Nursing Care Quality Assurance Commission (NCQAC)
Meeting Agenda
September 11, 2020
8:30 AM- 5:00 PM
111 Israel Road SE | Tumwater, WA 98501
Town Center 2 Room 530

To attend via webinar, please register for the meeting at:
https://attendee.gotowebinar.com/register/3625605914971097613

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

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
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
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 September 4, 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 September 4, 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 January 8, 2021 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 – Jeannie Eylar, 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. July 10, 2020
      b. August 5, 2020
   2. Advanced Practice Sub-committee
      a. April 15, 2020
      b. June 17, 2020
      c. July 15, 2020
   3. Discipline Sub-committee
      a. June 16, 2020
III. Consent Agenda – DISCUSSION/ACTION, continued
   4. Consistent Standards of Practice Sub-committee
      a. June 2, 2020
   5. Research Sub-Committee
      a. June 15, 2020

B. Letter from NCSBN President Julia George, July 16, 2020

C. Performance Measures
   1. Legal
   2. Washington Health Professional Services (WHPS)
   3. Nursing Education
      a. Nursing Program Approval Panel (NPAP)
      b. Nursing Assistant Program Approval Panel (NAPAP)

D. July 2019 through June 2020 board pay summary

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. July 16, 2020
   2. August 6, 2020
   3. August 20, 2020
   4. September 3, 2020
   COVID-19 Emergency Meetings
   5. August 18, 2020

B. Nursing Assistant Program Approval Panel (NAPAP)
   1. July 16, 2020
   2. August 10, 2020
   COVID-19 Emergency Meetings
   3. July 8, 2020
   4. August 12, 2020

V. 9:00 AM – 9:30 AM Chair Report – Jeannie Eylar– DISCUSSION/ACTION
A. NCSBN annual meeting, August 12, 2020
   1. Election results
   2. Advanced Practice Compact

B. Sub-committee and panel meetings
   1. Review sub-committee or panel position description
   2. Review commission member expectations
   3. Call calendar: is all information for sub-committee/panel correct
VI. 9:30 AM – 10:15 AM Executive Director Report – Paula Meyer – DISCUSSION/ACTION

A. Budget Report – Adam Canary, Kathy Anderson
   1. Budget Status Report June 2020
   2. Budget Status Report June 2020 Narrative

B. Strategic Plan Update
   1. Communications
   2. WHPS
      a. NCQAC-WHPS position statement
   3. Academic Progression in Nursing/Licensed Practical Nurses
   4. Nursing Assistants

C. NCSBN multifactor authentication: Duo

D. COVID swabs: healthcare providers that can complete procedure

E. HELMS update

F. Virtual meetings, communication allowed and not allowed during a public meeting – Gail Yu

G. August 26 Long Term Care and Nursing Education Summit

10:15 AM – 10:30 AM Break

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

A. Advanced Practice – Dr. Laurie Soine, Chair
   1. Update on advanced practice compact motion at NCSBN Annual meeting

B. Consistent Standards of Practice – Tiffany Randich, Chair
   1. Administration of Cannabis/ Marijuana Products in School Settings:
      Kindergarten-Twelve (K-12) Grades, Public and Private Schools
      (July 13, 2019)- Revision

C. Discipline – Adam Canary, Chair
   1. Procedure W42 Drug and Alcohol Testing draft revisions

D. Licensing – Jeannie Eylar, Chair
   1. Continued competency: Discuss retired active population concern and rules hearing date of November 13, 2020
   2. Retired nurse requirements for vaccines
   3. Consideration of a joint meeting between the Licensing, Advanced Practice, and Consistent Standards of Practice Sub-committees to discuss the telemedicine collaborative
VII. Sub-committee Report – DISCUSSION/ACTION, continued
   E. Research – Dr. Mary Baroni, Chair
      1. Dr. Katie Haerling will give update on simulation research proposal to be
         submitted to Center for Regulatory Excellence October 2
      2. Membership updates

VIII. 11:30 AM – 12 Noon Education Report – Dr. Gerianne Babbo, Dr. Kathy Moisio -
       DISCUSSION/ACTION
       A. Nursing Education
          1. Nursing program fall guidance
          2. Nursing student clinical placements
          3. Action Now! publication
       B. Nursing Assistants
          1. Testing Update
          2. Other Covid-19 Impacts

12:00 PM – 1:00 PM Lunch

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 Apprenticeship in Nursing, Workforce Training and Education
    Coordinating Board Re-Imagine Grant – Mary Baroni, Kathy Moisio -
    DISCUSSION/ACTION
At the January 2020 meeting, the NCQAC adopted the briefing paper describing the use of
apprenticeship in nursing education for RN Nurse Techs and approved adding LPN students as
nurse techs to the rules. Working with the Workforce Training and Education Coordinating
Board (WFTECB), it was discovered that a federally funded grant was available, the Re-Imagine
Grant. Dr. Baroni and Dr. Moisio worked with the WFTECB staff to complete the application
and recognize a pathway for home care aides to nursing assistants to Licensed Practical Nurses
and have apprenticeship funds apply. The briefing paper adopted in January requires revisions to
recognize this work. At an emergency meeting, held on August 5, the NCQAC unanimously
passed this work. Dr. Baroni and Dr. Moisio present an update.

XI. 1:45 PM – 2:30 PM Emergency Rules, Waivers – Karl Hoehn
    DISCUSSION/ACTION
During the COVID 19 crisis, the NCQAC requested waivers, passed emergency rules and
continues to work on new systems for testing for nurses and nursing assistants. Mr. Hoehn
presents the updated rules and potential extension of the rules as needed. The
NCQAC may also ask if changes in the laws are needed.

2:30 PM – 2:45 PM BREAK
XII. 2:45 PM – 3:15 PM  Delegation Across Healthcare Settings - Paula Meyer - DISCUSSION/ACTION

RCW 18.79.260 describes Registered Nurse and Delegation of Tasks. WAC 246-840-010 (12) defines Delegation in two ways, one specific to Nurse Delegation in Community Based Care Settings. Ms. Meyer gives a brief history of the statute and rules on Nurse Delegation in Community Based Care Settings and some confusion related the practice of nursing assistants. For several years, stakeholders have worked on language to change this law. Ms. Meyer discusses potential language and work with stakeholders to address concerns.

XIII. 3:15 PM – 3:45 PM Memorandum of Understanding and Data Sharing Agreement regarding Balanced Billing – Catherine Woodard - DISCUSSION/ACTION

A recent statutory change required work on a Memorandum of Understanding among health care professions to address balanced billing. Ms. Woodard updates the NCQAC on the statement.

XIV. 3:45 PM – 4:00 PM Meeting Evaluation

XV. 4:00 PM Closing
July 16, 2020

Dear Colleagues,

I have missed seeing all of you since the Midyear Meeting. That seems so long ago! I hope you all have adjusted to our “new normal” and are able to enjoy the summer season.

Since that time, COVID-19 has certainly changed our universe. As you all know, NCSBN has cancelled all “in person” meetings through the summer and possibly longer. As a result, we had our first virtual Board of Director (BOD) meeting in May and we also met virtually earlier this week, July 13-14. I will report on our most recent BOD meeting and ask you to join us for the first virtual Delegate Assembly next month.

We began the BOD meeting in executive session, to discuss a peer-to-peer assessment of board members. This was the first year that the BOD has done a peer-to-peer assessment, so this opened a meaningful dialogue about how the BOD can capitalize on individual strengths and individual areas for improvement. If you’ve never done a peer-to-peer assessment, it can be rather intimidating. I mention this in my report only because I believe this is but one example of how your BOD pushes one another in continuous quality improvement, allowing us to function optimally in service to our membership.

As has been customary, we began our open BOD meeting with an environmental scan from BOD members and NCSBN staff. Themes/trends that were mentioned included: continued office closings throughout the U.S. and Canada, continued virtual board meetings and disciplinary proceedings, continued or extended regulatory waivers, significantly reduced state tax revenues and resulting budget cuts for state agencies. We received the government affairs update from Elliott Vice. Our Washington, D.C., office continues to actively engage stakeholders in issues of interest to NCSBN. Nothing political here, but to quote “Hamilton”— we are beginning to be sought after to be in “the room where it happens”! I mean this in the most positive way—we are regularly contacted by the White House, Centers for Medicare & Medicaid Services (CMS), Veterans Affairs and others.

We received and reviewed reports on the continued growth of Nursys e-Notify® and ORBS implementation. We also made appointments for fiscal year 2021 committee members and chairs. We heard an exciting report from Maryann Alexander and Brendan Martin about plans to expand the research agenda to add research studies related to COVID-19, for students, nurses and regulators. This will be important work undertaken to study the effects of regulatory changes and their impact on public protection. We also learned that the NCSBN International Research meeting has been postponed until March 23, 2021.

Finally, we reviewed and discussed plans for our virtual Delegate Assembly. NCSBN staff have done an enormous amount of work in planning for this meeting. It is overwhelming to think of all the details and nuances involved in planning for a virtual meeting of this size. Kudos to them and I look forward to “seeing” you in August! Please let me know if you have any questions about this report.

All my Best,

Julia George, MSN, RN, FRE
President
919.782.3211 ext. 250
Julie@ncbon.com

Letter from the President
Letter from the President
POST-BOARD MEETING UPDATE

September 11, 2020
NCQAC Business Meeting
Nursing Care Quality Assurance Commission (NCQAC)  
Advanced Practice Sub-committee Minutes  
April 15, 2020 7:00 pm to 8:00 pm

Committee Members:  
Laurie Soine, PhD, ARNP, Chair  
Donna Poole, MSN, ARNP, PMHCNS-BC  
Joanna Starratt, MSN, ARNP, CRNA (not able to attend)  
Kathleen Errico, PhD, ARNP, Pro Tem (not able to attend)  
Lindsey Frank, CD, OB-RNC, ARNP, CNM (not able to attend)

Staff:  
Mary Sue Gorski, PhD, RN, Director, Research and Advanced Practice  
Poppy J. Budrow, Administrative Assistant

7:17pm
Opening – Laurie Soine, Chair, called the meeting to order, led introductions, and read the public disclosure statement.

The subcommittee members recommended the minutes for January 15, 2020 and February 19, 2020, are submitted to the Nursing Commission for approval at the May 8 Nursing Commission meeting.

March 2020 joint CSPSC/APSC meeting was canceled due to pressing covid issues.

7:20
Old Business:

- Update – CMS Home Health and Medical Supplies Rules  
- Mary Sue spoke about the update to CMS Home Health and Medical Supply Health Care Authority (HCA) rule to meet the CMS requirement of a physician co-signature for all DME in the Home Health setting. New CMS permanent rules make this no longer necessary and CMS and HCA emergency rules are in effect until the permanent rules have been enacted.

- Update – Practice Hours Rules
  - Rules Hearing will be tomorrow (April 16, 2020) from 4-5pm. If the rules pass, there may be emergency rules going into effect which may mean a rapid implementation of these rules.

- COVID-19 Updates
  - The Nursing Commission and staff have been working on many emergency rules that will be in effect during the State of Emergency or 120 days. There are many rules regarding education and licensure and students finishing school. All of these are available on the DOH website for review.
New Business:

- None

Ending Items:

- Open Microphone is the portion of the meeting where members and public attendees are able to comment on topics discussed.
  - There is an important lesson to be learned from the Medicaid and Medicare Home Health rules. There was a large team effort that went into making it possible. Many national associations worked together including AANP. Clarification: NP, CNS, Physicians Assistants will be able to do home health certifications and orders. CMS also passed emergency actions. Hopefully the permanent rules will be in place by the end of the emergency situation. Just as a reminder that there are still some barriers to care that are not included in this bill such as ordering Diabetic Shoes.
  - There has been discussion regarding updating rules for Advanced Practice Registered Nurses. One individual suggested we should consider title protection for all four titles. The Washington State Health Care Authority posts jobs for CNS, but does not hire people who are Advanced Practice certified. What is and is not “advanced practice” title needs to be clarified. Using that title undermines the authority of those who are advanced educated and certified when someone can call themselves something they are not.

- The date of the next meeting will be June 17, 2020. The May meeting will be cancelled.
- The meeting was adjourned at 7:40pm
Nursing Care Quality Assurance Commission (NCQAC)
Advanced Practice Sub-committee Minutes
June 17, 2020 7:00 pm to 8:00 pm

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

Staff:
Mary Sue Gorski, PhD, RN, Research and Policy Analyst
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
   • Editorial correction of draft minutes for April 15, 2020 meeting under ‘Ending
     Items’. The minutes will be brought back at the next sub-committee meeting

III. Old Business
   • CMS Home Health and Medical Supplies Rules continues going through the process of
     transition from emergency waivers to rule.
   • Advisory Opinion titled “Naloxone prescribing clarification” was discussed and editorial
     changes were made in the document. The sub-committee recommended the revised draft
     be submitted at the July 10 business meeting for approval.
   • COVID-19 updates – emergency rules and waivers provide flexibility in the crisis but
     also sometime can conflict with current rules. See procedure below.

IV. New Business
   The procedure B 09.05 ARNP Application Exemption was revised and brought to the
   subcommittee for their input. The purpose of this procedure is to define the process for an
   advanced registered nurse practitioner (ARNP) applicant who requests an exemption of; the
   prescriptive authority requirements; or an applicant who requests an exemption of the
   educational preparation requirement; or who requests an exemption related to an emergency or
   permanent change in rules.

   Additions: 1) Exemption Request Due to Unintended and/or Unanticipated Consequences of Rule
   Changes. 2) In selected cases, an AP Panel will review and give recommendations. The AP Panel
   is made up of; at least one Advanced Practice NCQAC member; and at least one additional pro-
tem NCQAC member with expertise when possible in the practice area of the applicant; a staff attorney; and the Director of Advanced Practice.

- The sub-committee discussed and reviewed the procedure for any editorial changes and expressed support for the changes.

V. **Ending Items**
- Open Microphone No comments
- Date of Next Meeting – July 15, 2020
- Adjournment – 7:40 PM
Nursing Care Quality Assurance Commission (NCQAC)
Advanced Practice Sub-committee Minutes
July 15, 2020  7:00 pm to 8:00 pm

Sub-Committee Members Present:
Laurie Soine, PhD, ARNP, Chair
Donna Poole, MSN, ARNP, PMHCNS-BC
Kathleen Errico, PhD, ARNP, Pro Tem
Lindsey Frank, CD, OB-RNC, ARNP, CNM
Joanna Starratt, MSN, ARNP, CRNA
Megan Kilpatrick, ARNP-CNS, RN

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

I. 7:00 PM Opening – Donna Poole
Call to order
- Introduction
- Public Disclosure Statement
- Roll Call

II. Standing Agenda Items
- Announcements/Hot Topic/NCQAC Business Meeting Updates
  The subcommittee members discussed the workshop that took place during the
two-day business meeting. Data collected through licensure was presented and
was broken up by LPN’s, RN’s and ARNP’s.
- Welcome to our newest subcommittee member, Megan Kilpatrick.
- Review of Draft Minutes: June 17, 2020 reviewed with consensus to send the
draft minutes to the September 11 commission meeting for approval.

III. Old Business
- Update – Procedure B 09.05 ARNP Application Exemption Requests
  o Subcommittee reviewed the document that was slightly edited, with no
  recommendations for change.
  o AG Gail Yu made some editorial changes prior to the vote.

IV. New Business
- NCSBN Annual Meeting, delegate vote on AP compact language; proposed motion;
  The board of directors remove the amendment to require 2080 hours of practice prior to
issuing a multistate advanced practice license in the Advanced Practice Compact and
reconstitute a task force with members from multiple states with full authority advanced
practice.
  o Mary Sue and Donna discussed the proposed motion.
V. Ending Items

- Open Microphone
  - Angela Johnson- Is there an AP compact proposal in this state?
  - Donna- No there is not a proposed AP compact at this time the motion relates the proposed NCSBN model language that could affect it if we choose to move forward with an AP compact in the state. Washington state does have a proposal for an RN compact that has not passed the legislature. It does not affect the individual state RN or ARNP license.
  - Angela Johnson- Are they leaning toward the practice hours versus independent practice because more states have the requirements?
  - Donna- Many states that have passed the RN compact have practice hours requirements and this may be part of the reason they have proposed this. We think it is a step back for our state in terms of advanced practice nursing.

- Date of Next Meeting – August 19, 2020
- Adjournment – 7:59 PM
Nursing Care Quality Assurance Commission (NCQAC)
Discipline Sub-committee Minutes
June 16, 2020  3:30 pm to 5:15 pm

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United States: +1 (646) 749-3122
Access Code: 297-633-269

Committee Members:
Adam Canary, LPN, Chair
Lois Hoell, MS, MBA, RN
Sharon Ness, RN
Tiffany Randich, RN
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
Margaret Holm, JD, RN ad hoc
Lori Linenberger, WHPS

Public:
Katherine Ander, RN
I.  3:30 pm opening – Adam
   • Call to order – digital recording announcement
   • Roll call

II. May 19, 2020 Minutes – Adam
    o Approved.

III. Performance measures – Grant, Karl, John
    o Grant gave the highlights of the spreadsheet.
    o Lois noticed a big jump in cases opened between April and May. April was likely lower
due to COVID-19.
    o Teresa noted that CMT is opening more cases for a statement only.
    o Ms Ander asked Grant to elaborate on his strategy for improving performance measures.
      He explained the move to focus more on the cases before they get past the timelines while
whittling away at the backlog.
    o Cass noted the trending looks better. Now we’ll have new issues to cope with.
    o In Karl’s highlights, he noted it is an interesting time. Legal’s latest staff attorney started
      April 1st and they are beginning to feel the deluge from Investigations. They have also
been working on many COVID-19 issues that are not reflected in performance measures.
    o A staff attorney who had been on leave is also back to work. They had a dip in finalized
cases but Karl expects that measure to come up. Their case numbers will rise with the
investigative bolus.
    o John reported no unusual occurrences on the compliance report. Non-compliance usually
      involved alcohol or cannabis and use occurred on personal time.
    o Two nurses voluntarily withdrew from the program: one because of cancer, and the other
      because the nurse found the program no longer benefitted her. She had been in for five
years but quit her job to take care of her children. Lois asked and John answered that the
      nurse with cancer was working at the time she withdrew, but not the other nurse.
    o John added graduations to the report to look at positive outcomes. Will add anything else
      the commission finds useful.
    o Lois suggested WHPS put a blurb in the newsletter occasionally. At this time we’re not
      doing a newsletter. Cass said the pro-tems and the Communications Task Force are
working with WHPS on a communications plan. Their aim is to take away the stigma;
      must look at the legality of reporting certain information and privacy issues.

IV. Procedure review – Catherine, Grant
    • I.05.03 File Format for Evidence DRAFT
      o This procedure was updated to reflect current practices regarding the paperless
environment and moving the Medication Administration Discrepancy Documentation
(MADD) worksheet to an appendix as part of the report instead of embedded in the file as
evidence.
      o This is not a commission procedure but rather one Paula can sign. We presented it as an
FYI to the DSC.

V. Introduction to the complaint form (revisions) – Teresa
   o Lois had edits to this document so we agreed to table it until the next DSC meeting.

VI. Literature review – Catherine, John
American Society of Addiction Medicine: *Public Policy Statement on Physicians and Other Healthcare Professionals with Addiction*

- John brought this information to the commission in conjunction with the one-page position statement under review to look at concepts, language, and the underpinning of WHPS. This philosophical document focuses on stigma and impairment.
- The discussion touched on the difference between nurses’ and physicians’ programs and the fact that the physicians’ program is standardized across the country and is supported by a surcharge to their licensing fee. John pointed out that the physicians’ program is more research-based and uses more resources.
- Dawn wondered what works best? Have graduates analyzed the program? Dawn thinks their feedback might be worthwhile. John said there’s no feedback loop except for the program evaluation at the end.
- Cass pointed out that NCSBN, who makes recommendations for our programs, is universal. She also mentioned the movers and shakers at Citizens Advocacy Council for their view on SUD programs.
- John said we can’t look at a standard program across the board. Guidelines must be actively implemented. The philosophical underpinning of monitoring is a fairly standardized approach. The emphasis is on the clinical side like spokes in a wheel. Must collaborate with treatment providers.

### 2020 NSBN Midyear Meeting Presentation: *Outcomes of Substance Use Disorder (SUD) Monitoring Programs*

- Catherine presented the highlights of Richard Smiley’s research on SUD monitoring program findings. The most notable is recommending seven-day/week check-ins for best outcomes. Paula assigned Mary Sue Gorski’s research team to review this work and make recommendations for procedure implementation.

### Journal of Nursing Regulation: *Nurses with Substance Use Disorder: Promoting Successful Treatment and Reentry, 10 years Later*

- Catherine also presented highlights of this timely article. Lois reflected on how stigma still follows the nurse.

#### VII. Internal Control Review – Catherine

- Catherine explained the process that will begin in August in the WHPS program. It is similar to but not the same as an audit when done internally. Looking at processes and practice to identify and mitigate risk. The commission requested this of the WHPS program.

#### VIII. Strategic plan update: WHPS – John

- The one-page position statement should be ready by the September meeting. Cass is very excited to have two techy pro-tems working on the Communications Task Force to review this.
- John said the last couple of months have been tough for outreach. We have sent out a message that WHPS is here to help for the past several weeks in the GovDelivery message.
- Alicia is working through the channels to update documents. C4PA must approve.
- Grant has been reviewing drug court models and how we can adapt something similar to replace SUAT. This will get the commission members involved earlier on to make decisions about WHPS nurses who are non-compliant.

#### IX. Work plan – Adam

- Everything is on target.
X. Meeting evaluation – all
  - Lois: hearty discussion. Much to address, hard information.
  - Sharon: good questions and discussions. Looking at how to help nurses with SUD; surprised to see the number of nurses in the program are not up.
  - Tiffany: information-dense. Good discussion. WHPS is forward-moving.
  - Tracy: agrees with all. Good to talk even if we can’t see everyone. Concerned about long-term effects on nurses re: COVID-19. Hoping for a return to normal. Difficult for nurses and how will it impact SUD?
  - Dawn: enjoyed the meeting and the discussion. WHPS issues are interesting. Wonders if there are similar programs for police.
  - Cass: great. Loved the content. Progress re: WHPS is exciting. Thinks as a nation we should go to system-oriented health care for providers.
  - Barb: good meeting.
  - Helen: dense with information.
  - Teresa: a lot of information about WHPS. Loves the meetings. Compassionate and enthusiastic. Good to be concerned about health care workers.
  - John: has said enough. Appreciates the input and support.
  - Grant: Appreciates everyone’s time and commitment.
  - Karl: good meeting. Pleasure to work together.
  - Adam: went well. Drinking from a fire hydrant. Professional is best for the public.

