This meeting will be held by webinar. NCQAC members will participate by webinar according to Governor Jay Inslee’s COVID 19 Operational and Workplace Guidance in Response to Novel Coronavirus. Staff will be available in Town Center 2 Room 145.

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

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

### Staff:
- Paula R. Meyer, MSN, RN, FRE, Executive Director
- Kathy Anderson, Director, Finance
- Chris Archuleta, Director, Operations
- Gerianne Babbo, Ed.D, MN, RN, Director, Education
- Shad Bell, Assistant Director, Operations
- Amber Bielaksi, 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
Brandon Williams, Performance and Policy Analyst
Catherine Woodard, Director, Discipline

If you have questions regarding the agenda, please call the Nursing Care Quality Assurance Commission (NCQAC) office at 360-236-4713. Agenda items may be presented in a different order. If you wish to attend the meeting for a single item, contact our office at the number listed above and request a specific time scheduled for that item. If you have limited English language expertise call 360-236-4713 before March 12, 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 March 12, 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 May 8, 2020 NCQAC meeting. For a copy of the actual recording, please contact the Public Disclosure Records Center (PDRC) at PDRC@doh.wa.gov.

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

Smoking and vaping are prohibited at this meeting.

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

II. 8:35 AM Call to Order
  A. Introductions
  B. Order of the Agenda

III. 8:40 AM – 9:00 AM Chair Report – Tracy Rude – DISCUSSION/ACTION
  A. Request to work with Washington Medical Commission: Disruptive physicians and cases that appear to be system errors
  B. NCQAC Annual Evaluation

IV. 9:00 am – 9:30 am Executive Director Report – Paula Meyer – DISCUSSION/ACTION
  A. COVID 19 update
  B. Rules Update – Brandon Williams
     1. Rescheduling hearing for ARNP rules hearing
     2. Nurse Technician rules and need to open additional sections
V. 9:30 AM – 10:30 AM Sub-committee Report – DISCUSSION/ACTION

A. Advanced Practice – Laurie Soine, Chair
   1. Meeting with Congressional members and staff on Medicaid requirement for physician signature
   2. Creation of an Advisory Opinion to clarify the word “confirm” in WAC 246-840-4980. “The ARNP shall confirm or provide a current prescription for naloxone when 50 MED or when prescribed to a high-risk patient.”

B. Consistent Standards of Practice – Tiffany Randich, Chair
   1. Draft Supervised Injection Services Advisory Opinion

C. Discipline – Adam Canary, Chair
   1. A34 Early Remediation Procedure
   2. W34 Substance Use Evaluation and Treatment Services Procedure
   3. W40 Medication Use Procedure

D. Licensing – Jeannie Eylar, Chair
   1. Review Continuing Competency proposal
   2. Review proposed changes to nurse licensing application questions

VI. 10:30 AM – 10:45 AM BREAK

VII. 10:45 PM – 11:15 PM Nominations Committee – Ella Guilford, Chair, DISCUSSION/ACTION

   A. Slate of Candidates -- DRAFT
   B. Candidates’ presentations
   C. NCQAC and NCSBN Award Nominations

VIII. 11:15 AM – 11:30 AM 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.

IX. 11:30 AM Meeting Evaluation

X. 11:45 AM Closing
Department of Health Nursing Care Quality Assurance Commission

Advisory Opinion

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: Role of the Nurse in (SIS)  
Number: NCAO 19.00

References:
- Chapter 18.79 RCW Nursing Care
- WAC 246-840 Practical and Registered Nursing
- Chapter 49.19 RCW Safety-Health Care Settings
- Chapter 49.17 RCW Washington Industrial Safety and Health Act (WISHA)
- Chapter 296-62 WAC General Occupational Health Standards
- Chapter 246-887 WAC Pharmacy-Regulations Implementing the Uniformed Controlled Substance Act
- Chapter 69.41 RCW Legend Drugs-Prescription Drugs

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

Phone: (360) 236-4703

Email: NursingPracticeConsultation.NCQAC@doh.wa.gov

Effective Date: TBD

Supersedes: Not Applicable

Approved By: Nursing Care Quality Assurance Commission

Conclusion Statement

The Nursing Care Quality Assurance Commission (NCQAC) concludes that it is within the scope of practice of the registered nurse and licensed practical nurse to provide nursing care in a supervised injection services (SIS) facility within their legal scope of practice. The NCQAC recommends nurses follow the Registered Nurses' Association of Ontario Implementing Supervised Injection Services Best Practice Guidelines, recognizing that some information or practices specific to Canadian statutes, regulations, or policies may not be applicable in the U.S. or the state of Washington. The nurse must be aware of potential legal challenges related to participating in SIS. The NCQAC cannot provide legal advice.

