MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

2114

2001 SENATE HUMAN SERVICES

SB 2114

2001 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2114

Senate Human Services Committee

☐ Conference Committee

Hearing Date January 22, 2001

Tape Number		Side A	Side B	Meter #
	1	X	X	
January 24, 2001	1	X		
January 24, 2001	1		X	39
January 24, 2001	2	X		
January 29, 2001	2		X	13.6
March 28, 2001	1	X		
Committee Clerk Signature		Carol Kolodzichuk		

Minutes:

The Senate Human Services Committee was called to order by Senator Lee with all Senators present. The hearing for 2114 was held in the Brynhild Haugland Room.

DR. CONSTANCE KALANEK, Executive Director of the ND Board of Nursing introduced bill and supports amendments to it. (Written testimony). SENATOR KILZER : When you change the term nursing assistant, does that change the term entirely from code or are there other locations where it will still be made? DR. KALANEK: We have tried to be consistent in our changes. There may be some other parts that it is included and we can deal with it at another time.

SUSAN McNABOE, Registered Nurse, Williston supports bill. (Written testimony)

MARY SMITH, ND Nurses Association, supports bill. SENATOR LEE: Are there any changes in the actual procedure for discipline or conduct in an action. DR. KALANEK: There is no significant change in the investigative process.

PENNI WESTON, Registered Nurse and board member of the ND Nurses Association, supports this bill and proposed an amendment. (Written testimony)/ SENATOR LEE: Are you familiar with the Medical Assistant Training Module that is being provided by Minot State University? Yes, Do you have any information from ND regarding higher error record with people who are administering medications in a non medical setting. MS. WESTON: When I came into my present position the medications were being administered by people that the Mrg did not put on the Registry of the Board of Nursing. Gave them the self study manual and let them complete that. We had situations of medication that was given for Parkinson's disease that is given in different dosages. We ran out of one of those strengths and because they didn't realize that you just couldn't break it in half, they were actually giving a wrong medicine because it doesn't become the same dosage. SENATOR MATHERN: On the amendment explain that we would be leaving in other folks to administer medications. MS. WESTON: Our concern was if you look at the way it was currently written they could delegate to someone who is not on the registry. So we felt that by putting that terminology in as a compromise. SENATOR LEE pointed out that the amendment is the same as Dr. Kalanek's amendment.

BONNIE SELZLER, Assistant Director of Mental Health, Dept of Human Services, supports bill.

(Written testimony) SENATOR LEE asked why adult foster care facilities were included. MS. SELZLER: Dept of Human Services met with BON and this is just clarification.

KIRSTEN FRIEDT, Registered nurse, ABLE, Inc of Dickinson, supports bill. (Written testimony). She does not support Penni Weston's amendment.

ELAINE D. TAYLOR, President of NDLPN Association, supports bill and proposes amendment. (Written Testimony)

MELANA HOWE, RN, Director of Patient Care Services, Hettinger, supports bill and amendment. (Written testimony)

SHELLEY PETERSON, President of ND Long Term Care Association, supports bill and amendments. (Written testimony) SENATOR POLOVITZ: Who was the questionnaire sent to? MS. PETERSON: It was sent to all 88 nursing homes and 30 basic care facilities. 2/3 of them respond. Statistics in testimony.

JANIS GAULT, Rolette, supports bill. I work as a LPN and am furthering my education. I understand that a 2-year LPN in other states is different. SENATOR LEE: So you support the continuing ed provision? Yes. SENATOR KILZER: How many years have you worked as an LPN? MS. GAULT: Since 1989. SENATOR KILZER. Would you continue to work at the same time that you are doing your continuing education or would you have to stop work according to your planning. MS. GAULT: I would continue to work and do continuing education at the same time. My Grandparents stepped in and helped with the kids.

VALARIE EIDE, RN, Nursing Home Administrator of Good Shepherd, Watford City, supports bill. Gave an illustration of Maria being a RN in 49 other states, but not in ND. I had no inquiries when I needed a Director of Nursing position. I could not hire Maria, even though she would be an exceptional candidate.

GLENICE DARWIN, Director of Nursing Service at Good Samaritan Center, Arthur, ND, supports bill. (Written test.) Proposed an amendment.

BRUCE BOWERSOX, Administrator at Hillsboro, supports bill. We have a tremendous need for nurses. Next 5-10 years will put an additional strain on supply of nurses. SENATOR MATHERN: Have you ever had a situation where a nurse from another area left because of education? MR. BOWERSOX: An RN in Minn. came to work at our facility. She took 3-4 bachelor level classes, and after a number of years of trying this she went back to Minnesota because it was easier.

CARY KROSTAD, supports amendment. There must be core values cannot allow unlicensed to administer medication. SENATOR MATHERN: Are you in favor of or opposed regarding the 30 hour continuing education? MS. KROSTAD: Opposed.

ARNOLD THOMAS, President of the ND Health care Association, supports the bill .(Written testimony).

There was no other testimony. The hearing was closed on SB 2114.

The meeting on January 24, 2001 was called to order by Senator Lee. Dr. Clayton Jenson of Fargo was welcomed to the committee. He is Dr. Of the day. He will give us a little insight on 2114 and the availability of a Distance Learning Program, capable of delivering nursing education to all facilities in ND. It originates in USD and is very well done. It is an excellent program for continuing ed or advanced education toward degrees. It is possible for every LTC facility to satellite. An estimate of cost is $2500 per month. It is a mechanism for nursing education for CNA, LPN, administrators, training people within a community. SENATOR LEE asked if it would be available on fee basis. DR. JENSON said that is was possibly negotiable. SENATOR MATHERN asked if we can get UND or somebody to fill in the excess time. SENATOR POLOVITZ: Is this philosophically a real plus to attract people to work in these homes. DR. JENSON: Yes, it allows rooted workers to go from CNA to LPN and not

leave the facility. A lot to be said to make maximum use of all communications we can use.

