Alaska Board of Nursing

Agenda Item #1

Roll Call/Call to Order

ALASKA BOARD OF NURSING MEETING AGENDA

AUGUST 7 & 8, 2024

MISSION STATEMENT:

The mission of the Alaska Board of Nursing is to actively promote and protect the health of the citizens of Alaska through governance of the practice of nursing.

Meeting Details

Meeting Name: Alaska Board of Nursing Meeting

Meeting Start Time: 9:00 AM (AKST)

Meeting Start Date: August 7, 2024

Meeting End Time: 4:00 PM (AKST)

Meeting End Date: August 8, 2024

Meeting Locations: 1. Board/Staff - Suite 102, Atwood Building, Anchorage, AK

2. Zoom for Public Attendees (Limited In-Person Space)

Join Zoom Meeting

https://us02web.zoom.us/j/86347861871?pwd=aotusHzyEEHd20L0b6z0hmCgTWuUMQ.1

Meeting ID: 863 4786 1871

Passcode: 184200

Links

Board of Nursing: Nursing.Alaska.gov

Wednesday August 7, 2024

Agenda

1. Roll Call/Call to Order (9:00 - 9:03)
    - Introduction of new board member
2. Ethics Disclosures (9:03 – 9:04)
3. Board Activities
4. Consent Agenda Items (9:05 – 9:10)
    - Review/Approve Meeting Agenda
5. Public Comment (09:15- 09:35)

    5. A. Introduction: Dean of Nursing, Charter College, Cynthia D Booher PhD,RN,DNS-CT,CNE
6. New legislation, regulation update (9:40 – 10:00)
    - **HB 237: TEMPORARY PERMIT FOR LAPSED NURSE LICENSE –** Creates a temporary license to be issued as part of the reinstatement process for nursing licenses. Requirements for the temporary license are set by the board in regulation.
7. Delegation Regulation regarding controlled PRN medications, change request (10:00-10:20)

    Presenter: Jason Sauders, BSN, RN, Crossroads Counseling

Break (10:20-10:40)

8. APU Nursing Program update: NCLEX Passing Rates (10:40-11:00)

    Presenters: Staci Seagle and Lisa Moore
9. Development of Alaska Nursing Workforce Center (11:00-11:30)
    Presenter: Jeannie Monk
10. Request to the board regarding education and licensure (11:30-11:45)
    Presenter: Leanne Stewart, APRN
11. PDMP Update- (11:45-12:00)
    Presenter: Lisa Sherrell, PDMP Manager

Adjourn for Lunch (12:00 – 1:30)

12. (1:30-2:15) Distance Education. Institutional Authorization.
    Presenter: Tyler Eggen, Program Coordinator, Education and Early Development, Alaska Commission on Post Secondary Education (ACPE)

13. Proposed Regulation Changes and Updates- Setting up a work group (2:15-3:30)

    Presenter: Patty Wolf MSN, RNC-OB

Break at the discretion of the Board

14. Annual Review of National Certification Bodies per 12 AAC 44. 420. (3:30-3:45)

15. Advisory Opinion updates (3:45-4:00)

    Presenter: Danette Schloeder, DNP, RNC-OB, C-EFM, C-ONQS

16. Review/Assign Action item Assignments and due dates for Board Members (4:00-4:30)

    Presenter: Danette Schloeder, DNP, RNC-OB, C-EFM, C-ONQS

    Adjourn

Thursday, August 8, 2024

17. Call to Order/Roll Call (0900)

    Discussion of the following topics may require executive session. Only authorized members will be permitted to remain in the Board/Zoom room during executive session.

18. Executive Session (09:05)
    Reading of orders
19. Investigative and Probation Reports
    Presenters: Investigations Team

Break 10:30-10:45

20. Regulation Project updates (10:45-12:00)

Adjourn for Lunch 12:00-1:30

21. Licensing Reports (1:30- 2:00)

    RN: Madeleine Henderson and Laura Souders, Occupational Licensing Examiners

    CNA: Michelle Griffin, Occupational Licensing Examiner

    CNA Program updates: Kelly Olson, RN, Nursing Consultant

22. Division Updates (2:00-2:45)

    Legislative Update: Glenn Saviers, Deputy Director

    Financials: Melissa Dumas, Administrative Operations Manager

23. Public Comment Period (2:45 – 3:00)
24. Prioritize Board of Nursing tasks and Develop Time Frames. (3:00)
    - Strategic Plan and previous action items
25. Set 2025 BON meeting schedule.
    - Jan- March meeting
    - May/June
    - August/September
    - November
26. For the Good of the Order

    Presenter: Danette Schloeder, DNP, RNC-OB, C-EFM, C-ONQS

    - Assign/Review action items.
    - Any further topics to cover?
    - Agenda ideas for future meetings
    - Evaluation of board meeting
27. Chair Final Comments (4:00)

    Adjourn

Alaska Board of Nursing

Agenda Item #2

Ethics Disclosures

Alaska Board of Nursing

Agenda Item #3

Board Activities

Alaska Board of Nursing

Agenda Item #3

Consent Agenda Items

Letter FROM THE President

POST-BOARD MEETING UPDATE

July 19, 2024

Dear Members:

The Board of Directors (BOD) met July 9–10 in Chicago, cognizant of the fact that this will be the last time this year that the current board members will convene for a board meeting. This is also the last board meeting for me after four years of having the honor and privilege to serve as president of the BOD for this incredible organization. How these past four years have flown. The BOD and the membership have certainly experienced unexpected challenges and opportunities in nursing regulation.

In August, the delegates will vote on a president-elect, directors-at-large and, at the conclusion of the meeting, Phyllis Polk Johnson will begin her term as president after serving as president-elect for three years. Nothing in the world is constant but change, and so it is with NCSBN.

During this past board meeting, the customary environmental scan revealed topics of interest and themes related to LPN education, APRN regulation, Operation Nightingale, military education equivalency, IV hydration clinics, medication aides, national workforce data, scope of practice and reports of upcoming changes in leadership at nurse regulatory boards.

Highlights of meetings attended by the CEO and officers included the World Health Organization Global Partners, International Nurse Regulator Collaborative, the American Nurses Association Membership Assembly, Tri-Council for Nursing, and a joint meeting of leadership representatives of NCSBN and the Interstate Commission of Nurse Licensure Compact Administrators.

The BOD also heard and appreciated formal reports from the CEO and the chief officers about activities and work updates related to nursing regulation, testing, finance and information technology. The BOD met in closed session to review the CEO's performance assessment, a process that the BOD conducts annually.

Staff provided work plans and progress reports related to the Model Act and Rules Committee and the Governance Review and Bylaws Committee. Both committees have been charged by the BOD with significant work and the development of member engagement plans that will result in recommendations to be acted on by the Delegate Assembly in the future.

The BOD made appointments and reappointed members to the NCLEX® Examination Committee, NCLEX® Item Review Subcommittee and Awards Committee for fiscal year 2025 (FY25). Once again, the interest and engagement of the membership was evident as we received more applications than open positions. Thank you to all of you who applied.

NCSBN
Leading Regulatory Excellence

Letter FROM THE President

POST-BOARD MEETING UPDATE, CONTINUED

Finally, I look forward to spending time with you all at the 2024 NCSBN Annual Meeting in Chicago in August, focusing on this year's theme "**Every Moment Matters: Realizing Lasting Impact**." Staff and the BOD have planned time for networking, beginning with the welcome reception Tuesday evening at the Lincoln Park Zoo Wildlife Center, time to celebrate each other through the EO Service Awards and NCSBN Awards, time to act on business and time for reflection on the words of some great speakers who will inform and energize our work as regulators going forward.

As I think about my personal involvement with NCSBN that has spanned the last 25 years, I recognize and appreciate the NCSBN moments that developed me as a nursing regulator. Moments created by connection, support, resources, and information sharing around public protection. I am profoundly grateful for the opportunities afforded to me by involvement with NCSBN.

Warmly,

Jay Douglas, MSM, RN, CSAC, FRE

President
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Fraud Detection Guidance for Employers and Educators

Purpose

To provide guidance to nursing education programs, employers and others who assess nursing applicants for advanced study, employment, certification and other uses.

Context

There is no immunity to fraud. It is experienced by almost every sector in the population. It is costly and devastating to those who are subject to it. When it invades the health professions, it becomes a serious health concern, a risk to public safety and violates public trust in the health care system. For this reason, this guidance is issued to nursing programs, employers, accreditors and others to increase awareness and help institute methods of fraud detection and prevention.

Fraud in nursing can present itself via a fraudulent nursing program or other deceitful or counterfeit methods. Mechanisms that may be used to deceive nursing regulatory bodies (NRBs), employers, educators and others can include:

- Obtaining a false nursing diploma/degree without having completed an approved nursing program; this can include a program that sells a nursing diploma/degree without providing sufficient education;
- Buying or forging a counterfeit license;
- Lying about one's experience, background, past work history; or
- Covering up a criminal background,.

Individuals then use the fake credentials to apply for a nursing license, apply for a job or enroll in an advanced nursing program. Prevention requires awareness and astute detection methods. It is essential that everyone is aware that fraud exists and of some basic methods that may prevent it. To assist with this identification, basic guidance for detecting fraudulent credentials is provided.

Recommendations

While there is no guarantee that these recommendations will prevent fraudulent individuals from entering your institution, if your institution does not already employ these methods, they should be added to your current processes for further protection.

1. Provide initial and ongoing fraud detection training for all individuals who will be reviewing and accepting applicants for your institution or agency.
2. Identify and close loopholes that evade rules or the law.
3. Fraudulent individuals look for the easiest entry routes. If your institution/agency has fewer requirements than others, be extra vigilant.
4. Check nursys.com to ensure every applicant has a valid unencumbered license.
5. Make sure the program where the applicant graduated was approved by the NRB in the state where the program is located.

6. Check references. Many cases where the applicant has provided deceitful information on an application can be identified by verifying references. Special attention should be given to former employers and institutions of higher learning. Ask for a business email address if one is not provided.
7. Review all transcripts and other documents carefully. Details on reviewing transcripts or other documents for potential fraud can be found in NCSBN's *Licensure of Internationally Educated Nurses Resource Manual* (https://www.ncsbn.org/public-files/23_IEN_manual.pdf, pages 19–25).
8. Educational institutions and practice settings alike should have an Institution e-Notify account and enroll all their nurses. e-Notify, a component of, nursys.com is a free nurse licensure notification system where institutions can receive real-time notifications about nurses enrolled in a nursing education program or employed at their institution. The system provides licensure and publicly available discipline data directly to the institutions as the information is entered into the Nursys database by NRBs. Nursys is the only national nurse licensure and disciplinary database. If an NRB identifies a nurse with fraudulent credentials and revokes his/her license, that information will immediately be reported to the Nursys database and to e-Notify institution account holders. Educators and employers will quickly receive a message about the license revocation and can take appropriate actions.
9. Be alert to red flags such as inconsistencies in the information on applications and transcripts (e.g., time to completion of degree, sequencing of courses, etc.) or criminal background checks. Although a red flag does not directly indicate guilt or innocence, a red flag serves as a warning sign for inconsistency and the need for additional investigation.
10. Report to your NRB any nurse who has been deceitful, provided fraudulent information to your institution or you feel is unsafe. This will prevent these nurses from moving to another institution and threatening the safety of others. Once the NRB takes action, the information will be placed into Nursys alerting others about that individual.

It is important to recognize that the majority of nurses are honest, competent and caring individuals, so the public has no need for concern. This, however, serves as a reminder to schools and employers that there are occasional opportunists who may cover up their background to obtain a job, attend a nursing program or use fraudulently obtained credentials to pose as a nurse and seek employment.

The following organizations and individuals support the Fraud Detection Guidance for employers and educators:

- National Council of State Boards of Nursing
- American Association of Colleges of Nursing
- American Association of Critical-Care Nurses Certification Corporation
- American Nurses Association
- American Organization for Nursing Leadership
- Missouri State Board of Nursing
- National League for Nursing
- Organization for Associate Degree Nursing
- Washington State Board of Nursing
- Laurie A. Badzek, LLM, JD, RN, FNAP, FAAN, Dean and Professor, Ross and Carol Nese College of Nursing, Penn State University

- Eileen Collins, PhD, RN, ATSF, FAAN, Dean and Professor, University of Illinois Chicago College of Nursing
- Connie W. Delaney, PhD, RN, FAAN, FACMI, FNAP, Professor and Dean, University of Minnesota School of Nursing
- Jennifer Doering, PhD, RN, FAAN, Associate Dean and Head of School, University of Wisconsin-Milwaukee, School of Nursing
- Nancy Edwards, PhD, MSN, ANP-BC, FAANP, Professor, Purdue University School of Nursing, Lafayette, Indiana
- Linda Flynn, PhD, RN, FAAN, Dean and Professor, Rutgers School of Nursing, Chair, BTAA Collaborative of Nursing Deans
- Eileen Fry Bowers, PhD, JD, RN, CPNP-PC, FAAN, Dean and Professor, University of San Francisco School of Nursing and Health Professions
- Patricia Hurn, PhD, RN, FAAN, Dean and Professor, University of Michigan School of Nursing
- Yolanda Ogbolu, PhD, RN, FAAN, Bill and Joanne Conway Dean and Professor, University of Maryland Baltimore School of Nursing
- Robin Newhouse, PhD, RN, NEA-BC, FAAN, Dean and Distinguished Professor, Indiana University School of Nursing, Deputy Chair, University Clinical Affairs Cabinet, Associate Vice President for Academic Affairs, IU Health
- Patricia M. Noga, PhD, RN, NEA-BC, FAAN, representing the American Organization for Nursing Leaders
- Karen Rose, PhD, RN, FGSA, FAAN, Dean and Professor, The Ohio State University, College of Nursing
- Linda D. Scott, PhD, RN, NEA-BC, FNAP, FAAN, Dean and Professor, School of Nursing, University of Wisconsin-Madison; President-Elect, American Academy of Nursing
- Lepaine Sharp-McHenry, DNP, RN, FACDONA, Dean and Professor, University of Nebraska Medical Center College of Nursing
- Leigh Small, PhD, RN, CPNP-PC, FNAP, FAANP, FAAN, Dean and Professor, Michigan State University College of Nursing
- Julie Zerwic, PhD, RN, FAHA, FAAN, Kelting Dean and Professor, University of Iowa, College of Nursing

About NCSBN

Empowering and supporting nursing regulators across the world in their mandate to protect the public, NCSBN is an independent, not-for-profit organization. As a global leader in regulatory excellence, NCSBN champions regulatory solutions to borderless health care delivery, agile regulatory systems and nurses practicing to the full scope of their education, experience and expertise. A world leader in test development and administration, NCSBN's NCLEX® Exams are internationally recognized as the preeminent nursing examinations.

NCSBN's membership is comprised of the nursing regulatory bodies (NRBs) in the 50 states, the District of Columbia and four U.S. territories. There are seven exam user members and 25 associate members that are either NRBs or empowered regulatory authorities from other countries or territories.

The Effects of the COVID-19 Pandemic on Nursing Education Programs

Nancy Spector, PhD, RN, FAAN; and Josephine Silvestre, MSN, RN

ABSTRACT

Background: The U.S. Boards of Nursing (BONs) collect annual report data from their nursing programs as part of their approval process. This paper highlights the 2020 and 2021 annual report data on the effect of coronavirus disease 2019 (COVID-19) on all nursing programs in 17 BONs in 2020 and 19 in 2021. **Method:** Nursing programs answered 16 questions on the effect of COVID-19 on their programs. Because BONs require annual report data, all programs in the participating states answered the questions, which included 798 programs in 2020 and 929 in 2021. **Results:** Major disruptions in nursing education occurred during the pandemic. Clinical experiences and didactic classes were greatly affected, though alternative strategies were used. Student and faculty attrition rates were particularly high in 2021. **Conclusion:** The authors call for a national forum where nurse leaders analyze what happened and make recommendations for future crisis events. **[*J Nurs Educ*. 2024;63(5):312-319.]**

The National Council of State Boards of Nursing (NCSBN) has members that include Boards of Nursing (BONs) in the United States, 23 associate boards worldwide, and seven examination user boards in Canada. Examination user boards, similar to BONs in the U.S., have an exclusive mandate related to the regulation of the profession and public protection, and they use the NCLEX as their licensure examination (NCSBN, 2023). The U.S. BONs approve nursing education programs with established criteria to ensure they meet minimum requirements.

In 2020, the NCSBN released the findings of a large, mixed-methods study identifying the quality indicators of nursing programs. From this study, the NCSBN, along with an expert panel, developed evidence-based quality indicators of nursing programs, which became the foundation for our Regulatory Guidelines (Spector et al., 2020). Currently, many of the BONs use the NCSBN evidence-based Regulatory Guidelines when they approve nursing programs.

Many BONs also request annual reports from their programs as part of their approval process. To assist the BONs with this, as well as to develop a consistent national nursing education database, the NCSBN established an Annual Report Program. The survey for the programs is based on the quality indicators identified, and any additional questions requested by BONs also are included. The surveys are sent to BONs in either September or January, and then the results are reviewed, verified, and cleaned before the final report, along with graphs, tables, matrices, and text responses are provided to the BONs. This program began in 2020, and for the first 2 years, the coronavirus disease 2019 (COVID-19) pandemic was in full swing. Therefore, in 2020 and 2021, the NCSBN included 16 questions about the effect of the pandemic on the nursing programs. This article reviews those responses.

LITERATURE REVIEW

When the COVID-19 pandemic reached the U.S. in 2020, hospitals and other health care facilities were not experienced with making decisions about nursing students continuing their clinical experiences during a crisis. Additionally, this was a chaotic time, as not much was known about the COVID-19 virus. Consequently, many health care facilities closed their doors to nursing students, which prevented students from participating in clinical experiences with actual patients (NCSBN, 2021). At the same time, many nursing programs pivoted to online learning to avoid students being in contact with the virus. Additionally, there was a lack of personal protective equipment (PPE) in the early phases of the pandemic, and many health care facilities were unable to provide PPE to students (NCSBN, 2021). Therefore, the academic climate in nursing education changed drastically in a short time during the COVID-19 pandemic.

Because of the havoc the pandemic presented to nursing education programs, faculty needed to find creative ways to continue teaching. In a survey, the BONs reported several strategies that nursing education programs used during the pandemic to continue teaching students. Major alternative strategies for clinical experiences included increasing the percentage of simulation; following a 2:1 ratio of clinical hours to simulation; using virtual reality, virtual simulation, or augmented reality; and implementing unfolding case studies (NCSBN, 2021). Other strategies were reported as well (NCSBN, 2021) (**Table A**; available in the online version of this article).

Nursing education also was affected internationally by the pandemic. Goni-Fuste et al. (2021) conducted a systematic review in Spain related to students' experiences during global

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pandemics from 2003 to 2020. They found there was a need to adapt nursing education during pandemics, which included presenting information about the pandemic and knowledge and concern about risk and preventative behavior. The researchers reported that nursing programs provided alternative teaching strategies for educating students because of the frequent need to suspend clinical placements. The review examined the willingness of students to work or volunteer during a pandemic and explored the factors that made them more or less willing. Another theme in this review was the emotional effect of a pandemic on the students, and the authors suggested some strategies to support students. Ethical dilemmas with the care of patients during a pandemic also were identified as themes in this systematic review. For example, they explored attitudes with duty to care, resource allocation, and decisions regarding which patients should be admitted to critical care units. Many of these same themes also occurred in the U.S. during the COVID-19 pandemic (Emory et al., 2021; Feeg et al., 2021; Michel et al., 2021).

International nursing programs experienced similar challenges during the pandemic. One cross-sectional multicenter international study examined the COVID-19 nursing education experience with 30 nurse educators working in the 60 highest-ranked nursing schools in the world (based on the 2020 QS World University Ranking list) and found that 48% of faculty encountered internet-related problems, 44% reported difficulty in adapting the curriculum to distance education, and 65% had issues providing examinations to students (Kalanlar, 2022). In a Canadian qualitative study, nursing faculty described their experiences in the pandemic as being overwhelming and exhausting from working extra hours to support students and adapting to remote teaching (VanLeeuwen et al., 2021).

Similarly, nursing students reported unpreparedness related to the sudden new normality. In a cross-sectional survey study conducted in Belgium, almost half of the surveyed students (n = 301) could not continue their clinical placement as planned, and they perceived there were little to no opportunities for practicing nursing skills (Ulenaers et al., 2021). This can be aligned with U.S. nursing students' worries about passing the NCLEX and being prepared to practice competently (Feeg et al., 2021; Michel et al., 2021). Although Ulenaers et al. (2021) reported students were satisfied with the support provided by the nursing schools, students in another study by Michel et al. (2021) criticized their nursing faculty for being ill-prepared and for their unresponsiveness to help. Some students regarded online education as inadequate and expressed their concerns about not being able to get a job as a nurse because they had such limited experiences in school during the pandemic (Michel et al., 2021).

One curricular deficit the pandemic uncovered was that many programs lacked strategies in emergency preparedness, as was seen with the chaotic movement to online education and with attempts to arrange quality alternative clinical experience activities when many health care facilities abruptly closed their doors to nursing students (Michel et al., 2021). Michel et al. (2021) suggested future planning should consider how a crisis affects faculty and students, alternative teaching strategies, collaborative agreements with practice facilities, and understanding regulatory requirements. Students also should receive safety training about the pandemic and know how to safely use PPE. This lack of readiness for crisis situations also was seen globally (NCSBN, 2022).

Transition to practice in the U.S. also was difficult during the pandemic. Smith et al. (2021) conducted a descriptive study that included 295 new graduates, representing 136 programs across 38 states. These new graduates reported up to 240 hours of clinical experiences were replaced by other modalities, such as virtual simulation or other experiences. Many reported large gaps in time since they had worked with actual patients. These new graduates often feared being overwhelmed or providing unsafe care. This study suggests that practice needed to work collaboratively with education to transition these new graduates. Indeed, the pandemic illustrated to the nursing community that developing practice-academic partnerships is important for the future of nursing education (Spector et al., 2021). In this model, the practice setting will provide hands-on experiences for nursing students while being supervised by faculty. At the same time, the students also receive academic credits. In those regions where this model was in effect during the COVID-19 pandemic, the nursing students were considered essential workers and were able to care for patients in health care facilities for their clinical experiences (Spector et al., 2021).

METHOD

Data Source

NCSBN collects survey data for many BONs' annual reports of nursing programs. In 2020 and 2021, the annual report survey included 16 questions about the effects of the COVID-19 pandemic on the programs' education. This descriptive study evaluated the effects at the start of the pandemic in 2020 compared with the effects of the pandemic in 2021.

Participating Nursing Programs

All prelicensure nursing education programs from BONs participating in the annual reports program were eligible to participate in this evaluation; two BONs chose not to participate in the COVID-19 survey because they had conducted their own surveys. The final sample participating in the COVID-19 survey included 17 BONs (n = 798 nursing programs) in 2020 and 19 BONs (n = 929 nursing programs) in 2021 (Leader to Leader, 2023).

Procedure

NCSBN developed a universal set of nursing education questions based on the evidence (Spector et al., 2020), which provided a consistent national database for this study. In addition to the core set of questions, an additional set of 16 closed- and open-ended questions addressing the effects of COVID-19 on nursing education was included. NCSBN solicited participation of BONs throughout the U.S. and its territories. The universal set of questions along with the COVID-19 questions were sent to all prelicensure programs at participating BONs using Qualtrics® software. The BONs determined the time of distribution based on their rules or typical annual report distribution time point. Survey links were created and sent to the

TABLE 1
Overall Effect of the COVID-19 Pandemic on the Nursing Program

Effect of COVID-19	2020[a]	2021[b]
	n (%)	
Major disruption	382 (47.9)	208 (22.4)
Quite a bit	276 (34.6)	336 (36.2)
Somewhat	120 (15)	288 (31)
A little	12 (1.5)	80 (8.6)
Not at all	8 (1)	17 (1.8)

Note. COVID-19 = coronavirus disease 2019.
[a]*n = 798.*
[b]*n = 929.*

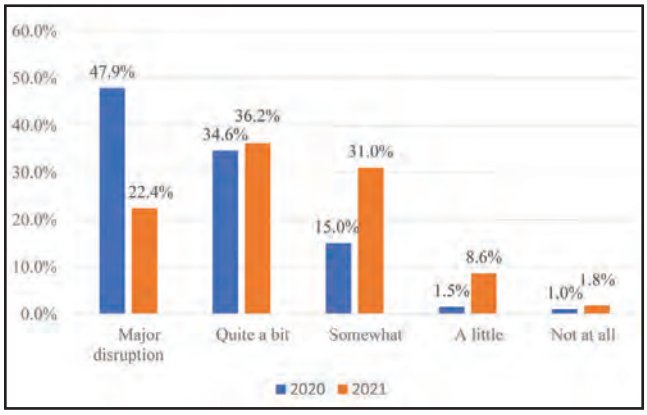

Figure 1. Overall effect of coronavirus disease 2019 on nursing program.

participating BONs for distribution to their prelicensure nursing programs. Nursing programs were provided a minimum of 30 days to complete the survey. Some BONs allowed their nursing programs an extended deadline depending on their board's rules. At the end of the survey completion deadline, NCSBN sent the BONs a list of nursing programs that submitted an annual report for the BONs to confirm that all of their prelicensure programs had completed the survey. After confirmation was received from the BONs that all prelicensure programs had submitted, NCSBN reviewed, cleaned, and verified all data. NCSBN then sent the BONs their final report, and at the end of the year, an aggregate report of all participating BONs was created and distributed to all participating BONs and posted on NCSBN's website (Spector et al., 2022).

Data Analysis

A total of 798 nursing programs in 2020 and 929 nursing programs in 2021 participated in the survey. Nursing programs were asked how seriously their programs were affected by COVID-19. In 2020, almost half (47.9%) of the programs stated COVID-19 caused a major disruption. By 2021, only 22.4% reported COVID-19 caused a major disruption, and 36.2% of programs reported COVID-19 had affected their program "quite a bit" (**Table 1** and **Figure 1**) (Leader to Leader, 2023). This may suggest nursing programs had observed some improvement from 2020 to 2021 or developed ways to adapt to the new environment created by COVID-19.

At the beginning of the pandemic in 2020, most of the nursing programs reported COVID-19 greatly affected didactic education (*n* = 740 [92.7%]) and clinical experiences with patients in clinical sites (*n* = 778 [97.5%]) (Leader to Leader, 2023) (**Table 2** and **Figure 2)**. COVID-19 continued to affect didactic education (*n* = 774 [83.3%]) and clinical experiences (*n* = 858 [92.4%]) in most programs into 2021. Simulation (*n* = 691 [86.6%],) and skills laboratories (*n* = 669 [83.8%]) also were greatly affected at the beginning of the pandemic. Although the effects on these parts of the program had eased by 2021, a majority of the programs reported experiencing continued effects.

The specific changes made to didactic education included moving to 100% online education, moving to partial online education, and implementing smaller class sizes. Most programs (*n* = 624) [78.2%]) moved to 100% online education at the start of the pandemic, whereas 21.8% (*n* = 174) did not. By 2021, 33% of the programs (*n* = 307) were still using 100% online education, while 67% (*n* = 622) had begun to move back to pre-pandemic modalities. Approximately one-fourth (*n* = 183 [23%]) of the nursing programs implemented smaller class sizes in 2020, and approximately one-third (*n* = 338 [36.4%]) of the programs implemented smaller classes in 2021. A very small percentage of programs (*n* = 19 [2.4%]) reported making no changes to didactic education at the start of the pandemic in 2020. Almost one-fourth of the programs (*n* = 182 [22.8%]) reported making other adaptations to didactic education at the start of the pandemic, such as conducting online examinations and using remote examination proctoring. By 2021, approximately one-third (*n* = 302 [32.5%]) of the programs reported using other adaptations, such as masking and social distancing for in-person classes (Leader to Leader, 2023).

The decision to close and cease in-person classes primarily was made by governor proclamation (*n* = 589 [73.8%]) and administration at the university, college, or educational organization (*n* = 759 [95.1%]) (Leader to Leader, 2023). In addition to modifying delivery of didactic education to an online format, approximately one-fourth of the programs (*n* = 183 [22.9%]) used smaller class sizes to navigate didactic education at the start of the pandemic. By 2021, approximately one-third of the programs (*n* = 338 [36.4%]) reported using smaller class sizes (**Table 3**).

In addition to ceasing in-person didactic education at the start of the pandemic, more than half (*n* = 423 [54%]) of the nursing programs reported face-to-face clinical experiences with patients at all sites were canceled, and the remaining programs canceled in-person clinical experiences to some extent (**Table 4**). These cancellations primarily were caused by restrictions made by the clinical settings. Only a few (*n* = 11 [1.4%]) nursing programs had not canceled in-person clinical experiences at the start of the pandemic in 2020. In 2021, 16% (*n* = 149) of nursing programs reported cancellation of in-person clinical experiences at all sites. Many clinical settings had relaxed their restrictions likely due to implementation of COVID-19 vaccine requirements, decreased community transmission and risk, and decreased COVID-19 hospitalizations and mortality. However, only 10.4% (*n* = 97)

TABLE 2
Effect of the COVID-19 Pandemic on Specific Aspects of the Nursing Program

Effect of COVID-19	2020[a]	2021[b]
	n (%)	
Didactic education		
Yes	740 (92.7)	774 (83.3)
No	58 (7.3)	155 (16.7)
Clinical experiences with patients in clinical sites		
Yes	778 (97.5)	858 (92.4)
No	20 (2.5)	71 (7.6)
Simulation in the simulation laboratory		
Yes	691 (86.6)	550 (59.2)
No	107 (13.4)	379 (40.8)
Skills laboratory		
Yes	669 (83.8)	592 (63.7)
No	129 (16.2)	337 (36.3)
Other parts of the program		
Yes	104 (13)	114 (12.3)
No	694 (87)	815 (87.7)

Note. COVID-19 = coronavirus disease 2019.
[a]*n = 798.*
[b]*n = 929.*

of the programs reported no cancellations in face-to-face clinical experiences, with modifications to in-person clinical experiences persisting through 2021.

Of the nursing programs that reported continued in-person clinical experiences at the start of the pandemic, only 10.2% (*n* = 37) reported their students had direct contact with COVID-19 patients during these experiences. Most of these programs reported students had sufficient PPE, whether provided by the health care facility, the program, or the students themselves, when in contact with COVID-19 patients (**Table 4**).

Nursing programs reported several alternatives to canceled in-person clinical experiences (**Table 5**). In 2020, almost all of the programs (*n* = 441 [96.1%]) that were required to cancel some portion of their clinical experiences reported the integration of virtual simulation. Programs also incorporated the use of simulation in the laboratory with mandated social distancing (*n* = 159 [34.6%]), simulation in the laboratory without mandatory social distancing (*n* = 300 [65.4%]), and other adaptations, such as simulation via Zoom (*n* = 227 [49.5%]). By 2021, most of these programs (*n* = 297 [73.5%]) were still using virtual simulation as an alternative to in-person clinical experiences (Leader to Leader, 2023). However, compared with 2020, a larger percentage of programs reported using more in-person simulation with mandated social distancing (*n* = 234 [57.9%] versus without mandated social distancing [*n* = 170 [42.1%]).

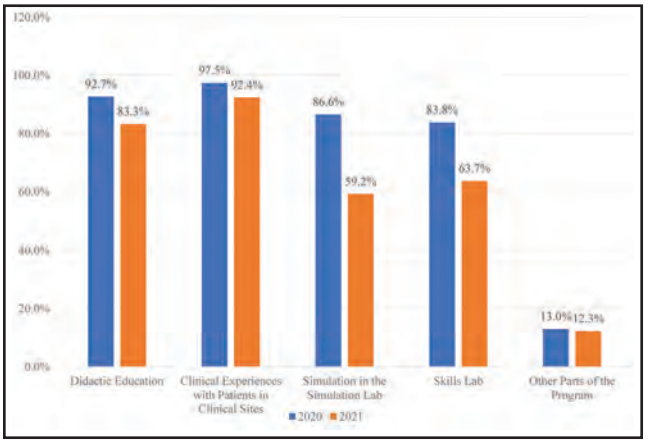

Figure 2. Effect of coronavirus disease 2019 on specific aspects of the nursing program.

Nursing programs were asked whether grading criteria were modified during the pandemic (**Table 6**). In 2020, one-fifth (*n* = 152 [19%]) of the programs reported changing their grading criteria, which included modifications such as using pass/fail grading and allowing multiple opportunities for testing. By 2021, only 9% (*n* = 84) of the programs reported using modified grading criteria. Student and faculty attrition also were examined (**Table 7**). The reported student attrition (*n* = 255 [32%]) and faculty attrition (*n* = 91 [11.4%]) at the beginning of the pandemic in 2020 was lower than in 2021 (*n* = 439 [47.3%] versus *n* = 178 [19.2%], respectively) (Leader to Leader, 2023).

Nursing programs reported the overall quality of education at their institution was approximately the same during the pandemic compared with before the pandemic, both in 2020 (*n* = 451 [56.5%]) and 2021 (*n* = 437 [49.8%]). In 2020, 33.3% (*n* = 266) of the programs reported lower overall quality, whereas only 6.5% (*n* = 52) reported overall higher quality. (**Figure 3** and **Table 8**).

DISCUSSION

The results of this survey illustrate that COVID-19 had a major adverse effect on nursing education in 2020 and 2021, although that effect was less in 2021. In 2020, 82.5% of the programs reported experiencing a major or quite a bit of a disruption as a result of the pandemic; in 2021, the programs reported that same disruption to be 58.6%. The improvement in 2021 may be attributed to a variety of reasons, such as more students were able to have clinical experiences with actual patients, and more programs brought students back for didactic classes (NCSBN, 2022). Moreover, nursing programs likely became more proficient with the alternative strategies of teaching students. Interestingly, during the pandemic, didactic and clinical education were affected the most in 2020 (92.7% didactic and 97.5% clinical), although the effects were still high in 2021 (83.3% didactic and 92.4% clinical). However, in 2020, most

TABLE 3
Changes to Didactic Education Due to the COVID-19 Pandemic

Change	2020[a] *n* (%)	2021[b] *n* (%)
Converted to 100% online education		
Yes	624 (78.2)	307 (33)
No	174 (21.8)	622 (67)
Percentage of didactic education converted to online		
76% to 90%	39 (24.4)	77 (15.9)
51% to 76%	34 (21.3)	82 (16.9)
26% to 50%	34 (21.3)	118 (24.4)
≤25%	36 (22.5)	134 (27.7)
Other comments	16 (10.0)	72 (14.9)
Not applicable	1 (0.6)	1 (0.2)
Smaller class sizes		
Yes	183 (22.9)	338 (36.4)
No	615 (77.1)	591 (63.6)
No changes		
Yes	19 (2.4)	71 (7.6)
No	779 (97.6)	858 (92.4)
Other adaptations		
Yes	182 (22.8)	302 (32.5)
No	616 (77.2)	627 (67.5)
Decision to close and cease face-to-face contact was made by:		
Governor proclamation		
Yes	589 (73.8)	555 (59.7)
No	209 (26.2)	374 (40.3)
Administration at the university, college, or educational organization		
Yes	759 (95.1)	853 (91.8)
No	39 (4.9)	76 (8.2)
Dean or director of the nursing program		
Yes	367 (46)	416 (44.8)
No	431 (54)	513 (55.2)
Faculty in the nursing program		
Yes	162 (20.3)	170 (18.3)
No	636 (79.7)	759 (81.7)
Other		
Yes	97 (12.2)	159 (17.1)
No	701 (87.8)	770 (82.9)

Note. COVID-19 = coronavirus disease 2019.
[a]*n = 798.*
[b]*n = 929.*

(86.6%) faculty reported simulation was adversely affected because of the pandemic; in 2021, this percentage dropped to 59.2% of the faculty. Similarly, in 2020, approximately three quarters (83.8%) of the faculty reported that skills laboratories were affected by the pandemic; in 2021, this percentage decreased to 63.7%. Faculty likely were able to decrease contagion in the simulation and skills laboratory more easily compared with actual clinical experiences and lectures.

In 2020, three-fourths (78.2%) of the programs reported converting to 100% online; the remaining programs reported using hybrid classes. However, 100% online teaching decreased to 33% in 2021, with many more programs converting to hybrid classes. The 2021 decrease in 100% online teaching likely benefitted some students and faculty who had difficulties with online education during the pandemic (Kalanlar, 2022; Michel et al., 2021). Another alternative strategy was that some programs reported decreasing their class size because of the pandemic (22.9% in 2020 versus 36.4% in 2021). There was a greater decrease in class size in 2021, which again might be attributed to a better understanding of alternative teaching methods.

Alternative strategies for clinical experiences included programs using either simulation in person (19.2% in 2020 versus 45% in 2021) or with mandated social distancing (34.6% in 2020 versus 57.9% in 2021). Research supports replacing up to 50% of in-person clinical experiences with simulation (Hayden et al., 2014). Another strategy for providing clinical experiences was that in 2020 most programs (96.1%) used virtual simulation, although this decreased to 73.5% in 2021. To date, the research has not supported virtual simulation as a replacement for clinical experiences (Foronda et al., 2020). Some schools decreased the number of clinical hours that were required for students to graduate (22.9% in 2020 and 8.4% in 2021), whereas other schools changed their grading criteria (19% in 2020 and 9% in 2021). This lowering of requirements is concerning as it could affect the quality of the nurses who graduate; this should be explored further for future crisis situations.

In 2020, of the nursing students who cared for patients in health care facilities, 10.2% had contact with COVID-19 patients; in 2021, this increased to 37.6% of nursing students. However, only 29.7% of the health care facilities provided PPE to students in 2020 and 36.8% in 2021. Generally, the nursing program or the students themselves provided the PPE. The nursing community might want to collaborate with practice

TABLE 4
Changes to Clinical Experiences During the COVID-19 Pandemic

	2020[a]	2021[b]
Change	***n* (%)**	
91% to 99%	423 (54)	149 (16)
76% to 90%	105 (13.2)	68 (7.3)
51% to 75%	53 (6.6)	60 (6.5)
26% to 50%	52 (6.5)	133 (14.3)
≤25%	41 (5.1)	286 (30.8)
None of the sites	11 (1.4)	97 (10.4)
Other	113 (14.2)	136 (14.6)
Students had direct contact with COVID-19 patients during clinical experiences		
n	364	684
Yes	37 (10.2)	257 (37.6)
No	327 (89.8)	427 (62.4)
Students had sufficient PPE when in contact with COVID-19 patients		
n	37	258
Yes, provided by health care facility	11 (29.7)	95 (36.8)
Yes, but some PPE was provided by the nursing program or the students themselves	10 (27)	73 (28.3)
Yes, but the nursing program and the students provided all PPE	5 (13.5)	37 (14.3)
No, please explain	1 (2.7)	2 (0.8)
Other	10 (27)	51 (19.8)

Note. COVID-19 = coronavirus disease 2019; PPE = personal protective equipment.
[a]*N = 798.*
[b]*N = 929.*

TABLE 5
Alternatives to Canceled In-Person Clinical Experiences During the COVID-19 Pandemic

	2020[a]	2021[b]
Alternative	***n* (%)**	
Simulation laboratory with manikins, faculty, and students present		
Yes	88 (19.2)	182 (45)
No	371 (80.8)	222 (55)
Simulation in the laboratory with manikins, faculty and students, although with mandated social distancing		
Yes	159 (34.6)	234 (57.9)
No	300 (65.4)	170 (42.1)
Virtual simulation		
Yes	441 (96.1)	297 (73.5)
No	18 (3.9)	107 (26.5)
Decreased number of clinical hours needed for graduation		
Yes	105 (22.9)	34 (8.4)
No	354 (77.1)	370 (91.6)
Other adaptations (e.g., simulation via Zoom)		
Yes	227 (49.5)	146 (36.1)
No	232 (50.5)	258 (63.9)

Note. COVID-19 = coronavirus disease 2019.
[a]*n = 459.*
[b]*n = 404.*

facilities and public health agencies about how to prevent this from happening in any future pandemics.

Decisions to close programs and cease face-to-face education were made most frequently in nursing schools by governor proclamation and school administration. Faculty, according to the findings of this survey, had little input in closing programs to face-to-face contact (20.3% in 2020 versus 18.3% in 2021). Particularly in nursing, when administrators make decisions about whether to close programs during a pandemic or a disaster, they should listen intently to nursing faculty because nursing is a health profession where clinical experiences are essential for students to apply the content learned in class and prepare to become professional nurses (Spector et al., 2020).

This survey also found attrition in both the student and faculty population during the pandemic, and this is concerning because of the ongoing nursing and faculty shortage. Student attrition was higher than faculty attrition, with 32% in 2020 and 47.3% in 2021. The 2021 figures show that nearly half of nursing students left their programs, which is difficult to understand. Some of the reasons students reported for leaving their programs included having difficulties in not adapting to the online or virtual formats, having personal responsibilities at home, and experiencing financial hardships. Faculty attrition was smaller but is still a major concern in nursing education because of the faculty shortage. In 2020, 11.4% of faculty left

TABLE 6
Nursing Program Modified Grading Criteria During the COVID-19 Pandemic

	2020[a]	2021[b]
Modification	***n* (%)**	
Nursing programs changed grading criteria (e.g., using pass/fail grading and providing students with multiple opportunities to test)		
Yes	152 (19)	84 (9)
No	646 (81)	845 (91)

Note. COVID-19 = coronavirus disease 2019.
[a]*n = 798.*
[b]*n = 929.*

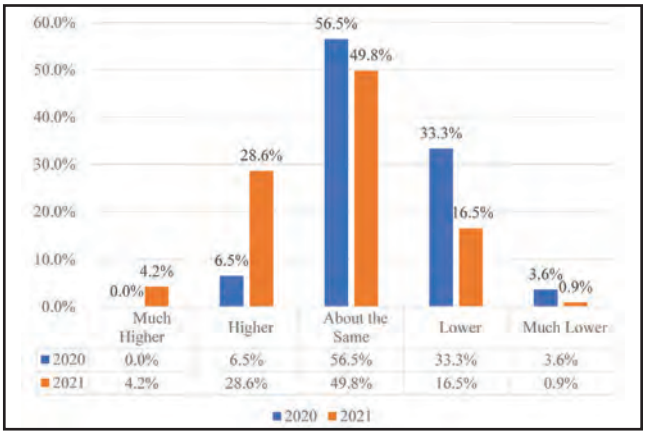

Figure 3. Overall quality of education during the coronavirus disease 2019 pandemic compared with prior to pandemic.

TABLE 7
Student and Faculty Attrition During the COVID-19 Pandemic

	2020[a]	2021[b]
Group	***n* (%)**	
Students		
Yes	255 (32)	439 (47.3)
No	543 (68)	490 (52.7)
Faculty (e.g., faculty with health conditions retiring early)		
Yes	91 (11.4)	178 (19.2)
No	707 (88.6)	751 (80.8)

Note. COVID-19 = coronavirus disease 2019.
[a]*n = 798.*
[b]*n = 929.*

TABLE 8
Overall Quality of Education During the COVID-19 Pandemic Compared With Before the Pandemic

	2020[a]	2021[b]
Overall Quality	***n* (%)**	
Much higher	0 (0)	37 (4.2)
Higher	52 (6.5)	251 (28.6)
About the same	451 (56.5)	437 (49.8)
Lower	266 (33.3)	145 (16.5)
Much lower	29 (3.6)	8 (0.9)

Note. COVID-19 = coronavirus disease 2019.
[a]*n = 798.*
[b]*n = 929.*

their positions; this increased to 19.2% in 2021. Some of the reasons faculty gave for leaving their jobs were worries about their health and safety, and difficulty adapting to online education. These data support nursing faculty collaborating with leaders in practice and health care about developing strategies to prevent attrition from happening in future crises.

