Nursing Care Quality Assurance Commission (NCQAC)
Consistent Standards of Practice Subcommittee Agenda
February 3, 2023 12:00 p.m. to 1:00 p.m.

Click here to register for this meeting: Zoom Registration and Address
Meeting ID: 870 8891 3980

Committee Members:	Sharon Ness, RN, Chair Helen Myrick, Public Member Ella Guilford, MSN, M.Ed., BSN, RN, Member Tiffany Randich, RN, LPN, Member Robin Fleming, PhD, MN, BSN, BA, RN, Pro Tem Jamie Shirley, PhD, RN, Pro Tem
Staff:	Deborah Carlson, MSN, BSEd, PMC, CPM, RN, Director of Nursing Practice Shana Johnny, DNP, MN, RN, Nursing Practice Consultant Holly Palmer, Administrative Assistant

If you have questions regarding the agenda, please call the Nursing Care Quality Assurance Commission (NCQAC) office at (360) 236-4744. 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) 236-4744 before **January 25, 2023**.

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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 **July 14, 2023,** 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. Comments from the public will be taken during the meeting as noted on the agenda. Use the question box on the meeting control panel to submit questions.

I. 12:00 PM Opening – Sharon Ness, Chair

A. Call to Order
B. Public Disclosure Statement – Ms. Ness
C. Introductions of members, staff, and public – Ms. Johnny

II. Standing Agenda Items

A. Announcements/Hot Topic/NCQAC Business Meeting Updates
B. Review of Draft Minutes: December 2, 2022
C. Subcommittee Work Plan Review – Ms. Johnny

III. Old Business

A. Advisory Opinion Request – Licensed Practical Nurse (LPN) Scope of Practice in Performing Endoscopy Procedures – Ms. Johnny/Debbie Carlson
B. Delegation – Ms. Carlson
    i. NCAO XX.XX Nursing Delegation to Nursing Assistants Advisory Opinion Draft
    ii. NCAO XX.XX Delegation of Enteral Feedings Advisory Opinion Draft
    iii. HB 1124-delegation blood glucose testing, and monitoring
C. Jurisprudence Module Update – Ms. Johnny
D. LPN scope of Practice & Pleural Cavity Drainage Devices – Ms. Johnny

IV. New Business

A. F03.04 Advisory Opinion Procedure Review
B. NCAO 16.01 Opioid Use Disorder – Medication Assisted Treatment – Nurse Care Managers Scope of Practice Advisory Opinion Revision
C. Licensed Practical Nurse (LPN) and Medical Assistant Scope of Practice Comparison
D. School Field Trips & Delegation – Ms. Carlson
E. Case Management Team (CMT) questions Cosmetic/Dermatology - Ms. Johnny
F. SSB 5229 Health Equity Education – Ms. Johnny
G. Meeting Length - Discussion

V. Public Comment – This time allows for members of the public to present comments to the subcommittee. If the public has issues regarding disciplinary cases, please call 360-236-4713**.**

VI. Ending Items

A. Review of Actions
B. Meeting Evaluation
C. Date of Next Meeting – April 7, 2022
D. Adjournment

Consistent Standards of Practice Subcommittee Workplan July 1, 2022 - June 30, 2023

Priority	Program Activity	Background	Deliverables	Deadline	Status	Comments	Lead
	Advisory Opinions, FAQs, and Interpretive Statements						
1	Nursing Delegation Advisory Opinion to NAs and HCAs	Nursing Delegation is complex with numerous questions based on setting, exceptions by setting, misunderstandings, and lack of clarity in the laws and rules.	Advisory Opinion	3/31/2023	In process	1-22-2022 Motion approved to develop Advisory Opinion; Partner workshops held; 10/7/22 Draft shared CSPSC; 12-7-2022 additional recommendations for changes made by CSPSC based on legal review	Shana Johnny Deborah Carlson
1	Delegation of Enteral Tube Feedings, Flushing, and Related Tasks to UAP	7/22/2022-Requests from DSHS/School Nurses for guidance re: delegation of NG Tube feeding & flushing. Consider expanding to cover all types of tube feedings and associated tasks.	Advisory Opinion	3/31/2023	In process	1-22-2022 Motion approved to develop Advisory Opinion; Partner workshops held; 10/7/22 Draft shared CSPSC; 12-7-2022 additional recommendations for changes made by CSPSC based on legal review	Shana Johnny Deborah Carlson
2	Endoscopy AO Request	Multispecialty Requestor asking for clarification of the SOP of an LPN in Endoscopy in ASFs and in-office settings	Advisory Opinion	12/31/2023	In process	Motion approved by Commission-November 2022; CSPSC provided resources/research; Schedule partner workshops early 2023	Shana Johnny Deborah Carlson

2	LPNs and Scope of Practice - Chest Tubes	7/22/22-A request from Kaiser-Jake Johnson, Home Health & Hospice Agency for clarification if LPN's can access and de-access established pleural cavity drainage catheters in their SOP. This skill is needed for management of symptoms related to pleural effusions for patients with chronic and terminal diagnoses.	FAQ Revision	12/31/2023	In process	Preliminary research document provided to Commission 10/7/2022 Request Motion at NC November 2022 meeting	Shana Johnny Deborah Carlson
2	Medication Assisted Treatment	Change in federal waiver requirements for buprenoprhine	Advisory Opinion Revision	3/31/2023	In process	CSPSC agenda 2-3-2023	Shana Johnny Deborah Carlson
3	Questions of Assignment	Very old position statement-discussed with legal-needs to be an interpretive statement and not an AO	Interpretive Statement	Not determined	On Hold	Some relationship to patient abandonment	Shana Johnny Deborah Carlson
3	Medication Organizer Device Letter from Secretary of Health	Letter supporting position statement issued by NCQAC	Rescind	Not determined	On Hold	Hold	Shana Johnny Deborah Carlson
3	Job Titles: Can a RN work as a LPN?	Undated	Advisory Opinion	Not determined	On Hold	Hold	Shana Johnny Deborah Carlson
3	Medication Organizer Device Position Statement	Undated	Advisory Opinion	Not determined	On Hold	Hold	Shana Johnny Deborah Carlson

3	School Nurse Field Trips and Medications Statement Review/Revision	Delegation laws and rules are complex and unclear-resources will help in providing guidance for delegation to UAP. This will include NAs, MAs, HCAs, STs, and non-credentialed persons (and include information on use of comfort kits in hospice)	Advisory Opinion	Not determined	On Hold	Hold	Shana Johnny Deborah Carlson
3	EpiPen Delegation in Schools	Continue to be confusion about whether RNs can delegate epipen administration to UAP	Advisory Opinion Revision or FAQ	Not determined	On Hold	Hold	

Priority	Program Activity	Background	Deliverables	Deadline	Status	Comments	Lead
	Rule Development						
1	ESSB 5229-Health Equity Education	ESSB 5529 aims to provide HCPs with the skills to recognize & reduce inequities in their daily work and increase skills to address systemic racism and bias. The Legislature passed Engrossed Substitute Senate Bill (ESSB) 5229 last year. • health care professionals are required to complete a minimum of 2 hours in health equity continuing education training every four (4) years. • The language required DOH to Ø Develop minimum standards (model rules) by January 1, 2023 DOH required to Identify free training program that meets minimum standards by July1, 2023. The Commission must adopt rules that meet or exceed minimum standards by Jan 1, 2024.	New rules for Health Equity education CE that outlines the administrative procedures and requirements for nurses	Adopt rules by Jan 1, 2024.	10/7/22-101 filing pending	CR-102 filed on 8/24, Rules hearing 9/29. Comments open until 9/29. 103 filed 10/2022 (4-6 weeks). Motion to NC 10/9/2022 to open the nursing rules (CR 101 process) to implement the continuing education requirements established in SB 5229 CR 101-pending.	Shana Johnny

1	SHB 1124 Delegation Glucose Monitoring, Testing, and Insulin Injections	Allows RN to delegate BG monitoring to NA any setting	Rule Revisions	12/31/2023	CR 101, CR 103-P	5-13-2022 NCQAC voted to begin rule making on 246-840-010, 700, 910, 920, 930, 940, 950, 960 on delegation. A number of sections already opened 246-840-010-Expedited rule filed in June to change the definition of nursing technician.246-840-930 – open in Emergency to Permanent rules. The CR-103P has been filed with an effective date of 9/9 to coincide with refiling of certain emergency rules. delegation also addressed in re-write of Chapter 246-841 Nursing Assistants DSHS reviewed 9/20/22, then interested parties workshops for the chapter review.	Deborah Carlson