SENATOR LEE: The basic degree is what one needs for fundamental knowledge. Continuing ed is designed to keep one updated on new techniques and procedures. DR. JENSON: Continuing education is an absolute must. Good Sam's requires continuing ed to be recertified. It you don't have continuing education you become a dinosaur in the profession.

The Dr. Was thanked for the opportunity afforded to the committee to hear about this possibility.

Committee discussion was held again on January 24, Tape 1, Side B, Meter 39.

General discussion on 2114 and 2241. SENATOR KILZER moved amendments. SENATOR FISCHER seconded it. Discussion pursued the SENATOR KILZER withdrew his motion along with the second of SENATOR FISCHER.

Discussion resumed on January 29, 2001, Tape 2, Side B, Meter 14.2

DR. KALANEK answered questions on the bill. SENATOR FISCHER moved amendments presented by Dr. Kalanek. SENATOR KILZER seconded it. Discussion Proof of progression towards degree; transitional license, additional 30 CE credits can be in either situation. Roll call vote carried 6-0. SENATOR MATHERN moved to further amend with Bonnie Selzer amendments. SENATOR POLOVITZ seconded it. Roll call vote carried 6-0. SENATOR POLOVITZ moved DO PASS AS AMENDED. SENATOR KILZER seconded the motion. Roll call vote carried 6-0. SENATOR LEE will carry the bill.

March 28, 2001, Tape 1, Side A, Meter 35.6

Discussion resumed on SB 2114. Voice vote carried for a DO CONCUR. SENATOR LEE will carry the bill.

FISCAL NOTE

Requested by Legislative Council
02/05/2001

Bill/Resolution No.:

Amendment to: SB 2114

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	1999-2001 Biennium		2001-2003 Biennium		2003-2005 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$6,000	$0	$6,000
Expenditures	$0	$0	$0	$0	$0	$0
Appropriations	$0	$0	$0	$0	$0	$0

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

1999-2001 Biennium			2001-2003 Biennium			2003-2005 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
$0	$0	$0	$0	$0	$0	$0	$0	$0

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

The Specialty Practice Registered Nurse License application fee may generate $3000.00 per biennium in additional revenue to the board. Estimate 30-50 nurses would qualify for this type of licensure.

Removal of the residency requirement could increase the number of nurses that renew their licenses (estimate of $3000 per biennium), as it would allow nurses to renew even though they are not residing or employed in ND.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

Will not affect state general fund.

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Will not affect state general fund

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and*

appropriations.

As an occupational board, the ND Board of Nursing follows NDCC 54-44-12 for appropriations. The Board of Nursing is funded primarily through licensure fees from RNs, LPNs, and APRNs.

Name:	Constance B Kalanek	**Agency:**	ND Board of Nursing
Phone Number:	(701) 328-9777	**Date Prepared:**	02/06/2001

FISCAL NOTE

Requested by Legislative Council
12/26/2000

Bill/Resolution No.: SB 2114

Amendment to:

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	1999-2001 Biennium		2001-2003 Biennium		2003-2005 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$6,000	$0	$6,000
Expenditures	$0	$0	$0	$0	$0	$0
Appropriations	$0	$0	$0	$0	$0	$0

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

1999-2001 Biennium			2001-2003 Biennium			2003-2005 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
$0	$0	$0	$0	$0	$0	$0	$0	$0

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

The Speciality Practice Registered Nurse License application fee may generate $3000 per biennium in additional revenue to the board. Estimate 30-50 nurses would qualify for this type of licensure.

Removal of the residency requirement could increase number of nurses that renew their license (estimate $3000 per biennium), as it would allow nurses to renew even if they are not working or residing in ND.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

No effect to state general fund.

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

No effect to state general fund.

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

As an occupational board, the ND Board of Nursing follows NDCC 54-44-12 for appropriations. The Board of Nursing is funded primarily through licensure fees from RNs, LPNs, and APRNs.

Name:	Connie Kalanek	**Agency:**	ND Board of Nursing
Phone Number:	(701) 328-9777	**Date Prepared:**	12/28/2000

Adopted by the Human Services Committee
January 29, 2001

PROPOSED AMENDMENTS TO SENATE BILL NO. 2114

Page 1, line 1, after the third comma insert "43-12.1-05,"

Page 1, line 2, remove "and"

Page 1, line 3, after "43-12.1-15" insert ", and 43-12.1-16"

Page 1, line 5, remove "and" and after "procedures" insert ', and the expiration date of the authority of a licensed nurse to delegate medication administration"

Page 2, after line 25, insert:

"9. "Transitional practical nurse license" means a license issued by the board to a person who meets all of the requirements for licensure by endorsement as a licensed practical nurse, except the educational requirements.

10. "Transitional registered nurse license" means a license issued by the board to a person who meets all of the requirements for licensure by endorsement as a registered nurse, except the educational requirements."