XI. Closing
  - Meeting adjourned at 5:18 pm.
I. 12:00 PM Opening – Tiffany Randich
Call to order 12:00 p.m.
• Introduction – Tiffany Randich
• Public Disclosure Statement – Tiffany Randich
• Roll Call – Deborah Carlson

II. Standing Agenda Items
1. Announcements/Hot Topic/NCQAC Business Meeting Updates
   a. Public Member Edie Higby resigned from the commission.
   b. During the May Business Meeting, Jeannie Eylar was voted in as Chair of the commission, Mary Baroni as vice chair and Adam Canary as secretary treasurer.
   c. Telehealth FAQ’s during COVID-19 was approved on 5-8-2020 as well as the Supervised Injection Services Advisory Opinion. Discussed the upcoming Advisory Opinion Stakeholder Workshops coming up.
2. National Council State Boards of Nursing Knowledge Network updates
   a. Decided to take this agenda item of the agenda and once they resume with updates we will bring this back on the agenda.
3. Review of Draft Minutes: February 4, 2020 reviewed with consensus to send the draft to the July 10th 2020 commission meeting for approval.
4. CSPSC Work Plan Review
   a. Debbie gave an update on the work plan. The plan is to still have the joint CSPSC and APSC meeting for the Prevention and Treatment of Opioid-Related Overdoes FAQ Revision.

III. Old Business
1. Joint Advanced Practice Subcommittee and Consistent Standards of Practice Subcommittee Meeting Update and Discussion- On Hold during COVID-19 Emergency
2. Statement Reviews and Discussion- On Hold during COVID-19 Emergency
IV. New Business
   1. Registered Nurse and License Practical Nurse (FAQ) Revision Infusion Therapy
      a. Request to add the National Infusion Center Association (NICA) Minimum Standards for In-Office Infusion from NICA. They requested to add that to our current FAQ. It is a guidance document specific to the setting for in-office infusions.

Ending Items
1. Open Microphone (as time permits)
2. Review of Actions
3. Meeting Evaluation
   a. Debbie- Overall meeting was great besides losing connection.
   b. Tori- I am happy to be back to the commission.
   c. Sharon- Good meeting, a little quiet but we are right on track
   d. Ella- Good meeting, I appreciate the organization of the schedule and information that we needed to review.
   e. Tracy- I will echo Sharon, I think we are all doing the best we can with what we have.
   f. Tiffany- I agree I think it was a great meeting.
4. Date of Next Meeting – August 4, 2020
5. Adjournment – Adjourned at 12:35 p.m.
Nursing Care Quality Assurance Commission (NCQAC)  
Research Sub-committee Minutes  
June 15, 2020  5:00 pm to 6:00 pm

Committee Members:  
Mary Baroni, PhD, RN  
Jeannie Eylar, MSN, RN  
Lois Hoell, MS, MBA, RN  
Laurie Soine, PhD, ARNP

Staff:  
Debbie Carlson, MSN, RN, Director of Nursing Practice  
Mary Sue Gorski, PhD, RN, Research and Policy Analyst  
Tori Lane, Nursing Practice Administrative Assistant

I. 5:00 pm Opening – Mary Baroni, Chair  
Call to order  
• Introduction  
• Public Disclosure Statement  
• Roll Call

II. Standing Agenda Items  
• Announcements/Hot Topic/NCQAC Business Meeting Updates  
  o Subcommittee members discussed the virtual May Business Meeting and the success with virtual format. The results of the voting were announced and Jeannie Eylar is now the Chair of the Commission, Mary Baroni is Vice Chair and Adam Canary is Secretary Treasurer.  
  o Draft Minutes for the January 20 and March 16, 2020 subcommittee meetings were reviewed with consensus to send the draft minutes to the July 10 commission meeting for approval.

III. Old Business  
• Discussed possible membership changes due to changes in the Commission membership.  
• Data use procedure  
  o Mary Sue gave background on the latest draft of the data use procedure for input from the subcommittee for review.

IV. New Business  
• Simulation Proposal – Dr. Katie Haerling (UW Tacoma/Pro-Tem appointment) presented her draft research proposal examining the use of simulation for clinical experiences.

V. Ending Items  
• Open Microphone (no public comments)

VI. Review of Actions- NONE
• Meeting Evaluation – All
• Date of Next Meeting – July 20, 2020
• Adjournment – 6:01 PM
WHPS Performance Measures

- Average days positive drug test turn-around
- Average days from significant non-compliance to NCQAC notification

WHPS Participation
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<td>Total Program Participation</td>
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<td>299</td>
<td>306</td>
<td>300</td>
<td>304</td>
<td>287</td>
<td>284</td>
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<tr>
<td>Average Days from Intake to Case Disposition</td>
<td>61</td>
<td>64</td>
<td>41</td>
<td>34</td>
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<td>19</td>
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<td>Average Days from Enrollment to Treatment Entry</td>
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<td>Average Days Positive Drug Test Turn-Around Time</td>
<td>6</td>
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<td>6</td>
<td>5</td>
<td>4</td>
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<tr>
<td>Positive Drug Tests Addressed Within Next Business Day</td>
<td>30/30 (100%)</td>
<td>42/42 (100%)</td>
<td>48/48 (100%)</td>
<td>46/46 (100%)</td>
<td>40/40 (100%)</td>
<td>30/30 (100%)</td>
<td>43/43 (100%)</td>
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<tr>
<td>Average Days from Significant Contract Non-Compliance determination to Discipline Notification</td>
<td>4</td>
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<td>5</td>
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<td>Late Nurse Monthly Reports (self, attendance)</td>
<td>36</td>
<td>29</td>
<td>21</td>
<td>22</td>
<td>21</td>
<td>23</td>
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<td>Employment rate</td>
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<td>~80%</td>
<td>~80%</td>
<td>~80%</td>
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<tr>
<td>Case File Integrity</td>
<td>29/30 (97%)</td>
<td>30/30 (100%)</td>
<td>28/30 (93%)</td>
<td>28/30 (93%)</td>
<td>27/30 (90%)</td>
<td>27/30 (90%)</td>
<td>28/30 (93%)</td>
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<tr>
<td>Number of missed tests</td>
<td>6</td>
<td>11</td>
<td>7</td>
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<td>3</td>
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<td>Number of outreach activities*</td>
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CNEWS, Washington Anesthesia Nurse Association
*Letters mailed within 30 days of NPAP meeting

September 11, 2020
NCQAC Business Meeting
*Letters mailed within 30 days of NPAP meeting

September 11, 2020
NCQAC Business Meeting
Data and Performance Measures Related to Nursing Assistant Training Programs

Descriptive Data:

Number of Director/Instructor Applications
(For Existing Programs)

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<thead>
<tr>
<th>Month</th>
<th>Data</th>
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<tr>
<td>JAN</td>
<td>19</td>
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<td>FEB</td>
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<td>MAR</td>
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<td>APR</td>
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<td>JUN</td>
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<td>JULY</td>
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<tr>
<td>AUG</td>
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</table>

YTD = 111
2019 = 137

Descriptive Data:

Total Number of Director/Instructor Applications
(Existing and New Programs Combined)

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<thead>
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<th>Data</th>
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<tr>
<td>JAN</td>
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<td>MAR</td>
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<td>8</td>
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<td>JUN</td>
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<td>SEP</td>
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<tr>
<td>NOV</td>
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<tr>
<td>DEC</td>
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</tbody>
</table>

YTD = 134
2019 = 224
Performance Measure:

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

**Target:** ≤ 5 Days

- JAN: 1
- FEB: 1
- MAR: 1
- APR: 1
- MAY: 1
- JUN: 1
- JULY: 2
- AUG: 2
- SEP: N/A
- OCT: N/A
- NOV: N/A
- DEC: N/A

September 11, 2020
NCQAC Business Meeting
Descriptive Data:

Number of New* Program Applications

<table>
<thead>
<tr>
<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>
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<tr>
<td>1</td>
<td>6</td>
<td>2</td>
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</table>

YTD = 15  
2019 = 40

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

Performance Measure:

New* Program Applications
Average Number of Days Receipt to Evaluation

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<tr>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
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<th>OCT</th>
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<th>DEC</th>
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<td>17</td>
<td>13</td>
<td>181</td>
<td>137</td>
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<td>38</td>
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</table>

2019 Average: 11 Days

*Does not include 2nd/subsequent reviews of revised applications
**COVID-19 Note: Impact on New Program Applications**

The COVID-19 response shifted the work of the unit dramatically between March and May 2020. Emphasis was necessarily on shifting existing programs to a live online format for classroom/theory content and laying out the NAR work pathway to assure a continuation of training to support the workforce in caring for the public. With this and COVID-19 updates came many new and constantly evolving issues and need for time spent on discussions, decisions, and policy adjustments. During this time, the Nursing Assistant Program Approval Panel (NAPAP) shifted from monthly to weekly meetings, and applications for new programs that had been submitted just prior to or during COVID-19 were on hold for review and processing, and new submission dropped off nearly completely.

In June and July, work shifted to a focus on resuming testing while approvals for live online classes continued as a daily activity. As of mid-August, we have approved the transition to a live online format for 78 nursing assistant training programs during COVID-19, and approximately 2,246 students have completed or are completing training in this format. Staff did have the ability to begin work on some of the backlog of program applications as well, and the timelines are beginning to normalize accordingly.

While timelines for Program Director and Instructor applications for existing programs have been maintained below benchmark throughout the COVID-19 response, the program application timelines are in dramatic contrast to the non-COVID-19 timelines for 2019 (which reflected an average of 11 days as the program application evaluation response time).
Descriptive Data:

Number of Complaints Opened for Investigation
2020

Performance Measure:

Complaint Investigations
Average Number of Days to Completion
FY20 vs. FY19 Commission Hours by Category

FY20 Total Hours = 7074 or $221,064
FY19 Total Hours = 8726 or $272,697
FY18 Total Hours = 7841 or $245,017
FY17 Total Hours = 5316 or $166,120

September 11, 2020
NCQAC Business Meeting
## Washington State Nursing Care Quality Assurance Commission

**NPAP DECISION SUMMARY REPORT**  
**Date:** July and August 2020 Updated 8/19/2020

<table>
<thead>
<tr>
<th>Actions</th>
<th>Number Added for this reporting period</th>
<th>2020 Panel Actions YTD</th>
<th>2019 Totals</th>
<th>2018 Totals</th>
<th>Instate Approved Programs</th>
<th>Out of State Approved Programs</th>
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<tbody>
<tr>
<td><strong>Letter of Determination:</strong></td>
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<td>5 LPN Programs</td>
<td>5 ADN Programs</td>
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<td></td>
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<td></td>
<td>25 ADN Programs</td>
<td>2 LPN-BSN Programs</td>
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<td>17 RNB Programs</td>
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<td>12 BSN Programs</td>
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<td>37 Total BSN Programs</td>
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<td>7 Refresher Programs</td>
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<td><strong>Intent to Withdraw Approval</strong></td>
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<td><strong>Letter of Decision:</strong></td>
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<td><strong>Approval – Programs</strong></td>
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<td><strong>Approval – Sub Change</strong></td>
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<tr>
<td><strong>Plan of Correction (POC) Required</strong></td>
<td>2</td>
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<td>6</td>
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<td>32</td>
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<tr>
<td><strong>Acceptance of Submitted Documents or POC</strong></td>
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<td>32</td>
<td>26</td>
<td>16</td>
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<td><strong>Additional Documents or Actions Required</strong></td>
<td>2</td>
<td>16</td>
<td>8</td>
<td>78</td>
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<tr>
<td><strong>Deferred Action</strong></td>
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<td>46</td>
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<td><strong>Removal of Conditional Approval</strong></td>
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<td><strong>Limit Student Enrollment</strong></td>
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<td><strong>Voluntary Closure</strong></td>
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<td><strong>Require Monitoring Report</strong></td>
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<tr>
<td><strong>Site Visit</strong></td>
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<td><strong>Removal of Moratorium on admissions</strong></td>
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<td><strong>Covid-19 Curriculum Adjustments</strong></td>
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**September 11, 2020**  
NCQAC Business Meeting
<table>
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<tr>
<th>Approvals- Miscellaneous (non-program)</th>
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<tr>
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<td>1</td>
<td>4</td>
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<tr>
<td>Not Accept</td>
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<tr>
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<td><strong>Out-of-State DL Student Waivers:</strong></td>
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<td>Accept</td>
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<td>Deny</td>
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<td><strong>Instructor Applications:</strong></td>
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<td><strong>Complaints:</strong></td>
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<td>Accept Report – No Further Action</td>
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<td><strong>Licensing Education Exemption (Waiver) Request:</strong></td>
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<td>Exemption Request Denied</td>
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<td>International Request Denied</td>
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</table>
Snapshot of Approved Nursing Assistant Training Programs (August 2020)

<table>
<thead>
<tr>
<th>Number of Nursing Assistant Training Programs (All Types)</th>
<th>200</th>
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<tbody>
<tr>
<td>• Traditional Programs</td>
<td>161</td>
</tr>
<tr>
<td>• Home Care Aide Alternative/Bridge Programs</td>
<td>22</td>
</tr>
<tr>
<td>• Medical Assistant Alternative/Bridge Programs</td>
<td>11</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:** Program numbers have ranged 180-200 total over last several years, but increased to >200 as 2019 came to a close and in early 2020. If the trend continues and the programs exceed 210 (5% increase above 200), then the status will be changed from “Stable” to “Notable Increase.”
# NAPAP REPORT 2020

<table>
<thead>
<tr>
<th>Activity</th>
<th>JAN 13</th>
<th>FEB 10</th>
<th>MAR 9</th>
<th>APR 13</th>
<th>MAY 11</th>
<th>JUNE 16</th>
<th>JULY 16</th>
<th>AUG 10</th>
<th>SEP 14</th>
<th>OCT 12</th>
<th>NOV 9</th>
<th>DEC 14</th>
<th>YTD</th>
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<td>Program Change Requests Approved</td>
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*Added to March (item was left off of the Feb report)
COVID-19 Emergency NAPAP Meetings 2020

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**Note--COVID-19 Impact on NAPAP Activities:** We know that COVID-19 has had unprecedented impacts in just about every arena of our lives. The two tables above reflect the impact on NAPAP in two key ways. First, NAPAP meetings are traditionally held monthly, and emergency meetings have been rare in previous years, often completely absent. Second, you will note a shift away from “usual” activities (those captured clearly in most rows) to a clustering of activity in the bottom row (“Other” review or process decisions). This shift relates to the need for NAPAP to navigate through unanticipated and evolving COVID-19 issues as they arise.
The Nursing Care Quality Assurance Commission (NCQAC) regulates the competency and quality of professional health care providers under its jurisdiction by establishing, monitoring, and enforcing qualifications for licensing, consistent standards of practice, continuing competency mechanisms, and discipline. Rules, policies, and procedures developed by the NCQAC must promote the delivery of quality health care to the residents of the state of Washington.

1. Each NCQAC member will attend all business meetings. Meetings are held on the second Friday of January, March, May, July, September and November unless otherwise scheduled by the NCQAC. In order to conduct business, even discussing business on the agenda, a quorum of the NCQAC must be present. If a NCQAC member is unable to attend a meeting, the commission member must inform the NCQAC chair and executive director at least 24 hours in advance of the meeting.

2. Attendance at all sub-committee and task force meetings is expected. Sub-committee and task force meetings are scheduled on an annual basis. If a NCQAC member is not able to attend at the scheduled time, revisiting the schedule can be an agenda item. If a commission member is not able to attend a meeting, the NCQAC member must communicate the absence to the chair of the sub-committee or task force. Recommendations for actions are considered at sub-committee and task force meetings. Attendance and participation are crucial to achieving consensus and presenting the recommendations at NCQAC business meetings.

3. Each NCQAC member is expected to be prepared for all meetings. Materials for the meetings are distributed prior to the meeting. If the materials are not received in a timely manner, the chair and staff person for the NCQAC, sub-committee or task force need to be informed. Decisions made by the NCQAC require every member to be fully informed.

4. Hearing dates are annually scheduled. Once a NCQAC member volunteers for a hearing date, they must make themselves available on that date. Every hearing panel must have three members to make decisions.

5. NCQAC members must be inquisitive. If the materials, discussion or motion is not clear, NCQAC members must ask questions. The outcomes of the decisions affect nursing practice in Washington.

6. The Uniform Disciplinary Act (UDA), RCW 18.130, is the basis for disciplinary action for all health professions in Washington. Every NCQAC member must be familiar with the UDA. Staff attorneys are available on all charging panels for questions. As a reviewing NCQAC member, use your staff attorneys for advice. In a hearing, the health law judge will review NCQAC member responsibilities according to the UDA.
7. Excellence in our work is expected. If a NCQAC member has concerns with the conduct or behaviors of a staff member, the NCQAC member speaks with the NCQAC chair. The NCQAC chair speaks with the executive director who guides and directs staff to improve performance. If a staff member has concerns with the conduct or behaviors of a NCQAC member, the staff person speaks with the executive director. The executive director brings the feedback to the attention of the NCQAC chair. The NCQAC chair and executive director work with the NCQAC member to improve performance.

8. Meeting etiquette
   a. At the beginning of all meetings, turn cell phones to silence mode. Breaks will be held and phone business can be conducted at that time.
   b. Arrive on time and ready to begin meetings according to the start time on the agenda.
   c. Stay for the full meeting. If a NCQAC member is not able to arrive on time or stay the full meeting, the NCQAC member must communicate this with the NCQAC chair or the executive director.
   d. Be engaged in the meeting. Listen to the presentations. Participate in the discussions and recommendations.
   e. Side conversations at all meetings are not allowed.

9. Professional appearance and conduct
   a. Dress for meetings is business attire. Dress as if the Governor will be attending.
   b. Pay attention to the topics. Reading newspapers, doing crossword puzzles, texting personal messages, are not allowed.
   c. Respect all members’ contributions and time. Interruptions are to be kept to a minimum. The chair will recognize each member and allow time to speak.
   d. The chair is responsible for conducting the business meetings and to enforce meeting etiquette, appearance and conduct.
   e. Profanity is not allowed at any meetings.
<table>
<thead>
<tr>
<th>Hearings</th>
<th>NPA Panel A</th>
<th>NPA Panel B</th>
<th>NA-PAP</th>
<th>Advanced Practice Sub-Committee</th>
<th>Licensing Sub-Committee</th>
<th>Consistent Standards of Practice Sub-Committee</th>
<th>Discipline Sub-Committee</th>
<th>Legislative Panel</th>
<th>Case Management Panel</th>
<th>Case Disposition Panel</th>
<th>Research Sub-Committee</th>
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<tr>
<td>3rd Thursday, 10am-12pm, GoToMeeting Call</td>
<td>1st Thursday of Month, 10am-12pm, GoToMeeting Call</td>
<td>2nd Day of every month, 7-8pm, GoToMeeting Call</td>
<td>2nd Wednesday every month, 7-8pm, GoToMeeting Call</td>
<td>Tiffian; Chair, RN (NP/EN)</td>
<td>Tichor, Jeannie; Chair</td>
<td>Tiffian; Chair</td>
<td>Caspar, Mary; Chair (RN)</td>
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<td>Nelson-Pearson, Dana</td>
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<td>Rade, Tracy</td>
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<td>Malligr, Anna</td>
<td>Graham, Sandra</td>
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July 1, 2019 to June 30, 2020 NCQAC Meeting Dates for Subcommittees, Panels and Hearing Dates, Subcommittee Information

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<th>Event</th>
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<td>NCQAC Meeting Dates for Subcommittees, Panels and Hearing Dates, Subcommittee Information</td>
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<td>September 11, 2020</td>
<td>NCQAC Business Meeting</td>
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September 11, 2020
NCQAC Business Meeting
# NURSING BUDGET STATUS REPORT 19-21 BIENNIAL

As of June 30, 2020

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<th>EXPENDITURES TYPES</th>
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<th>EXPENDITURES</th>
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<td>66.50</td>
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<td>$263,251</td>
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<td>Goods &amp; Services</td>
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<td>Rent</td>
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<td>$61,512</td>
<td>$30,402</td>
<td>$28,255</td>
<td>$2,147</td>
<td>92.94%</td>
</tr>
<tr>
<td>Legal Services</td>
<td>$35,868</td>
<td>$17,890</td>
<td>$14,006</td>
<td>$3,884</td>
<td>78.29%</td>
</tr>
<tr>
<td>Call Center</td>
<td>$153,612</td>
<td>$76,826</td>
<td>$84,624</td>
<td>($7,798)</td>
<td>110.15%</td>
</tr>
<tr>
<td>Public Disclosure</td>
<td>$283,216</td>
<td>$141,060</td>
<td>$153,828</td>
<td>($12,768)</td>
<td>109.05%</td>
</tr>
<tr>
<td>Revenue Reconciliation</td>
<td>$155,794</td>
<td>$76,844</td>
<td>$76,109</td>
<td>$735</td>
<td>99.04%</td>
</tr>
<tr>
<td>Online Healthcare Provider Lic</td>
<td>$446,674</td>
<td>$193,354</td>
<td>$153,460</td>
<td>$39,894</td>
<td>79.37%</td>
</tr>
<tr>
<td>Suicide Assessment Study</td>
<td>$31,070</td>
<td>$15,340</td>
<td>$9,912</td>
<td>$5,428</td>
<td>64.62%</td>
</tr>
<tr>
<td><strong>TOTAL SERVICE UNITS</strong></td>
<td>$2,315,552</td>
<td>$1,118,137</td>
<td>$1,212,062</td>
<td>($93,925)</td>
<td>108.40%</td>
</tr>
<tr>
<td><strong>INDIRECT CHARGES:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency Indirects (16.9%)</td>
<td>$3,592,569</td>
<td>$1,797,632</td>
<td>$1,656,122</td>
<td>$141,510</td>
<td>92.13%</td>
</tr>
<tr>
<td>HSQA Division Indirects (11.3%)</td>
<td>$2,402,132</td>
<td>$1,201,967</td>
<td>$986,655</td>
<td>$215,312</td>
<td>82.09%</td>
</tr>
<tr>
<td><strong>TOTAL INDIRECTS (28.2%)</strong></td>
<td>$5,994,701</td>
<td>$2,999,599</td>
<td>$2,642,777</td>
<td>$356,822</td>
<td>88.10%</td>
</tr>
<tr>
<td><strong>GRAND TOTAL</strong></td>
<td>$27,551,108</td>
<td>$13,812,465</td>
<td>$12,558,169</td>
<td>$1,254,296</td>
<td>90.92%</td>
</tr>
</tbody>
</table>

## NURSING REVENUE

<table>
<thead>
<tr>
<th>To-Date</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>BEGINNING REVENUE BALANCE</td>
<td>$6,047,486</td>
</tr>
<tr>
<td>19-21 REVENUE TO-DATE</td>
<td>$13,039,023</td>
</tr>
<tr>
<td>19-21 EXPENDITURES TO-DATE</td>
<td>$12,558,169</td>
</tr>
<tr>
<td>ENDING REVENUE BALANCE</td>
<td>$6,528,340</td>
</tr>
</tbody>
</table>
NURSING BUDGET STATUS REPORT – JUNE 2020

BUDGET/ALLOTMENTS:

This report covers the period of July 1, 2019 through June 30, 2020, twelve months into the biennium, with twelve months remaining, the halfway point. This is not a final June report, as the agency has to close out the fiscal year, which is a very time consuming process, and will not be complete until mid-September. The Nursing Commission budget is underspent by 9%. Within our direct budget, we are underspent in all line items except equipment, which is higher than budgeted due to COVID-19 and the need to work remotely. We were given the extra spending authority this biennium through the increased disciplinary workload decision package, and it took some time to get the additional staff on board and cases moving through the system. This had an impact on the rate of spending this first year of the biennium. The restrictions on travel, contracts and hiring the last few months have also resulted in lower expenditures than anticipated.