3	SB 5183: (SANE) Forensic Nurse Examiner Training Strategies development	The Office of Crime Victims Advocacy (OCVA) and commerce tasked to lead a workgroup to develop strategies for better access to training and to keep the cost affordable for nurses. Summary report expected to legislature.	Not required to write rules		27-page executive report is drafted and pending submission	Executive report provided to CSP 10/7/22 outlining strategies	Shana Johnny
	Other Projects						
Priority	Program Activity	Background and Issue	Deliverables	Deadline	Status	Comments	Lead
1	Nursing Assistant Training Requirements -	Questions about NA training waiver requirements post-COVID-19	Summary of Training Requirements to NCQAC	1/13/2022	Completed	Report on the 1-13-2023 NCQAC meeting agenda	Deborah Carlson
2	LPN and MA Scope of Practice Comparison	New bill increasing scope of practice of the MA. Request from Executive Director to develop a document comparing the LPN and MA scope of practice.	Document	3/31/2023	In process	Document developed in collaboration with the MA Program; On 2-3-2023 CSPSC agenda with plans to take forward to NCQAC 3-10-2023	Deborah Carlson

3	Nursing Delegation Resource Guidance/Toolkit	Delegation laws and rules are complex and unclear - resources will help in providing guidance for delegation to UAP. This will include NAs, MAs, HCAs, STs, and non-credentialed persons (and include information on use of comfort kits in hospice)	Guidance Document	7/31/2023	In process	Initiated with the Nursing Delegation Advisory Opinion draft - complex and will take more time to develop	Margaret Holm Shana Johnny
1	Jurisprudence Module	Transition JP module from NCSBN platform to NCQAC Articulate platform	JP module transition from pilot to production & placed on practice website	~~12/1/2022~~ 12/30/2022	In process	Final review completed. Working with WATECH to get posted on the web.	Deborah Carlson
3	Vent/Vent-Trach Models of Care for Pediatric Patients (Placeholder)	Possible legislative proposal to develop a new model of care for pediatric patients getting vent/vent-trach care so they can be cared for at home	None at this time	None	Follow Bill Proposals	Being discussed/ followed at the Legislative Panel meetings	Deborah Carlson

Nursing Care Quality Assurance Commission (NCQAC)
Consistent Standards of Practice Subcommittee Minutes
December 2, 2022 12:00 p.m. to 1:00 p.m.

Subcommittee Members Present:	Sharon Ness, RN, Commission Member, Chair Helen Myrick, Public Commission Member Ella Guilford, MSN, Med, BSN, RN, Commission Member Robin Fleming, PhD, MN, BSN, BA, RN, Pro Tem Jamie Shirley, PhD, RN, Pro Tem
Subcommittee Members Absent:	Tiffany Randich, RN, LPN, Pro Tem
Staff Present:	Deborah Carlson, MSN, BSEd, PMC, CPM, RN, Nursing Practice Director Shana Johnny, DNP, MN, RN, Nursing Practice Consultant Holly Palmer, Administrative Assistant Victoria Hayward, Public Health Nursing Consultant

I. 12:00 p.m. Opening – Sharon Ness, Chair
- a. The meeting was called to order at 12:00 p.m.
- b. Ms. Ness introduced the Subcommittee members.
- c. Shana Johnny introduced the Nursing Care Quality Assurance Commission (NCQAC) staff members in attendance.
- d. Ms. Ness read the public disclosure statement.

II. Announcements/Hot Topic/NCQAC Business Meeting Updates
- a. The Subcommittee presented a motion at the November 18, 2022, NCQAC business meeting to create a Licensed Practical Nurse (LPN) Scope of Practice in Performing Endoscopy Procedures Advisory Opinion; The Commission passed the motion.
- b. Nursing Licensing Fees increased as of December 1, 2022
- c. Recruiting for a new Executive Director is ongoing. Interviews are being held, the Commission will introduce the final three candidates to the full Commission at the March NCQAC business meeting.
- d. Consensus reached to send the October 7, 2022, draft meeting minutes to the January 13, 2023, NCQAC Business Meeting.
- e. Ms. Johnny reviewed the subcommittee work plan.

III. Old Business
- a. Ms. Carlson updated members on the Vent/Vent-Trach Models of Care for Pediatric Patients Consortium. There is continued discussion around providing parents the training required to be a Nursing Assistant (NA) and allowing payment through the state for those parents to care for their children in their homes. This proposal will require a legislative process. Due to the complexity, the Consortiums proposed that legislation be submitted to start a feasibility study, and the Commission may be involved in that; if that occurs, Paula Meyer, Executive Director, has suggested that

Margaret Holm participate in the work related to that study. This item is on the agenda of the December 7, 2022, Legislative Panel.

b. Ms. Johnny updated on the Licensed Practical Nurse (LPN) Scope of Practice in Performing Endoscopy Procedures Advisory Opinion; the Commission passed a motion to create the advisory opinion at the November 18, 2022, Business meeting; Ms. Carlson is beginning draft documents and has reached out to providers who work in this practice area to provide additional content.

c. Ms. Johnny provided an update on HB 5183, Forensic Nurse Training; a rules package (CR-103) has been filed and will be effective December 24, 2022. All regulatory boards must adopt or adapt the model rules that DOH created; interested parties' meetings have been held; implementation timelines were discussed; as well as effective ways to increase involvement and input; in early 2023, workshops will begin on a regional basis; these rules will not take effect until 2024.

IV. New Business

a. Ms. Carlson updated members on the Washington State Department of Social and Health Services (DSHS) training for Nursing Assistant Delegation – Expiration of COVID-19 Waiver; The waiver has expired, but there are questions related to the requirements for training for Nursing Assistants (NAs); Ms. Carlson will draft a statement for the full Commission to consider at the January 2023 business meeting.

b. The Commission is getting increased complaints from the public related to cosmetic/dermatological procedures offered by providers working out of "mobile clinics" that provide services in an in-home atmosphere; this issue will be brought to the subcommittee in February 2023 for further discussion related to potentially updating the existing Advisory Opinion.

c. Ms. Carlson provided an update on the Health Environment for All (HEAL) Act; there are discussions around how nursing is related to environmental health in the broader picture; more information will be forthcoming.

d. Ms. Johnny updated the members on the Chest Tube Devices Frequently Asked Questions Revision/Clarification – LPN Role Request; This request has been sent back to the original requester to provide the subcommittee with additional information.

    i. Ms. Carlson provided an update on Delegation; the legal unit has suggested minor changes to the Advisory Opinion for Nursing Delegation to Nursing Assistants and Home Care Aids, as well as to the Delegation of Enteral Feedings Advisory Opinion; these will be updated and presented to the subcommittee at the February 2023 meeting.

V. Public Comment

a. Members of the public were given the opportunity to provide comments to the Subcommittee

- Debra Strom- recommends caution with AO LPN SOP on monitoring sedation for an endoscopy procedure. She is requesting the Commission review the American College of Anesthesiology & American College of Gastroenterology definitions on levels of sedation. These definitions have yet to match in the past. Ms. Strom indicates that there is a slippery slope with what GI clinicians call light sedation. Misapplication of an AO by a healthcare organization could occur if applied to an at-risk population or different settings. One should be clear on the practice setting, patient population and risk factors involved. The medical clinics see the College

of Anesthesiology as experts in this area because they rescue patients from unattended consequences.

VI. Ending Items

a. Review of Actions
b. Meeting Evaluation – None
c. Date of Next Meeting – February 3, 2023
d. Meeting Adjourned at 1:07 p.m.