Page 2, line 26, replace "9" with "11"

Page 4, line 23, replace "Staff" with "A person"

Page 4, line 28 , replace "Group" with "Within group", replace "and" with an underscored comma, and after "facilities" insert ", and adult foster care facilities"

Page 4, line 29, replace "and" with "or"

Page 5, line 1, replace "Human" with "Within human" and remove "A licensed nurse may"

Page 5, remove lines 2 and 3

Page 5, after line 8, insert:

"**SECTION 4. AMENDMENT.** Section 43-12.1-05 of the 1999 Supplement to the North Dakota Century Code is amended and reenacted as follows:

43-12.1-05. Board of nursing - Composition - Term of office. There is a state board of nursing whose members must be appointed by the governor which must consist of five registered nurses, three licensed practical nurses, and one public member. Each board member must be appointed for a term of four years. No appointee may be appointed for more than two consecutive terms. An appointment for an unexpired term of more than eighteen months will constitute a full term. Terms of nurse board members must be evenly distributed to allow two licensed nurse board members to be appointed or reappointed each year. ~~The members of the board holding office on August 1, 1995, may continue to serve as members for their respective terms.~~"

Page 8, line 7, remove the overstrike over "~~Renewal requires proof of progression towards~~"

Page 8, line 8, remove the overstrike over "~~meeting the~~", after "~~educational~~" insert "academic", remove the overstrike over "~~requirements~~" and insert immediately thereafter "of thirty hours of continuing education activity", and remove the overstrike over the period

Page 9, line 11, after the comma insert "specialty practice registered nurse,"

Page 9, line 19, after "certification" insert "or evaluation"

Page 9, line 22, after "certification" insert "or evaluation"

Page 10, line 23, after "reprimand" insert ", place on probation,"

Page 12, after line 9, insert:

"**SECTION 13. AMENDMENT.** Section 43-12.1-16 of the 1999 Supplement to the North Dakota Century Code is amended and reenacted as follows:

43-12.1-16. ~~(Effective through July 31, 2001)~~ Delegation of medication administration. A licensed nurse may delegate medication administration to a person exempt under subsection 9 of section 43-12.1-04."

Renumber accordingly

Date: 1/29/01

Roll Call Vote #: 1

2001 SE..ATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2114

Senate HUMAN SERVICES Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Amendment

Motion Made By Sen Fischer Seconded By Sen Kilzer

Senators	Yes	No	Senators	Yes	No
Senator Lee, Chairperson	✓		Senator Polovitz	✓	
Senator Kilzer, Vice-Chairperson	✓		Senator Mathern	✓	
Senator Erbele	✓				
Senator Fischer	✓				

Total (Yes) 6 No 0

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Dr. Kalanek

Date: 1/29/01

Roll Call Vote #: 2

2001 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2114

Senate HUMAN SERVICES Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken further amend

Motion Made By Sen Mathern Seconded By Sen Polovitz

Senators	Yes	No	Senators	Yes	No
Senator Lee, Chairperson	✓		Senator Polovitz	✓	
Senator Kilzer, Vice-Chairperson	✓		Senator Mathern	✓	
Senator Erbele	✓				
Senator Fischer	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Bonnie Schafer amendments (Dept)

Date: 1/29/01

Roll Call Vote #: 3

2001 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2114

Senate HUMAN SERVICES Committee

☐ Subcommittee on _____

or

☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Do pass as amended

Motion Made By Sen Polovitz Seconded By Sen Kilzer

Senators	Yes	No	Senators	Yes	No
Senator Lee, Chairperson	✓		Senator Polovitz	✓	
Senator Kilzer, Vice-Chairperson	✓		Senator Mathern	✓	
Senator Erbele	✓				
Senator Fischer	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Sen Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2114: Human Services Committee (Sen. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2114 was placed on the Sixth order on the calendar.

Page 1, line 1, after the third comma insert "43-12.1-05,"

Page 1, line 2, remove "and"

Page 1, line 3, after "43-12.1-15" insert ", and 43-12.1-16"

Page 1, line 5, remove "and" and after "procedures" insert ", and the expiration date of the authority of a licensed nurse to delegate medication administration"

Page 2, after line 25, insert:

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Page 5, after line 8, insert:

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43-12.1-05. Board of nursing - Composition - Term of office. There is a state board of nursing whose members must be appointed by the governor which must consist of five registered nurses, three licensed practical nurses, and one public member. Each board member must be appointed for a term of four years. No appointee may be appointed for more than two consecutive terms. An appointment for an unexpired term of more than eighteen months will constitute a full term. Terms of nurse board members must be evenly distributed to allow two licensed nurse board members to be appointed or reappointed each year. ~~The members of the board holding office on August 1, 1995, may continue to serve as members for their respective terms.~~"

Page 8, line 7, remove the overstrike over "~~Renewal requires proof of progression towards~~"

Page 8, line 8, remove the overstrike over "~~meeting the~~", after "~~educational~~" insert "academic", remove the overstrike over "~~requirements~~" and insert immediately thereafter "of thirty hours of continuing education activity", and remove the overstrike over the period

Page 9, line 11, after the comma insert "specialty practice registered nurse,"

Page 9, line 19, after "certification" insert "or evaluation"

Page 9, line 22, after "certification" insert "or evaluation"

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Page 12, after line 9, insert:

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43-12.1-16. ~~(Effective through July 31, 2001)~~ Delegation of medication administration. A licensed nurse may delegate medication administration to a person exempt under subsection 9 of section 43-12.1-04."

Renumber accordingly

2001 HOUSE HUMAN SERVICES

SB 2114

2001 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2114

House Human Services Committee

☐ Conference Committee

Hearing Date March 7, 2001

Tape Number	Side A	Side B	Meter #
Tape 1	X		4160 to end
Tape 1		X	0 to end
Tape 2	X		0 to 4100

Committee Clerk Signature Connie Easton

Minutes:

Chairman Price, Vice Chairman Devlin, Rep. Dosch, Rep. Galvin, Rep. Klein, Rep. Pollert, Rep. Porter, Rep. Tieman, Rep. Weiler, Rep. Weisz, Rep. Cleary, Rep. Metcalf, Rep. Niemeier, Rep. Sandvig

Chairman Price: Open hearing on SB 2114.

