
<td>0</td>
<td>11</td>
<td>6_Opened _4_Closed _1_CMT Referral</td>
<td></td>
</tr>
<tr>
<td>Investigative Reports Reviewed</td>
<td>4</td>
<td>5</td>
<td>_Action Required _5_No Action Required</td>
<td></td>
</tr>
<tr>
<td>Program Closures</td>
<td>0</td>
<td>5</td>
<td>_5_Sanction ___Approval Withdrawn</td>
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</tr>
<tr>
<td>Other Review or Process Decisions***</td>
<td>1</td>
<td>12</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*DPOC = Directed Plan of Correction; POC = Plan of Correction  **Does not include 2nd/subsequent reviews
<table>
<thead>
<tr>
<th>Activity</th>
<th>DEC</th>
<th>YTD</th>
<th>Status</th>
<th>Additional in the Queue</th>
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</thead>
<tbody>
<tr>
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<td>45</td>
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<td>2</td>
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<tr>
<td>**Does not include 2nd/subsequent reviews</td>
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<td></td>
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</tr>
<tr>
<td>Program Substantive Change Reviewed</td>
<td>0</td>
<td>5</td>
<td>3 Approved, 1 Deferred, 1 Denied</td>
<td></td>
</tr>
<tr>
<td>Program Director/Instructor Applications Requiring Panel Review</td>
<td>0</td>
<td>10</td>
<td>7 Approved, 3 Deferred, 1 Denied</td>
<td></td>
</tr>
<tr>
<td>Site Visit Summaries Reviewed</td>
<td>1</td>
<td>5</td>
<td>2 Accepted, 3 Additional Documents/Actions Required, 1 Program Status Change, 1 Deferred</td>
<td></td>
</tr>
<tr>
<td>DPOC/POC* or Other Program Conditional Requirement Reviewed</td>
<td>1</td>
<td>23</td>
<td>1 Accepted, 18 Additional Documents/Actions Required, 2 Deferred, 2 Program Status Change</td>
<td></td>
</tr>
<tr>
<td>Complaints Reviewed</td>
<td>0</td>
<td>11</td>
<td>6 Opened, 4 Closed, 1 CMT Referral</td>
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</tr>
<tr>
<td>Investigative Reports Reviewed</td>
<td>1</td>
<td>6</td>
<td>Action Required, 6 No Action Required</td>
<td></td>
</tr>
<tr>
<td>Program Closures</td>
<td>0</td>
<td>5</td>
<td>5 Sanction, Approval Withdrawn</td>
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</tr>
<tr>
<td>Other Review or Process Decisions***</td>
<td>0</td>
<td>12</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* *DPOC = Directed Plan of Correction; POC = Plan of Correction*
The following questions were discussed at a meeting between WSNA and some of the members of the Washington State Nursing Care Quality Assurance Commission (Nursing Commission) on August 15, 2019. Many of these questions currently remain unresolved, and are bucketed into three target audiences: NCSBN, the Nursing Commission, and the legislature.

**QUESTIONS FOR NCSBN:**

1. Clarifying changes to bill language

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>STATUS</th>
<th>COMMENTS</th>
<th>NCQAC response</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the Compact, “Commission” refers to the Interstate Commission of Nurse Licensure Compact Administrators (p. 2, line 36) – can “Interstate Commission” be substituted in WA bill to alleviate confusion with the Nursing Commission?</td>
<td>Unresolved</td>
<td>Because any changes to the Compact require adoption by all party states (p. 19, line 6), it is unclear whether the legislature would be allowed to make changes, even for the purpose of clarification.</td>
<td>Yes. This change is included in the 2020 legislation. Yes. Language clarifying that “Rap Back” is not authorized, and the confidentiality of background check information, is included in the 2020 legislation. The NCQAC strategic plan identifies a communication strategy that includes evaluating a name change from the Nursing Care Quality Assurance Commission to the WA State Board of Nursing. This would require a statutory change.</td>
</tr>
<tr>
<td>The lobbyists representing NCSBN in Washington state have suggested amendments to clarify the language</td>
<td>Unresolved</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. Data on uptake of Compact licenses

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>STATUS</th>
<th>COMMENTS</th>
<th>NCQAC response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there data from Compact states on how many nurses have a state license v. a home state compact license?</td>
<td>Unresolved</td>
<td>This has implications for both the fiscal note for the Compact bill.</td>
<td>Received data from NCSBN on both states in original compact and in enhanced compact (current). Attached the report. This data assists with projections for the fiscal note on a bill.</td>
</tr>
<tr>
<td>How will the requirement to change home state license upon moving to another state be enforced?</td>
<td>Unresolved</td>
<td>Nurses Associations have reported anecdotally that nurses wait until the expiration of their former state’s home license before transferring to the new state.</td>
<td>In the original compact, nurses were given 30 days to change their state of residence once they move to a new state. The enhanced compact rules, 402-403, (attached) describe the requirements and transfer of multistate license when the nurse’s state of residence changes. NCQAC will work with WSNA and other organizations to educate members, employers and nurses on all rules and requirements.</td>
</tr>
</tbody>
</table>

*Attachment #1*  
*Attachment #2*
### 3. Tool to educate nurses on variation in state practice acts

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>STATUS</th>
<th>COMMENTS</th>
<th>NCQAC response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will NCSBN produce a good tool to educate nurses on key differences in practice acts by state?</td>
<td>Unresolved</td>
<td>Because nurses with a Compact license must follow the nurse practice act in the state that the patient is in, WSNA has concern over liability for a nurse who may not be familiar with differences in practice acts by state (e.g., delegation). Because there is some uniformity in practice acts, a tool to call out substantial differences by state would help educate nurses who elect to practice under a Compact license.</td>
<td>NCQAC agreed to produce a tool with the practice statements from all states. The tool will be developed and approved by NCQAC, shared with executive officers from other states and territories. WSNA, ANA, NCSBN are all welcome to contribute and comment.</td>
</tr>
</tbody>
</table>

### 4. Liability

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>STATUS</th>
<th>COMMENTS</th>
<th>NCQAC response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would not knowing the practice act in another state mean loss of license in WA?</td>
<td>Resolved</td>
<td>In WSNA’s discussion with the Nursing Commission, the Commission indicated</td>
<td>NCQAC works within the process defined in the Uniform Disciplinary Act (UDA), RCW 18.130. There must be a complaint, and investigation and evidence to support any and all actions on a WA state license. If there was patient harm in another state, and the nurse holds a Multistate</td>
</tr>
</tbody>
</table>
### 5. Disciplinary volume

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>STATUS</th>
<th>COMMENTS</th>
</tr>
</thead>
</table>
| What has been the experience of Compact states around changes in disciplinary volume once they entered the Compact? | Unresolved | **Response from NCSBN and attached 2015 report**<br>Anecdotal information about NLC state experience includes the following and may vary among states:<br><li>NLC states may experience approximately one remote state discipline case per 10,000 licensees per year.</li><li>For example, if Washington has 100,000 licensees, on average may experience about 10 discipline cases per year due to remote state nurse violations. This is
generally a small number out of the overall number of cases per year that a BON has.

- A nurse practicing in a remote state will hold a multistate license. In order to hold a multistate license, the nurse must be in good standing, with no active discipline.

- Multistate licensees whose PSOR is Washington will also practice in other NLC remote states and may have violations and investigations there resulting in a discipline case, at the same rate. Therefore, the cases tend to balance out.

A few other points:
- No NLC state, in its history, has needed to increase investigation or discipline staff due to joining NLC.
- The NLC statute authorizes a member state to recover the costs of investigations from a licensee. Very few NLC states do this.
- NLC states do not indicate any appreciable increase in overall number of discipline cases due to joining NLC.

*Attachment #3*
6. Licensure fees

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>STATUS</th>
<th>COMMENTS</th>
<th>NCQAC response</th>
</tr>
</thead>
<tbody>
<tr>
<td>What has been the experience of Compact states around revenue loss from licensees moving to other home states?</td>
<td>Unresolved</td>
<td>WSNA has heard from state nurses’ associations in Compact states that their state nursing board/commission experienced significant revenue loss (e.g., because out-of-state nurses currently licensed in WA would no longer need a WA license).</td>
<td>The NCQAC determined there may be a loss in revenue due to the volume of endorsement applications. Please see attached analysis of the number of licensees residing outside WA. The fee for a Multistate license would be different than a single state license. The attachment also captures projected fees needed to maintain budget requirements.</td>
</tr>
</tbody>
</table>
### QUESTIONS FOR NURSING COMMISSION:

#### 7. Knowledge of who is practicing in Washington state

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>STATUS</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>What mechanism can be put into place so that the Nursing Commission knows who is practicing in WA state – with either a single state or a Compact license (both home state and other states)?</td>
<td>Unresolved</td>
<td>Other state nurses’ associations in Compact states have raised concerns that they no longer know who is practicing in their state with nurses able to come in under the compact license. According to the Nursing Commission, they currently have demographic data for 80% of nurses who hold a WA license. This information is necessary for workforce planning purposes.</td>
</tr>
</tbody>
</table>

#### 8. Licensure fees

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>STATUS</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>If WA joins the Compact, how will the fee assessment work? How will this be</td>
<td>Unresolved</td>
<td></td>
</tr>
</tbody>
</table>
calculated? What will be the difference between a single state license and a Compact home state license?

9. **Compliance with WA Open Public Meetings law**

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>STATUS</th>
<th>COMMENTS</th>
<th>NCQAC response</th>
</tr>
</thead>
<tbody>
<tr>
<td>How will the Nursing Commission ensure that nurses and organizations representing nurses are informed of the Interstate Commission of Nurse Licensure Compact Administrators public meetings?</td>
<td>Resolved</td>
<td>The Compact bill states that “all meetings shall be open to the public, and public notice shall be given” (p.10, line 23). Section 9 of the legislation says that “public notice” is met by posting on the state board/commission website. In its discussion with WSNA, the Nursing Commission stated that it could push out meeting information via GovDelivery. It is imperative that is done so public does not have to rely on memory to check NCSBN website for such notices.</td>
<td>All meetings of the Nurse Licensure Compact Administrators would be announced on the Gov Delivery system and posted to the NCQAC webpage.</td>
</tr>
</tbody>
</table>
## 10. Delayed implementation date

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>STATUS</th>
<th>COMMENTS</th>
<th>NCQAC response</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the Compact legislation moves forward in Washington state, could a delayed implementation date be included?</td>
<td>Unresolved</td>
<td>Based on the time it has taken other states to be ready to issue Compact licenses following the passage of the Compact legislation, the Nursing Commission has suggested that a delayed implementation date may be useful.</td>
<td>Unless another date is specified in the bill, it will take effect ninety days after final adjournment of the legislative session in which it is enacted. There is at least one year needed for the implementation of the NLC. This year allows the NCQAC the time needed to provide education, IT system integration, and staff training. Therefore, the earliest a Multistate license could be issued from WA would be 13 months after the bill is passed. The NCQAC would like further discussion on the appropriate effective date to include in the legislation.</td>
</tr>
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</table>
### QUESTIONS FOR LEGISLATURE:

**1. State-specific education requirements**

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>STATUS</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Washington State Legislature requires all health care providers,</td>
<td>Unresolved</td>
<td>The Nursing Commission provided other state examples of education requirements that only pertain to the home state license. These included:</td>
</tr>
<tr>
<td>including nurses, to take continuing education related to suicide</td>
<td></td>
<td>• <strong>New York State</strong> – traumatic brain injury training requirement that pertains only to those nurses with a NY home state license</td>
</tr>
<tr>
<td>prevention – is the legislature OK with setting a dual standard related</td>
<td></td>
<td>• <strong>Oklahoma</strong> – bioterrorism training requirement that pertains only to those nurses with an OK home state license</td>
</tr>
<tr>
<td>to this requirement it enacted?</td>
<td></td>
<td>The NCQAC could communicate this requirement in a variety of manners: with the Gov Delivery message announcing the NLC; on the application for a multistate license, on the webpage. Therefore, nurses would have the requirements and resources available to have them comply with not only WA licensure requirements but those of other states. This information could be included in the document collecting practice standard in the states.</td>
</tr>
</tbody>
</table>
### 11. Protection of Washington’s Nurse Practice Act

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>STATUS</th>
<th>COMMENTS</th>
<th>NCQAC response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does a section need to be added to the Nursing Commission statute to show that only the Washington State Nursing Care Quality Assurance Commission can change Washington’s Nurse Practice Act?</td>
<td>Unresolved</td>
<td>Due to concern over the broad authority the Compact gives to the Commission of Nurse Licensure Compact Administrators, this section could be added for protection and clarity. WSNA concern is maintaining full scope of practice in WA. The Nursing Commission also said it could draft an intent section for the Compact bill to express clarity around this issue.</td>
<td>The 2020 legislation includes language explicitly prohibiting the Interstate Commission from adopting rules or bylaws which determine or alter the scope of nursing practice in a state or the methods and grounds for disciplining a nurse in a state, among other things.</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Total Active M/S RN/PN Individuals</td>
<td>Total Active M/S Licenses</td>
<td>% of All Active M/S Licenses</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------------------</td>
<td>---------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>AR</td>
<td>52,647</td>
<td>61,362</td>
<td>85.80%</td>
</tr>
<tr>
<td>AZ</td>
<td>83,483</td>
<td>113,992</td>
<td>73.24%</td>
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<tr>
<td>CO</td>
<td>73,302</td>
<td>85,479</td>
<td>85.75%</td>
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<td>15,051</td>
<td>21,534</td>
<td>69.89%</td>
</tr>
<tr>
<td>FL</td>
<td>54,800</td>
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<td>13.18%</td>
</tr>
<tr>
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<td>24,677</td>
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<tr>
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<td>70,084</td>
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<tr>
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<tr>
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<td>76,071</td>
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</tr>
<tr>
<td>KY</td>
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<td>93,431</td>
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<tr>
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<td>93,894</td>
<td>88.32%</td>
</tr>
<tr>
<td>ME</td>
<td>23,766</td>
<td>30,550</td>
<td>77.79%</td>
</tr>
<tr>
<td>MO</td>
<td>110,242</td>
<td>149,106</td>
<td>73.94%</td>
</tr>
<tr>
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<td>57,229</td>
<td>64,063</td>
<td>89.33%</td>
</tr>
<tr>
<td>MT</td>
<td>17,191</td>
<td>22,668</td>
<td>75.84%</td>
</tr>
<tr>
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<td>21,262</td>
<td>69.28%</td>
</tr>
<tr>
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<td>32,669</td>
<td>36,319</td>
<td>89.95%</td>
</tr>
<tr>
<td>NH</td>
<td>20,993</td>
<td>27,379</td>
<td>76.68%</td>
</tr>
<tr>
<td>NM</td>
<td>22,879</td>
<td>34,461</td>
<td>66.39%</td>
</tr>
<tr>
<td>OK</td>
<td>7,455</td>
<td>71,942</td>
<td>10.36%</td>
</tr>
<tr>
<td>SC</td>
<td>75,106</td>
<td>83,170</td>
<td>90.30%</td>
</tr>
<tr>
<td>SD</td>
<td>17,752</td>
<td>22,975</td>
<td>77.27%</td>
</tr>
<tr>
<td>TN</td>
<td>119,587</td>
<td>132,143</td>
<td>90.50%</td>
</tr>
<tr>
<td>TX</td>
<td>404,751</td>
<td>475,459</td>
<td>85.13%</td>
</tr>
<tr>
<td>UT</td>
<td>34,958</td>
<td>38,348</td>
<td>91.16%</td>
</tr>
<tr>
<td>VA</td>
<td>123,428</td>
<td>134,880</td>
<td>91.51%</td>
</tr>
<tr>
<td>WI</td>
<td>83,153</td>
<td>117,449</td>
<td>70.80%</td>
</tr>
<tr>
<td>WVPN</td>
<td>2,069</td>
<td>7,814</td>
<td>26.48%</td>
</tr>
<tr>
<td>WVRN</td>
<td>5,986</td>
<td>34,885</td>
<td>17.16%</td>
</tr>
<tr>
<td>State</td>
<td>Multi-State Licenses</td>
<td>Total Licenses</td>
<td>Percentage</td>
</tr>
<tr>
<td>-------</td>
<td>---------------------</td>
<td>----------------</td>
<td>------------</td>
</tr>
<tr>
<td>WY</td>
<td>1,805</td>
<td>10,947</td>
<td>16.49%</td>
</tr>
</tbody>
</table>

**Implemented 1/19/18**

**NOTE:** The 25 original NLC states implemented NLC such that all nurses residing in the state, in good standing at time of enactment, received a multistate license. In the states that implemented enhanced NLC starting 1/19/18 (that were not in the original NLC), only nurses who applied for a multistate license, may have been eligible to be issued a multistate license.
The Interstate Commission of Nurse Licensure Compact Administrators

Final Rules

Effective January 1, 2019
SECTION 100. DEFINITIONS

(1) "Commission" means the Interstate Commission of Nurse Licensure Compact Administrators.