Within the service unit section, we are overspent in FBI Background Checks, Adjudicative Law Judges, the Call Center and Public Disclosure units. Some of these higher costs are due to the high volume of calls, requests and workload associated with COVID-19. We continue to work with HSQA on all of the Service Unit budgets to ensure they are correctly billed out to NCQAC.

We anticipate utilizing the majority of our allotments/budget by the end of the biennium. The additional 24 licensing staff paid out of COVID-19 funds to meet the governor’s request of a quick turnaround for applications ended in July. Due to the license renewal extension, any renewals that were not paid on time need to be manually processed, thus adding workload. We hired an additional four temporary FTEs out of our regular Nursing funds through the end of the year to assist with this increased workload.

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 $6.5 million. Our revenues have fluctuated over the past few months, as there has been a high volume of applications coming in for Nurses assisting with COVID-19 and some licensees have utilized the extension of their license renewal dates until September 30, 2020.

Even though our revenue balance is higher than recommended, we will be having withdrawals for the HELMS project over the next four year, which will have a major impact on our overall revenues. Right now, we have the excess revenue to cover the first few years. We will continue to evaluate, as we may need to adjust fees to cover our share of the costs of the HELMS project in the future.
# COMMUNICATIONS TASK FORCE UPDATE
## Nurse Care Quality Assurance Commission Business Meeting
### September 2020

<table>
<thead>
<tr>
<th>#</th>
<th>Topic</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>• Objective of this Status Report</td>
<td>Jen Anderson, 3 min</td>
</tr>
<tr>
<td></td>
<td>• Strategic Plan update</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• PM Tools – MS Teams and SmartSheet</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Website Platform Options Consideration - Ongoing</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>• Acknowledgements</td>
<td>Jae Heidenreich, 2 min</td>
</tr>
<tr>
<td></td>
<td>• Business Requirements Gathering - Ongoing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Content Audit Performed - Completed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Unit Owners Survey Activity:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• WHPS – Completed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Licensing – Completed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Discipline – Completed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Practice – Completed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Education – Completed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Audience Survey Design and Review – Ongoing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Web Analytics Behavioral Flow Documentation – Next Up</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• WHPS Outreach Plan Documented – Completed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Emergency Communication Plan Documentation – Ongoing</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>• Website Analysis Performed – Completed</td>
<td>Rebecca Mosley, 2 min</td>
</tr>
<tr>
<td></td>
<td>• Messaging Approach / Design – Ongoing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Flyers, Website, Governance</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>• Summary</td>
<td>Cass Tang, 2 min</td>
</tr>
</tbody>
</table>
The Nursing Care Quality Assurance Commission (commission) recognizes the need to establish a means of providing early identification and treatment options for nurses whose competency may be impaired due to substance use disorder. The commission intends that such nurses be treated and their treatment monitored so that they can return to, or continue to practice their profession in a manner that safeguards the public. The Washington Health Professional Services (WHPS) program is the commission’s approved substance use monitoring program [www.doh.wa.gov/whps](http://www.doh.wa.gov/whps). The commission may refer nurses to WHPS as either an alternative to or in connection with disciplinary action.

The American Nurses Association Code of Ethics recognizes the duty to take action to protect patients by reporting concerns and to ensure the potentially impaired nurse receives assistance. This includes supporting the return to practice of nurses who have sought assistance and are ready to return to practice. Creating an environment that encourages reporting is vital to reducing the stigma, rehabilitating the nurse, and protecting the public. This approach is consistent with just culture, which encourages a response to the nurse’s illness while maintaining accountability.

In addition, nurses may voluntarily participate in WHPS without being referred by the commission. Nurses voluntarily participating are not subject to disciplinary action for their substance abuse, and do not have their participation made known to the commission as long as they meet WHPS requirements. Voluntary participation carries the advantage of immediate intervention and referral to treatment, bypassing what may otherwise be a long legal process before formal intervention. When there is no potential of patient harm, healthcare professionals and employers may meet statutory reporting requirements by referring a nurse directly to WHPS. **Contact WHPS at 360-236-2880, option #1, or whps@doh.wa.gov.**

The commission regulates the competency and quality of nurses under its jurisdiction by establishing, monitoring, and enforcing qualifications for licensing, consistent standards of practice, continuing competency mechanisms, and discipline. In accordance with the National Council of State Boards of Nursing, the commission supports the rehabilitation of nurses with substance use disorder through early identification, referral for treatment, and monitoring.

Empowers and associations may request live onsite and webinar presentations from WHPS. Contact WHPS at 360-236-2880 or whps@doh.wa.gov.
NOTE NEW DATE AND TIME

RN scope of practice and education requirements, demand, roles, and activities
US and Canada

Agenda

10:00 AM -10:10 AM   Introductions – Paula Meyer
10:10 AM -10:20 AM   Introduction to packet of materials – Mary Sue Gorski
  1) Summary May 11 webinar  2) RN to BSN Grid  3) Academic Progression Models.
10:20 AM -10:30 AM  Historical perspective and summary of first two webinars March 24 and May 11 - Paula Meyer
10:30 AM -10:50 AM    Discussion and questions – Paula Meyer
  1) Describe RN scope of practice and education requirements in your State or Province.
  2) Describe the demand, roles, and activities for RNs in your area. Where do they work? Is there a shortage?
  3) How does this relate to PN practice? Where do they overlap?
10:50 AM -10:55 AM    Summary – Paula Meyer
10:55 AM -11:00 AM    Next steps – Mary Sue Gorski

We hope you will join us for the third in four interactive one-hour sessions to discuss the current and future education preparation, scope of practice, and competencies for LPNs and RNs. The specific agenda is above and the reading materials are attached.

Paula R. Meyer MSN, RN, FRE
Executive Director
Nursing Care Quality Assurance Commission
Washington State Department of Health

Please contact Mary Sue Gorski with questions:
Mary Sue Gorski, PhD, RN
Director Research and Advanced Practice
Nursing Care Quality Assurance Commission
marysue.gorski@doh.wa.gov

Future Topic for Discussion in final Webinar

October 6 - LPN and RN education, role, scope, and demand overlap. Identify specific areas of concern and potential solutions.
**Nursing Care Quality Assurance Commission**  
**2019-2024**  
**Strategic Plan**

**Goal:** Increase the number of safe, qualified nursing assistants by 10% annually

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Staff Responsibility</th>
<th>Resource projections (time, staff, money, etc.)</th>
<th>Deadlines</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1—Implement the NCQAC’s full statutory authority over the competency evaluation of nursing assistants by <strong>establishing a direct contract with the testing vendor</strong></td>
<td>Kathy Moisio (coordinating with the Contracts Unit and Paula Meyer)</td>
<td>Kathy Moisio to shift portion of her FTE to this work by adding: general program and investigation support from the recent addition of a Program Specialist (Stephanie Bryant); program application review support (Margaret Kelly); and general program support (half-time through June 2020) (Poppy Budrow)</td>
<td>• First contract negotiated and fully in place by <strong>December 2019</strong></td>
<td></td>
</tr>
<tr>
<td>2—Assure there are no gaps in testing services in the contract transition to the NCQAC</td>
<td>Kathy Moisio (coordinating with the Contracts Unit and Paula Meyer)</td>
<td>Same as above</td>
<td>• First contract negotiated and fully in place by <strong>December 2019</strong></td>
<td>• No gaps in testing services <strong>January 1, 2020 onward</strong></td>
</tr>
</tbody>
</table>
| 3—Negotiate the first contract as a short-term contract (12-18 months) with performance measures that support immediate quality improvement in key areas and perform ongoing evaluation to assure they are achieved: | Kathy Moisio (coordinating with the Contracts Unit and Paula Meyer) | • Same as above  
• Ultimately, there will likely be a need for FTE support for testing (since DSHS currently has 1 FTE and support staff assigned) and since Poppy Budrow plans to | • First contract negotiated and fully in place by **December 2019** | • Contract terms will likely allow for |
• **Testing capacity** allows for completion of testing by first-time test-takers within 30 days of applying at least 90% of the time

• **Testing capacity** allows for completion of testing by repeat test-takers within 45 days of applying at least 90% of the time

• A first-time test-taker pass rate of 80% is identified as an achievable benchmark for Washington without compromising the safety and quality of basic care provided *(this will include working with the NCQAC to identify allowable modifications to the evaluation approach and assuring training of and consistency across evaluators so that testing validity and reliability are not compromised)*

• A plan and timeline is established for **moving the written/oral testing from a paper-pencil format to an electronic format** at regional testing centers

• A plan and timeline is established for **building capacity for higher volume skills testing** *(i.e. regional test centers vs. 5-7 students at a time)*

• A plan and timelines are established for **data and reports to be provided by the vendor in meaningful format(s) for monitoring and evaluating achievement of performance measures**

<table>
<thead>
<tr>
<th>4—Develop a new inter-local agreement with DSHS and DOH/HSQA to reflect the shift of competency evaluation to the NCQAC and to assure the following:</th>
<th>Kathy Moisio in coordination with Contracts Unit, Paula Meyer, possibly Legal</th>
<th>This work will need to be integrated into current staff roles/responsibilities</th>
<th>• Finalized by December 31, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>transition out in June 2020. We will need to monitor efficiencies instituted, progress, and outcomes to determine long-term FTE needs</td>
<td></td>
<td></td>
<td>a phase-in process on some of the new performance measures during the contract period (Jan. 1, 2020-June 30, 2021)</td>
</tr>
</tbody>
</table>
- Roles and responsibilities of each agency are clearly articulated.
- State and Federal requirements are met
- Data needs of each agency are clearly articulated and met
- A governance structure is established that provides for evaluation of data/performance measures and streamlined articulation and functionality of all processes (across agencies and externally from the customer perspective)

Staff, and the other agencies involved:
- DSHS staff (Candy Goehring, Jody Pilarski, and/or Anne Richter or other appointee(s));
- DOH/HSQA staff (Diane Young and/or other appointee(s))

<table>
<thead>
<tr>
<th>5</th>
<th>Negotiate a longer-term contract for competency evaluation that operationalizes the work of the LTC Budget Proviso (ESHB 1109) to revise testing (see item #6 below for details)</th>
<th>Kathy Moisio in coordination with Contracts Unit and Paula Meyer and other relevant entities (to be determined based on work of the LTC Budget Proviso).</th>
<th>To be determined based on work of the LTC Budget Proviso (through June 2021)</th>
</tr>
</thead>
</table>
| 6 | Achieve the mandates of the continued work of the LTC Budget Proviso (ESHB 1109), which reflect key stakeholder priorities and recommendations from the report to the Governor and Legislature (December 2018): | Project Management: Kathy Moisio  
Leader Participation/Steering:  
- Tracy Rude, Steering Committee Chair  
- Paula Meyer, Steering Meetings | • Budget Proviso Funding ($50,000 each year of the biennium for facilitation)  
• Staff, Commissioner, and Pro Tem Participation and Expertise  
• Participation and Expertise of Diverse Stakeholders Serving on the Steering Committee and/or Workgroups  
• Interim Report to Legislature (on Workplan), November 2019  
• Progress Report to Legislature November 2020  
• Budget Proviso Work Completed by June 30, 2021 |

6(a) Create a competency-based common curriculum for nursing assistant training programs that meets the following mandates of ESHB 1109:
- includes knowledge and skills relevant to current practices
- removes or revises outdated content
- integrates specialty trainings
- provides for educational progression
- does not add training hours unnecessarily
- meets all federal and state requirements

6(b)—Revise testing with a long-term plan that meets the following mandates of ESHB 1109:
- aligns directly with the learning outcomes of the common curriculum
- improves access
- reduces costs
- provides for consistent evaluation
- increases pass rates
- provides support for languages other than English

6(c)—Develop Data Capacity:
- Identify data sources to begin to use data as a tool to assure timeliness of training, testing, and certification of long-term care workers
- Work with regional workforce councils to begin to use data as a tool to project worker shortages and ongoing demand

<table>
<thead>
<tr>
<th>Workgroup or Consult Participation (Staff and Commission Members and Pro Tem Members):</th>
<th>Operations and policy staff assisting with technology, web communications, packets, etc.</th>
<th>Implementation and QA/QI of work products July 2021-June 2024</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tracy Rude, Testing Workgroup</td>
<td>Expert Facilitation and Report-Writing Support</td>
<td></td>
</tr>
<tr>
<td>Sandra Graham, Testing Workgroup</td>
<td>Regular Meetings, Meeting Space, and Technology to Achieve Objectives</td>
<td></td>
</tr>
<tr>
<td>Adam Canary, SNF Staffing Workgroup</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gerianne Babbo, Curriculum Workgroup</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mary Baroni, Consult on Progression/ Curriculum Workgroup</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amy Murray, Data Workgroup</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7—Streamline the regulatory configuration for nursing assistants by:

7(a)—Obtaining licensing and discipline authority for the nursing assistant professions

Paula Meyer and Kathy Moisio coordinating with DOH/HSQA leadership and stakeholders; with a professional, external LEAN facilitator for a 3- to 7-day LEAN exercise to be completed by February 2020

For the LEAN Process (to be implemented prior to pursuing objective 7(a)):

- Cost of a professional, external LEAN facilitator for a 3- to 7-day LEAN exercise to be completed by February 2020
**OR**

**7(b)—Identifying other effective, sustainable alternative(s) through a LEAN exercise involving key/diverse stakeholders**

<table>
<thead>
<tr>
<th>Potential statutory change involved, policy staff would also participate</th>
<th>Intensive exercise (~$20,000-$35,000 to be shared by the NCQAC and DOH/HSQA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Staff time to coordinate and participate in a LEAN exercise (to be absorbed into current role/FTE)</td>
<td>- If statutory change pursued, legislation to be drafted/complete by September 1, 2020 for the 2021 session</td>
</tr>
<tr>
<td>- Space and equipment/supplies to conduct the LEAN exercise (to be absorbed by current resource allocations)</td>
<td>- If authority for licensing/discipline is obtained, a transition plan would follow 2021-2022 --with continued implementation, evaluation, and ongoing QA/QI efforts 2022-2024 and beyond.</td>
</tr>
</tbody>
</table>

**For Obtaining Licensing/Disciplining Authority (Objective 7(a)):**

<table>
<thead>
<tr>
<th>Staff time and coordination to pursue statutory change</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Staff time to coordinate staff transitions and possible space transition(s), if successful</td>
</tr>
<tr>
<td>- Staff shifting to be budget neutral</td>
</tr>
</tbody>
</table>

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**8—Support statutory changes related to nursing assistants to remove setting-dependent barriers to scope and to facilitate maximal use of nursing assistants (This reflects recommendations from the LTC Budget Proviso report to the Governor and Legislature in December 2018 and is expected to be brought forward as legislation from WSNA in the 2020 and/or 2021 session(s).)**

<table>
<thead>
<tr>
<th>Paula Meyer, Kathy Moisio, Policy Staff (TBD)</th>
<th>Staff time to provide information and support and connect this work to the LTC Budget Proviso curriculum work (so they dovetail) as appropriate</th>
</tr>
</thead>
</table>

---

**Legislative Sessions 2020 and/or 2021**

- Integrate with LTC Budget Proviso curriculum work to be completed by June 30, 2021
This chart provides information on which licensed health care providers are authorized under Washington law to administer COVID-19 tests by collecting nasal swab specimens. Providers should consult the information for their profession in the table below and the governing laws and any policies or guidance issued by the regulatory program, board, or commission for their profession. Providers must comply with the standards of practice and any other legal requirements applicable to their profession when collecting nasal swab specimens.

**Self-ordering tests:** Washington law permits individuals to order their own COVID-19 tests, without a health care provider’s order or prescription. A health care provider’s order may be required by a laboratory in its discretion, by an insurance company for payment purposes, or under the FDA’s requirements for a particular authorized test. Unless otherwise provided, health care providers may collect nasal swab specimens for self-ordered COVID-19 tests.

**Observation of self-administered nasal swabs by health care providers:** Washington law does not require a licensed health care provider to observe an individual performing their own swab for a COVID-19 test. The FDA may require a licensed health care provider to observe an individual performing their own swab for particular tests. The FDA’s Emergency Use Authorization for the specific test being used should be consulted for any such requirements.

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Advanced Registered Nurse Practitioner</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes*</td>
<td>No</td>
<td>Per DOH policy, EMS personnel may perform nasopharyngeal and less invasive swabs during the declared COVID-19 emergency provided that they:</td>
</tr>
<tr>
<td>Dentist</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes*</td>
<td>No</td>
<td>• Have received medical program director (MPD)</td>
</tr>
<tr>
<td>Emergency Medical Services (EMS) Provider</td>
<td>Yes</td>
<td>Yes*</td>
<td>Yes</td>
<td>Yes*</td>
<td>Yes*</td>
<td>Yes*</td>
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approved specialized training to perform the skill;
- Are acting under the medical direction of the county MPD or an MPD delegate physician, such as the local health officer, and a DOH-approved MPD protocol is in place; and
- Are acting under the operational direction of the appointed incident commander or director of the local or state emergency management organization.

*The EMS MPD does not need to be present for EMS providers to conduct the activity.
|-----------------------|----------------------------------|-----------------------|--------------------------------------|-----------------------|------------------------------------------|-----------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| Home Care Aide        | Yes, in specific settings*       | Yes**                 | Yes, in specific settings*           | Yes**                 | Yes, in specific settings*               | Yes**                 | Requires patient-specific delegation by RN. Home care aides must be certified under chapter 18.88B RCW and meet other requirements of RCW 18.79.260 and RCW 18.88B.070.  
|                       |                                  |                       |                                      |                       |                                          |                       | *Delegation permitted only in community-based and in-home care settings:  
|                       |                                  |                       |                                      |                       |                                          |                       | • Assisted Living Facilities  
|                       |                                  |                       |                                      |                       |                                          |                       | • Adult Family Homes  
|                       |                                  |                       |                                      |                       |                                          |                       | • Residential Homes for individuals with developmental disabilities  
|                       |                                  |                       |                                      |                       |                                          |                       | • In-home settings (temporary or permanent)  
|                       |                                  |                       |                                      |                       |                                          |                       | Does not include acute care or skilled nursing facilities.  
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<tr>
<th></th>
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<th></th>
<th>** Supervision means initial direction and periodic inspection at least every 90 days by RN delegator.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Assistant (MA) – Registered and Certified</td>
<td>Yes</td>
<td>Yes*</td>
<td>Yes</td>
<td>Yes*</td>
<td>Yes</td>
<td>Yes</td>
<td>Delegation required. * Must be supervised by RN, ARNP, PA, MD, DO or ND. The requirements for the supervising health care practitioner to be physically present and immediately available in the facility are waived under Governor Inslee’s Proclamation 20-32 through at least September 1, 2020. The supervisor only has to be immediately available, which may be by remote means.</td>
</tr>
<tr>
<td>Naturopathic Physician</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>N/A</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Nurse – Licensed Practical (LPN)</td>
<td>Yes</td>
<td>Yes*</td>
<td>Yes</td>
<td>Yes*</td>
<td>Yes</td>
<td>Yes</td>
<td>* Supervision means initial direction and periodic inspection. Must be supervised by licensed physician and surgeon, dentist, osteopathic</td>
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September 11, 2020
NCQAC Business Meeting
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<tr>
<td>Nurse — Registered (RN)</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>physician and surgeon, physician assistant, osteopathic physician assistant, pediatric physician and surgeon, advanced registered nurse practitioner, registered nurse, or midwife.</td>
</tr>
<tr>
<td>Nursing Assistant — Registered and Nursing Assistant — Certified</td>
<td>Yes, in specific settings*</td>
<td>Yes**</td>
<td>Yes, in specific settings*</td>
<td>Yes**</td>
<td>Yes, in specific settings*</td>
<td>Yes**</td>
<td>Requires patient-specific RN delegation.</td>
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<td>• Community mental health facilities</td>
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<td>• Nursing homes</td>
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<td>• Hospitals</td>
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</tr>
<tr>
<td>Nursing Technician</td>
<td>Yes*</td>
<td>Yes**</td>
<td>Yes*</td>
<td>Yes**</td>
<td>Yes*</td>
<td>Yes**</td>
<td>** Supervision means initial direction and periodic inspection at least every 90 days by RN delegator. Requires validation of skill. *Only if they have demonstrated this is in their nursing education program. ** Must be under direct supervision of RN who is on the premises and immediately, quickly, and easily available.</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Must be properly trained to perform the test.</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Refer to Pharmacy Commission's Plan 19 (see page 8) for information related to pharmacists ordering,</td>
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<tr>
<td>Pharmacy Intern</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Requires pharmacist delegation and immediate supervision, as defined in WAC 246-945-001(44).</td>
</tr>
<tr>
<td>Pharmacy Technician</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Requires pharmacist delegation and immediate supervision, as defined in WAC 246-945-001(44).</td>
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<tr>
<td>Physician - Allopathic (MD)</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Physician Assistant - Allopathic</td>
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<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Physician Assistant - Osteopathic</td>
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<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td></td>
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<tr>
<td>Physician – Osteopathic</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Respiratory Care Practitioner</td>
<td>Yes</td>
<td>Yes*</td>
<td>Yes*</td>
<td>Yes*</td>
<td>Yes*</td>
<td>Yes*</td>
<td>* All actions within scope of this profession require standing/direct order and administer, and reporting COVID-19 tests.</td>
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<tr>
<td>Unlicensed School Employees (K-12)</td>
<td>Yes, in K-12 Public and Private Schools</td>
<td>Yes*</td>
<td>Yes, in K-12 Public and Private Schools</td>
<td>Yes*</td>
<td>Yes, in K-12 Public and Private Schools</td>
<td>Yes*</td>
<td>Requires RN delegation, supervision, and training.</td>
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<td>* Supervision means initial direction and periodic inspection.</td>
</tr>
</tbody>
</table>
Title: Drug and Alcohol Testing

Number: W42.03

Reference:
- RCW 18.130.160
- RCW 18.130.175
- WAC 246-840-750 through 246-840-780
  Procedures W03.02, W06.02, W11.02

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

Effective Date: Date Reviewed: August 2020

Supersedes: W17.01, W19.01, W20.01, W42.01, W42.02

Approved:

  Jeannie Eylar, MSN, RN
  Chair
  Nursing Care Quality Assurance Commission

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

<table>
<thead>
<tr>
<th>Nurse Status</th>
<th>Minimum Per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not practicing</td>
<td>12-18</td>
</tr>
<tr>
<td>Practicing</td>
<td>24-36</td>
</tr>
<tr>
<td>During Transition Contract</td>
<td>12-18</td>
</tr>
</tbody>
</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, telephone, or mobile application), 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 physical limitations, health complications, or exigent circumstances.
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 management team 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 Requests (MIR)

WHPS recognizes nurses in the program may request monitoring interruptions to travel away from their home area or for other reasons when testing may be challenging. Interruptions from monitoring must be balanced against the foundation daily check-ins.
provide, and accountability to achieve greatest success on the path to sustained recovery. Therefore, case managers will follow the procedure when considering a monitoring interruption for approval. To minimize the need for monitoring interruptions, the WHPS case management team and Recovery Trek may assist nurses in locating approved drug and alcohol testing sites nearest their location anywhere in the country.