Constance Kalanek: Executive Director of the N. D. Board of Nursing. (See written testimony.) On behalf of the board, I wish to offer testimony in support of SB 2114 relating to the Nurse Practices Act 43-12.1. (Written testimony included section by section summary of the revisions made to the Nurse Practices Act 43-12.1 along with rationale for the changes, proposed amendments to SB 2114, and Proposed Revisions to NDAC Title 54, Rule Revision.)

Rep. Weiler: Can you explain in section 7, the transitional license?

Kalanek: The transitional license is the license that nurse obtains if she does not meet the educational requirements. So an LPN that doesn't have an Associates Degree or an RN who doesn't have Bachelor's Degree would be licensed under a transitional license.

Rep. Weiler: Why then the need for the CE activity requirements?

Kalanek: Currently we have in place an academic requirement for transitional license fees. They have eight degrees to complete their degree, whether it is an LPN or an RN. In negotiation with facilities and the health care environment the board agreed to give that individual another option. So they could choose the academic requirement or the CE requirement to renew their license.

Rep. Porter: On page 2 where we start talking about the specialty practice registered nurse - last session we dealt with the registered nurse first assistant and insurance mandate requiring insurance companies to pay the coverage and the Board of Nursing got up and said that they didn't need the requirements of the advanced practices nurses so you were opposed to that bill. Is this the board's way of getting around that and next session we're going to see a bill that mandates separate payments for RN first assists?

Kalanek: The bill in the last session was for the RN first assistants, specifically. This definition is for any specialty process. It's the boards way of recognizing those individuals who do have a specialty practice. It does give that additional recognition.

Rep. Porter: When we get into the medication administration program, some of the concerns that have come up relate to schools and secretaries giving medication. Is the medication administration program of schools exempted from that now, or are they brought into it to make sure people are working in conjunction with what is being done with the DD facilities? What is being done as far as schools?

Kalanek: That is a very complex issue. We've worked with the school nurses on the medication administration issue, and there are a number of schools that do have school nurses. When a nurse is present in a school, they are subject to the Nurse Practices Act and must abide by that Act.

Rep. Porter: If this section becomes law and there is a contract to a public health unit for providing school nursing, and that nurse is not present over the new hour which a child needs the medication, then the parents can't authorize the secretary to give that medication - the person needs to go back and be retrained in medication administration the way it is described in the Nurse Practice's Act?

ConstanceKalanek: That exemption deals with the Human Services Department. In light of your question, once the nurse leaves the school proper the administrator is responsible for the medication administration.

Rep. Weisz: Page 8, section 7 where you added the 30 hours of continuing education - is that a one time thing, yearly?

Constance Kalanek: It is not specifically laid out in the bill. The requirement would be for renewal and be on a two-year time frame.

Bonnie Selzler: Assistant Director of Mental Health Services, Department of Human Services. (See written testimony.) In response to HB 1403 of the 1999 Legislative Session, representatives from the Department of Human Services, the Board of Nursing, the North Dakota Medical Association, the North Dakota Nurses Association, the North Dakota Association of Community Facilities and other private providers met regularly to discuss the ramifications of unlicensed staff providing medication. The results of those efforts were previously reported to the Interim Budget Committee on Health Care as directed by HB 1403. The changes detailed in subsection 9

of Section 3 of SB 2114 reflect the consensus of that group. The Department of Human Services supports SB 2114.

Kirsten Friedt: RN, Able, Inc. (See written testimony.) Medication administration and delegation of nursing tasks have long been a gray area for nurses employed by facilities such as ABLE, Inc. I urge you to place a DO PASS on SB 2114.

Rep. Weisz: Under the revision it says "may delegate" - so that isn't a requirement, so the center or the home could still delegate that to somebody without your involvement, or does this require your involvement if you are on staff?

Kirsten Friedt: I will defer that question to Dr. Kalanek.

Constance Kalanek: It is permissive in that nurses who work in those facilities are covered by the Nurse Practices Act.

Mike Hillman: Academic Affairs, N. D. University. I don't have prepared testimony, but I do want to speak strongly in favor of the proposed amendment - Section 7, page 8, lines 24 and 25. Without those changes the transitional license education requirement would not reflect North Dakota's current nursing practice. There would be vast difference in the education requirements between nurses educated in the state and those educated out side the state.

Chairman Price: You're talking about the 30 hour requirements?

Mike Hillman: Yes. The 30 hours would be removed and replaced by requirements developed in rules by the Board of Nursing.

Susan McNaboe: RN, CNOR, CRNFA, Operative Services of Mercy Medical Center. (See written testimony.) I am speaking today in support of SB 2114, specifically to Section 1, item 8. (Discussed specialization in nursing practices.)

Elaine Taylor: LPN and President of the N. D. Licensed Practical Nurses Association. (See written testimony.) NDLPNA wishes to speak in favor of SB 2114.

Rep. Porter: What is your education level as far as an LPN? Do you have an Associates Degree?

Elaine Taylor: No, I graduated in 1964.

Rep. Porter: You never went back to school?

Elaine Taylor: No, I was grandfathered in.

Rep. Porter: One of the points that you brought up was a nursing shortage, and we dealt with that in other aspects of this committee early on. Some people tell there is not a nursing shortage, some people tell us it is just a demographic problem. Your education level is in the majority of LPN's who don't hold an Associate Degree. If someone is working in Minnesota as an LPN for 20 years and decides to move to rural North Dakota, do you think that person is qualified to practice as an LPN in rural North Dakota as they were for the last 20 years in Minnesota?

Elaine Taylor: I think you really have to look at their experience, their capabilities, and I think the person that is hiring them could certainly be checking into this. Yes, I think they need to be given credit for their work experience.