Meeting Minutes

Collaboration with Health Systems Oversight & Nursing Commission

December 14, 2022

Attendees: Commissioner Sharon Ness, Shana Johnny, Debbie Carlson, Holly Palmer, Seana Reichold, Karl Hoehn, John Hilger (Community Health Systems), Alexander Rinedahl (Facilities investigator manager, Health Systems Oversight), Commissioner Jonathan Alvarado

Health Systems Oversight feedback:

- The WACs guiding Ambulatory Surgical Facilities (ASF) are 246-330-205, 210, 220, and 225.
- ASF WACs govern RNs, ARNPs, and CRNAs. However, the laws/rules don't drill down to LPN scope of practice.
- Facilities may claim their procedures and levels of anesthesiology are less complex than an ASF. However, this argument doesn't equate because each facility has a different clientele and specialty. Complications don't reduce themselves in the presence of a GI facility or other practice site. For example, Gastrointestinal (GI) procedures and levels of anesthesia, sedation is typically done with propofol, which induces deep sedation. GI procedures come with the risk of bleeding from a torn or nicked airway or arteries. A provider is sedating patients, removing tissue, and potentially cutting different areas where mishaps can happen.
- A more complex assessment is needed for these procedures. These procedures involve assessing levels of wakefulness, airway management, and making multiple decisions about patient care. for an LPN pushing Intravenous (IV) medication, especially with conscious sedation, it involves a more skilled assessment. For example, "Do I give more, or fewer drugs based on the assessment?"
- If an LPN is pushing IV drugs (based on protocols or no protocols), with a physician, an LPN, and no other nurse in the room, ASF staff feel this is within the scope of an RN and not an LPN.
- The staffing challenges are fueling this inquiry and the reality of how these roles may function given the nursing shortage is concerning. Staffing challenges are not a good

reason to place patients at risk using less skilled individuals in a potentially critical area because of these shortages. Caution should occur in responding to the nursing shortage in ways that jeopardize public health. An LPN doing conscious sedation, assessments, and monitoring high-risk geriatric patients is a risky practice.

Commissioner's feedback:

- There is concern about using LPNs in conscious sedation and endoscopy procedures. A circulating nurse needs to be an RN and ACLS certified.
- What is it about this procedure that's driving the inquiry? Is it a rural, urban, or city site? What is the setup? What is the geographical distance from a hospital? What is the standard workflow regarding rooms? What resources do these centers have?
- LPNs needs to practice safely. "It's not when things happen, but when bad things happen," i.e., the airway is usually never a long-term thing you can deal with; you only have a little time. "Who are these people asking for clarification?" "Is this because of a staffing issue?" The inquiry response requires a lot more thinking behind the setup. The nursing commission needs to be aware of what's happening with staffing.

Nursing Commission's Legal team feedback:

The impression from the requestor includes three takeaways:

- The requestor's argument centers on procedures they are doing that are fundamentally different and somewhat expected in an anesthesia setting. The requestor provides an argument about why their setting does not require this level of expertise as a standard anesthesia setting.
- Hiring and retaining good people.
- The realizations that the ASF rules bound the facility to use only RNs.

There is reinforcement that an RN needs to be in the room for a patient's general or deep sedation. In AFS WAC 246-330-110, discussion occurred about the exemption options.

- Are these exemptions helpful for facilities? If the facility is doing minor procedures, would this exemption be considered? Are there ways LPNs can work in the system?

Draft advisory opinion feedback:

- A similar question arose from a private office whether LPNs could do conscious sedation in Endoscopy. An office-based reference is in the Advisory Opinion (AO) for consideration.

- The draft AO is written broadly with references to **best practices** and **current guidelines** focusing on public safety. The AO includes standards of practice for staffing from recognized national organizations. Staffing shortages are not a factor for this advisory analysis.
- The AOs listed support the draft LPN role in Endoscopy:
  - ❖ Registered Nurse and Licensed Practical Nurse Scope of Practice-
  - ❖ Administration of Sedating, Analgesic, and Anesthetic Agents
  - ❖ Compounding and Reconstituting Medications
  - ❖ Infusion Therapy Management- (Allows LPNs to give IV meds & IV push meds).
- The main factors emphasized for LPN scope of practice is that the activity is a routine, noncomplex procedure with an anticipated predictable patient outcome. These factors need an assessment before using an LPN Registered Nurse and Licensed Practical Nurse Scope of Practice.
- The requestor wanted to know if the LPN could be a circulating nurse. An ASF facility requires an RN circulator if deep sedation or anesthesia is needed. The ASF regulations do not address conscious sedation. In hospital regulations, the circulating nurse must be an RN, and there is no exception to the kind of sedation used.
- Office-based regulations talk very little about these details.
- Ms. Carlson clarified that under the nursing rules, LPNs can perform a focused assessment that includes monitoring respiratory or cardiac status under the direction of an RN or an authorized healthcare provider Registered Nurse and Licensed Practical Nurse Scope of Practice. LPNs can assist an RN, ARNP, or an authorized healthcare provider in an emergency procedure. i.e., administering ACLS medication if competent.
- Our advisory opinion defines deep sedation in the AO for the Administration of Sedating, Analgesic, and Anesthetic Agents.
- There are concerns about disseminating information that LPNs can manipulate the endoscope and take biopsies. There are too many complications that can occur.
- The AO document mentions an FDA-approved self-monitoring anesthesia machine. This machine is out of circulation.
- The Commission should further assess the LPN's role in Endoscopy and monitoring patient sedation. The balanced discussion should look at safety and, at the same time,

modernize the definition of practice. These inquiries will continue to occur because of the staffing shortages.

- Ms. Carlson - LPNs can't lead activities but can assist teams Registered Nurse and Licensed Practical Nurse Scope of Practice.
- The American Society for Gastrointestinal Endoscopy (ASGE) recommends a minimum of one RN and a second staff person: an RN or LPN in a hospital setting. There should be an RN in the room for moderate sedation.
- A clear statement was made that LPNs have a role in Endoscopy. However, the LPNs role in this advisory needs to be further refined and clarified.
- The ASF WAC requires a nurse to report to a nurse. When facility surveys are conducted, we look at this requirement. For example, an LPN needs to report to an RN. Nurses don't report to doctors, office personnel, or managers.
- Ms. Carlson clarifies that in nursing laws, an LPN can be directed by a physician, nurse practitioner, or authorized provider, an RN does not need to be involved Registered Nurse and Licensed Practical Nurse Scope of Practice.
- The draft AO process includes a review by interested party workshops, the Consistent Standards of Practice Subcommittee (CSPSC), and the Nursing Commission for final approval or denial

Community Health Systems feedback:

- We have a section in the law about exemptions for ASF and other licensing facilities. A licensee can submit an exemption request or proposal for any requirement found in the rules. If a facility submits a formal exemption request to use LPNs differently, ASF uses an internal process review that includes collaborating with the Nursing Commission.
- The Commission's authority is to issue an AO in response to questions from nurses, associations, and consumers. AOs are received more broadly and in a generalized way. Whereas, ASF has the authority to receive an exception from a licensed holder and can set up precise criteria for whether this could be allowed or not. If you have a particular ASF that wants the exception, it's best dealt with by ASF staff. The nursing commission would not likely weigh in on the exemption piece.

Next steps: Send out AO for written comments and clarification

Washington State's Board of Nursing
NCQAC
Nursing Care Quality Assurance Commission

NCAO 31.00 Nursing Delegation to the NA-R/NA-C and HCA-C
Adopted:
Reviewed/Revised:
Rescinded:
NursingPractice@doh.wa.gov
ARNPPractice@doh.wa.gov Telephone: 360 236-4703

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. This advisory opinion does not address state or federal proclamations or rule waivers that temporarily change some regulatory requirements in emergency or disaster situations.

Advisory Opinion: Nursing Delegation to the Nursing Assistant-Registered/Nursing Assistant-Certified, and Home-Care Aide-Certified

Purpose

This advisory opinion provides guidelines about nursing delegation to the nursing assistant-registered/nursing assistant-certified (NA-R/NA-C) and home care aide-certified (HCA-C). The nurse must follow the principles of nursing delegation and nursing laws and rules specific to the setting.

Background

Nursing delegation is a complex, formal process requiring the nurse to reach a clinical decision based on the analysis of evidence or data specific to the client's response, the task, the competencies of the available care provider, and the location where the procedure will be performed. The nurse must determine the status of each component and whether it meets the standards for safe delegation.