The final question on the survey asked faculty to give their opinions on the quality of education during 2020 and 2021. The results illustrated faculty began to feel more comfortable with their alternative teaching strategies in 2021. In 2020, only 6.5% of the faculty reported the quality of their teaching was higher or much higher than before the pandemic, whereas in 2021, almost one-third (32.8%) reported the quality of their teaching as higher or much higher. Similarly, in 2020, 36.9% of the faculty reported the quality of education was lower or much lower than before the pandemic compared with 17.4% of the faculty in 2021. These data suggest providing faculty with resources and strategies for teaching during a pandemic or crisis would be valuable.

The findings of this study, as well as other nursing education studies on the pandemic, indicated most nursing students were not able to have clinical experiences with actual patients during the pandemic. Clinical experiences are important for students to apply the content they have learned and practiced such as assessment, clinical judgment, management, and documentation. Additionally, some faculty and students had difficulty using online platforms during didactic education. Therefore, a national nursing education forum on what happened during the COVID-19 pandemic to nursing education and how to plan for future crisis events would be an exceptional outcome of this pandemic. The nursing education community then could hold regional meetings to distribute the information so that faculty at all levels would be involved. A document containing information on emergency preparedness could be developed and added to the curriculum. Additionally, suggestions regarding alternative teaching strategies could be provided, along with data and evidence to support the strategies.

A major challenge for nursing education during the pandemic was that many health care facilities closed their doors to students. This not only prevented students from caring for actual patients and decreased their confidence and experience, it also prevented health care facilities from obtaining care that nursing students provide to patients, thus relieving their overwhelmed staff. This lack of clinical experiences is one possible reason that nursing students' licensure pass rates declined during the pandemic (NCSBN, 2022).

Besides developing alternative strategies for students' clinical experiences, a national nursing education forum could call for practice and education to collaborate much more closely than they do now. Some programs did collaborate with practice during the pandemic (Spector et al., 2021); in such cases, nursing students were able to access health care facilities and provide care to patients. The COVID-19 pandemic has indicated the need for the nursing profession to take steps to prevent the chaos that ensued during the pandemic from ever happening again during any future crisis or pandemic.

LIMITATIONS

Although much of the data collected were quantitative, such as the percentage of clinical experiences that were cancelled, some data represent participants' opinions (e.g., "What is the quality of education now compared with before the pandemic?"). Data from opinions are subjective and therefore may not be reliable. Additionally, the participants had to recall previous situations and may not have accurately remembered what occurred during the pandemic.

CONCLUSION

This survey found nursing education suffered immensely during the pandemic. Oftentimes, students were not able to care for patients directly, and their didactic classes were 100% remote. When students were able to have clinical experiences in health care settings, the students or their nursing program often had to provide PPE. Faculty and students reported difficulties in adjusting so quickly to alternative teaching strategies. There was increased student and faculty attrition during the pandemic, particularly during 2021. Students' NCLEX pass rates fell significantly, and nursing students who were educated during the pandemic reported feeling incompetent and scared. One valuable outcome of the COVID-19 pandemic might be for nursing to have a national forum where nurse leaders can discuss what happened during the pandemic and deliberate on how they can move forward more successfully in the future during similar crisis situations.

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TABLE A

Alternative Teaching Methods During the COVID-19 Pandemic

- Working across disciplines to obtain funding for PPE and required testing in long-term care sites
- Conducting reverse case studies; students were given patient information, and they devised the clinical presentation and care involved, which then was discussed in class
- Front-loading clinical experiences or didactic content depending on the positivity rates
- Using alternative clinical sites, such as calls to older adults in isolation who might be suffering from depression or lack of support
- Participating in telehealth experiences with faculty or APRNs
- Taking fewer students to clinical experiences with shorter hours
- Rotating students through several types of clinical rotations
- Participating in reflective journaling
- Holding skills tests by video
- Developing a skills boot camp

Note. COVID = coronavirus disease 2019; PPE = personal protective equipment; APRN = advanced practice nurse.

Alaska Board of Nursing

Public Comment Period

Alaska Board of Nursing

Agenda Item #6

Implementation of HB 237, Regulation update

Draft proposal RE: Implementation of HB 237- Adding the section (g) and (h) that is **BOLD**

12 AAC 44.320 Temporary Permits

(a) Repealed 7/28/95.
(b) The board may issue a temporary nonrenewable permit to an applicant for license by endorsement who submits

(1) a completed application as required in 12 AAC 44.305(a)(1)(A) – (G);

(2) the application fee, the fingerprint processing fee, the license by endorsement fee, and the temporary permit fee specified in 12 AAC 02.280;

(3) verification of a current license issued by another licensing jurisdiction to practice as a registered nurse or a practical nurse; the license must be in good standing and unencumbered; and

(4) the applicant's fingerprint information described in 12 AAC 44.319(a).

(c) Repealed 7/28/95.
(d) A temporary nonrenewable permit issued under (b) of this section is valid for six months from the date of issuance or until a permanent license is issued or denied, whichever occurs first.
(e) The board may issue a temporary nonrenewable permit to an applicant by examination who

(1) applies for licensure by examination on a form provided by the department in accordance with 12 AAC 44.290;

(2) has not (A) failed the NCLEX examination; and -23- (B) failed to appear and take the NCLEX examination for which the applicant was registered;

(3) pays the application fee, the fingerprint processing fee, the license by examination fee, and the temporary permit fee specified in 12 AAC 02.280;

(4) submits a certified or notarized nursing program verification form directly from the school of nursing attended verifying successful completion of the nursing program;

(5) submits the applicant's fingerprint information described in 12 AAC 44.319(a); and

(6) submits an evaluation of the applicant's nursing education by the Commission on Graduates of Foreign Nursing Schools Credentials Evaluation Service, with a full education, course-by-course report if the applicant is a practical nurse applicant or registered nurse applicant who graduated from a school of nursing outside of the United States or Canada, except Quebec, Canada.

(f) The temporary nonrenewable permit issued under (e) of this section is valid for six months or until the results of the NCLEX are made available to the board and notification of the results is received by the temporary permit holder whichever occurs first.

(g) The board may issue a temporary permit to an applicant for reinstatement who meets the requirements of

(1) 12 AAC 44.317(a)(1)-(3) and (a)(5) if the licensed has been lapsed or retired less than one year; or

(2) 12 AAC 44.317(b)(1)-(4) if the license has been lapsed or retired one year or more.

(h) A temporary nonrenewable permit issued under (g) of this section is valid for six months from the date of issuance or until the lapsed or retired license reinstatement is issued or denied, whichever occurs first. Only one temporary nonrenewable permit may be issued during each period a license is lapsed or retired.

Authority: AS 08.68.100 AS 08.68.200 AS 08.68.210 AS 08.68.170

Alaska Board of Nursing

Agenda Item #7

Delegation Regulation Change Request

To the Alaska State Board of Nursing and all present stakeholders:

In May, I presented a list of concerns regarding the contents of the Alaska Nursing Practice act specifically related to Nursing Delegation. The Board voted unanimously to establish a working committee of stakeholders to discuss the matters I presented and to provide a list of recommendations. In June, a committee meeting was scheduled then canceled due to difficulty securing enough stakeholders. While this committee is still set to meet once enough nursing professionals have been found, there is no set date for a future meeting. Most of the concerns I brought to the board are not particularly time sensitive and can be managed when time allows, however one of the topics I covered does require a more expedient resolution: the prohibition against delegating PRN Controlled substances.

At our last meeting I introduced an individual I called “James” who has experienced profound seizure activity all of his life. He was prescribed Nayzilam (Intranasal Midazolam, a Schedule IV controlled substance) to be administered as an intervention for seizures lasting more than 5 minutes or for cluster seizures. Since my last presentation, James had to be moved to a higher level of care for a health situation not directly related to his seizure disorder. He is recovering well and staff from our agency are visiting with him daily to help him cope with being in a different care setting. If James is able to reach his previous baseline, the agency will need to determine whether or not we can provide safe and appropriate care for him in the home he has lived in for years. There are many decision points that will have to be considered but his access to appropriate rescue medications for his seizure disorder will be a major factor.

James was the original impetus for me reviewing state rules relating to delegation and is the main reason for me to continue to push for change. To that end, I am bringing the topic of Delegation of PRN controlled substances to the board again. The other matters I presented previously can wait until we have a quorum of stakeholders to discuss but this one has the potential to be very time sensitive for at least one life-long Alaskan.

I am asking the board to consider making this change in a timely manner rather than waiting until a committee can be formed:

> ***12 AAC 44.965(e)*** *The administration of PRN medication~~, other than controlled substances,~~ may be delegated under this section if a nurse is not available on-site. Before the administration of PRN medications may be delegated, the nurse shall first assess the patient to determine whether on-site patient assessment will be required before administration of each dose of PRN medication. The written instructions provided to the person under 12 AAC 44.950(a)(7) must meet the requirements of (d) of this section, and must also include*
>
> > *(1) when to administer the PRN medication to the patient;*
> > *(2) the procedure to follow for the administration of the PRN medication, including dosage amount, frequency, and duration; and*
> > *(3) the circumstances under which the person should contact the delegating nurse*

Discussion:
It is likely that this rule was originally meant to provide protections to patients, UAPs and Nurses in a time when medication regulations were not as secure. We have seen the results of the Opioid Epidemic and are aware of the risks for misuse/abuse of controlled substances. Times change however and as new medications come to the market and our understanding of old medications change, we have to acknowledge when a regulation becomes more of a barrier than a protection. This rule does not stop UAPs from having to handle and record controlled substance counts, and in cases with work-arounds (schools, prisons, residential habilitation providers) it doesn't even stop them from administering the medications, it only removes the opportunity for meaningful oversight by a licensed nursing professional.

The state of Alaska has made it clear in rules and in support documents that it is up to each nurse to determine whether or not it is appropriate to delegate a task as long as it is not prohibited by the rules. To determine this, the rules lay out extremely clear requirements to safeguard all involved (See: 12 AAC 44.950 - 965). I believe that these rules provide sufficient guidance for a reasonable Nursing Professional to determine whether or not they may safely delegate a prn controlled substance in a given situation.

I imagine that this rule may have persisted out of a concern for the safety of patients and workers but I feel this concern is not supported by current evidence. I completed a review of Nursing practice acts from across the United States to determine whether other states allowed this delegation and found that there are only 16 US states that do not allow the delegation of PRN controlled medications. Of those states, 12 prohibit nursing delegation of medication under ANY circumstances.

Allow Med Delegation	**Don't Allow Med Delegation**		
Alaska	**Arizona**	**California**	**Connecticut**
Arkansas	**Delaware**	**Massachusetts**	**Mississippi**
Florida	**New York**	**Pennsylvania**	**Oklahoma**
Ohio	**South Carolina**	**Tennessee**	**Virginia**

What this means is that of the 38 states that allow the delegation of medication administration, 34 have been allowing nurses to delegate the administration of PRN controlled substances for years without major incident. Interestingly, as I presented at our last meeting, there are UAPs in the state of Alaska right now who are administering prn controlled substances to school children without major incident. They are just doing it without a nursing delegation and without the same rules, oversight and accountability of someone who has been delegated by a nurse. Because of this, I strongly believe that making this change will improve patient safety and quality of life rather than reduce it. For James and others like him, this decision has the potential to affect his and living situation significantly.

Thank you for your time and consideration.
Jason Sanders, RN

4. Nurses may not delegate the administration of PRN Controlled Substances

Proposed solution:

Remove the words “other than controlled substances” from 12 AAC 44.965(e).

Add the following items to the medication training course requirements required by the BON per 12 AAC 44.965(c):

- Oversedation and Falls
- Food to Drug Interactions (Specifically Alcohol)
- Addiction vs. Tolerance vs. Dependence
- Narcan

Alaska Board of Nursing

Break

Alaska Board of Nursing

Agenda Item #8

APU Nursing Program Update

ALASKA PACIFIC UNIVERSITY

Alaska Pacific University Nursing Programs

Alaska Board of Nursing
August 2024 Update

Staci Seagle MSN-Ed, RN, CGCP
Lisa Moore MSN, RNC-MNN

APU LPN PROGRAM

Staci L. Seagle, MSN-Ed, RN, CGCP

End of Program Student Learning Outcomes (EPSLOs)

Key Strategic Program Measure	Target Measure Description/Definition	Target Measure Success		
		Red: Not Met	Yellow: Partially Met	Green: Measure Met
LPN Program Completion Rate	At least 60% of students will complete the program In two semesters (100% of program length)			Completion rate 86%
NCLEX-PN Licensure Exam Pass Rate	At least 80% of all first time test-takers during the calendar year will pass the NCLEX –PN.			100% first-time pass rate
Graduate Job Placement	ELA: 80% of graduates will obtain employment as an LPN within one year of graduation			88%

End of Program Student Learning Outcomes (EPSLOs)

Key Strategic Program Measure	Target Measure Description/Definition	Target Measure Success		
		Red: Not Met	Yellow: Partially Met	Green: Measure Met
EPSLO #1: Explain various ways of knowing and healing from Alaska Indigenous populations in the delivery of holistic nursing care across the lifespan in a variety of settings.	80% of the students will achieve 70% or higher on the ATI end-of-program Comprehensive Predictor Exam in the following subscale QSEN Category: Patient Centered Care (PCC) and NLN category Human Flourishing (HF).			QSEN PCC 16/18 (89%) NLN HF 17/18 (94%)
	80% of students in the cohort will obtain a score of at least satisfactory on the Clinical Evaluation Tool (CET) in sections related to QSEN Competencies Patient Centered Care and Evidence-Based Practice (EBP) at the completion of Practical Nursing Clinical Concentration.			100%
	80% of students will achieve a score of at least satisfactory on CET post clinical experience in the category Professional Behaviors.			100%
	80% of the students will respond on the end-of-program student survey with at least the answer *improved* in the subcategory of *Developing an individualized plan of care with a focus on cultural safety and utilizing the nursing process and patient centered care.*			100%

End of Program Student Learning Outcomes (EPSLOs), cont.

Key Strategic Program Measure	Target Measure Description/Definition	Target Measure Success		
		Red: Not Met	Yellow: Partially Met	Green: Measure Met
EPSLO #2: Understand culturally safe communication within the context of a collaborative team approach to improve client safety and quality improvement.	80% of the students will achieve 70% or higher on the ATI end-of-program Comprehensive Predictor Exam in the following subscale QSEN Category: Teamwork and Collaboration (TC) and NLN category Professional Identity (PI).			QSEN TC 18/18 (100%) NLN PI 18/18 (100%)
	80% of students will achieve a score of at least 4 in the communication category on the Interprofessional Simulation Performance Rubric.			100%
	80% of students will achieve a score of at least satisfactory on CET post clinical experience in the category Teamwork and Collaboration.			100%
	80% of the students will respond on the end-of-program student survey with the answer of at least *improved* in the subcategory of *Interprofessional communication, delegation and teamwork and Interprofessional practice and teamwork.*			100%
	80% of students will answer at least *somewhat agree* to questions 12-13 on the Interprofessional Simulation Student Evaluation Survey			100%

End of Program Student Learning Outcomes (EPSLOs), cont.

Key Strategic Program Measure	Target Measure Description/Definition	Target Measure Success		
		Red: Not Met	Yellow: Partially Met	Green: Measure Met
EPSLO #3: Provide culturally safe focused individual assessments through the integration of foundational concepts, critical thinking, clinical reasoning, evidence-based practice, and the use of the nursing process.	80% of the students will achieve 70% or higher on the ATI end-of-program Comprehensive Predictor Exam in the following subscale QSEN Category: Patient Centered Care (PCC), Informatics (IN) and the NLN category Nursing Judgement (NJ).		QSEN IN 10/18 (56%)	QSEN PCC 16/18 (89%) NLN NJ 16/18 (89%)
	80% of students will achieve a score of at least 4 in all categories on the Interprofessional Simulation Performance Rubric.			94%
	80% of students will achieve a score of at least satisfactory on CET post clinical experience in the category Patient Centered Care.			100%
	80% of the students will on the end-of-program student survey with the answer of at least *improved* in the subcategories of *Prioritization and efficiency related to taking care of a group of patients in a variety of settings and Safety.*			100%
	80% of students will answer at least *somewhat agree* to questions 5-11 on the Interprofessional Simulation Student Evaluation Survey			100%

End of Program Student Learning Outcomes (EPSLOs), cont.

Key Strategic Program Measure	Target Measure Description/Definition	Target Measure Success		
		Red: Not Met	Yellow: Partially Met	Green: Measure Met
EPSLO #4: Develop evidence-based nursing practice to improve client outcomes.	80% of the students will achieve 70% or higher on the ATI end-of-program Comprehensive Predictor Exam in the following subscale QSEN Category: Evidence Based Practice (EBP) and the NLN category Spirit of Inquiry (SI).		NLN SI 5/18 (27%)	QSEN EBP 15/18 (83%)
	80% of students will achieve a score of at least 4 in all categories on the Interprofessional Simulation Performance Rubric.			100%
	80% of students will achieve at least a satisfactory on the CET section: Evidenced Based Practice			100%
	80% of the students will respond to on the end of the program student survey with the answer of at least *improved* in the subcategories of the use of evidence when implementing therapeutic nursing interventions in a variety of settings and Informatics.			100%
	80% of students will answer at least *somewhat agree* to questions 12-13 on the Interprofessional Simulation Student Evaluation Survey			100%

End of Program Student Learning Outcomes (EPSLOs), cont.

Key Strategic Program Measure	Target Measure Description/Definition	Target Measure Success		
		Red: Not Met	Yellow: Partially Met	Green: Measure Met
EPSLO #5: Discuss nursing advocacy through adherence to professionalism, ethical and legal frameworks, and patient-centered care	80% of students will achieve 70% or higher on the ATI end-of-program Comprehensive Predictor Exam in the following subscale QSEN Category: Quality Improvement (QI) & Patient Centered Care (PCC) and the NLN category Nursing Judgement (NJ).		QSEN QI 10/18 (56%)	QSEN PCC 16/18 (89%) NLN NJ 16/18 (89%)
	80% of students in the cohort will obtain a score of at least satisfactory on the Clinical Evaluation Tool in sections related to QSEN Competencies Patient Centered Care at the completion of Practical Nursing Clinical Concentration			100%
	80% of students will achieve at least a satisfactory on the CET section: Safety and Quality Improvement			100%
	80% of students will, on the end of the program student survey, respond with the answer of at least *improved* in the subcategories of *Utilization of professional legal and ethical standards and Quality Improvement.*			100%

Bethel - First Cohort
Graduated December 2022

Bethel - Second Cohort
Graduated April 2023

Fairbanks - First Cohort
Graduated December 2023

Fairbanks - Second Cohort
Graduated April 2024

Juneau - First Cohort Graduated April 2024

MatSu - First Cohort Graduated April 2024

APU ADN PROGRAM

- Lisa D. Moore, MSN, RNC-MNN

End of Program Student Learning Outcomes (EPSLOs)

Key Strategic Program Measure	Target Measure Description/Definition	Target Measure Success		
		Red: Not Met	Yellow: Partially Met	Green: Measure Met
ADN Program Completion Rate	At least 65% of students will complete the program in three semesters (100% of program length)			Completion rate 92%
NCLEX-RN Licensure Exam Pass Rate	At least 80% of all first time test-takers during the calendar year will pass the NCLEX–RN.			100% first-time pass rate
Graduate Job Placement	ELA: 90% of graduates will obtain employment as an RN within one year of graduation			100%

End of Program Student Learning Outcomes (EPSLOs)

Key Strategic Program Measure	Target Measure Description/Definition	Target Measure Success		
		Red: Not Met	Yellow: Partially Met	Green: Measure Met
EPSLO #1: Apply new knowledge representing the aspirations and collective wisdom across multiple populations, from individuals and families to Alaskan Indigenous people in the delivery of holistic nursing care across the lifespan.	The cohort average will be 65% or higher on the ATI end-of-program comprehensive predictor exam in the following QSEN Competency categories: EBP and Patient Centered Care			QSEN EBP: 71%, PCC: 86.5%
	90% of students in the cohort will obtain a score of satisfactory on the Clinical Evaluation Tool in sections related to QSEN Competencies EBP, Patient Centered Care at the completion of Med Surg II.			100%
	At least 90% of students taking the End-of-Program survey will agree that the program prepared them to meet EPSLO #1 (Rated at 3 or above on 5 point Likert scale)			100%

End of Program Student Learning Outcomes (EPSLOs)

Key Strategic Program Measure	Target Measure Description/Definition	Target Measure Success		
		Red: Not Met	Yellow: Partially Met	Green: Measure Met
EPSLO #2: Demonstrate culturally safe communication within the context of a collaborative team approach to improve client safety and quality improvement initiatives in a variety of settings.	The cohort average will be 65% or higher on the ATI end-of-program comprehensive predictor exam in the following QSEN competency categories: Safety, Quality Improvement, Teamwork and Collaboration, Patient Centered Care			QSEN Safety: 77.2%, QI: 75%, TC: 66.7%, PCC: 86.5%
	90% of students in the cohort will obtain a score of satisfactory on the Clinical Evaluation Tool in sections related to QSEN Competencies: safety, Quality Improvement and Teamwork and Collaboration at the completion of Med Surg II.			100%
	At least 90% of students taking the End-of-Program survey will agree that the program prepared them to meet EPSLO #2 (Rated at 3 or above on 5 point Likert scale)			100%

End of Program Student Learning Outcomes (EPSLOs)

Key Strategic Program Measure	Target Measure Description/Definition	Target Measure Success		
		Red: Not Met	Yellow: Partially Met	Green: Measure Met
EPSLO #3: Conduct culturally safe comprehensive assessments of individuals and families through the integration of foundational concepts, critical thinking, clinical reasoning, evidence-based practice, and the use of the nursing process.	The cohort average will be 65% or higher on the ATI end-of-program comprehensive predictor exam in the following QSEN Competency categories: EBP, Patient Centered Care, and Informatics			QSEN EBP: 71%, PCC: 86.5%, I: 100%
	90% of students in the cohort will obtain a score of satisfactory on the Clinical Evaluation Tool in sections related to QSEN Competencies EBP, Patient Centered Care and Informatics at the completion of Med Surg II.			94%
	At least 90% of students taking the End-of-Program survey will agree that the program prepared them to meet EPSLO #3 (Rated at 3 or above on 5 point Likert scale)			

End of Program Student Learning Outcomes (EPSLOs)

Key Strategic Program Measure	Target Measure Description/Definition	Target Measure Success		
		Red: Not Met	Yellow: Partially Met	Green: Measure Met
EPSLO #4: Apply evidence-based nursing practice to improve client outcomes across healthcare delivery systems.	The cohort average will be 65% or higher on the ATI end-of-program comprehensive predictor exam in the following QSEN Competency categories: EBP			QSEN EBP: 100%
	90% of students in the cohort will obtain a score of satisfactory on the Clinical Evaluation Tool in sections related to QSEN Competencies EBP at the completion of Med Surg II.			100%
	At least 90% of students taking the End-of-Program survey will agree that the program prepared them to meet EPSLO #4 (Rated at 3 or above on 5 point Likert scale)			100%

End of Program Student Learning Outcomes (EPSLOs)

Key Strategic Program Measure	Target Measure Description/Definition	Target Measure Success		
		Red: Not Met	Yellow: Partially Met	Green: Measure Met
EPSLO #5: Discuss nursing advocacy through adherence to professionalism, ethical and legal frameworks, and patient-centered care as part of individual nursing practice.	The cohort average will be 65% or higher on the ATI end-of-program comprehensive predictor exam in the following QSEN Competency categories: EBP and Patient Centered Care			QSEN EBP: 71%, PCC: 86.5%
	90% of students in the cohort will obtain a score of satisfactory on the Clinical Evaluation Tool in sections related to QSEN Competencies EBP and Patient Centered Care at the completion of Med Surg II.			100%
	At least 90% of students taking the End-of-Program survey will agree that the program prepared them to meet EPSLO #5 (Rated at 3 or above on 5 point Likert scale)			100%

Anchorage ADN – Third Cohort Graduated December 2023

Anchorage ADN – Fourth Cohort Graduating December 2024

Alaska Board of Nursing

Agenda Item #9

Development of Alaska Nursing Workforce Center

ALASKA HOSPITAL & HEALTHCARE ASSOCIATION

Why a State Nursing Workforce Center?

Nursing workforce centers are found in 40 U.S. states and work to address nursing shortages, support nursing education, protect the well-being of nurses, and other matters affecting the nursing workforce in order to meet the state's health care needs. These Centers engage in a variety of activities using evidence-based policy and strategy. Activities include data collection, analysis on the supply and demand for nurses, and the publication of reports and sharing of information on the nursing workforce. Nursing workforce centers also provide programs for nursing professional development, leadership engagement, sharing best practices, transition to practice support, and more.

Each state nursing workforce center works with state partners to ensure that the state has a well supported, robust, and sustainable workforce. Organizational structures, funding sources, and entity names vary; the state nurse workforce entities are commonly referred to as "Centers."

Focus of the Centers

Study the unique characteristics of a state's nursing workforce

- Gather data on supply, demand and educational pipeline of nurses (24 states).
- Explore regional and workplace setting differences to inform solutions (Oregon).

Increase the number of new nurses

- Collect data and test solutions to nurse faculty shortages (California, Connecticut, Hawaii, Idaho, Indiana, Louisiana, New Jersey, New York, Washington, and Wisconsin).
- Address inefficiencies in clinical experience scheduling and advocate for new clinical sites (California, Colorado, Connecticut, Hawaii, Idaho, Indiana, Maryland, Mississippi, New Jersey, Washington).
- Predict the need to increase nurse production which resulted in funding to more than double the students enrolled in nursing schools (North Dakota and Oregon).
- Coordinate scholarship programs (Colorado, Illinois, Indiana, New Jersey, New Mexico, New York, North Dakota, Pennsylvania, and Vermont).

Recruit nurses to the profession

- Create programs to increase interest and awareness of nursing to K-12 students (Arkansas, Colorado, Hawaii, Indiana, Mississippi, North Dakota, Washington).
- Build programs to diversify their nursing workforce including mentoring programs (Arkansas, California, Colorado, Connecticut, Illinois, Indiana, Louisiana, Michigan, Mississippi, New York, Pennsylvania, Washington, and Wisconsin).

Retain nurses in the workplace

- Ensure the well-being of the nursing workforce and improve workplace environment (California, Colorado, Hawaii, Idaho, Indiana, Maryland, Mississippi, New Jersey, North Dakota, Pennsylvania, South Dakota, Washington, and Wisconsin).
- Create training opportunities for nurses at all levels and in all settings to advance leadership and professional practice (Arkansas, California, Colorado, Connecticut, Hawaii, Illinois, Indiana, Louisiana, Maryland, Mississippi, Montana, New Mexico, North Dakota, Pennsylvania, Washington, and Wisconsin).
- Promote continual learning and academic progression for nurses (Arkansas, California, Colorado, Connecticut, Hawaii, Indiana, Maryland, Pennsylvania, and Washington).

Advocate for changes to improve the stability of a state's nursing workforce

- Provide critical employer- education connections through statewide planning and implementation of programs (Colorado, Connecticut, Indiana, North Dakota)
- Leverage connections through state nursing stakeholders to pass critical legislation such as Nurse Licensure Compacts and respond to the future needs of the nursing workforce needs following the COVID pandemic (Louisiana, North Dakota, Oregon, Louisiana, West Virginia, Arkansas).

Funding Strategies

Each Nursing Center is funded differently. There is no federal funding specifically for centers, although many Centers apply for and receive grant funding. Some of the funding strategies used by Centers include:

- Nurse license fee assessment (amount varies, average of $20) upon initial licensure and license renewal
- Federal or state grant funding or state general funds.
- Contributions of cash or in kind support from Center partners.

Incorporation

Across the nation, State Nursing Workforce Centers are established in a variety of ways. All of the Centers support the advancement of new and existing nurse workforce initiatives by sharing best practices in nursing workforce research, workforce planning, workforce development, and the formulation of workforce policy.

Types of establishment*	States
Centers established in state law	HI, FL, WA, OR, WI
501C3	WA, CA, CO, IN*, OR, CT, WI, ND, MS Included membership
BON	AL, IL, LA, IA, KY, SD
Hospital Association	MT, MS

Universities	FL, HI, MN, TN, NJ, GA, MA
State Government	UT, VA
AHEC	SC, VT
Professional Association	AZ, NM, ID, ND
Action Coalition	PA, NV

*One state may fall under multiple categories

Alaska Progress Towards Forming a Nursing Workforce Center

The Alaska Hospital and Healthcare Association (AHHA) has been convening potential stakeholders to discuss forming an Alaska Nursing Workforce Center since March 2024. ten people from Alaska, representing a variety of these stakeholders, atttended the National Forum of Nursing Workforce Centers annual conference in June 2024 to learn more about the work Centers are doing across the country.

Following the conference, meetings have been held to discuss the information gathered and the possibility of forming an Alaska Center. At a meeting on July 18, 2024, key partners made the decision to move forward with developing the concept of a Nursing Workforce Center in Alaska. AHHA has funding through June 2025 to convene partners and provide administrative support to develop the goals and desired outcomes of the nursing workforce center, secure consultant support if desired, and explore funding options.

The following stakeholders/partners have been engaged in the discussions so far. Additional partners will be welcome to join the process.

Education/Academic Nurse Education Programs
Alaska Pacific University
AHEC/Center for Rural Health
UAA School of Nursing
Charter College
University of Providence

Employers/Healthcare Industry
Alaska Native Tribal Health Consortium
Bartlett Regional Hospital
Foundation Health Partners
Providence Alaska Medical Center
Alaska Regional Hospital
Southeast Alaska Regional Health Consortium
South Peninsula Hospital

Associations/Other
Alaska Hospital and Healthcare Association
Alaska Nurses Association
APRN Alliance
Mat-Su Health Foundation
School Nurses Associaiton

Government Entities
Alaska Board of Nursing
State of Alaska Division of Public Health, School Nursing

Alaska Board of Nursing

Agenda Item #10

Request to the Board

Alaska Board of Nursing

Agenda Item #11

PDMP Update

Alaska Board of Nursing

Adjourned for Lunch

Alaska Board of Nursing

Agenda Item #12

ACPE-Distance Education and Institutional Authorization

Welcome to Institutional Authorization

A Discussion of Authorization Processes with Distance Education & Supervised Field Experiences

Tyler Eggen, Institutional Authorization Program Coordinator

Today's Topics

- What is Institutional Authorization?
- Institutional Authorization Roles & Responsibilities
- Institutional and Consumer Complaints
- Online Distance Education Regulations & SARA
- Supervised Field Experiences

What is Institutional Authorization (IA)?

- **An educational credential is valid if it is awarded by an entity with legal credential-granting authority.**
  - In Alaska, the Commission administers the statutes and regulations concerning postsecondary education.
- **States use various terms such as licensure, authorization, approval, etc. The term "Authorization" is commonly used to encompass the formal state conferral of credential-granting authority.**
- **Authorization is separate from accreditation.**

IA Roles & Responsibilities

- Compliance with Statutes & Regulations-Standards
- Consumer Protections
- Student Records

Types of Authorization

- **Authorization**
  - Degree Granting Institutions (non-UA)
  - Career & Technical Institutions
- **Exemption**
  - Statute (K-12, Recreational)
  - Regulatory (Short Course, At Cost, OTJ Training)
  - Special Action via Commission Action (UA, AVTEC)

Online & Distance Education Exemptions

- **Regulatory Exemption without triggering physical presence**
  - "Physical presence" means the presence within the state of paid staff or faculty, or a facility or address; in this paragraph, "faculty" and "staff' does not include site supervisors or mentors for local internships or practica, or adjunct personnel…
- **State Authorization Reciprocity Agreement (SARA)**

SARA Standards

- The institution must be located in a member state & recognized by proper authority
- Degree-granting, associate degrees & higher
- Institutionally accredited
- Meet financial responsibility requirements
- Must follow SARA policy as established by the states and regional compacts.

SARA Institutions

- Over 2,300 participate in SARA representing 49 states and several U S territories.
- Six institutions in Alaska participate.
- 624 SARA institutions enrolled Alaska students as of Fall 2022.
- If an out-of-state SARA institution violates the SARA policy regarding physical presence, they must meet the state's current non-SARA requirements.

Professional Licensing Programs

- As of July 1, 2024, colleges and universities that receive federal student aid must publicly state whether their programs lead to licensure in the state where the student resides.
- If the distance education program does not lead to the licensure where the student lives, the student must sign a waiver acknowledging they are aware, or the student cannot enroll.

Supervised Field Experiences

- **May also be called clinical placements, internship, student teaching or practicums**
- **Structure of SFE's:**
  - The institution has articulation agreements with SFE site provider for opportunities, or
  - Students seek out opportunities locally and work with institutional staff or faculty to ensure the experience counts for course credit.

Supervised Field Experiences

- Rule of 10 requirements.
- Host state boards or agencies responsible for professional licensing in a field requiring licensure or certification for practice, may apply their requirements to SARA participating institutions.

Two States with Board Oversight

QUESTIONS?

Resources

- ACPE Institutional Authorization
- National Council for State Authorization Reciprocity Agreement
- Washington State Board of Nursing
- Oregon State Board of Nursing

Alaska Board of Nursing

Agenda Item #13

Discussion: Proposed Regulation Changes & Updates. Setting up a work group.

Topic for this section:

1. Board to review presentation information from May meeting. Due to schedules and timing, a workgroup has yet to meet on the proposed suggestions.
2. Delegation Regulations: See presentation, request from earlier in the meeting (agenda #7), and additional proposal noted in this section of the agenda. Current delegation regulations are available for review.
3. Review terminology- Complex Nursing Skills and proposed solution (Slides 5 & 6)
4. Medication Administration Course Requirements: Scheduled agenda item for November Board meeting for full review.

Presentation to the Alaska State Board of Nursing: Delegations

Jason Sanders, RN BSN
May, 2024

As we prepare to Join the Nursing Licensure Compact (NLC)

- Review Alaska State Nursing Practice Act (NPA)
- Review Board of Nursing (BON) Advisory Opinions
- Review BON Guidance Documents

Do the rules meet the safety and service needs of Alaskans?

Are the rules up to date with current information?

Do the rules reflect the current face of medical and communication technology?

Are the rules clear, are there contradictions?

The Scope of this Presentation

- NPA: Nursing Delegations
  - 12 AAC 44.950. STANDARDS FOR DELEGATION OF NURSING DUTIES TO OTHER PERSONS
  - 12 AAC 44.955. DELEGATION OF ROUTINE NURSING DUTIES
  - 12 AAC 44.960. DELEGATION OF SPECIALIZED NURSING DUTIES
  - 12 AAC 44.965. DELEGATION OF THE ADMINISTRATION OF MEDICATION
  - 12 AAC 44.966. DELEGATION OF THE ADMINISTRATION OF INJECTABLE MEDICATION
  - 12 AAC 44.970. NURSING DUTIES THAT MAY NOT BE DELEGATED.
  - 12 AAC 44.975. EXCLUSIONS
- Advisory opinions: Medication
- BON Medication Administration training course requirements

1. “Complex Nursing Skills”

12 AAC 44.950(a)(6) performance of the delegated nursing duty would not require the person to whom it was delegated to exercise professional nursing judgment or knowledge or complex nursing skills;

and

12 AAC 44.955(a)(3) do not require the exercise of complex nursing skills;

and

12 AAC 44.970 Nursing duties that require the exercise of professional nursing knowledge or judgment or complex nursing skills may not be delegated. Nursing duties that may not be delegated include […]

1. “Complex Nursing Skills”

Concerns: Ambiguous Terminology

- “Complex Nursing Skills” not Defined in NPA or other Nursing Guidance from national sources
  - Basic and Specialized nursing skills/tasks ARE defined in NPA
- From 2007 to 2023, the term was used to justify an advisory opinion prohibiting administration of scheduled controlled substances
  - Advisory opinion contradicted by Board approval of Medication Administration A Guide for Training Unlicensed School Staff in 2013 and 2018 and 2021
  - Archived/retired in November of 2023

1. “Complex Nursing Skills” Solution

Proposed solution: Remove instances of “complex nursing skills” from the NPA rather than attempting to define it.

Reasoning:

- Are complex because of “nursing knowledge and judgment” which are already required
  - Example: You can teach someone the physical *skill* of driving in one afternoon but teaching the specialized *knowledge and judgment* for driving requires additional training and experience like driver’s education
- Difficult to define due to lack of consistent use of the term in Nursing Literature
  - Definition could reduce flexibility of NPA and lead to further contradictions in rule

2. Specific Settings for delegation of Medication Administration

12 AAC 44.965(b) Administration of medication may be delegated only to a

(1) “home and community-based services provider” as defined in 7 AAC 43.1110(8);

(2) “residential supported living services provider” as defined in 7 AAC 43.1110(15);

(3) school setting provider; in this paragraph, “school setting provider” means a person who is employed at a school that provides educational services to students age 21 or younger; or

(4) certified nurse aide employed by a long-term care facility licensed and certified by the Health Facilities Licensing and Certification section of the Department of Health.

and

Advisory opinion from February, 2024 1. APRNs, RNs, and LPN’s, may delegate the administration of medication to Certified Medical Assistant’s (CMA) if the CMA has completed the training course in administration of medication approved by the board and all requirements of delegation outlined in regulation 12 AAC 44.965 are met.

2. Specific Settings for delegation of Medication Administration

Concerns: Not Current, Redundant/Contradictory, Limits access to care

- Item (1) and (2) refer to 7 AAC 43.1110 to define the specific settings where nurses can delegate
  - 7 AAC 43.1110 was repealed in February of 2010
- 965(a): “The administration of medication is a specialized nursing task that may be delegated under the standards set out in 12 AAC 44.950”
  - 950(a): a nurse “may delegate the performance of nursing duties to other persons, including unlicensed assistive personnel, if the following conditions are met: […]”
  - AS 08.68.850 (12) "unlicensed assistive personnel" means persons, such as orderlies, assistants, attendants, technicians, members of a nursing client's immediate family, or the guardian of a nursing client, who are not licensed to practice practical nursing, registered nursing, medicine, or any other health occupation that requires a license in this state.

2. Specific Settings for delegation of Medication Administration

Concerns (cont…): Limits access to care

- The rule is exclusionary and removes flexibility for changes or new circumstances
  - Clearly illustrated by the Advisory opinion adding CMA's
- Omits some settings where medication administration might need to be delegated including Correctional facilities

2. Specific Settings for delegation of Medication Administration

Proposed solution: Remove section **12 AAC 44.965(b)** entirely, including any advisory opinions that would be added to section **(b)**.

Reasoning:

- **965(b)(1)** and **965(b)(2)** have been out of date since 2010 and may be difficult to re-define
- **7 AAC 44.950(a) (1-7)** already allows nursing delegation to UAPs and provides strong guidance regarding who can be delegated and in which situations
- Fails to anticipate the evolution of nursing practice and settings where care is provided

3. Case Study: “James”

3. Case Study: “James”

Date: 03/15/2024
RE: [redacted] DOB: [redacted] PT ID [redacted]

To Whom it May Concern,

I saw [redacted] in the office today. He has a diagnosis of intractable epilepsy. He would benefit from Nayzilam nasal spray as a rescue medication t0 help prevent seizure clusters and to treat prolonged seizures. I highly recommend having the rescue medication to help prevent complications from seizures.

Please reach out with any questions.

Sincerely,

Aka Mohamed Tom Bakhit

Electronically Signed by: MOHAMED B. TOM, MD

4. Nurses may not delegate the administration of PRN Controlled Substances

7 AAC 44.965(e) The administration of PRN medication, other than controlled substances, may be delegated under this section if a nurse is not available on-site. Before the administration of PRN medications may be delegated, the nurse shall first assess the patient to determine whether on-site patient assessment will be required before administration of each dose of PRN medication. The written instructions provided to the person under 12 AAC 44.950(a)(7) must meet the requirements of (d) of this section, and must also include

(1) when to administer the PRN medication to the patient;

(2) the procedure to follow for the administration of the PRN medication, including dosage amount, frequency, and duration; and

(3) the circumstances under which the person should contact the delegating nurse

4. Nurses may not delegate the administration of PRN Controlled Substances

Concerns: Limits access to care, Poorly regulated workarounds

- Removes the ability for a licensed nurse to delegate the administration of a controlled PRN medication under any circumstance, regardless of circumstances, leading to delayed or denied access due to regulations
  - “James” is currently denied access to a neurologist prescribed rescue medication in his home
  - School Children, Individuals with developmental disabilities, state prisoners, disabled elderly and home hospice patients may also be affected

- Work Arounds have been created in some setting to avoid limiting care
  - Home and Community Based Waiver services (7 AAC 130.227) and Correctional Facilities (22 AAC 05.120) have workarounds with little to no oversight in their regulations
  - Schools have a workaround with some nursing oversight that was reviewed and approved by the BON in 2012

4. Nurses may not delegate the administration of PRN Controlled Substances

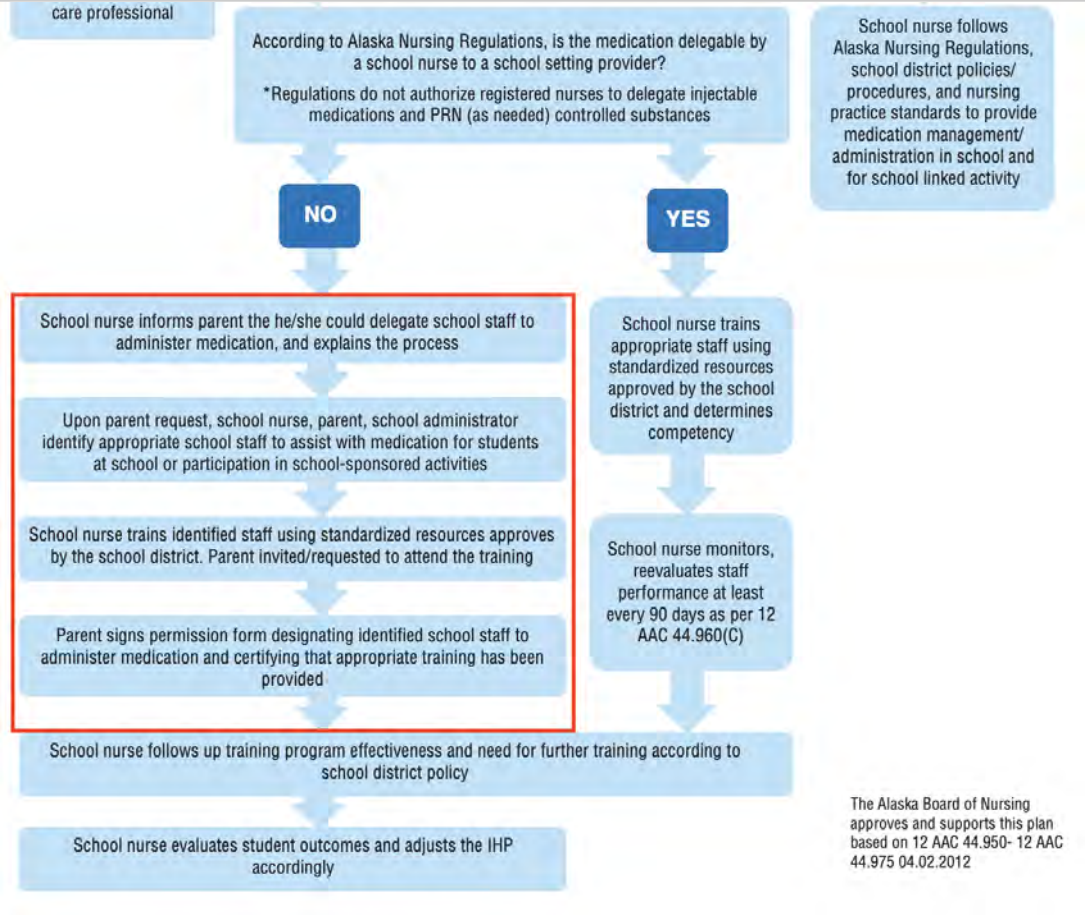
Title 22: Department of corrections

Chapter 05: Adult Facilities

22 AAC 05.120(d)

“Facility health care personnel shall supervise the prescription and administration of medication. The superintendent may designate appropriate staff members to assist facility health care personnel. The superintendent of each facility shall devise procedures to prevent access by prisoners to pharmaceuticals and medical records. Only correctional officers who have graduated from a training program for the identification and administration of medication may administer prescription medication when health care staff are not on duty.”