Background

The Washington State Nursing Care Quality Assurance Commission (NCQAC) received a formal request from the Washington State Nurses Association (WSNA) requesting the commission develop an advisory opinion to clarify the nursing scope of practice when participating in SIS and advise nurses of potential legal challenges to providing nursing services in those circumstances.
There are more than 90 SIS sites worldwide in nine countries (Switzerland, Germany, the Netherlands, Norway, Luxembourg, Spain, Denmark, Australia, and Canada). The first North American SIS facility opened in Vancouver, Canada in 2003. Supervised injection services have been shown to be effective, beneficial, cost-efficient, and safer for people who use drugs. They are effective in preventing diseases, overdose, and death. They are also effective in reducing drug use and increasing uptake in addiction treatment. Supervised injection services are beneficial because they allow nurses to meet people where they are at while eliminating barriers to health care and achieving greater level of health overall. Supervised injection services also decrease public safety problems from injecting in public locations and discarding equipment in unsafe locations.

People come to a SIS facility with their own obtained substances to inject under supervision. They also come to SIS sites to access a range of services including harm reduction education, immunization, point of care HIV testing, sexually transmitted disease screening, counseling, wound care, and other services. In a typical SIS facility, people inject their drug in the presence of a nurse. They can access clean supplies, take their time to inject, ask questions, and receive immediate care if they show signs of overdose or anaphylaxis. They are provided an opportunity to connect with peer workers and/or other members of the team for additional care.

No such facilities currently exist in the United States. The Drug Policy Alliance is advocating for SIS pilot programs in San Francisco and New York City. Correctional facilities are considering whether these sites should be in their settings. The Canadian Nurses Association, Focus on Harm Reduction for Injection Drug Use in Canadian Prisons, discusses harm reduction strategies in prisons, including SIS and needle sharing. SIS facilities have been endorsed by the American Medical Association, American Public Health Association, HIV Medicine Association and the Infectious Disease Society of America.

The Registered Nurses Association of British Columbia (RNABC) was asked, “Is providing clients with evidence-based information to safely give themselves intravenous injections within the scope of registered nursing practice? RNABC, now called the College of Registered Nurses of British Columbia (CRNBC), stated that:

“Assessing clients’ knowledge and skill to safely give themselves intravenous injections is within the scope for nursing practice. Teaching and promoting evidence-based self-care activities prevents illness and promotes health, especially in relation to high risk client behaviors. Providing this information fosters the therapeutic alliance between the registered nurses and the clients and can facilitate promoting healthier client activities . . . . Employers have an obligation to provide essential support systems so that registered nurses are able to meet the standards for Nursing Practice in British Columbia. The essential support systems include the necessary policies and resources to assist nurses to provide competent, evidence-based and ethical care (M. Aldersberg, RNABC, personal communication to M. Davis, Dr. Peter Centre, February 19, 2002, and reconfirmed by CRNBC in 2007).

The Canadian Nurses Association and the Canadian Association of Nurses in HIV/AIDS CARE (CANAC) and Harm Reduction Nurses Association (NRNA) issued a Joint Position Statement: Harm Reduction and Substance Abuse (March 2018) supporting using harm reduction strategies.
Laws and Rules – Legal Challenges

In 2017, King County, Washington took steps to allow two SIS sites that remain involved in controversy and legal challenges. Other cities have proposed them, including Philadelphia, Baltimore, and San Francisco. In February 2019, the federal Justice Department filed a lawsuit to prevent a nonprofit in Philadelphia from moving forward with plans for SIS sites, saying these facilities are illegal under federal law. Philadelphia plans to open the first supervised injection site in the United States in March 2020. In October, 2019, the United States District Court ruled that the nonprofit’s plan to allow people to bring in their own drugs and use them in a medical facility to help combat fatal overdoses does not violate federal law: https://www.documentcloud.org/documents/644521-2019-10-02-Memorandum-on-Safehouse.html. Institutions are conducting “mock” supervised injection services sites to raise awareness.