A. Nurses requesting a monitoring interruption must give their WHPS case management team a minimum of seven days’ notice to allow adequate time for review, absent exigent circumstances.

B. Case managers will not approve a monitoring interruption during the nurse’s first year in the WHPS program.

C. After the first year, case managers may approve no more than ten total monitoring days of monitoring interruption per year. Anything beyond ten monitoring days, such as an extended vacation out of the country or incarceration, will be time added to the length of the nurse’s contract. Exceptions are limited to medical emergencies and deaths in the immediate family.

D. Nurses who have had significant non-compliance within the previous year 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 prior to their request are not eligible for monitoring interruptions, except for those defined in ‘C’ above.

E. The case management team will schedule a nurse for a urine toxicology screen immediately upon their return from a monitoring interruption. They will schedule a PEth test within seven days upon return if the monitoring interruption lasted more than ten monitoring days. The case management team may add additional testing as appropriate depending on circumstances.

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.
   3. The case management team will document all activity in the nurse’s monitoring file.

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.
Title: Administration of Cannabis/Marijuana Products in School Settings: Kindergarten-Twelve (K-12) Grades, Public and Private Schools

Number: NCAO 17.010

References:
- RCW 18.79 Nursing Care (Commonly Known as the Nurse Practice Act)
- 28A.210 Health - Screening and Requirements
- RCW 69.51 Medical Cannabis
- RCW 69.50: Uniform Controlled Substance Act
- Substitute House Bill 1095: Medical Marijuana-Administration to Students
- WAC 246-840 Practical and Registered Nursing RN and LPN Scope of Practice Advisory Opinion

Contact: Deborah Carlson, MSN, RN
Director of Nursing Practice

Phone: 360-236-4703
Email: NursingPractice@doh.wa.gov

Effective Date: July 13, 2019

Conclusion Statement
The purpose of this advisory opinion is to clarify the scope of practice of the registered nurse (RN) and licensed practical nurse LPN in administering Food and Drug Administration (FDA)-approved prescription cannabis/marijuana-derived products in schools. It is within the scope of the RN or LPN to administer FDA-approved prescription cannabis/marijuana-derived products in schools. It is not within the scope of the RN or LPN to administer medically authorized marijuana-infused products in school settings, public and private schools, grades K-12.

Background and Analysis

September 11, 2020
NCQAC Business Meeting
The Nursing Care Quality Assurance Commission received a request from the Office of the Superintendent of Public Instruction (OSPI) to clarify the nursing scope of practice related to the passage of Substitute House Bill 1095: Medical Marijuana Administration to Students, which allows parents to give medically authorized marijuana-infused products to their child in the school setting. The OSPI requested clarification of the nursing scope of practice as follows:

- Identify the roles and responsibilities for administering medical marijuana products, validating medical marijuana authorizations, evaluating the student’s response to the product, providing emergency care, nursing documentation requirements, and storage and handling.
- Whether the nurse can administer, or delegate to assistive personnel to administer, an FDA-approved drug, containing cannabidiol. Epidiolex® is a prescriptive oral medicine containing cannabidiol used for treatment of rare seizure disorders. In September 2018, the DEA removed Epidiolex® from Schedule V controlled substances. The Washington State Pharmacy Quality Assurance Commission adopted emergency rules on May 20, 2020 to remove Epidiolex® from Schedule V controlled substances WAC 246-887-180 to align with federal law.
- The Drug Enforcement Agency DEA lists Epidiolex® as a Schedule V controlled substance (September 2018).

Key points include:

- **RCW 69.50.101** defines marijuana-infused products as products that contain marijuana or marijuana extracts, are intended for human use, and are derived from marijuana as defined in law, and have a tetrahydrocannabinol (THC) concentration no greater than ten percent. It does not include useable marijuana or marijuana concentrates.
- **RCW 69.50: Uniform Controlled Substance Act, RCW 18.79 Nursing Care and WAC 246-840 Practical and Registered Nursing** allow the registered nurse and licensed practical nurse to administer prescribed legend drugs and Schedule II-V controlled substances under the direction of a qualified health care practitioner.
- **RCW 69.51A.010** states that an authorization to use medical marijuana is not considered a prescription. Nurses may not administer, or delegate to assistive personnel to administer, authorized medical marijuana. Note: Licensed health care providers in Washington may provide an “authorization” to their patients to consume medical marijuana; this is not a “prescription” because marijuana is still a Schedule I drug under federal law.
- The new law does not include any provision for a parent-designated adult to administer authorized or prescribed marijuana products in the school setting. Only a parent or guardian can administer “authorized” marijuana-infused products. A nurse can only administer or delegate administration of those types of prescription or over-the-counter...
drugs specifically allowed under the school laws (Title 28A RCW), the Nurse Practice Act (Chapter 18.79 RCW), or other state or federal laws.

- WAC 246-840-700 requires nurses to communicate changes in status in a time period consistent with care needs to the appropriate members of the health care team. This includes written documentation. Nurses must document nursing care given and response to the care.

**Recommendations** The commission recommends the following:

- Refer to the RN and LPN Scope of Practice Advisory Opinion for an overview of nursing scope of practice.
- Use the Scope of Practice Decision Tree to help in the decision-making process.
- Follow the National Association of School Nurses (NASN) Cannabis/Marijuana Position Brief.
- Nurses, schools, and school districts should consult with legal consul as necessary.

**Prescription Cannabis/Marijuana Drived Products**

The commission determines:

- It is within the scope of practice of the trained and competent RN or LPN to administer FDA-approved prescriptive cannabidiol products (such as Epidiolex®) to students in schools governed by Title 28A RCW28A.210 RCW under the direction of a qualified health care practitioner with prescriptive authority. The health care practitioner must have a Drug Enforcement Agency (DEA) registration if the drug is a controlled substance, schedule II-V.

**Authorized Medical Cannabis/Marijuana Products**

The commission determines:
• It is not within the nursing scope of practice to administer or delegate to assistive personnel to administer or give authorized medical marijuana/cannabis products or marijuana-infused products.

• It is not within the nursing scope of practice to provide storage and handling of authorized medical marijuana/cannabis products or marijuana-infused products.

• It is not within the scope of practice of a nurse or of assistive personnel to act as a parent-designated adult to administer authorized medical marijuana/cannabis products or marijuana-infused products.

• The laws and rules do not prohibit a nurse from validating medical marijuana authorizations.

• The nurse must communicate changes in a student’s condition to members of the health care team.

• The nurse must document assessments, observations, care given, and response to care. The commission recommends keeping a record of when parents give authorized medical marijuana-infused products to their child.

• It is expected the nurse will give emergency care and first aid as necessary.

Conclusion
The commission determines it is within the scope of practice of a nurse to administer Epidiolex®, or other FDA-approved prescription marijuana/cannabinol-derived products. The commission determines it is not within the scope of practice for a nurse to administer or delegate to assistive personnel to administer or give authorized medical marijuana or marijuana-infused products to students at schools governed by Title 28A RCW.

References

American Cannabis Nurses Association: https://cannabisnurses.org/

American Journal of Nursing – Medical Marijuana – A Hazy State of Affairs for Nurses: https://journals.lww.com/ajnonline/Fulltext/2014/08000/Medical_Marijuana___A_Hazy_State_o_f_Affairs_for.18.aspx


Greenwich™ Biosciences, Inc.: Epidiolex®: https://www.epidiolex.com/


National Association of School Nurses – Medicinal Use of Marijuana – What School Nurses Need to Know: https://journals.sagepub.com/doi/full/10.1177/1942602X16638815


Washington State Department of Health Medical Marijuana Healthcare Practitioner Information Website: https://www.doh.wa.gov/YouandYourFamily/Marijuana/MedicalMarijuana/HealthcarePractitioners
Interpretive Statement

Revised – 10/18/11

Title: Patient Abandonment  Number: NCIS 1.0

References:
- Regulation of Health Professions – Uniform Disciplinary Act (RCW 18.130)
- Violations of Standards of Nursing Conduct or Practice (WAC 246-840-710):
- Nursing Care – (RCW 18.79):

Contact: Deborah Carlson, RN, MSN – Nurse Practice Advisor

Phone: (360) 236-4725

Email: debbie.carlson@doh.wa.gov

Effective Date: November 16, 2012

Supersedes: Patient Abandonment Policy A13.05

Approved By: Nursing Care Quality Assurance Commission

Statement

Nurse Technicians, Licensed Practical Nurses, Registered Nurses, and Advanced Registered Nurse Practitioners who abandon patients are in violation of the Standards of Nursing Conduct of Practice, WAC 246-840-700. The Nursing Care Quality Assurance Commission (Commission) concludes that patient abandonment occurs when a nurse, who has established a nurse-patient relationship, leaves the patient assignment without transferring or discharging nursing care in a timely manner. This applies in any health care setting; it applies to paid or unpaid nursing care. Employee problems do not constitute patient abandonment.

Background

The Commission establishes, monitors, and enforces standards of practice, RCW 18.79.010. The Commission interprets that a nurse-patient relationship begins when the nurse accepts assignment for nursing care. Assignment includes the patient care functions that the nurse is responsible to perform. A person authorized to administer, supervise, or direct the nurse may make the assignment. A nurse may accept a patient assignment based on professional judgment or through a contractual relationship. The Uniform Disciplinary Act (UDA), RCW 18.130, describes procedures for discipline. The Commission gets many complaints about employee problems. These are not subject to discipline by the Commission.
In compliance with WAC 246-840-700, transferring nursing care must include reporting (oral or written) of the patient’s condition, circumstances, and care needs to an appropriate caregiver. As defined in RCW 18.79.260, an appropriate caregiver is a licensed health professional whose scope of practice and qualifications permit transferring functions and responsibilities. In some settings, the nurse may also transfer care to an appropriate family member or other designated caregiver in some settings. The caregiver must accept the transfer of care and understand the report.

<table>
<thead>
<tr>
<th>Examples of Patient Abandonment</th>
<th>Examples of Employee Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ending a contractual relationship as the primary provider</td>
<td>Failing to call in, show up, or arrive late for an assigned shift</td>
</tr>
<tr>
<td>Leaving an emergency situation</td>
<td>Refusing to work, refusing to work extra hours, or not returning from, a scheduled absence</td>
</tr>
<tr>
<td>Leaving the patient care setting</td>
<td>Resigning at the end of a shift, without advanced notice, or not working the remaining posted work schedule</td>
</tr>
<tr>
<td>Leaving the patient in an unsafe situation to give care to an unassigned patient</td>
<td>Refusing to work in a setting because of inadequate orientation, education, training, or experience</td>
</tr>
<tr>
<td>Failing to report suspected abuse or neglect</td>
<td>Refusing to work in an unsafe situation</td>
</tr>
<tr>
<td>Sleeping on duty</td>
<td>Refusing to perform care that may be harmful to the patient</td>
</tr>
<tr>
<td>Giving care while impaired</td>
<td>Refusing to delegate a task to an unsafe caregiver</td>
</tr>
<tr>
<td>Giving care incompetently</td>
<td>Refusing an assignment because of ethical, religious, or cultural reasons</td>
</tr>
<tr>
<td>Delegating care to an unqualified caregiver</td>
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<tr>
<td>Failing to supervise staff carrying out delegated tasks</td>
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<td>Failing to give appropriate care</td>
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<tr>
<td>Failing to perform assigned patient responsibilities</td>
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<tr>
<td>Failing to give appropriate information when transferring or discharging care</td>
<td></td>
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<tr>
<td>Failing to notify an appropriate person about significant changes</td>
<td></td>
</tr>
<tr>
<td>Failing to communicate or document information</td>
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</tbody>
</table>

**Conclusion**

Patient abandonment violates the *Standards of Nursing Conduct of Practice*, WAC 246-840-700. This occurs when:

- The nurse establishes a nurse-patient relationship by accepting a nursing assignment, and
- The nurse ends the nurse-patient relationship without transferring or discharging responsibilities to an appropriate caregiver in a timely manner.

Examples help explain the difference between patient abandonment and employee problems of which the Commission does not have authority over.
Epinephrine Autoinjectors in Schools

FAQ

Can Symjepi®, an epinephrine injection, single-dose, pre-filled syringe recently approved by the Food and Drug Administration, be substituted for an epinephrine autoinjector (EAI) currently allowed to be delegated to unlicensed assistive personnel (UAP) in schools?

The Nursing Care Quality Assurance Commission does not have authority to interpret the laws governing the provision of health care in K-12, public and private schools. Chapter 28A.210.383 RCW provides that the Office of the Superintendent of Public Instruction (OSPI) and school districts have the authority to develop anaphylactic policies for schools.

The law specifies that epinephrine autoinjectors may be prescribed to be maintained by schools for use when necessary. RCW 28A.210.383(2)(a). However, it may be feasible for OSPI and school districts to develop written policies to allow a substitution for the EAI for an individual student when the substitution is permitted by the prescriber according to the student’s anaphylaxis care plan. RCW 28A.210.383(2)(b). RCW 28A.210.383(4)(b) provides: “In the event a school nurse or other school employee administers epinephrine in substantial compliance with a student’s prescription that has been prescribed by an authorized health care practitioner with prescriptive authority and written policies of the school district or private school, then the school employee, the school district or school of employment, and the members of the governing board and chief administrator are not liable in any criminal action or for civil damages as a result of administering epinephrine.” (RCW 28A.210.383).

RCW 28A.210.380 and RCW 28A.210.383 specifically require the use of an “autoinjector” to administer epinephrine. Symjepi® is not classified as an EAI. This may apply to prescriptions for individual students as well as for the school supply.

RCW 28A.210.370 allows self-administration of medications, including epinephrine, if the student meets the requirements under the treatment plan for anaphylaxis, and has a prescription from their health care practitioner. This may include self-administering epinephrine using an EAI or a prefilled medication device if authorized in the prescription.
Intravenous Therapy by Licensed Practical Nurses

Licensed Practical Nurses (LPN) may, under the supervision of a registered nurse, administer intravenous medications and fluids provided the LPN has had the appropriate practice and annual documented education.

Antineoplastic agents and investigational drugs may not be initiated by the licensed practical nurse, but may be monitored by the LPN under the direct supervision WAC 246-840-010 (22) (a) of an RN.

The LPN may administer fluids, medication, Total Parenteral Nutrition (TPN), blood or blood products via central venous catheters and central lines, access these lines for blood draws and administration of emergency cardiac medications via IV push if the following occurs:

1. Strict guidelines and protocols are in place.
2. The guidelines clearly state all policies and procedures.
3. Annual review and assessment of the LPN’s knowledge, skills and abilities is conducted.
4. Emergency cardiac medications given “IV push” shall be administered by the LPN only if:
   a. The LPN has direct supervision per WAC 246-840-010 (22) (a) or
   b. The LPN has a current ACLS certification.
5. Blood or blood products shall only be given with direct supervision as per WAC 246-840-010(22)(a).
6. It is within the scope of LPN practice to perform peripheral venipuncture (to start IV or draw blood), flush peripheral, PICC and central lines for the purpose of ensuring patency if the following occurs:
   a. The LPN completes an annual instructional program on the initiation of peripheral IV.
   b. Documentation of satisfactory completion of the instructional program and supervised practice is on file with the employer.
   c. Written policies and procedures are maintained by the employer.
Conclusion Statement
The Nursing Care Quality Assurance Commission (NCQAC) concludes that it is within the scope of practice for the appropriately prepared and competent registered nurse (RN) and licensed practical nurse (LPN) to provide and manage infusion therapy under the direction of an authorized health care practitioner. This may include placement and management of infusion devices, administration of medications (over-the-counter, legend drugs and controlled substances, schedule II-V), collection of blood specimens for laboratory testing, and use of interventional radiology imaging devices. The commission recommends the RN or LPN use the Interactive Scope of Practice Decision Tree to determine if an activity is within their legal and individual scope of practice.

Background and Analysis
Vascular and non-vascular access devices are commonly used in inpatient, outpatient, and community-based and in-home care settings. Phlebotomy and laboratory testing often coincides with access to vascular and non-vascular procedures. The Washington State nursing law (RCW 18.79) and rule (WAC 246-840-800) provide guidance for the safe practice of infusion therapy.
The nursing law and rule does not require a specific certification or training course. The organization or employer may require specific training or certification. Organizational policies and procedures may be more restrictive than law and rule and limit nursing scope of practice. The RN and LPN remain individually accountable and responsible for the care they provide.

**Recommendations**

The Nursing Care Quality Assurance Commission recommends the RN or LPN use the Interactive Scope of Practice Decision Tree. The RN and LPN must follow applicable laws, rules, standards, and guidelines that may be relevant to infusions, blood-borne pathogen/infection control, and use of medical imaging devices. The commission recommends the facility/organization or employer develop policies and procedures.

Other commission approved advisory opinions provide additional information that may be relevant to infusion management and therapy:

- RN and LPN Scope of Practice Advisory Opinion
- Administration of Sedating, Analgesic, and Anesthetic Agents Advisory Opinion
- Compounding Medications Advisory Opinion
- Standing Orders and Verbal Orders Advisory Opinion

Standing orders may be an option to allow the nurse to start and manage infusions, including starting more than one infusion line. The nurse does not require an additional order to restart an infusion line or device that is no longer patent unless the provider specifically directs the nurse not to restart the device or infusion. The nurse may want to consult with the authorized health care practitioner in situations when the nurse is unsure if the patient still requires the infusion line or device or if the access is insufficient to support the therapy needed. The nurse should be prepared to respond in an emergency that may involve administration of emergency medications.

**Registered Nurse**

It may be within the scope of practice of the RN to perform the following tasks related to infusion devices under the direction of an authorized health care practitioner:

- Insertion and removal of short peripheral catheter line intraosseous access, and subcutaneous infusion devices;
- Preparing, initiating, managing, and monitoring infusion pumps;
- Insertion or removal, site monitoring, care, and dressing changes of peripheral (including short peripheral or midline), CVAD, arterial, umbilical arterial catheter (UAC), umbilical venous catheter (UVC), intraspinal, intraosseous access, and subcutaneous infusion devices;
• Insertion or removal of, and administration of infusion fluids and medications via peripheral, CVAD, and arterial catheters including through an implanted vascular access port, hemodialysis VAD, and UAC) or UVC;
• Medication administration via a VAD using piggyback, push, or bolus methods;
• Transfusion of blood products;
• Infusion of biologic therapies, including stem cell therapies;
• Blood sampling via peripheral, VAD, and arterial devices;
• Administration of total parenteral nutrition;
• Monitoring patency of the peripheral, CVAD, and arterial catheters; and
• Changing infusion sets.

Licensed Practical Nurses
The LPN scope limits practice to providing routine and non-complex care. The complexity of the patient’s condition determines the nursing knowledge required to provide the level of care the patient needs. A more complex patient situation or less stable environment will create an increased need for consultation and/or the need for the RN to provide the full range of care requirements.

It may be within the scope of practice of the competent and appropriately trained LPN to perform the following tasks related to a VAD or other infusion devices under the direction of an authorized health care practitioner or under the direction and supervision of the RN:
• Insertion and removal of short peripheral catheter line intraosseous access, and subcutaneous infusion devices;
• Preparing, initiating, managing, and monitoring infusion pumps;
• Site monitoring, care, and dressing changes of peripheral (including short peripheral or midline), CVAD, arterial, umbilical arterial catheter (UAC), umbilical venous catheter (UVC), intraspinal, intraosseous access, and subcutaneous infusion devices;
• Administration of infusion fluids and medications via peripheral, CVAD, and arterial catheters including through an implanted vascular access port, hemodialysis VAD, and UAC) or UVC;
• Medication administration via a VAD using piggyback, push, or bolus methods;
• Transfusion of blood products;
• Infusion of biologic therapies;
• Blood sampling via a peripheral, VAD, and arterial device;
• Administration of total parenteral nutrition;
• Monitoring patency of the peripheral, CVAD, and arterial catheters;
• Changing infusion sets; and
• Assisting an authorized health care practitioner or RN in removing or reinserting a CVAD or arterial catheter.

It is not within the scope of a licensed practical nurse to perform the following tasks:
• Independent insertion or removal of a CVAD, arterial, or intraspinal catheter;
• Insertion of a peripherally inserted midline catheter.

The commission recommends facilities follow professional practice standards such as those published by the Infusion Nurses Society (INS), Association for Vascular Access (AVA), National Infusion Center (NICA), and Association for Radiologic and Imaging Nursing (ARIN).
**Conclusion**
The nurse is responsible to use nursing judgment to ensure safe practices including considering whether the patient care status, medication type, patient care environment, available resources, competency, or other factors make it safe to perform the activity. The burden rests on the nurse to maintain documented evidence of education and competence to perform the activity.

**References**

Infusion Nurses Society (INS): [https://www.ins1.org/](https://www.ins1.org/)

Association for Vascular Access (AVA): [https://www.avainfo.org/](https://www.avainfo.org/)

National Infusion Center (NICA):
[https://www.bing.com/search?q=national+infusion+center&FORM=IE8SRC](https://www.bing.com/search?q=national+infusion+center&FORM=IE8SRC)

Association for Radiologic and Imaging Nursing (ARIN):
[https://www.arinursing.org/resources/practice-guidelines/](https://www.arinursing.org/resources/practice-guidelines/)
The Nursing Care Quality Assurance Commission (NCQAC) issues this advisory opinion in accordance with WAC 246-840-800. An advisory opinion adopted by the NCQAC is an official opinion about safe nursing practice. The opinion is not legally binding and does not have the force and effect of a duly promulgated regulation or a declaratory ruling by the NCQAC. Institutional policies may restrict practice further in their setting and/or require additional expectations to assure the safety of their patient and/or decrease risk.