Nursing delegation is when the nurse transfers the performance of a nursing task that would not regularly be within the scope of the NA-R/NA-C or HCA-C. Nursing delegation is required if the task is not within the legal scope of the NA-R/NA-C or HCA-C. The delegating nurse is responsible and accountable for the client's nursing care and supervising the NA-R/NA-C or HCA-C to make sure the task was performed correctly and/or make corrective action. Routine care and activities based on core competencies do not require nursing delegation.

Factors that that Impact the Efficacy and Need for Delegation

1. Mutual Respect: As part of the observation and assessment process, consider aligning clients who share a similar identity or cultural background. This provides an opportunity to create a more respectable and inclusive environment for clients receiving care.

2. Nurse Delegator scope of practice: Includes nursing consideration that the delegating nurse must be qualified, trained, and competent to perform the task they are delegating.
3. Clinical context: Includes but is not restricted to environmental considerations especially access to and availability of appropriate resources (including staff) to safely achieve quality health care relative to the consumer population and needs.
4. Personnel considerations: Relate to the scope of practice and skill levels. Balancing staff levels and skill mix to meet varied client needs influences delegation. Nursing communication styles, collegial respect, confidence in team member capabilities, and team dynamics also significantly contribute to delegation outcomes.
5. Changing consumer needs and complexity: Greater acuity levels lead to more complex care than those with stable, chronic health conditions.
6. Legal and professional responsibilities: Accountability and responsibility for all nursing practices mandated in the laws and rules.
7. Setting-specific considerations: Whether delegation is allowed in a specific setting, what tasks may or may not be delegated, and required credentials.

Statement of Scope

It is within the scope of practice of the registered nurse (RN) or licensed practical nurse (LPN) to delegate routine and non-complex tasks to the NA-R/NA-C or HCA-C. for clients in a stable condition with a predictable outcome that do not require nursing judgment. A stable and predictable condition means a situation in when the individual's clinical and behavioral status is known and does not require the frequent presence and evaluation of a registered nurse. A client's status may be stable and predictable with an order for sliding scale insulin or terminal condition. Delegation must be within the legal parameters and scope of practice and competencies of the RN or LPN.

The laws and rules prohibit nursing delegation to the NA-R/NA-C and HCA-C of the following tasks, unless there is an exception:

- Tasks that require nursing judgment.
- Administration of medications:
  - Exception: The RN may delegate to the NA-R/NA-C or HCA-C administration of injectable insulin or non-insulin medications for treatment of diabetes in community-based (adult family homes, assistant living facilities, and community residential facilities for individuals with developmental disabilities), and home settings.
- Tasks that involve piercing of the skin:
  - Exception: The RN may delegate performing a Clinical Laboratory Improvement Amendments (CLIA)-waived blood glucose test to the NA-R/NA-C or HCA-C in any setting that delivers health care services.

RN Delegator

The RN may delegate nursing tasks to the NA-R/NA-C or HCA-C in any setting where nursing care is provided following the delegation process. RCW 18.79.260 allows only the RN to delegate nursing tasks to the NA-R/NA-C or HCA-C in community-based settings and in-home care settings. Delegation in community and in-home care settings is outlined in WAC 246-840-910 through WAC 246-840-970.

LPN Delegator

It is not within the scope of practice of the LPN to delegate tasks in community-based and in-home care settings. The LPN may delegate routine and non-complex tasks to the NA-R/NA-C in settings where RN delegation is not required, such as in a nursing home. the LPN may not delegate administration of medications in any setting. The delegation must be consistent with the nursing plan of care and medical orders. The LPN delegator must supervise the NA-R/NA-C and report outcomes to the RN. WAC 246-840-700.

NA-R/NA-C Credentials and Practice Settings

The scope of practice is the same for the NA-R and NA-C up to the level of the person's demonstrated competency as stated in RCW 18.88A.020. The NA-R and NA-C may provide care in nursing homes, community-based facilities, hospitals, hospice care facilities, home care agencies, hospice agencies, community behavioral health programs, or other facilities defined by the NCQAC (RCW 18.88A.020). The NCQAC expanded the setting (November 13, 2020) to include any entity for delivering health care services that have licensed nurses supervising the NA-R/NA-C performing within the nursing assistant scope of practice. State facility laws and rules may require a specific credential to provide care in that setting, such as enhanced service facility rules (WAC 388-107-0250) that allow the NA-C or HCA-C to work in that setting. Skilled Nursing Facilities require the NA-R to get the NA-C credential within four months from the date of employment. If there are no legal requirements for the NA-R to get the NA-C credential, the employer/facility may stipulate the requirement of the NA-R or NA-C.

Requirements and Recommendations

Nursing Delegation Process

The nurse must:

- Understand the responsibility, authority, accountability, and legal parameters specific to setting related to making delegation decisions.
- Understand and follow the nursing delegation process and requirements defined in the nursing laws
- Use the Criteria for Nursing Delegation (Chapter 246-840 WAC) and the Nursing Delegation Decision Tree (WAC 246-840-940) when delegating tasks to AP.
- Follow clinical practice standards.
- Complete an initial assessment or reassessment of the client using clinical judgment, analysis of the assessment data to determine actual problems or issues, the nurse's prioritization of identified problems, and identification of expected outcomes related to the problems, and the development of a plan of care for the client that identifies strategies to assist the client to attain expected outcomes.

The nurse may not delegate tasks for clients that require accompanying assessment and evaluation or whose condition is unstable and unpredictable.

HCA-C Credentials and Practice Settings

The HCA-C provides personal care services defined as, "Physical or verbal assistance with activities of daily living and instrumental activities of daily living provided because of a person's functional disability." RCW 74.39A.009. The laws and rules allow the RN to delegate to the HCA-C only in community-based, in-home care settings, and enhanced service facilities.

Training Requirements

Agencies and employers may establish nurse delegation training requirements. The nurse, NA-R/NA-C, and HCA-C must be knowledgeable about credentialing and training requirements related to the specific work settings. The nurse, NA-R/NA-C, and HCA-C must meet the training requirements as required by their employer or required by the laws or rules. Specific laws and rules define the requirements for nurse delegation training in some settings:

- Chapter 18.88B RCW: Long-Term Care Workers
- Chapter 388-112A WAC: Residential Long-Term Training Services Training
- The Washington State Department of Social and Health Services (DSHS) has authority regarding the training requirements and classes for RN Delegator's (RND's) DSHS Nurse Delegation Program Training Course.
- The NA-R/NA-C and HCA receiving delegation in community-based, in-home care settings, and enhanced services facilities must complete the Core Nursing Delegation Program prior to nursing delegation. The NA-R/NA-C and HCA in these settings must also complete the Special Focus on Diabetes Training if they are delegated to administer insulin or non-insulin injectable medications to treat Diabetes. Training Requirements and Classes | DSHS (wa.gov)

Employer Recommendations

The NCQAC does not have authority regarding facility licensing requirements or other state or federal laws and rules that may apply. The NCQAC recommends the following to ensure safe nursing delegation:

- Provide a clear role description of the NA-R/NA-C or HCA-C based on the training program completed.
- Develop policies and procedures for deviation, including a clear description of each person's role, responsibility, and accountability.
- Ensure adequate time for the nurse to carry out client assessment and provide ongoing client care.
- Ensure adequate time for the nurse to train the NA-R/NA-C or HCA-C and provide ongoing supervision, including support as needed.
- Provide educational opportunities for the nurse to develop the competence to delegate.
- Provide consultation from nurses who can provide expert clinical consultation on delegation as appropriate.
- Collaborate and communicate with outside agencies as necessary.

Client Rights

The delegating nurse is responsible for advocating for the client's right to receive appropriate care and accurate information. The nurse must obtain consent from the client for the NA-R/NA-C or HCA-C to perform the task instead of the nurse. The nurse must inform the client about who they can contact regarding concerns about the NA-R/NA-C or HCA-C, performance of the task, or their condition. The nurse is responsible for answering any questions or concerns the client may have regarding the delegation process.

Rescinding Delegation

WAC 246-840-960 defines the requirements when rescinding delegation to perform a task for a client to the NA-R/NA-C or HCA-C. The nurse must be knowledgeable and follow these steps when rescinding delegation regardless of the reason.