Nurses must understand the legal questions and challenges they may be faced with when providing nursing services within a SIS facility. Notwithstanding the recent U.S. District Court decision referenced above (which may be appealed), that concluded that a nonprofit providing SIS did not violate section 856(a)(2) of the Controlled Substances Act (colloquially known as the “Crack House” statute), opponents of harm reduction practices could invoke federal and state narcotics laws to shut down SIS facilities. A SIS site might be subject to police interference, clients could be arrested for drug possession, and staff members might fear arrest or discipline by professional licensing authorities. For those reasons, it is unlikely that a SIS facility would be established before these questions were resolved to some degree, and state and local authorities were able to provide some assurance to participants. State legislation authorizing politically controversial harm reduction interventions, such as syringe exchange programs, is not unprecedented. Depending on federal policy decisions, federal law enforcement may view the establishment of local SIS facilities as a direct challenge to national drug laws, triggering legal and political conflict. State laws and rules do not require malpractice coverage. Nurses working in SIS sites may not be eligible for coverage through their insurer. The NCQAC does not have authority over malpractice coverage.

Professional Nursing and Ethical Challenges

Nurses in any practice setting may encounter ethical concerns associated with illegal drug use. They may find themselves caught between evidence, ethics, and the law. SIS has come under attack from the public, politicians, and healthcare professionals. Nurses are not required to provide SIS and may decline to become involved based on their own conscience and ethical decisions. In today’s uncertain political climate, the NCQAC cannot guarantee that a decision to participate will not result in legal consequences. Each nurse must make their own choice whether to not to participate, based on their own analysis of legal risk.

Role of the Nurse

The type of nursing care provided in a SIS facility is within the scope of practice of a Washington-licensed RN or LPN. In these sites, nurses usually act as the client’s first point of contact with the health care system. They work directly with individuals using harm reduction strategies by establishing rapport, assessing level of knowledge and understanding of potential harms associated with injection drug use, providing education, preventing risky injection practices, monitoring for signs of drug overdose or anaphylaxis, and intervening in emergency situations. Nurses may make referrals based on
nursing assessment (such as addiction services, housing, food, income assistance, etc.) and support clients in accessing primary care services. SIS facilities may also include medication-assisted treatment (MAT) programs using nurse care managers.

It is not within the scope of practice of a registered nurse or licensed practical nurse to administer Schedule I controlled substances or illegal substances brought into the SIS facility. The RN or LPN may administer Schedule II-IV controlled substances and legend drugs with a valid prescription under the direction of an authorized health care practitioner.

**Recommendations**

The NCQAC recognizes U.S. nursing associations have not yet developed SIS standards of practice guidelines. The NCQAC recommends nurses follow the [Registered Nurses' Association of Ontario Supervised Injection Services Best Practice Guidelines](#), recognizing that some information or practices are specific to Canadian law or policies. Key considerations include:

- Engineering and work practice controls as required by the [United States Occupational Safety and Health Administration (OSHA)](https://www.osha.gov), Chapter 49.17 RCW Washington Industrial Safety and Health Act (WISHA), and Chapter 296-62 WAC General Occupational Health Standards, and other relevant laws and rules;
- Engineering and work practice controls relevant to workplace violence plan as required by Chapter 49.19 RCW Safety-Health Care Settings including developing a workplace violence plan, mandatory prevention training, and security;
- Storage and handling of legend drugs/controlled substances as required by Chapter 246-887 WAC Pharmacy-Regulations Implementing the Uniformed Controlled Substance Act, Chapter 69.41 RCW Legend Drugs-Prescription Drugs, Drug Enforcement Administration (DEA), and other relevant laws and rules;
- Processes for verification of prescriptions, including using the [Prescription Monitoring Program (PMP)](https://pmp.net) for controlled substances, to address administration of medications or prescriptions brought in by the client for a nurse to administer depending on what types of services the SIS site provides;
- Medical emergencies including staff training and competencies;
- Staffing plan including nurses, other health care professionals, and assistive personnel considering what type of services the SIS site provides; and
- [Standing Orders](#) for condition-specific health care needs such as health screening activities, treatment of common health problems, emergency care, screening, and urgent care needs. Examples may include immunizations, sexually transmitted infection (STI) screening and treatment, tuberculosis (TB) screening and treatment, pregnancy screening, birth control, wound care, mental health and substance use disorder screening tools, etc.