4. Nurses may not delegate the administration of PRN Controlled Substances



4. Nurses may not delegate the administration of PRN Controlled Substances

Proposed solution:

Remove the words “other than controlled substances” from 12 AAC 44.965(e).

Add the following items to the medication training course requirements required by the BON per 12 AAC 44.965(c):

- Oversedation and Falls
- Food to Drug Interactions (Specifically Alcohol)
- Addiction vs. Tolerance vs. Dependence
- Narcan

4. Nurses may not delegate the administration of PRN Controlled Substances

Reasoning:

- Has forced workarounds in some settings (Schools, Prisons)
  - AND Limits access to care in settings without workarounds (Such as Assisted Living homes like James')

- Delegation regulations and guidelines provide sufficient safeguards for Controlled PRN administration
  - 950(a)(3): "patient's medical condition must be stable and predictable" for the nurse to delegate
  - 950(b): "either the original delegating nurse or the substitute nurse [to] remain readily available for consultation by the [delegee] either in person or by telecommunication,"
  - 965(e)(3): nurse must provide guidance for when a delegee must call a nurse before administering a PRN

5. Case Study: “DJ Smooth”

6. Registered nurses may not delegate any injectable medications under any circumstances

12 AAC 44.970. NURSING DUTIES THAT MAY NOT BE DELEGATED
(13) except as provided in 12 AAC 44.966, the administration of injectable medications;

AND

12 AAC 44.966. DELEGATION OF THE ADMINISTRATION OF INJECTABLE MEDICATION.
(a) The administration of injectable medication is a specialized nursing task that may be delegated under the standards set out in 12 AAC 44.950(a), (c), and (d) and this section.
(b) The administration of injectable medication may be delegated only by an advanced practice registered nurse to a certified medical assistant. The certified medical assistant may only perform the delegated duty in a private or public ambulatory care setting, and the advanced practice registered nurse must be immediately available on site when the certified medical assistant is administering injectable medication.
(c) Repealed 5/16/2018.
(d) To delegate to a certified medical assistant the administration of an injectable medication to a patient the written instructions provided to the certified medical assistant under 12 AAC 44.950(a)(7) must also include the information required in 12 AAC 44.965(d)(1) – (3).

6. Registered nurses may not delegate any injectable medications under any circumstances

(e) The delegating advanced practice registered nurse is responsible for ensuring that the certified medical assistant maintains a national certification and for reviewing a current criminal background check upon hire, to be reviewed at five-year intervals. If the certified medical assistant has been convicted of a crime that, under AS 08.68.270 and 12 AAC 44.705, is substantially related to the qualifications, functions, or duties of a certified nurse aide, registered nurse, or practical nurse, the advanced practice registered nurse may not delegate the administration of injectable medications to that certified medical assistant.
(f) Repealed 3/19/2014.
(g) The delegating advanced practice registered nurse is responsible for ensuring that the certified medical assistant monitors the patient's response to the injection for a minimum of 15 minutes and reports and responds to any adverse reactions.

6. Registered nurses may not delegate any injectable medications under any circumstances

(h) In this section,

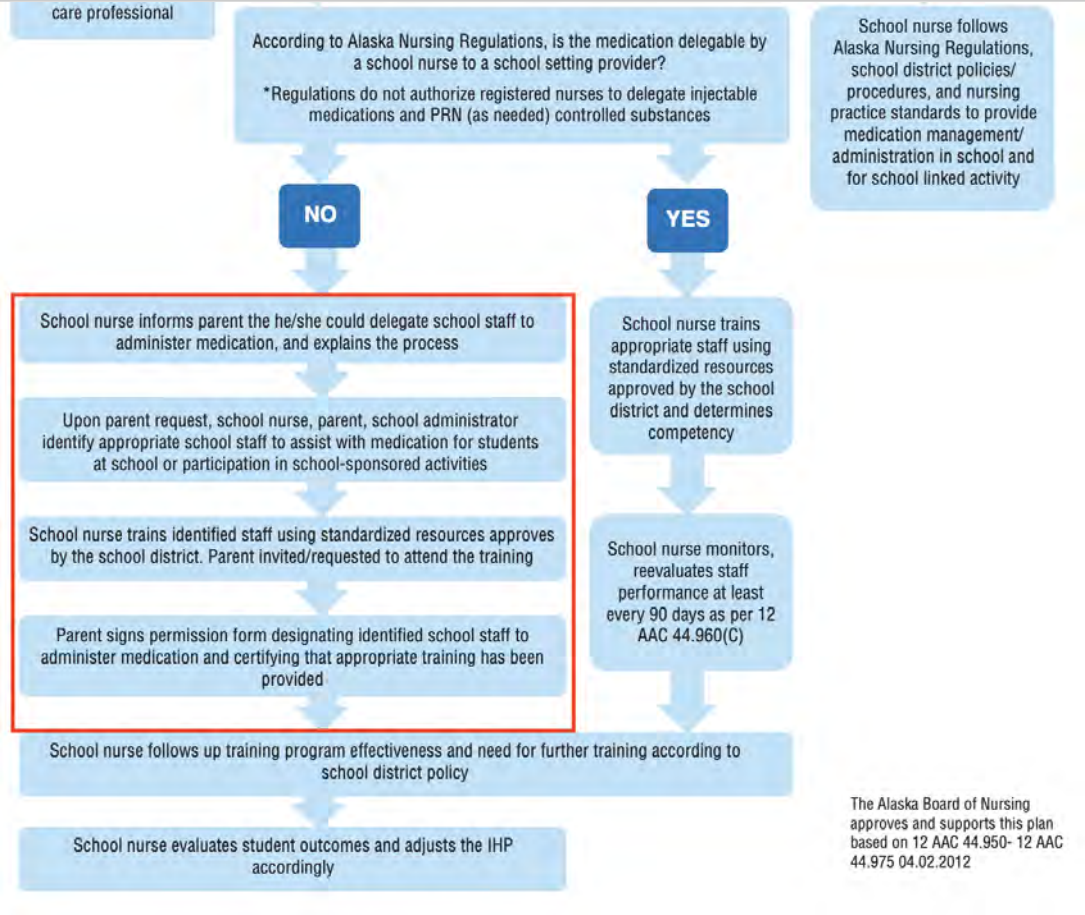
(1) "certified medical assistant" means a person who is currently nationally certified as a medical assistant by a national body accredited by the National Commission for Certifying Agencies (NCCA) and meets the requirements of this section;

(2) "immediately available on site" means that the advanced practice registered nurse is present on site in the unit of care and not otherwise engaged in a procedure or task that the advanced practice registered nurse may not immediately leave when needed;

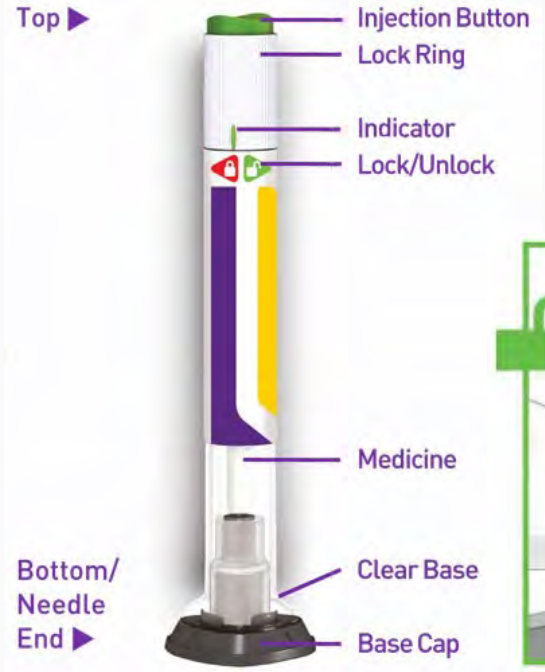
(3) repealed 5/16/2018.

(i) An advanced practice registered nurse may not delegate to a certified medical assistant or unlicensed assistive personnel the injection of a controlled substance under state or federal law.

6. Registered nurses may not delegate any injectable medications under any circumstances

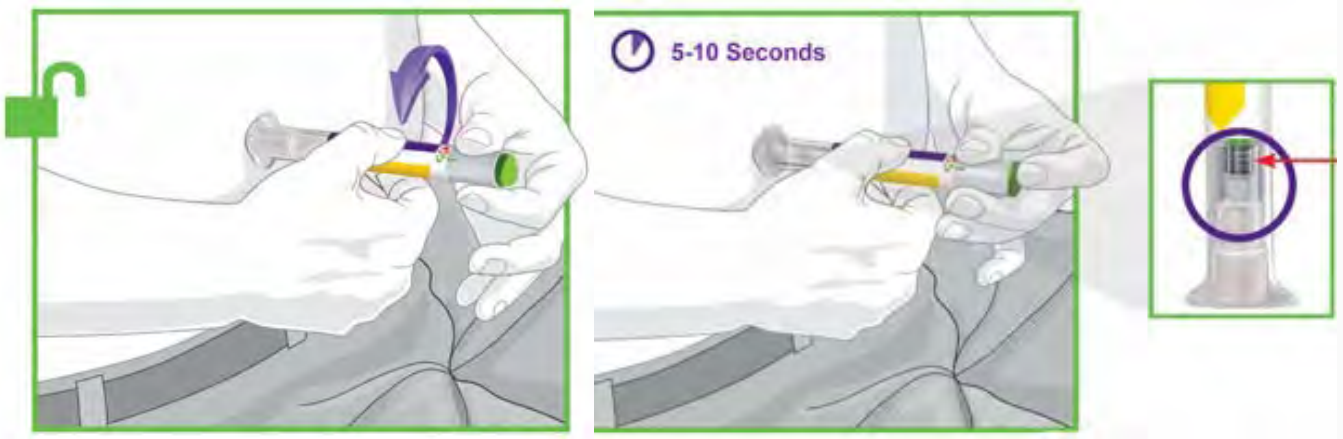


6. Registered nurses may not delegate any injectable medications under any circumstances



*Medical technology has evolved to increase safety and ease of administration

From: https://trulicity.lilly.com/how-to-use#how-to-use-trulicity-pen



6. Registered nurses may not delegate any injectable medications under any circumstances

Proposed solution: Change the rules to distinguish between subcutaneous and non-subcutaneous injections. Allow Registered Nurses and APRNs to delegate pre-filled subcutaneous injections in non-clinical settings as long as all other requirements for delegation in 950 and 965 are met. Add the following items to Medication Administration course requirements: Subcutaneous injections; Hypo- and Hyperglycemia; Epipen; Glucagon

Reasoning:

- There is a significant patient need for subcutaneous injections in many settings
  - Some settings have developed workarounds, some have not
- Medical technology has evolved to increase safety and ease of administration*
- The rule as written is not stopping UAPs from doing injections, just limiting the nurse's ability to oversee the task

7. Registered nurse may/may not delegate crushing, measuring and calculating medications

NURSING ADVISORY OPINIONS: MEDICATION
Crushing, measuring and calculating medications cannot be delegated. Reaffirming conclusion in 1993 position statement “Activities of Unlicensed Assistive Personnel” after a request from Pioneer’s Home for board opinion. SEE REVISION OCTOBER 2004, 12 AAC 44.950-975. Measuring and calculating medications can not be delegated. Crushing of medications is acceptable after an RN verifies that a medication may be crushed with a pharmacist

MEDICATION ADMINISTRATION COURSE REQUIREMENTS (MACR)
6. Measurement and Metrics

MEDICATION ADMINISTRATION COURSE REQUIREMENTS (MACR)
14.(a) . Crushed medications can be prepared by the pharmacy only

7. Registered nurse may/may not delegate crushing, measuring and calculating medications

Proposed solution: Retire the current advisory opinion and remove 14(a) from the MACR. Consider these alternatives

- “The crushing, splitting or opening of capsule medications may only be delegated after an RN verifies with a pharmacist or the prescribing physician that the medication may be crushed, split or opened.”
- “Measuring of non-injectable medications is a component of the task of Medication Administration and the procedure for measuring that medication must be included in the written instructions required by 12 AAC 44.965(d)(1) by the delegating nurse.”
- “The calculating of medications cannot be delegated to a UAP by a registered nurse as it requires the utilization of professional nursing judgment and knowledge as required in 12 AAC 44.950(a)(6).”

7. Registered nurse may/may not delegate crushing, measuring and calculating medications

Reasoning:

- It appears the boards intention was to allow UAPs to crush medications but had not made all changes to support that decision.
- Measuring is a skill utilized in most people's personal and professional lives. The inclusion of "Measurement and metrics" in the MACR should be sufficient to delegate UAPs to measure non-injectable medications (scoop of Metamucil, capful of Miralax, 15ml of Robitussin).
- Calculating dosage does require professional nursing judgement and knowledge and shouldn't be delegable.

8. Discussion: AK BON Medication Administration Course requirements

Alaska Board of Nursing
MEDICATION ADMINISTRATION COURSE REQUIREMENTS

Note: The delegation by nurses of nursing duties to other persons including unlicensed assistive personnel is governed by AS 08.68 and 12 AAC 44.950 through 970. These statutes and regulations may be accessed through the Board of Nursing website (www.nursing.alaska.gov). The course must be taught by a RN. A 90% is required on the post-test to pass.

OUTLINE OF REQUIREMENTS

Course objective

Content of course

Pretest & Post-test

Content to include:

1. Responsibilities of the caregiver
2. Types of medications/classifications
    a. Prescription vs. over the counter

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OUTLINE OF REQUIREMENTS

Course objective

Content of course

Pretest & Post-test

Content to include:

1. Responsibilities of the caregiver
2. Types of medications/classifications
   a. Prescription vs. over the counter

Does the pretest provide a benefit to the Nurse trainer or the UAP student?

8. Discussion: AK BON Medication Administration Course requirements

g. What you need to know and how to find it.
6. Measurement and metrics
7. Medical abbreviations
8. Storage of medications
9. Patient Bill of Rights
10. Confidentiality
11. Universal precautions
12. Second review of responsibilities
13. Medication errors
    a. When you are unsure of one of the six (6) rights
    b. What to do when an error is made
    c. Incident reports
14. Limitations
    a. Crushed medications can be prepared by the pharmacy only
    b. Each delegation is patient specific as per the regulations
    c. Delegation requires patient specific guidelines for documentation of delegated task
    d. PRN medications management for unstable medical conditions requiring ongoing assessment and adjustment of dosage or timing of administration is non-delegatable.
15. Review of 12 AAC 44.950 and 965
16. Resources for additional information

Post test - not computer based because you need to assess the reading and writing ability of the person being delegated to.

Post test must be passed with a score of 90%.

- There are MANY patient bills of rights
- Most rights are not relevant to medication administration training
  - Right to Refuse

8. Discussion: AK BON Medication Administration Course requirements

g. What you need to know and how to find it.

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15. Review of 12 AAC 44.950 and 965
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Post test - not computer based because you need to assess the reading and writing ability of the person being delegated to.

Post test must be passed with a score of 90%.

Universal: An approach to infection control developed in the 80's where all human blood and certain human body fluids are treated as if they are known to be infectious. Although the Blood Born Pathogen standard incorporates UP, the infection control community no longer uses UP on its own.

-osha.gov

8. Discussion: AK BON Medication Administration Course requirements

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15. Review of 12 AAC 44.950 and 965
16. Resources for additional information

Post test - not computer based because you need to assess the reading and writing ability of the person being delegated to.

Post test must be passed with a score of 90%.

Standard Precautions : Added additional elements to UP in order to protect healthcare workers not only from pathogens in human blood, but also pathogens present in body fluids to which UP does not apply like urine, feces, nasal secretions, sputum and vomit.

SP includes hand hygiene; the use of certain types of PPE based on anticipated exposure; safe injection practices; and safe management of contaminated equipment and other items in the patient environment.

SP is applied to all patients even when they are not known or suspected to be infectious

-osha.gov

8. Discussion: AK BON Medication Administration Course requirements

g. What you need to know and how to find it.

6. Measurement and metrics
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15. Review of 12 AAC 44.950 and 965
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Post test - not computer based because you need to assess the reading and writing ability of the person being delegated to.

Post test must be passed with a score of 90%.

Medication administration training is a separate act from Delegating Medications administration

12 AAC 44.950(a)(5) requires the <u>delegating</u> nurse to ensure:

"the person to whom a nursing duty is to be delegated is competent to perform the delegated duty correctly and safely and accepts the delegation of the duty and the accountability for carrying out the duty correctly;"

If the training nurse is not the delegating nurse, it is not their responsibility to assess the reading or writing ability of the person being trained. They should assess the person's ability to successfully complete the training during the course but that can be done without limiting the use of computer based testing.

To review, please consider the following propositions:

1. The use of the terminology “complex nursing skills” in the NPA is poorly defined. It requires review to remove or define it to reduce ambiguity.

2. **12 AAC 44.965(b)** which describes settings where medication administration may be delegated is out of date and, if enforced, would excessively limits access to care. It requires review to remove or edit it to make it current to allow safe delegation of medication administration in all settings where delegation may be required.

3. The prohibition against delegating the administration of PRN controlled substances in **7 AAC 44.965(e)** limits access to care and requires specific settings to create poorly regulated work-arounds. This situation requires review to remove the prohibition or maintain it. If it is maintained, I will request the board’s assistance with advocating for individuals like “James” to add a work-around into the rules for assisted living providers.

To review, please consider the following propositions:

4. The current rules for delegating the administration of injectable medications in **12 AAC 44.966** do not fully address the varying technology and complexity of different forms of injections. The prohibition against RNs delegating subcutaneous injections under any circumstances limits access to care and requires specific settings to create poorly regulated work-arounds. This situation requires review to either add an allowance for subcutaneous injections or maintain the rules as written. As above, if the rules are maintained, I will request the board's assistance with advocating for individuals like "DJ Smooth" to add a work-around into the rules for assisted living providers.

5. The advisory opinion related to crushing, measuring and calculating medications requires a review to provide clarity. Measuring of non-injectable medications should be considered a part of the medication administration task thus, delegable by the nurse to a UAP.

6. The Alaska board of nursing medication administration course requirements should be reviewed and items should be modified to meet current training needs.

I appreciate the board taking the time to hear my concerns and I hope you have found the information to be valuable. I am happy to provide further information on any of these topics as requested and am happy to answer questions if you have any.

I invite any of my fellow nurses to reach out as well. I can be reached at jsanders@crossroadcounseling.org

Current Regulations: Nursing Statutes and Regulations, Board of Nursing, Professional Licensing, Division of Corporations, Business and Professional Licensing (alaska.gov)

12 AAC 44.950. STANDARDS FOR DELEGATION OF NURSING DUTIES TO OTHER PERSONS.

(a) A nurse licensed under AS 08.68 may delegate the performance of nursing duties to other persons, including unlicensed assistive personnel, if the following conditions are met:

(1) the nursing duty to be delegated must be within the scope of practice of the delegating nurse; (2) a registered nurse must assess the patient's medical condition and needs to determine if a nursing duty for that patient may be safely delegated to another person;

(3) the patient's medical condition must be stable and predictable;

(4) the person to whom the nursing duty is to be delegated has received the training needed to safely perform the delegated duty, and this training has been documented;

(5) the nurse determines that the person to whom a nursing duty is to be delegated is competent to perform the delegated duty correctly and safely and accepts the delegation of the duty and the accountability for carrying out the duty correctly;

(6) performance of the delegated nursing duty would not require the person to whom it was delegated to exercise professional nursing judgment or knowledge or complex nursing skills;

(7) the nurse provides to the person, with a copy maintained on record, written instructions that include

(A) a clear description of the procedure to follow to perform each task in the delegated duty;
(B) the predicted outcomes of the delegated nursing task;
(C) how the person is to observe and report side effects, complications, or unexpected outcomes in the patient, and the actions appropriate to respond to any of these; and
(D) the procedure to document the performance of the nursing duty in the patient's record.

(b) A nurse who has delegated a nursing duty to another person shall provide appropriate direction and supervision of the person, including the evaluation of patient outcomes. Another nurse may assume delegating responsibilities from the delegating nurse if the substitute nurse has assessed the patient, the skills of the person to whom the delegation was made, and the plan of care. Either the original delegating nurse or the substitute nurse shall remain readily available for consultation by the person, either in person or by telecommunication.

(c) The delegation of a nursing duty to another person under this section is specific to that person and for that patient and does not authorize any other person to perform the delegated duty.

(d) The nurse who delegated the nursing duty to another person remains responsible for the quality of the nursing care provided to the patient.

Authority: AS 08.68.100 AS 08.68.805 AS 08.68.850 AS 08.68.340

12 AAC 44.965. DELEGATION OF THE ADMINISTRATION OF MEDICATION.

(a) The administration of medication is a specialized nursing task that may be delegated under the standards set out in 12 AAC 44.950, 12 AAC 44.960, and this section.

(b) Administration of medication may be delegated only to a

(1) "home and community-based services provider" as defined in 7 AAC 43.1110(8);

(2) "residential supported living services provider" as defined in 7 AAC 43.1110(15);

(3) school setting provider; in this paragraph, "school setting provider" means a person who is employed at a school that provides educational services to students age 21 or younger; or

(4) certified nurse aide employed by a long-term care facility licensed and certified by the Health Facilities Licensing and Certification section of the Department of Health.

(c) The person to whom the administration of medication is to be delegated must successfully complete a training course in administration of medication approved by the board. The training course in administration of medication approved by the board in this subsection will be reviewed by the board every two years.

(d) To delegate to another person the administration of routinely scheduled oral, topical, transdermal, nasal, inhalation, optic, otic, vaginal, or rectal medications to a patient the written instructions provided to the person under 12 AAC 44.950(a)(7) must also include

(1) directions for the storage and administration of medication, including the brand and generic name of the medication, the dosage amount and proper measurement, timing of the administration, recording the administration, the expected outcome of administration, and any contraindications to administration;

(2) possible interactions of medications;

(3) how to observe and report side effects, complications, errors, missed doses, or unexpected outcomes of the medications and appropriate response to such developments; and

(4) if the delegating nurse is not available on-site, the action that the person must take when medications are changed by order of a health care provider, including how to notify the delegating nurse of the change, how the delegating nurse will receive verification from the health care provider of the medication change, and how the nurse is to notify the other person if the administration of the change of medication is delegated.

(e) The administration of PRN medication, other than controlled substances, may be delegated under this section if a nurse is not available on-site. Before the administration of PRN medications may be delegated, the nurse shall first assess the patient to determine whether on-site patient assessment will be required before administration of each dose of PRN medication. The written instructions provided to the person under 12 AAC 44.950(a)(7) must meet the requirements of (d) of this section, and must also include

(1) when to administer the PRN medication to the patient;

(2) the procedure to follow for the administration of the PRN medication, including dosage amount, frequency, and duration; and

(3) the circumstances under which the person should contact the delegating nurse.

Authority: AS 08.68.100 AS 08.68.805 AS 08.68.850

12 AAC 44.966. DELEGATION OF THE ADMINISTRATION OF INJECTABLE MEDICATION.

(a) The administration of injectable medication is a specialized nursing task that may be delegated under the standards set out in 12 AAC 44.950(a), (c), and (d) and this section.

(b) The administration of injectable medication may be delegated only by an advanced practice registered nurse to a certified medical assistant. The certified medical assistant may only perform the delegated duty in a private or public ambulatory care setting, and the advanced practice registered nurse must be immediately available on site when the certified medical assistant is administering injectable medication.

(c) Repealed 5/16/2018.

(d) To delegate to a certified medical assistant the administration of an injectable medication to a patient the written instructions provided to the certified medical assistant under 12 AAC 44.950(a)(7) must also include the information required in 12 AAC 44.965(d)(1) – (3).

(e) The delegating advanced practice registered nurse is responsible for ensuring that the certified medical assistant maintains a national certification and for reviewing a current criminal background check upon hire, to be reviewed at five-year intervals. If the certified medical assistant has been convicted of a crime that, under AS 08.68.270 and 12 AAC 44.705, is substantially related to the qualifications, functions, or duties of a certified nurse aide, registered nurse, or practical nurse, the advanced practice registered nurse may not delegate the administration of injectable medications to that certified medical assistant.

(f) Repealed 3/19/2014.

(g) The delegating advanced practice registered nurse is responsible for ensuring that the certified medical assistant monitors the patient's response to the injection for a minimum of 15 minutes and reports and responds to any adverse reactions.

(h) In this section,

(1) "certified medical assistant" means a person who is currently nationally certified as a medical assistant by a national body accredited by the National Commission for Certifying Agencies (NCCA) and meets the requirements of this section;

(2) "immediately available on site" means that the advanced practice registered nurse is present on site in the unit of care and not otherwise engaged in a procedure or task that the advanced practice registered nurse may not immediately leave when needed;

(3) repealed 5/16/2018.

(i) An advanced practice registered nurse may not delegate to a certified medical assistant or unlicensed assistive personnel the injection of a controlled substance under state or federal law.

Authority: AS 08.68.100 AS 08.68.805 AS 08.68.850

To the Board:

This is a suggestion brought forward to address the gaps in the delegation regulations specifically pertaining to APRN's in the Outpatient setting delegating to ULP's.

Per Jennifer Austin, APRN, CPNP
In terms of updating regulations stipulating situations in which delegation of medication is allowed by RNs vs APRNs here are some suggestions:

1. Update language in nursing delegation regulation 12 AAC to:
a. (5) certified medical assistants
b. (5) certified medical assistants in outpatient clinical settings
c. (5) certified medical assistant or (6) unlicensed medical personnel in an outpatient clinical setting (this would be inclusive of uncertified MA's working in outpatient clinical settings)

2. Add language to the APRN delegation regulation to explicitly state:
a. An APRN may delegate the administration of medication via routine routes (Defined as oral, buccal, sublingual, ophthalmic, otic, intranasal, topical and rectal) to a [medical assistant (MA or CMA)] in an outpatient setting.
i. Can consider replacing [medical assistant (MA or CMA)] with [unlicensed medical personnel]
ii. Can consider adding language that an RN or the delegating APRN must be available to supervise medication administration if desired by the board.

DRAFT - Proposed suggestions:

12 AAC 44.965. DELEGATION OF THE ADMINISTRATION OF MEDICATION.

(a) The administration of medication is a specialized nursing task that may be delegated under the standards set out in 12 AAC 44.950, 12 AAC 44.960.~~, and this section.~~

~~(b) Administration of medication may be delegated only to a~~ (Repeal)

~~(1) "home and community-based services provider" as defined in 7 AAC 43.1110(8);~~

~~(2) "residential supported living services provider" as defined in 7 AAC 43.1110(15);~~

~~(3) school setting provider; in this paragraph, "school setting provider" means a person who is employed at a school that provides educational services to students age 21 or younger; or~~

~~(4) certified nurse aide employed by a long-term care facility licensed and certified by the Health Facilities Licensing and Certification section of the Department of Health.~~

* Plus stop regulation project ~~(5) Certified Medical Assistants~~

(c) The person to whom the administration of medication is to be delegated must successfully complete a training course in administration of medication approved by the board. The training course in administration of medication approved by the board in this subsection will be reviewed by the board every two years.

(d) To delegate to another person the administration of routinely scheduled oral, topical, transdermal, nasal, inhalation, optic, otic, vaginal, or rectal medications to a patient the written instructions provided to the person under 12 AAC 44.950(a)(7) must also include

(1) directions for the storage and administration of medication, including the brand and generic name of the medication, the dosage amount and proper measurement, timing of the administration, recording the administration, the expected outcome of administration, and any contraindications to administration;

(2) possible interactions of medications;

(3) how to observe and report side effects, complications, errors, missed doses, or unexpected outcomes of the medications and appropriate response to such developments; and

(4) if the delegating nurse is not available on-site, the action that the person must take when medications are changed by order of a health care provider, including how to notify the delegating nurse of the change, how the delegating nurse will receive verification from the health care provider of the medication change, and how the nurse is to notify the other person if the administration of the change of medication is delegated.

(e) The administration of PRN medication~~, other than controlled substances,~~ may be delegated under this section if a nurse is not available on-site. Before the administration of PRN medications may be delegated, the nurse shall first assess the patient to determine whether on-site patient assessment will be required before administration of each dose of PRN medication. The written

instructions provided to the person under 12 AAC 44.950(a)(7) must meet the requirements of (d) of this section, and must also include

(1) when to administer the PRN medication to the patient;

(2) the procedure to follow for the administration of the PRN medication, including dosage amount, frequency, and duration; and

(3) the circumstances under which the person should contact the delegating nurse.

Authority: AS 08.68.100 AS 08.68.805 AS 08.68.850

Alaska Board of Nursing

Break

Alaska Board of Nursing

Agenda Item #14

Review of National Certification Bodies

From Marianne Johnstone-Petty
July 7, 2024

Good afternoon, --

Thank you for the Recognized APRN Cert regulation and the NCSBN Approved APRN Licensure Certification Organizations & Exams. I put some considerations for re-wording of the regulations for Recognized Certification Bodies (12 AAC 44.420).

The NCSBN document is accurate except for lacking the Emergency Nurse Practitioner Certification through AANP; however, since you must have your FNP before sitting for the ENP, it makes sense that it is not included.

Concerning retired licenses, two of the documents that are attached are from ANCC and AANP (Links below), and the link for the AACN is below. However, I wonder if the AK BON maintaining a list of retired certifications is necessary. If an APRN has a license not on the current list, the applicant is required to provide the name of the Certifying Organization and its Accrediting Agency, along with verification (likely a URL) of documentation stating they maintain their certification as long as there are no lapses.

My understanding is that there are only two Accrediting Agencies used by our organizations: The Accreditation Board for Specialty Nursing Certification & the National Commission for Certifying Agencies. Is that correct? If so, each of those agencies have "look up" sites for current certifications, but unfortunately, I don't believe they had a way to look up Retired Certifications.

AANP Certification pass rate: https://www.aanpcert.org/resource/documents/annual/2023%20Certification%20Statistics.pdf
AACN Certification Data: https://www.nursingworld.org/~497d43/globalassets/docs/ancc/ancc-cert-data-website.pdf
AACN: https://www.aacn.org/certification/certification-renewal

Considerations for regulation wording:
12 AAC 44.420
(b) ~~The board will annually review national certification bodies to assure that board requirements are met.~~
(c) THE BOARD WILL CONSULT THE NATIONAL COUNCIL FOR STATE BOARDS OF NURSING TO ENSURE CERTIFYING ORGANIZATIONS ARE PROPERLY ACCREDITED.
(d) An applicant applying for an advanced practice registered nurse license by virtue of certification ~~from a body not on the board's current list of certification bodies shall supply the board with sufficient data to evaluate the authority of the certifying body.~~ WILL NEED TO SUPPLY THE NAME OF THE CERTIFYING BODY, THE CERTIFYING BODY'S ACCREDITATING AGENCY, AND EVIDENCE OF CURRENT LICENSURE.
(e) AN APPLICANT APPLYING FOR AN ADVANCED PRACTICE REGISTERED NURSE LICENSE WITH A RETIRED CERTIFICATION WILL NEED TO PROVIDE DOCUMENTATION FROM THE CERTIFYING BODY THAT THIS CERTIFICATION REMAINS ACTIVE AS LONG AS THERE ARE NO LAPSES IN CERTIFICATION.

NCSBN
Leading Regulatory Excellence

Approved APRN Licensure Certification Organizations and Exams

Updated June 2023

APRN Role	American Academy of Nurse Practitioners Certification Board (AANPCB)	American Association of Critical-Care Nurses (AACN)	American Midwifery Certification Board (AMCB)	American Nurses Credentialing Center (ANCC)	National Board of Certification & Recertification for Nurse Anesthetists (NBCRNA)	National Certification Corporation (NCC)	Pediatric Nursing Certification Board (PNCB)
Certified Nurse Midwife (CNM)			CNM-Women's Health /Gender Specific				
Certified Nurse Practitioner(CNP)	CNP-Adult-gerontology Primary Care AGNP FNP-Family Across the Lifespan, Primary Care FNP CNP-Psychiatric Mental Health (launches 2024) PMHNP ENP	CNP-Adult Gerontology Acute Care AGNP-AC ~~PCHNP-BC~~		CNP-Adult-gerontology Acute Care AGACNP-BC CNP-Adult-gerontology Primary Care AGPCNP-BC FNP-Family Across the Lifespan, Primary Care FNP-BC CNP-Psychiatric-mental Health Across the Lifespan (formerly known as Family Psychiatric-mental Health) PMHNP-BC		CNP-Women's Health/Gender Specific WHNP-BC NNP-Neonatal NNP-BC	CNP-Pediatric Primary Care CPNP-PC CNP-Pediatric Acute Care CPNP-AC
	Retired Exams NP-Adult CNP-Gerontology	**Retired Exams** CNP-Adult Acute Care		**Retired Exams** PNP-Pediatric Primary Care CNP-Acute Care CNP-Adult CNP-Gerontology CNP-Adult Psychiatric-mental Health			
Certified Registered Nurse Anesthetist (CRNA)					CRNA-Family Across the Lifespan		
Clinical Nurse Specialist (CNS)		Acute Care CNS-Adult-gerontology AGCNS-AG Acute Care CNS-Neonatal ACCNS-N Acute Care CNS-Pediatric,CNS-~~gerontology~~ ACCNS-P		CNS-Adult-gerontology ~~AG~~ ACCNS-AG			
		Retired Exams CCNS-Critical Care		**Retired Exams** CNS-Pediatric CNS-Gerontology CNS-Adult Health CNS-Adult Psych-mental Health CNS-Child/Adolescent Psych-mental Health			

Key:

Blue = Exam focus population aligns with APRN Consensus Model

Grey = Exam population is Pre-alignment

APRNs certified using "Pre-alignment" exams shall maintain practice aligning with that exam; they may maintain certification for licensure by endorsement/renewal. All certification programs offer a renewal option for exams that retired or that will retire.

ANCC
AMERICAN NURSES CREDENTIALING CENTER

2023 ANCC Certification Data

The data presented in the "tested," "passed," and "pass rate" columns are for **first-time test takers**. The "total certified" column is the total number of certificants for each certification program as of 12.31.2023.

2023 ANCC Certification Data	Tested	Passed	Pass Rate	Renewals	Total Certified	Notes
Nurse Practitioner						
Acute Care Nurse Practitioner				1,812	9,085	Renewal Only
Adult Nurse Practitioner				2,719	15,204	Renewal Only
Adult Psychiatric-Mental Health Nurse Practitioner				693	3,337	Renewal Only
Adult-Gerontology Acute Care Nurse Practitioner	3,179	2,628	83%	3,013	24,841	
Adult-Gerontology Primary Care Nurse Practitioner	913	725	79%	1,726	10,765	
Advanced Diabetes Management Nurse Practitioner				0	1	Renewal Only
Emergency Nurse Practitioner				27	116	Renewal Only
Family Nurse Practitioner	8,530	7,266	85%	14,326	97,007	
Gerontological Nurse Practitioner				401	2,459	Renewal Only
Pediatric Primary Care Nurse Practitioner				408	2,393	
Psychiatric-Mental Health Nurse Practitioner *(across the life span)*	8,791	7,880	90%	3,146	40,193	
School Nurse Practitioner				3	11	Renewal Only
Total Nurse Practitioner	**21,413**	**18,499**		**28,274**	**205,412**	
Clinical Nurse Specialist						
Adult-Gerontology Clinical Nurse Specialist	167	148	89%	189	1,742	
Adult Health Clinical Nurse Specialist				471	2,800	Renewal Only
Adult Psychiatric-Mental Health Clinical Nurse Specialist				528	3,106	Renewal Only
Advanced Diabetes Management Clinical Nurse Specialist				2	8	Renewal Only
Child/Adolescent Psychiatric-Mental Health Clinical Nurse Specialist				100	569	Renewal Only
Clinical Nurse Specialist Core				0	149	Renewal Only
Gerontological Clinical Nurse Specialist				46	253	Renewal Only
Home Health Clinical Nurse Specialist				3	8	Renewal Only
Pediatric Clinical Nurse Specialist				42	276	Renewal Only
Public/Community Health Clinical Nurse Specialist				39	195	Renewal Only
Total Clinical Nurse Specialist	**167**	**148**		**1,420**	**9,106**	

2023 ANCC Certification Data	Tested	Passed	Pass Rate	Renewals	Total Certified	Notes
RN Specialty Nursing						
Advanced Forensic Nursing				14	58	Renewal Only
Advanced Genetics Nursing				5	64	Renewal Only
Advanced Public Health Nursing				33	267	Renewal Only
Ambulatory Care Nursing	1,247	963	77%	610	6,431	
Cardiac-Vascular Nursing	642	496	77%	696	6,137	
Cardiac Rehabilitation Nurse				0	39	Renewal Only
Certified Care Coordination & Transition Management				86	423	Renewal Only
Certified Vascular Nurse				1	21	Renewal Only
College Health Nurse				2	47	Renewal Only
Community Health Nursing				10	91	Renewal Only
Faith Community Nursing				1	78	Renewal Only
General Nursing Practice				24	126	Renewal Only
Genetics Nursing				1	6	Renewal Only
Gerontological Nursing	438	326	74%	729	5,613	
Hemostasis Nursing				1	30	Renewal Only
High-Risk Perinatal Nursing				3	24	Renewal Only
Home Health Nursing				6	39	Renewal Only
Informatics Nursing	440	283	64%	430	3,401	
Medical-Surgical Nursing	3,380	2,620	78%	3,554	31,541	
Nurse Executive	1,149	759	66%	926	8,865	
Nurse Executive, Advanced	714	532	75%	731	5,941	
Nursing Case Management	214	137	64%	194	1,908	
Nursing Professional Development	1,033	807	78%	535	5,773	
Pain Management Nursing	146	98	67%	218	1,609	
Pediatric Nursing	142	101	71%	264	2,106	
Perinatal Nursing				29	159	Renewal Only
Psychiatric-Mental Health Nursing	1,330	967	73%	1,190	10,860	
Rheumatology Nursing				1	11	Renewal Only
School Nursing				2	14	Renewal Only
Total Specialty	**10,875**	**8,089**		**10,296**	**91,682**	
National Health Care Disaster	1	1	100%	80	422	Renewal Only
Grand Totals for 2023	**32,455**	**26,736**		**40,070**	**306,622**	

AMERICAN ACADEMY NURSE PRACTITIONERS CERTIFICATION BOARD

AANPCB 2023 Statistics

	Family NP	Adult-Gerontology Primary Care NP	Emergency NP Specialty**	Adult NP*	Gerontology NP*	Total
CERTIFICATIONS	177,049	20,140	1,882	7,338	157	206,566
Initial Examinations Number administered *Pass Rate*	17,362 *73%*	1,864 *90%*	261 *86%*	—	—	19,487
Recertifications	26,571	2,770	274	1,381	20	31,016

Initial Exams by Education Category

		Family NP	*Adult-Gerontology Primary Care NP*	*Total*
Masters	Number administered	14,952	1,508	16,460
	Pass Rate	*72%*	*90%*	*73%*
Post-graduate	Number administered	988	144	1,132
	Pass Rate	*72%*	*86%*	*73%*
Doctorate/DNP	Number administered	1,422	212	1,634
	Pass Rate	*83%*	*97%*	*85%*

* Exam retirement: Adult NP in 2016, Gerontologic NP in 2012

** Emergency NP Specialty examination was launched January 2017

Recognized Advance Practice Registered Nurse Certifications

12 AAC 44.420. RECOGNIZED CERTIFICATION BODIES. (a) The board may recognize national certification bodies that certify advanced practice registered nurse by exercising responsibility for

(1) approving the basic education course of study in the population focus;
(2) examining graduates of the course of study; and
(3) addressing the issue of ongoing competency.

(b) The board will annually review national certification bodies to assure that board requirements are met.

(c) The board will maintain a current list of certification bodies which it has reviewed and recognized.

(c) An applicant applying for an advanced practice registered nurse license by virtue of certification from a body not on the board's current list of certification bodies shall supply the board with sufficient data to evaluate the authority of the certifying body.

1. **National Board on Certification & Recertification of Nurse Anesthetists (NBCRNA)**
   - Initial and renewal certifications for nurse anesthetists
2. **National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties (NCC)**
   - Woman's Health Care Nurse Practitioner (formerly OB/GYN Nurse Practitioner)
   - Neonatal Nurse Practitioner
3. **The Pediatric Nursing Certification Board (PNCB)** Formerly National Certification Board of Pediatric Nurse Practitioners & Nurses (NCBPNP/N)
   - Pediatric Nurse Practitioner
4. **American Midwifery Certification Board**
   - Nurse Midwives
5. **American Nurses Credentialing Center (ANCC)**
   - Family/Individual across the lifespan
   - Adult-Gerontology Acute Care Nurse Practitioner
   - Adult-Gerontology Primary Care Nurse Practitioner
   - Psychiatric-Mental Health Nurse Practitioner (Across the Lifespan)
   - Adult-Gerontology Clinical Nurse Specialist
   - Pediatric Primary Care Nurse Practitioner

   If currently licensed or certified in the following population foci as of January 1, 2024, may continue to practice as long as that certification is maintained: (effective 8/1/18)
   - Adult Health
   - Family Health
   - Gerontological Nurse Practitioner
   - Acute Care / Emergency Nurse Practitioner
   - Adult Psychiatric/Mental Health
   - Child/Adolescent Psychiatric-Mental Health, Clinical Nurse Specialist PMHCNS-BC
   - Family Psychiatric/Mental Health
   - Women's Health

6. **American Academy of Nursing Practitioners Certification Board (AANPCB)**
   - Adult-Gerontology Nurse Practitioner

   If certified or licensed as of January 1, 2024, may continue to practice as long as that certification is maintained.
   - Emergency Nurse Practitioner
   - Family Nurse Practitioner
   - Gerontological Nurse Practitioner
7. **American Association of Critical-Care Nurses (AACN)**
   - Acute Care Nurse Practitioner
   - Adult-Gero Clinical Nurse Specialist
   - Pediatric Clinical Nurse Specialist
   - Neonatal Clinical Nurse Specialist

Alaska Board of Nursing

Agenda Item #15

Advisory Opinion Updates

Advisory Opinion Updates:

Will discuss the following advisory opinions, supporting resources, and suggested edits to create updated advisory opinions on the topics of Governance, Sexual Misconduct, and Safe to Practice.

Advisory Opinion

DISCIPLINARY SANCTIONS FOR

SEXUAL MISCONDUCT AFFECTING PATIENTS.