Documentation

The delegating nurse must document delegation process decisions, actions, and outcomes following employer, agency, or facility policies and procedures, using the fundamental principles of nursing documentation:

- Instructions for the task should be specific to the client and broken into individual components,
- Document specific steps or the delegated task,
- Document date(s), training, and competency assessment, and credential verification.

The NA-R/NA-C and HCA-C must document care provided. Preconstructed forms may be used. If the nurse uses a pre-constructed form to document a delegation, the nurse remains responsible for ensuring that retrievable evidence supports all actions and decisions recorded on the form. The NCQAC does not have an approved delegation "form." The NCQAC holds no legal authority to approve or endorse forms. There may be other documentation requirements as a function of the nurse's practice setting, governing the setting, position description, agency policies, and procedures. An example is the Washington State DSHS Program.

References

RCW 18.79 Nursing Care
WAC 246-840 Practical and Registered Nursing
Support for Practicing Nurses | Nursing Care Quality Assurance Commission (wa.gov)
Practice Guidance | Nursing Care Quality Assurance Commission (wa.gov)
Practice Information | Nursing Care Quality Assurance Commission (wa.gov)
Chapter 18.88A RCW: Nursing Assistants
Chapter 246-841 WAC: Nursing Assistants
Chapter 18.88b RCW: Long-Term Care Workers
Chapter 246-980 WAC: Home Care Aide
Washington State Department of Social and Health Services Nurse Delegation Program
Assigning and Delegating Care to Unregulated Care Providers – British Columbia College of Nurses and Midwives (March 2021)

NCAO XX.XX Nursing Delegation of Enteral Tube Feedings and Related Tasks to Assistive Personnel
Adopted:
Reviewed/Revised:
Rescinded:
NursingPractice@doh.wa.gov
ARNPPractice@doh.wa.gov Telephone: 360 236-4703

Advisory Opinion: Nursing Delegation of Enteral Tube Feedings and Related Tasks to Assistive Personnel (AP)

Purpose

This advisory opinion provides guidelines that define the when the nurse may delegate enteral tube feedings and related care to assistive personnel (AP). The nurse must follow the principles of nursing delegation and nursing laws and rules specific to the setting. Examples of AP include the nursing assistant-registered/nursing assistant-certified (NA-R/NA-C), home care aide-certified (HCA-C), or non-credentialed individuals.

Background

There are a variety of access routes into the gastrointestinal tract and a range of feeding tube types used for enteral feeding. There are many different types of enteral tubes based on their location in the gastrointestinal system, as well as their function. Three commonly used enteral tubes are the nasogastric/orogastric (NG/OG), Gastric-Button (G-Button), the percutaneous endoscopic gastrostomy (PEG) tube, and the percutaneous endoscopic jejunostomy (PEJ) tube. Examples of activities include insertion, reinsertion of a displaced tube, removal, tube feedings, flushing, medication administration, placement verification using pH testing, and routine maintenance.

Statement of Scope

It is within the scope of practice of the appropriately trained and competent registered nurse (RN) and licensed practical nurse (LPN) to perform enteral tube feedings and related care following clinical practice standards under the direction of an authorized health care practitioner.

It is within the scope of practice of the RN or LPN to delegate non-complex enteral tube feedings and related tasks for clients with a stable condition and predictable outcome to UAP. The delegating nurse must be appropriately trained and competent to perform enteral tube feedings and related care.

The LPN may delegate routine and non-complex tasks to the NA-R/NA-C in settings where RN delegation is not required. The delegation must be consistent with the nursing plan of care and orders for routine and non-complex medical regimens permitted by law or rule. The LPN delegator must supervise the NA-R/NA-C and report outcomes to the delegating RN. (WAC 246-840-700).

Community-Based and In-Home Care Settings

The RN may delegate enteral tube feedings and related tasks (including medication administration) in community-based settings, and in-home care settings to the NA-R/NA-C and HCA-C. RCW 18.79.260 defines a community-based setting as an adult family home (AFH), assisted living facility (ALF), or community residential facilities for the developmentally disabled certified by the Washington State Department of Health and Social Services. A community-based setting does not include adult day care, early childhood education programs, community behavioral health care facility, public or private kindergarten-twelve (K-12) grade schools, jail/correction center, medically fragile group homes, nursing homes, or any other settings in which health care might be provided. RCW 18.79.260 defines an in-home care setting as a temporary or permanent residence. It is not within the scope of the LPN to delegate nursing tasks in community-based or in-home care settings.

School Settings, Kindergarten-Twelve (K-12) Grades, Public and Private Settings

The laws and rules do not prohibit the school RN from delegating enteral tube feedings and related tasks (including medication administration) in K-12 grades, public and private settings to non-credentialed AP (RCW 28A.210). While the law does not prohibit the NA-R/NA-C from providing care in schools, their scope of practice does not allow nursing delegation of medications to the NA-R/NA-C in this setting. A person with NA-R/NA-C may work in the school as a non-credentialed AP but cannot identify themselves with the credential if they are performing tasks outside the NA-R/NA-C scope of practice

Other Settings

The RN or LPN may delegate enteral tube feedings and related care to the NA-R/NA-C or HCA-C in any setting where nursing care is provided. Examples include hospitals, acute care clinics, private clinics, ambulatory care facilities, adult daycares, jails/correctional centers, community behavioral health facilities, state psychiatric hospitals, early childhood programs (childcare

facilities, preschools, head start, or early head start programs), camps (unless sponsored by a K-12 school), medically fragile group homes, and enhanced service facilities. Delegation of medication administration to the NA-R/NA-C or HCA is not permitted in settings other than community-based and in-home care settings. Nursing delegation of enteral tube feedings and related care to non-credentialed assistive personnel is not allowed except in the school (K-12) settings.

Delegation of Medication Administration via Enteral Tubes

Nursing delegation of medication administration via an enteral feeding tube may only be done by the RN in community-based settings (adult family homes, assisted living facilities, community residential homes for individuals with developmental disabilities) and in-home care settings to the NA-R/NA-C or HCA-C. Nursing delegation of medication administration via an enteral feeding tube may only be done by the RN in schools, grades kindergarten-twelve (K-12) to non-credentialed AP. Medication administration via enteral tubes in any other setting is not allowed. It is not within the scope of the LPN to delegate administration of medications via an enteral tube in any setting.

Delegation Requirements and Recommendations

The nurse must understand the responsibility, authority, accountability, and legal parameters specific to setting related to making delegation decisions. The nurse must understand and follow the nursing delegation process and requirements defined in the nursing laws and rules considering the setting. The nurse must use the Criteria for Nursing Delegation (Chapter 246-840 WAC) and the Nursing Delegation Decision Tree (WAC 246-840-940) when delegating tasks to AP.

The delegating nurse must be competent in performing this activity. The nurse may not delegate enteral tube feedings or related tasks for clients that require accompanying assessment and evaluation or whose condition is unstable and unpredictable. The nurse must follow clinical practice standards.

Delegation of Medication Administration via Enteral Tubes

Nursing delegation of medication administration via an enteral feeding tube may only be done by the RN in community-based settings (adult family homes, assisted living facilities, community residential homes for individuals with developmental disabilities) and in-home care settings to the NA-R/NA-C or HCA-C. Nursing delegation of medication administration via an enteral feeding tube may only be done by the RN in schools, grades kindergarten-twelve (K-12) to non-credentialed AP. Medication administration via enteral tubes in any other setting is not allowed. It is not within the scope of the LPN to delegate administration of medications via an enteral tube in any setting.

References and Resources

- RCW 18.79 Nursing Care
- WAC 246-840 Practical and Registered Nursing
- Support for Practicing Nurses | Nursing Care Quality Assurance Commission (wa.gov)
- Practice Guidance | Nursing Care Quality Assurance Commission (wa.gov)
- Practice Information | Nursing Care Quality Assurance Commission (wa.gov)
- Support for Practicing Nurses | Nursing Care Quality Assurance Commission (wa.gov)
- My American Nurse: Enteral Nutrition-Evidence-based Strategies to Avoid Complications
- American Society for Parental and Enteral Nutrition (ASPEN) Resources
- National Institutes of Health (NIH): Gastrostomy Tube Replacement

Research- LPN scope of Practice & Pleural Cavity Drainage Devices 1/10/2023

Requestor-Kaiser Home Health and Hospice- **Jake Johnson, BSN, CHPN, RN Assistant Manager – Pierce, Kitsap, S. King**

Yaffa Vinikoor our CNS

Jolene Rhodes

Kaiser Situation: LPN Scope of Practice Regarding Pleural Cavity Drainage

Kaiser Background: Home Health & Hospice Agency would like to utilize competent LPNs to access, and de-access established pleural cavity drainage catheters. This skill is needed for management of symptoms related to pleural effusions for patients with chronic and terminal diagnoses. Request modification/clarification of intent on the LPN scope of practice about chest tube interventions.

