Washington State Board of Nursing
Consistent Standards of Practice Subcommittee Agenda
October 6, 2023 12:00 p.m. to 2:00 p.m.

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

Committee Members:	Sharon Ness, RN, Chair
	Ella Guilford, MSN, M.Ed., BSN, RN, Member
	Quiana Daniels, BSN, RN, LPN, Member
	Tiffany Randich, RN, LPN, Pro Tem
	Diana Meyer, DNP, RN, NEA-BC, FAEN, Pro Tem
Staff:	Deborah Carlson, MSN, RN, Director of Nursing Practice
	Shana Johnny, DNP, RN, Nursing Practice Consultant
	Margaret Holm, JD, RN, Nursing Practice Consultant
	Holly Palmer, Administrative Assistant
	Seana Reichold, BSN, JD, Staff Attorney

Questions:

Please contact us at 360-236-4703 if you:

- have questions about the agenda.
- want to attend for only a specific agenda item.
- need to make language or accessibility accommodations.

Language and Accessibility:

If you plan to attend and need language or accessibility services, WA BON can arrange help. Please contact us at least one week before the meeting, but no later than July 25, 2023.

Need this document in another format? Please call 800-525-0127.

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- Call: 711 (Washington Relay)
- Email: civil.rights@doh.wa.gov

Meeting Minutes:

WABON records meetings to help write accurate minutes. Minutes are then approved at the WABON business meeting. WABON posts minutes on our website nursing.wa.gov.

All minutes and recordings are public record. They are available on request from DOH at doh.wa.gov/about-us/public-records.

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. Ness and Ms. Johnny

II. Standing Agenda Items

A. Announcements/Hot Topics/WABON Business Meeting Updates
   i. Nurse Delegation COVID-19 Testing – Ms. Johnny
   ii. Acute Hospital-at-Home Care Model and Nurse Delegation – Ms. Carlson
   iii. CSPSC Quality Assurance Plan – Ms. Johnny
B. Review of Draft Minutes
   i. June 2, 2023
   ii. June 8, 2023

III. Old Business

A. Non-Surgical Cosmetic Procedures/Informed Consent – Discussion and request board approval to develop an advisory opinion on informed consent and/or add section to current Dermatologic and Cosmetic Advisory Opinion – Ms. Ness, Ms. Carlson
B. Nurse Delegation Advisory Opinions – Consider Frequently Asked Questions as an alternative – Ms. Carlson
   i. NCAO XX.XX Nursing Delegation to the Nursing Assistant-Registered/Nursing Assistant-Certified, and Home Care Aide-Certified Draft
   ii. NCAO XX.XX Nursing Delegation of Enteral Feedings and Related Tasks to Assistive Personnel (AP) Draft
   iii. NCAO 14.02 Delegation of Blood Glucose Testing/Monitoring and Insulin Injection to the Nursing Assistant or Home Care Aide in Community-Based and Home Care Settings Draft Revision

IV. New Business

A. NCAO 20.03 Death with Dignity – Aid-in-Dying: Role of the Nurse Advisory Opinion Draft Revision – Compliance with Death with Dignity Law Change – Discussion and consideration to request board approval to adopt – Ms. Carlson
B. NCAO 28.01 Standing Orders – Draft Revision – Rescinded state-wide standing orders post-pandemic – Ms. Carlson
C. Patient Abandonment Commonly Asked Questions Draft; Active Shooter Scenario –Ms. Carlson
D. Commonly Asked Questions - Emergency Care - Scope of Practice in Community-Based and Home-Care Settings Draft – Ms. Carlson

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 – December 1, 2023
D. Adjournment

Nurse Delegation & COVID -19 Testing Workgroup
Concerns and Guidance 9/19/2023 Final

WA Board of Nursing (WA BON), Office of Superintendent of Public Instruction (OSPI), Department of Social and Health Services (DSHS), The Washington State Department of Children, Youth**,** and Families **(**DCYF)- Juvenile Rehabilitation (JR)

Nursing practice questions continue to emerge about COVID testing post-waiver recension for those organizations that do not have nursing personnel available to continue testing and for alternative community-based settings that use care delivery models that don't require nursing delegation (**Addendum A)**. In August of 2023, WABON convened a meeting to engage interested parties to discuss their COVID testing concerns in their practice setting.

OSPI School Concerns

OSPI requests a definition of self-administration of covid testing. The Practice Unit reviewed statutes and rules to clarify the definition of self-administration" of tests. The nursing rules were reviewed to clarify and define student self-administration for medication, testing, or treatments. A clear definition was not found. However, in OSPI's 2022 Guidelines for Medication Administration, self-administration of medication in schools is defined as situations in which students carry and administer medication to themselves. The OSPI student agreement document outlines a formal assessment and agreement for self-administration of medication.

School Guidance

The Department of Health and WABON provides guidance to organizations to help define and determine the use of self-tests COVID-19 Self-Testing Guidance for Establishments (wa.gov). Self-testing is when an individual interprets the COVID test for themselves. If the individual does not interpret the test, it is not a self-test. FAQS- testing in schools.

School RNs can delegate CLIA-waived COVID-19 rapid tests to unlicensed K-12 in public or private school personnel. A letter dated May 18, 2023, posted on the WABON website, provides clarification and guidance regarding registered nursing practice authority to administer and delegate in the school setting COVID-19 CLIA-waived tests in school settings.

The waiver transition impacting COVID screening in community settings is broader than the WA BON's role. The BON provides frequently asked questions (FAQ's) guidance related to nursing statutes and rules. *(Clarify with AG to add FAQ that are outside nursing rule about the definition of self-administration or self-testing re: without assistive personnel or nursing delegation).*
School districts should consult with OSPI and their legal department to work towards a more explicit definition in their policy and procedures listed in their Guidelines for Administering Medications. Furthermore, a mechanism and source of authority for students to self-test for COVID should be clarified within their agency.

DCYF- Detention Centers Concerns

Two nurses oversee the COVID testing program, including providing direction, ordering supplies, and training staff for eight youth detention facilities.

The waiver for onsite covid testing allowed nursing staff to delegate testing to assistive personnel (AP) for testing. If onsite testing is unavailable, the patient needs transportation to outside facilities, risking exposure to others.

DCYF-JR Guidance

Application of the nursing delegation statutes and rules does not fit with the JR healthcare delivery model. A source of authority and mechanism is needed to carry out COVID testing in the JR setting, i.e., a legal opinion, standing order, or a memorandum for unlicensed staff to administer a COVID test. The workgroup discussed two potential care models that could be applicable in this setting. DCYF- JR staff should consult with DCYF legal staff to develop the appropriate delivery model. Further analysis and research into alternative models and the mechanism for how healthcare is delivered in the JR practice setting is beyond the purview of the workgroup.

Potential Care Models

In Loco Parentis

Consider the application of the *In Loco Parentis Model*. Juveniles are wards of the court and likely have a case manager or person who has guardianship or custodial authority to provide medical care and consent to facility staff to perform COVID testing. Custodial authority could be a pathway for securing testing.

Public Health Model

Consider harmonizing efforts with DOH on public health countermeasures. For example, anyone can obtain and administer Narcan to another person for a drug overdose Naloxone in Correctional Facilities for the Prevention of Opioid Overdose Deaths (2020) - National Commission on Correctional Health Care (ncchc.org).

DCYF, as an agency, could consider harmonizing agency-level efforts to provide alternative models for testing with the DOH's proposal for future standing order language or a modification of the case worker consent authority. Work with the jail medical director for different steps based on JR needs.

Local public health jurisdictions are vested with certain legal authorities that may help provide a pathway for onsite testing. Your local health department is interested in the movement of individuals in and out of facilities that impact public health. Consider contacting your local public health department to inquire about support or other models used.

DSHS

DSHS noted the document, "*Providers Authorized to Collect Nasal Swab Specimens for COVID-19 Testing"* indicates that testing is not a "nursing" but a "public health task," where observation and training may be required but not delegation. 9/19/2023-Shana emailed the owner of the document and Debbie provided a document revision.

Addendum A- Meeting Questions

1. Is delegation required for covid-19 testing?
2. Does a RN need to have an order to do the CLIA-waived lab test (OTC) or the PCR which is a diagnostic test?
3. What does loss of the waiver for the covid screening mean to settings other than schools and community-based and in home settings (e.g., correction centers, nursing homes, behavioral health settings).
4. Can unlicensed assistive personnel perform Point-of-Care (POC) COVID-19 testing with or without nursing delegation or without an order from an authorized practitioner.
5. Question about the types of tests being done in the schools.
   - Rapid Antigen Tests (CLIA-Waived) – Screening test, non-prescriptive
   - Polymerase Chain Reaction (PCR) Tests – Diagnostic test, prescriptive (Note – POC is available for PCR tests)

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Nursing Care Quality Assurance Commission
111 Israel Road SE, MS 47864
Tumwater, WA 98504

May 18, 2023

To : Martin Mueller via email at Martin.Mueller@k12.wa.us

Office of Superintendent of Public Instruction

From: Paula R. Meyer, Executive Director of the Nursing Care Quality Assurance Commission
Alison Bradywood, Executive Director of the Nursing Care Quality Assurance Commission

Regarding: Authority of Registered Nurses to Administer and Delegate COVID-19 CLIA-Waived Tests in School Settings

With the end of the federal COVID-19 Public Health Emergency declaration on May 11, 2023, and its increased flexibilities in testing regulation through the federal PREP Act, school nurses have raised questions regarding their authority to continue caring for their student populations by administering COVID-19 testing in schools. The Nursing Care Quality Assurance Commission (NCQAC) is issuing this letter to provide clarification regarding registered nursing practice authority in existing law and guidance.

Administration of CLIA-waived COVID-19 Tests in Schools

In accordance with prior NCQAC-issued guidance, it is within the scope of a registered nurse (RN) to administer Clinical Laboratory Improvement Amendments (CLIA)-waived tests without an order from a health care practitioner. See the NCQAC Frequently Asked Questions under Infusion Therapy, Phlebotomy, and Laboratory Tests. Tests that do not requiring puncturing of the skin may be initiated by an RN without an order from an authorized health care practitioner in a school setting. An RN may consult the test instructions or the FDA website to determine whether a particular test is CLIA-waived.

Delegation of COVID-19 Rapid Tests to Unlicensed Personnel in Schools

Under RCW 28A.210.305, an RN may provide nursing care to students in a school setting. This includes the authority to delegate routine and non-complex nursing tasks, such as administration of a CLIA-waived COVID-19 test without an order from a health care practitioner, to unlicensed assistive personnel (UAP) who are employees of public or private schools that conduct any of grades kindergarten through the twelfth grade.

Licensed RNs working in a school setting are advised to follow chapter 28A.210 RCW as well as the guidance in NCQAC Advisory Opinion 15.01: Registered Nurse Delegation in School Settings: K-12 Grades, Public and Private.

The PREP Act Liability Immunities Extend Through 2024

Per the 11th amendment to the declaration under the PREP Act for COVID-19 Medical Countermeasures, the Secretary of the federal Department of Health and Human Services has extended immunity from suit and liability for providers who administer or use COVID-19 tests that are subject to an FDA Emergency Use Authorization or relate to a federal grant or other federal agreement through December 31, 2024.

If you have further questions regarding registered nursing practice in Washington, please check out the NCQAC website, or address practice questions to nursingpractice@doh.wa.gov.