Explanatory Statement about Advisory Opinions

An advisory opinion adopted by the Alaska Board of Nursing is an interpretation of what the law requires. W
law, it is more than a recommendation. In other words, an advisory opinion is an official opinion the Alaska
practice of nursing as it relates to the health and safety of the Alaska healthcare consumer. Facility policies
their setting and/or require additional expectations related to competency, validation, training and superv
patient.

INTRODUCTION:

For the express purpose of protecting the public, Alaska statutes and regulations provide legal prohibitions against "*unprofessional conduct*" and "*sexual misconduct*" towards patients. (See Alaska statutory references below.). Most other state Boards of Nursing have gone even further and adopted more finite and specific policies. In addition, the National Council of State Boards of Nursing also recommends such specific guidelines. Therefore, both the NSCBN's guidelines and other state's policies are incorporated into the Alaska advisory opinion.

PURPOSE:

Accordingly, the following Alaska BON Advisory Opinion is designed for the strict objectives of;

1). protecting Alaska patients through clear and concise standards for enforcement against sexual misconduct; and

2). preemptive information to all nurses (RNs, (including ANPs and CRNAs) LPNs, and CNAs stating the professional boundaries required by law against sexual misconduct.

Statutory References

- A.S. 08.68.270(7) [prohibiting unprofessional conduct by RNs].
- A.S. 08.68.334(4) [prohibiting abuse of clients by CNAs]

Regulatory References:

- 12 AAC 44.770(28) [prohibiting sexual misconduct by Nurses]
- 12 AAC 44.870(18) [prohibiting sexual misconduct by CNAs]
- 12 AAC 44.990 [definitions of sexual contact, impropriety, misconduct, penetration]

ADVISORY OPINION:

The Alaska Board of Nursing, in keeping with its mission to protect the public health, safety, and welfare, believes it is imperative to take a strong position regarding the licensure and certification of individuals who engage in sexual misconduct towards patients or in the workplace, who have been convicted of sexual misconduct, or whose sexual misconduct outside the workplace may affect the ability to safely care for patients.

The Board's Advisory Opinion applies to all persons regulated by the Alaska Board of Nursing under A.S. 08.68 et seq., which includes all Registered Nurses, all Licensed Practical Nurses, and all Certified Nurse Aides, and all applicants for licensure or certification under this statute.

The Board adopts the following assumptions as the basis for its advisory opinion:

1). Patients* under the care of a Nurse/CNA are vulnerable by virtue of illness or injury, and the dependant nature of the Nurse/CNA-patient relationship.

2). Persons who are especially vulnerable include the elderly, children, the mentally ill, sedated and anesthetized patients, those whose mental or cognitive ability is compromised and patients who are disabled or immobilized.

3). Nurses and CNAs are frequently in situations where they provide intimate care to patients or have contact with partially clothed or fully undressed patients. Nurses/CNAs may also care for these patients without direct supervision.

4). There are appropriate boundaries in the Nurse/CNA-patient relationship which nurses and CNAs must clearly understand and be trusted not to cross.

5). Sexual misconduct towards patients or in the workplace raises serious questions regarding the individual's ability to provide safe, competent care to vulnerable patients.

6). Sexual misconduct which occurs outside of the workplace, including conviction of a crime, may raise questions as to whether that same misconduct will be repeated in the workplace and therefore affects the ability of the nurse or CNA to safely provide patient care.

***The terms "resident" "client" are often substituted for the term "**patient**" in health care facilities. For purposes of this document, "**patient**" includes all these terms.*

DISCIPLINARY SANCTIONS: *Any RN, LPN, or CNA committing sexual misconduct, as stated in the general and specific definitions set forth below, shall be subject to discipline up to and including revocation of licensure or certification.*

DEFINITION OF SEXUAL MISCONDUCT:

Below are the general and specific definitions of sexual misconduct to be applied to Alaska RNs, LPNs, and CNAs under A.S. 8.68.270(7) and A.S. 8.68.344.

"Sexual Misconduct" **– General Definition**

1). Engaging in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual; any verbal behavior that is seductive or sexually demeaning to a patient; or engaging in sexual exploitation of a patient.

2). A specific type of professional misconduct which involves the use of power, influence and/or special knowledge that is inherent in one's profession in order to obtain sexual gratification from the people that a particular profession is intended to serve. Any and all sexual, sexually demeaning, or seductive behaviors, both physical and verbal, between a service provider (i.e., a nurse/CNA) and an individual who seeks or receives the service of that provider (i.e., patient), is unethical and constitutes sexual misconduct.

3). Engaging in inappropriate sexual contact, exposure, gratification, or other sexual behavior with, or in the presence of a current patient. For purposes of this subsection, an adult receiving **psychiatric nursing services** shall continue to be a patient for two years after the termination of professional services. If the person receiving psychiatric nursing services is a **minor**, the person shall continue to be a patient for the purposes of this subsection for two years after termination of services, or for one year after the patient reaches the age of majority, whichever is longer.

"Sexual Misconduct" – **Specific Definition**

The following are **specific** definitions of sexual misconduct applied to Alaska RNs, LPNs, and CNAs (denoted as health care providers below):

1). A health care provider shall not engage, or attempt to engage, in sexual misconduct with a current patient, client, or key party[i]* inside or outside of the health care setting. Sexual misconduct shall constitute grounds for disciplinary action. Sexual misconduct includes, but is not limited to:

a). Sexual intercourse;

b). Touching of the breasts, genitals, anus or any sexualized body part, except as consistent with accepted community standards of practice for examination, diagnosis and treatment within the health care practitioner's scope of practice;

c). Rubbing against a patient, client or key party for sexual gratification;

d). Kissing;

e). Hugging, touching, fondling or caressing of a romantic or sexual nature;

f). Examination of, or touching genitals without using gloves;

g). Not allowing a patient or client privacy to dress or undress, except as may be necessary in emergencies or custodial situations;

h). Not providing the patient or client with a gown or draping, except as may be necessary in emergencies;

i). Dressing or undressing in the presence of the patient, client or key party;

j). Removing a patient's or client's clothing, gown or draping without consent, emergent medical necessity or being in a custodial setting;

k). Encouraging masturbation or other sex acts in the presence of the health care provider;

l). Masturbation or other sex acts performed by the health care provider in the presence of the patient, client or key party;

m). Suggesting or discussing the possibility of dating, sexual or romantic relationship prior to the end of the professional relationship

n). Soliciting a date with a patient, client or key party;

o). Discussing the sexual history, preferences or fantasies of the health care provider;

p). Any behavior, gestures or expressions that may reasonably be interpreted as seductive or sexual;

q). Making statements regarding the patient, client or key party's body, appearance, sexual history or sexual orientation other than for legitimate health care purposes;

r). Sexually demeaning behavior, including, but not limited to, any verbal or physical contact which may reasonably be interpreted as demeaning, humiliating, embarrassing, threatening, or harming a patient, client or key party;

s). Posing, photographing or filming the body, or any body part of a patient, client or key party, other than for legitimate health care purposes; and

t). Showing a patient, client or key party sexually explicit materials, other than for legitimate health care purposes.

u). Providing or offering to provide drugs or treatment in exchange for sexual favors.

v). Using or causing the use of anesthesia or any other drug affecting consciousness for the purpose of engaging in conduct that would constitute sexual misconduct.

2). A health care provider shall not:

a). Offer to provide health care services in exchange for sexual favors;

b). Use health care information to contact the patient, client or key party for the purpose of engaging in sexual misconduct;

c). Use health care information or access to health care information to meet or attempt to meet the health care provider's sexual needs.

3). A health care provider shall not engage, or attempt to engage, in the activities listed in subsection (1) of this section with a current patient, client or key party until after the provider-patient/client relationship ends. In the case of a patient who is a minor (under age 18), a health care provider shall not engage, or attempt to engage, in the activities listed in subsection (1) within one year after the patient reaches the age of majority or within one year after the provider/patient relationship ends, whichever is longer.

4). A health care provider shall not engage, or attempt to engage, in the activities listed in subsection (1) of this section if:

a). There is a significant likelihood that the patient, client or key party will seek or require additional services from the health care provider; or

b). There is an imbalance of power, influence, opportunity and/or special knowledge of the professional relationship.

5). When evaluating whether a health care provider is prohibited from engaging or attempting to engage in sexual misconduct, the regulator will consider factors, including, but not limited to:

a). Documentation of a formal termination and the circumstances of termination of the provider-patient relationship;

b). Transfer of care to another health care provider;

c). Duration of the provider-patient relationship;

d). Amount of time that has passed since the last health care services were provided to the patient or client;

e). Communication between the health care provider and the patient or client between the last health care services rendered and commencement of the personal relationship;

f). Extent to which the patient's or client's personal or private information was shared with the health care provider;

g). Nature of the patient or client's health condition during and since the professional relationship;

h). The patient or client's emotional dependence and vulnerability; and

i). Normal revisit cycle for the profession and service.

6). Patient, client or key party initiation or consent does not excuse or negate the health care provider's responsibility.

7). These rules do not prohibit:

a). Providing health care services in case of emergency where the services cannot or will not be provided by another health care provider;

b). Contact that is necessary for a legitimate health care purpose and that meets the standards of care appropriate to that profession; or

c). Providing health care services for a legitimate health care purpose to a person who is in a preexisting, established personal relationship with the health care provider where there is no evidence of, or potential for, exploiting the patient or client.

* "*Key Party*" refers to immediate family members and others who play a role in health care decisions of the patient or client.

Adopted by the Alaska Board of Nursing, July 2011

Attachment: NCSBN Foundational Findings:

The NCSBN's publication entitled Practical Guidelines for Boards of Nursing on Sexual Misconduct Cases (2009) makes several foundational findings for the protection of the public through sexual misconduct disciplinary standards. Specifically at page 1 this NCSBN Guide states the following:

"In 2007, Halter, Brown, and Stone reviewed the published empirical literature on sexual misconduct. The researchers drew the following conclusions from the studies they reviewed:

- Clear sexual boundaries are crucial to patient safety.
- Specific education about this subject, delivered in conducive environments, changes health care providers' attitudes toward sexual contact with patients.
- Sexual boundary violations result in significant and enduring harm to patients.
- Reported incidence of sexual misconduct in health care is low, and is concentrated in general practice and psychological therapies.
- Patient vulnerability is associated with higher prevalence of sexual misconduct."

Further, this NCSBN Guide at page 2 also underscores the impact on the public of such sexual misconduct; "The impact of sexual misconduct on patients is serious. The Council for Health Care Regulatory Excellence (2008) cites the following disorders and

complaints as being resultant of sexual misconduct by a health care provider to a patient/client:

- Post-traumatic stress disorder and distress;
- Major depressive disorder;
- Suicidal tendencies and emotional distrust;
- High levels of dependency on the offending professional;
- Confusion and disassociation;
- Failure to access health services when needed;
- Relationship problems;
- Disruptions to employment and earnings; and
- Use and misuse of prescription (and other) drugs and alcohol.

Practical Guidelines for Boards of Nursing on Sexual Misconduct Cases

NCSBN

National Council of State Boards of Nursing

Mission Statement

The National Council of State Boards of Nursing, composed of member boards, provides leadership to advance regulatory excellence for public protection.

Address inquiries in writing to NCSBN Permissions, 111 E. Wacker Drive, Suite 2900, Chicago, IL 60601-4277. Suggested Citation: National Council of State Boards of Nursing. (2009). *Practical Guidelines for Boards of Nursing on Sexual Misconduct Cases*. Chicago: Author.

Printed in the United States of America

Practical Guidelines for Boards of Nursing on Sexual Misconduct Cases

Developed by NCSBN's Discipline Resources Committee

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TABLE OF CONTENTS

INTRODUCTION

The purpose of this booklet is to provide boards of nursing (BONs) with practical guidelines in making decisions about sexual misconduct cases in their mission of public protection. This resource is not only pertinent, but timely.

In 2007, Halter, Brown and Stone reviewed the published empirical literature on sexual misconduct. This review provides details in the areas of: the prevalence of sexual misconduct, the impact on patients, factors associated with sexual boundary violations and themes for future research. The researchers drew the following conclusions from the studies they reviewed:

- Clear sexual boundaries are crucial to patient safety.
- Specific education about this subject, delivered in conducive environments, changes health care providers' attitudes toward sexual contact with patients.
- Sexual boundary violations result in significant and enduring harm to patients.
- Reported incidence of sexual misconduct in health care is low, and is concentrated in general practice and psychological therapies.
- Patient vulnerability is associated with higher prevalence of sexual misconduct.

For the purposes of this document, the term nurse refers to a registered nurse (RN) or a licensed practical/vocational nurse (LPN/VN), except in instances that indicate otherwise.

EXTENT OF THE PROBLEM

In NCSBN's analysis of 10 years of Nursys® data (NCSBN, 2009), 53,361 nurses were disciplined; of those, 636, or 0.57 percent, were included in the following categories: sexual misconduct, sex with client, sexual abuse, sexual language or sexual boundaries. Therefore, sexual misconduct is not a common complaint to a BON. The actual prevalence, however, is not known. Indeed, 38 to 52 percent of health care professionals report knowing of colleagues who have been sexually involved with patients (Halter et al., 2007).

The impact of sexual misconduct on patients is serious. The Council for Health Care Regulatory Excellence (2008) cite the following disorders and complaints as being resultant of sexual misconduct by a health care provider to a patient/client:

- Post-traumatic stress disorder and distress;
- Major depressive disorder;
- Suicidal tendencies and emotional distrust;
- High levels of dependency on the offending professional;
- Confusion and dissociation;
- Failure to access health services when needed;
- Relationship problems;
- Disruption to employment and earnings; and
- Use and misuse of prescription (and other) drugs and alcohol.

USING THIS RESOURCE

The intent of this document is to provide a user-friendly resource that provides practical guidelines for BONs. This includes:

- Introductory information, statistics and a reference list with additional sources;
- Definition of terms;
- Guidelines for selecting evaluators for establishing sanctions and fitness for practice. These were either gleaned from the literature or they are examples from Member Boards. BONs can select the guidelines that best meet their needs;
- A detailed framework for deciding when and how to take action in sexual misconduct cases. This would be most helpful for those BONs that would like more consistency in the way they handle sexual misconduct cases;
- An easy to follow *Sexual Misconduct Pathway* to serve as a quick reference when handling sexual misconduct cases; and
- Four cases:
    - A high-profile case which highlights how to use the framework and the pathway;
    - A long-term care case study that is typically seen in BONs with a discussion of how definitions can be helpful;
    - A hospital case study that integrates the fitness for practice guidelines; and
    - A case study of a member of a vulnerable population that details the use of the framework.

The information provided in this booklet has been derived from a variety of resources, including scientific reviews of the literature. Those interested in reading more about the research in this area, as well as an overview of the state of the science of professional misconduct, are referred to the work of Halter et al., 2007 and Carr, 2003.

DEFINITIONS

Below are general definitions of sexual misconduct used by the BONs. The definitions below include language from BONs' laws and regulations and could be adapted by other BONs. See Case 2 at the end of this booklet to illustrate how definitions can be beneficial to BONs.

Sexual Misconduct

1. Engaging in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual; any verbal behavior that is seductive or sexually demeaning to a patient; or engaging in sexual exploitation of a patient or former patient.
2. A specific type of professional misconduct which involves the use of power, influence and/or special knowledge that is inherent in one's profession in order to obtain sexual gratification from the people that a particular profession is intended to serve. Any and all sexual, sexually demeaning, or seductive behaviors, both physical and verbal, between a service provider (i.e., a nurse) and an individual who seeks or receives the service of that provider (i.e., client), is unethical and constitutes sexual misconduct.
3. Engaging in inappropriate sexual contact, exposure, gratification, or other sexual behavior with, or in the presence of, a patient. For purposes of this subsection, an adult receiving psychiatric nursing services shall continue to be a patient for one year after the termination of professional services. If the person receiving psychiatric nursing services is a minor, the person shall continue to be a patient for the purposes of this subsection for one year after termination of services, or for one year after the patient reaches the age of majority, whichever is longer (Wisconsin Board of Nursing).

The following are more specific definitions of sexual misconduct designed for all health care providers:

1. A health care provider shall not engage, or attempt to engage, in sexual misconduct with a current patient, client, or key party* inside or outside of the health care setting. Sexual misconduct shall constitute grounds for disciplinary action. Sexual misconduct includes, but is not limited to:
    a. Sexual intercourse;
    b. Touching of the breasts, genitals, anus or any sexualized body part, except as consistent with accepted community standards of practice for examination, diagnosis and treatment within the health care practitioner's scope of practice;
    c. Rubbing against a patient, client or key party for sexual gratification;
    d. Kissing;
    e. Hugging, touching, fondling or caressing of a romantic or sexual nature;
    f. Examination of, or touching genitals without using gloves;
    g. Not allowing a patient or client privacy to dress or undress, except as may be necessary in emergencies or custodial situations;
    h. Not providing the patient or client with a gown or draping, except as may be necessary in emergencies;
    i. Dressing or undressing in the presence of the patient, client or key party;
    j. Removing a patient's or client's clothing, gown or draping without consent, emergent medical necessity or being in a custodial setting;
    k. Encouraging masturbation or other sex acts in the presence of the health care provider;
    l. Masturbation or other sex acts performed by the health care provider in the presence of the patient, client or key party;
    m. Suggesting or discussing the possibility of a dating, sexual or romantic relationship prior to the end of the professional relationship;
    n. Terminating a professional relationship for the purpose of dating or pursuing a romantic or sexual relationship;
    o. Soliciting a date with a patient, client or key party;
    p. Discussing the sexual history, preferences or fantasies of the health care provider;
    q. Any behavior, gestures or expressions that may reasonably be interpreted as seductive or sexual;
    r. Making statements regarding the patient, client or key party's body, appearance, sexual history or sexual orientation other than for legitimate health care purposes;
    s. Sexually demeaning behavior, including, but not limited to, any verbal or physical contact which may reasonably be interpreted as demeaning, humiliating, embarrassing, threatening, or harming a patient, client or key party;

*Key party refers to immediate family members and others who play a role in health care decisions of the patient or client.

t. Posing, photographing or filming the body, or any body part of a patient, client or key party, other than for legitimate health care purposes; and

u. Showing a patient, client or key party sexually explicit materials, other than for legitimate health care purposes.

2. A health care provider shall not:

   a. Offer to provide health care services in exchange for sexual favors;

   b. Use health care information to contact the patient, client or key party for the purpose of engaging in sexual misconduct;

   c. Use health care information or access to health care information to meet or attempt to meet the health care provider's sexual needs.

3. A health care provider shall not engage, or attempt to engage, in the activities listed in subsection (1) of this section with a former patient, client or key party within two years after the provider-patient/client relationship ends.

4. After the two-year period of time described in subsection (3) of this section, a health care provider shall not engage, or attempt to engage, in the activities listed in subsection (1) of this section if:

   a. There is a significant likelihood that the patient, client or key party will seek or require additional services from the health care provider; or

   b. There is an imbalance of power, influence, opportunity and/or special knowledge of the professional relationship.

5. When evaluating whether a health care provider is prohibited from engaging or attempting to engage in sexual misconduct, the regulator will consider factors, including, but not limited to:

   a. Documentation of a formal termination and the circumstances of termination of the provider-patient relationship;

   b. Transfer of care to another health care provider;

   c. Duration of the provider-patient relationship;

   d. Amount of time that has passed since the last health care services were provided to the patient or client;

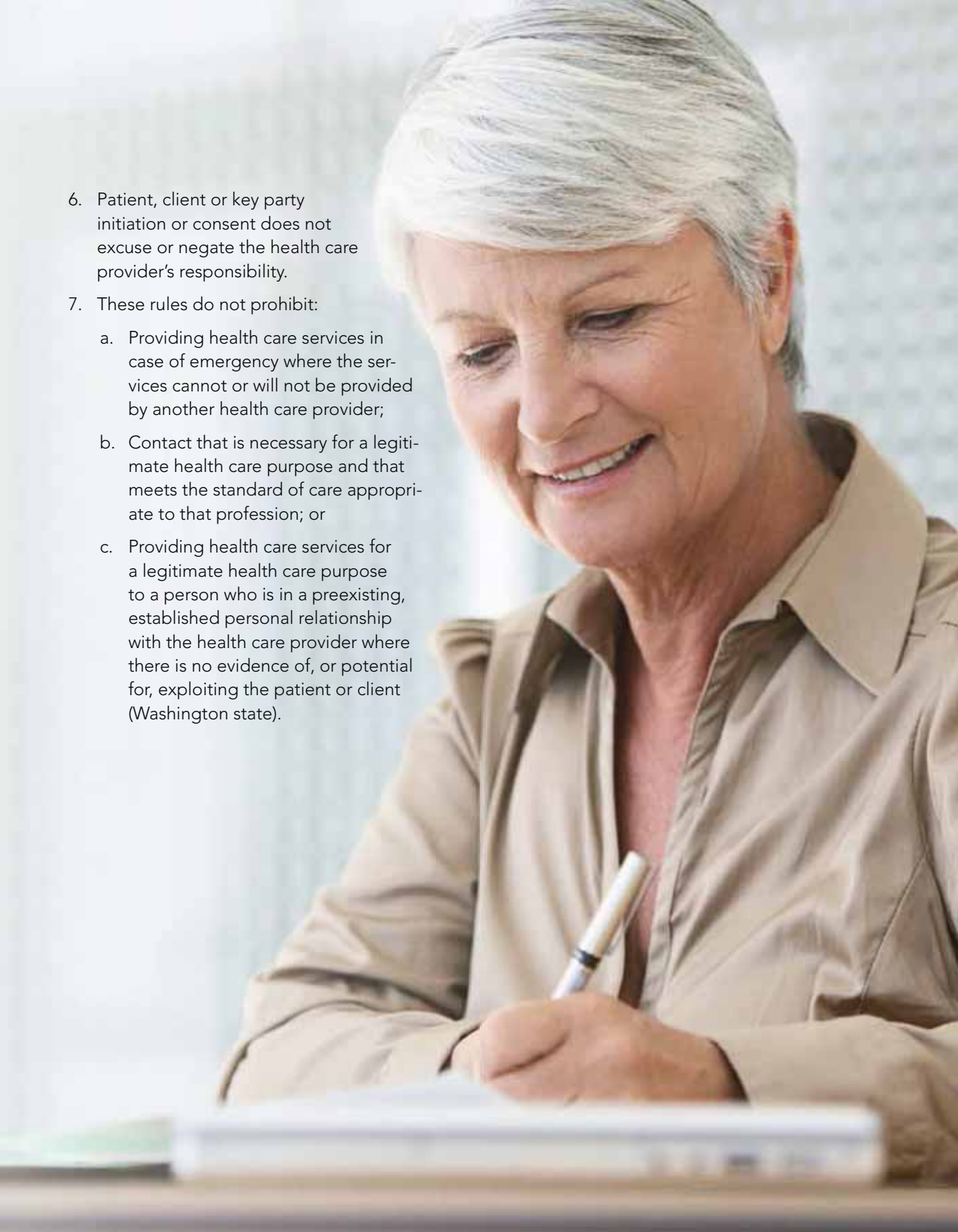
   e. Communication between the health care provider and the patient or client between the last health care services rendered and commencement of the personal relationship;

   f. Extent to which the patient's or client's personal or private information was shared with the health care provider;

   g. Nature of the patient or client's health condition during and since the professional relationship;

   h. The patient or client's emotional dependence and vulnerability; and

   i. Normal revisit cycle for the profession and service.



6. Patient, client or key party initiation or consent does not excuse or negate the health care provider's responsibility.
7. These rules do not prohibit:
    a. Providing health care services in case of emergency where the services cannot or will not be provided by another health care provider;
    b. Contact that is necessary for a legitimate health care purpose and that meets the standard of care appropriate to that profession; or
    c. Providing health care services for a legitimate health care purpose to a person who is in a preexisting, established personal relationship with the health care provider where there is no evidence of, or potential for, exploiting the patient or client (Washington state).

Sexual Impropriety

The term includes the following offenses:

1. Making sexually demeaning or sexually suggestive comments about or to a patient, including comments about a patient's body or undergarments.
2. Unnecessarily exposing a patient's body or watching a patient dress or undress, unless for therapeutic purposes or the patient specifically requests assistance.
3. Examining or touching genitals without the use of gloves when performing an otherwise appropriate examination.
4. Discussing or commenting on a patient's potential sexual performance, or requesting details of a patient's sexual history or preferences during an examination or consultation, except when the examination or consultation is pertinent to the issue of sexual function, dysfunction or reproductive health care. Discussion of a patient's sexual practices and preferences shall be fully documented in the patient's chart.
5. Soliciting a date from a patient.
6. Volunteering information to a patient about one's sexual problems, preferences or fantasies.

Sexual Violation

The term includes the following offenses:

1. Sexual intercourse between a nurse and a patient during the professional relationship.
2. Genital to genital contact between a nurse and a patient during the professional relationship.
3. Oral to genital contact between a nurse and a patient during the professional relationship.
4. Touching of breasts, genitals, or any other body part for any purpose other than appropriate examination or treatment.
5. Using prolonged or improper examination techniques or continuing examination techniques after the patient has refused or withdrawn consent.
6. Encouraging a patient to masturbate in the presence of the nurse or masturbating while a patient is present.
7. Providing or offering to provide drugs or treatment in exchange for sexual favors.
8. Using or causing the use of anesthesia or any other drug affecting consciousness for the purpose of engaging in conduct that would constitute a sexual impropriety or sexual violation (Pennsylvania State Board of Nursing).

OTHER RELEVANT DEFINITIONS:

Nurse/Patient Relationship

1. A nurse or unlicensed assistive personnel (UAP) shall not engage or attempt to engage a former client, or former client's immediate family member or significant other, in sexual or romantic conduct if such conduct would constitute abuse of the nurse/patient relationship. The nurse/patient relationship is abused when a nurse or nursing technician uses and/or benefits from the nurse's professional status and the vulnerability of the client due to the client's condition or status as a patient.

a. Due to the unique vulnerability of mental health and chemical dependency clients, nurses and nursing technicians are prohibited from engaging in or attempting to engage in sexual or romantic conduct with such former clients, or their immediate family or significant other, for a period of at least two years after termination of nursing services. After two years, sexual or romantic conduct may be permitted with a former mental health or chemical dependency client, but only if the conduct would not constitute abuse of the nurse/client relationship.

b. Factors which the BON may consider in determining whether there was abuse of the nurse/client relationship include, but are not limited to:

i. The amount of time that has passed since nursing services were terminated;

ii. The nature and duration of the nurse/client relationship, the extent to which there exists an ongoing nurse/client relationship following the termination of services, and whether the client is reasonably anticipated to become a client of the nurse in the future;

iii. The circumstances of the cessation or termination of the nurse/client relationship;

iv. The former client's personal history;

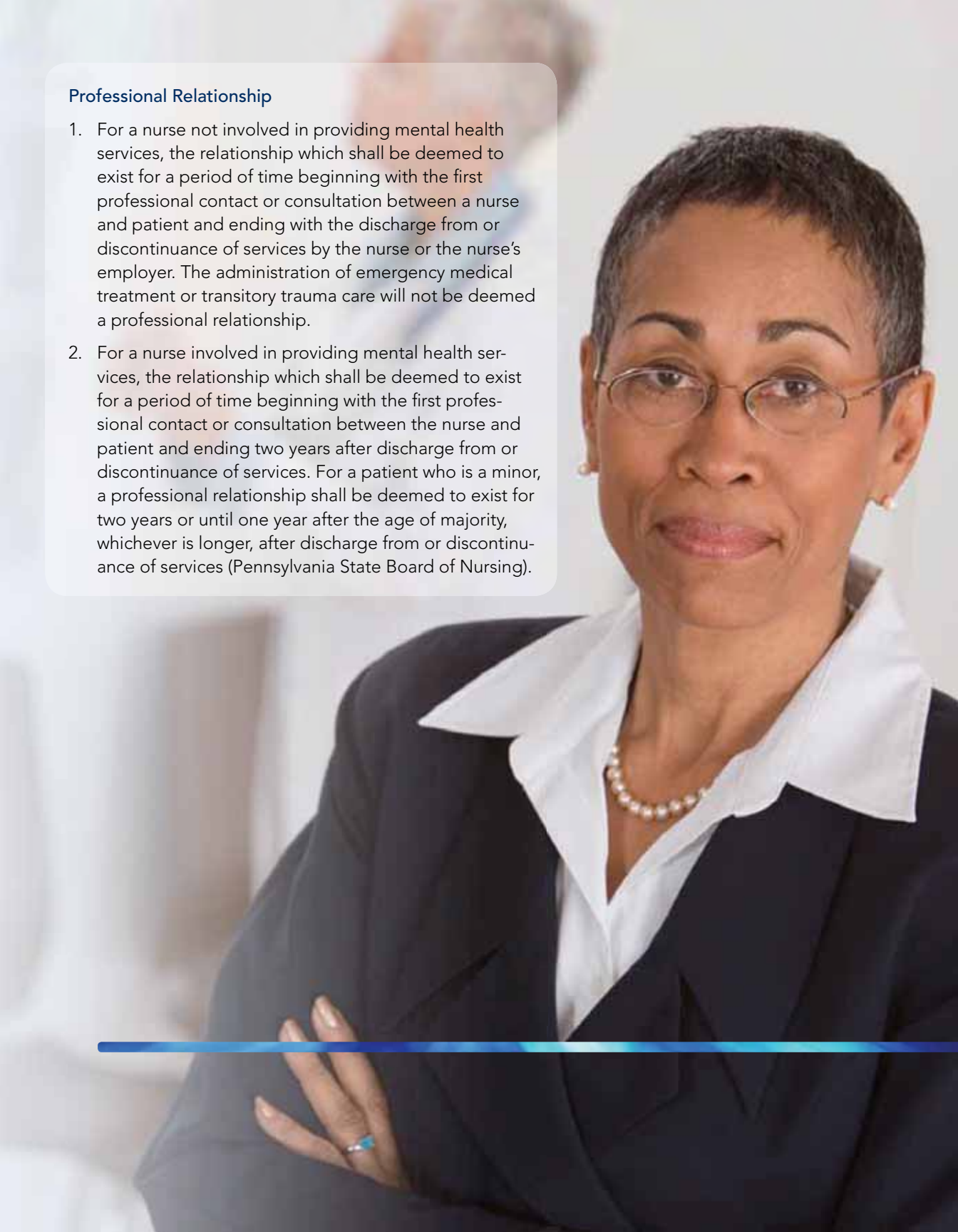
v. The former client's current or past mental status, and whether the client has been the recipient of mental health services;

vi. The likelihood of an adverse impact on the former client and others;

vii. Any statements or actions made by the nurse during the course of treatment suggesting or inviting the possibility of sexual or romantic conduct;

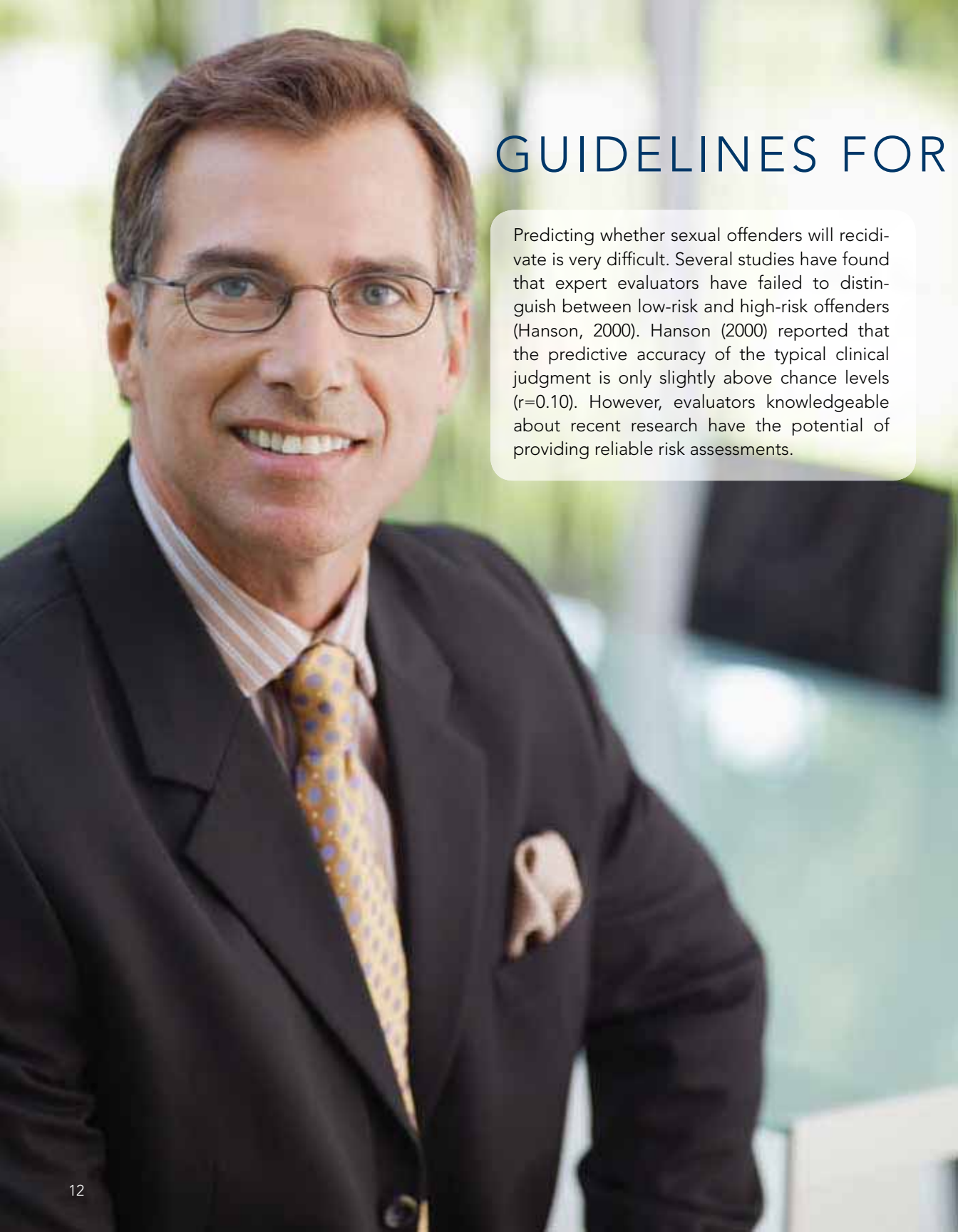
viii. Where the conduct is with a client's immediate family member or significant other, whether such a person is vulnerable to being induced into such relationship due to the condition or treatment of the client or the overall circumstances; and

ix. Key party is defined as immediate family members and others who would be reasonably expected to play a significant role in health care decisions of the patient or client and includes, but is not limited to, the spouse, domestic partner, sibling, parent, child, guardian and person authorized to make health care decisions of the patient or client (Washington state).



Professional Relationship

1. For a nurse not involved in providing mental health services, the relationship which shall be deemed to exist for a period of time beginning with the first professional contact or consultation between a nurse and patient and ending with the discharge from or discontinuance of services by the nurse or the nurse's employer. The administration of emergency medical treatment or transitory trauma care will not be deemed a professional relationship.
2. For a nurse involved in providing mental health services, the relationship which shall be deemed to exist for a period of time beginning with the first professional contact or consultation between the nurse and patient and ending two years after discharge from or discontinuance of services. For a patient who is a minor, a professional relationship shall be deemed to exist for two years or until one year after the age of majority, whichever is longer, after discharge from or discontinuance of services (Pennsylvania State Board of Nursing).



GUIDELINES FOR

Predicting whether sexual offenders will recidivate is very difficult. Several studies have found that expert evaluators have failed to distinguish between low-risk and high-risk offenders (Hanson, 2000). Hanson (2000) reported that the predictive accuracy of the typical clinical judgment is only slightly above chance levels (r=0.10). However, evaluators knowledgeable about recent research have the potential of providing reliable risk assessments.

SELECTING AN EVALUATOR

The following are criteria that BONs might consider when selecting an expert evaluator to conduct an evaluation of the nurse accused of sexual misconduct. At a minimum, evaluators should be selected on the basis of their membership in and adherence to the practice and ethical standards espoused by professional associations and BONs, such as the Association for the Treatment of Sexual Abusers (ATSA) or the American Psychology and Law Society (APLS). In addition:

- Consider a senior practitioner in his/her field: a psychologist, nurse, social worker or psychiatrist who has experience evaluating health care professionals.
- Consider an evaluator who uses a multidisciplinary approach to evaluating sexual misconduct cases. The multidisciplinary approach can include screening for comorbid disorders, such as attention deficit hyperactivity disorder (ADHD), mood disorders, Axis II disorders, cognitive impairment, dementia, compulsivity, as well as any underlying physical disorder.
- Consider evaluators who are certified in performing neuropsychiatric testing.
- Look for demonstrated skill in setting up rehabilitation plans specifically for patients who are health care providers.
- Obtain references from those who have used the evaluator's services (ideally for third-party evaluations).

The prospective evaluator should:

- Have an understanding of public policy, safety issues and know how to perform an evaluation for a third party (the BON). (An evaluator does not have to be a forensic psychologist, but does need to realize he/she is serving a different purpose than providing routine therapy services.);
- Be willing to review detailed descriptions of allegations;
- Be willing to broaden sources of evaluation, e.g., at least a brief phone interview with the complainant to assure a clear picture of what is alleged;
- Be committed to obtaining an understanding of the nursing field involved; and
- Be willing to consult with nurses, not only regarding the nursing field, but also the setting, to gain appreciation of the elements, potential risk and the ethical implications of the situation.

Many states have Web sites that provide information on the selection of experts for conducting assessments of sexual offender. An example of such a Web site is http://www2.state.id.us/socb. See Box 1 for the criteria cited on Idaho's Sexual Offender Classification Board (SOCB) Web site. See Case 3 in this booklet to illustrate how to use these guidelines to select an evaluator.

Box 1

Idaho State Web Site Suggestions for Evaluator Criteria for Sexual Misconduct Offenders

- Certified evaluator; and
- Licensed psychiatrist or licensed masters or doctoral level psychologist, social worker, counselor or marriage/family therapist.

Specialized Training

- Must have attended 200 hours of formal conferences, symposia or seminars related to the treatment and evaluation of adult sexual offenders. A list of the qualifying scope of training is indicated in the SOCB administrative rules or may be requested from the SOCB.

Experience Qualifications

- At least 2,000 hours of adult sexual offender treatment and evaluation experience within the preceding 10 years, including:
  - At least 250 hours of adult sexual offender evaluation experience; and
  - At least 250 hours of adult sexual offender treatment experience.

Understanding

- Should have a thorough understanding and a broad knowledge of sexuality in the general population.
- Should also have a good understanding of basic theories and typologies of sexual offenders and sexual assault victims.

Continuing Education Requirement

- Attendance of 40 hours at formal conferences, symposia or seminars related to the treatment and evaluation of adult sexual offenders within the preceding two years is required to maintain certification.
- Up to 10 of these hours may be obtained from online educational sources during a two year period.

Please see Box 2 for the *Standards for Psychosexual Evaluations*, required by Idaho's Sexual Offender Classification Board Web site.

Box 2

Standards for Psychosexual Evaluations: Idaho State Web Site

Outlined below are required areas of mental health sex offense-specific evaluations. It is minimally required that evaluators use some type of offense-specific psychological testing. No single test should be seen as absolute or predictive; rather, results should be seen as contributing to the overall evaluation of the sex offender and his/her risk to the community. Effective evaluations must include multiple risk factors. The evaluator should be cognizant that an offender's self-report is demonstrated by research to be the least reliable source of information during the evaluation and shall take steps not to rely solely on self-report information.

1. Accurate identification of the offender, including his/her current legal status and reason(s) for conducting the evaluation.
2. A list of all sources of information utilized in the evaluation.
3. Results of all psychological, physiological, medical testing, and examinations, including a summary of the clinical interview and a complete DSM-IV diagnosis.
4. Background information to include family; medical; educational; military; interpersonal development; sexual; occupational; recreational; criminal; and as applicable, institutional history.
5. Offense history to include: specific descriptions of the convicting offense(s) as explained by the offender and the victim(s) or the victim(s) representative; number of victims; characteristics of victim(s); relationship of offender to victim(s); number of violations of each victim; seriousness of offense(s); and predatory nature of offense(s).
6. A sexual history provided by the offender. Verification by polygraph is highly recommended.
7. Assessment of offender's sexual behavior, general characteristics, including sexual deviances, and personality profile.
8. Risk of reoffense, risk to the community, amenability to treatment, intent of offender upon release to the community, and the basis for the assessed risk.
9. Recommendation if offender is an appropriate candidate for future violent sexual predator review and rationale for the recommendation. For offenders being reviewed by the Board, a recommendation for or against classification of offender as a violent sexual predator and rationale for the recommendation.

Polygraphy, physiological and/or viewing time measures are highly recommended, but not required. Those recommendations are found at: http://www2.state.id.us/socb.

The Federation of Medical Boards has guidelines for selecting an evaluator to assess physicians who are accused of sexual misconduct, found in Box 3. Their guidelines are more general than those found on the Idaho Web site. The elements of their evaluation process are in their document, *Addressing Sexual Boundaries: Guidelines for State Medical Boards* (http://www.fsmb.org/pdf/GRPOL_Sexual%20Boundaries.pdf).

Box 3

Federation of State Medical Boards Suggestions for Evaluator Criteria

1. Evaluators should be licensed health care professionals with demonstrated knowledge, based upon education, training and supervised experience. Their expertise should be related to the evaluation of sexual misconduct and recognition of the characteristics of physicians who have engaged in sexual misconduct with patients or patient surrogates.
2. The evaluation should be conducted by an independent evaluator to avoid a conflict of interest.
3. There should be no prior professional or personal relationship between the evaluator and the physician being evaluated.
4. Former sexual misconduct offenders should not be approved to conduct evaluations.
5. Evaluator(s) should be approved in advance by the board.

The American Psychology-Law Society released their *Specialty Guidelines for Forensic Psychology* on Sept. 2, 2008, (http://www.ap-ls.org/links/92908sgfp.pdf). Under Section 4, which outlines the competence of the evaluator, the following criteria are specified:

- Scope of competence;
- Gaining and maintaining competence;
- Representing competencies;
- Knowledge of the legal system and the legal rights of the individuals;
- Knowledge of the scientific foundation for opinions and testimony;
- Knowledge of the scientific foundation for teaching and research;
- Considering the impact of personal beliefs and experience;
- Appreciation of individual differences; and
- Appropriate use of services and products.

The ATSA set their practice standards in 2005 and their general training and qualification standards can be found in Box 4.

It is anticipated that BONs will review these criteria and choose those that would best serve their needs.

Box 4

General Training and Qualification: Association for the Treatment of Sexual Abusers

- Professionals providing clinical service, who do not have graduate or professional degrees, have had specific training and experience in working with individuals who sexually offend and are under the direct supervision of a qualified mental health professional.
- Professionals providing clinical services participate in a minimum of 2,000 supervised hours of face-to-face clinical contact with individuals who sexually offend before providing unsupervised clinical services.
- Professionals obtain and document annual continuing education in the field of sexual abuse. Continuing education includes courses, seminars, conferences, workshops, and other training experiences.
- Professionals have education, training, and experience in the evaluation, treatment, and management of individuals who sexually offend. Members working with a specialized population have education, training, and experience specific to that population (for example, clients with developmental disabilities, or clients with mental illness).
- Professionals complete courses, training, and/or gain experience in order to become knowledgeable about the following areas (the order does not indicate priority):
    - Assessment and diagnosis;
    - Cognitive therapy;
    - Counseling and psychotherapy;
    - Cultural/ethnic issues;
    - Ethics as applied to working with a forensic population;
    - Human development with special attention to sexual development;
    - Interviewing skills;
    - Knowledge of family dynamics as related to sex offending;
    - Psychometric and psychophysiological testing;
    - Psychopathology;
    - Relapse prevention;
    - Relationship and social skills training;
    - Risk assessment;
    - Sexual arousal control;
    - Social support networks; and
    - Victim awareness and empathy.