The NCQAC recommends that nurses working in these facilities consult with their legal advisors about the potential legal ramifications.
Conclusion

The ethical and legal debate continues about SIS facilities. The purpose of this advisory opinion is to clarify that while it is within the nurse’s scope of practice to provide nursing care related to harm reduction strategies, the NCQAC cannot provide legal advice.

References


Canadian Nurses Association Harm Reduction Website: https://www.cna-aiic.ca/en/policy-advocacy/harm-reduction


U.S. Department of Labor Occupational Safety and Health Administration (OSHA): https://www.osha.gov/


Substance Abuse and Mental Health Services Administration – Medication Assisted Treatment: https://www.samhsa.gov/medication-assisted-treatment/statutes-regulations-guidelines
PURPOSE:
The intent of the Early Remediation Program (ER) is to protect patients by resolving allegations of practice deficiencies of a less serious nature through an action plan that consists of remedial education and training.

PROCEDURE:

A. When the Nursing Care Quality Assurance Commission (NCQAC) receives a report of substandard nursing practice, staff follow the Case Intake procedure (A50) to initiate a case file, and schedule for the next Case Management Team (CMT) meeting. The CMT reviews the report and makes one of three decisions:

1. Close the matter without action (see procedure A06 Review of Commission Reports).
2. Authorize the case for full investigation.
3. Authorize the case for preliminary investigation and identify the case as a potential candidate for the ER program.

Reports that identify a newly licensed nurse or a nurse who had inadequate orientation should be considered for the ER Program.
B. Practice deficiencies include but are not limited to:

1. Substandard nursing practice.
2. Failure to properly conduct a patient assessment, document treatment, or administer medications.
3. Failure to comply with scope of practice requirements or delegation laws and regulations.
4. Non-therapeutic conduct that does not rise to the level of abuse.

Practice deficiencies do not include drug diversion, patient abuse, fraud, theft, deceit or other willful misconduct, or conduct resulting in more than minor patient harm. Willful misconduct means that the nurse had reason to believe the action taken could result in harm or injury to the patient.

C. The CMT determines when a nurse is eligible for the ER Program using the following criteria:

1. The nurse’s continued practice does not pose a threat to patient safety.
2. The identified practice deficiencies could be corrected by remedial education, on-the-job training or practice monitoring within six months or less.
3. The alleged conduct resulted in no or minor patient harm.
4. The nurse acknowledges the conduct and is willing and able to participate.
5. The nurse has no current charges or disciplinary history of unprofessional conduct and has not previously participated in the ER Program.

D. In a case identified as a potential candidate for the ER Program, an assigned Nursing Consultant Institutional (NCI) conducts a preliminary investigation to confirm the alleged conduct.

E. The preliminary investigation may include interviews of the complainant, nurse and any other key witnesses, as well as obtaining additional documentation.

F. NCQAC staff presents the preliminary results to a CMT panel. The CMT panel consisting of three Commission members make a decision based on the following:

1. When the preliminary investigation results demonstrate the allegation(s) are unsubstantiated, lack jurisdiction, or are below threshold the case is closed (see procedure A22).
2. When the preliminary investigation results substantiate the allegations, the CMT panel determines the appropriate terms for a suggested action plan to remedy the identified deficiencies in nursing practice.
3. When the preliminary investigation results demonstrate the case is no longer appropriate for the ER Program, the CMT Panel shall authorize the file for full investigation or closure.

G. An investigator may refer cases to the ER Program during an investigation, or the RCM or staff attorney may refer after the investigation.