(2) "Compact" means the Nurse Licensure Compact that became effective on July 20, 2017 and implemented on January 19, 2018.

(3) "Convert" means to change a multistate license to a single-state license if a nurse changes primary state of residence by moving from a party state to a non-party state; or to change a single-state license to a multistate license once any disqualifying events are eliminated.

(4) "Deactivate" means to change the status of a multistate license or privilege to practice.

(5) "Director" means the individual referred to in Article IV of the Interstate Commission of Nurse Licensure Compact Administrators Bylaws.

(6) "Disqualifying Event" means an incident, which results in a person becoming disqualified or ineligible to retain or renew a multistate license. These include but are not limited to the following: any adverse action resulting in an encumbrance, current participation in an alternative program, a misdemeanor offense related to the practice of nursing (which includes, but is not limited to, an agreed disposition), or a felony offense (which includes, but is not limited to, an agreed disposition).

(7) "Independent credentials review agency" means a non-governmental evaluation agency that verifies and certifies that foreign nurse graduates have graduated from nursing programs that are academically equivalent to nursing programs in the United States.

(8) "Licensure" includes the authority to practice nursing granted through the process of examination, endorsement, renewal, reinstatement and/or reactivation.

(9) "Prior Compact" means the Nurse Licensure Compact that was in effect until January 19, 2018.

(10) "Unencumbered license" means a license that authorizes a nurse to engage in the full and unrestricted practice of nursing.

202. QUERYING THE COORDINATED LICENSURE INFORMATION SYSTEM

(1) Upon application for multistate licensure, with the exception of renewal by a nurse, a party state shall query the Coordinated Licensure Information System to determine the applicant’s current licensure status, previous disciplinary action(s), current participation in an alternative program, and any current significant investigative information.

(2) Upon discovery that an applicant is under investigation in another party state, the party state in receipt of the nurse licensure application shall contact the investigating party state and may request investigative documents and information.


SECTION 300. IMPLEMENTATION

301. IMPLEMENTATION DATE

The Compact shall be implemented on January 19, 2018.


302. TRANSITION

(1) (a) A nurse who holds a multistate license on the Compact effective date of July 20, 2017, and whose multistate license remains unencumbered on the January 19, 2018 implementation date and who maintains and renews a multistate license is not required to meet the new requirements for a multistate license under the Compact.

(b) A nurse who retained a multistate license pursuant to subsection (a) of this section and subsequently incurs a disqualifying event shall have the multistate license revoked or deactivated pursuant to the laws of the home state.

(c) A nurse whose multistate license is revoked or deactivated may be eligible for a single state license in accordance with the laws of the party state.

(2) A nurse who applies for a multistate license after July 20, 2017, shall be required to meet the requirements of Article III (c) of the Compact.

(3) During the transition period, a licensee who holds a single state license in a Compact state that was not a member of the prior Compact and who also holds a multistate license in a party state, may retain the single state license until it lapses, expires or becomes inactive."
(b) The home state may issue a single state license pursuant to its laws.

(3) A party state shall not issue a single state license to a nurse who holds a multistate license in another party state.


402. APPLICANT RESPONSIBILITIES

(1) On all application forms for multistate licensure in a party state, an applicant shall declare a primary state of residence.

(2) A nurse who changes primary state of residence to another party state shall apply for a license in the new party state when the nurse declares to be a resident of the state and obtains privileges not ordinarily extended to nonresidents of the state, including but not limited to, those listed in 402 (4) (a) – (e).

(3) A nurse shall not apply for a single state license in a party state while the nurse holds a multistate license in another party state.

(4) A party state may require an applicant to provide evidence of residence in the declared primary state of residence. This evidence may include, but is not limited to, a current:

(a) driver’s license with a home address;
(b) voter registration card with a home address;
(c) federal income tax return with a primary state of residence declaration;
(d) military form no. 2058 (state of legal residence certificate); or
(e) W2 form from the United States government or any bureau, division, or agency thereof, indicating residence.

(5) An applicant who is a citizen of a foreign country, and who is lawfully present in the United States and is applying for multistate licensure in a party state may declare either the applicant’s country of origin or the party state where they are living as the primary state of residence. If the applicant declares the foreign country as the primary state of residence, the party state shall not issue a multistate license, but may issue a single state license if the applicant meets the party state’s licensure requirements.
406. CREDENTIALING AND ENGLISH PROFICIENCY FOR FOREIGN NURSE GRADUATES

(1) A party state shall verify that an independent credentials review agency evaluated the credentials of graduates as set forth in Article III (c)(2)ii.

(2) The party state shall verify successful completion of an English proficiency examination for graduates as set forth in Article III (c)(3).


407. DEACTIVATION, DISCIPLINE AND REVOCATION

A party state shall determine whether a disqualifying event will result in adverse action or deactivation of a multistate license or privilege. Upon deactivation due to a disqualifying event, the home state may issue a single state license.


SECTION 500. ADMINISTRATION

501. DUES ASSESSMENT

(1) The Commission shall determine the annual assessment to be paid by party states. The assessment formula is a flat fee per party state. The Commission shall provide public notice of any proposed revision to the annual assessment fee at least ninety (90) calendar days prior to the Commission meeting to consider the proposed revision.

(2) The annual assessment shall be due within the Commission’s first fiscal year after the implementation date and annually thereafter.


502. DISPUTE RESOLUTION.

(1) In the event that two or more party states have a dispute, the parties shall attempt resolution following the steps set out in this rule.

(2) The parties shall first attempt informal resolution. The Compact Administrators in the states involved shall contact each other. Each Compact Administrator shall submit a written statement describing the situation to the other Compact Administrators involved
Compact Administrator shall respond to the written statement within thirty calendar days.

(3) The Compact Administrator may appear before the Executive Committee at a time and place as designated by the Executive Committee.

(4) The Executive Committee shall make a recommendation to the Commission concerning the issue of non-compliance.

_History: Adopted August 14, 2018; effective January 1, 2019._
Impact the NLC has on BON Investigator Caseload

- Increased caseload: 3 (17%)
- Little or no impact on caseload: 12 (67%)
- Decreased caseload: 1 (6%)
- Don’t know: 2 (11%)
Impact the NLC has on BON Attorney Caseload

- 14 (74%) Little or no impact on caseload
- 1 (5%) Increased caseload
- 1 (5%) Decreased caseload
- 3 (16%) Don’t know
Nominations Committee

Purpose:

1. Select members of the Nursing Care Quality Assurance Commission (NCQAC) who are qualified and willing to serve in leadership positions.
2. Select members of the NCQAC and staff to be nominated for awards. Complete applications as necessary.

Membership:

1. At least three members of the NCQAC appointed by the Chair.
2. No member should serve more than two consecutive years on the nominations committee.

Duties and Responsibilities:

1. Select at least two candidates each for the position of NCQAC Chair, Vice Chair, and Secretary/Treasurer.
2. Nominate NCQAC members and staff for awards, such as the NCSBN annual awards. Complete and submit applications.

Timeline for leadership nominations and elections:

1. November meeting -- NCQAC Chair appoints new members to the Nominations Committee.
2. January meeting -- Announces opening for nominations for the NCQAC annual award.
3. March meeting --
   a. Verbally presents the slate of candidates to the NCQAC. The NCQAC approves the slate of candidates.
   b. Candidates may speak to the NCQAC
4. May meeting --
   a. Election of the Officers, according to Procedure H02.
5. July meeting --
   a. New officers take office
   b. Presents the NCQAC annual award.

Staff:
Executive Director or designee

Adopted: 7/06, 7/08
Revised: 6/08, 9/10, 11/11, 3/13, 3/17
Approved: 7/06, 7/08, 3/13, 3/17
Washington State Nursing Care Quality Assurance Commission

Position Description

Commission Chair Person

Qualifications:

Served on the Nursing Care Quality Assurance Commission (NCQAC) a minimum of one year at the time the term as the chair is to begin.
Demonstrated leadership characteristics by serving at least one of the following:
- Chair of a sub-committee
- Chair of a panel
- Leadership in employment, association or community work

Duties and Responsibilities:

1. Provides strategic vision and leadership to the NCQAC, in collaboration with the Executive Director, determining NCQAC priorities, policy, and practice.
2. Conducts meetings of the NCQAC according to Roberts Rules of Order. Votes when necessary to make or break a tie.
3. Appoints chairpersons and members of all regular and special committees, panels, and task forces.
4. Participates as a member of the Legislative Panel.
5. Represents the NCQAC in public forums.
6. Appoints members to the Nominating Committee at the November meeting, receives the list of nominations in March, and oversees the election of officers in May.
7. Plans for succession and smooth transition to the next chair person.
8. Addresses NCQAC member performance issues.
9. Uses signatory authority on documents as required.
10. Serves as a delegate to the National Council of State Boards of Nursing for the annual delegate assembly held each August.

Approved: 7/06, 7/08
Revised: 10/08
03/11
03/13/15
01/11/19
Commission Vice Chair Person

Qualifications:

Served on the Commission a minimum of one year at the time the term begins as vice chair.
Demonstrated leadership characteristics by serving at least one of the following:
   Chair of a sub-committee
   Chair of a panel
   Leadership in employment, association or community work

Duties and Responsibilities:

1. Assumes the duties of the Chair as needed.
2. Chairs the Legislative Panel.
3. Provides assistance to the Chair and Executive Director as needed.
4. Participates at the HSQA Boards and Commission Forum as a representative of the NCQAC.
5. Participates in National Council of State Board of Nursing meetings and events as available.
6. Participates on NCQAC duties with various task forces, committees, charging panels, hearings.

Approved: 07/06, 07/08
Revised: 06/08
            03/11
            09/13
            03/13/15
Washington State Nursing Care Quality Assurance Commission

Position Description

Secretary Treasurer

Qualifications:

Served on the Nursing Care Quality Assurance Commission (NCQAC) a minimum of one year at the time the term is to begin.
Demonstrated leadership characteristics by serving at least one of the following:
   Chair of a sub-committee
   Leadership in employment, association or community work

Duties and Responsibilities:

1. Reviews the minutes from the NCQAC business meetings prior to publishing in the packet of materials for the next business meeting. Editorial comments and substantive comments are forwarded to the executive director’s administrative assistant within two weeks of receipt of the draft minutes.
2. Gathers input from NCQAC members on budgetary priorities through the strategic planning process.
3. Reviews the biennial budget proposals with the executive director prior to being submitted through the Department of Health.
4. Reviews the monthly budget reports with the budget manager.
5. Presents the budget reports at the NCQAC business meetings.
6. Participates in state budget meetings as directed by the chair.
7. Conducts the NCQAC business meeting in the absences of the Chair or Vice Chair.

Approved: 03/13/15
Revised: 03/13/15
Revised: 09/09/16
NURSING BUDGET STATUS REPORT – OCTOBER 2019

BUDGET/ALLOTMENTS:

This report covers the period of July 1, 2019 through October 31, 2019, four months into the biennium, with twenty months remaining. The prior biennium financial information is not yet completed, so the beginning revenue balance may change slightly. The Nursing Commission budget is underspent by 11%. This report includes the additional spending authority granted the Commission during the 19-21 budget process. Our total budget for the 19-21 biennium is almost $27 million.

Within our direct budget, we are significantly underspent in staff salaries & benefits, as we received the additional authority for eight new FTES and are still trying to get that staff hired. As of today, there are still two vacancies. We are overspent in travel, due to the two-day meeting in Spokane during July. Under equipment, we are overspent since we just replaced the commission’s computers. These higher, up front expenditures will be offset with lower expenditures in future months.

Within the service unit section, we are overspent in HSQA Investigations and slightly in the Call Center. We will be discussing with HSQA their billing methods and determine if these are legitimate charges, and if so, whether adjustments need to be made to our budget. The budget for the On-line Licensing Project are being assessed quarterly, so this report only captures the first quarter.

As with the beginning of any biennium, invoices and billings are somewhat lagged, but we expect to have a much better picture of our finances after the first six months of the biennium. We also anticipate being fully staffed soon, and having more disciplinary cases moving through the system and over to the Attorney General’s Office. We expect to spend our full budget, reduce backlog and start improving performance measures soon.