**Title:** Determining, Pronouncing, and Certifying Death  
**Number:** NCAO XX.XX

**References:**  
- RCW 18.79 Nursing Care  
- WAC 246-840 Practical and Registered Nursing  
- Interactive Scope of Practice Decision Tree

**Contact:** Deborah Carlson, MSN, RN  
Nursing Practice Director

**Phone:** 360 236-4703

**Email:** NursingPractice@doh.wa.gov

**Effective Date:** TBD

**Supersedes:** Determination and Pronouncement of Death (January 31, 1997)

**Approved By:** Nursing Care Quality Assurance Commission

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**Conclusion Statement**

The Nursing Care Quality Assurance Commission determines it is within the scope of practice of the appropriately prepared and competent licensed practical nurse (LPN), registered nurse (RN), and advanced registered nurse practitioner (ARNP) to determine and pronounce death, using assessment of the obvious, presumptive, or conclusive signs of death. It is not within the scope of the nursing assistant-registered (NA-R) or the nursing assistant-certified (NA-C) to determine, or pronounce death. It is within the scope of the ARNP to certify death (RCW 70.58). It is not within the scope of the LPN or RN to certify death. The Nursing Care Quality Assurance Commission recommends the nurse use the Interactive Scope of Practice Decision Tree.

**Background and Analysis**

RCW 18.79.240 allows the RN to determine and pronounce death. WAC 246-840-830 identifies the requirements for the RN to determine and pronounce death. RCW 18.79 and WAC 245-840 do not address settings. The laws and rules do not specifically address whether the LPN can determine and pronounce death but does not explicitly prohibit the LPN from pronouncing or determining death. The LPN or RN may accept orders regarding care of the patient from an authorized health care practitioner.

A death occurring within a health facility and may be managed differently than death that occurs outside a health care facility. There are sections of legislation and regulation that may be relevant to the process of pronouncement death in a specific practice setting. There may be other applicable legislation and regulations of a death occurs outside a health care facility. Centers for Medicare and Medicaid Services (CMS) regulations or other federal regulations may apply. Accreditation standards (e.g. Joint...
Commission) may also apply. Washington state facility laws do not specify how death is pronounced or how a body is removed.

**WAC 246-840-830** requires the following for the RN to determine and pronounce death:

- There must be written policies and procedures related to the determination and pronouncement of death in the organization where the nurse is employed, or works under contract provided:
  - The decedent was under the care of a health care practitioner to qualified to certify cause of death;
  - The decedent was a patient of the organization with which the nurse is associated; and
  - There is a DNR or POLST in the decedent’s record when the decedent was assisted by mechanical life support systems at the time of determination and pronouncement of death.
- The nurse who assumes responsibility must be knowledgeable of the laws and regulations regarding death and human remains that affect the nurse’s practice of this responsibility, including those specific to the setting in which they are employed, or under contract:
- The nurse who assumes responsibility must:
  - Perform a physical assessment of the patient’s condition;
  - Ensure that family, the patient’s primary care practitioner, and other appropriate caregivers are notified of the death;
  - Document the findings of the assessment and notification in all appropriate records.

Relevant state laws and rules include (but not limited to):

- **Chapter 70.58 RCW Vital Statistics**
- **Chapter 68.50 RCW Human Remains**
- **Chapter 70.02 RCW Medical Records – Health Care Information Access and Disclosure**
- **Chapter 72.23 RCW Public and Private Facilities for the Mentally Ill**
- **Chapter 72.40 RCW State Schools for Blind, Deaf, and Sensory Handicapped**
- **Chapter 70.245 RCW Washington Death with Dignity Act**
- **Chapter 388-76-10225 WAC Adult Family Home Minimum Licensing Requirements**
- **Chapter 388-78A-2640 WAC Assisted Living Facility Licensing Rules**
- **Chapter 388-97-0160 WAC Nursing Homes**
- **Chapter 246-335 WAC In-Home Services Agencies**
- **Chapter 110-300-0475 WAC Foundational Quality Standards for Early Learning Programs**

**Recommendations**

Pronouncement of death is often done to provide assurance and support to family and to verify that this was an expected, natural death. It is appropriate for the nurse to perform a final assessment and pronounce death as a natural continuation of compassionate and timely nursing care. In some circumstances (such as an unexplained or unexpected death), the medical examiner, coroner and/or law enforcement must be notified prior to release of the body. The commission recommends the following:

- Organizations establish policies and procedures, seeking legal advice, to ensure consideration of relevant legislation and regulation when developing processes to support nurses in pronouncing
and determining death.

- Employers should access assistance from legal services to consider relevant legislation and regulation when developing policy or processes in the pronunciation of death.

- The nurse should include expected death and actions in the nursing care plan considering organizational policies and procedures and legal requirements specific to the setting.

- The nurse should notify the most responsible health care practitioner as soon as possible so care and removal of the body can occur according to the organization policies and procedures.

- The nurse should take appropriate clinical action when the death of the patient is unexpected and immediately notify the most responsible health care practitioner and the medical examiner, coroner, and/or law enforcement, if required by law, rule, or organization policies and procedures.

- The nurse should assess family needs and help identify resources and support systems for assistance in cases of expected or unexpected death.

- The nurse must care for the body of the deceased in a sensitive, respectful and compassionate manner:
  - Respect the cultural and religious beliefs of families and loved ones.
  - Support the family with funeral arrangements and transfer of the body.
  - Remove medical equipment or drains (except for autopsy cases).
  - Assist with post-mortem tissue or sample procurement.
  - Assist with processes for organ or tissue transplantation.

- The nurse should document appropriately including:
  - Time of death or time of discovery;
  - Health care practitioner’s name who pronounced death if other than the nurse completing the documentation;
  - Start and end time of resuscitation attempts, if initiated;
  - Post-mortem care;
  - Whether medical equipment was removed or left in place;
  - Disposal of medication and/or equipment;
  - List of belongings and name of family member, or other, who accepted the belongings, and/or list of belongings left with the patient;
  - Disposition of the body, telephone number, and address of the funeral home or other site the body was transferred to;
  - Family members and others who were present at the time of death and/or note the name of the person who notified and viewed the body;
  - Emotional support, care, and education given to the family or friends.

- The nurse should assist with the safe disposal or return of medication and equipment.

- The nurse should evaluate and reflect on their own emotions and fitness to practice following a patient’s death, and access support services as needed.
Determining and Pronouncement of Death by Physical Assessment:
Death is determined using clinical criteria based on direct, measurable observation, or examination of the patient. Expected death implies the death of the patient was anticipated and planned for with a written and documented plan. Nurses who pronounce death must understand the signs of death including the obvious, presumptive, and conclusive signs of death (American Heart Association):

The nurse should immediately implement emergency resuscitation procedures until directed by an authorized health care practitioner in the absence of a “Do Not Attempt Resuscitation (DNR)”, Health Care Advanced Directive, or Physician’s Order for Life-Sustaining Treatment (POLST). Exceptions apply in the case of an obvious (signs incompatible with life) or conclusive death, or in cases of exposure of the rescuer to injury (unsafe scene, hazardous environment, or threat to the rescuer).

Certifying Death by the ARNP
There is a distinction between pronouncing death and certifying death. The ARNP may certify death following RCW 70.58.

Conclusion
It is within the scope of practice of the appropriately prepared and competent licensed practical nurse (LPN), registered nurse (RN), and advanced registered nurse practitioner (ARNP) to determine and pronounce death, using assessment of the obvious, presumptive, or conclusive signs of death. It is not within the scope of the nursing assistant-registered (NA-R) or the nursing assistant-certified (NA-C) to determine, or pronounce death. It is within the scope of the ARNP to certify death (RCW 70.58). It is not within the scope of the LPN or RN to certify death.

References


Virginia Hilton, RH, Director of Nursing
Tacoma Lutheran Home & Retirement Community
1301 N Highland Parkway
Tacoma, WA 98406

Dear Ms. Hilton:

At their January 31, 1997 meeting, the Washington State Nursing Care Quality Assurance Commission (Nursing Commission), considered your request for an advisory opinion. In response to the question posed, “Can a Licensed Practical Nurse (LPN) pronounce death? Under what circumstances?”

Yes, the Licensed Practical Nurse may pronounce death under the delegating authority of the Registered Nurse (RN). The requirements as outlined in WAC 246-839-830 would apply:

**Determination and Pronouncement of Death**

A nurse may determine and pronounce death, but shall not certify death as defined in **RCW 70.58.160** unless the nurse is an Advanced Registered Nurse Practitioner (ARNP) or certified nurse midwife as defined in **WAC 246-840-830**.

1. A nurse midwife may assume responsibility for the determination and pronouncement of death only if there are written policies and procedures relating to the determination and pronouncement of death in the organization with which the nurse is associated as an employee or by contract, provided the nurse’s practice of the responsibility.
   
   a. The decedent was under the care of a health care practitioner qualified to certify cause of death; and
   
   b. The decedent was a patient of the organization with which the nurse is associated; and
   
   c. There is a “do not resuscitate order” in the patient’s record when the decedent was assisted by mechanical life support systems at the time of determination and pronouncement of death.

2. A nurse who assumes responsibility of the determination and pronouncement of death shall be knowledgeable of the laws and regulations regarding death and human remains.
(3) A nurse who assumes responsibility for the determination and pronouncement of death shall:

(a) Perform a physical assessment of the patient’s condition;

(b) Insure that family and physician and other care givers are notified of the death; and

(c) Document the findings of the assessment and notification in all appropriate records.

Under Registered Nurse delegation the Licensed Practical Nurse remains responsible for assuring their own competency in the skills to determine death. The facility should include in the LPN personnel file, documentation of the LPN skills assessment or credentialing used for competency assurance. With this documentation, the Registered Nurse can use his/her delegating authority to permit the Licensed Practical Nurse to pronounce death when the Registered Nurse is unavailable.

Any opinion issued by the Commission is advisory and intended for the guidance of the requesting parties only. The opinion is not legally binding and does not have the force and effect of a duly promulgated regulation or declaratory ruling by the Commission.

Sincerely,

Victoria Fletcher, RN, MSN, ARNP
Commission Chairperson

Adopted: January 31, 1997
Nurses at the Table: Action Now! for Nursing Education

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Abstract

Nursing faculty shortages are a crisis at both the state and national levels. In celebration of the Year of the Nurse and Midwife, we share the successes of Action Now!, a movement spearheaded by the Washington Center for Nursing; the Washington Board Of Nursing; and the Council on Nursing Education in Washington State. Securing sustainable financing for nursing programs was the top goal set by the Action Now! coalition. In addition, three major nursing unions assisted with legislative advocacy, helping to secure significant funding from the state legislature to increase nursing educator salaries. We offer background information about how a diverse coalition of nursing organizations joined forces with key stakeholders to address this crisis in nursing education. The article describes vision and implementation for Action Now!, our successes and lessons learned, and the effort to move forward with ongoing challenges to identify and address barriers in nursing education.


DOI: 10.3912/OJIN.Vol25No01Man04

Key Words: Action Now!, nursing workforce, nursing education, nurse educator salary, nursing shortage, nurse educator shortage, legislative advocacy, year of the nurse and midwife
The Action Now! initiative was spearheaded by WCN, the statewide central nursing resource center; the Washington State Nursing Care Quality Assurance Commission (NCQAC), the state regulatory board for nurses (Washington State Department of Health, n.d.); and the Council on Nursing Education in Washington State (CNEWS), the statewide organization of deans and directors of Washington nursing programs. The Washington State Nurses Association; the Service Employees International Union (SEIU) Healthcare 1199NW; and United Food & Commercial Workers (UFCW) 141 Nursing Union provided analysis and strategic expertise to help secure the additional funding for nursing faculty salaries from the state legislature. This was key because the nursing unions had the ability to lobby the legislature and had existing relationships at the state capitol. As not-for-profit organizations, neither the WCN nor CNEWS are permitted to lobby, due to funding and capacity constraints. The NCQAC also had limitations on lobbying. Ultimately, support from these unions led to a new appropriation of $40 million to increase nursing educator salaries by the state legislature. The article describes vision and implementation for Action Now!, our successes and lessons learned, and the effort to move forward with ongoing challenges to identify and address barriers in nursing education.

**Background: An Environment of Opportunity**

The American Association of Colleges of Nursing (AACN) recognizes a nursing education shortage, asserting that faculty shortages at nursing schools across the country are limiting student capacity at a time when the need for professional registered nurses continues to grow (AACN, 2019). According to national data, Washington State nursing programs turn away an estimated 34% of qualified applicants (NLN, 2017).

The Washington Health Sentinel Network, a quarterly workforce survey of employers of all health professions recognized by the National Bureau of Labor Statistics has reported prolonged vacancies for Certified Nursing Assistants, Licensed Practical Nurses (LPNs), Registered Nurses (RNs), and Advanced Practice Registered Nurses (APRNs) in a variety of practice settings statewide (Gattman, 2018). Since its establishment in 2016, employers report exceptional vacancies for these healthcare providers across a variety of facilities (Gattman, 2018). When completing the WA Health Sentinel Network survey, employers are asked the question "...recently (in the past few months) have you had exceptionally long vacancies..." (Skillman, 2016). Exceptional vacancies are defined as vacancies that are longer than expected (S. Skillman, personal communication, December 12, 2019) and are considered an indicator of shortage.

Exceptional vacancies are defined as vacancies that are longer than expected.

The Sentinel Network noted that nurse educators have higher than usual demands, including increased program array and numbers of students enrolled, and an ongoing increase in service requirements. In addition, new specialties, such as psychiatric/mental health nursing, are growing in demand. Educators are also increasingly required to acquire expertise in simulation and the need for simulation coordinators and faculty lead has grown. Existing nurse educators also spend significant time mentoring new faculty (Aragon & Skillman, 2018).

Other efforts at the federal and state levels highlighted the need for a stronger healthcare workforce. Funded by the Centers for Medicaid and Medicare Innovation, the Healthier Washington Initiative is the state plan to redesign the healthcare system to achieve better population health, reward high-quality care, and curb healthcare costs. WCN was invited to participate in the Healthier Washington Initiative efforts to strengthen the overall health workforce of the state and increase access to equitable care.

In sum, the nursing workforce is clearly a key workforce to transform Washington State's health system to meet the needs of our aging and demographically shifting communities. However, it was obvious that while we had an environment of opportunity, there were challenges to improving outcomes. To move forward, we needed more information.
The Crisis in Nursing Education: Further Analysis

For years, the WCN provided staff and collaborated regularly with the CNEWS to advance nursing education. However, it was clear that the complexity of this crisis required a change in structure from narrowly focused groups addressing the problem on an individual basis, to convening a broad group of stakeholders. First, we worked to clearly define the crisis.

In 2008, the WCN published "A Master Plan for Nursing Education in Washington State" ([MPNE]; WCN, 2008). This plan included a set of state-specific recommendations to address the nursing shortage. The plan outlined steps to ensure the supply of a more highly educated nursing workforce and to provide quality care to an increasingly diverse, growing, and aging population. A status update on Washington's MPNE (WCN, 2014) found the following areas of continued focus since the original 2008 plan:

- Assuring the continued competency of nursing professionals
- Assuring an adequate supply of nursing professionals
- Enhancing educational access throughout Washington State
- Promoting a more diverse nursing workforce

In response to growing concerns by CNEWS about the rapid turnover among deans and directors of nursing, the WCN saw an opportunity to study and quantify their concerns. In December 2017, leaders at the WCN surveyed nurse educators in the state of Washington and published their results (Aragon & Ellis, 2017). The most frequent reason for nurse educators to consider leaving was for higher pay, followed by lack of a manageable workload (Aragon & Ellis, 2017). Alarmingly, the survey reported that 70% of Washington nursing education administrators identified at least one faculty vacancy in their nursing program. The survey went on to report:

- Approximately 40% of Washington nursing faculty report being dissatisfied or very dissatisfied with their income.
- Reflective of workload, faculty work an average of 50 hours per week when school is in session, and 20 hours per week when school is not in session.
- Thirty eight percent of community and technical college faculty and 40% of four-year college and university nursing faculty expect to be retired by 2027.

While updating the administrative rules for nursing education prior to 2016, the NCQAC also heard several challenges faced by the nursing education community, specifically:

- Clinical practice experiences
- Faculty qualifications, preparation, and salary issues
- Program resource issues
- Academic progression for all levels of nursing education

These challenges became the basis of our Action Now! strategy. Figure 1 illustrates additional challenges identified by nurse faculty employed in Washington State.

Figure 1. Washington State Nursing Faculty Challenges 2017. (used with permission)
Meanwhile, some nursing education programs reported to the NCQAC that they would not be able to admit as many students as planned, due to a shortage of faculty (M. Schaffner, personal communication, October 3, 2018). Washington State nursing schools already lack space for qualified candidates as an estimated 34% of qualified applicants to nursing schools are turned away (NLN, 2017).

In addition, 29% of RN nursing programs hired new nurse administrators. (M. Schaffner, personal communication, October 3, 2018). High turnover created concerns of instability in administration of nursing programs and can hinder program function. NCQAC was also increasing the number of granted faculty exceptions, commonly known as waivers. Such waivers permit nursing schools to hire faculty who hold a Bachelor of Science Degree in Nursing (BSN) but lack a graduate degree, as required by the nursing education rules set forth by Washington Administration Code 246-840-529 (Wash.Admin.Code, 2016).

The NCQAC then requested that the WCN work with them to convene a “Solution Summit.” The goal of the summit was to obtain greater public input to address the four key problems facing nursing education as identified by the NCQAC: faculty concerns; academic progression; clinical experiences; program resources (as listed above in detail).
The coalition steering committee concentrated on four complex issues, or “big rocks” facing nursing. Members had previously identified that these four priority core issues were obstacles to produce a nursing workforce in Washington State to serve our growing and changing communities. We ultimately formally defined these issues as a lack of quality practice experiences for all students; a nursing faculty shortage due to inability to recruit and retain nurse faculty and/or administrators that emphasize diversity; nursing education funding that fails to keep pace to sustain programs; and a lack of opportunity for nurses to advance their education. After agreeing upon the Action Now! initiative as the strategy, we developed these as stated priorities; identified strategic imperatives; and created action plans. Figure 2 illustrates the strategy map we used as a framework to implement the project vision. This section will briefly discuss each of these individual strategies.

Figure 2. Action Now! Steering Map (used with permission)
More residency and preceptorship programs are needed for nursing students.

To frame the nurse faculty priority, we worked to learn lessons from salary increases in state government. Action Now! invited state employees involved in the planning and implementing of the pay increase to present to the steering committee. In particular, this strategy provided the Action Now! steering committee with information about how to build the case for increasing nurse educator pay with the use of data.

Priority #3: Sustainable Financing for Nursing Programs. Financing for nursing programs encompasses more than nurse faculty pay. However, after convening through two years, Action Now! leaders determined that nurse faculty pay was the top priority on an individual and systemic level. Nurse faculty pay in educational institutions lags compared to other forms of nursing practice (WCN, 2008). This is a barrier to attracting the best-qualified faculty. A healthy pool of the best qualified faculty is necessary to meet demand so that programs can admit more students, who then graduate to practice nursing in different settings and roles. These graduates become nurse educators, nurse practitioners, researchers, and organizational leaders. As an example of one strategy to research potential funding sources, a subcommittee of Action Now! studied the approaches of other states.

Priority #4: Academic Progression for All Nurses. Health needs are changing. Nurses must be prepared to deliver increasingly complex care and have skills to lead healthcare into the future. The IOM report (2011) recommended an increase in the percentage of nurses with a BSN or higher degree to 80% by 2020, as well as increasing the number of graduate-level prepared nurses. In addition, a bachelor’s degree is required to pursue advanced degrees in nursing and for key nursing leadership roles.

Washington State has made significant progress, propelled by strong partnerships formed over the past few years among community colleges, four-year colleges, and universities. The WCN has received grants to boost academic progression in nursing from the Robert Wood Johnson Foundation from 2012-2016. At a national level, the WCN is...
a founding partner in the National Education Progression in Nursing Initiative to promote academic progression for nursing at all levels nationwide (NEPIN, 2019) and to promote academic progression for nursing at all levels nationwide help ensure our nation’s population has access to high-quality, patient-centered care.

**Action Now! Successes and Lessons Learned**

**Our Successes**
The work of *Action Now!* leaders to address the nursing faculty shortage in Washington State has resulted in a new appropriation of $40 million to increase nursing educator salaries by the state legislature. This investment reflects an approximate 26.5% increase in salary, is aligned with salary needs estimated by the *Action Now!* steering committee, and directly resulted from advocacy by a coalition of nursing unions.

Securing sustainable financing for nursing programs was among the top goals set by the *Action Now!* coalition when it was formed in 2016. The goal of increasing salaries is to address nurse educator recruitment and retention issues, and to ensure that Washington State can fully enroll the currently open nursing student opportunities that are unfilled due to lack of nurse faculty. With an aging population and a strong demand for more nurses, ensuring we can graduate the maximum number of nursing students is critical to our state’s healthcare system.

The Workforce Education Investment Act, Washington State House Bill 2158 (2019), directly addresses what nurse educators have consistently found as the most challenging issue associated with faculty recruitment and retention: pay that is dramatically lower than what first year nurses earn in a hospital setting and in direct care settings. Beyond nurse faculty raises, two-year and technical schools are using funds from House Bill 2158 (2019) to reinforce nursing programs by adding needed nursing faculty and expanding LPN, ADN, and simulation programs.

**Lessons Learned**
Shared governance among nursing organizations with different missions, roles, and culture in the nursing community is not easy to create, but is necessary to success. Maximizing or building on the strength of each organization is key.

As the state nursing workforce center, the WCN worked with CNEWS to survey the Washington State nurse faculty population. The survey was adapted from the Oregon Center for Nursing nurse faculty survey (Allgeyer & Bitton, 2017). It is important to disseminate the findings from such surveys to support the efforts for improvement. Thus, the results were published in December of 2017 (Aragon & Ellis, 2017).

Yearly, NCQAC collects and reports data from approved nursing education programs across the state. Reports included important data that reflected the number of full and part time nurse faculty; retirement rates of nursing faculty; demographics; and other characteristics of nurse educators and nursing schools.

CNEWS is an organization of deans and directors of schools of nursing in community and technical colleges and four-year colleges and universities. For many years they met regularly to share challenges and offer support to each other. A troubling trend the group observed was the high rate of turnover in their organization. To address this concern, one of the co-leads specifically studied dean and director turnover. The results indicated a potentially negative impact to student NCLEX scores. (S. Bear, personal communication, December 1, 2016).

The union faction of WSNA, SEIU Healthcare 1199NW, and UFCW 21 were collectively known as the nursing coalition at the state legislature. There, they coordinated legislative advocacy around numerous health workforce issues, including nurse faculty salaries. Using information provided from the *Action Now!* Steering Committee, they crafted a brief document stating the needed legislative appropriation and justification for the dollars. They also crafted a question and answer sheet in anticipation of questions from lawmakers. This coalition was important to achieving funding to significantly increase faculty salaries, as discussed above.