GUIDELINES FOR ESTABLISHING SANCTIONS FOR SEXUAL ABUSERS

The expert evaluator that the BON hires will consider a range of risk factors. No single risk factor can be linked to recidivism of sexual offenders. Hanson (2000) reports on the strongest predictors of sexual offense recidivism, as obtained from a meta-analysis by Hanson and Bussière (1998). All of these factors have been replicated in at least four studies, thereby providing evaluators with some evidence upon which to base their decisions. The single strongest predictor was sexual interest in children as measured by phallometric measurement (r=0.32, with total sample size of 4,853 and a total of seven studies). While the correlations are weak, the following are also identified as risks, in descending order:

- Any deviant sexual preference (r=0.22; sample size 570; five studies).
- Prior sexual offenses (r=0.19; sample size 11,294; 29 studies).
- Treatment drop out (r=0.17; sample size 806; six studies).
- Any stranger victims (r=0.15; sample size 465; four studies).
- Antisocial personality (r=0.14; 811 sample size; six studies).
- Any prior offenses (r=0.13; sample size 8,683; 20 studies).
- Age of accused (young) (r=0.13; sample size 6,969; 21 studies).
- Early onset of sexual deviance (r=0.12; sample size 919; four studies).
- Any unrelated victims (r=0.11; sample size 6,889; 21 studies).
- Any boy victims (r=0.11; sample size 10,294; 19 studies).
- Single (never married) (r=0.11; sample size 2,850; eight studies).
- Diverse sexual crimes (r=0.10; sample size 6,011; five studies).

Hanson (2000) cautions that this list is not an exhaustive list, but an evidence-based starting point for evaluators. New items should be added as the evidence becomes available. Anger, for example, did not rank high enough in the meta-analysis to be included, though chronic hostility has shown to predict recidivism in other studies. Clinicians are also interested in dynamic life factors, rather than the listed static factors, though there has been less research in that area. Preliminary research, however, supports the following dynamic factors (Hanson, 2000):

- Intimacy deficits – problems with forming satisfactory love relationships.
- Negative peer influences – peers with deviant lifestyles or inadequate coping strategies.
- Attitude tolerant of sexual offending – feeling that women like being raped or that adult-child sex is harmless.
- Problems with emotional/sexual self-regulation – feelings of sexual entitlement or the tendency to cope using sexual thoughts or behavior.
- General problems with self-regulation – poor self control or unable to follow societal conventions.

Other dynamic factors include substance abuse, acute anger and lack of cooperation with community supervision. Scales have been developed that combine individual risk factors into summary scores, and examples can be found at http://www.atsa.com/pdfs/InfoPack-Risk.pdf. While there is agreement that evaluators should consider valid risk factors, disagreement arises on the best method to combine the factors.

See Figure 1 for the Washington state sanction schedule and refer to the following document for an example from the Texas Board of Nursing: http://www.bon.state.tx.us/disciplinaryaction/pdfs/sexmis.pdf.

Figure 1

Washington's 2009 Mandatory Sanction Schedule
Sexual Misconduct or Contact

SEXUAL MISCONDUCT OR CONTACT (including conviction for sexual misconduct)				
Severity	**Tier/Conduct**	**Sanction Range** In consideration of aggravating and mitigating circumstances		**Duration**
		Minimum	**Maximum**	
least ↓ greatest	**A**. Inappropriate conduct, contact or statements of a sexual or romantic nature.	Conditions that may include reprimand, training, monitoring, probation, supervision, evaluation, etc.	Oversight for three years, which may include reprimand, training, monitoring, supervision, evaluation, probation, suspension, etc.	Zero to three years
	B. Sexual contact, romantic relationship or sexual statements that risk or result in patient harm.	Oversight for two years, which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc.	Oversight for five years, which may include suspension, probation, practice restrictions, training, monitoring, supervision, evaluation, etc., or revocation.	Two to five years, unless revocation
	C. Sexual contact, including, but not limited to, contact involving force and/or intimidation.	One year suspension and oversight for five additional years, which may include suspension, probation, practice restrictions, training, monitoring, supervision, probation, evaluation, etc., and demonstration of successful completion of evaluation and treatment.	Permanent conditions, restrictions or revocation.	Six years to permanent

FITNESS FOR PRACTICE GUIDELINES

BONs must make difficult decisions about whether nurses are fit to practice after they've successfully completed a treatment program for sexual offenders. The following are some guidelines they might consider. See Case 3 to illustrate how these guidelines might be applied to a case. Carr (2003) suggests elements for professional sexual misconduct monitoring with physicians. Those have been adapted in Box 5 as possible elements of monitoring contracts with nurses.

Box 5

Essential Elements of a Professional Sexual Misconduct Monitoring Contract

- Agreement for sexual abstinence outside of the primary relationship.
- Agreement for abstinence from any form of cybersex, including, but not limited to: accessing pornographic Web sites; soliciting sex from the Internet; texting sexual messages; taking inappropriate sexual photos; and e-mailing, blogging, facebooking, tweeting, skyping, webcamming, instant messaging, posting, etc., sexual messages on the Internet.
- Abstinence from mood altering drugs/alcohol, if indicated, with drug screens.
- Workplace monitoring with regular reports.
- Nurse's physician and therapist, if indicated, acceptable to the BON.
- Couples therapy, if indicated.
- Compliance with any prescribed medications.
- Mandates for ongoing training, such as ethical boundaries, if indicated.
- Notification of appropriate staff in the workplace of past issue(s). These personnel should not act as detectives, but should report concerns promptly.
- Patient surveillance forms disguised to look like patient satisfaction forms, if indicated.
- Use of informed, licensed chaperones.
- Group therapy with other professionals, if indicated.
- Sex Addicts Anonymous groups, if indicated.
- Other 12-step groups, as indicated.
- Relapse prevention plan.
- Peer practice monitor.
- Agreement for support and encourage recovery for spouse/significant family and other family.
- Agreement for targeted practice, if limited.
- Agreement for provisions for portability if nurse should move.
- Agreement to submit to polygraph, if warranted.
- Agreement to allow free exchange of information between all involved, including the BON.

Box 6 presents some possible general guidelines, gleaned from the substance abuse literature, that the expert evaluator will consider when deciding if the rehabilitated sex offender is fit for practice. Before considering fitness for practice guidelines, the following should have been documented to the BON:

- The nurse must have successfully participated in a treatment process;
- A specific relapse plan should be designed; and
- The nurse must provide the BON with documentation of adherence to the treatment plan.

Box 6

Guidelines for Fitness for Practice

- Global Assessment Functioning (GAF) of at least 70.
- Has adequate control of emotions (such as sadness, anxiety, anger, fear, etc.).
- Has adequate energy to perform eight hours of work per day.
- Has adequate cognitive capacity (in terms of ability to focus, concentrate, remember things and organize material).
- Has reached a comfort level in interpersonal interactions.
- Is not abusing substances or engaging in compulsive behaviors of any kind (over spending, over eating, sexual addictions, alcohol, gambling, etc.).
- Has reached a comfort level in coping with circumstances that led up to treatment.
- Is agreeable to transition into work hours and responsibilities (such as part-time work for the first one to two weeks).
- Has achieved competence to handle ethical and professional responsibilities.
- Is willing to participate in posttreatment surveillance (i.e., feedback forms from coworkers and patients, polygraphs).

Some further guidelines for regulators include:

- Ask the sexual abusers what they have learned to stop the behavior.
- What specific steps they are going to take to prevent it from ever happening again?
- Let the abusers know that they do not get credit for leaving themselves in harm's way.
- The abusers should be able to recognize and avoid the red flags (J. Tallant, personal communication, April 8, 2009).

There is evidence to support that health care professionals who violate sexual boundaries can successfully return to work without recidivism (Abel, Osborn & Warberg, 1998). Abel, Osborn & Warberg (1998) reports that of the cases treated at the Behavioral Medicine Institute of Atlanta, 47.7 percent returned to practice with a recidivism rate of less than 1 percent in seven years. With the selection of an expert evaluator (Boxes 1-4) and when the offending nurse receives expert treatment, the BONs can use the information in Boxes 5 and 6 for ongoing surveillance of the offending nurse, in their very difficult job of protecting the public in sexual misconduct cases.

FRAMEWORK FOR DECIDING WHEN/HOW TO TAKE ACTION IN SEXUAL MISCONDUCT CASES

This comprehensive framework will be valuable to BONs as they review complaints of sexual misconduct. See Cases 1 and 3 at the end of this booklet to illustrate how this framework might be used.

FIRST CONSIDER: Should the complaint be opened for investigation in the first place? If it should, decide what priority it should be given (e.g., any potential emergency action is priority A and all other sexual misconduct is priority B).

- How egregious is the misconduct alleged?
- Were there aggravating circumstances that warrant higher priority, such as force, intimidation, stalking or highly vulnerable patient (e.g., mental health patient, comatose)?
- What is the source of or nature of the complaint?
- Is it anonymous or possibly biased? Is it rumor and hearsay versus observation (e.g., "I heard that…")?

- What is the alleged victim's condition/diagnosis? Is there any indication of cognitive impairment, temporary (post-operative) or otherwise (such as dementia)?
- Is there a history of similar allegations against other staff?
- Do we know anything about the alleged perpetrator? Is there any prior history such as an allegations in another place?

NEXT CONSIDER: Once opened for investigation, can we develop the case and when will we have a case worth charging (*prima facie case*)? Where is the evidence located? What can I get? Where can I find it?

- Is there forensic evidence (e.g., a rape kit)? Were there medical reports?
- If it occurred at a facility, was an internal investigation conducted? Can we get a copy of the report? (Note: has an initial investigation by the facility had a dilatory effect on our investigation?) We may have to obtain a subpoena.
- Were there witnesses to the incident or other relevant observations beyond the victim? Oftentimes people don't see the incident, but they may see other things, such as running out of the room, closing the door, etc.
- How credible are the alleged victim's allegations? Is the story consistent to various parties? Was there appropriate postincident behavior? Sometimes victims wait awhile and it might be appropriate, but the investigators must know about it. Did the victim report to someone right after the episode or provide credible reasons why not? How does the victim present as a witness generally?
- Consider the state's duty to report requirements. If none, consider contacting law enforcement anyway (see Law Enforcement Coordination section).

ALSO CONSIDER:

What is the licensure status of the alleged perpetrator?

- Is the alleged perpetrator still working at the facility?
- If he/she is fired or on administrative leave, is there a chance he/she is working elsewhere?
- Ask the licensee about work status when you interview him/her, as this is relevant to making an argument for imminent danger justifying a summary action.

- Presume the alleged perpetrator is working if he/she is actively licensed, regardless of what anyone says.
- Find out if the individual is licensed in more than one state; if so, where? Are there any applications open?
- Is the nurse amenable to having his/her license put on an inactive status, voluntarily, pending resolution?

Law enforcement coordination: Is law enforcement involved?
Should they be?

Initiate coordination:

- At what stage is the investigation? You need to know whom to communicate with. Do they anticipate filing any charges?
- If there is still an investigation, then reach out to the detective/special assault unit and ask for what they have. Ask if you can shadow the officers as they conduct key interviews, especially when the alleged victim or licensee is to be interviewed. If the law enforcement investigation is stalled or stale, ask why. Acknowledge that they have different levels of proof and a different focus on their investigation.
- How much of the critical evidence is now tied up in police files? Will they release a copy?
- Can you rely on what was filed in criminal court alone? Usually mere fact of criminal charges does not equal professional misconduct. An Affidavit of Probable Cause is not evidence; instead it is the affiant swearing there is sufficient evidence in the police report to support the charges. Remember that it's double hearsay. Usually the investigating officer tells the prosecuting attorney what happened and then the prosecuting attorney reiterates that to the judge in his affidavit. It still might be reliable enough to base the initial charges on. However, you will likely need to have the underlying police report and/or the officer, victim and other witnesses available to testify at the time of the expedited hearing, if you want a summary action.

Note: There are risks in getting ahead of a county prosecutor. If the police report is already filed with the prosecuting attorney for precharging review, reach out to the prosecuting attorney. Questions to ask include:

- Have you reviewed the file?
- Do you anticipate filing charges and for what sort of crimes?
- What are your proof concerns?
- Would you have a problem with us moving ahead and using evidence from the police report?
- If we file charges, it is likely that the licensee will receive a copy of everything relied upon, including what was obtained in confidence from the police investigation, such as contact information for witnesses. Will the regulatory action result in a release of the internal police investigation to the respondent precriminal charges? Will this spoil the authority's investigation against the licensee? Will it spoil your working relationship with the local authorities?

How should you best approach alleged victims/witnesses when it is appropriate to investigate?

- Interview the victim separately in a safe environment whenever possible.
- Ask questions in a neutral, objective and nonjudgmental fashion.
- If possible, record the interview.
- A phone interview may be all that is available.
- Get the victim's statement in writing.
- Take notes as to what he/she says, transpose, and go over the notes with him/her.
- Make sure victims/witnesses agree with every aspect of content and then have him/her sign the statement.
- Consider composing a memo to file by the investigator as to what he/she observed/heard, in addition to the alleged victim's statement; this is often helpful because subsequent legal review by the attorney will use it to aid the BON in determining sufficiency.
- It is beneficial to have two investigators. One investigator should ask questions – preferably this investigator is the same sex as the victim and has a calming disposition, if appropriate. The other investigator can record impressions, take careful notes of content, and make accurate and detailed observations as to how well the victim presents as a potential live witness.

Are you legally barred from disseminating preconviction data?

- If you are charging the licensee while he/she is still being investigated by the police or in the case of a deferred prosecution, take steps to bar further release of all preconviction data to the public, since you are relying on this information.
- Move for a protective order regarding the evidence and keep the fact the licensee is being investigated out of your pleadings or discussions with the media.
- Once criminal charges are filed, however, the licensee is entitled to discovery and usually gets most of the police report.
- If the authority is opposed to your BON getting ahead of the criminal matter, ask whether they would still be willing to share their investigative results so that you can prepare your case. Then once the local authorities are ready to file their charges, you can do the same in your forum.

If we are barred from using police investigation materials or it's not advisable, can we and when should we, develop our own investigation? Will this result in impeachable evidence?

- The more you document the alleged victim's or other witnesses' story, the more you create opportunities for opposing counsel to point out inconsistencies.
- If you go to hearing before the prosecuting attorney does, do you create the risk that the defense counsel gets to pretry the criminal matter and test the case in advance to find weaknesses?
- Can you be sure fragile witnesses can stand two full hearings?
- What is the greater goal, taking the license or incarcerating the predator?

Is the licensee incarcerated?

- Arrested and released without charges or bail? Then the nurse is still free to practice and the law enforcement investigation remains nonpublic.
- Arrested, charged and on bail? The criminal information is public. Ask the prosecutor to request that the judge restrict the licensee from practicing, pending trial.
- In jail and has not posted bail? How high is bail set? They only need to come up with 10 percent of the bail amount and there is no way of knowing when he/she might post bail. How soon is the trial?

ANTICIPATE

MEDIA RESPONSE

- Has the incident gone public or might it go public? Arrest/charges are a matter of public information; witnesses could go to press at any point.
- Prepare a media release in anticipation.
- Consider developing, in every such case, a standard report sent from the front-line staff up the organization's hierarchy so that upper management won't be blind-sided by outside inquiries or media reports.
- Rapid response to media inquiries is essential; you can't put them off. For example, you might say, "Let me give you the person who can give you the answers as soon as possible." Quickly ascertain the appropriate spokesperson and direct them to respond promptly.
- Decide on and stick with a consistent message during the investigation. For example:
    - "We take these sorts of complaints very seriously."
    - "Upon hearing of these allegations, we immediately opened a complaint on a priority basis."
    - "Allegations of this nature are serious and must be thoroughly investigated."
    - "We are still actively investigating this matter and are working in close coordination with local law enforcement."

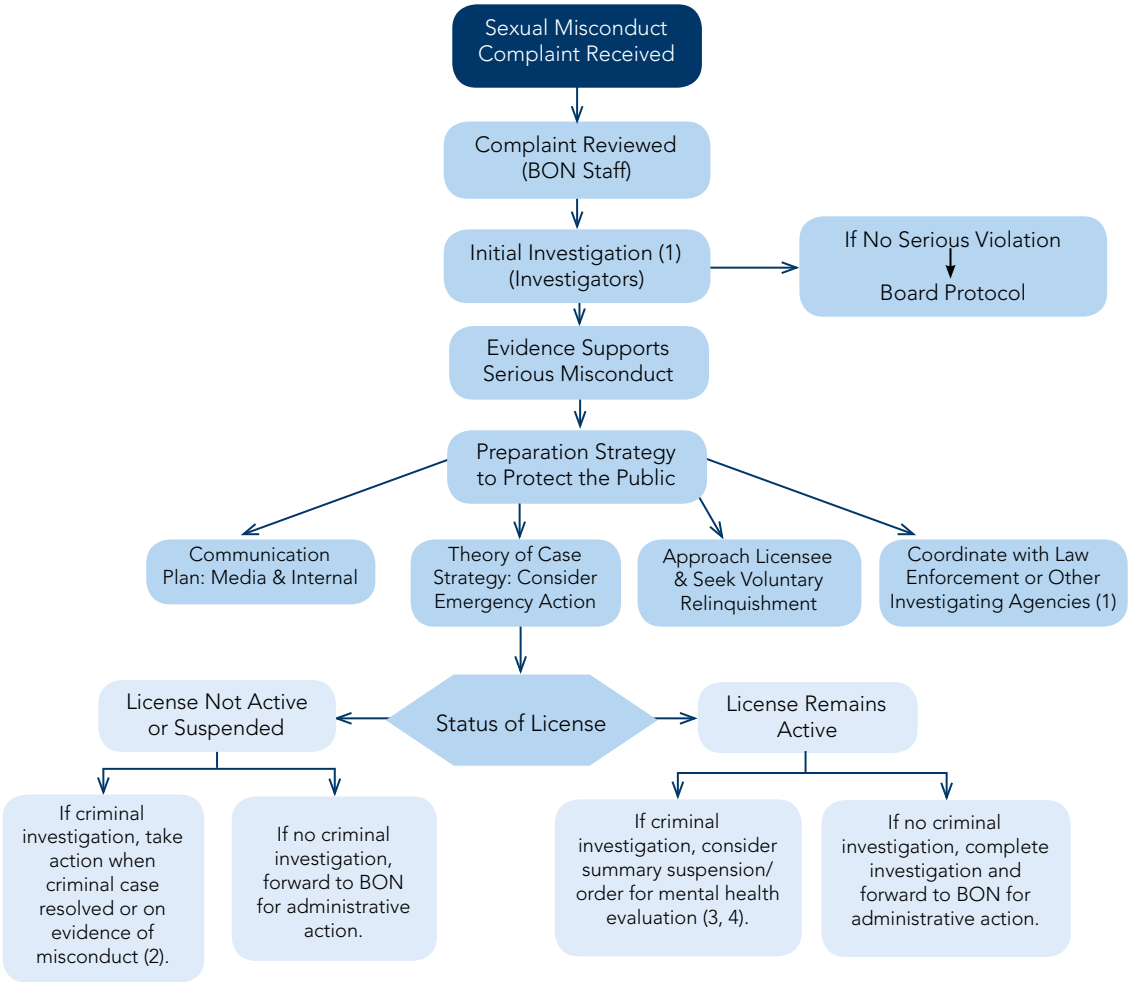
Summary (emergency) action or not?

Once you have developed minimum legal sufficiency in terms of supporting evidence and have the green light from law enforcement, how should you proceed?

- Summary action or standard charges? Even if you have serious allegations and enough to charge, strategically, there are sexual misconduct cases where it would be more effective to not risk rushing to full hearing on an expedited basis. Instead, consider issuing standard charges and using discovery to build a better case and/or anticipate that the media coverage of the charges will result in more victims coming forward. Also, if the criminal matter resolves with a plea bargain, you can amend your charges to cite only the new conviction and avoid having to prove the underlying case.

SEXUAL MISCONDUCT PATHWAY: BON MANAGEMENT

The following is a user-friendly summary of major points for BONs to consider when reviewing sexual misconduct cases. See Case 1 to illustrate how to use this pathway.



1. Administrative investigations become secondary to a criminal investigation. It is important to understand that law enforcement may need to protect evidence involving their investigation from becoming public knowledge. Offering assistance may help to involve the BON in the investigative process. It may also keep BON investigators close to the criminal progression and details of the allegations. It is important that agencies understand what the BON will need to proceed with action on the nurse's license.

2. If the nurse remains inactive from nursing practice, it may be important to delay administrative action until criminal action has been completed or until reports are released by other agencies (police, courts, etc.). Many BON laws and rules include charges for levels of criminal prosecution.

3. To protect the public, it may be necessary to take action prior to a criminal action (or in lieu of a criminal action) being completed realizing that the action may not include all possible charges by the BON.

4. Consider making a formal request to the court or law enforcement for the license to make their license inactive (even if not granted).

The following cases are based upon real incidents adjudicated by BONs. Some information has been changed to protect the anonymity of those involved.

CASE 1

The investigator received a complaint that a male nurse (Mr. A) had been accused of a rape in a neighboring state. Mr. A had allegedly raped the wife of the complainant while Mr. A was hosting a swinger's party. The complainant attached nude photos of Mr. A and his wife (also an RN) from the Internet. The couple was active on a proswinger Web site and had elicited contact with other swingers.

The complainant noted that at the party, Mr. A had penetrated the complainant's wife while in the hot tub. He stated that it was discussed prior to the party that the rules forbid any sexual intercourse with others' spouses. The complainant went on to discuss specifics of swinger parties and rules that are laid out in advance.

The complainant also noted that his wife was given some liquor from Mr. A's bar that he believes was spiked with a narcotic. His wife complained of being drugged prior to the incident with Mr. A in the hot tub.

A police report had been filed, but the police noted that they did not have a criminal case. Members were at the party as swingers, they were in various stages of dress and there was noted alcohol use. The complainant stated he understood that there would probably not be criminal charges, but insisted his wife was raped by Mr. A and that the BON should monitor his behaviors.

The BON investigator continued to investigate these complaints and gathered police reports.

The BON was then contacted by a hospital in their state and told that Mr. A was being charged with rape of a patient. The patient claimed that Mr. A had drugged her with morphine and then forced her to have oral sex with him. The facility police reported that the bed sheet had been secured and sent for DNA testing. They had to get a court order to have Mr. A provide a DNA specimen and were able to get an oral swab from him.

Issues for the BON to consider:

- The nurse has an active license and he can still work; yet, he is facing possible first-degree felony charges.
- There are no charges against him. The police want to wait for the DNA results before charging him with a crime.
- There are very serious accusations, but the BON cannot go public with these because the police will not give them the report until the prosecutor releases it.
- The nurse also has licensure in an adjoining state.

Discussion/Recommendations:

1. What can you do while the police are awaiting the results of the DNA results? In this case, the DNA is delayed because the state crime lab has a backlog of cases to complete. Contact the nurse and ask him to voluntarily go inactive. If he refuses to go inactive, the BON might order a mental health evaluation.
2. What should you do if you hear he is working at another hospital in the area as an agency nurse? Contact them and ask if he is working there, though you may be unable to tell them why you are asking.
3. Contact local facilities (hospitals, nursing homes) and local nursing agencies asking if he is employed with them. He could be connected to several other agencies. If you locate any employers, point them to available public records (such as court actions or police reports). Contact his agency, though he could be connected with another nursing agency and could be working elsewhere.

Conclusion of Case

Mr. A is arrested and charged with a first-degree felony. The BON investigator contacts him again and asks him to go on inactive status. He agrees to go inactive, but states he must contact an attorney. Mr. A still insists he is innocent and that he will be found not guilty. He asks what the BON will do if he is found not guilty. He is told that the BON will still go forward with some form of action because his history shows that sexual activities (such as swinging, using pornographic Web sites) are a part of his lifestyle and this concerned the BON. The investigator tells him that he expects the BON will still want a mental health evaluation and that they may still take administrative action.

The investigator makes contact with Mr. A's attorney (who had a history of working with the BON and had a good rapport with the investigator) and is told that Mr. A will go inactive. Days later, the investigator received another call from the attorney; Mr. A had committed suicide.

Utilizing Consistent Guidelines

In order to provide consistent guidelines to BONs, the *Sexual Misconduct Pathway* or the Framework for Deciding When/How to Take Action in Sexual Misconduct Cases can be used to consistently make decisions in sexual misconduct cases.

In this case, using the pathway, we find that the complaint was reviewed and is serious. Strategies to protect the public were taken in this case by quick action of the BON to make sure he is put in an inactive status. The BON also checked his licensure status in an adjoining state. Coordination with law enforcement was outlined. A media plan, however, was not discussed and should be considered, as this could very well be a visible case. Referring to the framework we find that the BON should prepare a media release in anticipation. If there are calls to the BON, everyone should know to say, "Let me give you the person who can give you the answers as soon as possible." Then you get someone quickly to give that message and get back that same day.

CASE 2

January 2006

An allegation was received from an administrator of a long-term care facility (Facility A) regarding inappropriate behavior of an LPN employee. The allegation was that the nurse had followed a female coworker into a medication room, closed the door, and started hugging and kissing her. She pushed him away and left the room. The nurse resigned before being terminated from Facility A for inappropriate sexual advances towards a coworker.

Upon investigation, there were no practice issues identified, the nurse denied the allegation and there was insufficient evidence for the BON to take action. The female coworker, however, did provide a statement that the offender trapped her in a corner, started hugging and kissing her, and told her that she was denying her needs for him. She stated that she kept pushing him away and was frightened by his behavior. She asked for an escort to her vehicle that evening when leaving the facility because she was concerned that he would continue to pursue her.

June 2006

A second allegation was received from a long-term care facility (Facility B) that the nurse was terminated after two residents complained of sexual misconduct. The allegations, however, could not be substantiated by internal investigations.

The first alleged incident occurred in April 2006. Resident T claimed the nurse felt all over her body looking for a Duragesic patch. When she informed him it was on her back, he allegedly asked her "What are you going to do for me since I did something for you?" Resident T had a history of Guillian-Barre syndrome, drug and alcohol abuse, and frequently made unfounded allegations against staff, particularly about not getting medication that she was supposed to have gotten. Resident T was asked to make a statement; she made an initial statement the next morning and then gave a second, very detailed statement. When contacted, her husband said she often has hallucinatory episodes, hears voices and makes accusations about not getting her medication.

Upon interview, the nurse said Resident T got angry because she alleged that the medication was not administered. Even though the nurse stated that he was trying to change a patch, he did not sign out a patch to administer.

Further investigation showed that Resident T had an order for a Duragesic patch to be changed every 72 hours; it had been applied earlier that morning and was not due to be changed. Resident T also had an order for Xanax four times a day, which was on a 9 am, 1 pm, 5 pm and 9 pm schedule. The nurse signed out Xanax at 6 am, but

did not document having administered the medication in the medication administration record or in the nurses' notes.

Resident T gave a very detailed statement about the nurse giving her some medication and rubbing her breasts. Further, the nurse rubbed her back and shoulders and asked her about a rash on her body. She told him it was psoriasis and that her husband brought some powder for it. He asked her where the powder should be administered and she showed him her stomach. The nurse asked where else, and she pointed toward her groin area. The patient claimed he then pulled her pants down and rubbed that area. The nurse then asked her what she was going to do for him since he had done something for her by giving her the medication.

While her husband verified that Resident T sometimes heard voices and had visual hallucinations, she had never made an allegation of sexual misconduct.

The second alleged incident occurred in June 2006.

Resident S claimed that the nurse came into her room, began feeling around her chest area and fondled her breasts. He then attempted to pull her pants down. Resident S, who is deaf and mute, has a history of dementia, psychosis, bipolar disorder, and problems with long and short term memory. She communicates with sign language, and can make her needs known and express herself.

The facility was instructed by their corporate office to terminate the nurse, who was still on probation, and to report the allegations to the BON.

Upon further investigation, the following information was provided:

1. A criminal background check that was done by Facility B came back with an arrest for rape in 1984, but the district attorney dropped the charges when the victim was unavailable.
2. The nurse applied for employment at a third long-term care facility (Facility C). Review of his application for employment at Facility C showed that he had failed to include his employment at Facility B on his work history. When interviewed, the nurse stated he was afraid he would not find employment because of false accusations, so he left his employment at Facility B off the application. He insisted that the allegations of sexual misconduct were unfounded. He said that the 1984 allegation of rape was made by an ex-girlfriend who was angry that he broke up with her and that the charges were dropped because a rape kit was negative for signs of rape. He also claimed to have been a police officer in New Orleans from 1984 through 1990, but Louisiana could find no records to verify this. He was terminated from Facility C for falsifying his application for employment.
3. A site visit of Facility B was made and both residents were interviewed. Both residents were consistent in their account of what happened and had never spoken with each other. The stories of what happened were similar; the director of nursing confirmed that neither resident had ever made an allegation of inappropriate sexual behavior against any other employee or resident.

A review of work history indicated the following:

April 2005 – September 2005: resigned, failed to work out notice.

September 2005 – January 2006: resigned before being terminated for inappropriate sexual advances toward a female nurse.

May 2006 – June 2006: terminated after two residents complained of sexual misconduct. Review of application showed he claimed to work at a facility from 2000 through 2005 that closed in 1995.

August 2006: terminated for falsifying application.

At this point, the nurse's license was temporarily suspended based on the complaint by his female coworker and complaints of two residents, the falsification of employment application and signing out the Xanax at 6 am without an order. He was scheduled for an administrative hearing.

Further information was provided from the Department of Health by a health facility surveyor. The Department of Certification and Licensure had conducted a site survey and reported the following:

As part of the survey process, they request to hold a group session with residents cognizant enough to be interviewed. During that session, they ask questions of the residents about the facility and the care they receive. A male resident told them that there was something going on that they needed to know about and that needed to stop. He said that five different female residents had come to him and told him about a male nurse who was propositioning them. He refused to identify the residents. Other residents spoke up and informed them of a resident who is deaf and mute, who had been molested by this same nurse, and that the resident was given a whistle to wear around her neck in case the nurse in question ever came into her room again. The residents were frightened of the nurse, felt uncomfortable around him and felt that if he told them to do something, they had better obey. At that point, the surveyors conducted an investigation into the complaints of the residents and interviewed the resident with a whistle around her neck. The resident was able to communicate via sign language and shared explicit details about the incident, including a demonstration of the nurse raising her blouse, fondling her breasts and attempting to pull her pants down.

At the administrative hearing, testimony was provided by the female coworker who was trapped in the medication room by the nurse, by an investigator who had interviewed both residents and by two Department of Health facility surveyors who had conducted the group session with residents.

The BON's hearing panel found the nurse guilty of all charges and revoked his nursing license.

Issues to Consider:

- Employer/employee issue of charges by coworker of sexual harassment;
- Work history shows many short-term positions;
- Seeks vulnerable patients with credibility issues, history of dementia, substance abuse, difficulty with communication;
- Incidents occur at times when he is the only nurse on unit and is assigned to residents in question;
- Stories of victims are very similar in nature;
- Physically imposing presence, seeks to intimidate victims;
- Collaboration with other state agencies; and
- Based on a criminal background check, his story about why charges were dropped is different from what the record reflects.

There was no specific language about sexual misconduct in law, so charges were based on:

- Engaged in conduct likely to harm the public (three complaints of sexual misconduct);
- Made incorrect entries or failed to make essential records (falsified employment application); and
- Administering medication except as legally directed (signed out Xanax at time not ordered).

Utilizing this Resource for this Case

A specific definition would have assisted the BON in this case. This booklet has several definitions for BONs to review and they might either select one of them or they might use one as a starting point for developing their own definition. There are two very detailed definitions and three more general ones. One of the detailed definitions would have probably been useful for this BON.

CASE 3

The BON received a report from a local hospital indicating they had terminated one of their nurses based on allegations by four female patients that this same male nurse had inappropriately touched them during their hospitalizations. The reported incidents occurred during the period June 29, 2005, to Oct. 30, 2006.

The 50-year-old male nurse, against whom the allegations were made, had been licensed as an RN for 10 years and had worked at the hospital where the alleged incidents occurred for over 14 years in various capacities. At the time of the alleged incidents, he was employed as the charge nurse on the night shift on a neurosurgical floor. Other staff on the floor included 16 female and four male nurses; eight female certified nursing assistants (CNAs); one male nurse apprentice/student; one male physician; nine female and one male therapist.

Patient SS reported that the night following back surgery, after her husband had gone home for the night, she had become upset and panicky. She indicated that the night shift nurse entered her room and was attempting to comfort her. He pulled a pill from his pocket and told her to take it, which she did. He then began massaging her neck and shoulders and proceeded to massage her breasts under her gown. When SS attempted to pull her pillow up over her chest in an effort to get him to stop, he pushed the pillow down again. This happened a couple of times. When SS told the nurse to stop, he asked if he could massage her legs, to which she answered no. SS reported the incident to hospital administration. When interviewed, the nurse admitted giving back rubs to SS and admitted to giving medication to SS, and failed to document the medication he gave. He also admitted massaging SS's shoulders, neck and temple and that he stopped when SS asked him to do so. He denied ever touching her breasts. The hospital investigated the complaint and could not corroborate the patient's allegations. No further action was taken.

While recovering from surgery for a brain abscess, Patient CW awoke, under the influence of postoperative sedation, to find the nurse fondling her breasts. She asked him to stop, which he did only when another nurse came into the room. CW reported that the nurse was cupping her breasts in his hands and she felt he would not have stopped had another nurse not entered the room. CW reported the incident to hospital administration and filed a police report. The nurse initially denied that he had touched CW's breasts and then later admitted he had touched her while assessing for a pain response. Following this incident, the nurse was relieved of his charge nurse duties and was required to comply with various terms and conditions in order to retain his employment at the facility.

Following spinal fusion surgery, Patient ES was unable to lie on her back because of a drain that had been inserted at the surgical site. ES reported that the night following her surgery, the same nurse entered her room and she felt him run his hand from her ankle to her groin, at which time he asked her,

"Does this feel good?". ES began to cry and the nurse left the room. ES adamantly denied that the Jackson Pratt drain line and her foley catheter had in any way become entangled that night. On interview, the nurse admitted that he gave ES thigh massages that night and that his hand may have brushed against her pubic area where the drain lines and catheter lines had become tangled. ES reported the incident to hospital administration shortly after it occurred. Following this incident, the hospital terminated the nurse's employment and reported him to the BON.

Following receipt of the hospital report, a fourth patient, AG, contacted the hospital to report an incident that had occurred following her admission through the hospital emergency room when she experienced a transient ischemic attack (TIA). On her transfer from the emergency room to the floor, the same nurse gave her two pills for her complaint of a headache. During the night, AG awoke from a sound sleep to find the nurse sitting on her bed holding her left hand. The curtain was pulled around her bed. AG reported that she was very frightened by his unexplained presence in her room with the curtain drawn. She did not report the incident until she was later completing a patient satisfaction form received from the hospital.

Following receipt of the report from the hospital, the BON had received a call from AC, the nurse's niece, who reported that her uncle (the nurse under investigation) had sexually abused her as a child. That incident occurred when she lived in the nurse's home in 1991, at 11 years of age. The BON received police reports of the investigation into these allegations and was aware that the police had not pursued the case because of the length of time that had passed since the time of the alleged incidents.

All four women patients testified at a hearing that they were scared and upset by the nurse's conduct. The hearing officer for this case indicated that during the hearing, the testifying patients were still visibly upset when they described what had happened to them. The allegations made by the niece, AC, were not considered in the administrative hearing on this case.

Investigation into the Allegations

1. Interviews with the nurse manager who filed the original report with the BON, as well as the hospital risk manager.
2. Interview with the nurse against whom the complaint was filed.
3. Interview with the nurse's niece, AC.
4. Interviews with patients ES, AG, SS and CW.
5. Review of police report on the allegations filed by AC.

Complicating Factors

- There were no witnesses to any of the allegations against this nurse.
- During the course of the investigation, one of the alleged victims contacted the local newspaper, which ran her story and, on several occasions, contacted the BON for information about the case.
- At the time of the evidentiary hearing on this case, one of the patient's testifying was under indictment for use of methamphetamine.

Final Order of the BON

The BON adopted in full the hearing officer's Findings of Fact and Conclusions of Law. The BON took further action to revoke the RN license of the respondent. The BON took further action to deny any application for reinstatement of the revoked license until two years from the date of the order. The BON took further action to condition any future consideration of reinstatement of license on the following:

1. Payment of all investigative and prosecution costs and attorney fees incurred by the BON in connection with the case proceedings;
2. Demonstration to the satisfaction of the BON that the respondent is no longer a danger to patients and is fit to practice nursing;
3. Respondent agreeing to all conditions, terms and restrictions the BON deems reasonable and necessary to place on respondent's license; and
4. Respondent complying with all other requirements for licensure imposed by BON statutes and rules.

Utilizing Evaluator Guidelines and Fitness for Practice

The BON reviewing this case might select an expert evaluator for fitness to practice. The guidelines in this document provide some important criteria, including that the evaluator is a member of a professional board or association, such as the ATSA or the APLS. This professional should be licensed and preferably should be certified in evaluation of sexual misconduct cases. There are other criteria that the BON might select, such as numbers of hours educated on sexual offender treatment or hours spent in formal conferences. Some practical criteria might include being willing to review detailed allegations and committed to understanding the nursing field involved.

The evaluator and BON must consider guidelines for fitness to practice when the two years of license revocation is over and they might refer to the specific recommendations published in this resource. For example, has the nurse reached a comfort level with interpersonal relationships? Does he/she have an adequate control of emotions? Has the nurse achieved competence in handling ethical and professional responsibilities? The evaluator whom the BON chooses will help to make this difficult decision related to fitness to practice.

Case 4

Mr. R is a 32-year-old male who was diagnosed as mentally ill with a schizoaffective disorder. Mr. R was also diagnosed with post-traumatic stress disorder related to physical and sexual abuse endured as a child, and has a history of suicidal ideation and gestures. He was incarcerated in a residential health care unit of a state prison for attempted murder. In this particular residential health care unit, the state can accommodate up to 32 prisoners, while offering a full range of hospital services.

For about three months Mr. R was having explicit sexual conversations with a nurse while she was on duty in the unit. The nurse, Ms. B, talked about sexual experiences and watched Mr. R masturbate. Eventually, the two masturbated with each other and kissed. One of the custodial staff observed this behavior and reported it to the nursing supervisor.

In this particular state any employer of a nurse must report potential violations of the rules and law to the state board of nursing (BON).

The nursing supervisor, along with the state police, who are responsible for investigating any criminal activity in state prisons, reported the complaint to the BON. Eventually, after receiving permission from the courts, Mr. R was set up with a wire to record a conversation with Ms. B, which he did, thus confirming the sexual misconduct.

Ultimately, Ms. B admitted discussing sexual experiences with Mr. R, masturbating with him and kissing him. She denied ever touching his penis. The police concluded that although an inappropriate relationship occurred, there was insufficient evidence to charge her with sexual battery. However, the expert witness used by the police stated that there has been serious emotional harm done to this patient because the nurse took advantage of her powerful position. Ms. B was prosecuted for patient abuse and was terminated from her job. After a full investigation by the BON and a review of all the evidence, Ms. B's license was permanently revoked.

Utilizing the Framework in this Case

Take the elements of this case through the *Framework for Deciding When/How to Take Action in Sexual Misconduct Cases* guidelines that are available in this booklet. For example, look at the items under **First Consider.** How egregious is the misconduct? While the authorities couldn't charge her with sexually battery, they did prosecute her with patient abuse. What is the alleged victim's diagnosis? The victim is clearly from a vulnerable population, being a prisoner, mentally ill and having a history of abuse. As mentioned earlier in this resource, sexual abuse in this population is more frequent than in other populations.

Then look under **Next Consider.** Can we develop the case? Where is the evidence? What evidence can be obtained? Where can it be found? In this case, while the patient's credibility could possibly be in question, the BON was able to review the legally obtained tape recordings and the nurse's confession to the police to validate the complaint. Further, their use of an expert witness verified that serious harm was done to the patient. In this state the mandatory reporting to the BON by the nursing supervisor was beneficial to protecting the public.

Questions under **Also Consider** would be evaluated next. During the BON investigation the nurse was terminated, but her license was still active. The BON should find out if the nurse was employed elsewhere and whether she was licensed in other states. According to the framework, they should presume that she is working since she was actively licensed. They should also inquire whether she is amenable to being put on an inactive status during the investigation. In this case the law enforcement authorities cooperated fully with the BON's investigation easier in their mission of public protection.

Because of the highly sensitive subject matter involved in this case, a statement may need to be prepared in anticipation of any media coverage. Develop a standard report for front-line staff to respond to media inquiries. Respond to the media directly and in a timely manner. Stick with consistent messages, such as "We are still actively investigating this matter and are working in close coordination with local law enforcement."

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APPENDIX 1

SUMMARY OF THE NCSBN'S 2009 SURVEY ON SEXUAL MISCONDUCT

In January 2009 a survey was electronically sent to those individuals listed on NCSBN's Discipline Knowledge Network. The survey was sent to executive officers of BONs in jurisdictions where no contact was listed. The purpose of the survey was to find out the needs of BONs related to their work with sexual misconduct cases. There were 26 boards that responded, and of those, 46 percent were definitely satisfied with how their BON handles sexual misconduct cases; 50 percent were somewhat satisfied; and four percent (one BON) was not satisfied at all. The following are direct responses taken from these surveys offering some specific reasons BONs were satisfied:

- A two-pronged approach exists that involves a BON ordered evaluation by a center that specializes in diagnosis and treatment of sexual disorders, and/or BON action based upon evidence that is reliable, probative and substantial.
- Board members are actively involved in the disciplinary process to determine guilt or innocence in sexual misconduct cases.
- Excellent investigators and attorneys (two comments).
- The BON is very careful in investigating the cases, deliberating over the findings and determining appropriate outcomes.
- The law gives specific examples of what is considered sexual misconduct. We have guidelines to determine appropriate sanctions based on conduct, as well as aggravating and mitigating factors.

The following are direct responses taken from these surveys offering some of the problems or needs that the BONs have related to sexual misconduct:

- Problems occur when there is an ongoing criminal investigation and the BON cannot obtain evidence from law enforcement. In these cases the BON will request that the licensee place his/her license on inactive status.
- The BON is at a disadvantage when a stipulated agreement comes before them as they do not have all of the facts in the case. They have a difficult time determining whether or not the recommended discipline is adequate, given the amount of information available to accept the terms or reject them.
- Obtaining evidence, completing the investigation and developing a charge document for BON execution can be a lengthy process.
- Guidelines to provide consistency would be helpful (three comments).
- Need a definition.

- It depends on the administrative law judge who is assigned to the case. Some have standards that we disagree with. Also, if the petitioner seeks a writ, the superior court judge may rule on technicalities that are not favorable to consumer protection from our perspective.
- We do not have experts in sexual misconduct to whom we can refer licensees for evaluations, if the licensee has not already been evaluated.