REVENUES:

The recommended revenue balance or “reserve” should be approximately 12.5% of our budget, or approximately $3.4 million. Our current estimated revenue balance is $6.6 million. Once billings are up to date and we are fully staffed, we expect to start using part of our excess balance, thus getting closer to our recommended balance over the next few years.
## NURSING BUDGET STATUS REPORT 19-21 BIENNium

As of October 31, 2019 (beginning revenue balance not finalized yet, as prior biennium final adjustments are still in process)

### DIRECT EXPENDITURES: BIENNIAL BUDGET/ALLOTMENT EXPENDITURES VARIANCE % SPENT

<table>
<thead>
<tr>
<th>Expenditure Types</th>
<th>Biennial Budget</th>
<th>To-Date</th>
<th>Variance</th>
<th>% Spent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Direct Expenditures:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FTEs (monthly)</td>
<td>66.51</td>
<td>66.51</td>
<td>61.83</td>
<td>4.68</td>
</tr>
<tr>
<td>Staff Salaries &amp; Benefits</td>
<td>$14,078,364</td>
<td>$2,380,685</td>
<td>$2,130,791</td>
<td>$249,894</td>
</tr>
<tr>
<td>Commission Salaries</td>
<td>$618,000</td>
<td>$100,000</td>
<td>$91,352</td>
<td>$8,648</td>
</tr>
<tr>
<td>Goods &amp; Services</td>
<td>$1,097,998</td>
<td>$159,405</td>
<td>$125,303</td>
<td>$34,102</td>
</tr>
<tr>
<td>Rent</td>
<td>$934,695</td>
<td>$155,900</td>
<td>$127,876</td>
<td>$28,024</td>
</tr>
<tr>
<td>Attorney General (AG)</td>
<td>$1,628,488</td>
<td>$199,421</td>
<td>$167,056</td>
<td>$32,365</td>
</tr>
<tr>
<td>Travel</td>
<td>$394,992</td>
<td>$65,332</td>
<td>$67,474</td>
<td>($2,142)</td>
</tr>
<tr>
<td>Equipment</td>
<td>$79,992</td>
<td>$13,332</td>
<td>$28,306</td>
<td>($14,974)</td>
</tr>
<tr>
<td>IT Support &amp; Software Licenses</td>
<td>$408,326</td>
<td>$66,635</td>
<td>$45,412</td>
<td>$21,223</td>
</tr>
<tr>
<td><strong>TOTAL DIRECT</strong></td>
<td><strong>$19,240,855</strong></td>
<td><strong>$3,140,710</strong></td>
<td><strong>$2,783,570</strong></td>
<td><strong>$357,140</strong></td>
</tr>
</tbody>
</table>

### SERVICE UNITS:

<table>
<thead>
<tr>
<th>Service Units</th>
<th>Biennial Budget</th>
<th>To-Date</th>
<th>Variance</th>
<th>% Spent</th>
</tr>
</thead>
<tbody>
<tr>
<td>FBI Background Checks</td>
<td>$647,065</td>
<td>$106,424</td>
<td>$104,043</td>
<td>$2,381</td>
</tr>
<tr>
<td>Office of Professional Standards</td>
<td>$323,880</td>
<td>$53,308</td>
<td>$48,807</td>
<td>$4,501</td>
</tr>
<tr>
<td>Adjudication Clerk</td>
<td>$176,861</td>
<td>$29,080</td>
<td>$25,549</td>
<td>$3,531</td>
</tr>
<tr>
<td>HP Investigations</td>
<td>$61,512</td>
<td>$10,116</td>
<td>$16,333</td>
<td>($6,217)</td>
</tr>
<tr>
<td>Legal Services</td>
<td>$35,868</td>
<td>$5,121</td>
<td>$5,121</td>
<td></td>
</tr>
<tr>
<td>Call Center</td>
<td>$153,612</td>
<td>$25,256</td>
<td>$25,802</td>
<td>($546)</td>
</tr>
<tr>
<td>Public Disclosure</td>
<td>$283,216</td>
<td>$46,576</td>
<td>$41,453</td>
<td>$5,123</td>
</tr>
<tr>
<td>Revenue Reconciliation</td>
<td>$155,794</td>
<td>$25,256</td>
<td>$25,802</td>
<td>($546)</td>
</tr>
<tr>
<td>Online Healthcare Provider Lic</td>
<td>$7,188</td>
<td>$7,188</td>
<td>$7,188</td>
<td>$7,188</td>
</tr>
<tr>
<td>Suicide Assessment Study</td>
<td>$31,070</td>
<td>$5,121</td>
<td>$5,121</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL SERVICE UNITS</strong></td>
<td><strong>$1,876,066</strong></td>
<td><strong>$314,581</strong></td>
<td><strong>$289,863</strong></td>
<td><strong>$24,718</strong></td>
</tr>
</tbody>
</table>

### INDIRECT CHARGES:

<table>
<thead>
<tr>
<th>Indirect Charges</th>
<th>Biennial Budget</th>
<th>To-Date</th>
<th>Variance</th>
<th>% Spent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency Indirects (15.4%)</td>
<td>$3,518,296</td>
<td>$575,534</td>
<td>$514,934</td>
<td>$60,600</td>
</tr>
<tr>
<td>HSQA Division Indirects (11.5%)</td>
<td>$2,352,470</td>
<td>$384,825</td>
<td>$344,035</td>
<td>$40,790</td>
</tr>
<tr>
<td><strong>TOTAL INDIRECTS (26.9%)</strong></td>
<td><strong>$5,870,766</strong></td>
<td><strong>$960,359</strong></td>
<td><strong>$858,969</strong></td>
<td><strong>$101,390</strong></td>
</tr>
</tbody>
</table>

### GRAND TOTAL:

- **$26,987,687**
- **$4,415,650**
- **$3,932,402**
- **$483,248**
- **89.06%**

### NURSING REVENUE

<table>
<thead>
<tr>
<th>Revenue Type</th>
<th>To-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning Revenue Balance</td>
<td>$6,136,330</td>
</tr>
<tr>
<td>17-19 Revenue To-Date</td>
<td>$4,459,526</td>
</tr>
<tr>
<td>17-19 Expenditures To-Date</td>
<td>$3,932,402</td>
</tr>
<tr>
<td>Ending Revenue Balance</td>
<td>$6,663,454</td>
</tr>
</tbody>
</table>
Nursing Care Quality Assurance Commission
Performance Measures

Credentials issued % in 14 Calendar Days
Target = 95%

Intake/Assess completed % within 21 days

Open Investigations % beyond 170 days

Investigations % completed within 170 days

Open in Case Disposition % beyond 140 days

Case Disposition % completed within 140 days
Legal Performance Measures

Legal Case Closures

- Number of Cases Forwarded to AAG
- Finalized with Legal Review only
- Finalized by Default or Final Order After Hearing
- Finalized by STID, AO or APUC (Settlements)
- Other (releases, reinstatements)

Legal Caseloads

- Average Caseload per Attorney
- Total Cases Assigned to Legal
- Total Finalized Cases
- Target Finalized Cases per Attorney
- Average of Finalized Cases per Attorney (Target 10 per month)

Legal Performance

- Percentage of Legal Reviews Sent to RCM in 30 Days or less
- Document drafting time: Percentage of Drafts to AAG or SOA Served in 30 Days or less
- Target (77%)
WHPS Performance Measures

WHPS Measures

- **Average Days Positive Drug Test Turn-Around Time**
- **Average Days from Significant Contract Non-Compliance to Discipline Notification**
- **Linear (Average Days Positive Drug Test Turn-Around Time)**
- **Linear (Average Days from Significant Contract Non-Compliance to Discipline Notification)**

WHPS Participants

- **No Data.**
- **Transitional period for reporting system.**
Data and Performance Measures Related to Nursing Assistant Training Programs

Descriptive Data:

**Number of Director/Instructor Applications**

<table>
<thead>
<tr>
<th>2019</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
<th>JULY</th>
<th>AUG</th>
<th>SEP</th>
<th>OCT</th>
<th>NOV</th>
<th>DEC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>23</td>
<td>12</td>
<td>13</td>
<td>11</td>
<td>22</td>
<td>23</td>
<td>20</td>
<td>22</td>
<td>17</td>
<td>22</td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>

Existing Programs Only Total = 213

Descriptive Data:

**Total Number of Director/Instructor Applications**

(Existing and New Programs Combined)

<table>
<thead>
<tr>
<th>2019</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
<th>JULY</th>
<th>AUG</th>
<th>SEP</th>
<th>OCT</th>
<th>NOV</th>
<th>DEC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>29</td>
<td>37</td>
<td>18</td>
<td>28</td>
<td>35</td>
<td>30</td>
<td>28</td>
<td>31</td>
<td>24</td>
<td>29</td>
<td>17</td>
<td></td>
</tr>
</tbody>
</table>

New and Existing Programs Total = 325
Performance Measure:

**Director/Instructor Applications (For Existing Programs)**
Average Days Receipt to Evaluation Response

Target: ≤ 5 Days

<table>
<thead>
<tr>
<th>Month</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>JAN</td>
<td>3</td>
</tr>
<tr>
<td>FEB</td>
<td>2.5</td>
</tr>
<tr>
<td>MAR</td>
<td>1</td>
</tr>
<tr>
<td>APR</td>
<td>1</td>
</tr>
<tr>
<td>MAY</td>
<td>1</td>
</tr>
<tr>
<td>JUN</td>
<td>1</td>
</tr>
<tr>
<td>JUL</td>
<td>1</td>
</tr>
<tr>
<td>AUG</td>
<td>1</td>
</tr>
<tr>
<td>SEP</td>
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2019
Descriptive Data:

*Does not include 2nd/subsequent reviews of revised applications

Performance Measure:

*Does not include 2nd/subsequent reviews of revised applications
Descriptive Data:

Performance Measure:
# Nursing Care Quality Assurance Commission

## Current Rules in Progress, January 2020

<table>
<thead>
<tr>
<th>Rules</th>
<th>CR 101 Adopted</th>
<th>CR 102 Adopted</th>
<th>CR 103 Adopted</th>
<th>CR 105 Adopted</th>
<th>Hearing Date</th>
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<tbody>
<tr>
<td>Scope of Practice</td>
<td>• CR-101 filed <strong>December 5, 2018</strong> WSR# 19-01-002</td>
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<td>WAC 246-840-300 WAC 246-840-700 through 246-840-710</td>
<td>• <strong>Workshops completed:</strong> Jan 22, 2019- Spokane Jan 23, 2019- Richland Jan 24, 2019- Kent</td>
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<td><strong>Spring/Summer 2020</strong>- Continue stakeholder work.</td>
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<tr>
<td>Continuing Competency</td>
<td>• CR-101 filed <strong>December 5, 2019</strong> WSR#19-01-001</td>
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<td><strong>Currently facilitating outreach workgroups to obtain additional input.</strong></td>
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<td>Rules</td>
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<td>ARNP Practice Hour Renewal Requirement</td>
<td>• CR-101 for the purpose of removing the requirement of two hundred fifty practice hours for ARNP licensure renewal and ARNP interstate endorsement. &lt;br&gt;• CR-101 filed July 22, 2019 WSR# 19-15-093 &lt;br&gt;<strong>Workshops:</strong> September 30, 2019 October 9, 2019</td>
<td>• CR-102 Preliminary Review Required and Completed &lt;br&gt;• CR-102 Resubmitted into RMS December 6, 2019</td>
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<td>WAC 246-840-360 and WAC 246-840-342</td>
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<td>ARNP Opioid Prescribing Rules</td>
<td>• Motion to open rules on November 9, 2018. &lt;br&gt;• File CR-101 after 2019 Legislative Session. &lt;br&gt;• CR-101 filed July 22, 2019 WSR# 19-15-092 &lt;br&gt;<strong>Workshops:</strong> TBD</td>
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<td>WAC 246-840-460 through WAC 246-840-4990</td>
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<td>ARNP Opioid Prescribing-Implementation of SSB 5380 (Sec 10)</td>
<td><strong>CR-105 NOTES</strong> &lt;br&gt;• Motion to file CR-105 on May 10, 2019. &lt;br&gt;• Draft language to commission for approval on July 12, 2019. &lt;br&gt;• CR105 filed August 29, 2019. WSR 19-18-040</td>
<td>• CR-103 Submitted into RMS on November 07,2019</td>
<td>CR-105 to implement SSB 5380 (Section 10). NCQAC must adopt amendment to the rules by January 1, 2020. ARNPs must inform patients of their right to refuse an opioid prescription and the</td>
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<td>Rules</td>
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<td>Temporary Practice Permits</td>
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<td>WAC 264-840-095</td>
<td>• Developing CR-101 to decrease length of time from 6 months to a 1 month time period, allowable 30 day extension. • Waiting to submit CR-101 after other rule packages finalized.</td>
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January 10, 2020
NCQAC Business Meeting
75
During the 2019 Legislative Session the Legislature passed Substitute Senate Bill 5380. This bill amended RCW 69.50.312, which requires all prescriptions for controlled substances to be electronically communicated, beginning January 1, 2021. The bill also directed the Department of Health (Department) to create a waiver process for practitioners due to (in part) economic hardship, technological limitations, or other exceptional circumstances.

At the same time there is a federal requirement that will also be going into effect on January 1, 2021 that requires electronic prescribing for all controlled substances for any Medicare Part D providers. The federal language also directed the Secretary to create a waiver process, although there is no federal waiver to date. This waiver process will be separate from the Departments waiver, however as both progress, the federal language may ultimately impact how the Departments waiver is processed.

There are exceptions to this mandate, which include:
- Prescriptions issued by veterinarians, as that practice is defined in RCW 18.92.010;
- Prescriptions issued for a patient of a long-term care facility as defined in RCW 18.64.011, or a hospice program as defined in RCW 18.64.011;
- When the electronic system used for the communication of prescription information is unavailable due to a temporary technological or electronic failure;
- Prescriptions issued that are intended for prescription fulfillment and dispensing outside Washington state;
- When the prescriber and pharmacist are employed by the same entity, or employed by entities under common ownership or control;
- Prescriptions issued for a drug that the United States Food and Drug Administration or the United States Drug Enforcement Administration requires to contain certain elements that are not able to be accomplished electronically;
- Any controlled substance prescription that requires compounding as defined in RCW 18.64.011;
- Prescriptions issued for the dispensing of a non-patient-specific prescription under a standing order, approved protocol for drug therapy, collaborative drug therapy agreement, in response to a public health emergency, or other circumstances allowed by statute or rule where a practitioner may issue a non-patient-specific prescription;
- Prescriptions issued under a drug research protocol;
- Prescriptions issued by a practitioner with the capability of electronic communication of prescription information under this section, when the practitioner reasonably determines it is impractical for the patient to obtain the electronically communicated prescription in a timely manner, and such delay would adversely impact the patient's medical condition; or
- Prescriptions issued by a prescriber who has received a waiver from the department.

The Department will be creating the waiver process to establish the criteria for prescribers to receive a waiver from the Department to exempt them from complying with the electronic prescribing mandate which goes into effect on January 1, 2021. The waiver will be available for those who can demonstrate an inability to utilize an electronic prescribing system due to economic hardship, technological limitations that are not reasonably in the control of the practitioner, or other exceptional circumstance demonstrated by the practitioner.
The Department has heard of private companies implementing their own policies on electronic prescribing of controlled substances. This waiver would not automatically exempt a prescriber from a private company’s policy, although they may choose to accept it.

Please look for future updates on the electronic prescribing mandate as the Department continues to work on creating the waiver.

If you have questions please contact Cori Tarzwell, HSQA policy analyst, Cori.Tarzwell@DOH.WA.GOV or 360-236-4981.
Frequently Asked Questions
School Nursing, Public and Private, Kindergarten through Twelve Grade Schools: Asthma Management Registered Nurse Scope of Practice

Can the registered nurse in the school setting delegate to non-credentialed assistive personnel to assist a student using a peak flow meter to determine the need for inhaled medications for asthma?

It is within the scope of an appropriately trained and competent registered nurse in the kindergarten through twelve grade, public and private school setting (RCW 28A.210 Common School Provisions: Health-Screening and Requirements) to delegate the use of a peak flow meter following the student’s health care plan and the prescribed medication based on peak flow meter readings. The health care plan must include actions to take in case of an emergency situation. The Nursing Care Quality Assurance Commission recommends the registered nurse use the Scope of Practice Decision Tree to determine if an activity is within their scope of practice.