**Moving Forward with Ongoing Challenges**
**Policy Challenges**

While House Bill 2158, the Workforce Investment Act (2019), was a tremendous victory that provided $40 million in funding to increase salaries by 26.5% for community college faculty. It is now important to address compensation for nurse educators in four-year colleges and universities so as to not create inequities between these two systems. The unintended consequence of salary inequity is increased recruitment and retention of students for nursing programs in community and technical colleges, but not for programs in four-year colleges and universities.

The success of Action Now! has created support for two additional initiatives; academic progression for LPNs to a BSN and recruitment and retention of diverse nurse faculty. The WCN received a planning grant to support a workgroup of nurse educators, higher education policy makers, and interested stakeholders to create a blueprint for a direct transfer agreement for LPNs to pursue a BSN degree. The WCN also received a two-year implementation grant to expand workshops for nurses seeking to become professors. These workshops, designed for practicing nurses and promising nursing students of underrepresented groups, increase awareness of and encourage nurses to consider a career in nursing education. The workshops provide an overview of the requirements and the work life of nurse educators in community colleges, four-year public colleges and universities, and private four-year colleges and universities. While nurse faculty representing diverse backgrounds also agree that compensation is the greatest barrier to recruitment and retention, an intentional focus on the unique issues facing diverse nurses is needed.

In revising the two remaining priorities, the steering committee decided that the most imminent focus is equitable compensation for the four-year colleges and universities. The priority related to quality practice experiences will remain on the list, allowing the coalition to identify opportunities to pursue this goal.

**Continued Stakeholder Engagement**

Action Now! steering committee and workgroup members committed tremendous time and energy throughout the two years of their gathering. Inevitably, work demand and turnover necessarily changes the composition of the coalition. Action Now! leaders sent an e-mail to workgroup members acknowledging accomplishments and the end of the first chapter of this work, thanking them for their partnership. In addition, stakeholders were asked to respond with details about their area of focus in the initiative and the most important priorities from their perspective. We have received some feedback, such as how the vision for Action Now! will continue related to further promoting completion of the BSN degree.

Communication within the Action Now! coalition will include ongoing efforts to address the four “big rocks,” or significant barriers. The WCN and NCQAC will continue to take the lead to assure continued data collection about the nursing workforce. While data are collected by the NCQAC, the WCN provides the analysis and reports to describe specific characteristics of the nursing workforce. In addition, the WCN and the University of Washington Center for Health Workforce Studies collaborate to monitor trends in nursing workforce demand noted by employers. CNEWS is a key forum for nurse educators to take leadership to improve and strengthen nursing education with nursing partners and key stakeholders to prepare future generations of nurses.

**Conclusion**

A positive finding of the WCN 2017 Washington State nurse educator survey (Aragon & Ellis, 2017) is that these educators enjoy professional satisfaction, especially when it comes to relationships with students, colleagues, management, and professional autonomy. A handful of survey respondents were in their 70s, demonstrating that this is a career with potential for longevity. As more and more faculty approach retirement, it is crucial for leaders in nursing education to be able to increase recruitment and retention of the next generation of faculty. Nursing education is an attractive career choice which is ideally pursued for workplace satisfaction, and should not be deterred by inadequate compensation and unmanageable workload. The efforts of the Action Now! coalition have made important strides to address their identified barriers in nursing education and hope that the discussion of our initiative will prove useful to others with similar goals.

**Authors**
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Sofia Aragon is the Executive Director for the Washington Center for Nursing. The WCN is the state nursing workforce and resource center advancing nursing leadership, diversity, and workforce development for LPNs, RNs, and ARNPs. She is also the Immediate Past President of the National Forum of Nursing Workforce Centers. Her previous roles include Senior Governmental Affairs Advisor for the Washington State Nurses Association, representing the legislative interests of registered nurses, the School Nurse Organization of Washington and Advanced Registered Nurse Practitioners United of Washington State. She also serves on the board of directors of the WA Low Income Housing Alliance to address homelessness and affordable housing in WA State and on the board of Asian Pacific Americans for Civic Empowerment, which works to elevate the civic engagement of API residents. She earned a Bachelor of Arts degree in Economics from the University of Washington, a Bachelor of Science in Nursing degree from Seattle University and a Juris Doctor from Loyola University-Chicago School of Law.

NOTE: The acronym ARNP is used in Washington State (Central Nursing Resource Center, 2005, § 4).

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Dr. Babbo has been a nurse educator for the past 28 years, serving as a tenured professor and Associate Dean of Nursing at Olympic College. Dr. Babbo led the team for the first RN-BSN program in the community college setting in Washington State, and the third in the nation. She is currently the Director of Nursing Education for the Nursing Care Quality Assurance Commission of Washington State.

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Dr. Sarah Bear is a Nursing Education Consultant for the Washington State Department of Health Nursing Care Quality Assurance Commission. She has a broad range of nursing education experience in the community college, private university, and public university settings. Her area of research includes exploration of factors contributing to retention of academic nursing program dean and directors. Dr. Bear’s clinical practice included hospice, medical surgical, and emergency department nursing.

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Dr. Schaffner has served in public policy administration and administration for over thirty-years. She has held positions in nursing education and at the time of this writing was the Associate Director of Nursing Education for the Washington State Nursing Commission. She continues her work in healthcare by now serving as a Clinical Consultant in long-term care services.

References


September 11, 2020  
NCQAC Business Meeting  
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To: Sen. Andy Billig, Senate Majority Leader  
    Rep. Laurie Jinkins, Speaker of the House,  
    Sen. Mark Schoesler, Senate Minority Leader  
    Rep. J.T. Wilcox, House Minority Leader  

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

Re: Request to Extend Emergency Proclamation 20-37  

Date: August 26, 2020  

The Nursing Care Quality Assurance Commission (NCQAC) recommends a further extension of the waivers included in Proclamation 20-37, which you previously extended until September 1, 2020. The Proclamation waives the requirements for nursing assistants working in nursing homes to become certified within four months of hire, namely RCW 18.88A.030(2)(a) and WAC 388-97-1660(3)(a)(i).  

The NCQAC specifically supports an extension of this waiver until stakeholders (providers, long term care associations and the Department of Social and Health Services) can work with the Legislature on legislation that would allow workers who cannot meet the 120-day standard to continue to work in this setting. The effort to draft legislation has begun with an agency/provider stakeholder group through DSHS. At a minimum, an extension through February 2021, would help alleviate the stress on skilled nursing facility providers who are challenged to ensure that adequate staff are available to serve patients. An extension through February 2021 allows time for the new testing format to work its way through the unprecedented backlog, enabling current nursing assistants to become certified. We fully support the ultimate certification of these workers and are committed with our partners to resolving this backlog of nursing assistants who have not been able to complete their certification examination.  

The extension continues to be critical to assure adequate care providers for long-term care residents and is a longer-term need than hoped:  

- We currently estimate a backlog of 3,000 first-time test-takers due to the 5-month suspension of testing due to COVID-19.  

- As of July 31, 2020, reports indicate that Washington already has 4,155 fewer nursing assistants than it had at the end of 2019—67% of them lost between May 31 and July 31. This represents a 5.5% decrease in overall workforce since December--in an essential field
where vacancies were already high—and is truly a crisis. If a nursing assistant typically cares for 20 individuals each day, this deficit represents 83,100 patients without nursing assistant care. Further reductions risk public safety as we work our way through the testing backlog.

- NCQAC has been working with Pearson/VUE, the testing company. The testing of clinical skills using six foot distancing guidelines and isolation standards by the testing company resumed in Phase 2 counties across the state on August 14, 2020. The oral/written portion of the examination is being converted to computer based testing for availability at 26 test centers throughout Washington and 5 more in neighboring Oregon locations.

- Working through the testing backlog will take more time than hoped. For skills testing, we have found that several evaluators obtained other employment during the 5-month lay-off; this is limiting testing capacity. Also, computer-based written or knowledge test was slated to be available on August 31, 2020, but the testing company has now informed us that it will not be ready for launch by that date; we are awaiting an updated launch date.

- Nursing Assistants have not been able to become certified since the test centers closed in March. Therefore, without the extension, they can no longer be employed after 120 days; this reduces staff available to our already overburdened long-term care facilities.

- Coupled with increased COVID-19 testing in long-term care facilities (which we fully support)—these circumstances are likely to produce a perfect storm, further reducing nursing and nursing assistant staffing as those who test positive are unable to work during self- isolation.

Please let me know if you need any further information. You can reach me by cell phone at (360) 239-4310 or by email at paula.meyer@doh.wa.gov.

Thank you for all of your work, your time, and your support.

Cc:  Amber Leaders  
     Kristin Peterson  
     John Wiesman  
     Candace Goehring  
     Bill Moss
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/wsatc 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.


The Nursing Care Quality Assurance Commission COVID-19 Pandemic
Regulatory Statement

The Nursing Care Quality Assurance Commission (NCQAC) Commissioners and staff acknowledge that it is an unprecedented time in health care. Most NCQAC Commissioners are themselves practicing nurses and many supporting staff are nurses. We understand the realities of nursing and are very aware of the current stresses to our healthcare system. We know that you are experiencing stress and anxiety and may be concerned about being able to maintain standards of nursing practice. In making disciplinary decisions, the Commissioners always consider the facts and totality of the circumstances surrounding any complaint; including systems, scarce resources, and the fact that this is an ongoing emergency and some circumstances are beyond the control of an individual. We want to assure you that the standard of care is always considered in context. The standard of care may evolve with the dynamic nature of a pandemic or disaster, if resources become scarce.

Working within a quickly changing environment can be challenging and distressing. In this situation, it is important to make reasonable efforts to comply with any direction from NCQAC and your workplace policies and procedures pertaining to COVID-19 management. Please see the NCQAC website for the most updated practice resources related to the COVID-19 emergency. Nurses are encouraged to contact our practice consultants with specific concerns or questions. While NCQAC will continue to receive complaints and reports during the COVID-19 pandemic, the complaints will be assessed to include all information within the context of the circumstances in which nurses are working. The Commissioners have faith that the nurses in Washington State have risen to the occasion and treated their patients to the best of their ability.
RCW 18.79.260

Registered nurse—Activities allowed—Delegation of tasks.

(1) A registered nurse under his or her license may perform for compensation nursing care, as that term is usually understood, to individuals with illnesses, injuries, or disabilities.

(2) A registered nurse may, at or under the general direction of a licensed physician and surgeon, dentist, osteopathic physician and surgeon, naturopathic physician, optometrist, podiatric physician and surgeon, physician assistant, advanced registered nurse practitioner, or midwife acting within the scope of his or her license, administer medications, treatments, tests, and inoculations, whether or not the severing or penetrating of tissues is involved and whether or not a degree of independent judgment and skill is required. Such direction must be for acts which are within the scope of registered nursing practice.

(3) A registered nurse may delegate tasks of nursing care to other individuals where the registered nurse determines that it is in the best interest of the patient.

(a) The delegating nurse shall:
   (i) Determine the competency of the individual to perform the tasks;
   (ii) Evaluate the appropriateness of the delegation;
   (iii) Supervise the actions of the person performing the delegated task; and
   (iv) Delegate only those tasks that are within the registered nurse's scope of practice.

(b) A registered nurse, working for a home health or hospice agency regulated under chapter 70.127 RCW, may delegate the application, instillation, or insertion of medications to a registered or certified nursing assistant under a plan of care.

(c) Except as authorized in (b) or (e) of this subsection, a registered nurse may not delegate the administration of medications. Except as authorized in (e) of this subsection, a registered nurse may not delegate acts requiring substantial skill, and may not delegate piercing or severing of tissues. Acts that require nursing judgment shall not be delegated.

(d) No person may coerce a nurse into compromising patient safety by requiring the nurse to delegate if the nurse determines that it is inappropriate to do so. Nurses shall not be subject to any employer reprisal or disciplinary action by the nursing care quality assurance commission for refusing to delegate tasks or refusing to provide the required training for delegation if the nurse determines delegation may compromise patient safety.

(e) For delegation in community-based care settings or in-home care settings, a registered nurse may delegate nursing care tasks only to registered or certified nursing assistants or home care aides certified under chapter 18.88B RCW. Simple care tasks such as blood pressure monitoring, personal care service, diabetic insulin device set up, verbal verification of insulin dosage for sight-impaired individuals, or other tasks as defined by the nursing care quality assurance commission are exempted from this requirement.
(i) "Community-based care settings" includes: Community residential programs for people with developmental disabilities, certified by the department of social and health services under chapter 71A.12 RCW; adult family homes licensed under chapter 70.128 RCW; and assisted living facilities licensed under chapter 18.20 RCW. Community-based care settings do not include acute care or skilled nursing facilities.

(ii) "In-home care settings" include an individual's place of temporary or permanent residence, but does not include acute care or skilled nursing facilities, and does not include community-based care settings as defined in (e)(i) of this subsection.

(iii) Delegation of nursing care tasks in community-based care settings and in-home care settings is only allowed for individuals who have a stable and predictable condition. "Stable and predictable condition" means a situation in which the individual's clinical and behavioral status is known and does not require the frequent presence and evaluation of a registered nurse.

(iv) The determination of the appropriateness of delegation of a nursing task is at the discretion of the registered nurse. Other than delegation of the administration of insulin by injection for the purpose of caring for individuals with diabetes, the administration of medications by injection, sterile procedures, and central line maintenance may never be delegated.

(v) When delegating insulin injections under this section, the registered nurse delegator must instruct the individual regarding proper injection procedures and the use of insulin, demonstrate proper injection procedures, and must supervise and evaluate the individual performing the delegated task weekly during the first four weeks of delegation of insulin injections, as required by the commission. If the registered nurse delegator determines that the individual is competent to perform the injection properly and safely, supervision and evaluation shall occur at least every ninety days thereafter, as determined by the commission.

(vi)(A) The registered nurse shall verify that the nursing assistant or home care aide, as the case may be, has completed the required core nurse delegation training required in chapter 18.88A or 18.88B RCW prior to authorizing delegation.

(B) Before commencing any specific nursing tasks authorized to be delegated in this section, a home care aide must be certified pursuant to chapter 18.88B RCW and must comply with RCW 18.88B.070.

(vii) The nurse is accountable for his or her own individual actions in the delegation process. Nurses acting within the protocols of their delegation authority are immune from liability for any action performed in the course of their delegation duties.

(viii) Nursing task delegation protocols are not intended to regulate the settings in which delegation may occur, but are intended to ensure that nursing care services have a consistent standard of practice upon which the public and the profession may rely, and to safeguard the authority of the nurse to make independent professional decisions regarding the delegation of a task.

(f) The nursing care quality assurance commission may adopt rules to implement this section.

(4) Only a person licensed as a registered nurse may instruct nurses in technical subjects pertaining to nursing.
(5) Only a person licensed as a registered nurse may hold herself or himself out to the public or designate herself or himself as a registered nurse.

RCW 18.88A.030
Scope of practice—Nursing home employment—Voluntary certification—Rules.

(1)(a) A nursing assistant may assist in the care of individuals as delegated by and under the direction and supervision of a licensed (registered) nurse or licensed practical nurse.

(b) A health care facility shall not assign a nursing assistant-registered to provide care until the nursing assistant-registered has demonstrated skills necessary to perform competently all assigned duties and responsibilities.

(c) Nothing in this chapter shall be construed to confer on a nursing assistant the authority to administer medication unless delegated as a specific nursing task pursuant to this chapter or to practice as a licensed (registered) nurse or licensed practical nurse as defined in chapter 18.79 RCW.

(2)(a) A nursing assistant employed in a nursing home must have successfully obtained certification through: (i) An approved training program and the competency evaluation within four months after the date of employment; a period of time defined in rule by the commission; or (ii) alternative training and the competency evaluation prior to employment.

(b) Certification is voluntary for nursing assistants working in health care facilities other than nursing homes unless otherwise required by state or federal law or regulation.

(3) The commission may adopt rules to implement the provisions of this chapter.

RCW 18.88A.087
Certification—Alternative training—Credentialing reciprocity—Report.

(1) The commission shall adopt criteria for evaluating an applicant's alternative training to determine the applicant's eligibility to take the competency evaluation for nursing assistant certification. At least one option adopted by the commission must allow an applicant to take the competency evaluation if he or she:

(a)(i) Is a certified home care aide pursuant to chapter 18.88B RCW; or

(ii) Is a certified medical assistant pursuant to a certification program accredited by a national medical assistant accreditation organization and approved by the commission; and
(b) Has successfully completed at least twenty-four hours of training that the commission determines is necessary to provide training equivalent to approved training on topics not addressed in the training specified for certification as a home care aide or medical assistant, as applicable. In the commission's discretion, a portion of these hours may include clinical training.

(2)(a) By July 1, 2011, the commission, in consultation with the secretary, the department of social and health services, and consumer, employer, and worker representatives, shall adopt rules to implement this section and to provide, beginning January 1, 2012, for a program of credentialing reciprocity to the extent required by this section between home care aide and medical assistant certification and nursing assistant certification. By July 1, 2011, the secretary shall also adopt such rules as may be necessary to implement this section and the credentialing reciprocity program.

(b) Rules adopted under this section must be consistent with requirements under 42 U.S.C. Sec. 1395i-3(e) and (f) of the federal social security act relating to state-approved competency evaluation programs for certified nurse aides.

(3) Beginning December 1, 2012, the secretary, in consultation with the commission, shall report annually by December 1st to the governor and the appropriate committees of the legislature on the progress made in achieving career advancement for certified home care aides and medical assistants into nursing practice.

RCW 18.88A.100

Waiver of examination for initial applications.

The secretary shall waive the competency evaluation and certify a person to practice within the state of Washington if the commission determines that the person meets commonly accepted standards of education and experience for the nursing assistants. This section applies only to those individuals who file an application for waiver by December 31, 1991.
WSR 20-14-065
EMERGENCY RULES
DEPARTMENT OF HEALTH
(Nursing Care Quality Assurance Commission)
[Filed June 26, 2020, 1:48 p.m., effective June 26, 2020, 1:48 p.m.]

Effective Date of Rule: Immediately upon filing.


The nursing care quality assurance commission (commission) is adopting emergency rules in response to the coronavirus disease (COVID-19). This emergency rule supersedes similar emergency rules filed on April 24, 2020, as WSR 20-10-014. This emergency rule retains the amendments adopted as WSR 20-10-014 and in addition, waives the requirements for an ARNP to submit evidence of completing continuing education in order to return to active status when holding an inactive license, or when returning to active status from expired status.

The rules in chapter 246-840 WAC are the licensing requirements for LPNs, RNs, and ARNPs. The emergency rules amend training program options, delegation requirements, and removing additional continuing education hours for specific ARNP credentials.


Statutory Authority for Adoption: RCW 18.79.010, 18.79.050, 18.79.110, 18.79.260, and 18.79.340.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: The immediate amendment of these rules is necessary for the preservation of public health, safety, and general welfare. Essential functions including increasing and maintaining the availability of health care professionals must continue while taking necessary measures to help treat and prevent the spread of COVID-19. The amendments remove specific barriers that nurses face to providing care in response to COVID-19. Waiving the requirement for continuing education removes a barrier for nurses with a retired active license and will allow them to immediately begin working. Waiving the restriction that ARNPs with an inactive or expired license must complete clinical practice hours and the newly amended continuing education requirements removes barriers to rejoining the health care workforce. Allowing LPN students to practice as nursing technicians addresses the demand for more healthcare professionals in the workforce. Amending language to add clarification to the preceptor rules and simulation rules eliminates current obstacles in nursing education to address the demand for more healthcare professionals. Amending the requirements for nurse delegation to waive requirements and streamline the process will remove barriers for nurses to complete high demand duties. More health care professionals will be available to respond to current demands because of these changes. Observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to protecting immediate public interests.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 9, Repealed 3.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 9, Repealed 3.
Date Adopted: June 26, 2020.

Paula Meyer, RN, MSN, FRE
Executive Director

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

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

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

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

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

(a) Nurse practitioner (NP);
(b) Certified nurse midwife (CNM);
(c) Certified registered nurse anesthetist (CRNA); and
(d) Clinical nurse specialist (CNS).

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

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

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

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

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

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

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

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

12) "Delegation" means the licensed nurse transfers the performance of selected nursing tasks to competent individuals in selected situations. The nurse delegating the task is responsible and accountable for the nursing care of the client. The nurse delegating the task supervises the performance of the unlicensed person.
Nurses must follow the delegation process following the RCW 18.79.260. Delegation in community and in-home care settings is defined by WAC 246-840-910 through 246-840-970.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30) "Nursing technician" means a nursing student preparing for RN or LPN licensure who meets the qualifications for licensure under RCW 18.79.340 who is employed in a hospital licensed under chapter 70.41 RCW or a nursing home licensed under chapter 18.51 RCW, or clinic. The nursing student must be in a nursing
educational program in the United States or its territories that is approved by the National Council Licensure Examination-RN or National Council Licensure Examination-PN. Approved nursing education programs do not include nontraditional schools as defined in subsection ((27))((26) of this section.

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

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

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

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

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

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

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

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

AMENDATORY SECTION  (Amending WSR 16-04-097, filed 2/1/16, effective 3/3/16)

WAC 246-840-125 Retired active credential.

(1) A registered or licensed practical nurse may place their credential in "retired active" status by meeting the requirements of this section.

(2) A registered or licensed practical nurse who holds a retired active credential may only practice in intermittent or emergent circumstances.

(a) Intermittent means the registered or licensed practical nurse will practice no more than ninety days a year.

(b) Emergent means the registered or licensed practical nurse will practice only in emergency circumstances such as earthquakes, floods, times of declared war, or other states of emergency.

(3) To obtain a retired active credential a registered or a licensed practical nurse must:

(a) Meet the requirements in WAC 246-12-120.

(b) Pay the appropriate fee in WAC 246-840-990.

(4) To renew a retired active credential the registered nurse or licensed practical nurse must:

(a) Meet the requirements in WAC 246-12-130. The retired active credential fee is in WAC 246-840-990.

(b) (Have completed forty-five hours of continuing nursing education every three years in compliance with WAC 246-840-220 (2)(b). Education may include CPR and first aid.

(c) Demonstrate they have practiced at least ninety-six hours every three years. Practice may be paid or volunteer, but must require nursing knowledge or a nursing license.

(d) Renew their retired active credential every year on their birthday.

(5) To return to active status the registered or licensed practical nurse must((a))(a) meet the requirements in WAC 246-12-140. The active renewal fee is in WAC 246-840-990.

(b) Meet the continuing competency requirements in WAC 246 840-230 (5)(d).
(6) A registered or licensed practical nurse who holds a retired active credential is subject to a continuing competency audit as outlined in WAC 246-840-220, 246-840-230, and 246-840-240.)