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Acute Care Hospital-at-Home Care Model – Nursing Delegation Overview

October 6, 2023

Overview

During the COVID-19 pandemic, the Centers for Medicare & Medicaid Services gave hospitals expanded flexibility to care for Medicare patients outside their walls. The Acute Hospital Care At Home program expands on the successful Hospital Without Walls program authorized in March to support additional models proven to provide effective hospital care at home.

The program requires an in-person physician evaluation and screening protocols to assess medical and non-medical factors before care at home begins, with beneficiaries admitted only from emergency departments and inpatient hospital beds. A registered nurse (RN) must evaluate each patient once daily in person or remotely, and either registered nurses or mobile integrated health paramedics will conduct two in-person visits daily based on the patient's nursing plan and hospital policies. Hospitals must report quality and safety data to CMS at a frequency based on their prior experience with the Hospital-at-Home model.

Currently, a hospital or health system that wants to roll out such a program must request a waiver from CMS. This waiver will remain in place until at least the end of 2024, although some experts anticipate policy changes allowing such programs to remain in place permanently.

Nurse Delegation Issues

We received a question from a hospital that is approved by CMS for the Hospital-at-Home Program regarding nurse delegation for a patient that is admitted as a hospital patient and being cared for at home. The issues for discussion include:

- The nursing laws and rules allow RN delegation to a nursing assistant-registered/nursing assistant-certified (NA-R/NA-C) in home care settings including medication administration with limitations – If the patient is considered a "hospital patient", does it allow the RN to delegate following the delegation laws and rules that apply in the home setting? In the hospital setting, a RN can delegate some tasks to the NA-R/NA-C. Medication administration is not allowed. Sterile procedures, tasks that require nursing judgment, tasks that involve central lines, tasks that involve piercing or puncturing of tissue (except for blood glucose testing) cannot be delegated. Examples of tasks that could be delegated in the hospital setting include other CLIA-waived lab tests that do not involve piercing or puncturing of the tissue, EKGs, and applying oxygen via mask/nasal cannula.

Brainstorming a Framework for the CSPSC Workplan

On September 1, 2023, as part of a quality improvement and planning effort for the CSPSC meetings, the practice unit, legal, and CSPSC staff met to provide feedback on a new framework that prioritizes activities for the CSPSC work plan. The team reviewed guiding documents, including the WABON strategic plan, the DOH Strategic Plan to Advance DEI, BON Policy requirements on AO revisions, the CSP roles and responsibilities document, and best practices for prioritizing activities. A criteria for prioritizing work activities was discussed (Table 1).

Table 1- Draft Criteria for CSPSC Workplan Activities

- Compliance - (Are there statutes/rules that support change).¶
- BON Policy - (What does our policy say about CSP activities? I.e., AOs reviewed yearly, revisions every five years,¶
- Public safety/Risk,¶
- Alignment with BON strategic plan,¶
- Public/Organization Demand - WSNA wants something, and then it becomes a priority; any requests that aren't in our realm,¶
- Resources - (Do we have the capacity)? Some projects and workgroup activities don't need to go through SC, l ¶
- Impact - (many licensees or organizations affected),¶
- Political - (This would be a risk variance beyond what we could do as a sub-committee. It would involve a task force or workgroup). (Addendum A-Priority Matrix) below ¶

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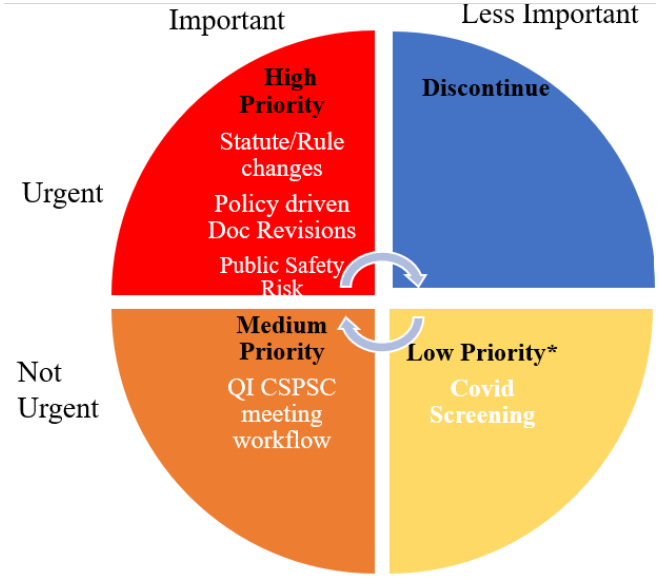

Addendum A-Priority Matrix¶

*Pause/Revisit work, schedule a plan.¶

Nursing Care Quality Assurance Commisison (NCQAC)
Consistent Standards of Practice Subcommittee Minutes
June 2, 2023

Committee Members Present:	Sharon Ness, RN, Chair Helen Myrick, Public Member Tiffany Randich, RN, LPN, Pro Tem
Absent:	Jamie Shirley, PhD, RN, Pro Tem Ella Guilford, MSN, M.Ed., BSN, RN, Member Robin Fleming, PhD, MN, BSN, BA, RN, Pro Tem
Staff Present:	Deborah Carlson, MSN, PMC, CPM, RN, Director of Nursing Practice Shana Johnny, DNP, MN, RN, Nursing Practice Consultant Holly Palmer, Administrative Assistant Jessilyn Dagum, Policy Analyst Shad Bell, Assistant Director of Operations & Communications Seana Reichold, Staff Attorney

Opening:
Sharon Ness called the meeting to order at 12:00 PM. The Consistent Standards of Practice subcommittee members and staff were introduced. Commissioner Ness read the Public Disclosure Statement was read aloud.

Standing Agenda Items:
All items have been tabled until the next subcommittee meeting, on June 8th, 2023, to allow adequate time for rules updates.

Old Business:
Health Equity Continuing Education Rule: SSB 5229 (2022) - Jessilyn Dagum and Shana Johnny presented a PowerPoint to review the draft language. As part of the language change, language referencing tribal engagement and cultural humility was removed because more space and attention to this topic needs to occur separately from rulemaking. The intent is to assemble a workgroup based on feedback from the workshops. This tribal workgroup will help inform proposed language moving forward. We would like to cast a broader net to all tribes for this work. Fawzi Belal with Washington Center for Nursing (WCN) provided comments on collaboration between WCN and NCQAC to develop training to meet the requirements of the new rules. Suggestions for minor edits were provided to maintain conformity. The consensus was reached to move the draft language with suggested edits forward to the full Commission at the July 14, 2023, Business Meeting for approval.

Delegation of Blood Glucose Testing and Monitoring Rule: HB 1124 (2022) – Ms. Dagum and Debbie Carlson reviewed the draft language of the updated rule. NCQAC received additional feedback from Washington State Hospital Association (WSHA); that feedback will be incorporated into the final document. The consensus was reached to move the draft language with suggested edits forward to the full Commission at the July 14, 2023, Business Meeting.

New Business:
All items have been tabled until the next subcommittee meeting on June 8th, 2023.

Public Comment:
The public was given the opportunity to comment on agenda items.

Ending Items
Review of Actions: Health Equity Continuing Education Rule draft language and Delegation of Blood Glucose Testing and Monitoring Rule draft language moved forward to July 14, 2023, NCQAC Business Meeting.

Date of Next Meeting – June 8, 2023
Adjournment 1:33pm

Nursing Care Quality Assurance Commisison (NCQAC)
Consistent Standards of Practice Subcommittee Minutes
June 8, 2023

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

Opening:
Subcommittee Chair Sharon Ness called the meeting to order at 2:02 PM. The Consistent Standards of Practice subcommittee members and staff were introduced. Commissioner Ness read the Public Disclosure Statement aloud.

Standing Agenda Items - Announcements/Hot Topics/NCQAC Business Meeting Updates: Debbie Carlson provided an update to the Subcommittee:
The Health Equity Education Rules will be presented to the full Commission at the July 14, 2023, NCQAC Business meeting.

The Assistant Attorney General (AAG) is reviewing the newest Blood Glucose Rules draft, including recommendations from previous meetings. When the review is completed, Ms. Carlson and Ms. Dagum will provide the draft to the Subcommittee.

The waiver for Covid testing in schools has expired, leading to questions about delegating CLIA-wave and PCR tests in schools. Ms. Carlson will be working to have documents approved by the Commission by the start of school in the fall to provide clarity.

NCSBN is offering an IV Hydration Information meeting for those interested.

Consensus was reached to forward the draft minutes from April 7, 2023, to the July 14, 2023, NCQAC Business meeting for approval.

Old Business:
Seattle-King-County Public Health Nursing – Elimination of Nursing Positions: Ms. Carlson reviewed the background of the issue and the concerns raised. A letter has been formulated and shared with the Subcommittee. The full Commission will review the letter at the July 14, 2023, NCQAC Business Meeting.

NCAO 31.00 Nursing Delegation to the Nursing Assistant-Registered/Nursing Assistant-Certified, and Home Care Aide-Certified: This work is on hold while waiting for the Blood Glucose Delegation Rules to be finalized.

NCAO XX.XX Nursing Delegation of Enteral Feedings and Related Tasks to Assistive Personnel (AP): This work is on hold while waiting for the Blood Glucose Delegation Rules to be finalized.

Non-Surgical Cosmetic Procedures – Ongoing Discussion: The Medical Commission has provided an informed consent document that we will modify to fit nursing.

Frequently Asked Questions – Licensed Practical Nurses Revision: Cardiology and Respiratory Procedures (Chest Drainage Units) – Discussion: Minor changes have been made, the AAG has reviewed the document, and Ms. Ness will provide a copy to the Subcommittee members who were unable to attend this meeting. Provided they have no objections or suggestions for changes, this document will be moved forward to the July 14, 2023, NCQAC Business Meeting.

New Business:
Nurse Licensure Compact (NLC): The NLC will be implemented **by July 24, 2023.** NCQAC has multiple internal processes and workgroups in place to accomplish this work.

Public Comment:
The public was provided time to comment on agenda items.

Ending Items
Review of Actions: Ms. Ness will review Frequently Asked Questions – LPN Revision: Cardiology and Respiratory Procedures with Tiffany Randich and Robin Fleming, and it will be forwarded to the July 14, 2023, NCQAC Business Meeting, as well as the letter regarding the Seattle-King County Public Health Elimination of Nursing Positions and the draft minutes from the April 7, 2023, subcommittee meeting.

Date of Next Meeting – August 4, 2023
Adjournment: Meeting was adjourned at 2:54pm.

Washington State's Board of Nursing
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Consistent Standards of Practice Subcommittee

INFORMED CONSENT FOR CARE – NURSE'S ROLE

Introduction

The issue of informed consent and the nurse's role may be an issue with questions about informed consent as well as discipline cases that may arise in the discipline process. Informed consent is based upon the ethical principle of autonomy. This principle provides individuals with the right to make free, uncoerced, and informed decisions. Informed consent can be oral or written and should be documented. The universal role of a nurse is as an advocate in ensuring patient's comprehension and agreement to the treatment plan, providing education needed to make informed decisions involving health care and treatment options, and communicating questions and concerns to the healthcare team. One of the current issues is the role of the nurse in obtaining informed consent for cosmetic procedures. The Nursing Care Quality Assurance Commission does not currently have an advisory opinion or other guidance documents about informed consent for cosmetic procedures or any other procedure.

Informed Consent Overview

There are two major important characteristics to remember about consent.

- Informed – Sufficient information about the care should be provided to the patient. This includes the risks, consequences of refusing the care, and possible alternatives to the care before obtaining consent.
- Voluntary – Consent should be obtained without coercion, threat, or under the influence of any impairing substance.