Can the registered nurse in a school setting delegate to non-credentialed assistive personnel to mix medications in a nebulizer chamber for administration for inhalation via mask or mouthpiece?

It is within the scope of an appropriately trained and competent registered nurse in the kindergarten through twelve grade, public and private school setting (RCW 28A.210 Common School Provisions: Health-Screening and Requirements) to delegate preparing a medication in a nebulizer chamber for inhalation via a mask or mouthpiece following the student’s health care plan and the prescribed medication. The order falls within the category of an oral medication whether or not the mask or spacer covers the mouth or the mouth and nose. Medications ordered intranasally are not included in this category. The Nursing Care Quality Assurance Commission recommends the registered nurse use the Scope of Practice Decision Tree to determine if an activity is within his or her scope of practice.
Can the registered nurse in a school setting delegate to non-credentialed assistive personnel to administer a range order of medications for asthma, such as one to two puffs, using an oral inhaler?

It is within the scope of an appropriately trained and competent registered nurse in the kindergarten through twelve grade, public and private school setting (RCW 28A.210 Common School Provisions: Health-Screening and Requirements) to delegate following a range order of medications, such as administering one to two puffs, using an oral inhaler based on the prescription and specific criteria and identified in the health care plan. The Nursing Care Quality Assurance Commission recommends the registered nurse use the Scope of Practice Decision Tree to determine if an activity is within his or her scope of practice.

Can non-credentialed assistive personnel in the school setting provide urgent or emergent care for urgent asthma episodes?

Non-credentialed assistive personnel may assist the student in identifying emergent or urgent asthma episodes in the kindergarten through twelve grade, public and private school setting (RCW 28A.210 Common School Provisions: Health-Screening and Requirements). This may include using the use of a peak flow meter and administration of quick-relief medications (such as inhaled bronchodilators). The nurse must include these activities in the emergency health care plan and medication prescription/orders, including the frequency that the medication can be given, from an authorized health care practitioner. The emergency health care plan must include actions to contact emergency services as appropriate.

What criteria should the school nurse consider in determining whether it is safe and appropriate to delegate asthma-related tasks to non-credentialed assistive personnel?

The school nurse should use professional judgment and consider the following criteria to determine safe and appropriate delegation of asthma-related tasks to non-credentialed assistive personnel in the kindergarten through twelve grade, public and private school setting (RCW 28A.210 Common School Provisions: Health-Screening and Requirements):

- A health care plan and emergency care plan written by the school registered nurse in collaboration with the parent/guardian should be in place.
- The school registered nurse has received written orders related to the frequency of administration of bronchodilators, or other asthma-related medications, and any emergency orders.
The delegated non-credentialed assistive personnel is competent to perform delegated asthma-related tasks.

The delegated non-credentialed assistive personnel is certified in cardiopulmonary resuscitation (CPR) and first aid (strongly recommended).

The parents/guardians have provided the school/school nurse with the necessary equipment and supplies to perform delegated asthma-related tasks.

The parents/guardians have provided the school/school nurse with the required authorization forms and emergency information.

Consider the following when delegating non-credentialed assistive personnel to monitor or provide emergency assistance to a student prepared to perform some or all of the asthma-related tasks independently:
  - Documentation from the health care provider indicating the student’s level of independent functioning;
  - Nursing documentation that the student has demonstrated competence in determining the need for assistance and use of medication administration devices and/or bronchodilator use;
  - Assurance the student will follow school policies and safety procedures;

Can a student have a parent-designated adult (PDA) to provide asthma-related tasks? RCW 28A.210 Common School Provisions: Health-Screening and Requirements does not include allow an exception for a student to have a PDA to provide asthma-related tasks.

What circumstances would be considered unsafe for the registered nurse in a school setting to delegate to non-credentialed assistive personnel asthma-related tasks? The following would be considered unsafe situations in which to delegate to non-credentialed assistive personnel asthma-related tasks in the kindergarten through twelve grade, public and private school setting (RCW 28A.210 Common School Provisions: Health-Screening and Requirements):

- Newly diagnosed students with moderate to severe asthma, and the health care plan has not been written or approved;
- Medically fragile student with health complications or multiple health problems that require nursing assessments before performing any authorized task;
- Student with a history of non-compliance with treatment plans;
- Student who has been authorized to function independently by the health care provider, but cannot consistently demonstrate competence in asthma-related tasks in the school setting. These students should be referred back to the health
care provider for further evaluation before delegating care to non-credentialed assistive personnel.
Can the licensed practical nurse in a school setting delegate to assistive personnel for asthma management?

It is not within the scope of practice for the licensed practical nurse to delegate to assistive personnel nursing tasks in the public and private, kindergarten through twelve grade school setting (RCW 28A.210 Common School Provisions: Health-Screening and Requirements). Only the registered nurse may delegate to assistive personnel to perform asthma management tasks in this setting.
Request for advisory opinion from the American Lung Association, Seattle Headquarters, Asthma Management in School Settings Committee

Background information: The following questions were generated by a multi-disciplinary committee charged with developing a standard approach to the management of asthma in K-12 schools. The management guidelines are based on national asthma care principles. Individual nursing care plans for students with asthma will be developed according to orders from authorized prescribers, with parental input, based on a philosophy of self-management by the student. Registered nurses in school settings function under a special provision which allows them to delegate and supervise the administration of oral medications to unlicensed school personnel. The Commission assumes that the registered nurse uses the nursing process to assess the care needed, verify orders, individualize standard guidelines based on the student’s needs, and that certain tasks will not be delegated when the registered nurse determines that care is too complex.

May an RN in a school setting delegate to an unlicensed school employee, the following tasks related to the care of children with asthma?

Assist a student using a peak flow meter to determine the need for inhaled medications for asthma:
Yes, if the plan of care includes the use of a peak flow meter to determine whether or not medication is indicated, the unlicensed school employee who has been trained and is supervised by the registered nurse may verify readings on the peak flow meter and assist the student to follow the instructions on the plan of care. The care plan must include information about when a health care provider or the EMS system should be activated.

Mix liquid medications in a nebulizer chamber for administration via oral inhalation:
Yes, if the registered nurse has taught and supervised the assistive personnel to place medication in a nebulizer chamber, and if she has determined this is a safe procedure within an individual plan of care, this activity is part of the process of administration of oral medications.

Assist a student who uses a mask or Aerochamber-style spacer for inhaled medications for asthma—the medication is ordered “by mouth”, but the device also covers the nose:
Yes, if the medication is ordered for oral inhalation, it falls within the category of “po” or “by mouth” whether or not the mask or spacer covers the mouth or the mouth and the nose. Medications ordered to be administered intranasally are not included within this category. (reference: telephone communication with Joe Honda, Pharmacy Board Consultant, 8/24/00)
Initiation of an individualized plan to deal with urgent asthma episodes which may include the use of peak flow meters:
Yes, the assistive personnel may assist the student to identify emergent and urgent situations, including the use by the student of peak flow meters so that the student may determine his or her own status, as long as the registered nurse has included these activities in the plan of care. The registered nurse may not delegate nursing assessment or the nursing process (clinical decision making) to an unlicensed individual.

Orders for inhaled medication which provide a varying dose of medication (i.e. 1-2 puffs):
Yes, if such orders are clarified with the authorized prescriber by the registered nurse, this type of medication may be delegated. The registered nurse should contact the authorized prescriber to determine, for instance, under which circumstances one versus two puffs of an asthma medication should be administered.

Adopted: September 8, 2000
Frequently Asked Questions
School Nursing, Public and Private, Kindergarten through Twelve Grade Schools:
Diabetes Mellitus Management
Registered Nurse

Can the school registered nurse delegate administration of injectable glucagon to non-credentialed assistive personnel?
The school law does not provide an exception for the registered nurse in the kindergarten through twelve grade, public and private school setting (RCW 28A.210 Common School Provisions: Health-Screening and Requirements) to delegate administration of injectable glucagon to non-credentialed assistive personnel. RCW 28A.210.330 does allow a parent to authorize a parent-designated adult (PDA) to perform this task in this setting. The law allows a school staff person to volunteer to be a PDA or the parents can select a person not employed by the school to be the PDA. The Nursing Care Quality Assurance Commission recommends the registered nurse use the Scope of Practice Decision Tree to determine if an activity is within their scope of practice.

Can the school registered nurse delegate the administration of intranasal glucagon powder to non-credentialed assistive personnel?
The Food and Drug Administration (FDA) approved the first treatment for severe hypoglycemia that can be administered without an injection July 24, 2019. Baqsimi™ nasal powder. It is within the scope of the appropriately trained and competent registered nurse in the in the kindergarten through twelve grade, public and private school setting (RCW 28A.210 Common School Provisions: Health-Screening and Requirements) to delegate this medication to non-credentialed assistive personnel. RCW 28A.210.260(5) requires a school nurse to administer intranasal medications when a licensed practical nurse or registered nurse is on the premises. RCW 28A.210.260(1)(5) allows delegation of an intranasal medication only if a licensed practical nurse or
registered nurse is not on the premises to administer the medication. **RCW 28A.210.330** allows a parent-designated adult (PDA) to administer an intranasal medication for diabetes. A school employee may volunteer to act as a PDA. After an intranasal spray (legend drug or controlled substance) is administered by non-credentialed assistive personnel, the employee must summon emergency medical assistance as soon as possible. The law does not stipulate which types of legend drugs or controlled substances administered intranasally, or specific conditions in which emergency medical assistance must be summoned. The Nursing Care Quality Assurance Commission recommends the registered nurse use the [Scope of Practice Decision Tree](#) to determine if an activity is within their scope of practice.

**Can the school registered nurse delegate non-credentialed assistive personnel to perform blood glucose fingersticks?**

The school law does not provide an exception for the registered nurse in the kindergarten through twelve grade, public and private school setting (**RCW 28A.210 Common School Provisions: Health-Screening and Requirements**) to delegate the task of performing a blood glucose capillary stick. **RCW 28A.210.330** allows a parent to authorize a parent-designated adult (PDA) to perform this task. The law allows a school staff person to volunteer to be a PDA or the parents can select a person not employed by the school to be the PDA. The Nursing Care Quality Assurance Commission recommends the registered nurse use the [Scope of Practice Decision Tree](#) to determine if an activity is within their scope of practice.

**Can the school registered nurse delegate non-credentialed assistive personnel to obtain blood glucose readings from an implanted continuous blood glucose monitoring device?**

It is within the scope of an appropriately trained and competent registered nurse in the kindergarten through twelve grade, public and private school setting (**RCW 28A.210 Common School Provisions: Health-Screening and Requirements**) to delegate non-credentialed assistive personnel to obtain blood glucose readings from an implanted continuous monitoring device. The Nursing Care Quality Assurance Commission recommends the registered nurse use the [Scope of Practice Decision Tree](#) to determine if an activity is within their scope of practice.
Frequently Asked Questions
School Nursing, Public and Private, Kindergarten through Twelve Grade Schools:
Diabetes Mellitus Management
Licensed Practical Nurse

Can the licensed practical nurse in the school setting delegate administration of nursing tasks for diabetes to non-credentialed assistive personnel? It is not within the scope of practice for the licensed practical nurse to delegate nursing tasks to non-credentialed assistive personnel in the public and private, kindergarten through twelve grade school setting (RCW 28A.210 Common School Provisions: Health-Screening and Requirements). Only the registered nurse may delegate to assistive personnel to perform asthma management tasks in this setting.
PURPOSE:

Washington Health Professional Services (WHPS) randomly tests body fluid, hair, nail or other biological samples to monitor contract compliance.

“Drug testing is a valuable tool for monitoring compliance with board orders and alternative program agreements and in assuring patient safety in a population who have a known substance use disorder who are or will be returning to nursing practice.” Substance Use Disorder in Nursing, National Council of State Boards of Nursing (NCSBN), 2011, p.140-141.

PROCEDURE:

I. Random Testing
   A. Urine testing frequency

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<th>Nurse Status</th>
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<td>Not practicing</td>
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<tr>
<td>Practicing</td>
<td>24-36</td>
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<tr>
<td>During Transition Contract</td>
<td>12-18</td>
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</table>
B. The case manager may increase, decrease, or modify testing at their discretion. Examples of modified testing include adding hair, nail, or blood tests. The case manager may request additional testing any time there is reasonable cause to believe the nurse may be at risk for relapse. From NCSBN’s *Substance Use Disorder in Nursing*, the case manager considers these criteria when increasing drug testing frequency:

1. Length of time without use (longer sobriety equals less frequent testing).
2. Identified or reported as unable to practice due to substance use disorder.
3. Expert evaluator findings and recommendations from the treatment program.
4. Severity of disease.
5. Multiple drug use history.
6. Prior treatment history and relapse history.
7. Work setting (supervised, observed practice equals less frequent testing; isolated, independent work setting equals more frequent testing).

C. The nurse must activate their drug screening service account prior to their first scheduled check-in date. The nurse receives drug screening service information in their Program Participation Contract and the *WHPS Handbook*. Nurses must check-in daily (online or telephone), Monday through Friday, except on Washington State holidays.

D. The nurse must test on the same calendar day as selected in order to maintain contract compliance.

E. A collection site technician will observe the sample collection. However, not all collection sites offer observed collection services. If observed collection is not available, the nurse will submit a sample in a dry room setting.

F. Nurses are responsible for payment of the drug screen and fees.

II. Collection of Alternative Biological Samples

A. Situations may necessitate alternative testing (saliva, nails, hair, blood, or breath) to augment evaluation or monitoring. Circumstances that may require alternative testing include, but are not limited to:

1. The nurse is unable to submit a urine toxicology screen on a regular basis due to work or other limitations.
2. A third party evaluator (drug testing contractor or a treatment service) recommends hair testing.
3. The nurse returns to active monitoring after a period of absence (e.g., an extended vacation).

B. The case manager may schedule alternative testing when the nurse has particular work or personal circumstances that increase or point to the risk of relapse, including but not limited to:

1. Use history and past issues of non-compliance.
2. Working in a high-risk setting.
3. Frequent abnormal or dilute urine specimens.
4. Working in high-risk profession (e.g., CRNA).
5. Worksite monitor reports of concern.

III. Monitoring Interruption

Nurses should notify WHPS at least 14 calendar days prior to being away from their home/work area. This allows nurses to request a monitoring interruption for a vacation, medical leave, or education. The case manager may approve a suspension from the daily check-in or requirement to test only under circumstances where the nurse is:
1. Traveling outside the country and can provide documentation of travel.
2. Hospitalized and in a condition where they are not able to check in or test, including in-patient treatment for Substance Use Disorder.
3. Participating in an educational program outside the country.
4. Incarcerated.

The WHPS case management team or Recovery Trek may assist nurses in locating approved drug and alcohol testing sites near their location. Nurses who have had significant non-compliance within the previous two years as defined in Procedure W32 or a repeated pattern of three or more missed check-ins within a three-month period as defined in Procedure W43 are not eligible for monitoring interruptions except for hospitalization or incarceration.