Rep. Porter: The way that the bill is currently written is either or the academic requirement, or 30 hours of continuing education and education activities, but there isn't anything specific to past work experience. So what you are telling me, is that looking at their past work experience that the LPN from Minnesota is fully capable if they would meet the 30 hours of continuing education activity?

Elaine Taylor: Yes, that is the feeling that I have.

Rep. Porter: Explain to me the differences in the work performed by an RN and an LPN, and what modules are available to you as an LPN for education requirements to do other intervention?

Elaine Taylor: LPN's that I am familiar with through the association and others that are not members, they have the opportunity to work in charge positions - a lot of them work in clinics and in long term care. So those that work in hospital facilities may be team leaders, but they are generally called floor nurses. They are assigned X number of patients and are responsible for them. Through our national federation we have opportunities to get continuing education. We have workshops, but we are not required as a state to have X number of hours.

Rep. Porter: I am interested in the starting of IVs, type of medications that can be administered. If you take ACLS course, can you intimate a patient on orders of a physician - those types of things?

Elaine Taylor: I have not had that course. I have had an IV Therapy course which was conducted through the Board of Nursing.

Rep. Porter: What is the number of LPNs that are members of your association?

Elaine Taylor: NDLPNA has anywhere from 40 to 60 members at any given time. In the national federation there is 950,000 in the United States.

Penni Weston: RN and Board Member of N.D. Nurses Association. (See written testimony.) We support the revisions with one exception. We are not supportive of the exemption of those individuals who provide medications in specific settings. NDNA believes licensed nurses should be and must be involved in any setting where nursing care is rendered, either through direct care or delegation. Delegation implies licensed nurse responsibility, which cannot be permissive under the law.

Rep. Porter: Your comments about medication errors - last session when the DD facilities were in talking about this particular exemption - if I remember right there is a higher rate of medication errors where licensed professionals work than where unlicensed professionals work. Do you have those statistics available?

Penni Weston: I do not have the statistics. One of the things I can tell you why I believe that is the case is that in order to know that a medication error has occurred you have to have enough knowledge to know that it has been a medication error. The medication system is only as good as the people that monitor that.

Rep. Porter: Does every DD facility in the State of North Dakota employ a nurse?

Penni Weston: I would have to defer that question to the DD facility.

Rep. Porter: According to your objection to this training in utilization of medication administration individuals, then every DD facility in the state would have to employ a nurse. Is that correct?

Penni Weston: My objection is that there should be some nurse involved in some way. I believe that the way the exemption is written the facilities could choose not to have licensed nurses involved.

Chairman Price: Do you work in a DD facility or long term care center?

Penni Weston: I work in an assistant living facility.

Chairman Price: You talked about defining nursing tasks and others are having heartburn with the fact that HIFCA is looking at feeding, particularly since there have been a lot of long term care settings that have used family members as volunteers. What is the position right now on making non-occupied bed, is that considered a nursing task?

Penni Weston: I defer that to the Board of Nursing whether they consider that a nursing task or not.

Chairman Price: Just because a task is defined a nursing task I have a real situation a bed that has nobody in it being considered a nursing task.

Vice Chairman Devlin: I assume you made the same arguments to the ad hoc committee.

Penni Weston: Yes we did.

Vice Chairman Devlin: How many nurses there are in the state that would qualify to belong to your organization, and how many do?

Penni Weston: The licensed nurses, the RN's in the state, the statistics are about 10% of the eligible population. Right around 700.

Melana Howe: Director of Patient Care Services, West River Regional Medical Center and President of the North Dakota Organization of Nurse Executives. (See written testimony.) I am speaking in support of SB 2114 and specifically Sections 1 and 3 as they relate to supervision through delegation and licensure. The proposed revisions are timely, practical, and make good sense.

Chairman Price: The question I have is the change from nurse assistant to unlicensed assisted person. How is the public going to perceive this? How are you going to define that person. Are you going to say to that person "we're going to have an unlicensed assisted person come in to - whatever" - how is the public going to review the change?

Melana Howe: I don't know that the public will really be aware of the change. There name tags don't say unlicensed - they say respiratory therapist, surgical technician - all these are certified. It is a team these days. The way the wording is changed, it recognizes everybody.

Chairman Price: Will we not here of CNA's anymore?

Melana Howe: Their tags will continue to say CNA - it just won't say unlicensed.

Rep. Porter: Are you having trouble obtaining and retaining nurses in your rural area?

Melana Howe: No, but crunches are occurring in other areas, not nurses, but in lab techs, laundry, dietary, etc. I think there is a crunch in health care in rural North Dakota. I think some of it is economics of the business, and economics of rural America. In health care there is some really icky jobs, that is the reality of the business. There are some horrible shifts, some horrible responsibilities - liability wise as far as just the job itself. You are doing some nasty type hands on work. There are people who aren't even drawn to this business because of that.

Rep. Porter: Specifically looking at this bill, in the portion dealing with transitional licenses, if you had the opportunity to hire an RN from Montana that had worked for 10-15 years in that state, would see that just the ability to do 30 hours of continuing education in order to work in North Dakota would suffice, or do you think they should have to go back to school and get a Bachelor's Degree in order to work in North Dakota.

Melana Howe: You're talking to an old nurse and I have worked in six different states in my nursing career. Some of the states require continuing education. Most of the states did not. North Dakota is the only state that required a four year degree. I've seen nurses with degrees, I've seen nurses with two year RN's (two year Associate Degree). I support the 30 credit hours as an option. I think this industry has changed a lot. Especially the registered nurses in the specialty areas, the neonatal areas, the ICU - whatever. They are functioning almost at the level as residents function at. I do not think we should cut education requirements. I think all states should require continuing ed. What this does is it requires those of us that were licensed before 1988 to continue to move forward and progress.