Consent is also an on-going process, which can be obtained implicitly or explicitly. A nurse can watch for non-verbal cues as implicit consent (e.g., holding out arm to have blood pressure taken) or have consent be obtained explicitly through verbal agreement or in writing. Although documentation is not consent itself, documented information about the consent process and how consent was obtained can potentially help mitigate risks and complaints if any misunderstandings arise. It is in the best interest of the nurse to verbally share details about a nursing intervention before and during the performance of the intervention.

When delivering routine nursing care, nurses provide information, support, and guidance. Consent may be implied or explicitly communicated verbally, nonverbally, or in electronic or written form.

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Nurses may be involved in formal informed consent process that address operative and other invasive procedures, blood product administration, research or clinical trials, high risk medication administration (e.g. chemotherapy).

Informed consent for treatment is essential. A general principle of informed consent is that it is the health care provider doing the procedure or treatment that obtains the informed consent of the patient. Obtaining informed consent isa process that requires a detailed exchange of information concerning the treatment or procedure so that the patient can make a knowledgeable choice about the proposed plan.

Informed consent is the process in which a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention. The patient must be competent to make a voluntary decision about whether to undergo the procedure or intervention. Informed consent is a legal and ethical obligation of health care providers.

The Joint Commission requires documentation of all elements of informed consent, "In a form, progress note or elsewhere in the record." The following elements are required:

1. Nature of the procedure
2. Risks and benefits of the procedure
3. Reasonable alternatives
4. Risks and benefits of alternatives
5. Assessment of the patient's understanding the above elements.

Quick Safety 21: Informed consent: More than getting a signature (Updated: April 2022) | The Joint Commission

In most situations, the nurse is not functioning in the primary role of performing or ordering provider for a particular procedure but may act as witness and provide educational aspects of the consent process. The witness must be impartial and must sign and date the consent from at the time the consent process occurs. A signature of the witness means:

- The requirements for informed consent have been satisfied
- Consent is voluntary and freely given by the patient.

In some situations, it is appropriate for the nurse to undertake the consent process in a primary role. Examples may include (but not limited to) insertion of a PICC line, transfusion of blood or blood products, sigmoidoscopy, radiology procedures, and research/clinical trials.

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Advanced Registered Nurse Practitioner's Role

Advanced Registered Nurse Practitioners (ARNPs) are independent practitioners under Washington law and may (and are obligated to) undertake the consent process in situations where they are the ordering or performing provider for the procedure.

RCW 18.79.256 Advanced registered nurse practitioner—Scope of practice—Document attestation.

An advanced registered nurse practitioner may sign and attest to any certificates, cards, forms, or other required documentation that a physician may sign, so long as it is within the advanced registered nurse practitioner's scope of practice.
[2015 c 104 § 1.]
[2015 c 104 § 1.]

Washington State Laws and Rules

Washington law requires health care providers to obtain informed consent. The overall law defines the term health care provider broadly.
RCW 7.70.060: Consent form—Contents—Prima facie evidence—Shared decision making—Patient decision aid—Failure to use. (wa.gov)

- Nature and character of proposed treatment
- Anticipated results of proposed treatment
- Possible alternative forms of treatment
- Possible risks, complications, and anticipated benefits of the treatment or alternative forms of treatment, including non-treatment
- A statement that patient elects not to be informed o the elements (if applicable)

RCW 7.70.020: Definitions. (wa.gov)
The definition of a health care provider includes an ARNP and Nurse (not specific to RN or LPN).

RCW 7.70.050: Failure to secure informed consent—Necessary elements of proof—Emergency situations. (wa.gov)

RCW 7.70.065: Informed consent—Persons authorized to provide for patients who do not have capacity—Priority—Unaccompanied homeless minors. (wa.gov)

Patient Rights Guidelines (wa.gov)

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consentforms.pdf (nursinglaw.com)

WAC 246-919-605: Use of laser, light, radiofrequency, and plasma devices as applied to the skin.

The rules define what is required including informed consent. Physician must obtain informed consent including that a non-physician may perform the procedure to administer medications or substances for cosmetic purpose or the use of prescriptive devices for cosmetic purposes.

WAC 246-919-606: Nonmedical cosmetic procedures
The rules define what is required including informed consent. Physician must obtain a consent form prior to treatment that lists foreseeable side effects and complications, and the identity and license of the delegate or delegates who will perform the procedure; and

Other States

The Arizona Board of Nursing has an advisory opinion on Informed Consent.
July 31, 1996 (azbn.gov)

The Massachusetts Board of Nursing requires the nurse performing cosmetic procedures to review and verify informed consent that clearly informs the patient of the operators qualification, licensure, and expected outcomes of the procedure.
AR 13-01 Cosmetic and Dermatologic Procedures.doc (live.com)

Nevada has a statement about nurses performing cosmetic procedures that states the patient have granted informed consent. The statement includes the nurse's requirements for informed consent if a nurse is providing a nursing intervention.
NEVADA STATE BOARD OF NURSING

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Nurse Delegation Advisory Opinions Overview for Discussion

We met with the Gail McGaffick and Katerina LeMarche with the Washington State Hospital Association (WSHA) to discuss concerns about the following advisory opinion drafts with a recommendation to consider developing Frequently Asked Questions as an alternative to the advisory opinions as this may be easier to understand addressing specific questions that are commonly received by the staff. Developing FAQs instead of advisory opinions would provide a simpler way of providing information about the delegation requirements.

- NCAO XX.XX Nursing Delegation to the Nursing Assistant-Registered/Nursing Assistant-Certified, and Home Care Aide-Certified Draft – the primary purpose is to provide an overview of general delegation to the NA and HCA in any setting. The nurse delegation law and rules are multifaceted and the tasks that may be delegated, as well as who the nurse can delegate to, vary based on setting. It is very difficult to define the differences based on various settings.
- NCAO XX.XX Nursing Delegation of Enteral Feedings and Related Tasks to Assistive Personnel (AP) Draft – the primary purpose is to provide an overview of delegation of enteral feedings in any setting. This is also difficult to define the differences for various settings.
- NCAO 14.02 Delegation of Blood Glucose Testing/Monitoring and Insulin Injection to the Nursing Assistant or Home Care Aide in Community-Based and Home Care Settings Draft Revision - The primary purpose of the revision is to address the statement that CBG could only be delegated in community-based and in-home settings for compliance with the law change that allows nurse delegation to a NA in any setting where health care is being provided. The initial advisory opinion was developed as requested from WA DSHS to clarify language in the law. At the time, regarding blood glucose testing, the only term in the law used was “monitoring” blood glucose testing. DSHS wanted clarification that “monitoring” included performing a capillary blood glucose test. A second request was to clarify the term, injectable “insulin” for diabetes, as other non-insulin medications are now available to treat diabetes. The term “insulin” is not defined in the law or rule. We are also getting many questions about new technology for insulin administration and blood glucose testing using continuous blood glucose monitoring systems and insulin administration. This provided an opportunity to provide a formal document from the board.

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. 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

Title:	Death with Dignity (Aid-in-Dying): Role of the Nurse	*Number:* NCAO 20.02
References:	RCW 18.79 Nursing Care WAC 246-840 Practical and Registered Nursing RCW 70.245 Washington Death with Dignity Act WAC 246-978 Death with Dignity Requirements EHB 1608, Sec.2, Chapter 102, Laws of 2020	
Contact:	Deborah Carlson, MSN, BSEd, RN, CPM Director of Nursing Practice	
Phone:	360 236-4703	
Email:	NursingPractice@doh.wa.gov or ARNPPractice@doh.wa.gov	
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Approved By:	Nursing Care Quality Assurance Commission	

Conclusion Statement

Advanced registered nurse practitioners (ARNPs), registered nurses (RNs), and licensed practical nurses (LPNs) may be involved in providing nursing care, within their scope of practice, to patients who make the choice to end their life through the Washington State Death with Dignity Act (RCW 70.245). Nurses are accountable and responsible for providing compassionate and comprehensive care to all patients, regardless of their end-of-life choices. Nurses may decline active participation in the implementation of aid-in-dying, but they remain responsible for the full scope of end-of-life care including providing information, symptom management, and other palliative or end-of-life interventions. The advisory opinion clarifies the nursing roles and responsibilities in palliative and end-of-life care.

Background and Analysis

RCW 70.245 Washington Death with Dignity Act, enacted in 2009, allows an eligible individual with a terminal diagnosis and prognosis to legally request and obtain medications from a qualified health care practitioner to end their life. The RCW 70.245 Washington Death with Dignity Act allows a Doctor of Medicine (MD) or Doctor of Osteopathy (DO) who has primary responsibility for the care and treatment of the patient with terminal illness to prescribe such medications. The act does not allow an advanced registered nurse practitioner to write a

prescription for this purpose. The WAC 246-978 Death with Dignity Requirements implement the law. See the Washington State Department of Health Death with Dignity Act webpage for common questions and answers containing general information about the Death with Dignity Act. Neither the RCW, the WAC, nor the information page provide guidance for nurses involved in the care of the patient, beyond the clarification that ARNPs may not prescribe.

This lack of recognition of the direct and intimate role of nurses in the care of patients at the end of life leaves nurses in a potential moral quandary regarding their responsibilities to patients. Aid-in-dying is a new area of ethical concern about which public opinion and public policy has evolved quite rapidly such that professional organizations and individual clinicians are still evolving their positions. The situation is exacerbated by the role of most nurses as employees of health care institutions that may have additional policies regarding aid-in-dying. Unlike physicians and ARNPs who have the option to act as independent practitioners outside their association with an institution, most nurses practice solely under the auspices of their employer. Additionally, nurses have their own personal beliefs about the ethical acceptability of aid-in-dying and their own willingness to be involved. Across the profession, there is a wide range of views that need to be accommodated. Nurses are challenged to define their practice while negotiating the space among these personal, professional, institutional, and legal constraints.

The American Nurses Association's (ANA) position statement, The Nurse's Role when a Patient Request Medical Aid in Dying (2019), clarifies many of the questions nurses are asking. The position of the ANA is that although nurses are strictly prohibited by law from prescribing or administering aid-in-dying medications, they nonetheless have an obligation to provide all other appropriately supportive care to patients at the end-of-life. This care includes providing objective information, managing distressing symptoms, coaching family and care providers in the management of patient care, and remaining engaged, non-judgmental, and attentive to the evolving needs of the dying and their families. They further suggest that nurses have an obligation to not only be knowledgeable about this issue, but also to be engaged in public policy conversations and research to further explore its merits and consequences.

This position is aligned with the ANA's *Code of Ethics for Nurses* (2015) and *Nursing: Scope and Standards of Practice* (2015). For example, they argue that nurses are not "actively participating" in aid-in-dying when providing information, supporting discussion, or being present with a patient. Instead, all these actions are the nurse's ethical "response to the patient's quality-of-life self-assessment" (p. 3) consistent with Interpretive Statement 1.4 of the *Code* that nurses "should provide interventions to relieve pain and other symptoms in the dying patient consistent with palliative care practice standards and may not act with the sole intent to end life" (ANA, 2015, p. 3). This is a significant departure from the previous ANA position statement aid-in-dying of 2013 that prohibited participation by nurses in aid-in-dying.

This advisory opinion will not reiterate the positions taken in the ANA statement, but refers readers to that document for further exploration. Nor does this opinion take a position on the essential question of the acceptability of aid-in-dying itself. Aid-in-dying is legal in Washington State and, as such, nurses need to be prepared to provide care in this context. The context requires consideration of two issues not fully addressed in the ANA statement: employer restrictions on nursing practice and conscientious objection.