IV. Positive Drug Screen Results
   A. The case management team reviews positive drug test results daily, but not later than the next business day after posting.
   B. If the positive test is a result of a known prescribed medication and the nurse does not have a Prescription Information Form on file, WHPS immediately contacts the nurse.
      1. WHPS instructs the nurse to contact their prescriber to have them fax the Prescription Information Form to WHPS within 48 hours.
      2. If WHPS does not receive the Prescription Information Form within 48 hours:
         a. The case management team will gather interim verification of the nurse’s prescription, which may include contact with the prescriber, pharmacist, or review of the Prescription Monitoring Report.
         b. WHPS may choose to inform the prescriber that WHPS may direct the nurse to cease practice unless the prescriber submits the form by the next business day.
         c. Any unauthorized use may result in cease practice for the nurse.
   C. If the positive test is not the result of a known, prescribed medication, and the nurse denies substance use:
      1. WHPS requires collection sites to divide samples into two, referred to as split samples. WHPS provides the nurse with the opportunity to have an independent laboratory test the split sample for confirmation.
      2. The nurse may request a Medical Review Officer (MRO) review.
      3. WHPS will direct the nurse to cease practice.

V. Dilute Samples
   A. Urine specific gravity below 1.003 in conjunction with a creatinine level below 20 mg/dl constitutes a dilute sample. Dilute samples may mask the presence of drugs and/or metabolites; therefore, all dilute sample submissions result in additional testing.
   B. The WHPS Handbook includes information on dilute samples and how nurses can avoid them.
   C. All dilute sample submissions will result in a test (standard panel + EtG) scheduled for the next business day.
   D. A second dilute sample within three months results in WHPS sending a non-compliance notice to the nurse, requires a written explanation from the nurse, and may require alternative testing.
E. Any combination of three dilute or abnormal sample submissions within a three-month period requires the nurse to undergo a medical evaluation to determine cause.
F. WHPS considers a positive dilute test as a valid positive test.

VI. Abnormal Samples
A. A urine creatinine level of less than 15 mg/dl constitutes an abnormal sample.
B. The WHPS Handbook includes information on abnormal sample submissions and how to avoid them.
C. All abnormal sample submissions will result in a test (standard panel + EtG) scheduled for the next business day.
D. A third abnormal sample submission within three months results in WHPS sending a non-compliance notice to the nurse, requires a written explanation from the nurse, requires a medical evaluation to determine possible cause, and may require alternative testing.
E. Following a medical evaluation that is negative for physical cause, subsequent dilute or abnormal sample submissions requires alternative testing and notification of the Work Site Monitor (WSM). WHPS may also require the nurse to cease practice and refer the nurse to the Substance Use and Abuse Team (SUAT).
F. WHPS considers a positive abnormal test as a valid positive test.

VII. Out-of-Temperature Range Samples
A. WHPS considers out-of-temperature range samples as invalid.
B. When the collection site receives an out-of-temperature range sample, the nurse must remain at the collection site and submit a second sample per the collection site’s procedures.
C. WHPS considers the nurse’s failure to submit a second sample under these circumstances as a positive test.

VIII. Substituted or Adulterated Samples
A. WHPS considers substituted or adulterated samples as positive tests.

IX. Medical Review Officer (MRO) Review
A. WHPS offers MRO services upon request through the case manager according to the Program Participation Contract and WHPS Handbook. The nurse is responsible for all MRO fees.
B. The MRO posts their opinion in the case notes for case manager review.
DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE

Title: Unauthorized Substance Use
Number: W44.02

Reference:
- RCW 18.130.160
- RCW 18.130.175
- WAC 246-840-750 through 246-840-780

Contact:
Paula R. Meyer, MSN, RN, FRE
Executive Director
Nursing Care Quality Assurance Commission

Effective Date: March 8, 2019
Date Reviewed: March 2019
Supersedes: W11.01, W44.01

Approved:
Tracy Rude, LPN
Chair
Nursing Care Quality Assurance Commission

PURPOSE:
For public protection and the purposes of monitoring, the National Council of State Boards of Nursing Substance Use Disorder in Nursing (2011) defines relapse as “any unauthorized use or abuse of alcohol, medications or mind-altering substances. Patient safety is jeopardized if a relapse is not identified early. Consistent monitoring and immediate identification of relapse is critical as it puts the nurse’s health in immediate jeopardy and may be fatal.” (Page 216)

PROCEDURE:

I. The nurse will:
   A. Immediately report all unauthorized substance use to Washington Health Professional Services (WHPS), and if applicable, the Worksite Monitor (WSM) and Peer Support Group (PSG).
   B. Immediately cease practice.
   C. Complete an observed drug test as scheduled and requested by WHPS.
   D. Schedule a Substance Use Disorder (SUD) evaluation according to Procedure W34 Substance Use Evaluation and Treatment Services. The nurse must schedule the SUD evaluation within two days.
   E. Begin recommended level of treatment as soon as possible.
   F. Not return to practice until the treatment counselor and WHPS determine the nurse is safe to practice.
II. WHPS will:
   A. Verify practice cessation with the WSM.
   B. Review all instances of unauthorized substance use at the next scheduled case staffing meeting or sooner.
   C. Assess each case individually according to relapse behavior. WHPS will consider:
      1. Use after a period of abstinence.
      2. Return to prior use pattern.
      3. Little or no program contact.
      4. Program participation type.
      5. Use within the context of active practice.
      7. Current SUD evaluation.
   D. Refer any unauthorized substance use that occurs after the first 90 days of program participation to the Substance Use and Abuse Team (SUAT) within 30 days of receiving the confirmatory test results. (Refer to Procedure A20. Substance Abuse Orders.) WHPS may not consider unauthorized substance use during the first 90 days as relapse due to a lack of period of abstinence or significant recovery time. The report to SUAT will include the following information and documentation:
      1. Evaluation summary with diagnosis and treatment recommendations from the nurse’s healthcare provider.
      2. Positive drug or alcohol screen, including positive tests reported from sources outside WHPS, with Medical Review Officer (MRO) review if applicable.
      3. Complete significant non-compliance history.
      4. Synopsis of program history, referred to as the Trek Story in the Recovery Trek monitoring system.
      6. Incident report.
   E. Notify SUAT of any delay in submitting necessary documentation.
   F. In the interest of public safety, cases that involve, but are not limited to, workplace diversion, patient harm, or illegal activity (e.g., medication resale) may necessitate restarting contract lengths and terms.

III. Amended Program Participation Contracts (See Procedure W35 Terms and Conditions of Contract Compliance.)
   A. When an SUD evaluation results in an elevated diagnosis, WHPS will adjust contract terms and conditions accordingly.
   B. The nurse has ten working days to return the amended contract. If the nurse fails to return the contract or chooses not to accept the contract, WHPS will refer the nurse to NCQAC and may discharge the nurse from the program.
DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE

Title: Washington Health Professional Services (WHPS) Program Non-Compliance and Discharge Criteria
Number: W32.02

Reference: RCW 18.130.160
RCW 18.130.175
WAC 246-840-750 through 246-840-780

Contact: Paula R. Meyer, MSN, RN, FRE
Executive Director
Nursing Care Quality Assurance Commission

Effective Date: TBD
Date Reviewed: March 2019

Supersedes: W01.01 and W02.01, W32.01

Approved:
Tracy Rude, LPN
Chair
Nursing Care Quality Assurance Commission

PURPOSE:
To define significant non-compliance with the WHPS program and circumstances under which WHPS may refer a nurse to NCQAC for potential discipline or discharge a nurse from the program.

PROCEDURE:

I. Referral to NCQAC
   A. Significant non-compliance with contract and program requirements will result in referral to NCQAC. (See Appendix A. Significant Non-Compliance, attached to this procedure.)
   B. WHPS will refer a voluntary nurse to NCQAC:
      1. Who presents with a significant psychiatric issue.
      2. Who exhibits behaviors that may result in patient harm.
      3. Who is in significant non-compliance with their monitoring contract and deemed to pose a risk to patient safety.
   C. When WHPS refers a nurse to NCQAC, they will make the nurse’s entire monitoring record available to NCQAC.
D. The WHPS director will make the referral within three business days of case staffing. (See Procedure W36 Case Management; also see Procedure W44.02 for referrals related to unauthorized substance use.)

E. The referral memo to NCQAC will include:
   1. Reason for entry into WHPS.
   2. Diagnosis.
   3. Reason for referral.
   5. Current monitoring status.
   6. Any actions taken by WHPS.

II. Program Discharge
   A. WHPS may discharge a nurse for the following, but not limited to:
      1. No contact for up to two weeks.
      2. Uncooperative or unwilling to comply with monitoring requirements (e.g. refusal to take a scheduled drug test or sign a release of information).
   B. WHPS refers the nurse to NCQAC within three business days of case staffing.
   C. WHPS will notify the Worksite Monitor (WSM), if any, of the nurse’s discharge from the program.
      1. The nurse may continue to legally practice under their license.
      2. WHPS can no longer monitor the nurse’s safety to practice.
   D. The nurse may re-enroll in the program after the disciplinary process, and at the discretion of WHPS, to document recovery efforts.
   E. Nurses re-admitted to WHPS after discharge must complete the entire intake process, including providing a current (within the previous 90 days) substance use disorder evaluation.

III. Withdrawal Due To Financial Reasons
   A. WHPS will inform NCQAC via a referral memo when the nurse withdraws due to financial reasons and is eligible to return to monitoring when able.
   B. When the nurse withdraws in writing, WHPS will include the nurse’s statement in the referral memo.
   C. WHPS strongly recommends that the nurse continue to document all recovery activities.

IV. Incarceration
   A. WHPS will place incarcerated nurses on extended monitoring interruption status.
   B. WHPS will extend the Program Participation Contract for the length of time the nurse is incarcerated.
   C. WHPS will inform NCQAC of the nurse’s incarceration when greater than one year.

V. License Suspension
   A. Nurses under license suspension may choose to remain in or return to WHPS. Participating in the program provides evidence of recovery in the event the nurse applies for reinstatement.
B. All contract terms remain in effect and the nurse must meet all program expectations.
I. Compliance with all aspects of the WHPS Program is expected. For any instance of significant non-compliance, WHPS will take one or more of the following actions, including but not limited to:
A. NCQAC referral – Mandatory for unauthorized substance use, third missed drug test, practicing without approval, or discharge from the program
B. Program discharge
C. Removal from practice
D. Increase in drug test frequency
E. Additional testing including, but not limited to, hair, nail, or blood analysis
F. Referral for substance use evaluation
G. Contract extension
H. Practice restriction modification
I. Work Site Monitor (WSM) notification
J. Cease practice

II. Significant non-compliance includes, but is not limited to:
A. Unauthorized substance use
B. Positive drug test not explained by valid prescription
C. Missed drug tests *(Three missed tests within two years; see Procedure W43.01)*
D. Specimen substitution or adulteration
E. A pattern of behavior inconsistent with good recovery
F. Drug diversion
G. Prescription forging, tampering, or modifying
H. Illegal possession of drugs (legend, controlled, or illegal drugs)
I. Arrests involving use or possession of alcohol or drugs
J. Accepting employment or modified duties without prior approval
K. Violation of work practice restrictions
L. Absences from treatment
M. Refusal to attend or excessive absences from required meetings
N. Refusal to sign requested information releases
## Violations Involving Documentation Errors

<table>
<thead>
<tr>
<th>Description of Violation</th>
<th>Aggravating &amp; Mitigating Factors</th>
<th>Harm (Tier)</th>
<th>Charge</th>
<th>Duration Of Sanction</th>
<th>Cost Recovery or Fine</th>
<th>Conditions</th>
<th>Time For Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Documentation Errors – 1 – 2 Times Only Within Short Time Period, i.e., Over 1-2 Shifts</td>
<td>Risk of Recurrence\nSee appendix for list of aggravating and mitigating factors</td>
<td>(A) No or Minimal Patient Harm or Low Risk of Harm</td>
<td>Close case\nNOC\nSOA</td>
<td>N/A\nN/A\n0-3 yrs</td>
<td>N/A\nN/A\nCost Recovery $1000 per violation</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>II. Pre-Charting Procedures Or Medications</td>
<td>Risk of Recurrence\nSee appendix for more aggravating and mitigating factors.</td>
<td>(A) No or Minimal Patient Harm or Low Risk of Harm</td>
<td>SOA/STID</td>
<td>0-3 yrs Until successful completion of coursework</td>
<td>Cost Recovery $1000 per violation</td>
<td>1. 6 Contact hour course in Documentation\n2. Obtain passing score\n3. Submit course evaluation for approval\n4. JP Module</td>
<td>1. 90 days\n2. 90 days\n3.120 days\n4. 90 days</td>
</tr>
<tr>
<td>III. Falsification of Records Deliberate changing or falsification of documentation to cover up error</td>
<td>Risk of Recurrence\nLikely Cause(s) of Error:\n• Lack of fiduciary concern\n• Error in performance of procedure or intervention\n• Poor judgment\nSee appendix for more aggravating and mitigating factors.</td>
<td>(A) No or Minimal Patient Harm or Low Risk of Harm\n(B) Patient Harm or Risk of Severe Patient Harm\n(C) Severe Harm or Death</td>
<td>SOA/SOC\nSOA/SOC</td>
<td>0-3 yrs\n2-5 yrs</td>
<td>Fine/Cost Recovery $1000 per violation</td>
<td>1. 24 Contact hour Documentation course\n2. Obtain passing score\n3. Submit course evaluation for approval\n4. 12 Contact hour Nursing Ethics course\n5. Obtain passing score\n6. Submit evaluation for approval\n7. Notification to current &amp; future employers\n8. Employer reports-quarterly\n9. Direct RN supervision\n10. No employment with an agency, home health, hospice, community care settings\n11. Request modification</td>
<td>1. 120 days\n2. 120 days\n3. 150 days\n4. 90 days\n5. 90 days\n6. 120 days\n7. Duration\n8. Duration\n9. Unless modified\n10. Unless modified\n11. 12-24</td>
</tr>
</tbody>
</table>
### IV – VI Relate to Documentation of Patient Assessment & Observations