Grant Wilz: Director of Nursing, Baptist Home, Inc. The question asked earlier on Section 2, line 18 regarding having an unlicensed person on the name tag, each of the facilities would be allowed to use a name for that unlicensed assisted person. I have had the opportunity to interview, hire, and evaluate staff. Do I think that 30 continuing credit hours are going to be enough to say that person can practice in North Dakota - I can't answer that. I think there are a lot of people with Bachelor's Degrees. Some of them are great, some of them are duds. It depends really on the person, and I do agree that it depends on their experience. I don't think that is something that the committee or could be addressed in law. I think that should be left to the professional organization of the Board of Nursing working with their members to make that determination. I don't think North Dakota should give up their educational requirements - the Bachelor's Degree or an Associate's Degree, but I do believe in experience.

Rep. Weisz: Do you feel the standard nursing care in the surrounding states is substantially lower than North Dakota?

Grant Wilz: I have a lot of pride in North Dakota, so I would not say the standard of care is less than other places. I think the people and the education that we offer - I think we do a better job.

Rose Stoller: Executive Director of the Mental Health Association of North Dakota. We support this bill with one exception. We testified last session and renew our concerns today about the section allowing for medication administration by non-nurses in residential treatment centers, facilities for persons with developmental disabilities, adult foster care facilities, and regional human service centers. Our concern is primarily to the administration of medications to persons with mental illness.

Shelly Peterson: President of the North Dakota Long Term Care Association. (Written testimony.) (Briefly outlined the Association's position on education requirements for nurses.) We are supportive of all aspects of SB 2114 and respectively request your support.

Rep. Klein: How many classroom credits does it take an LPN to get an RN degree?

Shelly Peterson: I don't know.

Mary Ann Marsh: Chair of the Nursing Department, Dickinson State University. The LPN is required to complete 65 credit hours in order to get their Associate's Degree. So we would need to take a look a perspective student from their out-of-state program and how their program they graduated from compares with ours, and then allow approval if they are from an accredited program.

Rep. Klein: The North Dakota have a law that you have to have 44 hours from the institute to graduate from that institution. Does that apply to nurses also?

Mary Ann Marsh: The program that we have at Dickinson State is an Associate of Applied Science and Practice Nursing. It is a 65 credit hour program which includes general education courses as well as the nursing courses. So is the 44 hours a general education requirement for an Associate's Degree?

Rep. Klein: No, this is on a four year degree.

Mary Ann Marsh: Oh, for the on- campus. Yes, there is a minimum requirement.

Vice Chairman Devlin: Shelly, are you more comfortable leaving the 30 hours in or you okay with just leaving it wide open and leaving it with the board?

Shelly Peterson: We are very comfortable with the 30 hours. We have a very positive working relationship with the Board of Nursing. We have a greater comfort when we know what the law says.

Arnold Thomas: President of the North Dakota Health Care Association. We agree with the Board of Nursing's decision.

Evelyn Quigley: Senior Executive and Chief Nursing Officer, MeritCare. (See written testimony.) I am here to speak in support of SB 2114. It is our belief that a DO PASS VOTE on SB 2114 would provide for the transitional licensure needed to provide incentive for nurses in border communities to begin practicing in North Dakota. It would allow time to address the long-term need for solutions rather than a dramatic dismantling of a system of excellence in nursing.

Rep. Metcalf: Is it easier in Minnesota to get nurses than it is in North Dakota?

Evelyn Quigley: I would say that on an average we have openings for 25 to 30 nurses, and that would include licensed practical nurses and RNs. Because our hospital is located in North Dakota, it is more challenging at times to have positions within the hospital because nurses from the hospital move into ambulatory care to have another experience. The hours make a difference. That is where health care is going is into ambulatory service.

Rep. Metcalf: Are there nurses in Minnesota that would be willing to work in North Dakota that cannot or will not because of the educational requirements?

Evelyn Quigley: I am not certain about nurses that are not working in North Dakota because of the requirements. We do have nurses in North Dakota that are there working toward their education. We work with this through tuition reimbursement. We work this through our professional organizations.

Glenn Thom: President , N.D. Society for Respiratory Care. (See written testimony.) As respiratory therapists licensed to deliver patient care alongside the nurses in the State of North Dakota, we feel the amendments made in Reengrossed SB 2114 are positive changes to the North

Dakota Century Code, with one notable exception. The clients described in lines 3 and 4 of page 5 do not fall into the category of persons which can safely be covered by the services of "unlicensed assistive personnel". We recommend that unlicensed assistive personnel be excluded from the delivery of medications to residents of facilities licensed under Chapter 15-16.

Rep. Porter: Were you involved in the interim negotiations of this particular part of this Century Code?

Glen Thom: I was not, but I came one on one with the Board of Nursing.

Chairman Price: In your career as a health care professional have you encountered problems with patients in these facilities that have had medication administrations?

Glen Thom: What typically happened is as a respiratory therapist we get to see these people after they have aspirated and contracted pneumonia - some of the individuals on mechanical ventilators. Typically we will get them when they have gone down the road already as part of a bad effect of not being monitored appropriately.

Chairman Price: Were these people in a social model or a medical model?

Glen Thom: They were in a social model, originally.

Chairman Price: Dr. Kalanek, we have a couple of more questions for you if you don't mind.

Vice Chairman Devlin: I would like you to tell the committee specifically what your intent will be under the language requirements as established by the board. Has the board discussed this?

Constance Kalanek: The board hasn't looked at it in detail. They have given it a cursory amount of discussion. Some of the things discussed were define continuous practice, to define continuing education activity. Defining the experienced nurse coming into North Dakota, and then to clearly outline what continuing education activities would be acceptable by the board.

All those things need to be explored in great detail. That is why we use the Nursing Practice Committee which is made up of about 25 individuals.