Employer Restrictions on Nursing Practice

The Washington state law allows employers to establish policy related to the implementation of aid-in-dying within their institutional boundaries (which may include both in-patient, out-patient, and homecare settings). Most in-patient settings restrict patients from ingesting medications that will end their lives; policies for outpatient and homecare settings are more variable and evolving. A study in the *Journal of Pain and Symptom Management* (JPSM), Dignity, Death, and Dilemmas: A Study of Washington Hospices and Physician-Assisted Death (2014), summarizes the content of hospice policies in Washington State. Examples of policies include:

- Restricting or allowing staff to be present at the time of patient self-administration of the medication, as well as the duration between ingestion and death.
- Restricting or allowing staff involvement with the process to obtain life-ending medication.
- Restricting or allowing providing information about the law.
- Preventing or allowing a patient from ingesting a lethal dose of medication on the premises of a health care facility.
- Requiring, encouraging, or discouraging the participation of LPNs, RNs, or ARNPs in the process.
- Restricting or allowing initiating communication and notification of the patient's attending physician.
- Restricting or allowing staff to witness necessary legal documents.

Health care institutions may legitimately create policies that are consistent with their philosophy and mission. Health care entities are prohibited, however, from limiting the provision of information about Washington's Death with Dignity Act or information about what relevant resources are available or how to access those resources. EHB 1608, Sec.2, Chapter 102, Laws of 2020.

The most common and ethically defensible limitation is to not allow nurses to be present at the time of medication administration. This restriction has several advantages. Since nurses are legally constrained from administering the life-ending medications, the policy prevents nurses from being pressured by patients or families to assist in administration—an act that in any other circumstance would be well within the nurse's scope of practice. Additionally, it allows nurses who are ethically opposed to aid-in-dying to avoid needing to explicitly opt-out of this most active participation in the process. For nurses who would be comfortable participating at this stage, it also prevents them from providing support to the patient and family at a critical moment in the dying trajectory. Nurses, particularly hospice and homecare nurses, often develop significant empathetic relationships with patients and families over the course of their care and absence at this time can potentially be experienced by the patient as professional abandonment. This is a significant departure from the standard hospice commitment to non-abandonment and the promise to witness with the patient through the dying process. While physicians and ARNPs may choose to practice as independent providers at times like this and be present despite institutional policies, nurses choosing to be present outside their nursing role risk violating professional boundaries. Again, nurses need to decide for themselves whether the restrictions on practice imposed by institutional policies are aligned with their vision of professional practice.

Institutional policies that further restrict nursing practice, such as limiting the nurse's ability to provide objective and non-judgmental information about legal options or provide counseling and emotional support as the patient thinks through their end-of-life decisions are ethically problematic in that they significantly impinge on nursing scope of practice and professional standards of care. In 2020 the Washington legislature clarified that a health care entity may not limit a health care provider's provision of information about and regarding Washington's death with dignity act, Chapter RCW 70.245, information about what relevant resources are available in the community, and how to access those resources for obtaining care of the patient's choice. A health care entity may not discharge, demote, suspend, discipline, or otherwise discriminate against a health care provider for providing such information. EHB 1608, Sec.2, Chapter 102, Laws of 2020. EHB 1608, Sec.2, Chapter 102, Laws of 2020.

Conscientious Objection

It is broadly accepted that aid-in-dying is a situation in which a nurse may appeal to conscientious objection to avoid acting in a manner that is contrary to their own moral values. While ensuring that patients receive the beneficial care they desire is a fundamental ethical value, it is necessarily balanced by the right of health care providers to maintain their own moral integrity (Magelssen, 2011). "Having moral integrity implies having an internally consistent set of basic moral ideas and principles and being able to live and act in accordance with these" (Magelssen, 2011, p. 18). When a nurse finds that actively participating in aid-in-dying conflicts with deeply held values and judgments, it is reasonable to consider this objection. (Deeply held values are contrasted with those which are capricious, arbitrary, or situationally convenient.)

Although there are multiple formulations of the criteria such objections must meet, Brock (2008) delineates three criteria:

1) The patient is informed of the full range of care options.
2) The patient must be referred to another provider who can provide the services.
3) The refusal must not create an undue burden on the patient.

Interestingly, the Death with Dignity Initiative explicitly does not require physicians to refer patients requesting aid-in-dying to another provider.

Conscientious objection applies to specific actions, not to patients. Such objections cannot be raised to avoid providing general nursing care for a patient, but only to withdraw from participating in a specific action. For example, in the common example of abortion, a nurse may decline to participate in actively implementing a surgical abortion procedure but may not decline to provide post-operative care to that patient. Conscientious objection cannot be used as a claim to refuse to care for a patient based on their social standing, beliefs, or preferences, nor on the bias or prejudice of the nurse.

This suggests that the only activity nurses may request to avoid is being present when patients are ingesting the medications that will end their lives. Given that so many institutions already restrict nurses from being present anyway, this significantly limits the instances in which nurses may reasonably claim conscientious objection to avoid providing care to a patient. However, nurses should be attentive to their own self-presentation and their ability to provide

compassionate and non-judgmental care to a patient who is making a decision that is contrary to their deeply held beliefs. If other staff are reasonably available and can substitute for the objecting nurse, it may benefit both the patient and the nurse to make this change. Such an accommodation, however, does not remove the obligation of the nurse to reflect on the opportunity for developing a more empathetic and patient-centered stance.

Recommendations

The NCQAC determines that in addition to all standard nursing care the following behaviors are consistent with the standard of care when providing nursing care to patients who have chosen to end their own life:

- Empathetically explore end-of-life options with the patient and family and link them to services, other health care providers or resources to meet their needs;
- Explain the law as it currently exists;
- Maintain confidentiality about the end-of-life decision-making;
- Provide palliative care for the patient, including administration of medications and treatments for pain and symptom management.;
- Follow Portable Orders for Life Sustaining Treatment (POLST)/advanced directives;
- Determine and pronounce death;
- Collaborate and consult with health care team members;
- Understand the ethical and moral dilemmas related to aid-in-dying
- Understand professional organizations' positions related to aid-in-dying;
- Reflect on personal and professional values and request accommodation on the basis of conscientious objection if needed;
- Understand the employer philosophy, policies, and procedures related to end-of-life decisions and aid-in-dying;
- Understand institutional policy regarding the presence of nurse when a patient self-administers a prescribed lethal dose of medication;
- Be involved in policy development within the health care institution and the community.

Nurses who choose not to be involved:

Under the conditions listed above, nurses may decline to be present when patients are ingesting medication to end their lives. In this situation, the nurse should:

- Request to be relieved from providing care on the basis of conscientious objection;
- Continue to provide standard supportive and palliative care to ensure the patient's comfort and safety and avoid abandonment.
- Withdraw only when assured that alternative sources of care are available for the patient and care has been responsibly transferred to another provider;
- Maintain confidentiality;
- Reflect on self-presentation and the development of a non-judgmental stance to ensure patients feel respected despite differences in values
- Be involved in policy development within the health care institution and community.

Nurses shall not:

- Administer the medication that will lead to the end of the patient's life;
- Breach confidentiality of patients exploring or choosing assisted suicide;
- Subject patients or families to disrespectful, judgmental comments or actions because of their decision to choose aid-in-dying
- Subject colleagues to disrespectful comments or actions due to their decision to continue to provide care to a patient who has chosen aid-in-dying;
- Abandon or refuse to provide comfort and safety measures to patients.

Institutional Policy Constraints:

If institutional policies prohibit staff from participating in the aid-in-dying process with interested patients, the NCQAC recommends that the patient be referred to their attending physician, the Washington State Department of Health and/or the patient rights organization, End of Life Washington, to obtain information and initiate the legal process.

Conclusion

Providing care throughout the dying process to patients choosing to end their life through the Death with Dignity Act is within the nursing scope of practice and does not violate any professional norms. However, nurses exploring their obligations to the dying are confronted with a complex set of considerations. Aid-in-dying is legal in the State of Washington. Professional nursing standards require that nurses treat the dying with compassion and avoid abandonment. Individual agencies may have policies that limit nurses' participation in end-of-life care. Individual nurses may have deeply held moral beliefs. All these factors need to be weighed as the nurse decides how to pursue a particular course of action. Nurses must make a choice that is congruent both with their professional obligations and their own moral integrity.

References

American Nurses Association (ANA) – The Nurse's role when a patient requests medical aid in dying. (2019): https://www.nursingworld.org/~49e869/globalassets/practiceandpolicy/nursing-excellence/ana-position-statements/social-causes-and-health-care/the-nurses-role-when-a-patient-requests-medical-aid-in-dying-web-format.pdf

Brock D. W. (2008). Conscientious refusal by physicians and pharmacists: who is obligated to do what, and why? *Theoretical Medicine and Bioethics, 29,* 187-200.

Campbell, C.S. and Black, M.A. (2013). Dignity, Death, and Dilemmas: A Study of Washington Hospices and Physician-Assisted Death: https://www.jpsmjournal.com/article/S0885-3924(13)00270-4/abstract

Death with Dignity National Center: https://www.deathwithdignity.org/about/

End of Life Washington: https://endoflifewa.org/

Magelssen, M. (2012). When should conscientious objection be accepted? Journal of Medical Ethics, 38, 18-21.

Nursing Care Quality Assurance Commission Practice (NCQAC) Advisory Opinions: https://www.doh.wa.gov/LicensesPermitsandCertificates/NursingCommission/PracticeInformation

- Completion of Death Certificates by Advanced Registered Nurse Practitioners
  - Guideline – Completion of Death Certificates
- Death, Determination and Pronouncement by Licensed Practical Nurses
- Provider Orders for Life-Sustaining Treatment (POLST)
  - Frequently Asked Questions about POLST

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

NCAO 20.03 Death with Dignity (Aid-in-Dying) Role of the Nurse
Adopted: November 8, 2019
Reviewed/Revised: November 13, 2020, September 9, 2021, **TBD**
Rescinded:
NursingPractice@doh.wa.gov
ARNPPractice@doh.wa.gov Telephone: 360 236-4703

Advisory Opinion: Death with Dignity (Aid-in-Dying): Role of the Nurse

Purpose

The advisory opinion clarifies and provides guidance about the roles and scope practice for the nurse in providing palliative and end-of-life care through the Washington Death with Dignity Act (Chapter 70.245 RCW).

Background

The Washington Death with Dignity Act (Chapter 70.245 RCW) allows an eligible individual with a terminal diagnosis and prognosis to legally request and obtain medications to end their life from the a licensed advanced registered nurse practitioner (ARNP), physician (MD), osteopathic physician (DO), or physician assistant (PA). WAC 246-978 Death with Dignity Requirements implement the law. A qualified patient may select the attending or qualified health care provider of the patient's choosing. If the patient selects the ARNP, the patient must also select an MD or DO to serve as the patient's consulting medical provider. The MD or DO and ARNP may not have a direct supervisory relationship with each other. See the Washington State Department of Health Death with Dignity Act webpage for common questions and answers containing general information about the Death with Dignity Act.