1. When the investigator is referring the case they shall write a closure memo recommending expedited closure of the investigation and referral to the ER program. The case manager will present the case to the CMT panel for approval.
2. When an RCM initiates the referral, they will present the case at a Case Disposition Panel (CDP) meeting. The RCM and staff attorney review the case prior to requesting the ER referral.

3. When the case meets the ER criteria, the CMT panel will develop an action plan.

H. NCQAC staff sends the action plan to the nurse.

1. When the nurse accepts the action plan, the disciplinary process is over and the case is closed in the ILRS database. The action plan is monitored by the compliance officer.

2. When the nurse declines the action plan, the CMT panel authorizes the case for full investigation.

I. The nurse must complete the action plan within six months of accepting it. The compliance officer presents the case summary report to the CMT panel for a decision. The summary report includes:

1. The initial complaint.

2. The preliminary investigation report.

3. The action plan results.

J. The CMT panel considers the timely and successful completion of an action plan as the final step in the process of non-disciplinary remediation.

1. When the action plan results demonstrate failure to meet the action plan requirements, the compliance officer sends the nurse written notice. When the nurse believes they have met the requirements, they may provide a statement. The CMT Panel will review information from the NCI, as well as any statement submitted by the nurse before making a final decision.

2. Criteria for the CMT panel to consider when returning a case for full investigation may include, but not be limited to:

   a. The nurse was unable to substantially complete the action plan or demonstrate rehabilitation.

   b. The nurse was unable to complete the action plan within the time frame outlined in the action plan.

   c. Discovery of additional facts indicate the alleged conduct resulted in significant patient harm or was more serious than originally alleged.

   d. Case management receives a report with allegations of additional practice deficiencies or unprofessional conduct.

K. When the nurse participated in the ER Program but failed to successfully complete the action plan within six months, a new case may be opened on the original conduct. In determining appropriate sanctions, the Commission may consider participation in the action plan a mitigating factor under WAC 246-16-890(3)(c)(voluntary remedial action); (4)(d)(potential for successful rehabilitation); and/or (4)(e)(present competence to practice).
PURPOSE: Describe the process, personnel, and actions associated with Substance Use Disorder (SUD) evaluations used by the Washington Health Professional Services (WHPS) program.

PROCEDURE:

I. SUD Evaluation Referrals
   
   A. A WHPS case manager will provide the nurse with at least three evaluation referrals, ensuring the nurse has a role in their choice of SUD evaluation services.
   
   B. The nurse must complete Release of Information authorization(s) with both WHPS and the evaluating service/provider.
   
   C. WHPS reserves the right to require higher-level evaluations; e.g., addictions specialist, mental health evaluations, and pain management.
D. WHPS accepts evaluations by Division of Social and Health Services (DSHS) certified services as described in Section II of this procedure. WHPS will make appropriate exceptions for nurses residing in another state.

Note: DSHS certified services are found in the Directory of Certified Mental Health, Substance Use Disorder, and Problem and Pathological Gambling Services.

E. Evaluations should adhere to the format contained in this procedure. Adherence to the evaluation format provides thorough, consistent evaluations and recommendations for treatment.

F. If the nurse completed an acceptable evaluation prior to contacting WHPS, the nurse may request that the SUD evaluator send a copy of the evaluation and treatment recommendations to WHPS. Acceptable evaluations must have occurred within the previous 90 days and meet all WHPS requirements.

G. A case manager will notify the WHPS Director of any concerns involving the quality of evaluation services.

II. Evaluator Requirements

A. Evaluations must be conducted by a:


2. M.D. or D.O. Addiction Specialist.

3. WHPS-approved licensed evaluator with expertise in substance use disorder, including a Psychologist, Marriage and Family Therapist, Clinical Social Worker, Mental Health Counselor, or Advanced Registered Nurse Practitioner. WHPS may require evaluators in these categories to provide a copy of their curriculum vitae.

III. Intake Evaluation Requirements

A. The evaluator shall:

1. Complete a bio-psychosocial history.

2. Use at least two chemical dependency screening tools, i.e., SASSI, MAST, CAGE, and DAST). The SASSI is preferred but not required.