Vice Chairman Devlin: When I see this next time, the administrative rules won't all of a sudden say a 100 hours of continuing education or something like that?

Constance Kalanek: I would hope not.

Vice Chairman Devlin: Do you have a specific number for even general areas - is that 30 hours in the realm of what you are talking about?

Constance Kalanek: I think we need to look at other states to see what their requirements are. We are currently in the process of conducting a survey of 1,500 nurses here in the state on the continuing education competent area, and we are presently tabulating that data. We will review that also to help us outline what the nurses think is responsible. We expect there may be some changes requirements for renewals for all nurses.

Rep. Cleary: Could we add "no more than 30 hours", and that would maybe be satisfactory?

Constance Kalanek: The university system spoke in favor of this continuing education amendment. We negotiated with them yesterday and discussed this at great length, and we were able to come to a consensus that they would not oppose the continuing Ed options. It was left to the board to decide what would be appropriate number of hours.

Rep. Cleary: I like it this way - the amendment - because then you can take into consideration a lot of other factors.

Rep. Weisz: The current amendment doesn't limit how you define continuing education activity. Wouldn't the only limitations be the actual 30 hours? I would assume you would have flexibility even to define that differently depending on the number of years of service somebody has already incurred. Isn't that correct?

Constance Kalanek: That really is the purpose of the rules - to guide the board in implementing that particular law.

Rep. Weisz: This bill allows you to do the rule making as you see fit - the type of education activity that is required. The only limitations in this bill, in reality, is the 30 hours. We're not saying how you should promulgate the rules of what those 30 hours should be, or what flexibility that the board would have or anything else. In your response to the question by Rep. Devlin, you were implying that you wanted your amendment in there because you thought you needed this flexibility to promulgate rules having to do with the type of activity is required, etc., etc. This doesn't prohibit that, correct?

Constance Kalanek: No, it does not.

Chairman Price: Let's say, for example, that you have someone coming in who really would like to get the four year degree, and they have a special area they would like to work towards - you could help tailor a play for them even if they may not do it in eight years or whatever - the 30 hours they do every two years could be patterned towards that I would assume.

Constance Kalanek: That is correct.

Chairman Price: So if you have someone that is here - say from a military base and will only be here three years - there's could be basically very general - so you are looking at helping pattern it towards their particular situation as much as what is available. Do you think the board would take a look at some of the out-of-state courses that are available over the Internet as a piece of it?

Constance Kalanek: I believe so. As long as those courses are approved by a provider.

Chairman Price: Part of the concern is that we want it flexible, but yet we don't want it so onerous that nobody is going to go for it, because obviously this person is going to paying for it out of their own pocket. It is going to be within "what is available to me". Do you think we can

come to some language that gives us some reassurance that it is not going to be too cumbersome, but yet gives you enough flexibility?

Constance Kalanek: We would certainly be open to that discussion.

Vice Chairman Devlin: I understand that you and Shelly's two groups have a great relationship, but for whatever reason one of you may not be there, move on the another job and the relationship deteriorates, will you involve Long Term Care, the Medical Association and different ones in at least the discussions on the number of hours required before the board sets them?

Constance Kalanek: Yes. The Nurses Practice Committee would be called upon to set those parameters. If I were not to be present, they would continue.

Chairman Price: Close SB 2114.

2001 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2114 A

House Human Services Committee

☐ Conference Committee

Hearing Date March 13, 2001

Tape Number	Side A	Side B	Meter #
Tape 2	X		2670 to 3720
Committee Clerk Signature	Connie Easton		

Minutes:

COMMITTEE WORK:

CHAIRMAN PRICE: Let's look at SB 2114. There were some amendments that Dr. Kalanek talked about. Page 12, they wanted to make sure that the specialty practice registered nurse was included on line 15 and line 19. The other issue has to do with page 8 for the continuing education. At the very least we have to insert the word "or" because it says "of". It should be academic "or" the 30 hours of continuing education. We looked at the 30 hours as being tailored to the nursing question by the board depending upon their particular circumstances.

REP. PORTER: I would move those three amendments.

REP. WEISZ: Second.

CHAIRMAN PRICE: (Discussed changes to amendments.) I have a motion and a second. Discussion? Seeing none all in favor signify by saying Aye (13 Yes, 0 No, 1 Absent).

REP. SANDVIG: A couple of people had a concern about the unlicensed assisted personnel giving medication to residents. I was wondering if we wanted to do anything about that.

CHAIRMAN PRICE: Personally, I don't. That came out of HB 1403 last session. Exemption was in place for many, many years. When we did some things in '95 that was supposed to be looked at. Something didn't happen, so it went away without the final discussion on it. So in HB 1403 we directed the department and the Board of Nursing to come back to us with language that they agreed upon. That is what we've got. The objection comes from Mr. Gayle, Respiratory Care. We didn't have any testimony last time that there had been problems.

REP. WEISZ: He didn't indicate that the problem had to do with mis-medication. His issue was that he didn't think the person watched over enough to see if there was reaction to medication that was prescribed. He didn't really address that they had a problem.

REP. TIEMAN: I move the bill.

REP. METCALF: Second.

CHAIRMAN PRICE: Further discussion? Seeing none the clerk will take the roll on a **DO PASS as amended.**

12 YES 1 NO 1 ABSENT

2001 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2114

House Human Services Committee

☐ Conference Committee

Hearing Date March 21, 2001

Tape Number	Side A	Side B	Meter #
1		x	2236 to 2382
1		X	4990 to end
Committee Clerk Signature	Connie Easton		

Minutes:

Chairman Price: We are bringing back SB 2114. The Council of the Board of Nursing and the Attorney Generals office noticed one place where they forgot to add something.