This lack of recognition of the direct and intimate role of nurses in the care of patients at the end-of-life leaves nurses in a potential moral quandary regarding their responsibilities to patients. Aid-in-dying is a new area of ethical concern about which public opinion and public policy has evolved quite rapidly such that professional organizations and individual clinicians are still evolving their positions. The situation is exacerbated by the role of most nurses as employees of health care institutions that may have additional policies regarding aid-in-dying. Unlike physicians and ARNPs who often act as independent practitioners outside their association with an institution, most nurses practice solely under the auspices of their employer. Additionally, nurses have their own personal beliefs about the ethical acceptability of aid-in-dying and their own willingness to be involved. Across the profession, there is a wide range of views that need to be accommodated. Nurses are challenged to define their practice while negotiating the space among these personal, professional, institutional, and legal constraints.

The American Nurses Association's (ANA) position statement, The Nurse's Role when a Patient Requests Medical Aid in Dying (2019), clarifies many of the questions nurses are asking. The position of the ANA is that although nurses are strictly prohibited by law from prescribing or administering aid-in-dying medications, they nonetheless have an obligation to provide all other appropriately supportive care to patients at the end-of-life. This care includes providing objective information, managing distressing symptoms, coaching family and care providers in the management of patient care, and remaining engaged, non-judgmental, and attentive to the evolving needs of the dying and their families. They further suggest that nurses have an obligation to not only be knowledgeable about this issue, but also to be engaged in public policy conversations and research to further explore its merits and consequences.

This position is aligned with the ANA's *Code of Ethics for Nurses* (2015) and *Nursing: Scope and Standards of Practice* (2015). For example, the ANA argues that nurses are not "actively participating" in aid-in-dying when providing information, supporting discussion, or being present with a patient. Instead, all these actions are the nurse's ethical "response to the patient's quality-of-life self-assessment" (p. 3) consistent with Interpretive Statement 1.4 of the *Code* that nurses "should provide interventions to relieve pain and other symptoms in the dying patient consistent with palliative care practice standards and may not act with the sole intent to end life" (ANA, 2015, p. 3). This is a significant departure from the previous ANA position statement aid-in-dying of 2013 that prohibited participation by nurses in aid-in-dying.

This advisory opinion will not reiterate the positions taken in the ANA statement but refers readers to that document for further exploration. Nor does this opinion take a position on the essential question of the acceptability of aid-in-dying itself. Aid-in-dying is legal in Washington State and, as such, nurses need to be prepared to provide care in this context. The context requires consideration of two issues not fully addressed in the ANA statement: employer restrictions on nursing practice and conscientious objection.

Employer Restrictions on Nursing Practice

Washington state law allows employers to establish policy related to the implementation of aid-in-dying within their institutional boundaries (which may include both in-patient, out-patient, and homecare settings). Most in-patient settings restrict patients from ingesting medications that will end their lives; policies for outpatient and homecare settings are more variable and evolving. A study in the *Journal of Pain and Symptom Management* (JPSM),

Dignity, Death, and Dilemmas: A Study of Washington Hospices and Physician-Assisted Death (2014), summarizes the content of hospice policies in Washington State. Examples of policies include:

- Restricting or allowing staff to be present at the time of patient self-administration of the medication, as well as the duration between ingestion and death.
- Restricting or allowing staff involvement with the process to obtain life-ending medication.
- Restricting or providing information about the law.
- Preventing or allowing a patient from ingesting a lethal dose of medication on the premises of a health care facility.
- Requiring, encouraging, or discouraging the participation of LPNs, RNs, or ARNPs in the process.
- Restricting or allowing initiating communication and notification of the patient's attending physician.
- Restricting or allowing staff to witness necessary legal documents.

Health care institutions may legitimately create policies that are consistent with their philosophy and mission. Health care entities are prohibited, however, from limiting the provision of information about Washington's Death with Dignity Act or information about what relevant resources are available or how to access those resources. RCW 70.03.020.

The most common and ethically defensible limitation is to not allow nurses to be present at the time of medication administration. This restriction has several advantages. Since nurses are legally constrained from administering the life-ending medications, the policy prevents nurses from being pressured by patients or families to assist in administration—an act that in any other circumstance would be well within the nurse's scope of practice. Additionally, it allows nurses who are ethically opposed to aid-in-dying to avoid needing to explicitly opt-out of this most active participation in the process. For nurses who would be comfortable participating at this stage, it also prevents them from providing support to the patient and family at a critical moment in the dying trajectory. Nurses, particularly hospice and home care nurses, often develop significant empathetic relationships with patients and families over the course of their care and absence at this time can potentially be experienced by the patient as professional abandonment. This is a significant departure from the standard hospice commitment to non-abandonment and the promise to witness with the patient through the dying process. While

physicians and ARNPs may choose to practice as independent providers at times like this and be present despite institutional policies, nurses choosing to be present outside their nursing role risk violating professional boundaries. Again, nurses need to decide for themselves whether the restrictions on practice imposed by institutional policies are aligned with their vision of professional practice.

Institutional policies that further restrict nursing practice, such as limiting the nurse's ability to provide objective and non-judgmental information about legal options or provide counseling and emotional support as the patient thinks through their end-of-life decisions are ethically problematic in that they significantly impinge on nursing scope of practice and professional standards of care. In 2020, the Washington legislature clarified that a health care entity may not limit a health care provider's provision of information about and regarding Washington's death with dignity act, Chapter RCW 70.245, information about what relevant resources are available in the community, and how to access those resources for obtaining care of the patient's choice. A health care entity may not discharge, demote, suspend, discipline, or otherwise discriminate against a health care provider for providing such information. RCW 70.03.020.

Conscientious Objection

It is broadly accepted that aid-in-dying is a situation in which a nurse may appeal to conscientious objection to avoid acting in a manner that is contrary to their own moral values. While ensuring that patients receive the beneficial care they desire is a fundamental ethical value, it is necessarily balanced by the right of health care providers to maintain their own moral integrity (Magelssen, 2011). "Having moral integrity implies having an internally consistent set of basic moral ideas and principles and being able to live and act in accordance with these" (Magelssen, 2011, p. 18). When a nurse finds that actively participating in aid-in-dying conflicts with deeply held values and judgments, it is reasonable to consider this objection. (Deeply held values are contrasted with those which are capricious, arbitrary, or situationally convenient.)

Although there are multiple formulations of the criteria such objections must meet, Brock (2008) delineates three criteria:

1) The patient is informed of the full range of care options.
2) The patient must be referred to another provider who can provide the services.
3) The refusal must not create an undue burden on the patient.

Interestingly, the Death with Dignity Initiative explicitly does not require physicians to refer patients requesting aid-in-dying to another provider.

Conscientious objection applies to specific actions, not to patients. Such objections cannot be raised to avoid providing general nursing care for a patient, but only to withdraw from participating in a specific action. For example, in the common example of abortion, a nurse may decline to participate in actively implementing a surgical abortion procedure but may not decline to provide post-operative care to that patient. Conscientious objection cannot be used as a claim to refuse to care for a patient based on their social standing, beliefs, or preferences, nor on the bias or prejudice of the nurse.

This suggests that the only activity nurses may request to avoid is being present when patients are ingesting the medications that will end their lives. Given that so many institutions already restrict nurses from being present anyway, this significantly limits the instances in which nurses may reasonably claim conscientious objection to avoid providing care to a patient. However, nurses should be attentive to their own self-presentation and their ability to provide compassionate and non-judgmental care to a patient who is making a decision that is contrary to their deeply held beliefs. If other staff are reasonably available and can substitute for the objecting nurse, it may benefit both the patient and the nurse to make this change. Such an accommodation, however, does not remove the obligation of the nurse to reflect on the opportunity for developing a more empathetic and patient-centered stance.

Statement of Scope

Nurses are accountable and responsible for providing compassionate and comprehensive care to all patients, regardless of their end-of-life choices. Nurses may decline active participation in the implementation of aid-in-dying, but they remain responsible for the full scope of end-of-life care including providing information, symptom management, and other palliative or end-of-life interventions.

The NCQAC determines that in addition to all standard nursing care the following behaviors are consistent with the standard of care when providing nursing care to patients who have chosen to end their own life:

- Empathetically explore end-of-life options with the patient and family and link them to services, other health care providers or resources to meet their needs;
- Explain the law as it currently exists;
- Maintain confidentiality about the end-of-life decision-making;
- Provide palliative care for the patient, including administration of medications and treatments for pain and symptom management.;
- Follow Portable Orders for Life Sustaining Treatment (POLST)/advanced directives;
- Determine and pronounce death;
- Collaborate and consult with health care team members;
- Understand the ethical and moral dilemmas related to aid-in-dying
- Understand professional organizations' positions related to aid-in-dying;
- Reflect on personal and professional values and request accommodation on the basis of conscientious objection if needed;
- Understand the employer philosophy, policies, and procedures related to end-of-life decisions and aid-in-dying;
- Understand institutional policy regarding the presence of nurse when a patient self-administers a prescribed lethal dose of medication;
- Be involved in policy development within the health care institution and the community.

Nurses who choose not to be involved:

Under the conditions listed above, nurses may decline to be present when patients are ingesting medication to end their lives. In this situation, the nurse should:

- Request to be relieved from providing care on the basis of conscientious objection;
- Continue to provide standard supportive and palliative care to ensure the patient's comfort and safety and avoid abandonment.
- Withdraw only when assured that alternative sources of care are available for the patient and care has been responsibly transferred to another provider;
- Maintain confidentiality;
- Reflect on self-presentation and the development of a non-judgmental stance to ensure patients feel respected despite differences in values
- Be involved in policy development within the health care institution and community.

Nurses shall not:

- Administer the medication that will lead to the end of the patient's life;
- Breach confidentiality of patients exploring or choosing assisted suicide;
- Subject patients or families to disrespectful, judgmental comments or actions because of their decision to choose aid-in-dying
- Subject colleagues to disrespectful comments or actions due to their decision to continue to provide care to a patient who has chosen aid-in-dying;
- Abandon or refuse to provide comfort and safety measures to patients.

Institutional Policy Constraints:

If institutional policies prohibit staff from participating in the aid-in-dying process with interested patients, the NCQAC recommends that the patient be referred to their attending physician, the Washington State Department of Health and/or the patient rights organization, End of Life Washington, to obtain information and initiate the legal process.

Requirements and Recommendations

Providing care throughout the dying process to patients choosing to end their life through the Death with Dignity Act is within the nursing scope of practice and does not violate any professional norms. However, nurses exploring their obligations to the dying are confronted with a complex set of considerations. Aid-in-dying is legal in the State of Washington. Professional nursing standards require that nurses treat the dying with compassion and avoid abandonment. Individual agencies may have policies that limit nurses' participation in end-of-life care. Individual nurses may have deeply held moral beliefs. All these factors need to be weighed as the nurse decides how to pursue a particular course of action. Nurses must make a choice that is congruent both with their professional obligations and their own moral integrity.

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)

Death with Dignity Act | Washington State Department of Health
- Washington Death with Dignity Act Chapter 70.245 RCW
- Death with Dignity Act Requirements Chapter 246-978 WAC

ANA Position Statement: The Nurse's Role When a Patient Requests Medical Aid in Dying | OJIN: The Online Journal of Issues in Nursing (nursingworld.org)

Dignity, Death, and Dilemmas: A Study of Washington Hospices and Physician-Assisted Death - Journal of Pain and Symptom Management (jpsmjournal.com)

Death With Dignity National Center | End-Of-Life Advocacy and Policy Reform

End of Life Washington - Your life. Your death. Your choice.

Brock D. W. (2008). Conscientious refusal by physicians and pharmacists: who is obligated to do what, and why? *Theoretical Medicine and Bioethics, 29,* 187-200.

Magelssen, M. (2012). When should conscientious objection be accepted? Journal of Medical Ethics, 38, 18-21.