AMENDATORY SECTION  (Amending WSR 19-08-031, filed 3/27/19, effective 4/27/19)

WAC 246-840-365 Inactive and reactivating an ARNP license.
To apply for an inactive ARNP license, an ARNP shall comply with WAC 246-12-090 or 246-12-540, if military related.
   (1) An ARNP may apply for an inactive license if he or she holds an active Washington state ARNP license without sanctions or restrictions.
   (2) To return to active status the ARNP:
         (a) Shall meet the requirements identified in chapter 246-12 WAC, Part 4;
         (b) Must hold an active RN license under chapter 18.79 RCW without sanctions or restrictions;
         (c) Shall submit the fee as identified under WAC 246-840-990; and
         (d) Shall submit evidence of current certification by the commission approved certifying body identified in WAC 246-840-302(1)(f).
         (e) Shall submit evidence of thirty contact hours of continuing education for each designation within the past two years; and
         (f) Shall submit evidence of two hundred fifty hours of advanced clinical practice for each designation within the last two years:
            (3) An ARNP applicant who does not have the required practice requirements, shall complete two hundred fifty hours of supervised advanced clinical practice for every two years the applicant may have been out of practice, not to exceed one thousand hours.
   (4) The ARNP applicant needing to complete supervised advanced clinical practice shall obtain an ARNP interim permit consistent with the requirements for supervised practice defined in WAC 246-840-340 (4) and (5)).

   (((5)))(2) To regain prescriptive authority after inactive status, the applicant must meet the prescriptive authority requirements identified in WAC 246-840-410.

AMENDATORY SECTION  (Amending WSR 19-08-031, filed 3/27/19, effective 4/27/19)

WAC 246-840-367 Expired license.
When an ARNP license is not renewed, it is placed in expired status and the nurse must not practice as an ARNP.
   (1) To return to active status when the license has been expired for less than two years, the nurse shall:
       (a) Meet the requirements of chapter 246-12 WAC, Part 2;
       (b) Meet ARNP renewal requirements identified in WAC 246-840-360; and
       (c) Meet the prescriptive authority requirements identified in WAC 246-840-450, if renewing prescriptive authority.
   (2) ((Applicants who do not meet the required advanced clinical practice requirements must complete two hundred fifty hours of supervised advanced clinical practice for every two years the applicant may have been out of practice, not to exceed one thousand hours).
       (3) The ARNP applicant needing to complete supervised advanced clinical practice shall obtain an ARNP interim permit consistent with the requirements for supervised practice defined in WAC 246-840-340 (4) and (5)).
       (4)) If the ARNP license has expired for two years or more, the applicant shall:
        (a) Meet the requirements of chapter 246-12 WAC, Part 2;
        (b) Submit evidence of current certification by the commission approved certifying body identified in WAC 246-840-302(3);
        (c) ((Submit evidence of thirty contact hours of continuing education for each designation within the prior two years;
Submit evidence of two hundred fifty hours of advanced clinical practice completed within the prior two years; and

Submit evidence of an additional thirty contact hours in pharmacology if requesting prescriptive authority, which may be granted once the ARNP license is returned to active status.

If the applicant does not meet the required advanced clinical practice hours, the applicant shall obtain an ARNP interim permit consistent with the requirements for supervised advanced clinical practice as defined in WAC 246-840-340 (4) and (5).

**AMENDATORY SECTION** (Amending WSR 19-08-026, filed 3/27/19, effective 4/27/19)

WAC 246-840-533 Nursing preceptors, interdisciplinary preceptors, and proctors in clinical or practice settings for nursing students located in Washington state.

1. Nursing preceptors, interdisciplinary preceptors, and proctors may be used to enhance clinical or practice learning experiences after a student has received instruction and orientation from program faculty who confirm the student is adequately prepared for the clinical or practice experience. For the purpose of this section:

   a. A nursing preceptor means a practicing licensed nurse who provides personal instruction, training, and supervision to any nursing student, and meets all requirements of subsection (4) of this section.

   b. An interdisciplinary preceptor means a practicing health care provider who is not a licensed nurse, but provides personal instruction, training, and supervision to any nursing student, and meets all requirements of subsection (5) of this section.

   c. A proctor means an individual who holds an active credential in one of the professions identified in RCW 18.130.040 who monitors students during an examination, skill, or practice delivery, and meets all requirements of subsection (6) of this section.

2. Nursing education faculty are responsible for the overall supervision and evaluation of the student and must confer with each primary nursing and interdisciplinary preceptor, and student at least once during each phase of the student learning experience:

   a. Beginning;

   b. Midpoint; and

   c. End.

3. A nursing preceptor or an interdisciplinary preceptor shall not precept more than two students at any one time.

4. A nursing preceptor may be used in nursing education programs when the nursing preceptor:

   a. Has an active, unencumbered nursing license at or above the level for which the student is preparing;

   b. Has at least one year of clinical or practice experience as a licensed nurse at or above the level for which the student is preparing;

   c. Is oriented to the written course and student learning objectives prior to beginning the preceptorship;

   d. Is oriented to the written role expectations of faculty, preceptor, and student prior to beginning the preceptorship; and

   e. Is not a member of the student's immediate family, as defined in RCW 42.17A.005(27); or have a financial, business, or professional relationship that is in conflict with the proper discharge of the preceptor's duties to impartially supervise and evaluate the nurse.

5. An interdisciplinary preceptor may be used in nursing education programs when the interdisciplinary preceptor:

   a. Has an active, unencumbered license in the area of practice appropriate to the nursing education faculty planned student learning objectives;

   b. Has the educational preparation and at least one year of clinical or practice experience appropriate to the nursing education faculty planned student learning objectives;

   c. Is oriented to the written course and student learning objectives prior to beginning the preceptorship;

   d. Is oriented to the written role expectations of faculty, preceptor, and student prior to beginning the preceptorship; and

   e. Is not a member of the student's immediate family, as defined in RCW 42.17A.005(27); or have a financial, business, or professional relationship that is in conflict with the proper discharge of the preceptor's duties to impartially supervise and evaluate the nurse.
(6) A proctor who monitors, teaches, and supervises students during the performance of a task or skill must:
(a) Have the educational and experiential preparation for the task or skill being proctored;
(b) Have an active, unencumbered credential in one of the professions identified in RCW 18.130.040;
(c) Only be used on rare, short-term occasions to proctor students when a faculty member has determined that it is safe for a student to receive direct supervision from the proctor for the performance of a particular task or skill that is within the scope of practice for the nursing student; and
(d) Is not a member of the student’s immediate family, as defined in RCW 42.17A.005(27); or have a financial, business, or professional relationship that is in conflict with the proper discharge of the preceptor's duties to impartially supervise and evaluate the nurse.

(7) A practice/academic partnerships model may be used to permit practice hours as a nursing technician, as defined in WAC 246-840-010(30), to be credited toward direct care nursing program clinical hours, and academic credit. Use of this model must include:
(a) A nursing preceptor or nursing supervisor who has experience and educational preparation appropriate to the faculty-planned student learning experience. The nursing preceptor or nursing supervisor must be responsible for ensuring the requirements of WAC 246-840-880 are met;
(b) Nursing program faculty that work with health care facility representatives to align clinical skills and competencies with the nursing student-employee work role/responsibilities;
(c) Nursing student-employees with faculty-planned clinical practice experiences that enable the student to attain new knowledge, develop clinical reasoning/judgment abilities, and demonstrate achievement of clinical objectives and final learning outcomes of the nursing program if the nursing student-employee is in the final nursing course;
(d) The nursing student-employee use of reflection on the development or achievement of clinical objectives and final learning outcomes as designed by nursing education faculty;
(e) Nursing education faculty responsible for the overall supervision and evaluation of the nursing student-employee on a weekly basis;
(f) Evaluation by nursing education faculty to include documentation of the nursing student-employee achievement of clinical objectives and final learning outcomes and competencies of the nursing program; and
(g) Nursing technicians be enrolled in a commission-approved nursing program and be in good standing to receive academic credit.

AMENDATORY SECTION  (Amending WSR 16-17-082, filed 8/17/16, effective 9/17/16)

WAC 246-840-534 Use of simulation for clinical experiences in LPN, RN, or RN to BSN nursing education programs located in Washington state.

(1) An LPN, RN, or RN to BSN nursing education program may use simulation as a substitute for traditional clinical experiences, after approval by the commission, not to exceed fifty percent of its clinical hours ((for a particular course)) across the curriculum required for the program type.
(a) Simulation as used in this section means a technique to replace or amplify real experiences with guided experiences evoking or replicating substantial aspects of the real world in a fully interactive manner.
(b) The nursing education program shall have an organizing framework providing adequate fiscal, human, technological, and material resources to support the simulation activities.
(c) Simulation activities must be managed by an individual who is academically and experientially qualified and who demonstrates currency and competency in the use of simulation while managing the simulation program.
(d) The nursing education program shall have a budget sustaining simulation activities and training of the faculty.
(e) The nursing education program shall have appropriate facilities, educational and technological resources and equipment to meet the intended objectives of the simulation.
(f) All faculty involved in simulations, both didactic and clinical, shall have training in the use of simulation and shall engage in ongoing professional development in the use of simulation.
(g) Faculty to student ratios in the simulation lab must be in the same ratio as identified in WAC 246-840-532 for clinical learning experiences.
(2) Faculty shall organize clinical and practice experiences based on the educational preparation and skill level of the student.
(3) Qualified simulation faculty must supervise and evaluate student clinical and practice experiences.
   (a) The nursing education program shall demonstrate that simulation activities are linked to
       programmatic outcomes.
   (b) The nursing education program shall have written policies and procedures on the following:
       (i) Short-term and long-term plans for integrating simulation into the curriculum;
       (ii) An identified method of debriefing each simulated activity; and
       (iii) A plan for orienting faculty to simulation.
   (c) Debriefing as used in this section means an activity following a simulation experience that is led by a
       facilitator, encourages reflective thinking, and provides feedback regarding the participant's performance.
   (d) The nursing education program shall develop criteria to evaluate simulation activities.
   (e) Students shall evaluate the simulation experience on an ongoing basis.
   (f) The program shall include information about use of simulation in its annual report to the commission.
   (4) The ratio of simulation hours to clinical experience hours will be calculated as follows:
       (a) One clock hour of simulation may be considered equivalent up to two clock hours of clinical
           experience if the following conditions are met:
           (i) The program holds full approval status by the commission, and is nationally accredited;
           (ii) The program has received commission approval to conduct simulation, and is in alignment with the
               provisions of this section;
           (iii) The program will collect evaluation data on simulation outcomes with tools provided by the
               commission.
       (b) One clock hour of simulation may be considered equivalent to one clock hour of clinical experience if
           one or more of the following conditions are present:
           (i) The program's approval status is conditional;
           (ii) The program is not nationally accredited; unless the program is in pre-accreditation status, and the
               commission has specifically granted approval for a one-to-two ratio;
           (iii) The program has not previously received commission approval to conduct simulation;
           (iv) The program is not in alignment with the provisions of this section;
           (v) The program is on a current plan of correction, unless the commission has specifically granted
               approval for a one-to-two ratio.

AMENDATORY SECTION  (Amending WSR 13-15-064, filed 7/15/13, effective 8/15/13)

WAC 246-840-840 Nursing technician.
The purpose of the nursing technician credential is to provide additional work related opportunities for
students enrolled in an LPN, ADN or BSN program, within the limits of their education, to gain valuable
judgment and knowledge through expanded work opportunities.
   (1) The nursing technician is as defined in WAC 246-840-010((H8))(30).
   (2) The nursing technician shall have knowledge and understanding of the laws and rules regulating the
       nursing technician and shall function within the legal scope of their authorization under chapter 18.79 RCW and
       shall be responsible and accountable for the specific nursing functions which they can safely perform as verified
       by their nursing program.
   (3) The nursing technician shall work directly for the hospital, clinic or nursing home and may not be
       employed in these facilities through a temporary agency.

AMENDATORY SECTION  (Amending WSR 13-15-063, filed 7/15/13, effective 8/15/13)

WAC 246-840-930 Criteria for delegation.
(1) Before delegating a nursing task, the registered nurse delegator decides the task is appropriate to
delegate based on the elements of the nursing process: ASSESS, PLAN, IMPLEMENT, EVALUATE.
(2) The setting allows delegation because it is a community-based care setting as defined by RCW 18.79.260 (3)(e)(i) or an in-home care setting as defined by RCW 18.79.260 (3)(e)(ii).

(3) Assess the patient's nursing care needs and determine the patient's condition is stable and predictable. A patient may be stable and predictable with an order for sliding scale insulin or terminal condition.

(4) Determine the task to be delegated is within the delegating nurse's area of responsibility.

(5) Determine the task to be delegated can be properly and safely performed by the nursing assistant or home care aide. The registered nurse delegator assesses the potential risk of harm for the individual patient.

(6) Analyze the complexity of the nursing task and determine the required training or additional training needed by the nursing assistant or home care aide to competently accomplish the task. The registered nurse delegator identifies and facilitates any additional training of the nursing assistant or home care aide needed prior to delegation. The registered nurse delegator ensures the task to be delegated can be properly and safely performed by the nursing assistant or home care aide.

(7) Assess the level of interaction required. Consider language or cultural diversity affecting communication or the ability to accomplish the task and to facilitate the interaction.

(8) Verify that the nursing assistant or home care aide:
   (a) Is currently registered or certified as a nursing assistant or home care aide in Washington state without restriction;
   (b) Has completed (both) the (basic caregiver training and) core delegation training before performing any delegated task;
   (c) Has a certificate of completion issued by the department of social and health services indicating completion of the required core nurse delegation training;
   (d) Has a certificate of completion issued by the department of social and health services indicating completion of diabetes training when providing insulin injections to a diabetic client; and
   (e) Is willing and able to perform the task in the absence of direct or immediate nurse supervision and accept responsibility for their actions.

(9) Assess the ability of the nursing assistant or home care aide to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision.

(10) If the registered nurse delegator determines delegation is appropriate, the nurse:
   (a) Discusses the delegation process with the patient or authorized representative, including the level of training of the nursing assistant or home care aide delivering care.
   (b) Obtains written or verbal consent (The patient, or authorized representative, must give written consent to the delegation process under chapter 7.70 RCW. Documented verbal consent of patient or authorized representative may be acceptable if written consent is obtained within thirty days;) under chapter 7.70 RCW, which must be documented in the patient record. Electronic consent is an acceptable format. (Written) Consent is only necessary at the initial use of the nurse delegation process for each patient and is not necessary for task additions or changes or if a different nurse, nursing assistant, or home care aide will be participating in the process.

(11) Document in the patient's record the rationale for delegating or not delegating nursing tasks.

(12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes:
   (a) The rationale for delegating the nursing task;
   (b) The delegated nursing task is specific to one patient and is not transferable to another patient;
   (c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide;
   (d) The nature of the condition requiring treatment and purpose of the delegated nursing task;
   (e) A clear description of the procedure or steps to follow to perform the task;
   (f) The predictable outcomes of the nursing task and how to effectively deal with them;
   (g) The risks of the treatment;
   (h) The interactions of prescribed medications;
   (i) How to observe and report side effects, complications, or unexpected outcomes and appropriate actions to deal with them, including specific parameters for notifying the registered nurse delegator, health care provider, or emergency services;
(j) The action to take in situations where medications and/or treatments and/or procedures are altered by health care provider orders, including:
   (i) How to notify the registered nurse delegator of the change;
   (ii) The process the registered nurse delegator uses to obtain verification from the health care provider of the change in the medical order; and
   (iii) The process to notify the nursing assistant or home care aide of whether administration of the medication or performance of the procedure and/or treatment is delegated or not;
   (k) How to document the task in the patient's record;
   (l) Document teaching done and a return demonstration, or other method for verification of competency; and
   (m) Supervision shall occur at least every (ninety) one hundred twenty days. With delegation of insulin injections, (the supervision occurs at least weekly for the first four weeks, and may be more frequent) after initial training on the task that the registered nurse considers appropriate, the registered nurse will assess the competence of the nursing assistant and determine further supervision needs as appropriate.

(13) The administration of medications may be delegated at the discretion of the registered nurse delegator, including insulin injections. Any other injection (intramuscular, intradermal, subcutaneous, intraosseous, intravenous, or otherwise) is prohibited. The registered nurse delegator provides to the nursing assistant or home care aide written directions specific to an individual patient.

IMPLEMENT

(14) Delegation requires the registered nurse delegator teach the nursing assistant or home care aide how to perform the task, including return demonstration or other method of verification of competency as determined by the registered nurse delegator.

(15) The registered nurse delegator is accountable and responsible for the delegated nursing task. The registered nurse delegator monitors the performance of the task(s) to assure compliance with established standards of practice, policies and procedures and appropriate documentation of the task(s).

EVALUATE

(16) The registered nurse delegator evaluates the patient's responses to the delegated nursing care and to any modification of the nursing components of the patient's plan of care.

(17) The registered nurse delegator supervises and evaluates the performance of the nursing assistant or home care aide, including direct observation or other method of verification of competency of the nursing assistant or home care aide. The registered nurse delegator reevaluates the patient's condition, the care provided to the patient, the capability of the nursing assistant or home care aide, the outcome of the task, and any problems.

(18) The registered nurse delegator ensures safe and effective services are provided. Reevaluation and documentation occurs at least every (ninety) one hundred twenty days. Frequency of supervision is at the discretion of the registered nurse delegator and may be more often based upon nursing assessment.

(19) The registered nurse must supervise and evaluate the performance of the nursing assistant or home care aide with delegated insulin injection authority (at least weekly for the first four weeks. After the first four weeks, the supervision shall occur at least every ninety days) as needed, but at least once every one hundred twenty days.

REPEALER

The following sections of the Washington Administrative Code are repealed:
WAC 246-840-210 Continuing competency definitions.
WAC 246-840-240 Extension.
WAC 246-840-361 Continuing education for ARNP license renewal.

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

WAC 246-841-405 Nursing assistant delegation.
Provision for delegation of certain tasks.
(1) Nursing assistants perform tasks delegated by a registered nurse for patients in community-based care settings or in-home care settings each as defined in RCW 18.79.260 (3)(e).
(2) Before performing any delegated task:
(a) Nursing assistants-registered must show the certificate of completion of ((both the basic caregiver training and)) core delegation training from the department of social and health services to the registered nurse delegator.
(b) Nursing assistants-certified must show the certificate of completion of the core delegation training from the department of social and health services to the registered nurse delegator.
(c) All nursing assistants must comply with all applicable requirements of the nursing care quality assurance commission in WAC 246-840-910 through 246-840-970.
(d) All nursing assistants, registered and certified, who may be completing insulin injections must give a certificate of completion of diabetic training from the department of social and health services to the registered nurse delegator.
(e) All nursing assistants must meet any additional training requirements identified by the nursing care quality assurance commission. Any exceptions to additional training requirements must comply with RCW 18.79.260 (3)(e)(v).
(3) Delegated nursing care tasks described in this section are:
(a) Only for the specific patient receiving delegation;
(b) Only with the patient's consent; and
(c) In compliance with all applicable requirements in WAC 246-840-910 through 246-840-970.
(4) A nursing assistant may consent or refuse to consent to perform a delegated nursing care task. The nursing assistant is responsible for their own actions with the decision to consent or refuse to consent and the performance of the delegated nursing care task.
(5) Nursing assistants shall not accept delegation of, or perform, the following nursing care tasks:
(a) Administration of medication by injection, with the exception of insulin injections;
(b) Sterile procedures;
(c) Central line maintenance;
(d) Acts that require nursing judgment.
NCQAC Table of current waivers and modifications

8/21/2020

Governor waivers identified by Proclamation number, e.g. {{20-32}}

{{E-Rules 1}} denotes emergency rules approved 4/8/2020 by NCQAC

{{E-Rules 2}} denotes rules approved 4/16/2020 by NCQAC

{{Secretary}} denotes waivers granted by the Secretary of Health

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RCW 18.79.260
Registered nurse—Activities allowed—Delegation of tasks.

(1) A registered nurse under his or her license may perform for compensation nursing care, as that term is usually understood, to individuals with illnesses, injuries, or disabilities.

(2) A registered nurse may, at or under the general direction of a licensed physician and surgeon, dentist, osteopathic physician and surgeon, naturopathic physician, optometrist, podiatric physician and surgeon, physician assistant, advanced registered nurse practitioner, or midwife acting within the scope of his or her license, administer medications, treatments, tests, and inoculations, whether or not the severing or penetrating of tissues is involved and whether or not a degree of independent judgment and skill is required. Such direction must be for acts which are within the scope of registered nursing practice.

(3) A registered nurse may delegate tasks of nursing care to other individuals where the registered nurse determines that it is in the best interest of the patient.

(a) The delegating nurse shall:
   (i) Determine the competency of the individual to perform the tasks;
   (ii) Evaluate the appropriateness of the delegation;
   (iii) Supervise the actions of the person performing the delegated task; and
   (iv) Delegate only those tasks that are within the registered nurse’s scope of practice.

(b) A registered nurse, working for a home health or hospice agency regulated under chapter 70.127 RCW, may delegate the application, instillation, or insertion of medications to a registered or certified nursing assistant under a plan of care.

(c) Except as authorized in (b) or (e) of this subsection, a registered nurse may not delegate the administration of medications. Except as authorized in (e) of this subsection, a registered nurse may not delegate acts requiring substantial skill, and may not delegate piercing or severing of tissues. Acts that require nursing judgment shall not be delegated.

(d) No person may coerce a nurse into compromising patient safety by requiring the nurse to delegate if the nurse determines that it is inappropriate to do so. Nurses shall not be subject to any employer reprisal or disciplinary action by the nursing care quality assurance commission for refusing to delegate tasks or refusing to provide the required training for delegation if the nurse determines delegation may compromise patient safety.

(e) For delegation in community-based care settings or in-home care settings, a registered nurse may delegate nursing care tasks only to registered or certified nursing assistants or home care aides certified under chapter 18.88B RCW. Simple care tasks such as blood pressure monitoring, personal care service, diabetic insulin device set up, verbal verification of insulin dosage for sight-impaired individuals, or other tasks as defined by the nursing care quality assurance commission are exempted from this requirement.

(i) "Community-based care settings" includes: Community residential programs for people with developmental disabilities, certified by the department of social and health services under chapter 71A.12 RCW; adult family homes licensed under
chapter 70.128 RCW; and assisted living facilities licensed under chapter 18.20 RCW. Community-based care settings do not include acute care or skilled nursing facilities.

(ii) "In-home care settings" include an individual's place of temporary or permanent residence, but does not include acute care or skilled nursing facilities, and does not include community-based care settings as defined in (e)(i) of this subsection.

(iii) Delegation of nursing care tasks in community-based care settings and in-home care settings is only allowed for individuals who have a stable and predictable condition. "Stable and predictable condition" means a situation in which the individual's clinical and behavioral status is known and does not require the frequent presence and evaluation of a registered nurse.

(iv) The determination of the appropriateness of delegation of a nursing task is at the discretion of the registered nurse. Other than delegation of the administration of insulin by injection for the purpose of caring for individuals with diabetes, the administration of medications by injection, sterile procedures, and central line maintenance may never be delegated.