Kaiser Assessment:

1. In review of the decision tree, the LPN may be allowed to complete intervention with your clarification. It is a simple skill with high benefits.
2. The LPN may be restricted from doing so by the vague language DOH provides regarding chest tubes.
    a. Did DOH intend for this to be in relation to acute symptoms secondary to pneumothorax or the more traditional "chest tube"? We would agree with this limitation.
    b. Did DOH consider LPN's accessing the chest drain for palliation of chronic symptoms secondary to pleural effusion?
3. The skill is easily taught and with predictable outcomes, clinician competency would also include limitations on volume of drainage allowed and or other predictable symptoms to indication cessation of intervention.
4. In absence of the RN a trained family member or patient may perform this skill, indicating that it is appropriate for the LPN to complete.
5. Additional consideration should be provided for hospice patients and families coping in the end of life, often the palliation of symptoms outweighs the risk of potential complications. Furthermore, the family may find discomfort in performing this skill on their terminally ill loved one as it may involve bodily fluids or wound care that is unpleasant to the grieving family.

Kaiser Recommendation:

1. Consider revising the language to permit a competent LPNs independent change out of chest tube bottles in circumstances of pleural effusion.
2. If unable to provide blanket permission for this independent practice of LPNs consider permitting an exemption for home health or hospice patients who are likely home bound.
3. Nursing practice consultation and or commission may find it beneficial to review the latest technology regarding this skill and it's ease for lay or trained individuals. This is a method we commonly use (nearly industry wide for home health and hospice patients)

References:

Source: https://doh.wa.gov/licenses-permits-and-certificates/nursing-commission/practice-information/frequently-asked-questions/licensed-practical-nurse#:~:text=respiratory%20therapy%20procedures%3F-,It%20is%20within%20the%20scope%20of%20practice%20of%20an%20appropriately,the%20registered%20nurse%2C%20following%20clinical

Decision Tree	
Question	Feedback
Is the activity, intervention, or role prohibited by the Washington state nursing laws and rules/regulations or any other applicable laws, rules/regulations, or accreditation standards or professional nursing scope and standards?	Currently – No. We would argue the language or intent of langue regarding chest tubes should be applied to acute conditions in a hospital setting and not applied to home bound / hospice patients.
Is performing the activity, intervention, or role consistent with evidence-based nursing and health care literature?	Yes
Are there practice setting policies and procedures in place to support performing the activity, intervention, or role?	Yes – in place and can adopt to include LPNs
Has the nurse completed the necessary education to safely perform the activity, intervention, or role?	Yes – we train all to same standard to know when to watch for deviations in their patient assessments.
Is there documented evidence of the nurse's current competence (knowledge, skills, abilities, and judgments) to safely perform the activity, intervention, or role?	Yes – we train all to same standard to know when to watch for deviations in their patient assessments.
Does the nurse have the appropriate resources to perform the activity, intervention, or role in the practice setting?	Yes – we consider that a Registered Nurse would have the same resources and interventions available that an LPN would have. If the RN is permitted to perform this skill, this would not be a barrier to the LPN.
Would a reasonable and prudent nurse perform the activity, intervention, or role in this setting?	Yes
Is the nurse prepared to accept accountability for the activity, intervention, or role and for the related outcomes?	Yes – feedback from staff
Results If Modified DOH Scope Of Practice Language for LPN	The nurse may perform the activity, intervention, or role to acceptable and prevailing standards of safe nursing care.

CSPSC Research

Canada- doc_Competency_Profile_for_LPNs_5th_Ed_2020_G_Respiratory.pdf (clpna.com) Describes LPN competencies on Page 65.

- LPNs-Demonstrate knowledge and ability to assist with insertion and removal of chest tubes
- Demonstrate knowledge and ability to setup, manage, and assess a chest drainage system. G-2-6 Demonstrate knowledge and ability to identify potential complications for patients with chest drainage system: • compromise in system patency • disconnection or malfunction • incorrect placement, dislodgement, or occlusion • hemorrhage • pulmonary edema • infection • subcutaneous emphysema
- I have been doing a little research on chest tubes – specifically in hospice/home settings. I do see that some patients go home with a chest tube with a drainage bag instead of the usual chest drainage unit. I have not taken care of anyone with one of the drainage bags (someone called it a palliative chest tube drainage bag).

Home Health chest tube example-ChestTube.pdf (umich.edu). Aspira® Drainage System - #CompassionateCare - Merit Medical

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE

Title:	Procedure	**Number:**	F03.04
Reference:	Chapter 34.05 RCW Administrative Procedure Act WAC 246-840-800 Scope of Practice-Advisory Opinions Tribal Public Health: Washington State Department of Health		
Contact:	Paula Meyer, MSN, RN, FRE Executive Director Washington State Nursing Care Quality Assurance Commission (NCQAC)		
Effective Date:	January 14, 2022	**Date Reviewed:**	January 14, 2022
Supersedes:	F01.02 Development, Rescinding and Archiving of Interpretive Statements, Advisory Opinions, Policy Statements, and Declaratory Orders, May 11, 2012 F03.02 Request for Interpretive Statement, Consistent Standards of Practice Sub-Committee Responsibilities and Actions, May 11, 2012 F02.03 Nursing Practice Advisory Opinions, Interpretive Statements, Policy Statements, and Declaratory Orders F03.03 Nursing Practice Advisory Opinions, Interpretive Statements, Policy Statements, and Declaratory Orders, July 10, 2015		
Approved:	Yvonne Strader, RN, BSN, BSPA, MHA, Chair Washington State Nursing Care Quality Assurance Commission (NCQAC)		

Purpose:

This procedure describes the process to adopt or rescind a nursing scope of practice advisory opinion. The Nursing Care Quality Assurance Commission (NCQAC) has authority to issue advisory opinions questions concerning the scope of practice for advanced registered nurse practitioners (ARNPs) registered nurses (RNs), licensed practical nurses (LPNs), nurse technicians (NTs), RCW 18.79.110. The NCQAC may issue or decline to issue an advisory opinion.

Definitions:

For this procedure, the following definitions apply:

A. Advisory Opinion – A written opinion in response to questions concerning the authority of various categories of nursing practitioners to perform particular acts. RCW 18.79.110.
B. Author – Staff members who support work to support the NCQAC.

Procedure:

A. Practice Nurse Consultants or Advisors provide informal consultation referring to the statutes and regulations, NCQAC approved advisory opinions, frequently asked questions, Scope of Practice Decision Tree, or other appropriate guidance documents.
B. The requestor may submit a request for a formal response from the NCQAC. Requests may come from the NCQAC, sub-committees, nurses, professional organizations, Tribes, public or private agencies, or other partners and stakeholders.
    a. The Director of Advanced Practice (or appointed lead author) provides overall coordination of requests for ARNP scope of practice advisory opinions.

b. The Director of Nursing Practice (or delegated lead author) provides overall coordination for RN, LPN, NT, and NA scope of practice advisory opinions.

Subcommittee Recommendations

A. The author instructs the requestor to submit the *NCQAC Review Request Form*.
B. The author reviews the written request to determine completeness and clarity.
C. The author saves the request and related documents in SharePoint.
D. The author notifies the requestor of receipt of the request and asks for additional information and clarification as appropriate.
E. The author conducts a comprehensive review, synthesis, and analysis specific to the request and completes the Advisory Opinion Question Review Summary.
F. The author saves the summary in SharePoint.
G. The author submits the formal request to the appropriate subcommittee to initiate NCQAC approval to draft the advisory opinion:
    a. Advanced Practice Subcommittee (APSC); or
    b. Consistent Standards of Practice Subcommittee (CSPSC).
H. The subcommittee makes recommendations to the NCQAC considering the following:
    a. Questions or controversy related to nursing scope of practice;
    b. Changes in technology related to the nursing scope of practice; and
    c. Legislation or regulatory changes related to nursing scope of practice.