<table>
<thead>
<tr>
<th>Description of Violation</th>
<th>Aggravating &amp; Mitigating Factors</th>
<th>Harm (Tier)</th>
<th>Charge</th>
<th>Duration Of Sanction</th>
<th>Cost Recovery or Fine</th>
<th>Conditions</th>
<th>Time For Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV. Developing Pattern Of Documentation Errors and/or Omissions Related to Patient Assessment &amp; Observations</td>
<td>Risk of Recurrence Likely Cause(s) of Error: • Inappropriate clinical judgment • Lack of time management skill &amp; organizational ability Consider individual practice responsibility and system influence and nurse’s demonstration of experiential learning See appendix for more aggravating and mitigating factors</td>
<td>(A) No or Minimal Patient Harm or Low Risk of Harm</td>
<td>SOA/SOC</td>
<td>0-3 yrs</td>
<td>Cost Recovery $1000 per violation</td>
<td>1. 24 Contact hour course in Patient Assessment including appropriate language on documentation 2. Obtain passing score 3. Submit course evaluation for approval</td>
<td>1. 120 days</td>
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<tr>
<td></td>
<td></td>
<td>(B) Patient Harm or Risk of Severe Patient Harm</td>
<td>SOA/SOC</td>
<td>2-5 yrs</td>
<td></td>
<td>4. JP Module</td>
<td>2. 120 days</td>
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<td></td>
<td></td>
<td>(C) Severe Harm or Death</td>
<td>SOC</td>
<td>3 yr Minimum</td>
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<td>3. 150 days</td>
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<td>4. 90 days</td>
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<tr>
<td>Description of Violation</td>
<td>Aggravating &amp; Mitigating Factors</td>
<td>Harm (Tier)</td>
<td>Charge</td>
<td>Duration Of Sanction</td>
<td>Cost Recovery or Fine</td>
<td>Conditions</td>
<td>Time For Completion</td>
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</tbody>
</table>
| V. Established Pattern Of Documentation Errors and/or Omissions of Essential Patient Information | Likely Cause(s) of Error:  
  - Practitioner lacked adequate knowledge or competence  
  - Lack of time management skill & organizational ability  
  - Inappropriate clinical judgment  
  - Disregard for patient safety & well being | (A) - No or Minimal Patient Harm or Low Risk of Harm  
(B) - Patient Harm or Risk of Severe Patient Harm | SOA/SOC | 0-3 yrs | Fine/Cost Recovery $1000 per violation | 1. 24 Contact hour course in Patient Assessment including documentation  
2. Obtain passing score  
3. Submit course evaluation for approval  
4. Worksite monitor to provide 40 hours of oversight of assessment & documentation  
5. Notice to current & future employers  
6. Employer reports quarterly  
7. Request modification  
8. JP Module | 1. 120 days  
2. 120 days  
3. 150 days  
4. 160 days  
5. Duration  
6. Duration  
7. 12—18 Months  
8. 90 days |
| Related To Patient Assessment & Observations | Errors/Omissions of the Following type(s):  
  - Missing assessment  
  - Inappropriate or inaccurate assessment  
  - Lack of attentiveness to changing condition  
  - Failure to recognize signs & symptoms  
  - Failure to document patient deterioration, pain, agitation or other signs of complications or reaction to illness or therapies | (C) - Severe Harm or Death | SOC | 3 yr Minimum | | |

Consider individual practice responsibility and system influence and nurse’s demonstration of experiential learning  
See appendix for more aggravating and mitigating factors
### Description of Violation

**VI. Significant Error(s) In Documentation of Essential Patient Information**

**Related To Patient Assessment & Observations With**

One or more of the following type(s):
- Missing or inaccurate assessment
- Lack of attentiveness
- Failure to recognize signs & symptoms
- Failure to document patient deterioration, pain, agitation or other signs of complications or reaction to illness or therapies

### Aggravating & Mitigating Factors

- **Risk of Recurrence**
- Likely Cause(s) of Error(s):
  - Practitioner lacked adequate knowledge or competence
  - Inappropriate clinical judgment
  - Disregard for patient safety & well being
  - Lack of attentiveness or surveillance

Consider individual practice responsibility and system influence and nurse’s demonstration of experiential learning

See appendix for more aggravating and mitigating factors

### Harm (Tier)

- **(A). No or Minimal Patient Harm or Low Risk of Harm**
- **(B). Patient Harm or Risk of Severe Patient Harm**
- **(C). Severe Patient Harm or Death**

### Charge

- **SOA/SOC**
- **SOC**

### Duration Of Sanction

- **0-3 yrs**
- **2-5 yrs**
- **3 yr Minimum**

### Cost Recovery or Fine

- Fine $1000 per violation

### Conditions

1. 120 days
2. 120 days
3. 150 days
4. Duration
5. Duration
6. Duration
7. 160 days
8. Unless modified
9. 18 to 24 months
10. 90 days
### VII & VIII Relate to Documentation of Medication Administration, Procedures and Treatments

<table>
<thead>
<tr>
<th>Description of Violation</th>
<th>Aggravating &amp; Mitigating Factors</th>
<th>Harm (Tier)</th>
<th>Charge</th>
<th>Duration Of Sanction</th>
<th>Cost Recovery or Fine</th>
<th>Conditions</th>
<th>Time For Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>VII. Developing Pattern Of Errors and/or Omissions In Documentation Related To Medication Administration, Procedures &amp; Treatments</td>
<td>Risk of Recurrence</td>
<td>(A) No or Minimal Patient Harm or Low Risk of Harm</td>
<td>SOA/SOC</td>
<td>0-3 yr</td>
<td>$1000 per violation</td>
<td>1. 24 hr Documentation class 2. Obtain passing score 3. Submit course evaluation for approval 4. JP Module</td>
<td>1. 120 days</td>
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<td>Likely cause(s) of Error:</td>
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<td>2. 120 days</td>
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<td>• Failure to follow agency policy</td>
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<td>3. 150 days</td>
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<td>• Lack of adequate knowledge or competence</td>
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<td>4. 90 days</td>
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<td>• Disregard for patient safety &amp; well being</td>
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<td></td>
<td>Consider individual practice responsibility and system influence and nurse’s demonstration of experiential learning</td>
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<td>See appendix for more aggravating and mitigating factors</td>
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</tbody>
</table>
### Description of Violation

VIII. Established Pattern of Errors and/or Omissions in Documentation Related To Medication Administration, Procedures & Treatment

5 or more of the following type(s):
- Missed medications and/or treatments
- Misrepresentation of patient's condition
- Failure to document care that has been provided

#### Aggravating & Mitigating Factors

- Risk of Recurrence
- Likely cause(s) of Error:
  - Failure to follow agency policy
  - Lack of adequate knowledge or competence
  - Disregard for patient safety & well being
  - Poor judgment

Consider individual practice responsibility and system influence and nurse’s demonstration of experiential learning

See appendix for more aggravating and mitigating factors

#### Harm (Tier)

(A) No or Minimal Patient Harm or Low Risk of Harm
(B) Patient Harm or Risk of Severe Patient Harm
(C) Severe Patient Harm or Death

#### Charge

- SOA/SOC
- SOA/SOC
- SOC

#### Duration Of Sanction

- 0-3 yrs
- 2-5 yrs
- 3 yr Minimum

#### Cost Recovery or Fine

- Fine/Cost Recovery $1000 per violation

#### Conditions

1. 24 hr. Documentation class
2. Obtain passing score
3. Submit course evaluation for approval
4. Notice to current & future employers
5. Employer reports quarterly
6. Indirect supervision
7. Worksite monitor to provide 40 hours of oversight of documentation
8. Request modification
9. JP Module

#### Time For Completion

- 1. 120 days
- 2. 120 days
- 3. 150 days
- 4. Duration
- 5. Duration
- 6. Duration
- 7. 180 days
- 8. 12-24 months
### Sanction Standards for RN and LPN

**Violations Involving Failure to Assess and/or Intervene on the Patient’s Behalf**

<table>
<thead>
<tr>
<th>Description of Violation</th>
<th>Aggravating &amp; Mitigating Factors</th>
<th>Harm (Tier)</th>
<th>Charge</th>
<th>Duration Of Sanction</th>
<th>Cost Recovery or Fine</th>
<th>Conditions</th>
<th>Time For Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Failure To Assess and/or Intervene On The Patient’s Behalf</td>
<td>Risk of Recurrence</td>
<td>(A) No or Minimal Patient Harm or Low Risk of Harm</td>
<td>SOA/SOC</td>
<td>0-3 yrs</td>
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<td>1. 120 days</td>
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<td>(B) Patient Harm or Risk of Severe Patient Harm</td>
<td>SOA/SOC</td>
<td>2-5 yrs</td>
<td>Fine $1000 per violation</td>
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<td></td>
<td>(C) Severe Harm or Death</td>
<td>SOC</td>
<td>3 yr Minimum</td>
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<td>3. Duration</td>
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<td>4. Unless modified</td>
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<td>7. If working as nurse</td>
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<td>9. 12 – 24 months</td>
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<td>10. JP Module</td>
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</tbody>
</table>

See appendix for more aggravating and mitigating factors.

**Risk of Recurrence**

Likely Cause(s) of Error/Omission:
- Lack of attentiveness
- Inadequate clinical judgment
- Faulty logic due to use of rote action
- Lack of appropriate priorities
- Poor or faulty monitoring
- Lack of agency/fiduciary concern

Consider individual practice responsibility and system influence and nurse’s demonstration of experiential learning.

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January 10, 2020
NCQAC Business Meeting

104
II. Failure to Recognize Risk Factors And Implement Prevention Techniques To Avoid Predictable, Preventable Condition(s)

Existence Of A Preventable Condition Including Decubiti, Stasis Pneumonia, Incidence Of Falls

Errors or Omissions of the following type:
- Failure to anticipate and/or recognize risk factors
- Failure to implement prevention techniques to reduce patient risk
- Faulty intervention
- Breach of infection precautions
- Failure to recognize equipment failure

<table>
<thead>
<tr>
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<th>Harm (Tier)</th>
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<th>Time For Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of Recurrence</td>
<td>No or Minimal Patient Harm or Low Risk of Harm</td>
<td>SOA/SOC</td>
<td>0-3 yrs</td>
<td>Fine $1000 per violation</td>
<td></td>
<td>1. 24 Contact hour course on Patient Assessment, obtain passing score, submit evaluative data</td>
<td></td>
</tr>
<tr>
<td>Likely Cause(s) of Error/Omission:</td>
<td>Patient Harm of Risk of Severe Patient Harm</td>
<td>SOA.SOC</td>
<td>2-5 yrs</td>
<td></td>
<td></td>
<td>2. 6 Contact hour course on Patient Safety, obtain passing score, submit evaluative data</td>
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<tr>
<td>- Lack of attentiveness</td>
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<td>3. Notice to current &amp; future Employers</td>
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<td>- Inadequate clinical judgment</td>
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<td>4. No employment in temporary agency, home health, hospice or community-based agency</td>
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<td>- Lack of appropriate priorities</td>
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<td>5. Employer reports addressing clinical judgment &amp; decision-making ability – quarterly</td>
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<td>- Poor or faulty monitoring</td>
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<td>6. Personal reports – Quarterly</td>
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<td>- Lack of evaluation of patient response to therapy</td>
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<td>7. Indirect RN supervision, No charge or supervisory responsibilities</td>
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<tr>
<td>- Failure to evaluate effectiveness of intervention</td>
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<td>8. Request Modification</td>
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<tr>
<td>Consider individual practice responsibility and system influence and nurse’s demonstration of experiential learning</td>
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<td>9. JP Module</td>
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<tr>
<td>See appendix for more aggravating and mitigating factors.</td>
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<td>12 months 90 days</td>
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</tbody>
</table>

January 10, 2020
NCQAC Business Meeting
Sanction Standards for RN and LPN
Violations Involving Medication Errors

<table>
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<tr>
<th>Description of Violation</th>
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<th>Conditions</th>
<th>Time For Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Practice of Pre-Pouring and/or Pre-Charting Medications</td>
<td>Risk of Recurrence</td>
<td>(A) No or Minimal Patient Harm or Low Risk of Harm</td>
<td>SOA/SOC</td>
<td>0-3 yrs</td>
<td>Cost Recovery $1000 per violation</td>
<td>1. 6 Contact hour course in Time Management 2. Obtain passing score 3. Submit course evaluation for approval 4. JP Module</td>
<td>1. 90 days</td>
</tr>
<tr>
<td></td>
<td>Likely Cause of Practitioner Error</td>
<td>(B) Patient Harm or Risk of Severe Patient Harm</td>
<td>SOA/SOC</td>
<td>2-5 yrs</td>
<td></td>
<td></td>
<td>2. 90 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(C) Severe Patient Harm or Death</td>
<td>SOC</td>
<td>3 yr Minimum</td>
<td></td>
<td></td>
<td>3. 120 days</td>
</tr>
<tr>
<td>II. Developing Pattern of Medication Errors</td>
<td>Risk of Recurrence</td>
<td>(A) No or Minimal Patient Harm or Low Risk of Harm</td>
<td>SOA/SOC</td>
<td>0-3 yrs</td>
<td>Cost Recovery $1000 per violation</td>
<td>1. 60 Contact hour course in Safe Medication Administration, including a minimum of 20 hours of theory and 40 hours of RN supervised medication administration</td>
<td>1. 90 days</td>
</tr>
<tr>
<td>2 to 5 Errors of the Following Type(s):</td>
<td>Likely Cause of Practitioner Error:</td>
<td>(B) Patient Harm or Risk</td>
<td>SOA/SOC</td>
<td>2-5 yrs</td>
<td></td>
<td></td>
<td>2. 90 days</td>
</tr>
<tr>
<td>• Missed dose(s)</td>
<td>- Failure to follow 6 &quot;rights&quot; for safe medication administration</td>
<td>(C) Severe Patient Harm or Death</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. 120 days</td>
</tr>
<tr>
<td>• Wrong time</td>
<td>- Lack of time</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Description of Violation</td>
<td>Aggravating &amp; Mitigating Factors</td>
<td>Harm (Tier)</td>
<td>Charge</td>
<td>Duration Of Sanction</td>
<td>Cost Recovery or Fine</td>
<td>Conditions</td>
<td>Time For Completion</td>
</tr>
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</tr>
<tr>
<td>III. Established Pattern Of Medication Errors</td>
<td>Risk of Recurrence</td>
<td>(A) No or Minimal Patient Harm or Low Risk of Harm</td>
<td>SOA/SOC</td>
<td>0-3 yrs</td>
<td>Fine $1000 per violation</td>
<td>1. 60 Contact hour course in Safe Medication Administration, including minimum of 20 hours of theory and 40 hours of RN supervised medication administration</td>
<td>1. 90 days</td>
</tr>
<tr>
<td>6 or More Errors of the Following Type(s):</td>
<td>Likely Cause of Practitioner Error:</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>- Failure to Follow 6 “rights” for safe medication administration</td>
<td></td>
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<tr>
<td></td>
<td>- Lack of time management skill &amp; organizational ability</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Consider individual practice responsibility and system influence and nurse’s demonstration of experiential learning</td>
<td></td>
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<tr>
<td></td>
<td>See appendix for More aggravating &amp; mitigating factors</td>
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</tr>
<tr>
<td></td>
<td>(B) Patient Harm or Risk of Severe Patient Harm</td>
<td>SOA/SOC</td>
<td>2-5 yrs</td>
<td>2. Obtain passing score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(C) Severe Harm or Death</td>
<td>SOC</td>
<td>3 yr Minimum</td>
<td>3. Submit course evaluation for approval</td>
<td></td>
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<td></td>
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<td></td>
<td>4. Current &amp; future employer notification &amp; reports</td>
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<td></td>
<td>5. Worksite monitor to provide additional 40-120 hours supervision of medication administration (If licensee is an LPN, an LPN may provide supervision)</td>
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<td></td>
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<td></td>
<td>6. 6 Contact hour course in time management at RCM discretion</td>
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<td>7. Request Modification 8. JP Module</td>
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<td></td>
<td>7. 12 months</td>
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<td>6. RCM discretion</td>
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<td>6-9 months</td>
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<td>5. 90 days</td>
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<td></td>
<td>4. Quarterly unless modified</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td>3. 120 days</td>
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<td>2. 90 days</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>1. 90 days</td>
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</tr>
</tbody>
</table>