Only 34.6 percent of the respondents reported that their BON has definitions of sexual misconduct. Examples include:

1. Engaging in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient, or engaging in sexual exploitation of a patient or former patient.
2. A specific type of professional misconduct which involves the use of power, influence and/or special knowledge that is inherent in one's profession in order to obtain sexual gratification from the people a particular profession is intended to serve. Any and all sexual, sexually demeaning or seductive behaviors, both physical and verbal, between a service provider (i.e., a nurse) and an individual who seeks or receives the service of that provider (i.e., client), is unethical and constitutes sexual misconduct.
3. Engaging in inappropriate sexual contact, exposure, gratification or other sexual behavior with, or in the presence of, a patient. For purposes of this subsection, an adult receiving psychiatric nursing services shall continue to be a patient for one year after the termination of professional services. If the person receiving psychiatric nursing services is a minor, the person shall continue to be a patient for the purposes of this subsection for one year after termination of services, or for one year after the patient reaches the age of majority, whichever is longer (Wisconsin).

When asked about guidelines, sanctions or mandatory schedules for sexual misconduct cases, no BON reported mandatory schedules. Some of the following guidelines were provided:

- Revocation for the most serious and fines for minor violations.
- Known sexual conduct with, or assault of, a patient would be a Priority I case and the investigation would be completed within five days. Verbally inappropriate conduct would be a Priority II.
- Suspension for one year or more, or revocation.
- Remedial education regarding boundaries, reprimand, probation; employer reports extend all the way up to revocation based on the scope and severity of the issues involved.
- Monetary fines, probation, suspension, community service, continuing education, counseling.
- Revocation is permanent in one state.
- Disciplinary guidelines for sexual misconduct: first offense carries a minimal punishment of a $250 fine, probation and an evaluation by the Intervention Project for Nurses. The penalties increase with further offenses or aggravating factors. The BON can deviate from the guidelines when determining discipline by using mitigating or aggravating factors unique to the case.
- Nonthreatening, unsolicited conduct or physical contact that serves no diagnostic or treatment purpose can lead to reprimand, probation or suspension from zero to five years. Any personal relationship that violates professional boundaries can lead to probation or suspension from two to seven years, or revocation. Any sexualized relationship or contact can lead to probation or

suspension for two to seven years, or revocation. Sexual contact involving, but not limited to, force, intimidation, or multiple victims leads to suspension for five years, indefinite suspension or permanent revocation.

Only four of the 26 states responding to the question had absolute bars. Related to fitness for practice, the BONs generally act on a case-by-case basis. Some specifically stated that they use psychiatric evaluations by qualified professionals when making fitness for practice decisions. One BON, when making fitness for practice decisions, replied, "The petitioner must submit convincing evidence of meeting the requirements set forth in the order and documentation of good character, stability of job and home. Initially, the petitioner must wait three years before returning to the BON to petition for reinstatement." Another BON uses the Intervention Project for Nurses to decide fitness for practice.

The BONs were asked about their experiences with cybersex/communication technologies and were asked to give examples. Seven of the 26 BONs reported cases related to cybersex/communication technologies and here were some of the examples:

- Nurse e-mailed photo taken with personal cell phone camera of OR patient;
- Nurse exchanged e-mails with patient that included photos;
- Viewing pornography at work;
- Soliciting sex via the Internet;
- Internet porn;
- Inappropriate behaviors involving e-mails;
- Text messages and cell phone photographs;
- Child pornography kept on a work computer;
- A nurse was convicted of multiple counts of possessing images of child pornography on his/her computer;
- A nurse had been convicted of making an arrangement for sexual contact with a child over the telephone; and
- A nurse used a coworker's camera phone to photograph a patient's genitals, then left the phone with the picture displayed for the phone's owner (also a nurse) to find.

Only two of the 26 BONs require sexual misconduct content in their nursing programs, though generally, it is assumed that this is discussed in ethics or other courses.

In summary, many BONs would like practical guidelines about how to make more consistent decisions in cases of sexual misconduct. This resource includes some actual definitions from BONs and some guidelines for selecting an evaluator, making decisions for fitness to practice and setting criteria for sanctions. The framework for making decisions and the *Sexual Misconduct Pathway*, as previously discussed, will also provide BONs with practical guidelines. Furthermore, the cases illustrate how to use the guidelines outlined in this booklet.

NOTES

NOTES

Alaska Board of Nursing

In response to questions from nurses and their employers, the members of the Board of Nursing addressed the issue of 'safety to practice'. In particular, nurses wanted to know if they should continue to practice while taking prescribed medications, including pain medications; whether they should refuse assignments to work overtime or extra shifts; whether they should consider retirement from practice when they have reached a certain chronological age.
The Board's "Position on Safety to Practice" provides thoughtful direction to assist nurses and their employers in addressing these concerns.

ALASKA BOARD OF NURSING
POSITION ON SAFETY TO PRACTICE
Adopted October 2014

One essential element of safe nursing practice is a nurse's functional ability: the competence and reliability with which a nurse is able to practice at any given time.
The board is aware that nurses sometimes experience situations that may compromise their ability to safely practice for either the short or long term. Some of these situations involve personal or job-related stress, sleep deprivation, the normal effects of aging, and episodic or persistent health conditions, some of which may require pain management or the use of maintenance-level prescribed medication. The list is not exclusive.

Whether a nurse should continue active nursing practice when that practice may be compromised depends upon the nurse's ability to function safely and effectively. The assessment of functional ability is an individualized process that does not lend itself to application of a set format based on select elements. On the contrary, assessment of functional ability requires active consideration of all relevant factors, such as diagnosis, prescribed treatment and situational events, as well as an evaluation of the impact of those factors on the individual being assessed.

Although constant evaluation of one's ability to safely and competently practice nursing is the responsibility of each individual nurse, the Board of Nursing remains the ultimate decision maker. In some instances, it may be necessary for the board to require objective physical and/or functional assessment, using reliable psychometric instruments and methods administered by qualified licensed professionals. For example, even though an individual nurse might perceive that she/he is capable of safe practice, a neuropsychiatric assessment, done at the Board's request, may indicate functional impairment.

Licensed nurses are accountable for assuring that their actions and behaviors meet all applicable standards at all times. This requires constant awareness of the demands of the job and a continual process of evaluation and assessment in order to make sure that the nurse is fit to practice and competent to safely perform those functions that fall within the defined scope of nursing practice and for which the nurse has accepted responsibility. Nurses who practice while not fit to do so may be subject to disciplinary action by the board including, among others, license suspension or revocation, remedial measures, or monitored practice.

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
POLICY

Title:	Safe to Practice	**Number** A40.01
Reference:		
Contact:	Discipline Manager	
Effective Date:	May 13, 2011	
Supersedes:		
Approved:		
	Chair **Washington State Nursing Care Quality Assurance Commission**	

PURPOSE:

This guideline addresses "safe to practice" concerns expressed by nurses and employers. Concerns expressed include, but are not limited to practicing while taking prescribed medications, including pain medications; refusing assignments to work overtime or extra shifts when feeling unsafe to practice; and retiring from practice when reaching a certain chronological age. This guideline provides direction to assist nurses and employers in addressing these concerns.

POLICY

One essential element of safe nursing practice is a nurse's functional ability. It is the competence and reliability with which a nurse is able to practice at any given time that determines the functional ability of the nurse.

The Nursing Care Quality Assurance Commission (NCQAC) is aware that nurses experience situations on occasion that may compromise their ability to safely practice for either a short or long period of time. Some of these situations involve personal or job-related stress, sleep deprivation, the normal effects of aging, and episodic or persistent health conditions, some of which may require pain management or the use of maintenance-level prescribed medication. The list is not all inclusive of every possible event that may limit a nurse's functional ability.

The nurse's ability to function safely and effectively determines whether a nurse should continue active nursing practice. The assessment of functional ability is an individualized process that does not lend itself to application of a set format based on select elements. On the contrary,

assessment of functional ability requires active consideration of all relevant factors, such as diagnosis, prescribed treatment and situational events, as well as an evaluation of the impact of those factors on the individual.

Constant evaluation of one's ability to safely and competently practice nursing is the responsibility of each individual nurse. Licensed nurses are accountable for assuring that their actions and behaviors meet all applicable standards at all times. This requires constant awareness of the demands of the job and a continual process of evaluation and assessment in order to make sure that the nurse is fit to practice and competent to safely perform those functions that fall within the defined scope of nursing practice and for which the nurse has accepted responsibility.

Employers are required to report nurses that are unsafe in practice to the NCQAC and must protect patients from harm.

The NCQAC investigates and evaluates violations of safe practice. In some instances, it may be necessary for the NCQAC to require objective physical and or functional assessment of the nurse using reliable psychometric instruments and methods administered by qualified licensed professionals. For example, even though an individual nurse might perceive that he is capable of safe practice, a neuropsychiatric assessment, done at the NCQAC request, may indicate functional impairment.

Nurses who practice while not fit to do so may be subject to discipline. Sanctions may include action by the NCQAC including, among others, remedial measures, monitored practice, license suspension or revocation.

Department of Commerce, Community, and Economic Development

BOARD OF NURSING

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

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An Advisory Opinion adopted by the Alaska Board of Nursing (AKBON) is an interpretation of Alaska law. While an advisory opinion is not law, it is the AKBON's official opinion on whether certain nursing procedures, policies, and other practices comply with the standards of nursing practice in Alaska. Facility policies may restrict practice further in their setting and/or require additional expectations related to competency, validation, training and supervision to assure the safety of their patient population and/or decrease risk. National evidence based standard references are included.

OPINION: Governance Policies
APPROVED DATE: 2/7/2018
REVIEWED DATE: 7/2024
REVISED DATE: 7/2024

ADVISORY OPINION

The Alaska State Board of Nursing (AKBON) receives frequent questions regarding (blank) The purpose of this opinion is to provide guidance to (explain).
In accordance with Alaska statute ( ) or Alaska regulation the Alaska State Board of Nursing (AKBON) has approved the following Advisory Opinion on (explain)
Information here

Mission of the Board of Nursing:

The mission of the Alaska Board of Nursing is to actively promote and protect the health of the citizens of Alaska through governance of the practice of nursing.

Vision Statement of the Board of Nursing:

To lead through ethical pursuit of the principles of right-touch regulation.

Guiding Principles of the Board of Nursing:

- Protection of the public.
- Minimum competency of all nurses and nurse aides regulated by the Alaska Board of Nursing.

- Due process and conduct
- Collaboration and transparency
- Evidenced-based regulation
- Responsive to the marketplace and healthcare environment.

Values of the Board of Nursing:

The Alaska Board of Nursing endorses the following values for application within all board activities and decisions, including those delegated to staff and themselves.

- **Integrity:** Doing the right thing for the right reason through informed, transparent, and ethical debate.
- **Accountability:** Taking ownership and responsibility for board processes and outcomes.
- **Quality**: Pursuing excellence and continuous improvement in all aspects of board work.
- **Vision:** Using the power of imagination and creative thought to foresee potential future nursing practice innovations.
- **Collaboration:** Forging solutions through appropriate partnerships, examining all sides of issues.
- **Leadership**: Providing positive direction for safe nursing practice in Alaska.

Goals: Refer to Strategic Plan

Meetings and Attendance:

Board meetings are held quarterly to conduct the business of the board. These meetings are typically, two days in duration and are held in person or virtually. The board may hold periodic publicly noticed and quasi-judicial telephonic meetings to conduct its business. Board member attendance at regularly scheduled meetings by phone or videoconference is acceptable when necessary.

Absences for emergencies are understandable and happen infrequently. The member should notify the executive administrator as soon as an absence becomes necessary. These absences shall be excused. Members are expected to plan vacations, work obligations, and other events around scheduled board meetings. These absences shall be unexcused. Partial attendance at board meetings (leaving early or arriving late) may affect the board's quorum and is a misuse of state resources. If more than three unexcused absences occur during a member's term, the board chair will discuss with the member whether continued service on the board is in the best interest of the state.

Materials for board consideration are sent at least 10 days in advance of the meeting. Board members are expected to carefully review the material in advance of the meeting.

Roles and Responsibilities:

The Alaska Board of Nursing is under the Division of Corporations, Business, and Professional Licensing. The board partners with the division to fulfill its mission as directed in AS 08. All board staff are employees of the division: the boards Executive Administrator supervises the licensing staff

and reports to the deputy Director, while the boards investigators report to the Chief Investigator. The Department of Law supplies attorney support for board matters.

The Executive Administrator is a partially exempt appointee of the Governor. The position is recruited by the division after seeking input on the nursing knowledge, training, and expertise desired by the board. The board may evaluate the Executive Administrator and provide its commendations and concerns to the Deputy Director for consideration.

Board members and staff should read the divisions *Guide to Excellence in Regulation* and refer to it regularly for education and advice on a variety of topics for which the members are legally responsible.

Election of Officers:

Alaska statute, 08.68.070 requires the board to annually elect a chairman and secretary from among its members. The board holds the election at the end of the last meeting of the calendar year, and the officers begin their terms January 1 of the next year. Members may serve multiple officer terms in either of the positions provided they are elected annually. The board may vote at any time to fill a vacancy or to hold an election, if the officer does not have the confidence of the board to continue in that position.

Position Descriptions:

Board Chair: This position generally directs the flow of the board meetings and ensures the work of the board progresses efficiently and effectively. Some responsibilities include:

- Working closely and collaboratively with the executive administrator to foster maximum effectiveness of the board.
- ~~Serving as a consultant to the executive administrator on the licensure and practice issues in accordance with 12 AAC 44.908(a)(5).~~
- Preparing the meeting agenda and materials in collaboration with the executive administrator.
- Leading and facilitating the meeting, ensuring that business is conducted in harmony with the boards mission, vision, values, goals, applicable laws, and organizational best practices.
- Understanding and effectively using Robert's Rules of Order.
- Ensuring that all board members are given the opportunity to express opinions and that members participate in all votes of the board.
- Maintaining a meeting pace that protects the board's agenda while preserving the integrity of the meeting content.
- Requesting the board's self-evaluation of its performance at least annually.
- Directing the board's completion of an annual report in accordance with statute.
- Delegating appropriately to the executive administrator.

Secretary: The secretary reviews the accuracy of the meeting minutes for the board review and approval and may be delegated additional duties by the chair or by board motion.

Executive Administrator: In accordance with 12 AAC 44.980, the Executive Administrator (EA) is the chief advisor to the board and works closely with the chair to ensure the work of the board is accomplished in harmony with the board's mission, vision, values, goals, applicable laws, and organizational best practices.

Decision-Making and Procedures:

In addition to the administrative procedures established in division policy and procedure, as well as in accordance with state law, regulation, and policy, the board has established the following decision-making guidance.

- APRN application review is delegated to the EA or to a licensed board member
- APRN cases are reviewed by the APRN member of the board or expert witness as determined appropriate by the investigator
- Affirmative professional fitness answers are reviewed by the board chair or delegated to the EA.
- Legal Advice – This section is no longer accurate and should be omitted.
- Board chair to sign the advisory opinion within 10 days- New templates do not require signature.
- Publication of board advisory notices will occur within 30 days of the board meeting via the board's website and listserv.
- Disciplinary guidelines. Outline of historical precedent is drafted by investigative staff and presented to the board to help inform decision making on a case-by-case basis.

REFERENCE: 08.68.070, 08.68.090, 08.68.275(f), 12 AAC 44.980

Alaska Board of Nursing

Agenda Item #16

Review and Assign Action Items

Alaska Board of Nursing

Chair Final Comments/Adjourn

Alaska Board of Nursing

Agenda Item #17

Roll Call/Call to Order

Alaska Board of Nursing

Agenda Item #18

Executive Session

Closed to the Public

Alaska Board of Nursing

Agenda Item #19

Investigative and Probation Reports

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Commerce, Community, and Economic Development

DIVISION OF CORPORATIONS, BUSINESS, AND PROFESSIONAL LICENSING
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PROBATION REPORT

DATE: July 18, 2024

TO: Alaska Board of Nursing

THROUGH: Erika Prieksat, Chief Investigator EP

FROM: Karina Medina, Investigator

SUBJECT: Probation Report for the August 2024 Meeting

The following is a complete list of individuals on probation for this Board. All individuals are in compliance with their agreements except as noted with a (*).

NAME	START DATE	END DATE	
Barbara Anderson	05/11/2023	05/11/2028	
Caressa Barth	01/06/2021	01/06/2026	
Samantha Bell	07/23/2021	07/23/2026	
Ronald Blury	08/11/2023	08/11/2024	
Sue Boma	11/05/2020	11/05/2025	
Kenneth Browne	08/20/2020	08/20/2025	
Mary Ann Egbert	08/11/2023	08/11/2024	
Viva Esquibel	05/17/2022	05/17/2027	
John Hacker	08/11/2023	08/11/2028	
Roxanne Huzieff	05/11/2023	05/11/2026	
Franklin Jones	05/01/2022	05/01/2027	
*Kris Kile	03/28/2019	09/28/2020	SUSPENDED
Shaylene Leinbach	08/08/2019	08/08/2024	
Kelly Linebarger	08/06/2021	08/06/2026	
Lisa Murrell	08/20/2020	08/20/2025	
Alice Nanuk	11/09/2023	11/09/2028	
*Amy Neel	02/04/2021	02/04/2026	SUSPENDED
Joyce Nesby	05/11/2023	05/11/2026	
*Amber Pe'a	02/06/2020	02/06/2025	SUSPENDED
Danielle Regan	08/20/2020	08/20/2025	
*Tasha Rine	08/11/2023	08/11/2028	SUSPENDED
Nicole Spinner	08/04/2022	08/04/2024	
Alixandra Stewart	08/11/2023	08/11/2028	
*Quenna Szafran	05/11/2023	05/11/2028	SUSPENDED
Ciri Vail	08/11/2023	08/11/2028	

Samantha Weber	08/16/2021	08/16/2026
Wendy Webster	11/09/2023	11/09/2025
*Sheriene Wilson	05/05/2022	05/05/2023 SUSPENDED
Jodi Wolcoff	03/15/2022	03/15/2027
Erika Yeager	11/01/2022	11/01/2024

The following were released after probation completion:

NAME	**START DATE**	**END DATE**
Amy Althiser	08/20/2020	04/11/2024
Shaun Groshong	05/11/2023	05/11/2024
Samuel Seale	01/19/2017	05/28/2024

Board Requests:
John Hacker – Modification Request
Ciri Vail – Modifications Request

License Actions:
Wendy Webster SURRENDER

END OF REPORT

THE STATE of ALASKA

Department of Commerce, Community, and Economic Development

DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING

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MEMORANDUM

DATE: July 16, 2024

TO: Board of Nursing

THRU: Erika Prieksat, Chief Investigator

FROM: Joy Hartlieb, Investigator

RE: Investigative Report for the August 08, 2024 Meeting

The following information was compiled as an investigative report to the Board for the period of April 25, 2024 thru July 15, 2024; this report includes cases, complaints, and intake matters handled since the last report.

Matters opened by the Paralegals in Anchorage and Juneau, regarding continuing education audits and license action resulting from those matters are covered in this report.

OPEN - 80

Case Number	Violation Type	Case Status	Status Date
ADVANCED NURSE PRACTITIONER			
2022-000085	PDMP Violation	Intake	01/25/2022
2023-001053	PDMP Violation	Intake	10/06/2023
2024-000454	Unprofessional conduct	Intake	05/20/2024
2024-000460	Standard of care	Intake	05/21/2024
2024-000492	Unprofessional conduct	Intake	06/04/2024
2019-000516	Standard of care	Complaint	07/02/2019
2020-000292	PDMP Violation	Complaint	11/03/2021
2020-000369	Prescriptive practice	Complaint	04/15/2020
2021-000969	Standard of care	Complaint	10/04/2022
2023-000066	Unprofessional conduct	Complaint	05/04/2023

2023-000849	Substance abuse	Complaint	08/21/2023
2023-000956	PDMP Violation	Complaint	09/14/2023
2023-001035	PDMP Violation	Complaint	11/15/2023
2023-001079	PDMP Violation	Complaint	11/15/2023
2023-001170	PDMP Violation: Failure to Register	Complaint	02/14/2024
2023-001171	PDMP Violation: Failure to Register	Complaint	02/14/2024
2023-001172	PDMP Violation	Complaint	02/14/2024
2023-001211	Standard of care	Complaint	01/10/2024
2024-000147	Unprofessional conduct	Complaint	03/20/2024
2024-000408	Substance abuse	Complaint	05/02/2024
2024-000431	PDMP Violation: Failure to Register	Complaint	05/15/2024
2024-000432	PDMP Violation: Failure to Register	Complaint	05/15/2024
2024-000532	PDMP Violation: Failure to Register	Complaint	06/12/2024
2018-000492	Standard of care	Investigation	07/08/2021
2020-001172	Patient or client abuse	Investigation	07/08/2021
2021-000478	Practice beyond scope	Investigation	04/19/2023
2021-001023	Standard of care	Investigation	06/02/2023
2019-000056	Falsified application	Litigation Initiated	11/05/2020
2019-000171	Prescriptive practice	Litigation Initiated	10/06/2020
2020-000302	Criminal action - no conviction	Litigation Initiated	11/05/2020
2021-000311	Unlicensed practice or activity	Litigation Initiated	

CERTIFIED NURSE AIDE

2024-000604	Unprofessional conduct	Intake	06/28/2024
2023-000379	License Application Problem	Complaint	05/24/2023
2024-000274	Substance abuse	Complaint	03/21/2024
2024-000610	Unlicensed practice or activity	Complaint	07/12/2024
2023-000866	Unprofessional conduct	Investigation	11/01/2023
2023-001003	License Application Problem	Investigation	12/05/2023
2024-000231	Substance abuse	Investigation	04/25/2024
2024-000363	License Application Review/Referral	Investigation	07/09/2024

2024-000421	Unprofessional conduct	Investigation	06/27/2024

LICENSED PRACTICAL NURSE

2024-000637	Criminal action - no conviction	Intake	07/12/2024
2023-000567	Unprofessional conduct	Complaint	06/23/2023
2024-000275	Unprofessional conduct	Complaint	04/04/2024

PRACTICAL NURSE

2024-000343	Unprofessional conduct	Intake	04/12/2024
2023-001191	Unprofessional conduct	Investigation	03/07/2024

REGISTERED NURSE

2024-000332	Unprofessional conduct	Intake	04/10/2024
2024-000490	Unprofessional conduct	Intake	06/04/2024
2024-000558	Unprofessional conduct	Intake	06/19/2024
2024-000600	Unprofessional conduct	Intake	06/27/2024
2024-000601	Action in another state	Intake	06/28/2024
2024-000609	Unlicensed practice or activity	Intake	07/01/2024
2021-000250	Unlicensed practice or activity	Complaint	04/06/2021
2021-000570	Unprofessional conduct	Complaint	07/08/2021
2021-001199	Unprofessional conduct	Complaint	01/07/2022
2022-000635	Unprofessional conduct	Complaint	07/06/2022
2022-000770	Unprofessional conduct	Complaint	04/17/2023
2023-000996	Unprofessional conduct	Complaint	09/25/2023
2023-001102	Unprofessional conduct	Complaint	12/26/2023
2023-001161	Substance abuse	Complaint	02/22/2024
2024-000128	License Application Review/Referral	Complaint	02/05/2024
2024-000223	Unprofessional conduct	Complaint	03/20/2024
2024-000269	License Application Review/Referral	Complaint	03/21/2024
2024-000318	Violation of agreement	Complaint	04/04/2024
2024-000351	Falsified application	Complaint	04/16/2024
2024-000422	Substance abuse	Complaint	05/06/2024

2024-000505	Unlicensed practice or activity	Complaint	06/06/2024
2024-000542	Unprofessional conduct	Complaint	06/17/2024
2024-000545	Substance abuse	Complaint	06/17/2024
2023-000242	Unprofessional conduct	Monitor	
2021-000766	Fraud or misrepresentation	Investigation	06/21/2023
2022-001170	Unlicensed practice or activity	Investigation	08/21/2023
2023-000522	Continuing education	Investigation	12/20/2023
2023-000611	Continuing education	Investigation	02/21/2024
2023-000615	Continuing education	Investigation	05/09/2024
2023-000820	Continuing education	Investigation	01/19/2024
2023-000965	Unprofessional conduct	Investigation	
2024-000014	Substance abuse	Investigation	03/11/2024
2024-000228	Substance abuse	Investigation	06/18/2024
2024-000292	Substance abuse	Investigation	06/10/2024

REGISTERED NURSE ANESTHETIST

2019-001275	Unprofessional conduct	Complaint	02/04/2020

Closed - 54

Case #	Violation Type	Case Status	Closed	Closure
ADVANCED NURSE PRACTITIONER				
2023-001164	Violation of licensing regulation	Closed-Intake	06/11/2024	No Action - Lack of Jurisdiction
2022-000359	Standard of care	Closed-Complaint	06/14/2024	No Action - No Violation
2023-000741	Unlicensed practice or activity	Closed-Complaint	06/11/2024	No Action - No Violation
2023-000971	Unethical conduct	Closed-Complaint	05/21/2024	No Action - Insufficient Evidence
2023-001118	Unprofessional conduct	Closed-Complaint	05/16/2024	No Action - No Violation
2023-001214	Unprofessional conduct	Closed-Complaint	05/21/2024	No Action - No Violation
2024-000180	Standard of care	Closed-Complaint	05/21/2024	No Action - No Violation

2024-000190	Unprofessional conduct	Closed-Complaint	06/28/2024	No Action - No Violation
2024-000249	Standard of care	Closed-Complaint	06/28/2024	No Action - Minor Offense
2023-000740	Unprofessional conduct	Closed-Investigation	06/13/2024	Advisement Letter
2023-001106	Criminal action - conviction	Closed-Investigation	06/05/2024	License Action
2023-001143	Unprofessional conduct	Closed-Investigation	05/08/2024	Advisement Letter
CERTIFIED NURSE AIDE				
2024-000310	Unprofessional conduct	Closed-Intake	06/17/2024	Incomplete Complaint
2024-000361	Unlicensed practice or activity	Closed-Complaint	06/13/2024	No Action - No Violation
2022-000940	Continuing education	Closed-Investigation	05/20/2024	License Action
2024-000219	Falsified application	Closed-Investigation	06/17/2024	Advisement Letter
LICENSED PRACTICAL NURSE				
2022-001167	Continuing education	Closed-Investigation	05/20/2024	License Action
PRACTICAL NURSE				
2024-000322	Patient or client abuse	Closed-Intake	06/11/2024	Incomplete Complaint
REGISTERED NURSE				
2024-000235	Unlicensed practice or activity	Closed-Intake	05/16/2024	Incomplete Complaint
2024-000336	Substance abuse	Closed-Intake	05/13/2024	Incomplete Complaint
2024-000345	Unprofessional conduct	Closed-Intake	06/11/2024	Incomplete Complaint
2024-000423	Unprofessional conduct	Closed-Intake	06/13/2024	Incomplete Complaint
2024-000543		Closed-Intake	06/17/2024	Closed - Case Opened
2024-000544		Closed-Intake	06/17/2024	Closed - Case Opened
2021-000802	Criminal action - no conviction	Closed-Complaint	06/11/2024	No Action - No Violation
2023-000648	Continuing education	Closed-Complaint	05/06/2024	No Action - No Violation
2024-000311	Unprofessional conduct	Closed-Complaint	06/12/2024	No Action - No Violation
2024-000356	License Application Review/Referral	Closed-Complaint	06/13/2024	No Action - No Violation
2024-000426	Continuing education	Closed-Complaint	05/15/2024	No Action - No Violation
2024-000427	Continuing education	Closed-Complaint	05/15/2024	No Action - No Violation
2019-000351	Probation violation	Closed-Investigation	06/05/2024	Advisement Letter

2019-001088	Substance abuse	Closed-Investigation	06/05/2024	License Action
2022-001151	Substance abuse	Closed-Investigation	06/05/2024	License Action
2022-001181	Unlicensed practice or activity	Closed-Investigation	06/04/2024	License Action
2023-000524	Continuing education	Closed-Investigation	05/20/2024	License Action
2023-000579	Continuing education	Closed-Investigation	05/20/2024	License Action
2023-000588	Continuing education	Closed-Investigation	06/27/2024	License Action
2023-000624	Continuing education	Closed-Investigation	07/01/2024	No Action - No Violation
2023-000634	Continuing education	Closed-Investigation	06/27/2024	License Action
2023-000653	Continuing education	Closed-Investigation	06/27/2024	License Action
2023-000656	Continuing education	Closed-Investigation	05/20/2024	License Action
2023-000661	Continuing education	Closed-Investigation	05/08/2024	No Action - No Violation
2023-000662	Continuing education	Closed-Investigation	05/08/2024	No Action - No Violation
2023-000708	Continuing education	Closed-Investigation	05/22/2024	License Action
2023-000719	Continuing education	Closed-Investigation	06/27/2024	License Action
2023-001054	Unprofessional conduct	Closed-Investigation	06/05/2024	License Action
2023-001173	Substance abuse	Closed-Investigation	05/09/2024	Advisement Letter
2024-000167	Unlicensed practice or activity	Closed-Investigation	06/05/2024	License Action
2024-000182	Unprofessional conduct	Closed-Investigation	06/11/2024	Advisement Letter
2024-000186	License Application Problem	Closed-Investigation	05/16/2024	Advisement Letter
2024-000349	License Application Review/Referral	Closed-Investigation	05/13/2024	Advisement Letter
2024-000409	Falsified application	Closed-Investigation	05/16/2024	Advisement Letter
2024-000414	Falsified application	Closed-Investigation	05/16/2024	Advisement Letter
2024-000417	Falsified application	Closed-Investigation	06/17/2024	Advisement Letter

END OF REPORT

Alaska Board of Nursing

Break

Alaska Board of Nursing

Agenda Item # 20

Regulation Projects

Topics for this section:

Regulation Project 2023200163:

Questions or clarifications needed from the Board per LAW review

1. LPN Scope of Practice- Please review and consider developing a scope of practice regulation for LPN's similar to the APRN Scope of Practice Regulation listed below, rather than the detail submitted. Can also adopt by reference.

   12 AAC 44.430. SCOPE OF PRACTICE. The board recognizes advanced and specialized acts of nursing practice as those described in the scope of practice statements published by national professional nursing associations recognized by the board for advanced practice registered nurses certified by the national certification bodies recognized by the board

Some research to consider (Added to the Board Book):

NCSBN Model rules

https://www.acha.org/ - ACHA Guidelines- Scope of practice for the LPN in College Health
Nurse Practice Standards - NALPN – National Association of Licensed Practical Nurses

2. Request to determine a definition for Cognitively impaired. See information page in this section.
3. 12 AAC 44.290 (3) (B)- Consider generalizing the branches of the military within regulation. See information page in this section. Note: When regulation projects are opened it subjects the entire section to review, hence these questions.
4. In previous discussions, the board wanted to remove the vendor names within regulation, especially surrounding the English Language proficiency exam. Does the board want to also adjust references to other vendors such as CGFNS or International Commission on Healthcare (linked to CGFNS)? 12 AAC 44.290(a)(3)(ii)(iii)

New Regulation Project:

Proposed Language Change to 12 AAC 44.740. See information page in this section.

NURSE PRACTICE STANDARDS
FOR THE LICENSED PRACTICAL & LICENSED VOCATIONAL NURSE

"NURSE PRACTICE STANDARDS" for the LPN/LVN

"Nursing Practice Standards" for the Licensed Practical Nurse/Licensed Vocational Nurse (LPN/LVN) is an avenue that NALPN meets the goals of its By-Laws to address Ethical and Principle Standards and to meet "Article II Objective" of the NALPN By-Laws as well, to explicate the Standards of Practical/Vocational Nursing. In our everchanging world, LPN's and LVN's have adjusted their practice to support those changes. As LPN's/LVN's practice in expanding roles in health care, "Nursing Practice Standards" are an imperative practice for LPN's, LVN's, as well as PN and VN students and their educators; all who practice with LPN's and LVN's.

PREFACE

The Standards of Practice were developed and incorporated by the NALPN Board of Directors to provide an essential benchmark to deliver the quality of health services, nursing care, and nursing services given by LPN's/LVN's which may be measured and assessed. These "Nurse Practice Standards" are applicable in all practice settings. The individual needs of the patient, the particular type of health care agency or other services, and the community resources, will vary according to the degree to which individual standards are applied.

The "Scope of Practice" of the Licensed Practical Nurse/Licensed Vocational Nurse has extended into specialized nursing services. These specialized fields of nursing services are provided below.

CODE

The code for the Licensed Practical Nurse/Licensed Vocational Nurse
was incorporated by NALPN in 1961 with a revision in 1979. The code provides a motivation for establishing, maintaining, and elevating professional nurse standards. As set forth in this code, upon entering the profession, each LPN/LVN, has the responsibility to adhere to the standards of ethical practice and conduct.

Each are to:

1. Know the "Scope of Practice" to maximize utilization of the LPN/LVN, as specified by the Nursing Practice Act and function within this "Scope of Practice".
2. Provide health care to all patients regardless of race, creed, cultural background, disease, or lifestyle.

3. In personal appearance, language, dress, and demeanor, uphold the highest standards.
4. Accept the responsibility for safe nursing by keeping mentally and physically fit and up to date educationally to practice safely.
5. Stay informed about issues affecting the practice of nursing, the delivery of health care. Where appropriate, participate in government and policy decisions.
6. Accept responsibility of membership of NALPN, participate to maintain the "Nurse Practice Standards", and employment of policies which lead to quality patient care.
7. Safeguard confidential information about the patient acquired from any source.

SCOPE

Licensed Practical Nurses/Licensed Vocational Nurses are a specialized field who represent the entry into the nursing practice profession. Practicing in places exists where different professions unite in their particular skills in a team effort. This effort is set to improve a patient's function and to protect the health and safety of the patients. Career advancement opportunities are present within the profession academic education, expansion of knowledge, expertise through both academic/continuing education and certification.

EDUCATION STANDARDS

The "Licensed Practical Nurse/Licensed Vocational Nurse"

1. Shall complete an educational program approved by the state nursing authority in practical nursing.
2. Shall successfully pass the National Council Licensure Examination for Practical Nurses.
3. Shall participate in the employing institution an initial orientation.

LEGAL & ETHICAL

The "Licensed Practical Nurse/Licensed Vocational Nurse"

1. Shall recognize and have a commitment to meet the moral and ethical practice of nursing obligations.
2. Shall not perform or accept professional responsibilities/duties which (s)he knows is not competent to perform.
3. Shall take responsibility in actions should situations arise where there is unprofessional conduct by a peer or other health care provider.

4. Shall hold a current LPN/LVN license to practice nursing in accordance with the law of their employment state.
5. Shall know and practice the scope of nursing practice instated by the Nursing Practice Act in their employment state.
6. Shall have a personal commitment to conform to the legal responsibilities essential for good nursing practice.

PRACTICE

The "Licensed Practical Nurse/Licensed Vocational Nurse"

1. As an accountable member of the health care team; shall accept assigned responsibilities.
2. As related to the assigned duties; shall function within the limits of educational preparation and experience.
3. With other members of the health care team; shall function in promotion of and in maintenance of good health. Shall aide in preventing disease and disability. Shall care for and rehabilitate individuals who are experiencing an altered state of health. Shall contribute to the ultimate quality of life until death.
4. For the individual patient or group; shall know and utilize the nursing process in planning, implementing, evaluating.
   a. Planning: The planning of nursing includes:
      - assessment and data collection of health status of the patient, the family, and community groups.
      - reporting information received from assessment.
      - identifying health goals.
   b. Implementation: The plan for nursing care is put into practice to achieve the stated goals and this includes:
      - Observing, reporting and recording significant changes which require different goals or intervention.
      - Apply skills and nursing knowledge to help promote and maintain health, to help prevent disease and disability, and to optimize functional capabilities of a patient.
      - Encouraging self-care as appropriate and assisting the patient and family with activities of daily living.
      - Carrying out therapeutic protocols and regimens prescribed by personnel in conjunction to state law.

c. Evaluations: The plan for nursing care and its implementations are evaluated to measure the progress toward the stated goals and will include appropriate person and/or groups to determine:
    - The relevancy of current goals in relation to the progress of the patient.
    - The recipient's involvement of care in the evaluation process.
    - The nursing action quality in implementation of the plan.
    - New goal setting or changing priorities in the care plan.
    - Shall participate in peer review and other evaluation processes.
    - Shall participate in the development of policies concerning the health, nursing needs of society, and in the roles and functions of the LPN/LVN.

CONTINUING EDUCATION

The "Licensed Practical Nurse/Licensed Vocational Nurse"

1. Shall seek and participate in continuing education activities that are accredited and offered by the National Association of Licensed Practical Nurses (NALPN) or other accredited organizations.
2. Shall take advantage of continuing education and/or certification opportunities which will lead to professional development and personal growth.
3. Shall regularly review career goals and choose continuing education activities that help to achieve these goals.
4. Shall be responsible for maintaining the highest possible level of professional capacity at all times.

SPECIALIZED NURSING PRACTICE

The "Licensed Practical Nurse/Licensed Vocational Nurse"

1. As set forth in this document, shall meet all standards of practice.
2. For practice in the chosen specialized nursing area, candidate shall present personal qualifications that demonstrate potential abilities.
3. At the staff level, shall have had at least one year nursing experience.
4. Shall provide documentation of completion of an approved agency course or program providing the knowledge and skills necessary for adequate nursing services in the specialized field.

ACHA Guidelines

Scope of Practice for the Licensed Practical Nurse in College Health

Introduction and Guiding Principles

The American College Health Association (ACHA) supports and recognizes the need for hiring well-qualified college health nurses to provide cost-effective nursing care and services within institutions of higher education.

Nursing Practice

ACHA embraces the following description and expectations for nursing as set forth by the American Nurses Association (ANA) and the American Academy of Ambulatory Care Nursing (AAACN):

The ANA describes nursing as "the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations" (n.d.-a).

The licensed practical nurse is any person licensed to practice practical nursing. Most state statutes define practical nursing as the performance of selected acts, including the administration of treatments and medications, promotion of wellness, maintenance of health, and prevention of illness of others under the direction of a registered nurse, a licensed physician, a licensed osteopathic physician, a licensed podiatric physician, or a licensed dentist.

Both registered nurses (RNs) and LPNs work autonomously within their scope of practice and level of competence and as part of a collaborative team to support safe, competent care for patients. All nursing personnel must hold a current license to practice within their state. All health care personnel should also hold a current CPR certification within their state as well. In general, LPNs are responsible for assisting RNs and providers by providing nursing care to their patients per individual state statutes.

Some of the typical job duties performed by LPNs include:

- Recording the patient's health history
- Administering intramuscular, oral, rectal, and topical medications (administering IV medications requires certification in some states)
- Performing physical assessments and measuring and documenting vital signs such as blood pressure, temperature, height, weight, pulse, and oxygen saturation
- Performing wound care including cleaning and bandaging injured areas
- Providing immunizations
- Providing patient education
- Monitoring fluid/food intake and output
- Transferring patients safely
- Collecting and performing lab testing including point of care testing
- Obtaining an EKG
- Triaging patient reactions to medications, IV sites, and nasogastric and gastrostomy tubes to identify early signs of complication and/or infections
- Observing patient mental health status
- Promoting health, focusing on exercise and nutrition, stress management, mental health and well-being (including depression and anxiety, drug and alcohol abuse, and tobacco use)
- Providing emotional support to patients
- Working within the guidelines of policy and procedure requirements, such as health and safety, risk management, and equality and diversity, written by the nurse's employer

LPN vs LVN

These two licensed nursing titles are the same. As used in the United States, the title LPN (licensed practical nurse) and LVN (licensed vocational nurse) describe the same position. Other than the state in which each of the terms is used, there are no other significant differences to these two titles and their scope of practice. The term LPN is used in 48 states; LVN is used only in the states of California and Texas.

To obtain the LPN or LVN designation, one must complete a 12-month educational and hands-on supervised clinical program, receiving a diploma at either a vocational school or local community college. Both LPN and LVN students receive classes in nursing, pharmacology, and biology and are required to pass the NCLEX-PN to obtain their license from the board of nursing.

The ANA (n.d.-b) lists the following stages of the nursing process:

Assessment:
The licensed practical/vocational nurse (LPN/LVN) is a highly valuable and integrated member of the medical care team. By partnering with RNs or providers, the LPN/LVN can perform a wide range of patient-care duties in many clinical settings. While the RN has a wider scope of practice and is responsible for more comprehensive patient assessments and duties, the LPN/LVN is qualified to conduct focused assessments to determine the health status of patients. The LPN is not to perform a comprehensive nursing assessment due to it being outside of their scope of practice.

Diagnosis:
LPNs cannot diagnose any medical condition or prescribe any medication. However, they can handle most of the routine tasks of day-to-day medical care.

Outcomes/Planning:
Based on the assessment and diagnosis, the nurse sets measurable and achievable short- and long-range goals for the patient. Assessment data, diagnosis, and goals are written in the patient's chart so that nurses as well as other health professionals caring for the patient have access to the information. Each problem is assigned a clear, measurable goal for the expected beneficial outcome.

Implementation:
The implementing phase is where the nurse determines interventions that were created to help meet the goals for the patient. This plan is specific to each patient and focuses on achievable outcomes. These tasks can be delegated to other persons who have been involved in the care of the patient.

Evaluation:
Once all nursing interventions have taken place, the nurse completes an evaluation to determine if the goals for patient have been met. The nurse bases (concludes) this evaluation by measuring whether the patient's condition has improved, is stabilized, or has worsened. In the event the condition of the patient has shown no improvement, or if the wellness goals were not met, the nursing process must be revised for the wellness of the patient. The LPN/LVN, in collaboration with the RN or provider, assists in adjusting the plan of care. The LPN/LVN is responsible for assessing, documenting, and communicating this process in a timely manner to ensure the patients' progress.

Documentation:
The LPN/LVN is individually accountable and responsible for the care the LPN/LVN provides. The nurse is required to document in patient records the nursing care given and the patient's response to the care provided. LPNs are accountable for documenting accurately, honestly, respectfully, and consistently under the principles, standards, practices, and laws.

College Heath LPN/LVN Standards of Practice

Standard 1: Education

Knowledge:

- Acquire the knowledge, skills, and abilities necessary to practice in college health.
- Seek and participate in ongoing educational opportunities related to clinical knowledge and enhancing professional skills.
- Understand health care systems.

Skills and Abilities/Proficiencies:

- Apply the nursing process.
- Execute ethical principles in decision making.
- Integrate evidence supported information and methodologies into current practice.

- Apply codes and standards of professional practice as established in the nurse practice acts for the states in which the LPN/LVN practices.
- Understand and comply with licensure laws for the state in which the LPN/LVN practices.

Standard 2: Nursing Process

Knowledge:

- Proficient and competent clinical skills are essential in providing optimal care.

Skills/Abilities/Proficiencies

- Critical thinking is used throughout all components of the nursing process. The RN or LPN uses critical thinking in clinical problem solving and decision making within their scope of practice. Critical thinking involves analyzing and interpreting a problem by using reasoning to find solutions and apply them in the evaluation by the LPN. This leads to safe, skillful nursing interventions and positive outcomes in the care of patients.
- Effective decision-making skills are one of the most important skills to have as an LPN. LPNs must have excellent decision-making skills to perform the necessary procedures quickly and effectively, especially in the case of an emergency. The ability to work under pressure is crucial and indispensable.
- Time management is a very important skill to have as an LPN. Efficacy management can help ensure that all patients receive the care they need in the manner that is most beneficial.

Standard 3: Collegiality

Knowledge:

- Understand the nurse practice act for the state in which the LPN/LVN practices.
- Identify patient rights and responsibilities in the current practice location.
- Understand the patient advocate role.
- Understand current HIPAA and FERPA requirements.