3. Provide written verification of a review of the nurse’s license history using the Department of Health’s website Provider Credential Search at www.doh.wa.gov.

4. Review driving abstract, provided by the nurse at the time of the evaluation.

5. Review criminal history report, provided by the nurse at the time of the evaluation.
6. Collect an observed, baseline urine drug screen, including EtG. WHPS may require additional testing.

B. Evaluation reports must include at a minimum:

1. Complete Bio/Psychosocial history of nurse.
2. Current Diagnostic and Statistical Manual of Mental Disorders (DSM 5) diagnosis and justification.
3. Six Dimensions of ASAM Criteria and level of care treatment recommendations per current American Society of Addiction Medicine (ASAM) Patient Placement Criteria; other recommendations such as mental health evaluations and pain management evaluations.
4. Results of the urine drug testing.
5. Professional opinion regarding safety to practice.
7. Any additional pertinent information.

C. If the nurse does not fully and clearly disclose all circumstances relevant to the purpose of the evaluation and/or provides contradictory statements to WHPS or the evaluator, WHPS will void the evaluation.

IV. Second Evaluation

A. If WHPS or the nurse disagrees with the evaluation or if the evaluation does not reflect the seriousness of events, either may request a second evaluation. The following conditions apply:

1. The secondary SUD evaluator must conduct the evaluation in accordance with this procedure and timelines established by WHPS.
2. The nurse must authorize release of information between each evaluation service (allowing services to communicate with each other regarding all aspects of their evaluations) and WHPS.
3. The WHPS Medical Director will review all second evaluations.

B. If there is a disagreement between the evaluations, WHPS will make the final monitoring and treatment decision based on all available information.

V. Treatment

A. Nurses must comply with all treatment recommendations contained in the evaluation report.
B. The case manager will contact the treatment service by letter or telephone to introduce themselves and ensure the nurse enters into the appropriate level of treatment.

C. Treatment services will submit reports to WHPS monthly, and include safety to practice concerns and any recommendations for additional SUD evaluation or assessment for pain management, mental health, or other issues.
PURPOSE: Washington Health Professional Services (WHPS) is an abstinence-based program. WHPS expects nurses in the program to remain free of all potentially dependence-producing medication, absent a medical need.

Nurses should use one primary prescriber, one dentist, and one pharmacy and inform their case manager. See the WHPS Handbook and Talbott Medication Guide for a Safe Recovery for quick medication management guides.

PROCEDURE:

I. Prescription Reporting

A. Before agreeing to the use of non-emergent, potentially dependence-producing medications, WHPS strongly encourages the nurse to consult with their case manager.

B. The nurse must notify WHPS as soon as possible of any potentially dependence-producing prescriptions and require the prescriber to submit the WHPS Prescription Information Form. The prescriber must report long-term medications to WHPS at least every 90 days.
C. The Prescription Information Form includes:

1. WHPS disclosure letter.
2. Diagnosis and medication regimen, to include dosage, schedule and expiration.
3. Appointment frequency.
4. Medication compliance.
5. Safety to practice while taking medications as prescribed.
6. A copy of the nurse’s Prescription Monitoring Program (PMP) report.

D. If WHPS does not receive documentation of prescribed medications, WHPS may consider the prescription use to be unauthorized.

II. Medication Review

A. The case management team will document all Prescription Information Forms in the nurse’s electronic file. A case note will accompany any unapproved prescriptions including the rationale and action taken.

B. The case management team will compare all positive drug tests with the nurse’s approved prescription list. If appropriate documentation is not in place, WHPS may consider the use of a prescribed medication as unauthorized substance use.

C. The WHPS medical director will review all initial Prescription Information Forms for approval or follow-up with the prescriber that include Talbott Medication Guide Class A/B medications, including Gabapentin. The medical director reviews the Prescription Information Form, including the prescriber’s determination of the nurse’s safety to practice and documents the review in the case notes.

D. The medical director may query the WA Prescription Drug Monitoring Program (PMP) database as needed to aid in medication management reviews. The medical director will place the PMP report in the case notes.