- Wrong frequency
- Wrong IV rate-wrong dose
- Wrong patient
- Wrong route

Consider individual practice responsibility and system influence and nurse’s demonstration of experiential learning

See appendix for More aggravating & mitigating factors
<table>
<thead>
<tr>
<th>Description of Violation</th>
<th>Aggravating &amp; Mitigating Factors</th>
<th>Harm (Tier)</th>
<th>Charge</th>
<th>Duration Of Sanction</th>
<th>Cost Recovery or Fine</th>
<th>Conditions</th>
<th>Time For Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IV. Pattern of Medication Errors</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>2 or More Errors of the Following Type(s):</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Wrong IV rate delivering wrong dose of medication</td>
<td>Risk of Recurrence</td>
<td>(A) - No or Minimal Patient Harm or Low Risk of Harm</td>
<td>SOA/SOC</td>
<td>0-3 yrs</td>
<td></td>
<td>1. 60 Contact hour course in Safe Medication Administration, including a minimum of 20 hours of theory and 40 hours of RN supervised medication administration</td>
<td>1. 90 days</td>
</tr>
<tr>
<td>• Wrong concentration or dosage of medication delivered IV</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>• Wrong route</td>
<td></td>
<td>(B) - Patient Harm or Risk of Severe Patient Harm</td>
<td>SOA/SOC</td>
<td>2-5 yrs</td>
<td>Fine $1000 per violation</td>
<td>2. Obtain a passing score</td>
<td>2. 90 days</td>
</tr>
<tr>
<td>• Wrong medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Wrong dose</td>
<td></td>
<td>(C) - Severe Harm or Death</td>
<td>SOC</td>
<td>3 yr Minimum</td>
<td></td>
<td>3. Submit course evaluation</td>
<td>3. 120 days</td>
</tr>
<tr>
<td>• Wrong patient</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>• Wrong time</td>
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<tr>
<td>Consider individual practice responsibility and system influence</td>
<td></td>
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<tr>
<td>Consider nurse’s demonstration of experiential learning</td>
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<tr>
<td><strong>Duration For Completion</strong></td>
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<td></td>
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</tr>
<tr>
<td>1.</td>
<td>90 days</td>
<td></td>
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<tr>
<td>2.</td>
<td>90 days</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3.</td>
<td>120 days</td>
<td></td>
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</tr>
<tr>
<td>4.</td>
<td>Quarterly unless modified</td>
<td></td>
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<tr>
<td>5.</td>
<td>Unless modified</td>
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<tr>
<td>6.</td>
<td>Unless modified</td>
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<tr>
<td>7.</td>
<td>6 to 9 months</td>
<td></td>
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<tr>
<td>8.</td>
<td>Unless modified</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
### Description of Violation

#### V. Single Significant Medication Error

<table>
<thead>
<tr>
<th>Type of Error</th>
<th>Likelihood of Recurrence</th>
<th>Harm (Tier)</th>
<th>Charge</th>
<th>Duration Of Sanction</th>
<th>Cost Recovery or Fine</th>
<th>Conditions</th>
<th>Time For Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrong concentration or dosage of medication delivered IV</td>
<td>No or Minimal Patient Harm or Low Risk of Harm</td>
<td>SOA/SOC</td>
<td>0-3 yrs</td>
<td>Fine $1000 Per violation</td>
<td>1. 60 Contact hour course in Safe Medication Administration, including a minimum of 20 hours of theory and 40 hours of RN supervised medication administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrong route</td>
<td>Practitioner Error</td>
<td>SOA/SOC</td>
<td>2-5 yrs</td>
<td></td>
<td>2. Obtain a passing score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrong medication</td>
<td>Medication with similar name or packaging</td>
<td></td>
<td></td>
<td></td>
<td>3. Submit course evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrong dose</td>
<td>Medication not commonly used</td>
<td></td>
<td></td>
<td></td>
<td>4. Worksite monitor to provide additional 20 -60 hours supervision of medication administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrong patient</td>
<td>Patient allergic</td>
<td></td>
<td></td>
<td></td>
<td>5. Worksite monitor to provide additional 20 -60 hours supervision of medication administration (If licensee is an LPN, an LPN may provide supervision)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrong time</td>
<td>Missed/Mistaken Physician Order</td>
<td></td>
<td></td>
<td></td>
<td>6. Current and future employer notification, worksite monitor, employer reports quarterly</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Practitioner lacked adequate knowledge or competence for administering medication
- Medication required testing to ensure proper therapeutic levels
- Inadequate or inaccurate patient assessment
- Inappropriate clinical judgment

- 1. 90 days
- 2. 90 days
- 3. 120 days
- 4. 120-150 days
- 5. Until supervised med admin complete

- 6. Quarterly unless modified
- 7. Duration
**Sanction Standards for RN and LPN**

**Failure to Comply with the Condition of an Order**

<table>
<thead>
<tr>
<th>Description of Violation</th>
<th>Aggravating &amp; Mitigating Factors</th>
<th>Harm (Tier)</th>
<th>Charge</th>
<th>Duration Of Sanction</th>
<th>New Fine</th>
<th>Conditions</th>
<th>Time For Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Failure To Comply With Any Term(s) Or Condition(s) Of One STID or Order</td>
<td>N/A</td>
<td>N/A</td>
<td>SOC</td>
<td>Suspension (2 yr min)</td>
<td>$1000 per violation</td>
<td>1. JP Module prior to reinstatement</td>
<td>8—12-24 months</td>
</tr>
<tr>
<td>II. Failure to Comply With Any Substantive Term(s) Or Condition(s) Any One STID or Order</td>
<td>N/A</td>
<td>N/A</td>
<td>SOC</td>
<td>Indefinite Suspension Until Compliance</td>
<td></td>
<td>1. Complete all conditions in original STID 2. JP Module prior to reinstatement</td>
<td></td>
</tr>
<tr>
<td>III. Failure to Comply with a prior order or STID. (Cost Recover or Fine)</td>
<td>N/A</td>
<td>N/A</td>
<td>Refer to Collections</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SUBSTANCE USE ORDERS/WHPS**
<table>
<thead>
<tr>
<th>Unprofessional conduct with a finding that the nurse misused drugs or alcohol or other finding substantiating a SUD</th>
<th>Nurse declines to enter/re-enter the WHPS program</th>
<th>SOC</th>
<th>Indefinite suspension</th>
<th>1. Minimum 12 consecutive months of abstinence documented by random observed drug testing, to include ETG/ETS (12 per year) by an independent, licensed testing entity prior to any petition for reinstatement 2. JP Module prior to reinstatement</th>
</tr>
</thead>
</table>
| Failure to Comply with any term(s) or conditions (s) of a Monitoring Contract or STID into WHPS  
A. Not practice related  
B. Impaired practice | | A. No charges  
B. SOC | B. Order into WHPS | A. Continued participation in WHPS with additional conditions set by WHPS  
B. Order |
| II. Failure to Comply with any substantive term(s) or condition(s) of any STID or Order into WHPS | A. Unsafe to practice with reasonable skill and safety | SOC | Indefinite suspension | 1. Minimum 12 consecutive months of abstinence documented by random observed drug testing, to include ETG/ETS (12 per year) by an independent, licensed testing entity. 2. Completion of chemical dependency treatment. 3. Participation in recovery support meetings. 2. JP Module prior to reinstatement |

**Sanction Standards for RN and LPN**  
**Practice on an Expired License**
<table>
<thead>
<tr>
<th>Description of Violation</th>
<th>Aggravating &amp; Mitigating Factors</th>
<th>Harm (Tier)</th>
<th>Charge</th>
<th>Duration Of Sanction</th>
<th>New Fine</th>
<th>Conditions</th>
<th>Time For Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Practice on an expired license from 6 to 12 months</td>
<td></td>
<td>N/A</td>
<td>Notice of Correction</td>
<td></td>
<td>None</td>
<td></td>
<td>1.60 days</td>
</tr>
<tr>
<td>II. Practice on an expired license from 1 to 3 years</td>
<td>Extenuating circumstances</td>
<td>N/A</td>
<td>Notice of Correction</td>
<td></td>
<td>None</td>
<td></td>
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</tr>
<tr>
<td>III. Practice on an expired license from 1 to 3 years</td>
<td>No extenuating circumstances involved</td>
<td>SOA</td>
<td>1–3 years</td>
<td>Cost recovery</td>
<td>1. Minimum of 3 hours education on the Nursing WAC 246-840 or UDA 18.130</td>
<td></td>
<td>1.60 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Minimum 6 hours education on Time Management</td>
<td></td>
<td>2.60 days</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. Minimum 6 hours education on Ethics</td>
<td></td>
<td>3.60 days</td>
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<td></td>
<td>4. JP Module</td>
<td></td>
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</tr>
<tr>
<td>IV. Practice on an expired license for over 3 years</td>
<td></td>
<td>N/A</td>
<td>SOC</td>
<td>1-3 years</td>
<td>$1000 per year</td>
<td>1. Minimum of 3 hours education on the Nursing WAC 246-840 or UDA 18.130</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>2. Minimum 6 hours education on Time Management</td>
<td></td>
<td>2.60 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. Minimum 6 hours education on Ethics</td>
<td></td>
<td>3.60 days</td>
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<td>4. May waive the clinical portion of the refresher course per WAC 246-840-130(3)(d) and (h)</td>
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<td>5. JP Module</td>
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</tbody>
</table>
### Sanction Standards for RN and LPN

**Failure to Complete Continuing Education**

<table>
<thead>
<tr>
<th>Description of Violation</th>
<th>Aggravating &amp; Mitigating Factors</th>
<th>Harm (Tier)</th>
<th>Charge</th>
<th>Duration Of Sanction</th>
<th>New Fine</th>
<th>Conditions</th>
<th>Time For Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuing Competency requirements not completed</td>
<td>All options to fulfill continuing competence requirements have not been fulfilled.</td>
<td>N/A</td>
<td>SOC</td>
<td>Indefinite</td>
<td>$5,000</td>
<td>1. License suspended (with Limited Education Authorization) until refresher course is completed satisfactorily 2. JP Module</td>
<td>1. 9 months</td>
</tr>
</tbody>
</table>

Reference:

Individual practice responsibility may include factors such as knowledge, competence, judgment, thoroughness.

System contributions & issues may include level of orientation and education provided; policies, procedures and systems in place including prescribing, order communication; product labeling, packaging and nomenclature; compounding; dispensing; distribution; administration, education; monitoring; and use.
The Legislative Process in Washington State

Gail S. Yu, AAG
January 2020
The Washington State Legislative Process Learning Goals

- Learn how to use the legislature’s website: www.leg.wa.gov
- Understand the legislative process
- Review how budget and policy proposals advance
- Discuss “lobbying” and the parameters of the health profession board/commission exemption
Overview of the Legislature

- Washington’s legislature is comprised of the state Senate and the House of Representatives
- There are 49 state legislative districts
- Each district has 1 state senator (4-year term) and 2 state representatives (2-year term)
- The legislature convenes in Olympia on the second Monday of January and is in session for 105 days during odd years (2019) and 60 days during even years (2020)
- A session may go long if the Governor calls an “extraordinary session” (usually for the budget)
- The period between legislative sessions is called the “interim”
How to use the Washington State Legislature website

Go to www.leg.wa.gov and use either the left sidebar or center section to:

- Find your District and Legislators
- Look up Laws and Rules
- Get Bill Information (either the status of current bills or from past sessions)
- Contact your Legislators
- Get information to be able to attend committee hearings or watch hearings on video
- And much more!
How to find your District Legislators

Go to www.leg.wa.gov and use Find Your District on the sidebar or center section

- For your Legislative (state) or Congressional (federal) districts
- By entering your address or
- Clicking on the map
How to get Bill Information

If you know the bill number, use Search by Bill Number (if searching for a bill from a past session, use the pull-down to change the biennium years).

You can also search for:

- Initiatives
- Prefiled bills (available in December)
- Newly introduced bills in either house once the session has begun
- Committee reports
- Activity reports
- And much more!
HOW A BILL BECOMES A LAW

To become law, a bill must pass out of committee and each house before the agreed-upon “cutoff” dates (2020 is a “short session”)

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 14, 2019</td>
<td>First Day of Session</td>
</tr>
<tr>
<td>February 22, 2019</td>
<td>Last day to read in committee reports (pass bills out of committee and read them into the record on the floor) in house of origin, except House fiscal committees and Senate Ways &amp; Means and Transportation committees.</td>
</tr>
<tr>
<td>March 1, 2019</td>
<td>Last day to read in committee reports (pass bills out of committee and read them into the record on the floor) from House fiscal committees and Senate Ways &amp; Means and Transportation committees in house of origin.</td>
</tr>
<tr>
<td>March 13, 2019</td>
<td>Last day to consider (pass) bills in house of origin (5 p.m.).</td>
</tr>
<tr>
<td>April 3, 2019</td>
<td>Last day to read in committee reports (pass bills out of committee and read them into the record on the floor) from opposite house, except House fiscal committees and Senate Ways &amp; Means and Transportation committees.</td>
</tr>
<tr>
<td>April 9, 2019</td>
<td>Last day to read in opposite house committee reports (pass bills out of committee and read them into the record on the floor) from House fiscal committees and Senate Ways &amp; Means and Transportation committees.</td>
</tr>
<tr>
<td>April 17, 2019*</td>
<td>Last day to consider (pass) opposite house bills (5 p.m.) (except initiatives and alternatives to initiatives, budgets and matters necessary to implement budgets, differences between the houses, and matters incident to the interim and closing of the session).</td>
</tr>
<tr>
<td>April 28, 2019</td>
<td>Last day allowed for regular session under state constitution.</td>
</tr>
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</table>

* After the 94th day, only initiatives, alternatives to initiatives, budgets and matters necessary to implement budgets, matters that affect state revenue, messages pertaining to amendments, differences between the houses, and matters incident to the interim and closing of the session may be considered.
How to check Bill status

Use Search by Bill Number

- “Bill Status-at-a-Glance” tells you where your bill is in the process
- “Bill History” shows progress and dates
- “Available Documents” provides the bill itself and staff-produced summaries of the content of the bill and testimony
- “Available Videos” has links to videos of committee hearings on bills
What is a “fiscal note”? 

A fiscal note is an estimate of the financial impact of a legislative bill.

The Legislature, agencies, and the Office of Financial Management (OFM) prepare fiscal analyses, estimating whether the bill will: have no fiscal impact; cost is non-zero but indeterminate; cost < or > $50,000; agency can absorb the cost; have other funding; or an appropriation from the Legislature is required. (An appropriation is required even though health profession costs are paid by licensees per RCW 43.70.250.)

Here’s an example from SB 5380—
The steps in the legislative process ("First House")

Once a member of the House or Senate introduces a bill, the bill must make it through all the steps in the chamber in which it was introduced (the "first house") and then it must go to the other chamber (or "second house") and go through the same steps there within the "cut-off" dates. (SB 5380’s partial history shown).

Prefiling of the bill occurs in December for introduction when the Legislature opens. Introduction, or First Reading the bill is introduced in its house of origin and referred to committee, usually for the bill’s subject matter, e.g., Health & LT Care.