(v) When delegating insulin injections under this section, the registered nurse delegator must instruct the individual regarding proper injection procedures and the use of insulin, demonstrate proper injection procedures, and must supervise and evaluate the individual performing the delegated task weekly during the first four weeks of delegation of insulin injections as required by the commission. If the registered nurse delegator determines that the individual is competent to perform the injection properly and safely, supervision and evaluation shall occur at least every ninety days thereafter an interval determined by the commission.

(vi) (A) The registered nurse shall verify that the nursing assistant or home care aide, as the case may be, has completed the required core nurse delegation training required in chapter 18.88A or 18.88B RCW prior to authorizing delegation.

(B) Before commencing any specific nursing tasks authorized to be delegated in this section, a home care aide must be certified pursuant to chapter 18.88B RCW and must comply with RCW 18.88B.070.

(vii) The nurse is accountable for his or her own individual actions in the delegation process. Nurses acting within the protocols of their delegation authority are immune from liability for any action performed in the course of their delegation duties.

(viii) Nursing task delegation protocols are not intended to regulate the settings in which delegation may occur, but are intended to ensure that nursing care services have a consistent standard of practice upon which the public and the profession may rely, and to safeguard the authority of the nurse to make independent professional decisions regarding the delegation of a task.

(f) The nursing care quality assurance commission may adopt rules to implement this section.

(4) Only a person licensed as a registered nurse may instruct nurses in technical subjects pertaining to nursing.

(5) Only a person licensed as a registered nurse may hold herself or himself out to the public or designate herself or himself as a registered nurse.
RCW 18.88A.030
Scope of practice—Nursing home employment—Voluntary certification—Rules.

(1)(a) A nursing assistant may assist in the care of individuals as delegated by and under the direction and supervision of a licensed (registered) nurse or licensed practical nurse.

(b) A health care facility shall not assign a nursing assistant-registered to provide care until the nursing assistant-registered has demonstrated skills necessary to perform competently all assigned duties and responsibilities.

(c) Nothing in this chapter shall be construed to confer on a nursing assistant the authority to administer medication unless delegated as a specific nursing task pursuant to this chapter or to practice as a licensed (registered) nurse or licensed practical nurse as defined in chapter 18.79 RCW.

(2)(a) A nursing assistant employed in a nursing home must have successfully obtained certification through: (i) An approved training program and the competency evaluation within four months after the date of employment; or (ii) alternative training and the competency evaluation prior to employment.

(b) Certification is voluntary for nursing assistants working in health care facilities other than nursing homes unless otherwise required by state or federal law or regulation.

(3) The commission may adopt rules to implement the provisions of this chapter.

RCW 18.88A.087
Certification—Alternative training—Credentialing reciprocity—Report.

(1) The commission shall adopt criteria for evaluating an applicant's alternative training to determine the applicant's eligibility to take the competency evaluation for nursing assistant certification. At least one option adopted by the commission must allow an applicant to take the competency evaluation if he or she:

(a)(i) Is a certified home care aide pursuant to chapter 18.88B RCW; or

(ii) Is a certified medical assistant pursuant to a certification program accredited by a national medical assistant accreditation organization and approved by the commission; and

(b) Has successfully completed at least twenty-four hours of training that the commission determines is necessary to provide training equivalent to approved training on topics not addressed in the training specified for certification as a home care aide or medical assistant, as applicable. In the commission's discretion, a portion of these hours may include clinical training.

(2)(a) The commission, in consultation with the secretary, the department of social and health services, and consumer, employer, and worker representatives, shall adopt rules to implement this section and to provide, beginning January 1, 2012, for a program of credentialing reciprocity to the extent required by this...
section between home care aide and medical assistant certification and nursing assistant certification. By July 1, 2011, the secretary shall also adopt such rules as may be necessary to implement this section and the credentialing reciprocity program.

(b) Rules adopted under this section must be consistent with requirements under 42 U.S.C. Sec. 1395i-3(e) and (f) of the federal social security act relating to state-approved competency evaluation programs for certified nurse aides.

(3) Beginning December 1, 2012, the secretary, in consultation with the commission, shall report annually by December 1st to the governor and the appropriate committees of the legislature on the progress made in achieving career advancement for certified home care aides and medical assistants into nursing practice.

**RCW 18.88A.100**

*Waiver of examination for initial applications.*

The secretary shall waive the competency evaluation and certify a person to practice within the state of Washington if the commission determines that the person meets commonly accepted standards of education and experience for the nursing assistants. This section applies only to those individuals who file an application for waiver by December 31, 1991.
RCW 18.79.260
Registered nurse—Activities allowed—Delegation of tasks.

*** CHANGE IN 2020 *** (SEE 2378-S.SL) ***

(1) A registered nurse under his or her license may perform for compensation nursing care, as that term is usually understood, to individuals with illnesses, injuries, or disabilities.

(2) A registered nurse may, at or under the general direction of a licensed physician and surgeon, dentist, osteopathic physician and surgeon, naturopathic physician, optometrist, podiatric physician and surgeon, physician assistant, osteopathic physician assistant, advanced registered nurse practitioner, or midwife acting within the scope of his or her license, administer medications, treatments, tests, and inoculations, whether or not the severing or penetrating of tissues is involved and whether or not a degree of independent judgment and skill is required. Such direction must be for acts which are within the scope of registered nursing practice.

(3) A registered nurse may delegate tasks of nursing care to other individuals where the registered nurse determines that it is in the best interest of the patient.

(a) The delegating nurse shall:
   (i) Determine the competency of the individual to perform the tasks;
   (ii) Evaluate the appropriateness of the delegation;
   (iii) Supervise the actions of the person performing the delegated task; and
   (iv) Delegate only those tasks that are within the registered nurse's scope of practice.

(b) A registered nurse, working for a home health or hospice agency regulated under chapter 70.127 RCW, may delegate the application, instillation, or insertion of medications to a registered or certified nursing assistant under a plan of care.

(c) Except as authorized in (b) or (e) of this subsection, a registered nurse may not delegate the administration of medications. Except as authorized in (e) of this subsection, a registered nurse may not delegate acts requiring substantial skill, and may not delegate piercing or severing of tissues. Acts that require nursing judgment shall not be delegated.

(d) No person may coerce a nurse into compromising patient safety by requiring the nurse to delegate if the nurse determines that it is inappropriate to do so. Nurses shall not be subject to any employer reprisal or disciplinary action by the nursing care quality assurance commission for refusing to delegate tasks or refusing to provide the required training for delegation if the nurse determines delegation may compromise patient safety.

(e) For delegation in community-based care settings or in-home care settings, a registered nurse may delegate nursing care tasks only to registered or certified nursing assistants or home care aides certified under chapter 18.88B RCW. Simple care tasks such as blood pressure monitoring, personal care service, diabetic insulin device set up, verbal verification of insulin dosage for sight-impaired individuals, or other tasks as defined by the nursing care quality assurance commission are exempted from this requirement.

(i) "Community-based care settings" includes: Community residential programs for people with developmental disabilities, certified by the department of social and health services under chapter 71A.12 RCW; adult family homes licensed under chapter 70.128 RCW; and assisted living facilities licensed under chapter 18.20 RCW. Community-based care settings do not include acute care or skilled nursing facilities.
(ii) "In-home care settings" include an individual's place of temporary or permanent residence, but does not include acute care or skilled nursing facilities, and does not include community-based care settings as defined in (e)(i) of this subsection.

(iii) Delegation of nursing care tasks in community-based care settings and in-home care settings is only allowed for individuals who have a stable and predictable condition. "Stable and predictable condition" means a situation in which the individual's clinical and behavioral status is known and does not require the frequent presence and evaluation of a registered nurse.

(iv) The determination of the appropriateness of delegation of a nursing task is at the discretion of the registered nurse. Other than delegation of the administration of insulin by injection for the purpose of caring for individuals with diabetes, the administration of medications by injection, sterile procedures, and central line maintenance may never be delegated.

(v) When delegating insulin injections under this section, the registered nurse delegator must instruct the individual regarding proper injection procedures and the use of insulin, demonstrate proper injection procedures, and must supervise and evaluate the individual performing the delegated task weekly during the first four weeks of delegation of insulin injections. If the registered nurse delegator determines that the individual is competent to perform the injection properly and safely, supervision and evaluation shall occur at least every ninety days thereafter.

(vi)(A) The registered nurse shall verify that the nursing assistant or home care aide, as the case may be, has completed the required core nurse delegation training required in chapter 18.88A or 18.88B RCW prior to authorizing delegation.

(B) Before commencing any specific nursing tasks authorized to be delegated in this section, a home care aide must be certified pursuant to chapter 18.88B RCW and must comply with RCW 18.88B.070.

(vii) The nurse is accountable for his or her own individual actions in the delegation process. Nurses acting within the protocols of their delegation authority are immune from liability for any action performed in the course of their delegation duties.

(viii) Nursing task delegation protocols are not intended to regulate the settings in which delegation may occur, but are intended to ensure that nursing care services have a consistent standard of practice upon which the public and the profession may rely, and to safeguard the authority of the nurse to make independent professional decisions regarding the delegation of a task.

(f) The nursing care quality assurance commission may adopt rules to implement this section.

(4) Only a person licensed as a registered nurse may instruct nurses in technical subjects pertaining to nursing.

(5) Only a person licensed as a registered nurse may hold herself or himself out to the public or designate herself or himself as a registered nurse.
Memorandum of Understanding
and Data Sharing Agreement
Between
Washington State Office of Insurance Commissioner
and
Washington State Department of Health,
and
Washington Medical Commission
and
Washington State Nursing Care Quality Assurance Commission
and
Chiropractic Quality Assurance Commission

1. INTRODUCTION
This Memorandum of Understanding and Data Sharing Agreement (MOU) is entered into by the Washington State Office of Insurance Commissioner (OIC), Washington State Department of Health (DOH), Washington Medical Commission (WMC), Washington State Nursing Care Quality Assurance Commission (NCQAC) and Chiropractic Quality Assurance Commission (CQAC).

The OIC regulates the business of insurance in Washington State and serves as the primary regulator for all insurance entities and persons domiciled in or conducting insurance transactions in Washington State.

Among other activities for public health protection, DOH protects individuals and families by licensing healthcare professionals and investigating complaints, which are conducted in collaboration with the commissions cited in this MOU. DOH also investigates and prosecutes complaints against healthcare providers and facilities regulated directly by the secretary of health or by health care boards and commissions except those professions regulated by WMC, CQAC, or NCQAC.

The WMC is responsible for licensure and discipline of physicians and physician assistants licensed under chapters 18.71, 18.71A and 18.71B RCW.

The NCQAC is responsible for licensure and discipline for nurses, including advanced registered nurse practitioners, licensed under chapter 18.79 RCW.

The CQAC is responsible licensure and discipline of chiropractors licensed under chapter 18.25 RCW.

The Balance Billing Protection Act (Act), (Chap. 427, Laws of 2019) makes a pattern of unresolved violations of the act by a provider “unprofessional conduct” under the Washington State Uniform Disciplinary Act. It gives DOH authority to take enforcement action against facilities that
have shown a pattern of unresolved violations of the Act. (RCW 18.130.180, 48.49.100, 70.41.510, 70.42.162 and 70.230.210).

Under the Act, and following its fact-finding, the OIC may transfer information to DOH, the WMC, the NCQAC, or the CQAC regarding patterns of unresolved violations of the Act. To promote the provision and spirit of the Act, all parties agree to engage in a process of information sharing as set forth in this MOU/Data Sharing Agreement.

2. DEFINITIONS
Public Information – means information that can be or currently is released to the public. It does not need protection from unauthorized disclosure, but does need integrity and availability protection controls.

Sensitive Information – means information that may not be specifically protected from disclosure by law, but is for official use only. Sensitive information is generally not released to the public unless specifically requested.

Confidential Information – means information that is specifically protected from disclosure by law. Confidential Information includes: personal information about individuals, such as financial account information, regardless of how that information is obtained; information concerning employee personnel records; information regarding IT infrastructure and security of computer and telecommunications systems.

Confidential Information Requiring Special Handling – means information that is specifically protected from disclosure by law and for which especially strict handling requirements are dictated, such as by statutes, regulations, or agreements; or serious consequences could arise from unauthorized disclosure, such as threats to health and safety, or legal sanctions.

Enforcement Action – means formal or informal disciplinary action against a health care provider under chapter 18.130 RCW or regulatory action requiring a health care facility to comply with the legal requirements of the Act.

Party – means any organization that is named as part of this agreement in Section 1, Introduction.

3. PURPOSE
The purpose of this MOU is to:

A. Facilitate effective implementation of relevant provisions of the Act, specifically RCW 18.130.180(21), 48.49.100, 70.41.510, 70.42.162 and 70.230.210.

B. Establish processes that the Parties will use to refer cases for potential enforcement and communicate the outcome of referrals.
C. Set out the terms and conditions under which the Parties will share and secure Confidential Information and records obtained by the OIC or a 3rd party as part of their respective regulatory duties under the Act.

D. Memorialize the expectations concerning communications between the Parties concerning the sharing of all Regulatory Information.

E. Define the safeguards against unauthorized use and re-disclosure of such Confidential Information to be employed by Parties.

4. SCOPE OF COOPERATION

A. DOH, WMC, NCQAC and CQAC agree to:
   1. For purposes of this MOU, consider OIC the “complainant” for any referral.
   2. Provide the OIC with a primary contact name, phone number, mailing address and an e-mail address for Complaint Response System (CRS) registration. The primary contact may designate secondary users for purposes of accessing the (CRS) account. OIC must be notified of any changes to the primary contact information.
   3. Use the OIC Complaint Response System (CRS) to transfer information and documents between OIC and all parties.
   4. Define the processes that they will use, consistent with the data confidentiality provisions of this agreement, to download the shared documents under this agreement into their respective complaint management systems. The parties will notify the OIC through CRS within two business days of taking each of the actions below:
      i. Confirming receipt of each complaint
      ii. Of either approval for investigation or closure without investigation
      iii. Of the decision to take formal or informal disciplinary action or to close a complaint without action, and
      iv. Of the outcome of any disciplinary action.

B. OIC agrees to:
   1. Provide documentation related to the cases referred under this MOU to DOH, WMC, NCQAC and CQAC for their use during enforcement actions.
   2. Cooperate with DOH, WMC, NCQAC and CQAC investigators, staff attorneys and assistant attorneys general in enforcement actions based upon the act. DOH, WMC, NCQAC or CQAC may request that OIC staff be made available for testimony if evidence or authentication of documents provided under this agreement is not available by any alternative means.
3. Include in the referral the data elements included in the DOH online provider/facility complaint form that are relevant to the referral. (https://fortress.wa.gov/dooh/opinio/s?s=ComplaintFormHPF)

5. DATA CLASSIFICATION, SHARING, AND SECURITY

Information received under this MOU may be confidential information requiring special handling.

The types of documents that OIC may share with the parties to this agreement include, but are not limited to:
1. A copy of the complaint with supporting documents, such as explanation of benefits (EOBs), provider/facility bills, or any other relevant info depending on the nature of the case, as determined by the OIC
2. A copy of any letters sent to the provider
3. A copy of any letters received from the provider
4. A letter of referral to the party

Some information exchanged under this MOU is Health Care Information under RCW 70.02.010(17) and is Confidential Information Requiring Special Handling under this MOU and under Washington State Information Security policies. Chapter 70.02 RCW restricts copying and public inspection of health care information per RCW 42.56.360(2).

When a health care provider or facility requests an adjudicative proceeding, DOH health law judges routinely enter a protective order prohibiting disclosure of health care information in the course of the proceeding.

DOH, WMC, NCQAC and CAQC agree to protect all health care information shared under this act in accordance with chapters 42.56 and 70.02 RCW.

DOH, WMC, NCQAC and CAQC will not make use of material and information for any purpose other than the performance of this agreement and will release information obtained under this MOU, other than Public Information, only to authorized employees, agents, or subcontractors, requiring such information for the purposes of carrying out this MOU, and as required by the rules of discovery in actions authorized under chapter 427 Laws of 2019 and chapter 18.130.180

DOH, HSQA Division, WMC, NCQAC and CAQC agrees to implement physical, electronic, and managerial safeguards to prevent unauthorized access, use, disclosure, modification or loss to material and information collected, used, or acquired in connection with this Contract. All Confidential Information, and information treated as Confidential Information, stored by each party will be encrypted using industry standard algorithms or cryptographic modules validated by the National Institute of Standards and Technology (NIST). Confidential Information transmitted by each party to OIC or to any employee, agent, or subcontractor under this agreement must be made using a method that ensures:
(1) All manipulations or transmissions of data during the exchange are secure;
(2) If intercepted during transmission the data cannot be deciphered;
(3) When necessary, confirmation is received when the intended recipient receives the data; and
(4) Encryption methods use industry standard algorithms, or cryptographic modules validated by the National Institute of Standards and Technology (NIST).

OIC reserves the right to monitor, audit, or investigate the use of material or information collected, used, or acquired by DOH, HSQA Division, WMC, NCQAC and CAQC through this agreement.

All DOH, WMC, NCQAC and CQAC staff annually acknowledge their duty to protect confidential information through completion of an annual confidentiality statement, attached as Exhibit A.

In the event of any suspected or actual breach of the security or confidentiality of the information covered by the Agreement, DOH, WMC, NCQAC and CQAC staff agree to notify OIC Staff responsible for the management of this Agreement within one (1) business day.

6. PERIOD OF PERFORMANCE
This MOU shall commence on the date of execution and shall continue until terminated by the parties or until the RCW provisions noted above are amended such that referrals between the parties are no longer authorized, whichever is earlier. As long as any Party has Confidential Information in its custody, the requirements imposed on both/all parties concerning the maintenance of data and records shared pursuant to this MOU shall continue until the records retention period for such data and records is concluded, and those data and records are destroyed.

7. AGREEMENT MANAGEMENT
A. OIC staff responsible for the management of this MOU is:
   Name: Lisa Heaton
   Title: Consumer Advocacy Program Manager, Consumer Protection Division
   Address: PO Box 40255
            Olympia, WA 98504-0255
   Telephone: 360/725.7095
   Email: LisaH@oic.wa.gov

B. DOH staff responsible for the management of this MOU is:
   Name: Marc Defreyn
   Title: Director, Office of Investigative and Legal Services
   Address: 111 Israel Rd. SE, Tumwater, WA 98501-7873
   Telephone: 360-236-4913
   Email: marc.defreyn@doh.wa.gov
C. WMC staff responsible for the management of this MOU is:
   Name: Micah Matthews
   Title: Deputy Executive and Legislator Director
   Address: 111 Israel Rd. SE, Tumwater, WA 98504-7866
   Telephone: 360-236-2834
   Email: micah.matthews@wmc.wa.gov

D. NCQAC staff responsible for the management of this MOU is:
   Name: Catherine Woodard
   Title: Director of Discipline
   Address: 111 Israel Rd. SE, Tumwater, WA 98504-7864
   Telephone: 360-236-4714
   Email: catherine.woodard@doh.wa.gov

E. CQAC staff responsible for the management of this MOU is:
   Name: Tammy Kelley
   Title: Licensing and Disciplinary Manager
   Address: 111 Israel Rd. SE, Tumwater, WA 98504-7858
   Telephone: 360-236-2326
   Email: Tammy.Kelley@doh.wa.gov

8. RECORDS MAINTENANCE
All parties shall retain all records, books or documents related to this MOU for the full term required by applicable records retention schedules. All parties agree to maintain Confidential Information in a manner consistent with this MOU and state law until such records have reached their retention period, and are appropriately disposed of.

9. INDEMNIFICATION
Each Party shall be responsible for any negligence or conduct attributable to its own employees in the performance of this MOU, or leading to breach of this MOU.

10. DISPUTES
In the event of an inconsistency in this MOU, unless otherwise provided, the inconsistency shall be resolved by giving precedence in the following order:

1. Applicable Federal and State statutes and regulations;
2. Terms and Conditions as contained in this MOU;
3. Any other amendments or provisions of this MOU;
4. Any other provision, term or material incorporated herein by reference or otherwise incorporated into this MOU by operation of law.
Except as otherwise provided in this MOU, when a dispute arises between the Parties and it cannot be resolved by direct negotiation, the Parties agree to participate in mediation in good faith. The mediator shall be chosen by agreement of the Parties. If the Parties cannot agree on a mediator, the Parties shall use a mediation service that selects the mediator for the parties. Nothing in this MOU shall be construed to limit the Parties’ choice of a mutually acceptable alternative resolution method such as a dispute hearing, a Dispute Resolution Board, or arbitration.

11. WAIVER
Any waiver by any Party with regard to any of its rights shall be in writing and shall not constitute a waiver to any other or future rights of the Party.

12. SEVERABILITY
If any provision of this MOU or any provision of any document incorporated by reference shall be held invalid, such invalidity shall not affect the other provisions of this MOU which can be given effect without the invalid provision, and to this end the provisions of this MOU are declared to be severable.

13. TERMINATION
This MOU shall remain in full force and effect until terminated as provided in this MOU. Either Party may terminate this MOU by giving ten (10) calendar days’ written notice to the other Party. The obligations of confidentiality shall continue and survive this MOU.

14. TERMINATION FOR CAUSE
Any Party may terminate this MOU in whole or in part at any time prior to the date of completion when it is determined that the other Party has failed to comply with the conditions of this MOU. The cancelling Party shall immediately notify the other Party in writing of the termination and the reasons for termination, together with the effective date of termination.

15. AMENDMENTS AND MODIFICATIONS
This MOU may be waived, changed, modified, or amended only by mutual agreement of the Parties. Such amendments shall not be binding unless they are in writing and signed by personnel authorized to bind each of the Parties.

16. JURISDICTION
This MOU shall be construed and interpreted in accordance with the laws of the State of Washington. The venue of any legal action pertaining to this MOU shall be the Washington State Superior Court for Thurston County unless the Parties agree in writing to another venue.
17. APPROVAL
This MOU, consisting of eight (8) pages, and one (1) attachment, is executed by the persons
signing below, who warrant they have the authority to execute this MOU.

By signing this MOU, all parties certify that their policies, procedures, and authority comply with
the confidentiality requirements of this MOU.

IN WITNESS WHEREOF, the Parties have executed this MOU and Data Sharing Agreement.

Washington Medical Commission

[Signature]
Micah Matthews
Name (Please Print)

Deputy Executive and Legislator Director
Title

06/01/2020
Date

WA Department of Health Contracts Office

Contract Specialist III

06/16/2020

Office of Insurance Commissioner

[Signature]
Marc Defreyn
Name (Please Print)

Director, Office of Investigative and Legal Services
Title

6/1/2020
Date

Washington State
Office of Insurance Commissioner
No. IAA2120
DOH Contract GVS25356

September 11, 2020
NCQAC Business Meeting

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