Skills and Abilities/Proficiencies:

- Initiate relationships with the individual patient (including the patient's significant other or support system, if necessary), other members of the campus community, and health care providers to provide college health services which demonstrate and support learning outcomes.

Standard 4: Ethics

Knowledge:

- Understand current state of nursing practice's Nurse Practice Standards.
- List the current, relevant nursing practice laws and regulations for the state in which the LPN/LVN practices.
- Review administrative and departmental policies and procedures which govern nursing practice in the state in which the LPN/LVN practices.

Skills and Abilities/Proficiencies:

- Perform self-evaluation of one's own nursing practice in relation to professional practice standards and relevant laws and regulations.
- Perform frequent self-evaluation of one's own nursing practice in relation to ethics.
- Provide nursing services in an organized manner to meet the existing needs and identify the future needs of the individual.
- Provide care and support of patient's decisions in an ethical manner.

Standard 5: Collaboration

Knowledge:

- List other departments on campus.
- Work with a team of providers, nurses, and clerical staff.

Skills and Abilities/Proficiencies:

- Identify opportunities to collaborate with other departments within the university.
- Collaborate with community members to plan, assess, identify outcomes, implement, and evaluate college health services and community health services when applicable.

Standard 6: Professional Practice Evaluation

Knowledge:

- Understand the nursing standards, laws, and regulations of the state in which the LPN/LVN practices.
- Review expectations set forth by the current practice location.

Skills and Abilities/Proficiencies:

- Identify strengths and areas for professional and personal growth.
- Create professional goals which may be based on evaluation by their supervisor.
- Utilize learning outcomes.
- Utilize constructive feedback for positive development.

Standard 7: Resource Utilization and Leadership

Knowledge:

- List interpersonal communication skills and available classes/courses that can help to develop these skills.

Skills and Abilities/Proficiencies:

- Describe the organizational chart at the current practice location.

Standard 8: Communication

Knowledge:

- Understand active communication skills.

Skills and Abilities/Proficiencies:

- Communication skills are a necessity when it comes to performing well as an LPN/LVN.
- LPNs work closely with patients and their families, as well as with doctors, nurses, and other members of the health care team, and being able to effectively relay information about the needs and condition of a patient is a vital part of ensuring optimal care.
- Clear and concise verbiage is as essential as the treatments offered.
- Empathy is essential when relating to patients.

References

American Nurses Association. (n.d.-a). What is nursing? http://www.nursingworld.org/EspeciallyForYou/What-isNursing

American Nurses Association. (n.d.-b). The Nursing Process. https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/the-nursing-process/

Resources

ACHA Guidelines: Scope of Practice for the Registered Nurse in College Health. Available at https://www.acha.org/Guidelines

National Council of State Boards of Nursing, Inc. (NCSBN) Scope of Practice Decision-Making Framework https://www.ncsbn.org/nursing-regulation/practice/decision-making-framework.page

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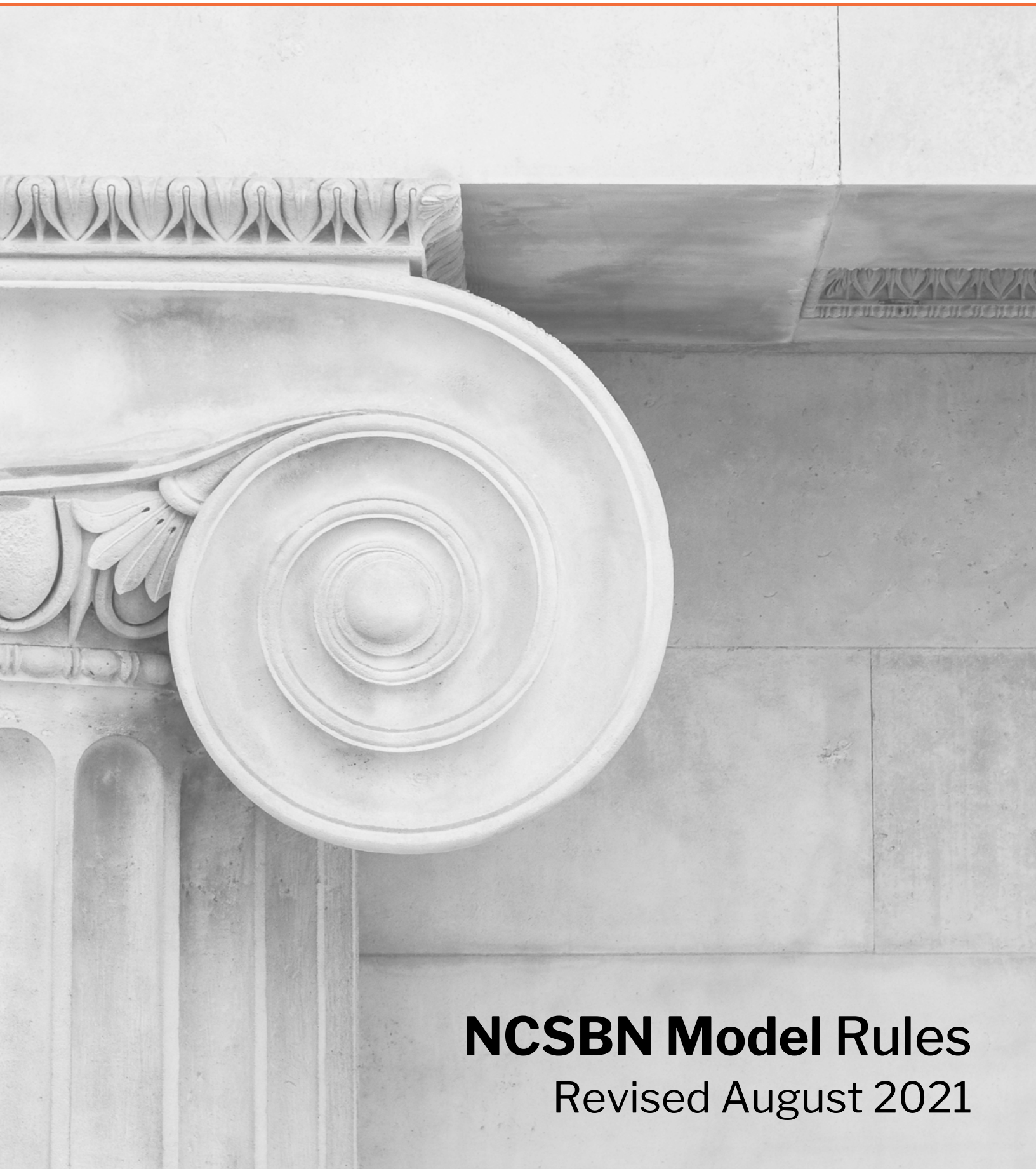

NCSBN Model Rules

Revised August 2021

Mission Statement

The National Council of State Boards of Nursing (NCSBN®) empowers and supports nursing regulators in their mandate to protect the public.

Address inquiries in writing to NCSBN Permissions, 111 E. Wacker Drive, Suite 2900, Chicago, IL 60601-4277.

NCSBN MODEL RULES (2021)

Table of Contents

Chapter 1. Title and Purpose

Chapter 2. Definitions

As used in Chapters 3 through 8 of this Act, unless the context thereof requires otherwise:

a. "Abandonment" means the intentional leaving a patient for whom the nurse is responsible without providing for another nurse or appropriate caretaker to assume care upon the nurse's leaving.

b. "Dual relationship" means when a nurse is involved in any relationship with a patient in addition to the therapeutic nurse- patient relationship.

c. "NCLEX-PN®" means the National Council Licensure Examinations for Practical Nurses.

d. "NCLEX-RN®" means the National Council Licensure Examinations for Registered Nurses.

e. "Nursing faculty" means individuals employed full or part time by an academic institution who are responsible for developing, implementing, evaluating and updating nursing program curricula.

f. "Preceptor" means an individual at or above the level of licensure that an assigned student is seeking who may serve as a teacher, mentor, role model, or supervisor in a clinical setting.

g. "Professional boundaries" means the space between the nurse's power and the patient's vulnerability; the power of the nurse comes from the professional position and access to private knowledge about the patient; establishing boundaries allows the nurse to control this power differential and allows a safe connection to meet the patient's needs.

h. "Professional-boundary crossing" means a deviation from an appropriate boundary for a specific therapeutic purpose with a return to established limits of the professional relationship.

i. "Professional-boundary violation" means the failure of a nurse to maintain appropriate boundaries with a patient and key parties.

j. "Sexualized body part" means a part of the body not conventionally viewed as sexual in nature that evokes arousal.

k. "Sexual misconduct" means any unwelcome behavior of a sexual nature that is committed without consent or by force, intimidation, coercion, or manipulation.

l. "Simulation" means a technique to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner (Gaba, 2004).

m. "Debriefing" means an activity that follows a simulation experience, is led by a facilitator, encourages participant's reflective thinking, and provides feedback regarding the participant's performance.

Chapter 3. Scope of RN, LPN/VN and APRN Practice

3.1.1 Standards Related to Licensed Practical/Vocational Nurse (LPN/VN), RN and APRN Professional Accountability

The LPN/VN, RN and APRN:

a. Accepts responsibility for individual nursing actions, competence, decisions and behavior in the course of nursing practice.

b. Maintains competence through ongoing learning and application of knowledge in nursing practice.

3.1.2 Standards Related to LPN/VN Scope of Practice

The LPN/VN, practicing to the extent of their education and training under the supervision of an RN, advanced practice registered nurse (APRN), physician or other authorized licensed health care provider:

a. Participates in nursing care, health maintenance, patient teaching, counseling, collaborative planning and rehabilitation.

b. Plans for patient care, including:

    1. Planning nursing care for a patient whose condition is stable or predictable.

    2. Assisting the RN, APRN, or physician in identification of patient needs and goals.

    3. Determining priorities of care together with the RN, APRN or physician.

c. Provides patient surveillance and monitoring

    1. Participating with other health care providers and contributing in the development, modification, and implementation of the patient centered healthcare plan.

d. Implements nursing interventions and prescribed medical regimens in a timely and safe manner.

e. Documents nursing care provided accurately and timely.

f. Collaborates and communicates relevant and timely patient information with patients and other health team members to ensure quality and continuity of care, including:

    1. Patient status and progress.

    2. Patient response or lack of response to therapies.

    3. Changes in patient condition.

    4. Patient needs and special requests.

g. Takes preventive measures to promote an environment that is conducive to safety and health for patients, others and self.

h. Respects patient diversity and advocates for the patient's rights, concerns, decisions and dignity.

i. Maintains appropriate professional boundaries.

j. Participates in systems, clinical practice and patient care performance improvement efforts to improve patient outcomes.

k. Assigns and delegates nursing activities to assistive personnel. The LPN shall:

1. Delegate only those nursing measures for which that person has the necessary skills and competence to accomplish safely.

Authority: Model Act Article III Section 1

3.2.1 Standards Related to RN Scope of Practice

The RN:

a. Practices within the legal boundaries for nursing through the scope of practice authorized in the Nurse Practice Act and rules governing nursing.

b. Provides patient surveillance and monitoring.

c. Identifies changes in patient's health status and takes appropriate action.

d. Documents nursing care, changes in the patient's condition and all relevant information.

e. Takes preventive measures to protect patient, others and self.

f. Delegates to another only those nursing measures for which that person has the necessary skills and competence to accomplish safely.

Authority: Model Act Article III Section 2

3.2.2 Standards Related to APRN Scope of Practice

a. The APRN shall comply with the standards for RNs as specified in Chapter 3 and to the standards set forth by the BON. Standards for a specific role and population focus of APRN supersede standards for RNs where conflict between the standards, if any, exists.

b. APRNs shall practice within standards established by the BON in rule and assure patient care is provided according to relevant patient care standards recognized by the BON, and other national standards of care.

c. Discipline of Prescriptive Authority

1. APRN discipline and proceedings is the same as previously stated for RN and LPN/VN in Chapter 7.

2. The BON may limit, restrict, deny, suspend or revoke APRN licensure, or prescriptive or dispensing authority.

3. Additional grounds for discipline related to prescriptive or dispensing authority include, but are not limited to:

1. Prescribing, dispensing, administering, or distributing drugs in an unsafe manner or without adequate instructions to patients according to acceptable and prevailing standards.

2. Selling, purchasing, trading, or offering to sell, purchase or trade drug samples.

3. Prescribing, dispensing, administering or distributing drugs for other than therapeutic or prophylactic purposes. or
4. Prescribing or distributing drugs to individuals who are not patients of the APRN or who are not within that nurse's role and population focus.

Authority: Model Act Article III Section 3

Chapter 4. Board of Nursing (BON)

4.1 Membership, Nominations, Qualifications, Appointment and Term of Office

4.2 Officers

4.3 Meetings

4.4 Guidelines

4.5 Vacancies, Removal and Immunity

4.6 Powers and Duties

4.7 Collection of Fees

a. The BON may collect the following fees:
    1. Application for licensure by examination
        a. RN < >
        b. LPN/VN < >
        c. APRN < >
    2. Application for licensure by endorsement
        a. RN < >
        b. LPN/VN < >
        c. APRN < >
    3. Temporary permit for endorsement applicant
        a. RN < >
        b. LPN/VN < >
        c. APRN < >

4. Renewal of licensure
    a. RN < >
    b. LPN/VN < >
    c. APRN < >
5. Late renewal < >
6. Reinstatement < >
7. Certified statement that nurse is licensed in jurisdiction < >
8. Duplicate or reissued license < >
9. Insufficient funds < >
10. Nursing education program survey and evaluation per level < >
11. Discipline monitoring < >
12. Copying costs < >
13. Criminal background check processing fees < >
14. Other miscellaneous costs

b. All fees collected by the BON are non-refundable.

Authority: Model Act Article IV Section 6

4.8 Executive Officer

Chapter 5. RN, LPN/VN and APRN Licensure and Exemptions

5.1 Titles and Abbreviations for Licensed Nurses

5.1.1 Titles and Abbreviations for APRNs

a. Individuals are licensed or granted privilege to practice as APRNs in the roles of certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS) and certified nurse practitioner (CNP) and in the population focus of family/individual across the lifespan, adult-gerontology, neonatal, pediatrics, women's health/ gender-related or psychiatric/mental health.

b. Each APRN shall use the designation "APRN" plus role title as a minimum for purposes of identification and documentation.

c. When providing nursing care, the APRN shall provide clear identification that indicates his or her APRN designation.

Authority: Model Act Article III Section 3

5.2 Examinations

5.3 Application for Licensure by Examination as an RN or LPN/VN

An applicant for licensure as an RN or LPN/VN shall:

a. Submit a completed application and fees established by the BON.

b. Graduate or be eligible for graduation from a <your jurisdiction> BON approved prelicensure program or a program that meets criteria comparable to those established by the <your jurisdiction> BON in its rules.

c. Pass an examination authorized by the BON.

   1. All RN applicants shall take and pass the NCLEX-RN®.

   2. All LPN/ VN applicants shall take and pass the NCLEX-PN®.

d. Submit to state and federal criminal background checks.

e. Report any criminal conviction, nolo contendere plea, Alford plea, deferred judgment, or other plea arrangements in lieu of conviction.

f. Report any condition or impairment (including but not limited to substance abuse, or a mental, emotional or nervous disorder or condition) which in any way currently affects or limits your ability to practice safely and in a competent and professional manner.

g. Report any actions taken or initiated against a professional or occupational license, registration or certification.

h. For an applicant who is a graduate of a prelicensure education program not taught in English, passage of an English proficiency examination that includes the components of reading, speaking, writing and listening.

i. Identify any state, territory or country in which the applicant holds a professional license or credential, if applicable. Required information includes:

   1. The number and status of the license or credential.

   2. The original state or country of licensure or credentialing.

j. Provide employment information including current employer if employed in health care, including address, telephone number, position and dates of employment and previous employer in health care, if any, if current employment is less than 12 months.

k. Provide information regarding whether the applicant previously applied for a license in another jurisdiction and either was denied a license, or withdrew the application or allowed the application to expire, if applicable.

l. Provide detailed explanation and supporting documentation for each affirmative answer to questions, as applicable, regarding the applicant's background.

Authority: Model Act Article V Section 3

5.4 Additional Requirements for Licensure by Examination of Internationally Educated Applicants

In addition to the requirements listed in Section 5.3, the requirements for licensure by examination of internationally educated applicants, includes:

a. Graduation from a foreign RN or LPN/ VN prelicensure education program that (a) has been approved by the authorized accrediting body in the applicable country and (b) has been verified by an independent credentials review agency to be comparable to a licensing board-approved prelicensure education program;

b. Acceptable documentation shall verify the date of enrollment, date of graduation and credential conferred. An official transcript and, if not in English, a certified translation is required prior to the approval to take the NCLEX®.

c. Passage of an English proficiency examination, if a graduate of a foreign prelicensure education program not taught in English or if English is not the individual's native language, that includes the components of reading, speaking, writing and listening.

Authority: Model Act Article V Section 3

5.5 Application for Licensure by Endorsement as an RN or LPN/VN

a. An applicant for licensure by endorsement in this state shall:

1. Submit a completed application and fees as established by the BON.
2. Graduate from a <your jurisdiction> BON-approved prelicensure program or a program that meets criteria comparable to those established by the <your jurisdiction>.
3. Hold a license as an RN or an LPN/VN that is not encumbered.
4. Pass an examination authorized by the BON.
5. Report status of all nursing licenses, including any BON actions taken or any current or pending investigations.
6. Submit to state and federal criminal background checks.
7. Report any criminal conviction, nolo contendere plea, Alford plea, deferred judgment, or other plea arrangements in lieu of conviction.
8. Report any condition or impairment (including but not limited to substance use, alcohol abuse, or a mental, emotional or nervous disorder or condition) which in any way currently affects or limits your ability to practice safely and in a competent and professional manner.
9. Report any actions taken or initiated against a professional or occupational license, registration or certification.
10. Report current participation in an alternative to discipline program in any jurisdiction.
11. Submit verification of licensure status provided directly from the U.S. jurisdiction of licensure by examination, or a coordinated licensure information system.

b. An applicant for licensure by endorsement as an RN or LPN/ VN in this state, whichever is applicable, shall provide the following information:

    1. Evidence of having passed the licensure examination required by this jurisdiction at the time the applicant was initially licensed in another jurisdiction.

c. Identification of any state, territory or country in which the applicant holds a health profession license or credential, if applicable. Required information includes:

    1. The number and status of the license or credential.

    2. The original state or country of licensure or credentialing.

d. The date and jurisdiction the applicant previously applied for a license in another jurisdiction and either was denied a license or withdrew the application, if applicable.

e. Detailed explanation and supporting documentation for each affirmative answer to questions, as applicable, regarding the applicant's background.

Authority: Model Act Article V Section 4

5.6 Renewal of Licenses

The renewal of a license must be accomplished by <date determined by the BON>. Failure to renew the license on or before the date of expiration shall result in the forfeiture of the right to practice nursing in this jurisdiction.

Authority: Model Act Article V Section 7

5.6.1 Application for Renewal of License as an RN or LPN/VN

An applicant for license renewal shall submit to the BON the required fee for license renewal and a completed application for license renewal that provides the following information:

a. Detailed explanation and supporting documentation for each affirmative answer to questions, as applicable, regarding the applicant's background.

b. Report any criminal conviction, nolo contendere plea, Alford plea, deferred judgment, or other plea arrangements in lieu of conviction.

c. Report status of all nursing licenses, including any BON actions taken or any current or pending investigations

d. Report any condition or impairment (including but not limited to substance use, alcohol abuse, or a mental, emotional, or nervous disorder or condition) which in any way currently affects or limits your ability to practice safely and in a competent and professional manner.

e. Report any actions pending, taken or initiated against a professional or occupational license, registration or certification.

f. Report current participation in an alternative to discipline program in any jurisdiction.

g. Failure to provide the requested information may result in non-renewal of the license to practice nursing or a disciplinary action.

Authority: Model Act Article V Section 6

5.7 Reactivation of License Following Failure to Renew

An individual whose license is inactive by failure to renew may apply for reactivation by submitting an application, paying a fee, meeting all practice requirements for renewal of licensure and satisfying the conditions listed below. At any time after a license has been inactive, the BON may require evidence of the licensee's current nursing knowledge and skill before reactivating the licensee to the status of active license. An applicant must:

1. Report any criminal conviction, nolo contendere plea, Alford plea, deferred judgment, or other plea arrangements in lieu of conviction.
2. Submit to state and federal criminal background checks.
3. Report status of all nursing licenses, including any BON actions taken or any current or pending investigations.
4. Report any condition or impairment (including but not limited to substance use, alcohol abuse, or a mental, emotional or nervous disorder or condition) which in any way currently affects or limits your ability to practice safely in a competent and professional manner.
5. Report any action taken or initiated against a professional or occupational license, registration or certification.
6. Report current participation in an alternative to discipline program in any jurisdiction.

Authority: Model Act Article V Section 7

5.7.1 Reinstatement Following Disciplinary Action

For those licensees applying for reinstatement following disciplinary action, compliance with all BON licensure requirements, as well as any specific requirements set forth in the BON's discipline order, is required. An applicant must:

1. Report any criminal conviction, nolo contendere plea, Alford plea, deferred judgment, or other plea arrangements in lieu of conviction.
2. Submit to state and federal criminal background checks.
3. Report status of all nursing licenses, including any BON actions taken or any current or pending investigations.
4. Report any condition or impairment (including but not limited to substance use, alcohol abuse, or a mental, emotional or nervous disorder or condition) which in any way currently affects or limits your ability to practice safely in a competent and professional manner.
5. Report any action taken or initiated against a professional or occupational license, registration or certification.
6. Report current participation in an alternative to discipline program in any jurisdiction.

Authority: Model Act Article V Section 8

5.8 Duties of Licensees

5.9 Criminal Background Checks

5.10 Exemptions to Licensure – Nursing Students

1. No provisions of this Act shall be construed to prohibit the practice of nursing if:

    a. The student is enrolled in a program located in this jurisdiction and approved by the BON or participating in this jurisdiction in a component of a program located in another jurisdiction and approved by a BON.

    b. The student's practice is under the auspices of the program.

    c. The student acts under the supervision of an RN serving for the program as a faculty member or teaching assistant.

    Authority: Model Act Article V Section 11

5.11 APRN Licensure

5.11.1 Application for Initial Licensure

a. An applicant for licensure as an APRN in this state shall submit to the BON the required fee as specified in Chapter 4, verification of licensure or eligibility for licensure as an RN in this jurisdiction and a completed application that provides the following information:

    1. Graduation from an APRN graduate or post-graduate program as evidenced by official documentation received directly from an APRN program accredited by a nursing accrediting body that is recognized by the U.S. Secretary of Education and/or the Council for Higher Education Accreditation (CHEA), or its successor organization, as acceptable by the BON.

    2. This documentation shall verify the date of graduation; credential conferred; completion of three separate graduate level courses in advanced physiology and pathophysiology, advanced health assessment, advanced pharmacology, which includes pharmacodynamics, pharmacokinetics and pharmacotherapeutics of all broad categories of agents; role and population focus of the education program; and evidence of meeting the standards of nursing education in this state.

b. Report any criminal conviction, nolo contendere plea, Alford plea, or other plea arrangement in lieu of conviction.

c. Requirements for Certification Programs

    1. Certification programs are accredited by a national accreditation body as acceptable by the BON.

    Authority: Model Act Article V Section 5

5.11.2 Application of an Internationally Educated APRN

An internationally educated applicant for licensure as an APRN in this state shall:

a. Graduate from a graduate or post-graduate level APRN program equivalent to an APRN educational program in the U.S. accepted by the BON.

b. Submit documentation through a BON approved qualified credentials evaluation process for the license being sought.

c. Has, if a graduate of a foreign prelicensure education program not taught in English or if English is not the individual's native language, successfully passed an English proficiency examination that includes the components of reading, speaking, writing, and listening;

d. Meet all other licensure criteria required of applicants educated in the U.S.

Authority: Model Act Article V Section 5

5.11.3 Application for Licensure by Endorsement

a. An applicant for licensure by endorsement as an APRN in this state shall submit to the BON the required fee as specified in Chapter 4, verification of eligibility for an license or privilege to practice as an RN in this jurisdiction and a completed APRN application that provides the following information:

    1. Graduation from a graduate or post-graduate level APRN program, as evidenced by an official transcript or other official documentation received directly from a graduate program accredited by a nursing accrediting body that is recognized by the U.S. Secretary of Education and/or CHEA, or its successor organization, as acceptable by the BON.

    2. This documentation shall verify the date of graduation; credential conferred; number of clinical hours completed; completion of three separate graduate level courses in advanced physiology and pathophysiology, advanced health assessment, advanced pharmacology, which includes pharmacodynamics, pharmacokinetics and pharmacotherapeutics of all broad categories of agents; role and population focus of the education program; and evidence of meeting the standards of nursing education in this state.

b. Not have an encumbered license or privilege to practice in any state or territory.

c. Report any conviction, nolo contendere plea, Alford plea, or other plea arrangement in lieu of conviction.

d. Report status of all nursing licenses, including any BON actions taken or any current or pending investigations.

e. Current certification by a national certifying body in the APRN role and population focus appropriate to educational preparation.

    a. Primary source of verification of certification is required.

f. Requirements of 5.3.d.-i. shall apply to APRNs.

Authority: Model Act Article V Section 5

5.11.4 Application for License Renewal

An applicant for license renewal as an APRN shall submit to the BON the required fee for license renewal, as specified in Chapter 4, and a completed license renewal application including:

a. Detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background.

b. Evidence of current certification(s), or recertification as applicable, by a national professional certification organization that meets the requirements of 8.2.1.

c. Submit a renewal application as directed by the BON and remit the required fee as set forth in rule.

Authority: Model Act Article V Section 5

5.11.5 Quality Assurance/Documentation and Audit

The BON may conduct a random audit of nurses to verify current APRN certification and/or continuing education. Upon request of the BON, licensees shall submit documentation of compliance.

Authority: Model Act Article V Section 5

5.11.6 Reinstatement of License

The reinstatement of APRN licensure is the same as previously stated for RNs and LPN/VNs in Chapter 5 plus the following:

a. An individual who applies for licensure reinstatement and who has been out of practice for more than five years shall provide evidence of successfully completing < > hours of a reorientation in the appropriate advanced practice role and population focus, which includes a supervised clinical component by a qualified preceptor.

b. Preceptor must the following requirements:

   1. Holds an active license or privilege to practice as an APRN or physician that is not encumbered and practices in a comparable practice focus.

   2. Functions as a supervisor and teacher and evaluates the individual's performance in the clinical setting.

c. For those licensees applying for licensure reinstatement following disciplinary action, compliance with all BON licensure requirements, as well as any specified requirements set forth in the BON's discipline order, is required.

Authority: Model Act Article V Section 5

Chapter 6. Prelicensure Nursing Education

6.1 Purpose of Nursing Education Standards

The purpose of nursing education standards is to ensure that graduates of nursing education programs are prepared for safe and effective nursing practice.

Authority: Model Act Article VI Section 1

6.1.1 Prelicensure Nursing Education Standards

All nursing education programs shall meet these standards:

a. The purpose and outcomes of the nursing program shall be consistent with the Act and BON promulgated administrative rules, regulations and other relevant state statutes.

b. The input of stakeholders shall be considered in developing and evaluating the purpose and outcomes of the program.

c. A systematic evaluation plan of the curriculum is in place.

d. The curriculum shall provide diverse didactic and clinical learning experiences consistent with program outcomes.

e. Faculty and students shall participate in program planning, implementation, evaluation and continuous improvement.

f. The nursing program administrator shall be professionally and academically qualified RN with institutional authority and administrative responsibility for the program.

g. The nursing program administrator shall be consistent in a nursing program, with no more than 3 nursing program administrators in 5 years.

h. Professionally, academically and clinically qualified faculty shall be sufficient in number, have a low turnover, and have the expertise to accomplish program outcomes and quality improvement.

i. The simulation center shall be accredited.

j. Written an easily accessible policies and procedures that have been vetted by students and faculty.

k. Formal mentoring of full-time and part-time faculty.

l. Formal orientation of adjunct faculty.

m. The school shall provide substantive and periodic workshops and presentations devoted to faculty development.

n. The program can provide evidence that their admission, progression, and student performance standards are based on data.

o. The fiscal, human, physical (including access to a library), clinical and technical learning resources shall be adequate to support program processes, security and outcomes.

Authority: Model Act Article VI Section 2

6.1.2 Required Criteria for Prelicensure Nursing Education Programs

a. Curriculum shall include experiences that promote clinical judgment; skill in clinical management, supervision and delegation; interprofessional collaboration; quality and safety; and navigation and understanding of health care systems.

   1. Distance education methods are consistent with the curriculum plan.

   2. Coursework shall include, but not be limited to:

      i. Sound foundation in biological, physical, social and behavioral sciences

      ii. Didactic content including prevention of illness and the promotion, restoration and maintenance of health in patients across the lifespan and from diverse cultural, ethnic, social and economic backgrounds.

      iii. Didactic and clinical experiences shall include Medical/ Surgical, obstetrics, pediatrics, Psychiatric/ Mental Health and Community Health.

      iv. 50% or more of clinical experiences, in each course, shall include direct patient care.

      v. Clinical experiences shall be supervised and occur directly with patients. Clinical experiences and simulation shall include a variety of clinical settings and are sufficient for meeting program outcomes.

   3. The program has processes in place to manage and learn from near misses and errors.

   4. The program has opportunities for collaboration with interprofessional teams.

   5. Professional responsibilities, legal and ethical issues, history and trends in nursing and health care.

b. Students

   1. The program shall hold students accountable for professional behavior, including honesty and integrity, while in their program of study.

   2. All policies relevant to applicants and students shall be readily available in writing and vetted by students and faculty.

   3. Students shall meet health standards and criminal background check requirements.

   4. English as a second language assistance is provided.

   5. Assistance is available for students with disabilities.

   6. All students have books and resources necessary throughout the program.

   7. Remediation strategies are in place at the beginning of each course and students are aware of how to seek help.

c. Administrator qualifications

1. Administrator qualifications in a program preparing for LPN/VN licensure shall include:

    a. A current, active RN license or privilege to practice that is not encumbered and meet requirements in the jurisdiction where the program is approved;

    b. A minimum of a graduate degree in nursing or bachelor's degree in nursing with a graduate degree;

    c. Experience in teaching, nursing practice and administration; and

    d. A current knowledge of nursing practice at the practical/vocational level.

2. Administrator qualifications in a program preparing for RN licensure shall include:

    a. A current, active RN license or privilege to practice that is not encumbered and meet requirements in the jurisdiction where the program is approved;

    b. A doctoral degree in nursing; or a graduate degree in nursing and a doctoral degree;

    c. Educational preparation or experience in academic teaching;

    d. Experience in nursing practice and administration; and

    e. A current knowledge of registered nursing practice.

d. Faculty

1. There shall be a minimum of 35% of the total faculty, including all clinical adjunct, part-time, or other faculty, are employed at the institution as full-time faculty.

2. The nursing faculty shall hold a current, active RN license or privilege to practice that is not encumbered and meet requirements in the state where the program is approved.

3. Faculty supervising clinical experiences shall hold a current active RN license or privilege to practice that is not encumbered and meet requirements in the jurisdiction where the clinical practicum is conducted.

4. Qualifications for nursing faculty who teach in a program leading to licensure as an LPN/VN should be academically and experientially qualified with a minimum of a bachelor's degree in nursing.

5. Qualifications for nursing faculty who teach clinical courses, including didactic or clinical experiences, in a program leading to licensure as an RN should be academically and experientially qualified with a minimum of a graduate degree in nursing.

6. Faculty can demonstrate participation in continuing education.

7. Interprofessional faculty teaching non-clinical nursing courses shall have advanced preparation appropriate for the content being taught.

8. Clinical faculty, preceptors and adjunct faculty shall demonstrate current clinical experience related to the area of assigned clinical teaching responsibilities.

9. Clinical preceptors shall have an unencumbered license to practice as a nurse at or above the level for which the student is being prepared, in the jurisdiction where they are precepting students.

10. Simulation faculty are certified.

Authority: Model Act Article VI Section 2

6.1.3 Determination of Compliance with Standards

Accreditation by a national nursing accrediting body, set forth by the United States Department of Education (USDE), is required, and evidence of compliance with the accreditation standards may be used for evaluating continuing approval.

Nursing programs must submit to the BON copies of accreditation related correspondence with the national nursing accrediting agency within 30 days of receipt.

Authority: Model Act Article VI Section 3

6.1.4 Purposes of Prelicensure Nursing Education Program Approval

a. To promote public protection through the safe practice of nursing by implementing standards for individuals seeking licensure as RNs and LPN/VNs.

b. To grant legal recognition to nursing education programs that the BON determines have met the standards.

c. To ensure graduates meet the educational and legal requirements for the level of licensure for which they are preparing and to facilitate their endorsement to other states and countries.

d. To provide the public and prospective students with a published list of nursing programs that meets the standards established by the BON.

Authority: Model Act Article VI Section 4

6.1.5 Establishment of a New Prelicensure Nursing Education Program

Before establishing a new nursing education program, the program shall contact the BON and complete the process outlined below:

a. Phase I – Application to BON. The proposed program shall provide the following information to the BON:

1. Identification of sufficient financial and other resources.

2. Governing institution approval and evidence of financial support that can be provided on an ongoing basis.

3. Evidence of the institution meeting state requirements, and regional or national accreditation by an accredited agency recognized by the USDE.

4. Evidence of the nursing program actively seeking pre-accreditation or candidate accreditation from a USDE recognized national nursing accrediting agency.

5. Clinical opportunities and availability of resources.

6. Evidence of clinical partnerships and availability of resources.
7. Availability of qualified faculty and program director.
8. A proposed timeline for initiating the program.

b. Phase II – Initial Approval for Admission of Students. The proposed program shall provide the BON with verification that the following program components and processes have been completed:

1. Employment of a qualified director.
2. A comprehensive program curriculum.
3. Establishment of student policies for admission, progression, retention, and graduation.
4. Policy and strategies to address students' needs including those with learning disabilities and English as a second language; and remediation tactics for students performing below standard.
5. When the BON determines that all components and processes are completed and in place, the BON shall authorize the program to admit students.

c. Phase III – Full Approval of Program. The BON shall fully approve the program upon:

1. Completion of BON program survey visit.
2. Submission of program's ongoing systematic evaluation plan.
3. Employment of qualified faculty.
4. Additional oversight of new programs will take place for the first 6 years of operation. This may include progress reports every 6 months on program leadership, consistency of faculty, numbers of students and trends of NCLEX pass rates, along with the regularly collected annual reports to the BON.

Authority: Model Act Article VI Section 5

6.1.6 Continuing Approval of Prelicensure Nursing Education Programs

a. Every < > years previously approved nursing education programs with full program approval status will be evaluated for continuing approval by the BON.

b. Warning signs that may trigger a focused site visit include:

1. Complaints from students, faculty and clinical agencies.
2. Turnover of program administrators, defined by more than 3 administrators in a 5 year period.
3. Frequent nursing faculty turnover.
4. Frequent cuts in numbers of nursing faculty.
5. Decreasing trends in NCLEX pass rates.

c. The BON may accept all or partial evidence prepared by a program, to meet national nursing accreditation requirements. The BON shall review and analyze various sources of information regarding program performance, including, but not limited to:

   1. Periodic BON survey visits, as necessary, and/or reports.

   2. Evidence of being accredited by a USDE recognized national nursing accredited agency.

   3. BON recognized national nursing accreditation visits, reports and other pertinent documents provided by the program.

   4. Results of ongoing program evaluation.

d. Continuing approval will be granted upon the BON's verification that the program is in compliance with the BON's nursing education administrative rules.

Authority: Model Act Article VI Section 6

6.1.7 Conditional Approval of Prelicensure Nursing Education Programs

a. The BON may grant conditional approval when it determines that a program is not fully meeting approval standards.

b. If the BON determines that an approved nursing education program is not meeting the criteria set forth in these regulations, the nursing program shall be given a reasonable period of time to submit an action plan and to correct the identified program deficiencies.

Authority: Model Act Article VI Section 7

6.1.8. Withdrawal of Approval

a. The BON shall withdraw approval if, after proper notice and opportunity, it determines that:

   1. A nursing education program fails to meet the standards of this Rule.

   2. A nursing education program fails to correct the identified deficiencies within the time specified.

Authority: Model Act Article VI Section 8

6.1.9 Appeal

A program denied approval or given less than full approval may appeal that decision. All such actions shall be in accordance with due process rights.

Authority: Model Act Article VI Section 9

6.1.10 Reinstatement of Approval

The BON may reinstate approval if the program submits evidence of compliance with nursing education standards within the specified time frame.

Authority: Model Act Article VI Section 10

6.2 Closure of Prelicensure Nursing Education Program and Storage of Records

a. A nursing education program may be closed due to withdrawal of BON approval or may close voluntarily.

b. Provisions shall be made for maintenance of the standards for nursing education during the transition to closure.

c. Arrangements are made for the secure storage and access to academic records and transcripts.

d. An acceptable plan is developed for students to complete a BON approved program.

e. Confirmation shall be provided to the BON, in writing, that the plan has been fully implemented.

Authority: Model Act Article VI Section 11

6.2.1 Prelicensure Nursing Education Program Closed Voluntarily

The program shall submit to the BON:

a. Reason for the closing of the program and date of intended closure.

b. An acceptable plan for students to complete a BON approved program.

c. Arrangements for the secure storage and access to academic records and transcripts.

Authority: Model Act Article VI Section 12

6.3 Innovative Approaches in Prelicensure Nursing Education Programs

A nursing education program may apply to implement an innovative approach by complying with the provisions of this section. Nursing education programs approved to implement innovative approaches shall continue to provide quality nursing education that prepares graduates to practice safely, competently and ethically within the scope of practice as defined in the Act.

Authority: Model Act Article VI Section 13

6.3.1 Purposes

a. To foster innovative models of nursing education to address the changing needs in health care.

b. To assure that innovative approaches are conducted in a manner consistent with the BON's role of protecting the public.

Authority: Model Act Article VI Section 14

6.3.2 Eligibility

a. The nursing education program shall hold full BON approval without conditions.

b. There are no substantiated complaints in the past 2 years.

c. There are no rule violations in the past 2 years.

Authority: Model Act Article VI Section 15

6.3.3 Application

a. A description of the innovation plan, with rationale, shall be provided to the BON at least < > days before the BON meeting.

Authority: Model Act Article VI Section 16

6.3.4 Standards for Approval

a. Eligibility criteria in 6.3.2 are met.

b. The innovative approach will not compromise the quality of education or safe practice of students.

c. Resources are sufficient to support the innovative approach.

d. Timeline provides for a sufficient period to implement and evaluate the innovative approach.

Authority: Model Act Article VI Section 17

6.3.5 Review of Application and BON Action

a. If the application meets the standards, the BON may:

   1. Approve the application; or

   2. Approve the application with modifications as agreed between the BON and the nursing education program.

b. If the submitted application does not meet the criteria in 6.3.2 and 6.3.4, the BON may deny approval or request additional information.

Authority: Model Act Article VI Section 18

6.3.6 Requesting Continuation of the Innovative Approach

a. If the innovative approach has achieved the desired outcomes and the final evaluation has been submitted, the program may request that the innovative approach be continued.

b. Request for the innovative approach to become an ongoing part of the education program must be submitted < > days prior to a regularly scheduled BON meeting.

c. The BON may grant the request to continue approval if the innovative approach has achieved desired outcomes, has not compromised public protection, and is consistent with core nursing education criteria.

Authority: Model Act Article VI Section 19

6.4 Simulation

A prelicensure nursing education program ("program") may use simulation as a substitute for traditional clinical experiences, not to exceed fifty percent (50%) of its clinical hours per course. A program that uses simulation shall adhere to the standards set in this section.

Authority: Model Act Article VI Section 20

6.4.1 Evidence of Compliance

A program shall provide evidence to the board of nursing that these standards have been met.

Authority: Model Act Article VI Section 21

6.4.2 Organization and Management

a. The program shall have an organizing framework that provides adequate fiscal, human, and material resources to support the simulation activities.

b. Simulation activities shall be managed by an individual who is academically and experientially qualified. The individual shall demonstrate continued expertise and competence in the use of simulation while managing the program.

c. There shall be a budget that will sustain the simulation activities and training of the faculty.

Authority: Model Act Article VI Section 22

6.4.3 Facilities and Resources

a. The program shall have appropriate facilities for conducting simulation. This shall include educational and technological resources and equipment to meet the intended objectives of the simulation.

Authority: Model Act Article VI Section 23

6.4.4 Faculty Preparation

a. Faculty involved in simulations, both didactic and clinical, shall have training in the use of simulation.

b. Faculty involved in simulations, both didactic and clinical, shall engage in on-going professional development in the use of simulation.

Authority: Model Act Article VI Section 24

6.4.5 Curriculum

a. The program shall demonstrate that the simulation activities are linked to programmatic outcomes.

Authority: Model Act Article VI Section 25

6.4.6 Policies and Procedures

The program shall have written policies and procedures on the following:

a. Short-term and long-term plans for integrating simulation into the curriculum;

b. Method of debriefing each simulated activity; and

c. Plan for orienting faculty to simulation.

Authority: Model Act Article VI Section 26

6.4.7 Evaluation

a. The program shall develop criteria to evaluate the simulation activities.

b. Students shall evaluate the simulation experience on an ongoing basis.

Authority: Model Act Article VI Section 27

6.4.8 Annual Report

a. The program shall include information about its use of simulation in its annual report to the board of nursing.

Authority: Model Act Article VI Section 28

Chapter 7. Discipline and Proceedings

7.1 Grounds for Discipline: behaviors and activities that may result in disciplinary action by the board shall include the following:

a. Failing to meet the initial requirements of a license.

b. Engaging in conduct that violates the security of the licensure or certification examination or the integrity of the examination results, including, but not limited to:

1. Having a license to practice nursing, a multi-state privilege to practice or another professional license or other credential denied for cause, revoked, suspended, or restricted.
2. Disciplined in this or any other state, territory, possession, or country or by a branch of the United States military.
3. Failing to cooperate with a lawful BON investigation.
4. Practicing without an active license.
5. Failing to comply with continuing education or competency requirements.
6. Failing to meet licensing board reporting requirements.
7. Violating or failing to comply with BON order or agreement.
8. Practicing beyond the legal scope of practice.
9. Violating jurisdictional health code.

c. Criminal conviction or adjudication in any jurisdiction for any crime that bears on a licensee's fitness to practice nursing.

d. Obtaining, accessing, or revealing healthcare information from a client record or other source, except as required by professional duties or authorized by law.

e. Threatening, harassing, abusing, or intimidating a patient.

f. Violating boundaries of a professional relationship such as physical, sexual, emotional, or financial exploitation of a patients or a patient's family member or caregiver. Financial exploitation shall include accepting or soliciting money, gifts, loans, or the equivalent during the professional relationship.

    1. Disruptive or abusive conduct in the workplace.

    2. Misappropriation of patient property or other property.

    3. Directly or indirectly offering, giving, soliciting, or receiving or agreeing to receive any fee or other consideration to or from a third party or exercising influence on the client for the financial or personal gain of the licensee.