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:	Standing Orders	*Number:* NCAO 28.00
References:	See References and Resources	
Contact:	Deborah Carlson, MSN, RN, Director of Nursing Practice	
	360-236-4703	
Email:	NursingPractice@doh.wa.gov ARNPPractice@doh.wa.gov	
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Conclusion Statement

It is within the scope of the appropriately trained and competent registered nurse (RN) or licensed practical nurse (LPN) to follow standing orders within the nurse's scope. Other terms commonly used for standing orders include protocols, pre-printed orders, pre-approved orders, order sets, care pathways, care plans, and clinical guidelines. Standing orders involving a medical regimen must be approved by an authorized health care practitioner (advanced registered nurse practitioner, physician and surgeon, dentist, osteopathic physician and surgeon, podiatric physician and surgeon, physician assistant, osteopathic physician assistant, optometrist, or licensed midwife within their scope of practice). The nurse may delegate specific tasks, to credentialed or non-credentialed unlicensed assistive personnel (UAP) to implement standing orders within the legal parameters and scope of practice of the nurse and UAP.

The nurse may provide medical services following approved standing orders without prior establishment of a provider-patient relationship between the authorized health care practitioner (prescriber) and the person receiving medical services. The prescriber creates a professional relationship with the nurse implementing the standing order that establishes the provider-patient relationship.

The nurse must use professional judgment and consult as necessary when permitted actions need clarification, unexpected patient symptoms, complications, or other situations occur. NCQAC advises using the Interactive Scope of Practice Decision Tree to determine whether performing directed activities following a standing order is within the nurse's legal and individual scope of practice. This advisory opinion is intended as a broad statement on using standing orders and is not meant to encompass all practice settings, related laws and rules, accreditation standards, standing orders or reimbursement requirements.

Background and Analysis

Standing orders are used in almost every health care setting. Washington state nursing laws and rules do not prohibit the nurse from implementing care following standing orders. Standing orders are evidence-based tools used to guide the assessment, diagnosis, and treatment of patient-specific clinical problems. Standing orders act as written care directives delineating the circumstances and describing the parameters of specific situations to carry out specific orders. Electronic health records systems commonly include use of clinical standing orders. Standing orders may be nurse-driven to provide consistent, safe and effective care (e.g. removal of indwelling catheters). Standing orders involving a medical regimen allows the nurse to provide timely interventions and removes barriers to care for various patient populations. Standing orders may be used in a variety of settings. Examples include patient populations with specific conditions (including medication refills and laboratory tests), symptoms, emergency/urgent care, routine processes (e.g. admission orders, pre-operative orders), occupational health, telephone triage, health screening activities, school health, medication assisted treatment (MAT), and preventive care (e.g. immunizations).

Factors that may influence an institution's decision to use standing orders may include (but not limited) reimbursement, accreditation standards, risk assessment. Facility policies may restrict the use of standing orders or scope of practice but may not expand nursing scope of practice.

Statutes and Regulations

The Washington state nursing laws and rules do not include language that prohibits or permits the nurse to follow standing orders. The RN and LPN may carry out medical regimens under the direction of an authorized health care practitioner. The RN and LPN may delegate care to UAP (such as the nursing assistant, home care aid, and medical assistant) following the delegation laws and rules within the nurse's and UAP's scope of practice. Other state laws and rules (but not limited to) define and describe requirements for using and authenticating standing orders. For example:

- Ambulatory Care Surgical facilities define protocols and standing orders as, "Written or electronically recorded descriptions of actions and interventions for implementation by designated ambulatory surgical facility staff under defined circumstances recorded in policy and procedure. Use of preestablished patient care guidelines or protocols. When used, these must be documented in the medical record and be preapproved or authenticated by an authorized practitioner or advanced registered nurse practitioner. Chapter 246-330 WAC
- Hospital rules defines protocols and standing orders as, "Written or electronically recorded descriptions of actions and interventions for implementation by designated hospital staff under defined circumstances under hospital policy and procedure. WAC 246-320-010. Chapter 246-320 WAC requires documentation in the medical record and preapproval or authentication by an authorized practitioner.

RCW 69.50.308, WAC 246-887, and the Drug Enforcement Agency (DEA) define requirements for controlled substances that may restrict the use of standing orders. There are specific requirements for electronic communication of prescription information following standing orders:

- Prescriptions issued for the dispensing of a nonpatient specific prescription under a standing order, approved protocol for drug therapy, collaborative drug therapy agreement, in response to a public health emergency, or other circumstances allowed by statute or rule where a practitioner may issue a nonpatient specific prescription. RCW 69.50.312. The nurse may administer legend drugs/controlled substances directly to a patient following a standing order within their scope of practice. Schedule II controlled substances may not be dispensed

following a standing order. RCW 69.50.308.

Federal regulations may apply to specific facilities, such as the Centers for Medicare and Medicaid Services.

State-Wide DSTs
The Washington State Department of Health may choose to issue state-wide standing orders. The nurse may follow approved state-wide standing orders or institutional standing orders. Currently, the following are approved for use in Washington State:

- Statewide Standing Order to Dispense Naloxone (PDF).

Recommendations

The RN and LPN may implement medical care based on patient-specific or condition-specific standing orders. Standing orders should be developed and approved by medical, pharmacy, and nursing leadership based on nationally recognized evidence-based guidelines and recommendations. The nurse must implement standing orders as written and stay within the confines of the directions outlined. Any deviation requires consultation with an authorized health care practitioner. Medical records documentation must reflect that the nurse is following a standing order, any consultation, deviation, or decision not to follow the standing order.

The nurse must exercise professional responsibility and prudent judgment when using standing orders and must be competent to follow standing orders, including specific procedures included in the standing order. The nurse must understand institutional policies and procedures and laws and rules related to standing orders specific to the facility or setting. The nurse may direct UAP to carry out standing order tasks within the nurse's and UAP's scope of practice. The nurse may delegate to UAP as allowed in the laws and rules following the delegation process.

The NCQAC recommends the institution:

- Involve nursing leadership and other health care professionals in developing and approving standing orders.
- Understand the applicable laws and rules (state and federal) that apply to standing orders.
- Develop standing orders based on nationally recognized and evidence-based evidence, within the applicable laws and rules required for the institution, and accreditation standards.
- Provide a method of maintaining a record of those approved and authorized to use standing orders.
- Specify documentation requirements.
- Establish authentication procedures.
- Specify process for authentication by an authorized health care practitioner.
- Establish institutional policies and procedures to implement standing orders.
- Review and revise standing orders as needed, or at minimum, annually.
- Communicate changes to standing orders as soon as possible to appropriate staff.
- Establish competency, validation, and training requirements.

Standing orders should include the following:

- Identify the patient population or condition to be treated according to the standing orders, including exceptions or contraindications.
- Specify which acts require any level of experience, training, education, or certification.

    - Conditions, symptoms, or situations in which the standing order will be used;
    - Assessment criteria;
    - Objective or subjective findings;
    - Plan of care including medical and pharmaceutical treatment based on assessment criteria;
    - Nursing actions;
    - Follow-up or monitoring requirements.
- Specify those who may perform the actions required using standing orders.
- Delineate under what circumstances the actions may be performed.
- Specify the scope of supervision required (if any).
- Identify special circumstances under which the person implementing the standing order is to immediately communicate with the medical provider.
- Identify limitations on the practice setting (if any).
- Provide a method of maintain a written record of those authorized to use standing orders.
- Establish a method for initial and continuing evaluation of the competence of those authorized to use standing orders.
- Use generic names of medication/biologics, exact dosages, and routes of administration. The NCQAC recommends following the Institute of Safe Medication Practices (ISMP) Institute for Safe Medication Practices (ISMP) Guidelines to avoid error-prone abbreviations, symbols, and dose designations.
- Specify documentation requirements.
- Specify authentication requirements considering state facility laws/rules and federal laws/rules (such as CMS requirements), and accreditation standards (such as Joint Commission).
- Provide a method of periodic review of standing orders.
- Delineate inclusion and exclusion requirements for which the nurse must consult with a medical practitioner for routine, urgent, or emergent situations including the communication process between the nurse and medical practitioner as appropriate.
- Identify diagnostic, procedural, and billing coding requirements.

Conclusion

The NCQAC concludes that nurses may follow standing order under the direction of an authorized health care practitioner. The NCQAC advises nurses to use the Interactive Scope of Practice Decision Tree. Nurses should always use professional nursing judgment and consider whether their actions are prudent and reasonable.

References

Laws and Rules

RCW 18.79 Nursing Care
WAC 246-840 Practical and Registered Nursing
RCW 28A.210.383 Epinephrine Auto injectors (EPI Pens)-School Supply-Use
RCW 69.41.095 Opioid Reversal Medication - Standing Order Permitted
RCW 69.50.312 Electronic Communication of Prescription Information
WAC 246-330 Ambulatory Surgical Facilities

Resources

Agency for Healthcare Research and Quality: Overview and Examples of Medical Standing Orders
American Academy of Family Physicians: Developing Standing Orders to Help Your Team Work to the Highest Level
Centers for Medicare and Medicaid Services (CMS) Regulations and Guidance

Immunization Action Coalition Standing Orders
Opioid Use Disorder – Medication Assisted Treatment: Nurse Care Managers and Scope of Practice (PDF)
Prevention and Treatment of Opioid-Related Overdoses (PDF)
Public Health Nurses: Dispensing Medications/Devices for Prophylactic and Therapeutic Treatment of Communicable Diseases and Reproductive Health (PDF)
Nursing Critical Care: Nurse Driven Protocols (Barto, D.), July 2019
Interactive Scope of Practice Decision Tree
Registered Nurse and Licensed Practical Nurse Scope of Practice (PDF)
Washington State Department of Health Behavioral Health Agencies/Opioid Treatment Program

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

NCAO 28.01 Standing Orders
Adopted: November 12, 2021
Reviewed/Revised: TBD
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: Standing Orders

Purpose

This advisory opinion provides guidance about the roles and scope of practice for the registered nurse (RN) and licensed practical nurse (LPN) in following standing orders.

Background

Standing orders are evidence-based tools used to guide the assessment, diagnosis, and treatment of patient-specific clinical problems. Standing orders act as written care directives delineating the circumstances and describing the parameters of specific situations to carry out specific orders. Electronic health records systems commonly include use of clinical standing orders. Standing orders may be nurse-driven to provide consistent, safe and effective care (e.g., removal of indwelling catheters). Standing orders involving a medical regimen allows the nurse to provide timely interventions and removes barriers to care for various patient populations. Standing orders may be used in a variety of settings. Examples include patient populations with specific conditions (including medication refills and laboratory tests), symptoms, emergency/urgent care, routine processes (e.g., admission orders, pre-operative orders), occupational health, telephone triage, health screening activities, school health, medication assisted treatment (MAT), and preventive care (e.g., immunizations).

Factors that may influence an institution's decision to use standing orders may include (but not limited) reimbursement, accreditation standards, risk assessment. Facility policies may restrict the use of standing orders or scope of practice but may not expand nursing scope of practice.