E. The medical director will review all prescriptions for long-term use (greater than 90 days) of potentially dependence-producing medications. The medical director may consult with other specialists or require additional assessments.

F. A nurse using long-term opioids requires the provider to submit a Written Agreement for Treatment to WHPS. The prescriber must also submit a Prescription Information Form every 90 days.
III. Medication Referral

A. WHPS may require specialty evaluations in some circumstances (e.g., pain management and psychiatry). WHPS may require the nurse to cease practice during the evaluation period.

B. The nurse will schedule the initial appointment within 30 days and notify WHPS of the evaluator, location, appointment date, and fax number.

C. The nurse must sign any necessary Releases of Information to allow communication between WHPS and the nurse’s medical providers.

D. The specialty evaluator will submit a written report to WHPS that addresses the appropriateness, rationale, and ongoing need for prescribed treatment and medications, and recommendations for alternatives (if available). WHPS requires the evaluator’s determination of the nurse’s ability to practice safely while using medication. If safety to practice is a concern, WHPS will require the nurse to cease practice.

E. WHPS requires the nurse to comply with all evaluation recommendations as determined by the WHPS medical director.
Background

In May 2019, the Nursing Care Quality Assurance Commission (NCQAC) requested a targeted workgroup to explore an evidence-based continuing competency framework to support a mechanism for meeting the legislative intent of the Revised Code of Washington (RCW) 18.79.010 and 18.79.110. ¹ ²

Nursing continuing competency rules listed in Washington Administrative Code (WAC) 246-840-200 through 246-840-260, adopted in 2011, requires all active nurses to complete at least 531 hours of practice and 45 hours of continuing education every three years.³ ⁴

The continuing competency workgroup reviewed key documents to inform decision-making related to the development of a revised model and rule change for Registered Nurses (RNs) and Licensed Practical Nurses (LPNs). A 2008 and 2017 study of the NCQAC continuing competency model and literature review revealed no new evidence that connected ongoing education and practice with continued competency for RNs or LPNs.⁵ At the same time, an evaluation of disciplinary complaints related to standards of care revealed no changes in the number of cases presented as complaints.⁶ The National Council State Boards of Nursing (NCSBN) 2014 Model Rules provides a consensus-based framework for determining nationally agreed-upon support and concurred continuing education does not directly translate into change or enhancement of practice.⁷

Overview

Four groups are vested in continuing competency; the consumer, nurse, employer, and state regulatory boards.
Key Stakeholders/Partners

- United Food and Commercial Workers Local 21
- Council for Nursing Education in Washington State
- Leading Age
- Parish nurses
- The Northwest Organization of Nurse Executives
- School Nurse Organization of WA
- The University of Washington, nurse educators
- Washington Center for Nursing
- Washington State Nurses Association
- Centralia College
- Joint Base Lewis-McCord
- Lummi Tribe
- Providence Hospital
- Sauk-Suiattle Tribe
- Service Employees International Union
- Swedish Hospital
- Veterans Affair Puget Sound Health Care System
- Washington Health Care Association
- Whatcom County Health Department
- Wenatchee Valley College

Workgroup meetings

In January 2019, the commission conducted public stakeholder meetings in Richland, Spokane, and Federal Way Washington. The continuing competency workgroup provided further input from July to December 2019. The proposed options provide a framework that considers diverse practice settings and supports a mechanism for meeting the legislative intent of RCW 18.79.010 and 18.79.110.

Proposed options using a PICK Chart

A PICK chart organizes six continuing competency options with the most straightforward implementation and the highest payoff. Figure 1 is a grid that identifies the position of each option based on workgroup input.
**Key take away**

- A blending of Option 3 & 4 results in the most sought after option from our stakeholder outreach groups.

- Options 3 & 4 would change the number of practice and CE hours to a minimum number of hours required. The mechanism should include minimum hours, [12 hours per year for education, and 96 hours per year for practice]. These hours spread over a year.

<table>
<thead>
<tr>
<th><strong>Active Nursing Practice</strong></th>
<th><strong>Continuing Education</strong></th>
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<tbody>
<tr>
<td>At least 96 hours in the preceding 12 month period (8 hours/month).</td>
<td>At least 8 hours in the preceding 12-month period 1 hour/month.</td>
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</table>
• The education and practice cycle is re-defined from three years to one-year and changed if needed by the investigation and discipline team. For example, a nurse licensed for only six months would need hours adjusted.