Committee Action Committees hold work sessions, public hearings, and executive sessions. If the bill doesn’t get scheduled for hearing and reported out to the whole chamber, it dies. It can get a “do pass,” “do pass as amended,” or “do pass substitute.” Staff prepares the “bill report.” Prevailing members sign a “majority” report and those who disagree sign a “minority” report.

Rules Committee The floor of the chamber must then pass the bill to the Rules Committee composed of members of both parties. The bill must also undergo a Second Reading and Third Reading before going on to the next chamber.

### Bill History

**2019 REGULAR SESSION**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 18</td>
<td>First reading, referred to Health &amp; Long Term Care. (View Original Bill)</td>
</tr>
<tr>
<td>Jan 25</td>
<td>Public hearing in the Senate Committee on Health &amp; Long Term Care at 8:00 AM. (Committee Materials)</td>
</tr>
<tr>
<td>Feb 8</td>
<td>Executive action taken in the Senate Committee on Health &amp; Long Term Care at 8:00 AM. (Committee Materials)</td>
</tr>
<tr>
<td></td>
<td>HLTC - Majority: 1st substitute bill be substituted, do pass. (View 1st Substitute) (Majority Report)</td>
</tr>
<tr>
<td></td>
<td>And refer to Ways &amp; Means.</td>
</tr>
<tr>
<td>Feb 11</td>
<td>Referred to Ways &amp; Means.</td>
</tr>
<tr>
<td>Feb 19</td>
<td>Public hearing in the Senate Committee on Ways &amp; Means at 3:30 PM.</td>
</tr>
<tr>
<td></td>
<td>(Committee Materials)</td>
</tr>
<tr>
<td>Feb 26</td>
<td>Executive action taken in the Senate Committee on Ways &amp; Means at 1:30 PM. (Committee Materials)</td>
</tr>
<tr>
<td></td>
<td>WM - Majority: do pass 1st substitute bill proposed by Health &amp; Long Term Care. (Majority Report)</td>
</tr>
<tr>
<td>Feb 28</td>
<td>Passed to Rules Committee for second reading.</td>
</tr>
<tr>
<td>Mar 5</td>
<td>Placed on second reading by Rules Committee.</td>
</tr>
<tr>
<td>Mar 7</td>
<td>1st substitute bill substituted (HLTC 19). (View 1st Substitute)</td>
</tr>
<tr>
<td></td>
<td>Rules suspended. Placed on Third Reading.</td>
</tr>
<tr>
<td></td>
<td>Third reading, passed; yeas, 47; nays, 0; absent, 1;-excused, 1. (View Roll Calls)</td>
</tr>
</tbody>
</table>
Next steps (“Second House,” Concurrence, Governor’s actions)

The bill must go through the same processes in the other chamber (“second house”).

**Concurrence, Dispute, and Conference Committees** If the bill has been amended by the second house, the first house must decide whether it concurs. If the two houses cannot resolve their differences, one of them can ask for a conference committee. Both houses must adopt the conference committee report for the bill to pass the Legislature.

**Enrolling** Once a bill has finally passed the Legislature, it is enrolled. The bill is signed by the Speaker of the House, the Chief Clerk of the House, the President of the Senate, and is sent to the Governor for action.

**Governor’s actions** The Governor may sign the bill or veto all or part of it. (The Legislature may vote to override). If the Governor does not act after a certain number of days, the bill passes as if signed. (SB 5380’s partial history shown).

**Carryover** If not passed in the long session, a bill can be reintroduced (at its present position) in the short session.
The Washington State Budget Process

- Washington State has 3 budgets:
  - Operating Budget – includes funding for services (such as agencies)
  - Capital Budget – includes funding for infrastructure
  - Transportation Budget – includes funding for transportation projects

- The state’s budget is on a biennial (two-year) cycle (2019-2021)
  - New budgets are developed during odd years (2019)
  - Supplemental budgets are developed during even years (2020)

- The Governor, House, and Senate each propose their own budgets.

- Each budget goes through the legislative process. A final, compromise budget must be passed by the House of Representatives and Senate, and signed into law by the Governor.

Budget information is available here: http://leap.leg.wa.gov/leap/budget/index_lbnls.asp
Lobbying

RCW 42.17A.005 Definitions

- (33) "Lobby" and "lobbying" each mean attempting to influence the passage or defeat of any legislation by the legislature of the state of Washington, or the adoption or rejection of any rule, standard, rate, or other legislative enactment of any state agency under the state administrative procedure act, chapter 34.05 RCW. Neither "lobby" nor "lobbying" includes an association's or other organization's act of communicating with the members of that association or organization.

- (34) "Lobbyist" includes any person who lobbies either on the person's own or another's behalf.

- (35) "Lobbyist's employer" means the person or persons by whom a lobbyist is employed and all persons by whom the lobbyist is compensated for acting as a lobbyist.

- Lobbying reports must be submitted monthly. RCW 42.17A.615.

RCW 18.79.410 Commission—Information to legislature.

- In addition to the authority provided in RCW 42.52.804, the commission, its members, or staff as directed by the commission, may communicate, present information requested, volunteer information, testify before legislative committees, and educate the legislature, as the commission may from time to time see fit.

RCW 42.52.804 Exemption—Health profession board or commission—Professional opinions.

- Members of a health profession board or commission as identified in RCW 18.130.040(2)(b) may express their professional opinions to an elected official about the work of the board or commission on which the member serves, even if those opinions differ from the department of health's official position. Such communication shall be to inform the elected official and not to lobby in support or opposition to any initiative to the legislature.
Questions?

www.leg.wa.gov
The National Apprenticeship Act (29 U.S.C. 50) was initially passed amid the Great Depression (1937) to develop standards and establish regulatory oversight of apprenticeship programs. The current resurgence of interest in apprenticeship programs emerged and was initially championed by the Obama administration in response to our most recent economic downturn between 2008-2012. In his 2014 state of the union address, former President Obama called for “more on-the-job training, and more apprenticeships that set a young worker on an upward trajectory for life. It means connecting companies to community colleges that can help design training to fit their specific needs” (Obama, 2014).

Basic principles of apprenticeships as work-based training programs include 1) apprentices being employed and salaried by the sponsoring employer during their training; 2) on-the-job skill development and job-related classroom instruction; 3) supervision of traineeship provided by sponsoring employer staff; and 4) the apprenticeship culminates with some type of credential that is essentially comparable to more traditional educational pathways. Current federal standards specify a minimum of 2,000 hours of on-the-job training as well as at least 144 hours of didactic, in-class instruction.

The Department of Labor subsequently launched Apprenticeship USA and received $90 million to promote the further expansion and registration of apprenticeship programs including providing State Accelerator Grants to develop state specific strategic plans and apprenticeship partnerships. http://apprenticeship-usa.com/. With federal DOL funding becoming available, many states have pursued grants to promote and expand apprenticeship programs in traditional trades of construction and manufacturing, as well as into new areas of healthcare and information technology.

**Washington State Apprenticeship and Training Council (WSATC)**

In Washington State, registered apprenticeship programs are reviewed, approved, and monitored by the Washington State Apprenticeship and Training Council, https://lni.wa.gov/licensing-permits/apprenticeship/wsutc and guided by the Washington Apprenticeship Act, RCW 49.04 (https://lni.wa.gov/licensing-permits/apprenticeship/_docs/Chapter4904RCWeffjuly2011.pdf) and Rules, WAC 296.05
As of April 2019, there were 180 occupations participating in Washington State Registered Apprenticeship Programs with the vast majority representing construction and other traditional trades. Among the top 25 apprenticeship occupations, the only one related to healthcare is the Medical Assistant (MA) program which was approved in 2014 in order to help community health centers assure an adequate MA workforce. (WSATC, 2019). Currently active health related apprenticeship programs include Medical and Dental Assistant pathways through the Washington Association for Community Health and Medical Assistant and Central Sterile Processing through the Healthcare Apprenticeship Consortium. The WSATC roster of all apprenticeship programs lists additional health related pathways that have been approved but are currently cancelled or inactive including one for Nursing Assistants as well as Physical Therapy Aides/Assistants, Paramedics, EMTs, Nursing Home Administrators, and a variety of technician pathways in a range of specialty practice including Respiratory Therapy, Pulmonary Lab, Urology, Pharmacy, School and Home Health.

In 2011, WSATC published a document titled, *Apprenticeships in the Healthcare Industry* (Mauldin) outlining opportunities and potential barriers to implementation of apprenticeship programs in healthcare occupations, several of which remain as challenges today. Among the most salient include the perception among some that the term “apprenticeship” is something applicable “for blue collar trades in construction and manufacturing” (Mauldin, 2011, pg. 28). In addition, the current structures for licensing, certification, and regulation of health professions vary from state to state and would require thoughtful collaboration with such entities as the WSATC which currently serves as the sole approval and monitoring agency. This document may be found at [https://www.apprenticeship.gov/apprenticeship-industries/healthcare](https://www.apprenticeship.gov/apprenticeship-industries/healthcare).

**SB 5236 Encouraging Apprenticeships**

During the 2019 regular legislative session, Senate Bill 5236 *Encouraging Apprenticeships* was introduced to amend RCW 28B.77.230 and add a new section to RCW 49.04. SB 5236 essentially proposes two initiatives. The first is to add a new section establishing an apprenticeship coordinator position to reach out specifically to public education and healthcare to encourage and assist in establishing registered apprenticeship programs in these occupational domains. The second is an amendment mandating a collaborative effort to address
policies and procedures to support “academic credit for prior learning”. Mandated collaborators for this amendment would include the Washington State Apprenticeship and Training Council (WSATC), the State Board for Community and Technical Colleges (SBCTC), the Council of Presidents (COP), Independent Colleges of Washington (ICW), private career schools in the state as well as 2 representatives each from business, labor, licensed healthcare professions, and 1 representative from Lieutenant Governor’s Office.

Although this legislation did not receive final action, it was monitored by the NCQAC Legislative Panel and is expected to be reintroduced in 2020. The Washington Center for Nursing (WCN) responded proactively by subcontracting the development of a document examining apprenticeship programs in healthcare which was presented to NCQAC in March 2019 (Trehearne, Bear, & Kuebel, 2019). NCQAC delegated follow-up on this matter to the executive team and a meeting was convened by WCN in July 2019 with representation from NCQAC, WCN, and WSNA. The essence of that discussion was shared at the November 2019 business meeting (NCQAC, 2019). Based on that discussion, NCQAC subsequently delegated to the Legislative Panel to consider and provide an updated summary for the January 2020 meeting.

**Healthcare Apprenticeship Programs – Current Examples**

Despite limited expansion of the apprenticeship model more broadly into the health professions, as Federal funding has become available, examples of such apprenticeships are beginning to emerge. Most notably these have been in the area of nursing assistants, transition to practice residency programs for new nurses, externships for nursing students, and to some extent, nursing career pathways such as LPN to RN and RN to BSN. Most have received federal Department of Labor funds although not all have been formally recognized as a “Registered Apprenticeship Program” through either state or federal apprenticeship oversight.

On November 13, 2018, NCSBN hosted an Education Consultants webinar focusing specifically on emerging apprenticeship models in healthcare (Spector, 2018). Several examples were presented, and additional programs identified for exploration. Representatives from the Wyoming BON and the Department of Aging presented their nursing assistant apprenticeship program sponsored by 3 long term care state facilities and using a standardized curriculum. Representatives from Kentucky briefly described their nurse externship model that they
describe as being complementary to formal nursing education programs. This program was initially championed by Norton Health with federal funds for junior level BSN and second semester Associate Degree nursing students to work and be paid essentially as nurse technicians during their summer breaks. It became the first state and nationally registered nurse apprenticeship program (Murray, 2019). Fairview Health Services, a Minnesota based healthcare system also received significant Department of Labor funding to support “apprenticeship” programs including tuition support for employees to complete their RN-to-BSN pathway in collaboration with 24 local colleges and universities in their state. Yale New-Haven Hospital has been recognized for its Nurse Residency Apprenticeship program that was DOL funded and now both state and federally registered as a formal apprenticeship program. Since apprenticeship programs are employer-initiated programs, the notion of conceptualizing transition to practice residency programs for nurses seems like a promising endeavor given that new nurses are already licensed thus avoiding the licensing/regulatory requirements of pre-licensure apprenticeship models. In addition to new RN residency options, the National Nurse Practitioner Residency and Fellowship Training Consortium (NNPRFT) provides standards and accreditation for nurse practitioner transition to practice across the nation including 9 programs functioning in Washington State, (https://www.nppostgradtraining.com/wp-content/uploads/2019/06/PNPTAN-map.pdf).

**Recommended Priorities**

Given the emerging interest in apprenticeship programs in healthcare, the following potential areas for expansion of such programs in Washington State are suggested based on increasing levels of licensing and regulatory challenges:

1. **Transition to Practice/RN and ARNP Residency Programs:** Programs such as the one at Yale New Haven Hospital and those recognized by NNPRFT could be further replicated in Washington State with few barriers to implementation since the “apprentices” would already be licensed practitioners.

2. **Nurse Externship/Nurse Technician Programs:** Since Washington State already recognizes, and registers Nurse Technicians as defined in WAC 246-840-101 and 246-840-840, the option for employers to consider seeking funding and approval for Nurse Technicians as part of a registered apprenticeship program appears viable. Although the noted WACs currently limit the Nurse Technician role to RN
students, RCW 18.79.340 does not specifically outline this limitation:

https://app.leg.wa.gov/rcw/default.aspx?cite=18.79.340 and NCQAC may want to consider taking steps to modify the WACs to include LPN students as well.

3. **Nursing Assistant Training Programs**: Given the existing examples of Nursing Assistant (NA) apprenticeship programs and the current LTC Proviso initiative seeking to standardize CNA curricula, this may be another potential apprenticeship opportunity. Consulting with the Wyoming BON and reviewing their standardized curriculum should be considered. Analyzing options for CNA career advancement should be also be explored. For example, additional education and training through apprenticeship pathways for NA advancement might allow for a broader scope of practice under nurse delegation similar to the Oregon’s Model of CNA1 and CNA2 designations.

Further inquiry with the Department of Labor and Industries (L&I) and other agencies responsible for oversight of CNAs and/or their education and training is important; these agencies include the following, all of which are involved in the LTC Workforce Development initiative: the DOH Credentialing Department, the Department of Social and Health Services (DSHS), the Workforce Education and Training Coordinating Board (WTB), the State Board of Community and Technical Colleges (SBCTC), and the Office of the Superintendent of Public Instruction (OSPI).

4. **Pre-Licensure Nursing Education Programs**: Given national accreditation and state approval processes, considering apprenticeship models for pre-licensure nursing programs would be far more challenging and complex at this point and would not be recommended for any initial apprenticeship initiatives.
References

Jopson AD, Skillman SM, Frogner BK. Use of Apprenticeship to Meet Demand for Medical Assistants in the U.S. Center for Health Workforce Studies, University of Washington, Sep 2019.


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WSATC (April 2019). WSATC First Quarter 2019 Report, Retrieved December 11, 2019 from:

https://www.lni.wa.gov/licensing-permits/apprenticeship/_docs/April2019.pdf