Statutes and Regulations

The Washington state nursing laws and rules do not include language that prohibits or permits the nurse to follow standing orders. The RN and LPN may carry out medical regimens under the direction of an authorized health care practitioner. Other state laws and rules (but not limited to) define and describe requirements for using and authenticating standing orders. For example:

- Ambulatory Care Surgical facilities define protocols and standing orders as, "Written or electronically recorded descriptions of actions and interventions for implementation by designated ambulatory surgical facility staff under defined

circumstances recorded in policy and procedure. Use of preestablished patient care guidelines or protocols. When used, these must be documented in the medical record and be preapproved or authenticated by an authorized practitioner or advanced registered nurse practitioner. Chapter 246-330 WAC

- Hospital rules defines protocols and standing orders as, "Written or electronically recorded descriptions of actions and interventions for implementation by designated hospital staff under defined circumstances under hospital policy and procedure. WAC 246-320-010. Chapter 246-320 WAC requires documentation in the medical record and preapproval or authentication by an authorized practitioner.

RCW 69.50.308, WAC 246-887, and the Drug Enforcement Agency (DEA) define requirements for controlled substances that may restrict the use of standing orders. There are specific requirements for electronic communication of prescription information following standing orders:

- Prescriptions issued for the dispensing of a nonpatient specific prescription under a standing order, approved protocol for drug therapy, collaborative drug therapy agreement, in response to a public health emergency, or other circumstances allowed by statute or rule where a practitioner may issue a nonpatient specific prescription. RCW 69.50.312. The nurse may administer legend drugs/controlled substances directly to a patient following a standing order within their scope of practice. Schedule II controlled substances may not be dispensed following a standing order. RCW 69.50.308.

Federal regulations may apply to specific facilities, such as the Centers for Medicare and Medicaid Services.

State-Wide Standing Orders

The Washington State Department of Health may choose to issue state-wide standing orders. This may occur during pandemic or disaster situations. The nurse may follow approved state-wide standing orders or institutional standing orders. Currently, the following are approved for use in Washington State:

- Statewide Standing Order to Dispense Naloxone (PDF).

Statement of Scope

The RN and LPN may implement care based on patient-specific or condition-specific standing orders. The Washington State Board of Nursing recommends nurses use the Interactive Scope of Practice Decision Tree.

Requirements and Recommendations

Standing orders should be developed and approved by medical, pharmacy, and nursing leadership based on nationally recognized evidence-based guidelines and recommendations. The nurse must implement standing orders as written and stay within the confines of the directions outlined. Any deviation requires consultation with an authorized health care practitioner. Medical records documentation must reflect that the nurse is following a standing order, any consultation, deviation, or decision not to follow the standing order.

The nurse must exercise professional responsibility and prudent judgment when using standing orders and must be competent to follow standing orders, including specific procedures included in the standing order. The nurse must understand institutional policies and procedures and laws and rules related to standing orders specific to the facility or setting. The registered nurse may direct UAP to carry out standing order tasks within the nurse's and UAP's scope of practice. The nurse may delegate to UAP as allowed in the laws and rules following the delegation process.

The NCQAC recommends the institution:

- Involve nursing leadership and other health care professionals in developing and approving standing orders.
- Understand the applicable laws and rules (state and federal) that apply to standing orders.
    - Develop standing orders based on nationally recognized and evidence-based evidence, within the applicable laws and rules required for the institution, and accreditation standards.
    - Provide a method of maintaining a record of those approved and authorized to use standing orders.
    - Specify documentation requirements.
    - Establish authentication procedures.

- Specify process for authentication by an authorized health care practitioner.
- Establish institutional policies and procedures to implement standing orders.
- Review and revise standing orders as needed, or at minimum, annually.
- Communicate changes to standing orders as soon as possible to appropriate staff.
- Establish competency, validation, and training requirements.

Standing orders should include the following:

- Identify the patient population or condition to be treated according to the standing orders, including exceptions or contraindications.
- Specify which acts require any level of experience, training, education, or certification.
    - Conditions, symptoms, or situations in which the standing order will be used;
    - Assessment criteria;
    - Objective or subjective findings;
    - Plan of care including medical and pharmaceutical treatment based on assessment criteria;
    - Nursing actions;
    - Follow-up or monitoring requirements.
- Specify those who may perform the actions required using standing orders.
- Delineate under what circumstances the actions may be performed.
- Specify the scope of supervision required (if any).
- Identify special circumstances under which the person implementing the standing order is to immediately communicate with the medical provider.
- Identify limitations on the practice setting (if any).
- Provide a method of maintain a written record of those authorized to use standing orders.
- Establish a method for initial and continuing evaluation of the competence of those authorized to use standing orders.
- Use generic names of medication/biologics, exact dosages, and routes of administration. The NCQAC recommends following the Institute of Safe Medication Practices (ISMP) Institute for Safe Medication Practices (ISMP) Guidelines to avoid error-prone abbreviations, symbols, and dose designations.
- Specify documentation requirements.
- Specify authentication requirements considering state facility laws/rules and

federal laws/rules (such as CMS requirements), and accreditation standards (such as Joint Commission).

- Provide a method of periodic review of standing orders.
- Delineate inclusion and exclusion requirements for which the nurse must consult with a medical practitioner for routine, urgent, or emergent situations including the communication process between the nurse and medical practitioner as appropriate.
- Identify diagnostic, procedural, and billing coding requirements.

References and Resources

- RCW 18.79 Nursing Care
- WAC 246-840 Practical and Registered Nursing
- RCW 28A.210.383 Epinephrine Auto injectors (EPI Pens)-School Supply-Use
- RCW 69.41.095 Opioid Reversal Medication - Standing Order Permitted
- RCW 69.50.312 Electronic Communication of Prescription Information
- 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)
- Overview and Examples of Medical Standing Orders | Agency for Healthcare Research and Quality (ahrq.gov)
- Standardized Protocols for Optimizing Emergency Department Care | ACEP
- American Academy of Family Physicians: Developing Standing Orders to Help Your Team Work to the Highest Level
- Centers for Medicare and Medicaid Services (CMS) Regulations and Guidance
- Immunization Action Coalition Standing Orders
- Opioid Use Disorder – Medication Assisted Treatment: Nurse Care Managers and Scope of Practice (PDF)
- Prevention and Treatment of Opioid-Related Overdoses (PDF)
- Public Health Nurses: Dispensing Medications/Devices for Prophylactic and Therapeutic Treatment of Communicable Diseases and Reproductive Health (PDF)
- Nursing Critical Care: Nurse Driven Protocols (Barto, D.), July 2019
- Registered Nurse and Licensed Practical Nurse Scope of Practice (PDF)
- Washington State Department of Health Behavioral Health Agencies/Opioid Treatment Program

Department of Health
Nursing Care Quality Assurance Commission

Interpretive Statement

Revised – 10/18/11

Title:	Patient Abandonment	*Number:* NCIS 1.0
References:	Regulation of Health Professions – Uniform Disciplinary Act (RCW 18.130) http://apps.leg.wa.gov/RCW/default.aspx?cite=18.130 Violations of Standards of Nursing Conduct or Practice (WAC 246-840-710): http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840-710 Nursing Care – (RCW 18.79) http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79&full=true	
Contact:	Deborah Carlson, RN, MSN – Nurse Practice Advisor	
Phone:	(360) 236-4725	
Email:	debbie.carlson@doh.wa.gov	
Effective Date:	November 16, 2012	
Supersedes:	Patient Abandonment Policy A13.05	
Approved By:	Nursing Care Quality Assurance Commission	

Statement

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

Background

The Commission establishes, monitors, and enforces standards of practice, RCW 18.79.010. The Commission interprets that a nurse-patient relationship begins when the nurse accepts assignment for nursing care. Assignment includes the patient care functions that the nurse is responsible to perform. A person authorized to administer, supervise, or direct the nurse may make the assignment. A nurse may accept a patient assignment based on professional judgment or through a contractual relationship. The *Uniform Disciplinary Act* (UDA), RCW 18.130, describes procedures for discipline. The Commission gets many complaints about employee problems. These are not subject to discipline by the Commission.

In compliance with WAC 246-840-700, transferring nursing care must include reporting (oral or written) of the patient's condition, circumstances, and care needs to an appropriate caregiver. As defined in RCW 18.79.260, an appropriate caregiver is a licensed health professional whose scope of practice and qualifications permit transferring functions and responsibilities. In some settings, the nurse may also transfer care to an appropriate family member or other designated caregiver in some settings. The caregiver must accept the transfer of care and understand the report.

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

Conclusion

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

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

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

Patient Abandonment Commonly Asked Questions

What is the legal definition of patient abandonment?

The Washington State nursing laws and rules do not define patient abandonment. The Washington State Board of Nursing (WABON) has investigated and disciplined nurses for issues surrounding the concept of abandonment as it relates to the nurse's duty to a patient. The WABON's position applies to the licensed practical nurse, registered nurse, and advanced registered nurse practitioner. Some behavior may be considered an employer-employment issue and not patient abandonment. The American Nurses Association (ANA) defines patient abandonment as, "a unilateral severance of the established nurse-patient relationship without giving reasonable notice to the appropriate person so that arrangements can be made for the continuation of nursing care by others…"

What does the Washington State Board of Nursing (WABON) consider to be patient abandonment.

The nurse's duty is not defined by any single event, such as clocking in or taking a report. From the WABON standpoint, the focus for disciplinary sanctions is on the relationship and responsibility of the nurse to the patient, not to the employer or employment setting. The primary concern is whether the nurse's actions compromised patient safety or caused patient abandonment. The nurse must: ~~The primary concern is whether the actions of the nurse compromised patient safety, or patient abandonment to occur, the nurse must:~~

- Have first accepted the patient assignment, thus establishing a nurse-patient relationship, and then
- Severed that nurse-patient relationship without giving reasonable notice to the appropriate person (e.g., supervisor, patient, contractor) so that arrangements can be made for the continuation of nursing care by others.

The failure to fulfill a nursing responsibility may result in unsafe nursing care. Failure to practice with reasonable skill and safety is a ground for disciplinary action by the WABON. The decision to take disciplinary action is based on the facts of the individual case, unique circumstances, of each situation, and their application to grounds for disciplinary action in the nursing laws and rules.

The concept of the nurse's duty to promote patient safety also serves as the basis for determining behavior that could be considered unprofessional conduct by the nurse. The Board believes nurses should be vigilant and exercise sound professional judgment when accepting assignments that may be requested by employers who need nurses to fill vacant shifts for licensed nursing staff or other staffing-related situations. Clear communication between staff and supervisors is essential to arrive at solutions that best focus on patient care needs without compromising ~~either~~ patient safety or a nurse's license.

Is it patient abandonment if a nurse is the sole provider of care of the patient, and no other care provider is available to relieve the nurse?

There are some unique circumstances about what may be considered patient abandonment. An example is a registered nurse with~~who has~~ a private practice or ~~who has~~ a contract to provide care to a patient who~~and~~ does~~id~~ not arrange for another qualified care provider to continue the care, may be considered patient abandonment. A complaint should be reported to the Washington State Board of Nursing (WABON) for possible disciplinary action. Conduct that~~which~~ is not actionable by the WABON~~,~~ is most appropriately addressed by the employer, consistent with employment laws, rules, and policies.

What is the nurse's responsibility?

The minimum standard of care ~~to which~~ the Washington State Board of Nursing (WABON) holds a nurse accountable requires the nurse to fulfill a patient care assignment or transfer responsibility ~~for that care~~ to another qualified person once a nurse has accepted an assignment.

What are some examples of an employee-employment issue vs. patient abandonment?