Approval Request

A. The subcommittee makes recommendations to the NCQAC.
B. The NCQAC approves the request to develop an advisory opinion, rejects the request, and asks for further clarification.
C. The author notifies the requestor of action taken based on direction from the NCQAC.

Advisory Opinion Drafting

A. The author initiates drafting of the advisory opinion.
    a. Subcommittees work jointly, depending on the request.
    b. The subcommittees reach consensus to determine which subcommittee presents the draft to the commission.
B. The Scope of Practice Decision Tree is used as the overall framework in developing an advisory opinion.
    a. The author reviews the Advisory Opinion Review Summary and conducts additional research and information gathering as necessary.
    b. The author reviews a list of internal and external partners/stakeholders.
    c. The author facilitates partner and interested party communication through formal workgroups, meetings, and informal methods (such as emails), and other opportunities to participate.
    d. The author follows the Washington State Department of Public Health Tribal Consultation and Collaboration Procedure.
    e. The author completes the draft advisory opinion with "draft" watermark and plain talk standard.
    f. The author saves the draft and related documents on SharePoint.
    g. The author consults with the NCQAC's assistant attorney general (AAG), as necessary, including submitting the draft for final review before forwarding to the NCQAC.

h. The author completes edits and sends the draft advisory opinion to the appropriate subcommittee;
i. The subcommittee accepts or makes edits to the draft:
    i. The author makes recommended edits (substantial edits may require additional research, partner and interested party work, and AAG review before a further review by the subcommittee).
j. The subcommittee agrees the draft is ready for the NCQAC's review:
    i. The author processes the request for the NCQAC's approval.
k. The NCQAC approves, amends, or rejects the opinion.
    i. The author follows-up as instructed by the NCQAC
    ii. The author notifies the requestor of action(s) taken.

Communication Plan

The author distributes the approved statement following established communication policies and procedures:

A. Remove the "draft" watermark and save the document on SharePoint.
    a. Send the final document to the Communications Specialist to send out on GovDel and posting on the appropriate NCQAC website.
    b. Send the final document to the assigned Administrative Assistant to post on the Advisory Opinion Tracking system in SharePoint
    c. Send the final document to the requestor and key partners and interested parties.

Document Tracking System

A tracking system of approved, rescinding, or archived Advisory Opinions will be maintained on the NCQAC's Operations SharePoint site. Directors and authors will work with the Operations Unit to ensure information in the tracking system is current.

R**eviewing, Rescinding, and Archiving**

The Director of Advanced Practice or the Director of Nursing Practice review the advisory opinions at least annually for accuracy and validity, considering changes in legislation or statutes, changes in nurse practice standards, safety concerns, controversies or concerns, changes in technology, informal consultation activities, or additional guidance. The appropriate subcommittee reviews advisory opinions at least every five years and makes recommendations to the NCQAC.

Washington State's Board of Nursing
NCQAC
Nursing Care Quality Assurance Commission

NCAO 16.01 Opioid Use Disorder – MAT: Nurse Care Managers and Scope of Practice
Adopted: 5/10/2019
Reviewed/Revised: 1/13/2023
Rescinded:
NursingPractice@doh.wa.gov
ARNPPractice@doh.wa.gov Telephone: 360 236-4703

Advisory Opinion: Opioid Use Disorder Medication Assisted Treatment – Nurse Care Managers and Scope of Practice

Purpose

This advisory opinion provides guidance and clarification about the roles and responsibilities of the registered nurse (RN) care manager and the use of standing orders for patients receiving medication assisted treatment (MAT) for opioid use disorder, such as buprenorphine, methadone, and naltrexone.

Background

On December 29, 2022, Congress eliminated the DATA-Waiver Program that required registration to prescribe buprenorphine for Medication Assisted Treatment (MAT). (Removal of DATA Waiver (X-Waiver) Requirement | SAMHSA). Federal law requires a Drug Enforcement Administration (DEA) registration to prescribe controlled substances. The DEA and SAMSHA are actively working on new training requirements for all prescribers that will go into effect June 21, 2013.

The DEA interprets that it is not within the scope of the RN to perform the initial assessment following standing orders. The HR 6353 - Ryan Haight Online Pharmacy Consumer Protection Act of 2008 requires an in-person medical evaluation by a qualified practitioner before prescribing medications for MAT. The act currently allows for controlled substance prescriptions via telehealth only in certain circumstances:

- Patient is being presented in a DEA-registered hospital or clinic.
- Non-DEA registered facility or provider where patients might seek access to a remote provider. An example is a patient who is seen by an advanced registered nurse practitioner (ARNP) who does not have the buprenorphine waiver. The ARNP can perform the initial evaluation required, and a qualified remote provider can prescribe the buprenorphine via telehealth.

Statement of Scope

The Nursing Care Quality Assurance Commission determined it is within the scope of practice of an appropriately prepared and competent registered nurse care manager to follow approved standing orders for patients receiving medication assisted treatment (MAT) for opioid use disorder such as buprenorphine, methadone, and naltrexone after the initial assessment.

Washington State's Board of Nursing
NCQAC
Nursing Care Quality Assurance Commission

NCAO 16.01 Opioid Use Disorder – MAT: Nurse Care Managers and Scope of Practice
Adopted: 5/10/2019
Reviewed/Revised: 1/13/2023
Rescinded:
NursingPractice@doh.wa.gov
ARNPPractice@doh.wa.gov Telephone: 360 236-4703

Requirements and Recommendations

1. The nurse must understand the Federal and State laws and rules relevant to MAT.
2. The nurse must be trained and competent to provide care in addiction management skills.
3. The nurse must follow clinical practice standards.
4. The nurse must follow standing orders, using nursing judgment and consult with a health care practitioner as appropriate.
5. The nurse must document care following best practices.
6. The nurse should promote a team environment in which nurses and other health care practitioners work to improve the care provided to opioid addicted individuals, including screening, assessment, induction, stabilization, maintenance, monitoring, addiction counseling, and relapse prevention services.

References and Resources

RCW 18.79 Nursing Care
WAC 246-840 Practical and Registered Nursing
Support for Practicing Nurses | Nursing Care Quality Assurance Commission (wa.gov)
Practice Guidance | Nursing Care Quality Assurance Commission (wa.gov)
Practice Information | Nursing Care Quality Assurance Commission (wa.gov)
Ryan Haight Online Pharmacy Consumer Protection Act of 2008
The Controlled Substances Act (dea.gov)
Medication-Assisted Treatment (MAT) | SAMHSA
Removal of DATA Waiver (X-Waiver) Requirement | SAMHSA
Telemedicine and Prescribing Buprenorphine for the Treatment of Opioid Use Disorder (hhs.gov)
DEA's Commitment to Expanding Access to Medication-Assisted Treatment

Washington State's Board of Nursing
NCQAC
Nursing Care Quality Assurance Commission

Licensed Practical Nurse and Medical Assistant Scope of Practice Comparison

Introduction

The following table is a comparison of the scope of practice of the Licensed Practical Nurse (LPN) and the Medical Assistant-Registered (MA-R), Medical Assistant-Certified (MA-C), Medical Assistant-Hemodialysis Technician (MA-HT), and Medical Assistant-Phlebotomist (MA-P). The list of activities is not inclusive of the activities the LPN may perform. The Registered Nurse and Licensed Practical Nurse Scope of Practice Advisory Opinion provides a summary of the LPN scope. See the Nursing Care Quality Assurance Commission (NCQAC) Support for Practicing Nurses for more guidance, information, and resources related to LPN scope of practice.