• During the investigation process, the commission may ask the nurse to produce CE and practice continuing competency hours. The requirement for education and practice hours apply to all nurses with complaints, including non-disciplinary cases. However, the monitoring and verification of this process refer to practice case violations or cases that are at the discretion of the commission.

• Education and practice hours are routine for all nurses with a practice complaint, and all nurses are required to send documents of continuing education and practice hours. It is within the discretion of the RCM to determine whether failure to provide documented practice and education hours or failure to respond to request of hours may be considered as an “aggravating factor.”

• Retired Active- clarify in rule, 90 days means, [an 8 - hour shift] or “a day” is [equivalent to 8 hours of practice] for nursing competency.

• Licensing staff will no longer review attestation or audit for continuing competency upon renewal, thus decreasing the processing time and increasing productivity.

• Tools from option 5 (Scope of Practice Decision Tree and the Jurisprudence Module) is incorporated and aligned with the Advanced Registered Nurse Practitioner (ARNP) scope of practice decision tree.
**Stakeholder Commentary**

While large hospitals may be able to provide CE and practice hours adequately through their system, the school health system isn’t able to mirror this network. Often, school nurses work alone and don’t have a mentoring system. As a specialty, school nurses are concerned about maintaining an appropriate level of competency without some requirement and accountability required by state licensure. How will nurses in non-traditional and non-direct clinical settings be evaluated?

A public hearing will be held in the future so, nurses from all practice areas are actively involved in decisions about professional competence determination within their practice settings. Stakeholders from education, regulatory bodies, state nurses associations, and consumers are encouraged to attend the public meeting.

**Evaluation**

An evaluation framework of the proposed continuing competency model is under consideration with the commission’s Research Sub-Committee.

**Draft Rule language**

Comments, suggestions, and input are valuable as we move further through the rulemaking process. Please send all comments to Brandon.Williams@doh.wa.gov or Shana.Johnny@doh.wa.gov.
References


Proposed Updates to Application Personal Data Questions

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.
2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.
3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?
4. Are you currently engaged in the illegal use of controlled substances?
5. Are you currently facing any criminal charge, or have you ever been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction?
6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?
   b. Diverted controlled substances or legend drugs?
   c. Violated any drug law?
   d. Prescribed controlled substances for yourself?
7. Have you ever been found in any proceeding or currently being investigated or charged with violating any state or federal law or rule regulating the practice of a health care profession? If “yes”, please attach an explanation and provide copies of all notifications, judgments, decisions, and agreements.
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?
9. Have you ever withdrawn an application for a credential or surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?
March 13, 2020
Election of Officers
Slate of Candidates

Chair
Jeannie Eylar
Yvonne Strader

Vice Chair
Mary Baroni
Sharon Ness
Tiffany Randich
Cass Tang

Secretary/Treasurer
Adam Canary
Please nominate your peers for the 2020 Annual NCQAC Award. Complete and submit the application to Lori Underwood or Kathy Moisio no later than close of business **March 21, 2020**. Lori and Kathy will present the applications to the Nominations Committee for their review and decision. Tracy Rude, the chair of the NCQAC, will present the Annual NCQAC Awards at the May 2020 business meeting.

Please complete the nomination form and submit to **Lori.Underwood@doh.wa.gov** or **Kathy.Moisio@doh.wa.gov**.

1. Name of nominee:
2. Nominee contact information:

3. Name of person(s) completing nomination form:
4. Contact information:
In 500 words or less, describe the exceptional performance behaviors demonstrated by the nominee that are deserving of the Annual NCQAC Award. Such behaviors should consider:

- **Individual performance beyond expectations**: consistently achieving or exceeding targeted performance measures or expectations for both quality and quantity of work within the last year. This may include individual performance or contribution to team performance.

- **Promotes and maintains excellence in working relationships** by adhering to the values the Nursing Commission Unit adopted. These include achievement and success, communication, honesty and integrity, respect, and teamwork.