    4. Aiding, abetting, directing, or assisting an individual to violate or circumvent any law or rule intended to guide the conduct of a licensed nurse or any other licensed healthcare provider.

g. Fraud, deception, or misrepresentation in the practice of nursing.

h. Unsafe practice, substandard care or unprofessional conduct, including, but not limited to:

    1. Altering, destroying, or attempting to destroy patient or employer records.

    2. Failing to supervise student experiences as a clinical nursing instructor.

    3. Failing to act to safeguard the patient from the incompetent, abusive or illegal practice of any individual.

    4. Discriminating on the basis of age, marital status, gender, sexual preference, race, religion, diagnosis, socioeconomic status or disability while providing nursing services.

    5. Leaving a nursing assignment prior to the proper reporting and notification to the appropriate department head or personnel of such an action.

    6. Knowingly abandon a patient in need of nursing care.

    7. Knowingly neglect a patient in need of nursing care.

    8. Demonstrating an actual or potential inability to practice nursing with reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, chemicals, or any other material or as a result of any mental or physical illnesses or conditions.

    9. Causing an immediate threat to the health or safety of a patient or the public.

    10. Delivering substandard or inadequate care.

i. Performing the delegation of a nursing function or undertaking a specific practice without the necessary knowledge, preparation, experience and competency to properly execute the practice that could reasonably be expected to result in unsafe or ineffective patient care.

j. Improper supervision or allowing unlicensed practice, including, but not limited to:

    1. Delegating a nursing function or a prescribed health function when the delegation could reasonably be expected to result in unsafe or ineffective patient care.

2. Failing to supervise the performance of acts by any individual working at the nurse's delegation or assignment.

3. Failing to follow appropriate and recognized standards and guidelines in providing administrative oversight of the nursing organization and nursing services of a health care delivery system or program.

4. Knowingly aiding, abetting assisting, advising or allowing an unlicensed person to engage in the unlawful practice of registered or practical nursing or in violating or circumventing a law or BON regulation or rule.

k. Drug related offenses, including, but not limited to:

1. Illegally obtaining, possessing, or distributing drugs for personal or other use or other violations of state or federal drug laws.

2. Unauthorized prescribing, dispensing, or administrating medication.

Authority: Model Act Article VII Section 1

7.2 Notification

a. The BON shall provide information as required by federal law to federal databanks, to a nationally recognized centralized licensing and discipline databank and may develop procedures for communicating with others in BON policy.

b. All nurse participants or nurse licensure applicants in alternative programs may be reported to a non-public national database that gives access to all states.

Authority: Model Act Article IV Section 5

Chapter 8. APRN

8.1 Standards

a. The APRN shall comply with the standards for RNs as specified in Chapter 3 and to the standards set forth by the BON. Standards for a specific role and population focus of APRN supersede standards for RNs where conflict between the standards, if any, exists.

b. APRNs shall practice within standards established by the BON in rule and assure patient care is provided according to relevant patient care standards recognized by the BON, and other national standards of care.

Authority: Model Act Article X Section 1

8.2 Licensure

8.2.1 Application for Initial Licensure

a. An applicant for licensure as an APRN in this state shall submit to the BON the required fee as specified in Chapter 4, verification of licensure or eligibility for licensure as an RN in this jurisdiction and a completed application that provides the following information:

   1. Graduation from an APRN graduate or post-graduate program as evidenced by official documentation received directly from an APRN program accredited by a nursing accrediting body that is recognized by the U.S. Secretary of Education and/or the Council for Higher Education Accreditation (CHEA), or its successor organization, as acceptable by the BON.

   2. This documentation shall verify the date of graduation; credential conferred; completion of three separate graduate level courses in advanced physiology and pathophysiology, advanced health assessment, advanced pharmacology, which includes pharmacodynamics, pharmacokinetics and pharmacotherapeutics of all broad categories of agents; role and population focus of the education program; and evidence of meeting the standards of nursing education in this state.

b. Report any criminal conviction, nolo contendere plea, Alford plea, or other plea arrangement in lieu of conviction.

c. Requirements for Certification Programs:

   1. Certification programs are accredited by a national accreditation body as acceptable by the BON.

   Authority: Model Act Article X Section 2

8.2.2 Application of an Internationally Educated APRN

An internationally educated applicant for licensure as an APRN in this state shall:

a. Graduate from a graduate or post-graduate level APRN program equivalent to an APRN educational program in the U.S. accepted by the BON.

b. Submit documentation through a BON approved qualified credentials evaluation process for the license being sought.

c. Has, if a graduate of a foreign prelicensure education program not taught in English or if English is not the individual's native language, successfully passed an English proficiency examination that includes the components of reading, speaking, writing, and listening;

d. Met all other licensure criteria required of applicants educated in the U.S.

Authority: Model Act Article V Section 5

8.2.3 Application for Licensure by Endorsement

a. An applicant for licensure by endorsement as an APRN in this state shall submit to the BON the required fee as specified in Chapter 4, verification of eligibility for a license or privilege to practice as an RN in this jurisdiction and a completed APRN application that provides the following information:

    1. Graduation from a graduate or post-graduate level APRN program, as evidenced by an official transcript or other official documentation received directly from a graduate program accredited by a nursing accrediting body that is recognized by the U.S. Secretary of Education and/or CHEA, or its successor organization, as acceptable by the BON.

    2. This documentation shall verify the date of graduation; credential conferred; number of clinical hours completed; completion of three separate graduate level courses in advanced physiology and pathophysiology, advanced health assessment, advanced pharmacology, which includes pharmacodynamics, pharmacokinetics and pharmacotherapeutics of all broad categories of agents; role and population focus of the education program; and evidence of meeting the standards of nursing education in this state.

b. Not have an encumbered license or privilege to practice in any state or territory.

c. Report any conviction, nolo contendere plea, Alford plea, or other plea arrangement in lieu of conviction.

d. Report status of all nursing licenses, including any BON actions taken or any current or pending investigations.

e. Current certification by a national certifying body in the APRN role and population focus appropriate to educational preparation.

    1. Primary source of verification of certification is required.

f. Requirements of 5.3.d.-i. shall apply to APRNs.

Authority: Model Act Article X Section 2

8.2.4 Application for License Renewal

An applicant for license renewal as an APRN shall submit to the BON the required fee for license renewal, as specified in Chapter 4, and a completed license renewal application including:

a. Detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background.

b. Evidence of current certification(s), or recertification as applicable, by a national professional certification organization that meets the requirements of 8.2.1.

c. Submit a renewal application as directed by the BON and remit the required fee as set forth in rule.

Authority: Model Act Article X Section 2

8.2.5 Quality Assurance/Documentation and Audit

The BON may conduct a random audit of nurses to verify current APRN certification and/or continuing education. Upon request of the BON, licensees shall submit documentation of compliance.

Authority: Model Act Article V Section 5

8.2.6 Reinstatement of License

The reinstatement of APRN licensure is the same as previously stated for RNs and LPN/VNs in Chapter 5 plus the following:

a. An individual who applies for licensure reinstatement and who has been out of practice for more than five years shall provide evidence of successfully completing < > hours of a reorientation in the appropriate advanced practice role and population focus, which includes a supervised clinical component by a qualified preceptor.

b. Preceptor must the following requirements:

    1. Holds an active license or privilege to practice as an APRN or physician that is not encumbered and practices in a comparable practice focus.

    2. Functions as a supervisor and teacher and evaluates the individual's performance in the clinical setting.

c. For those licensees applying for licensure reinstatement following disciplinary action, compliance with all BON licensure requirements, as well as any specified requirements set forth in the BON's discipline order, is required.

    Authority: Model Act Article X Section 2

8.3 Titles and Abbreviations

a. Individuals are licensed or granted privilege to practice as APRNs in the roles of certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS) and certified nurse practitioner (CNP) and in the population focus of family/individual across the lifespan, adult-gerontology, neonatal, pediatrics, women's health/ gender-related or psychiatric/mental health.

b. Each APRN shall use the designation "APRN" plus role title as a minimum for purposes of identification and documentation.

c. When providing nursing care, the APRN shall provide clear identification that indicates his or her APRN designation.

    Authority: Model Act Article X Section 3

8.4 APRN Education

8.4.1 Required Criteria for APRN Education Programs

The BON shall determine whether an APRN education program meets the qualifications for the establishment of a program based upon the following standards:

a. An APRN program shall appoint the following personnel:

   1. An APRN program administrator whose qualifications shall include:

      a. A current, active RN or APRN license or privilege to practice that is not encumbered in the state where the program is approved and/or accredited;

      b. A doctoral degree in a health-related field;

   2. A lead faculty member who is educated and nationally certified in the same role and population foci and licensed as an APRN shall coordinate the educational component, including curriculum development, for the role and population foci in the APRN program.

   3. Nursing faculty to teach any APRN nursing course that includes a clinical learning experience shall meet the following qualifications:

      a. A current, active APRN license or privilege to practice that is not encumbered in the state where the program is approved and/or accredited;

      b. A minimum of a master's degree in nursing or health related field in the clinical specialty;

      c. Current knowledge, competence, and certification as an APRN in the role and population foci consistent with teaching responsibilities.

   4. Adjunct clinical faculty employed solely to supervise clinical nursing experiences of students shall meet all the faculty qualifications for the program level they are teaching.

   5. Interdisciplinary faculty who teach non-clinical nursing courses shall have advanced preparation appropriate to these areas of content.

   6. Clinical preceptors shall have demonstrated competencies related to the area of assigned clinical teaching responsibilities.

   7. Clinical preceptors will be approved by faculty and meet the following requirements:

      a. Hold an active license or privilege to practice that is not encumbered as an APRN or physician and practices in a comparable practice focus; and

      b. Evaluate the individual's performance in the clinical setting.

b. The curriculum of the APRN nursing education program must prepare the graduate to practice in one of the four identified APRN roles, i.e., CRNA, CNM, CNS and CNP, and at least one of the six population foci, i.e., family/ individual across the lifespan, adult-gerontology, neonatal, pediatrics, women's health/ gender-related or psychiatric /mental health. The curriculum shall include:

   1. Three separate graduate level courses (the APRN core) in:

      a. Advanced physiology and pathophysiology, including general principles that apply across the lifespan.

      b. Advanced health assessment, which includes assessment of all human systems, advanced assessment techniques, concepts and approaches; and

      c. Advanced pharmacology, which includes pharmacodynamics, pharmacokinetics and pharmacotherapeutics of all broad categories of agents.

   2. Diagnosis and management of diseases across practice settings including diseases representative of all systems.

   3. Preparation that provides a basic understanding of the principles for decision making in the identified role.

   4. Preparation in the core competencies for the identified APRN role.

   5. Role preparation in one of the six population foci of practice.

c. Additional required components of graduate or post-graduate education programs preparing APRNs shall include the following:

   1. Each student enrolled in an APRN program shall have an RN license or privilege to practice that is not encumbered in the state of clinical practice, unless exempted from this licensure requirement under Article 5 section 10.

   2. Education programs offered by an accredited college or university that offers a graduate degree with a concentration in the advanced nursing practice role and at least one population focus, or post-masters certificate programs offered by an accredited college or university shall include the following components:

      a. Clinical supervision congruent with current national professional organizations and nursing accrediting body standards applicable to the APRN role and population focus.

      b. Curriculum that is congruent with national standards for graduate level and advanced practice nursing education, is consistent with nationally recognized APRN roles and population foci, and includes, but is not limited to:

         i. Graduate APRN program core courses; and

         ii. An advanced practice nursing core, including legal, ethical, and professional responsibilities of the APRN.

   3. The curriculum shall be consistent with competencies of the specific areas of practice.

4. APRN programs preparing for two population foci or combined nurse practitioner/clinical nurse specialist shall include content and clinical experience in both functional roles and population foci.

5. Each instructional track/major shall have a minimum of 500 supervised clinical hours as defined by the BON. The supervised experience is directly related to the role and population foci, including pharmacotherapeutic management of patients.

6. There shall be provisions for the recognition of prior learning and advanced placements in the curriculum for individuals who hold a master's in nursing and are seeking preparation in a different role and population focus. Post- masters nursing students shall complete the requirements of the master's APRN program through a formal graduate level certificate in the desired role and population focus. Post-master students must meet the same APRN outcome competencies as the master level students.

   Authority: Model Act Article XI Section 4

8.4.2 Models for Determining Compliance with Standards

The models for determining compliance with APRN education standards are the same as previously stated for RN and LPN/VN programs in Chapter 6.

Authority: Model Act Article X Section 5

8.4.3 Establishment of a New APRN Education Program

Before establishing a new nursing education program, the APRN program shall complete the process outlined below:

a. Application to the professional accrediting body.

b. The proposed program shall provide the following information to the BON:

   1. Results of a needs assessment, including identification of potential students and employment opportunities for program graduates.

   2. Identification of sufficient financial and other resources.

   3. Governing institution approval and support.

   4. Type of educational program proposed.

   5. Clinical opportunities and availability of resources.

   6. Availability of qualified faculty.

   7. A pool of available students.

   8. A proposed timeline for initiating and expanding the program.

      Authority: Model Act Article X Section 5

8.5 Prescriptive Authority

8.6 Discipline of Prescriptive Authority

a. APRN discipline and proceedings is the same as previously stated for RN and LPN/VN in Chapter 7.

b. The BON may limit, restrict, deny, suspend or revoke APRN licensure, or prescriptive or dispensing authority.

c. Additional grounds for discipline related to prescriptive or dispensing authority include, but are not limited to:

    1. Prescribing, dispensing, administering, or distributing drugs in an unsafe manner or without adequate instructions to patients according to acceptable and prevailing standards.

    2. Selling, purchasing, trading, or offering to sell, purchase or trade drug samples.

    3. Prescribing, dispensing, administering, or distributing drugs for other than therapeutic or prophylactic purposes. or

    4. Prescribing or distributing drugs to individuals who are not patients of the APRN or who are not within that nurse's role and population focus.

    Authority: Model Act Article X Section 1

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08/21

Regulation Project:

12 AAC 44.845(7)-
LAW has requested the need to define Cognitively impaired. Of note, this terminology is included in the federal law. Below is some research for the board to consider.

Wikipedia:
Cognitive.impairment is an inclusive term to describe any characteristic that acts as a barrier to the cognition process or different areas of cognition.

Mild.Cognitive.Impairment.(MCI) is a neurocognitive disorder which involves "cognitive impairments" beyond those expected based on an individuals age and education but which are not significant enough to interfere with instrumental activities of daily living.

Mayo Clinic:
Mild.CognitiveImpairment is the stage between the expected decline in memory and thinking that happens with age and the more serious decline of dementia.

Dementia Society of America
Mild.CognitiveImpairment is a condition in which people have memory or other thinking problems greater than normal for their ae and education, but their symptoms are not as severe as those seen in people with Alzheimer's disease.

Cleveland Clinic
Mild Cognitive Impairment happens when you have a slight decline in your mental abilities, like memory and completing complex tasks.

Alzheimer's Association
Mild Cognitive Impairment causes cognitive changes that are serious enough to be noticed by the person affected and by family members and friends but do not affect the individuals ability to carry out everyday activities.

Alzheimer's. Gov
Mild Cognitive Impairment is a condition in which people have more memory or thinking problems than other people their age. The symptoms of MCI are not as severe as those of Alzheimer's disease or related dementia.

American Psychological Association
Mild.CognitiveImpairment- The cognitive deficits associated with the condition are, by definition, mild enough that they don't interfere with the major activities of daily living. "Social and occupational functioning remain intact"

ICD 10 code- Mild Cognitive Impairment

12 AAC 44.290 (3) (B) a practical nurse applicant who has completed the United States Army Practical Nurse Program or Air Force Basic Medical Technician Corpsman Program (BMTCP) 4N051 (5 Skill Level) and who is on active duty or has been discharged for not more than five years from the date of application,

(i) a complete certified transcript of the applicant's military education, mailed directly to the board from the appropriate military program;

(ii) verification of employment, on a form provided by the board, confirming the applicant has, within the last five years, worked in the United States Army or Air Force in the nursing role for which the applicant was trained in either the U.S. Army Practical Nurse Program or the Air Force Base Medical Technician Corpsman Program (BMTCP) 4N051 (5 Skill Level);

(iii) an attestation affirming the applicant is familiar with the licensed practical nurse scope of practice advisory opinions adopted by the board;

Regulation is based on this information: 16_NCSBNAnalyiss_MilitaryLPNVN.pdf

Questions/Suggestions to the Board:

1. Consider: Generalize the language about branches of the military that would include all that have taken the available military training. Army and Airforce training have been consolidated and include Navy. Example:
2. ? Add for Navy- Hospital Corpsman Basic and or Hospital Corpsman Advanced Technical Field
3. Or the language can work with the removal of the AFSC code ("4N051 (5 Skill Level)) from the text so that it applies more generally to "a practical nurse applicant who has completed the United States Army Practical Nurse Program or Air Force Basic Medical Technician Corpsman Program".
4. Another question: Is (iii) applicable above with the creation of the LPN scope of practice within regulation?

Proposed Language change:

12 AAC 44.740

(c) The board may offer a license subject to this section the opportunity to participate in an alternative probation program **if the licensee voluntarily discloses, self-reports, and requests to participate**. Whether a licensee may participate in an alternative probation program is at the discretion of the board. A licensee participating in an alternative probation program shall meet the terms of the probation required by the board under the alternative probation program. The board will keep a licensee's participation in an alternative probation program confidential, except as required by law.

Per LAW, placing this language into regulation makes it clear when the board has the ability to grant a non-punitive alternative.

Alaska Board of Nursing

Adjourned for Lunch

Alaska Board of Nursing

Agenda Item # 21

Licensing and Program Reports

LICENSING SUMMARY

FISCAL 4TH QUARTER 2024 (APRIL 1, 2024- JUNE 30, 2024)

License Type	Method	4th Quarter Total	Running Total YTD
RN	Exam	112	364
	Endorsement	866	3100
	Reinstate	54	203
	Total:	1032	3667
		TOTAL ACTIVE:	22,232

FISCAL 4TH QUARTER 2024 (APRIL 1, 2024- JUNE 30, 2024)

License Type	Method	4th Quarter Total	Running Total YTD
LPN	Exam	10	18
	Endorsement	22	91
	Reinstate	2	11
	Total:	34	120
		TOTAL ACTIVE	802

FISCAL 4TH QUARTER 2024 (APRIL 1, 2024- JUNE 30, 2024)

License Type	Method	4th Quarter Total	Running Total YTD
APRN	Reinstate	8	23
	Initial	119	436
	Total:	127	436
APRN Preceptorship		15	57
		TOTAL ACTIVE APRN:	2415
		TOTAL ACTIVE PRECEPTORSHIPS:	70

PERMITS
FISCAL 4TH QUARTER 2024 (APRIL 1, 2024- JUNE 30, 2024)

License Type	4th Quarter Total	Running Total YTD
RN	272	1261
LPN	22	55
APRN	1	16
TOTAL:	295	1332

FISCAL 4TH QUARTER 2024 (APRIL 1, 2024- JUNE 30, 2024)

License Type	Method	4th Quarter Total	Running Total YTD
Retired		3	8
		TOTAL:	213
	Grand Total: All license types	1505	5643
		Grand Total Active Nurse Licenses:	25731

LICENSING STATISTICS FISCAL YEAR (POSSIBLE BAR CHARTS FOR EACH YEAR)

Licensing Statistics	2022 Fiscal year	2023 Fiscal year	2024 Fiscal year
RN Endorsement	3008	3310	3100
RN Examination	328	327	364
LPN Endorsement	82	116	91
LPN Examination	1	6	18
APRN	336	381	436

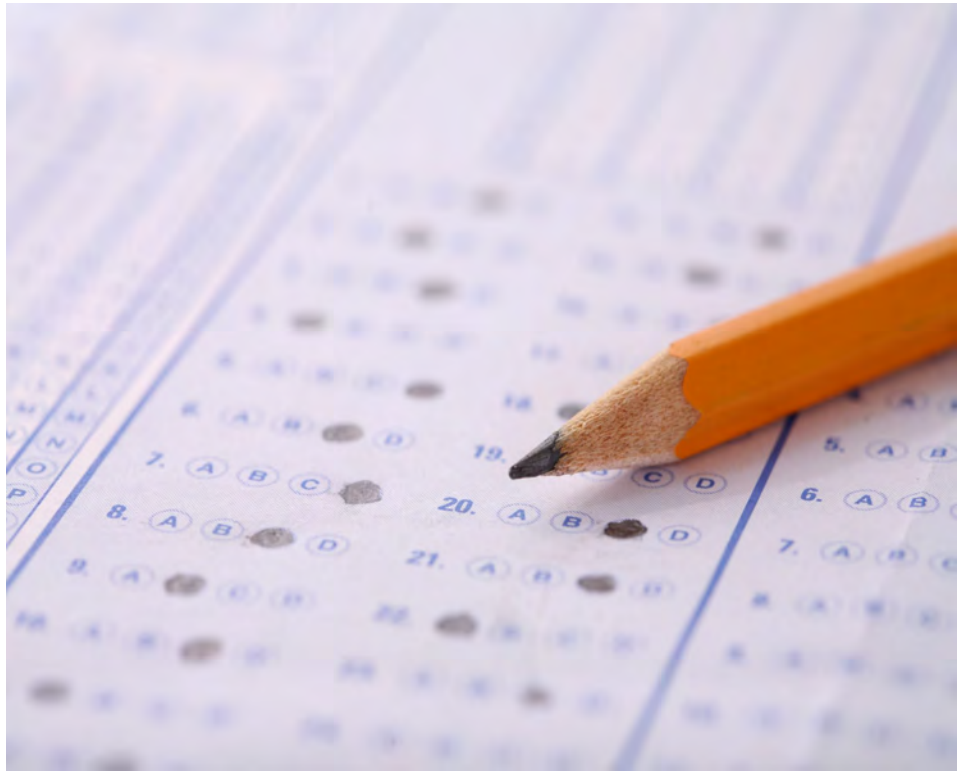
NCSBN EDUCATION PROGRAM SUMMARY
EDUCATED IN ALASKA
APRIL 1, 2024-JUNE 30, 2024

*NOTE: NCSBN does not provide data on “repeat testers” taken in other states. “First time tester” data shown here reflects testing information from all states, whereas “repeat tester” data reflects only our state. This means there may be a repeat testing candidate in another state not included in these totals.

NURSING PROGRAM	FIRST TIME TESTERS	PASS	PASS%	FAIL	FAIL%		REPEAT TESTERS	PASS	PASS%	FAIL	FAIL%
UAA A.A.S	27	27	100%	0	0%		5	3	60%	2	40%
UAA B.S.N.	54	52	96%	2	4%		3	1	33%	2	77%
CHARTER A.D.N	18	14	77.0%	4	33.0%		4	0	0%	4	100%
APU ADN	2	2	100%	0	0%		0	0	0.0%	0	0.0%
APU LPN	14	13	92%	1	8%		0	0	0%	0	0%

NCLEX PASS RATE YEAR TO DATE SUMMARY

NCLEX YTD SUMMARY



NCLEX Pass Rate Year to Date Summary Nursing Program	2022	2023	2024 YTD Jan. 1-June 30
UAA AAS	90% (73/80)	83% (67/81)	95% (57/60)
UAA BSN	89% (59/66)	87% (102/117)	92% (84/91)
Charter ADN	91% (49/54)	80% (61/76)	85% (29/34)
APU ADN	73% (11/15)	60% (12/20)	100% (24/24)
APU LPN	--	78% (7/9)	95% (20/21)

THANK YOU

- Laura Souders and Madeleine Henderson

Occupational Licensing Examiners

- boardofnursing@alaska.gov

CERTIFIED NURSE AIDE BOARD STATISTICS & UPDATES

Presented by Michelle Griffin, Licensing Examiner
(907) 269-8402
michelle.griffin@alaska.gov

CNA Q4 2024 CERTIFICATION REPORT

CNA Certifications by Recent Fiscal Quarter (oldest first):

	New Permanent certificates issued	*Reinstatements*	*Temporary certificates issued*	*Emergency Courtesy Certificates issued*	*Total permanent certificates*
FY 24 Quarter 1 7/1/23 – 9/30/23	144	3	13	0	2,983
FY 24 Quarter 2 10/1/23 – 12/31/23	48	2	12	0	3,027
FY 24 Quarter 3 1/1/24 – 3/31/24	133	0	15	0	2,046
FY 24 Quarter 4 4/1/24 – 6/30/24	**162**	**7**	**27**	**0**	**2,279**

CNA FEE WAIVER (4/8/2024 – 7/15/2024)

From the Board of Nursing Website (now offline): *For applications filed with the Alaska Division of Corporations, Business, and Professional Licensing between April 8, 2024 and July 15, 2024, the Alaska Certified Nurse Aide (CNA) initial application fees and certificate fees will be covered by the Alaska Division of Public Health, Section of Epidemiology via the CDC Strike Team Grant. CFDA number 93.923. Funding was approved to support efforts to address CNA staffing shortages at healthcare facilities statewide – a collaborative effort to address infection prevention and control gaps by removing a cost barrier limiting entry into the CNA profession. The $75 fingerprint processing fee and the examination fee paid to Credentia directly are still required.*

- **Originally, the predicted end date was 6/6/2024 but was extended through 7/15/2024**
- **The Board of Nursing received 285 applications during this time period.**

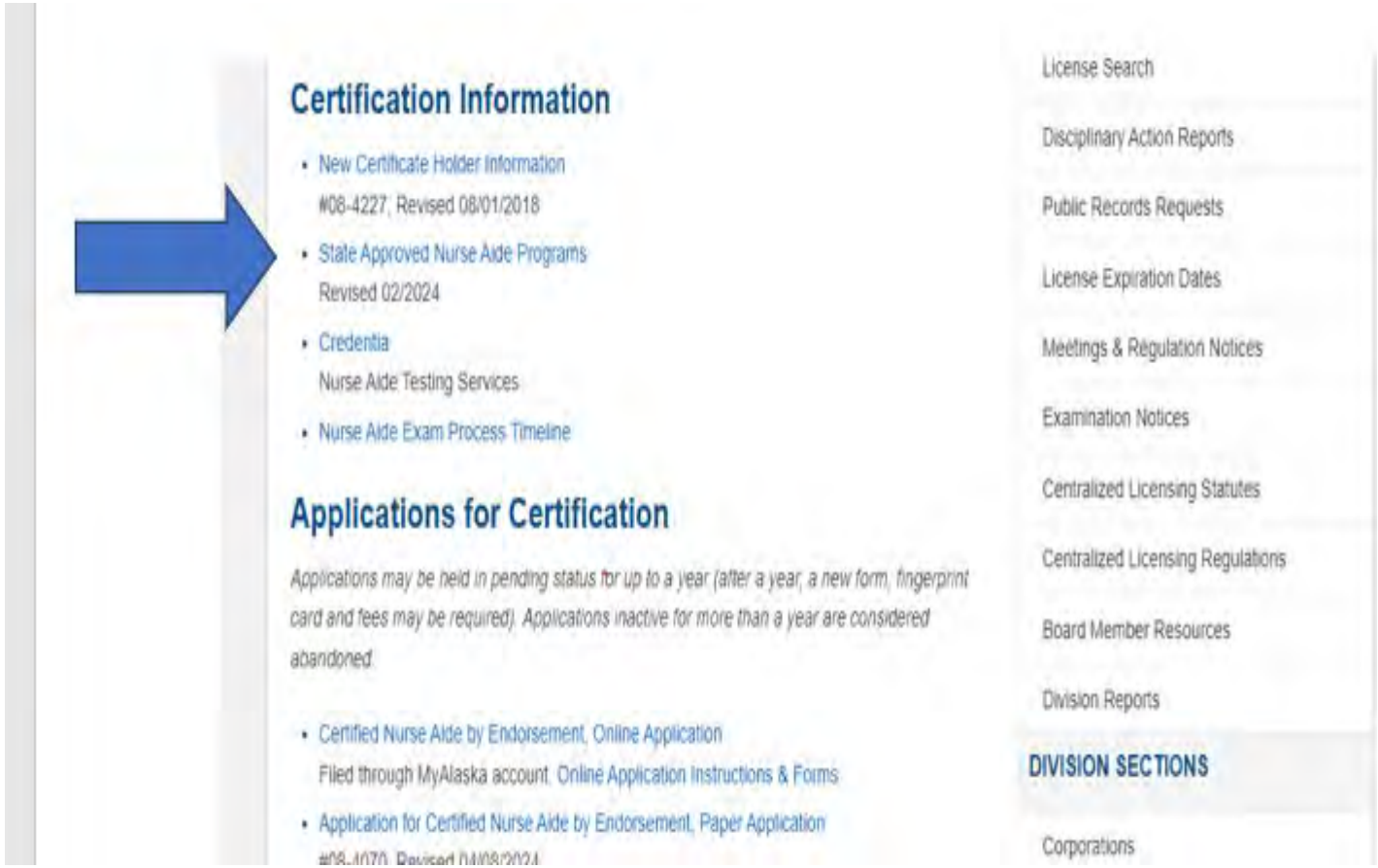
Nurse Aide Training Program Report FY24 Q4- Annual

August 2024 Board Meeting

Alaska Board of Nursing

- 34 State Approved Nurse Aide Training Programs

- Complete list is available on the AKBON Website- “Nurse Aide Registry” page under Certification Information.



NEWLY APPROVED INSTRUCTORS
12 AAC 44.840

Newly approved instructors

FY24 Q3

UAS Ketchikan- *1 New Instructor*

Providence Alaska Medical Center- *4 New Instructors*

Alaska Native Medical Center- *1 New Instructor*

*Overall program pass rate

FY24 (July 2023-June 2024): 79.3%

(FY23: 82.9%

- 377 written exams administered.
- 377 skills exams administered.
- 26 Programs had test takers.
- 14 Programs → Above 80%
- 4 Programs → 100% pass rate
- 12 Programs → Less than 80%

Exam Results by Program - FY24 Year to Date (YTD): July 2023 thru June 2024

All Programs

(Do not enter Data on this sheet - use individual Program sheets)

Program	ID #	First Time Skills	First Time Written	Passed Skills	Skills Pass Rate	Passed Written	Written Pass Rate	Passed Both	Overall Pass Rate
Alaska Job Corps (Palmer)	02246	2	2	1	50.0%	2	100.0%	1	50.0%
Alaska Technical Center (Kotzebue)	02233	0	0	N/A	N/A	N/A	N/A	N/A	NO TESTS
Alaska CNA Program (Anchorage)	02276	41	41	33	80.5%	36	87.8%	31	75.6%
Alaska Veterans & Pioneers Home	02292	3	3	2	66.7%	3	100.0%	2	66.7%
ASD - King Tech HS (Anchorage)	02268	0	0	0	N/A	0	N/A	0	N/A
Bartlett Hospital (Juneau)	02286	16	16	15	93.8%	16	100.0%	15	93.8%
Bethel	02271	15	15	15	100.0%	14	93.3%	13	86.7%
Central Peninsula Hospital (Heritage Place)	02289	20	20	19	95.0%	20	100.0%	19	95.0%
Denali Center	02287	16	16	15	93.8%	15	93.8%	14	87.5%
Heritage Place (Soldotna)	02016	15	15	14	93.3%	12	80.0%	11	73.3%
Kachemak Bay CC (Homer)	02020	8	8	7	87.5%	7	87.5%	6	75.0%
Kenai Peninsula College / KPBSD (Soldotna)	02226	17	17	16	94.1%	17	100.0%	16	94.1%
Kodiak College	02011	4	4	4	100.0%	4	100.0%	4	100.0%
Kodiak HS	02283	17	17	15	88.2%	15	88.2%	14	82.4%
Mat-Su Career & Tech HS (MSBSD)	02259	18	18	17	94.4%	18	100.0%	17	94.4%
Mat-Su CNA (@ Maple Springs)	02285	25	25	16	64.0%	24	96.0%	16	64.0%
Petersburg Medical Center	02019	1	1	1	100.0%	1	100.0%	1	100.0%
Prestige Care - Anchorage	02284	34	34	24	70.6%	31	91.2%	22	64.7%
Providence Seward Mountain Haven	02282	7	7	5	71.4%	7	100.0%	5	71.4%
PWSCC (Cordova)	02008	0	0	0	N/A	N/A	N/A	N/A	NO TESTS
SEARHC Sitka	02288	0	0	0	N/A	N/A	N/A	N/A	NO TESTS
South Peninsula Hospital	02290	6	6	6	100.0%	6	100.0%	6	100.0%
UAA - CNA	02280	27	27	20	74.1%	26	96.3%	19	70.4%
UAF CTC (Fairbanks)	02241	33	33	25	75.8%	33	100.0%	25	75.8%
UAF Nome	02241	2	2	0	0.0%	1	50.0%	0	0.0%
UAS Juneau	02229	11	11	10	90.9%	9	81.8%	9	81.8%
UAS Ketchikan	02236	15	15	12	80.0%	13	86.7%	11	73.3%
UAS Sitka	02223	11	11	10	90.9%	11	100.0%	10	90.9%
Valdez Combined	02275	3	3	3	100.0%	3	100.0%	3	100.0%
Wrangell Medical Center (SEARHC)	02009	10	10	9	90.0%	10	100.0%	9	90.0%
Year to Date Totals		377	377	314	83.3%	354	93.9%	299	79.3%

12 AAC 44.858

Training Program Pass Rates

FY24 Letters of Concern

(Alaska CNA, Alaska Veterans & Pioneers Home, Heritage Place, Kachemak Bay Campus/KPC, Mat-Su CNA, UAF Nome, Prestige, Providence Seward Mountain Haven & UAA Anchorage)

FY24 Letters of Warning

(Don Young Alaska Job Corps, UAF CTC Fairbanks and UAS Ketchikan)

Pursuant to regulations - programs have 90 days to submit a corrective action plan letter to the board

TRAINING PROGRAM PASS RATES
12 AAC 44.858

12 AAC 44.858. TRAINING PROGRAM PASS RATE. (a) An approved certified nurse aide training program must achieve at least an 80 percent cumulative annual pass rate.

(b) If an approved certified nurse aide training program fails to achieve at least an 80 percent cumulative annual pass rate, the board will issue a letter of concern by certified mail, with return receipt requested, to the program. Within 90 days after receipt of a letter of concern from the board, the approved certified nurse aide training program must submit to the board a report that

(1) analyzes the factors that are believed to be contributing to the low pass rate; and

(2) sets out the program's plan to achieve at least an 80 percent cumulative annual pass rate.

(c) The board will reevaluate the program one year after a letter of concern has been issued to an approved certified nurse aide training program.

(d) If an approved certified nurse aide training program reevaluated by the board under (c) of this section has failed to achieve at least an 80 percent cumulative annual pass rate, the board will issue a letter of warning to the program. Within 90 days after receipt of a letter of warning from the board, the approved certified nurse aide training program must submit to the board a report that

(1) analyzes the reasons the program's original plan to improve the low pass rate was unsuccessful; and

(2) sets out the program's additional plan to achieve at least an 80 percent cumulative annual pass rate.

(e) The board will reevaluate the program one year after a letter of warning has been issued to an approved certified nurse aide training program.

(f) If an approved certified nurse aide training program reevaluated by the board under (e) of this section has failed to achieve at least an 80 percent cumulative annual pass rate, the board will place the certified nurse aide training program on conditional approval. The certified nurse aide training program will continue on conditional approval until

(1) the certified nurse aide training program has achieved at least an 80 percent cumulative annual pass rate during two consecutive years; or

(2) approval of the certified nurse aide training program is withdrawn under 12 AAC 44.862.

(g) For purposes of this section, a certified nurse aide training program achieves at least an 80 percent cumulative annual pass rate if the year-end data shows that at least 80 percent of the graduates of the approved nurse aide training program, taking the National Nurse Aide Assessment Program competency evaluation for the first time, successfully passed that competency evaluation.

(h) If the training program does not respond to the letter of concern within 90 days, as required under (b) of this section, the board will withdraw approval for the nurse aide program as set out in 12 AAC 44.862.

NEW PROGRAM REQUESTS
12 AAC 44.830

No New Program Requests for FY24 Q4

Programs that remain on Provisional Approval:

- **Charter College**- (Prov. Approval August 2023) No tentative first course offering date set yet.. No first site visit scheduled yet.
- **Alaska Native Medical Center**- (Prov. Approval November 2023) Tentative first course offering date: July- August 2024. First site visit scheduled: 8/6/2024
- **Providence Alaska Medical Center**- (Prov. Approval May 2024) Tentative first course offering date: July- August 2024. First site visit scheduled: 8/6/2024.

TRAINING PROGRAM REVIEWS
12 AAC 44.857

FY24 Q4 On-Site Reviews Completed:

- Don Young Alaska Job Corps
- Alaska Technical Center
- Heritage Place
- KBCC/KPC- Kachemak Bay Campus
- Kenai Peninsula College-Soldotna
- Mat-Su CNA
- Providence Seward Mountain Haven
- SEARHC Sitka
- Providence Valdez

All program documentation reviewed, a tour of the classroom, skills and clinical site were completed. These programs have met the requirements set forth in regulations. Recommend these training programs be granted re approval for the next two years.

**Motions attached*

On site Reviews completed for 2024

ONGOING BUSINESS

- **FY23 Corrective Action Plans for annual pass rates to be reported and completed at November 2024 Board Meeting. (due to timelines of notices sent)**

2024 Self Evaluations will be reported at November 2024 Board Meeting

Thank you

Kelly Olson, RN
Nurse Consultant-Alaska Board of Nursing
kelly.olson@alaska.gov
(907)269-8098

Board Meeting August 2024
CNA Program Report
FY24 Q4 / Annual
State of Alaska Board of Nursing

There are currently 34 State Approved Nurse Aide Training Programs in Alaska. A complete list can be viewed on the website at: NUAStateApprovedTrainingProgramList.pdf (alaska.gov)

Instructor updates

12 AAC 44.840- Program Instructors

Newly approved instructors FY24 Q4 (April 2024 – June 2024) – 12 AAC 44.840

- **UAS Ketchikan**: 1 New Instructor
- **Providence Alaska Medical Center:** 4 New instructors with the new program
- **Alaska Native Medical Center:** 1 New instructor

Program Pass Rates

12 AAC 44.858 Training Program Pass Rate

FY24 Q4 Pass Rate
Reports (All progran

Overall program pass rate for FY24 (Annual) (July 2023-June 2024)- 79.3% *(FY23: 82.9%)*

- 377 exams (Written) & 377 (Skills) administered in FY24.
- 26 programs had test takers.
- 14 programs had an annual pass rate above 80%.
- 4 programs had an annual pass rate of 100%.
- 12 programs fell below 80% pass rate. (listed below)

Pursuant to 12 AAC 44.858 TRAINING PROGRAM PASS RATE, the following programs will receive letters of concerns:

- Alaska CNA
- Alaska Veterans & Pioneers Home
- Heritage Place
- Kachemak Bay Campus/Kenai Peninsula College- Homer
- Mat-Su CNA
- UAF Nome
- Prestige
- Providence Seward Mountain Haven
- UAA Anchorage

Pursuant to 12 AAC 44.858 TRAINING PROGRAM PASS RATE, the following programs will receive letters of warning:

- Don Young Alaska Job Corps
- UAF CTC Fairbanks
- UAS Ketchikan

12 AAC 44.858. TRAINING PROGRAM PASS RATE. (a) An approved certified nurse aide training program must achieve at least an 80 percent cumulative annual pass rate.

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(h) If the training program does not respond to the letter of concern within 90 days, as required under (b) of this section, the board will withdraw approval for the nurse aide program as set out in 12 AAC 44.862.

New Program Requests

No New Program Requests

FOLLOW UP FROM May 2024 Board Meeting

New Training Program Requests

12 AAC 44.830 Application for Training Program Approval

Programs that remain on Provisional Approval:

- **Charter College**- (Provisional Approval August 2023)
  No tentative first course offering date set yet. Facility is still working on further development of the program. No first site visit scheduled yet.

- **Alaska Native Medical Center**- (Provisional Approval November 2023)
  Tentative first course offering date: July- August 2024. First site visit scheduled: 8/6/2024.

- **Providence Alaska Medical Center**- (Provisional Approval May 2024)
  Tentative first course offering date: July- August 2024. First site visit scheduled: 8/6/2024.

Training Program Reviews

12 AAC 44.857 Training Program Review

On-site reviews done during FY24 Q4

- Don Young Alaska Job Corps
- Alaska Technical Center
- Heritage Place
- KBCC/KPC-Kachemak Bay Campus
- Kenai Peninsula College-Soldotna
- Mat-Su CNA
- Providence Seward Mountain Haven
- SEARHC Sitka
- Providence Valdez

All documentation reviewed, a tour of the classroom, skills and clinical site were completed. These programs have met the requirements set forth in regulations. I recommend these training programs be granted approval for the next two years (12 AAC 44.857)

On site reviews completed for 2024 for current state approved nurse aide training programs.

Ongoing Business

- **2024 Self Evaluations will be reported at November 2024 Board Meeting.**
- **FY23 Corrective Action Plans for annual pass rates to be reported and completed at November 2024 Board Meeting. (due to timelines of notices sent)**

Thank you,

Submitted by,
Kelly Olson RN
Nurse Consultant
Alaska Board of Nursing
August 2024

Alaska Board of Nursing

Agenda Item # 22

Division Updates

Alaska Board of Nursing

Public Comment Period

Alaska Board of Nursing

Agenda Item # 24

Discussion-Prioritize BON Tasks and Projects

Develop Timelines

Old Business to prioritize and develop timelines

- Review Medication Course Requirements, process, and regulations. Update as needed
- Research definition of Abandonment. Determine if updated position is needed.
- Research of states or boards to determine if a set number of CEU's could be developed for a valid advanced resuscitation card (ACLS, PALS, NRP) in lieu of a CEU certificate
- Review Education Site visit requirements and develop a plan
- Regulation projects in progress and new
- Review Strategic plan items
- Any other topics, tasks, or projects to add or consider?

ALASKA BOARD OF NURSING
STRATEGIC PLAN 2024-27

1 LICENSING

To license qualified persons for the practice of nursing and to certify qualified nurse aides

- 1A Actively work to to enact passage of the Nurse Licensure Compact (NLC)
- 1B Identify licensure barriers in regulations
- 1C Reduce license turnaround time
- 1D Complete the CNA Certifications Regulations Project
- 1E Review types of licenses offered
- 1F Review requirements for renewal and continuing education to identify efficiencies.

2 PRACTICE

To determine, communicate, and enforce nursing practice as established in statute and regulations.

- 2A Update LPN scope of practice
- 2B Review processes to address scope of practice questions
- 2C Review delegation regulations and develop guidelines for delegation
- 2D Review IV hydration clinics and related prescribing practices

3 EDUCATION

To approve, communicate, and enforce standards for the education of nurses and nurse aides for practice at all levels.

- 3A Update RN and LPN program site visit process
- 3B Review education regulations
- 3C Review the possibility of LPN and/or RN apprenticeship programs

4 GOVERNANCE

To assure the governance framework and culture supports the board's Values and Guiding Principles and accomplishment of its Mission, Vision, and Goals.

- 4A Create and implement a formal strategic plan
- 4B Formalize a system for board member education and onboarding

5 COMMUNICATION

To facilitate information exchange between the board and its colleagues, stakeholder groups, the public, and other agencies.

- 5A Engage with stakeholders (APRNA, AaNA, AHHA, etc.)
- 5B Increase communications with licensees

6 ORGANIZATION

To ensure the organizational infrastructure supports the board's Mission, Vision, and Goals.

- 6A Reconsider the board structure for numbers and types of licensed individuals. Support required legislation.

Alaska Board of Nursing

Agenda Item # 25

Set 2025 BON Meeting Schedule

Alaska Board of Nursing

Agenda Item # 26

For the Good of the Order

Alaska Board of Nursing

Chair Final Comments/Adjourn