Activity	LPN	MA-R	MA-C	MA-HT	MA-P
NA-C Training Requirement	Yes – Basic and routine nursing skills	No	No	No	No
Nursing Process	Assists the RN in implementing the nursing process using nursing knowledge and skills including assisting in developing nursing diagnosis, making nursing diagnosis, planning, implementation, evaluation, and adjustments as needed.	Task Specific	Task Specific	Task Specific	Task Specific
Responsibility and Accountability	Individually accountable and responsible	Individually accountable and responsible	Individually accountable and responsible	Individually accountable and responsible	Individually accountable and responsible
Patient and Task Complexity	Non-complex, routine, predictable outcomes	Non-complex, routine, predictable outcomes	Non-complex, routine, predictable outcomes	Non-complex, routine, predictable outcomes	Non-complex, routine, predictable outcomes

Assessment	Yes – Focused nursing assessments – makes basic observations, gathers data, and assists in identification of problems and needs relevant to the patient, collects specific data as directed, and communicates outcomes to RN or other HCP outcomes of the data collection process in a timely fashion to the appropriate supervising person	Monitoring - Limited • Vital signs • Observing and reporting	Monitoring - Limited • Vital signs • Observing and reporting	No	No
Clinical and Nursing Judgment	Yes – Performing activities requiring nursing knowledge, skill, and judgment necessary to carry out selected aspects of the designated nursing or medical regimen	No	No	No	No
Patient Education	Yes – Assists in providing health teaching of patients and provides routine health information and instruction recognizing nursing differences	No	No	No	No

Nursing Delegation	Yes – to NA-R/NA-Cs in some settings limited to routine and non-complex tasks allowed based on setting	No	No	No	No
Autoclaving, Sterilizing Equipment and Instruments	Yes	Yes	Yes	No	No
Aseptic Techniques	Yes – Routine, non-complex procedures in any setting including perioperative settings	Yes – Routine – Limits – not in a hospital setting	Yes – Routine – Limits – not in a hospital setting	No	No
Preparing and Assisting in Sterile Procedures	Yes – Routine • Can prepare and assist in routine and non-complex procedures in any setting	Yes - Routine • Can prepare only Limits – not in a hospital setting	Yes – Routine • Can prepare and assist Limits – not in a hospital setting	No	No
Oxygen Administration	Yes – Nasal Cannula, mask, tracheostomy mask or connector, isolette, oxyhood, or tent	Yes – Nasal cannula or mask	Yes – Nasal cannula or mask	Yes – Nasal cannula or Mask	No
Urinary Catheterization	Yes • Sterile or non-sterile • Urethral • Indwelling or intermittent • Suprapubic	Yes – Urethral • Sterile or non-sterile • Indwelling or intermittent	Yes – Urethral • Sterile or non-sterile • Indwelling or intermittent	No	No

Medications	Yes • By any route • Can compound and reconstitute medications • Can administer medications from multi-dose vials	Yes – Limited • Eye drops • Topical • Ointments • Vaccines (Including injectable)	Yes – Limited • ID, SQ, and IM injections • Cannot administer IV medications via central lines – may interrupt an IV line, administer injection, and restart at the same rate • By unit or single dosage or by a dosage calculated and verified by HCP. Multidose vaccine is considered a unit dose.	Yes – Limited • Subcutaneous, or topical administration of local anesthetics for fistula needle placement • Intraperitoneal administration of sterile electrolyte solutions and heparin for peritoneal dialysis	No
Controlled Substances	Yes • II-V Scheduled Drugs	No	Yes – Limited • III-V Scheduled Drugs [1]See MA-C Drug Administration Table	No	No
Experimental Drugs	Yes	No	No	No	No
Chemotherapy	Yes	No	No	No	No
Infusions • **Peripheral** • **Central Lines**	Yes • Can start IVs	No	Yes – Limited • Cannot start IVs	No	No

• **Arterial Lines**	• Can administer legend drugs via central, arterial, or peripheral lines, including IV push		• Can administer medications via peripheral lines – may interrupt IV line, administer and restart at the same rate		
Blood Products	Yes	No	No	No	No
Phlebotomy	Yes – Immediate or direct supervision not required • Capillary • Venous • Arterial	Yes - Limited • Capillary finger or heel stick	Yes - Limited • Capillary finger or heel stick • Venous	Yes - Limited • Venous	Yes - Limited • Capillary • Venous • Arterial invasive procedures under immediate HCP supervision • Line draws if IV fluid is stopped and restarted under immediate HCP supervision
Specimen Collection	Yes	Yes - Limited • Microbiological • COVID-19 testing • Instructing patients to collect urine and fecal specimens	Yes - Limited • Microbiological • COVID-19 testing • Instructing patients to collect urine and fecal specimens	No	No
Diagnostic Testing	Yes – Routine and Non-complex • EKG	No	Yes - Limited • EKG	No	Yes - Limited • EKG • CLIA-waived tests

	• EEG • Respiratory Testing • CLIA-waived tests • Moderate complexity tests • Radiology procedures		• Respiratory Testing • CLIA-waived tests • Moderate complexity tests		• Moderate complexity tests
Dialysis Procedures	Yes – Routine and Non-complex: No requirements for immediate supervision and no limits to setting • Hemodialysis • Peritoneal Dialysis	No	No	Yes - Limited • Connection to vascular catheter • In renal dialysis center under immediate RN supervision or in a home if a RN and physician are available for consultation	No
Standing Orders	Yes – Routine and Non-Complex	Yes – Limited Cannot give medications following standing orders – except vaccines	Yes – Limited • Cannot give medications following standing orders – except vaccines	Yes – Limited • Cannot give medications following standing orders – except vaccines	Yes
Direction, Delegation and Supervision[2]	Yes • HCP does not need to be on the premises	Yes • Direct or immediate	Yes • Direct or immediate	Yes • Direct or immediate	Yes • Direct or immediate

	• General direction and supervision	supervision required • HCP must be on the premises *Exceptions:* • PREP Act – Covid testing and vaccines • Telemedicine visits	supervision required • HCP must be on the premises • Blood Draws – HCP must be immediately available *Exceptions:* • PREP Act – Covid testing and vaccines • Telemedicine visits	supervision required • HCP must be on the premises	supervision required • HCP does not need to be present but must be immediately available for blood draws only
Health Care Provider (HCP)[3]: Directing or Delegating and Supervising[2]	• RN • ARNP • MD • DO • ND • PA • OD • DPM • DDS • Midwife	• RN • ARNP • MD • DO • ND • PA • DPM • OD	• RN • ARNP • MD • DO • ND • PA • DPM • OD	• RN • ARNP • MD • DO • ND • PA • DPM • OD	• RN • ARNP • MD • DO • ND • PA • DPM • OD

[1]MA-C Drug Administration Table **Prohibited from administering medication through a central intravenous line*

Drug Category	Routes Permitted*	Level of Supervision Required
Controlled Substances Schedule III, IV, and V	Oral, topical, rectal, otic, ophthalmic, or inhaled routes	Immediate supervision
	Subcutaneous, intradermal, intramuscular, or peripheral intravenous injections	Direct visual supervision

Other Legend Drugs	All other routes	Immediate supervision
	Peripheral intravenous injections	Direct visual supervision

[2]Definitions: Direction, Supervision, and Delegation

MA Definition:

- Delegation: Direct authorization granted by a health care practitioner (HCP) to a medical assistant to perform the functions authorized in RCW 18.360.050 which fall within the HCP's scope of practice and the training and experience of the MA.
- Supervision: Supervision of procedures by a health care practitioner who is physically present and is immediately available in the facility:

LPN Definition

- Direction: Instructions or orders to provide nursing services or carry out medical regimen under the direction of an authorized health care practitioner.
- Supervision: 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.
- Delegation: The term delegation does not apply to LPNs. The activity must be within the LPNs SOP already. Transferring the performance of a nursing task (that the person would not normally be allowed to do to competent individuals in selected situations following the delegation process. It must be within the LPN's SOP.

[3]Health Care Providers (HCPs)

• RN – Registered Nurse • ARNP – Advanced Registered Nurse Practitioner • MD – Physician and Surgeon • DO – Osteopathic Physician and Surgeon • ND – Naturopathic Physician	• PA – Physician Assistant • OD - Optometrist • DPM – Podiatric Physician and Surgeon • DDS - Dentist • Midwife

Case Management Team (CMT) questions regarding cosmetic dermatology complaints

1) What supervision/delegation is the standard

2) What is allowed regarding alcohol on the premises/clinic; can the practitioner partake, either before, during or after the procedure

3) As previously discussed, there are complaints about billing and the consent form

4) Research regarding Botox parties discussed during the CSP meeting

    a. Are Botox Parties Legal? Are They… | American Med Spa Association