The Washington State Board of Nursing (WABON) does not have jurisdiction over employers or employment-related issues or disputes. Other laws regulating facility licensure may apply certain responsibilities to the employer for patient safety, such as developing effective patient care systems or providing adequate numbers of qualified staff. ~~Other laws regulating facility licensure may apply certain responsibilities to the employer for provision of patient safety, such as development of effective patient care systems or provision of adequate numbers of qualified staff.~~ Specific requirements for a given facility may be obtained by contacting the applicable licensing authority for the institution. The WABON believes that the following are examples of employment issues that would not typically involve violations of nursing laws and rules:

- Resignation without advance notice, assuming the nurse's current patient care assignment and~~/or~~ work shift have~~s~~ been completed.
- Refusal to work additional shifts, either "doubles" or extra shifts on days off,~~;~~ and~~/or~~
- Other work-related issues, such as frequent absenteeism or tardiness, or conflicts. between staff/employees.
- Not showing up for work or not calling in.
- Refusing to work all remaining scheduled shifts after resigning.
- Refusing an assignment for religious, cultural, legal, or ethical reasons.
- Not returning from a leave of absence.
- Refusing to work in an unsafe situation.
- Refusing to delegate to an unsafe caregiver.
- Refusing to give care that may harm the patient.
- Refusing to accept an assignment or a nurse-patient relationship.
- Refusing to work mandatory overtime beyond the regularly scheduled number of hours.
- Refusing to work in an unfamiliar, specialized, or "high-tech" practice area when there has been no orientation, educational preparation, or employment experience.

- Refusing to “float” to an unfamiliar unit to accept a ~~full~~ patient assignment.

Examples of abandonment:

- Accepting the assignment and then leaving the unit without notifying a qualified person.
- Leaving without reporting to the on-coming shift.
- Leaving patients without any licensed supervision (especially at a long-~~-~~term care facility with no licensed person coming on duty).
- Sleeping on duty.
- Going off the unit without notifying a qualified person and arranging coverage of your patients
- Leaving in an emergency. ~~situation~~
- Overlooking or failing to report abuse or neglect.
- Giving care while impaired.
- Giving incompetent care.
- Delegating care to an unqualified caregiver.
- Failure to perform assigned responsibilities.
- Closing a private practice without making reasonable arrangements for the patient to transfer care.

Is it patient abandonment if a nurse is assigned to see a home-bound patient daily, but did not show up for a week, notify anyone, and did not arrange for another nurse to see the patient?

It is important to consider what the nurse-patient assignment involves. Acceptance of a patient assignment may vary from setting to setting and requires a clear understanding of the workload and the agreement to provide care. In this situation, since the nurse failed to see the patient for a week and failed to request another nurse visit, this may be considered patient abandonment. A complaint should be reported to the Washington State Board of Nursing (WABON) for possible disciplinary action. Conduct, that~~which~~ is not actionable by the WABON~~,~~ is most appropriately addressed by the employer, consistent with employment laws, rules, and policies.

Is it patient abandonment if it is unsafe for the nurse to provide care during an emergency or disaster?

A nurse may have to choose between the duty to provide safe patient care and protecting the nurse's own life during an emergency, including but not limited to disasters, infectious disease outbreaks, acts of terrorism, active shooter incidents, and workplace violence. Regardless of practice setting, position title or role, all nurses must adhere to nursing laws and rules. ~~All~~

~~nurses, regardless of practice setting or position title/role, are required to adhere to nursing laws and rules.~~ There is also no routine answer to the question, *"When does the nurse's duty to a patient begin?"* The nurse's duty is not defined by any single event such as clocking in or taking a report. From a BON standpoint, the focus for disciplinary sanctions is on the relationship and responsibility of the nurse to the patient, not to the employer or employment setting. The BON believes nurses should be vigilant and exercise sound professional judgment when accepting assignments that may be requested by employers who need nurses to fill vacant shifts for licensed nursing staff~~,~~ or other staffing-related situations. ~~-~~The nurse should take steps to protect patients if there is time and using a method that does not jeopardize the nurse's ~~personal~~ safety or interfere with law enforcement personnel.

An example is an active shooter incident. This scenario may include evacuating the area or preventing entry to a place~~n area~~ where the active shooter is located. However, during the situation, a nurse may find insufficient time to do anything but ensure their own safety. ~~However, during the situation a nurse may find there is not sufficient time to do anything but to ensure their own safety.~~ In this case~~re~~, as soon as the situation has been~~d~~ resolved the nurse should promptly resume care of patients.

Because active shooter training and Active Shooter Training (Federal Bureau of Investigations) provide the best available knowledge, the ethical response would be to maintain ~~the~~ safety of oneself instead of rushing to an injured party in a dangerous situation. A~~Of course, a~~s soon as the immediate danger to self is over, a nurse would go to any injured person and assist in the most informed and efficient way possible.

Clear communication between staff and supervisors is essential to arrive at solutions that best focus on patient care needs without compromising ~~either~~ patient safety or a nurse's license. The Washington State Board of Nursing (WABON) recommends developing and periodically reviewing policies and procedures to provide nurses with clear guidance and direction for patients to receive safe and effective care. ~~The Washington State Board of Nursing (WABON) recommends policies and procedures be developed, and periodically reviewed to provide clear guidance and direction to nurses for patients to receive safe and effective care.~~

What do I do if my employer requires me to stay for a double shift during a disaster, and I am already physically exhausted?

A nurse must accept only assignments that consider patient safety and are commensurate with the nurse's educational preparation, experience, knowledge, physical~~-~~, and emotional ability. ~~A nurse must accept only those assignments that take into consideration patient safety and that are commensurate with the nurse's educational preparation, experience, knowledge and physical and emotional ability.~~

How does the Washington State Board of Nursing (WABON) decide whether a complaint is patient abandonment or an employee-employment issue?

Complaints of "patient abandonment" when it is evidentobvious from the allegation that it is an employment issue will not be investigated by the WABON. Some general factors that would be considered in investigating a complaint alleging a nurse left an assignment by a nurse would include, but not be limited to:

- The extent of dependency or disability of the patient.
- Stability of the patient.
- The length of time the patient was deprived of care.
- Any harm to the patient/level of risk of harm to the patient.
- Steps taken by the nurse to notify a supervisor of the inability to provide care.
- Previous history of leaving a patientcarepatient care assignment.
- Emergencies that require nurses to respond, including but not limited to disasters, disease outbreaks, and bioterrorism.
- Workplace violence, including but not limited to an active shooter situation.
- Other unprofessional conduct concerningin relation to the practice of nursing.
- The nNurse's general competency regarding adherence to minimum nursing standards.

As with all allegations received by the WABON, the alleged conduct by a nurse will be thoroughly investigated to determine what, if any, violations of the nursing laws and rules have occurred. Depending upon the case analysis, actions may range from the case being closed with no findings or action all the way to suspension and/or revocation,/ or voluntary surrender of the nurse's license. If evidence of violations exists, the WABON must determine what sanction is appropriate to take on the nurse's license and what specific stipulation requirements will be applied. If evidence of violations exists, the WABON must then determine what level of sanction is appropriate to take on the nurse's license and what specific stipulation requirements will be applied.

Can the nurse invoke "Safe Harbor" in Washington State if the nurse feels they are being asked to accept an assignment that couldwould potentially cause the nurse to violate their duty to a patient?

Washington State does not have a "Safe Harbor" law. Safe Harbor is a means by which a nurse can request a peer review committee determination of a specific situation concerningin relation to the nurse's duty to a patient, affording nurse immunity from the board action against the nurse's license.

Commonly Asked Questions (CAQ)

Category: Nursing Assistant-Registered/Nursing Assistant-Certified (NA-R/NA-C): Emergency Care – Scope of Practice in Community-Based and In-Home Care Settings

Is the nursing assistant-registered/nursing assistant-certified (NA-R/NA-C) required to have current cardiopulmonary resuscitation (CPR) and first aid certification, and if so, what kind of CPR (Health Care Provider or Basic Life Support)?
CPR is considered a basic core competency for the NA-R/NA-C. The requirement for CPR is generally described in facility laws and/or rules. Most do not specify what type of CPR. The employer or institution can require the level of CPR required to work in the facility.

Can the nursing assistant perform cardiopulmonary resuscitation (CPR) without nursing direction, supervision, or RN delegation?
WAC 246-841-400: allows the nursing assistant-registered/nursing assistant-certified (NA-R/NA-C) to perform CPR independently, without nursing direction, supervision, or RN delegation. The NA-R/NA-C may use nursing judgment during an emergency.

Can the nursing assistant-registered/nursing assistant-certified (NA-R/NA-C) perform the Heimlich maneuver for choking without nursing delegation, and, if so, does the Good Samaritan law protect the nursing assistant?
The Heimlich maneuver is a routine procedure taught in cardiopulmonary resuscitation (CPR) and first aid courses. It may be within the scope of the NA-R/NA-C to perform the Heimlich maneuver and other CPR procedures without delegation if the NA-R/NA-C is competent. The RCW 4.24.300 Immunity from Liability for Certain Types of Medical Care (commonly known as the "Good Samaritan Law"), provides immunity only if the person rendering emergency care is not performed during the course of regular employment and is not receiving compensation for care.

Can the nursing assistant follow instructions in the Provider Order for Life Sustaining Treatment (POLST)?
The NA-R/NA-C may use nursing judgment during an emergency even if the patient's death is expected. The nursing assistant-registered/nursing assistant-certified (NA-R/NA-C) may follow instructions in Section A of the POLST indicated "CPR/Attempt Resuscitation" or "Do Not Attempt Resuscitation (DNAR) – Allow Natural Death" when a patient is non-responsive or has no heartbeat. The NA-R/NA-C may follow directions in section B of a POLST within their core competencies under the direction and supervision of the RN or LPN or through the RN delegation process, as appropriate. See the Physician's Order for Life Sustaining Treatment (POLST) Advisory Opinion for more information.

Can the nursing assistant give injectable epinephrine in community-based and in-home care settings?

The laws and rules do not permit the nursing assistant-registered/nursing assistant-certified (NA-R/NA-C) to give injectable epinephrine in community-based (adult family homes, assisted living facilities, and residential homes for individuals with developmental disabilities) and in-home care settings.

Can the nursing assistant give injectable glucagon or intranasal glucagon under nurse delegation in community-based and in-home care settings?

The laws and rules do not allow the registered nurse (RN) to delegate administration of injectable glucagon to the nursing assistant-registered/nursing assistant-certified (NA-R/NA-C) in community-based (adult family homes, assisted living facilities, and residential homes for individuals with developmental disabilities) and in-home care settings. The laws and rules do allow the RN to delegate administration of intranasal glucagon to the NA-R/NA-C in community-based and in-home care settings.

Is registered nurse delegation (RN) required for the nursing assistant to give naloxone for an opioid drug overdose to the nursing assistant or home care aide in community-based and in-home care settings?

The laws and rules do not allow the RN to delegate injectable naloxone for a suspected opioid drug overdose to the nursing assistant-registered/nursing assistant-certified (NA-R/NA-C) in community-based (adult family homes, assisted living facilities, and residential homes for individuals with developmental disabilities) and in-home care settings. The RN may delegate administration intranasal naloxone in these settings, although RN delegation is not required. See the Washington State Board of Nursing's Prevention and Treatment of Opioid-Related Overdoses Advisory Opinion for more information.

Is the nursing assistant protected under the "Good Samaritan" Law if they choose to administer injectable emergency medications such as glucagon or injectable epinephrine to a patient?

RCW 4.24.300: Immunity from liability for certain types of medical care, commonly referred to as the "Good Samaritan" law provides protection for individuals who are not compensated to provide emergency care. The nursing assistant-registered/nursing-assistant-certified (NA-R/NA-C) is not covered under the "Good Samaritan" law if for giving care during regular employment and receiving compensation for giving this care.