Dr. Kalanak: Discussed the additional amendments.

Chairman Price: It was added to the other sections as well, this was just missed.

Dr. Kalanak: Yes, this is to make it consistent.

Chairman Price: We will take a look at this and act on it later.

COMMITTEE WORK

Chairman Price: Committee pull out SB 2114.

Motion to reconsider action, second. Carried.

(Discussion on amendment)

Rep.Devlin: I move the amendment.

Rep. Weisz: I second.

Chairman Price: All those in favor signify by saying Aye. Opposed? Amendment carries by voice vote. We have SB 2114 as amended before us. What are your wishes?

Rep. Cleary: I move a do pass as amended.

Rep. Metcalf: I second.

Chairman Price: We have a motion and a second for a do pass as amended. Clerk will take the roll.

MOTION FOR A DO PASS AS AMENDED

YES, 14 NO, 0

CARRIED BY REP. CLEARY

Adopted by the Human Services Committee
March 13, 2001

VR
3/13/01

HOUSE AMENDMENTS TO SB 2114 HOUSE HS 3-13-01

Page 8, line 24, replace the first "of" with "or"

Page 8, line 25, remove "activity"

HOUSE AMENDMENTS TO SB 2114 HOUSE HS 3-13-01

Page 12, line 15, after the first comma insert "a specialty practice registered nurse,"

Page 12, line 19, after the first comma insert "a specialty practice registered nurse,"

Renumber accordingly

Date: 3-13-01
Roll Call Vote #: 1

2001 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2114

House Human Services Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Move three Amendments

Motion Made By Rep. Porter Seconded By Rep. Weisz

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price - Chairman	✓		Audrey Cleary	✓	
William Devlin - V. Chairman	✓		Ralph Metcalf	✓	
Mark Dosch	✓		Carol Niemeier	✓	
Pat Galvin	✓		Sally Sandvig	✓	
Frank Klein	✓				
Chet Pollert					
Todd Porter	✓				
Wayne Tieman	✓				
Dave Weiler	✓				
Robin Weisz	✓				

Total (Yes) 13 No 0

Absent 1

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 3-13-01
Roll Call Vote #: 2

2001 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2114

House Human Services Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken DO PASS as amended

Motion Made By Rep. Tieman Seconded By Rep. Metcalf

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price - Chairman	✓		Audrey Cleary	✓	
William Devlin - V. Chairman	✓		Ralph Metcalf	✓	
Mark Dosch	✓		Carol Niemeier	✓	
Pat Galvin	✓		Sally Sandvig	✓	
Frank Klein		✓			
Chet Pollert					
Todd Porter	✓				
Wayne Tieman	✓				
Dave Weiler	✓				
Robin Weisz	✓				

Total (Yes) 12 No 1

Absent 1

Floor Assignment Rep. Cleary

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
March 13, 2001 3:21 p.m.

Module No: HR-43-5508
Carrier: Cleary
Insert LC: 18200.0301 Title: .0400

REPORT OF STANDING COMMITTEE

SB 2114, as reengrossed and amended: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (12 YEAS, 1 NAY, 1 ABSENT AND NOT VOTING). Reengrossed SB 2114, as amended, was placed on the Sixth order on the calendar.

Page 8, line 24, replace the first "of" with "or"

Page 8, line 25, remove "activity"

Page 12, line 15, after the first comma insert "a specialty practice registered nurse,"

Page 12, line 19, after the first comma insert "a specialty practice registered nurse,"

Renumber accordingly

Date: 3-21-01
Roll Call Vote #: 1

2001 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2114

House Human Services Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Move to reconsider action by which SB 2114 passed out of Committee

Motion Made By Rep. Devlin Seconded By Rep. Porter

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price - Chairman	✓		Audrey Cleary	✓	
William Devlin - V. Chairman	✓		Ralph Metcalf	✓	
Mark Dosch	✓		Carol Niemeier	✓	
Pat Galvin	✓		Sally Sandvig	✓	
Frank Klein	✓				
Chet Pollert	✓				
Todd Porter	✓				
Wayne Tieman	✓				
Dave Weiler	✓				
Robin Weisz	✓				

Total (Yes) 14 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

18200.0302
Title.0500

Adopted by the Human Services Committee
March 21, 2001

VR
3/21/01

HOUSE AMENDMENTS TO SB 2114 HOUSE HS 3-22-01

In addition to the amendments adopted by the House as printed on pages 960 and 961 of the House Journal, Reengrossed Senate Bill No. 2114 is further amended as follows:

Page 6, line 10, after the first comma insert "specialty practice registered nurse,"

Renumber accordingly

Date: 3-21-01
Roll Call Vote #: 2

2001 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2114

House Human Services Committee

☐ Subcommittee on _____

or

☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Move amendment

Motion Made By Rep. Devlin Seconded By Rep. Weisz

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price - Chairman	✓		Audrey Cleary	✓	
William Devlin - V. Chairman	✓		Ralph Metcalf	✓	
Mark Dosch	✓		Carol Niemeier	✓	
Pat Galvin	✓		Sally Sandvig	✓	
Frank Klein	✓				
Chet Pollert	✓				
Todd Porter	✓				
Wayne Tieman	✓				
Dave Weiler	✓				
Robin Weisz	✓				

Total (Yes) 14 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 3-21-01
Roll Call Vote #: 3

2001 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2114

House Human Services Committee

☐ Subcommittee on _____

or

☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken DO PASS as amended

Motion Made By Rep. Cleary Seconded By Rep. Metcalf

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price - Chairman	✓		Audrey Cleary	✓	
William Devlin - V. Chairman	✓		Ralph Metcalf	✓	
Mark Dosch	✓		Carol Niemeier	✓	
Pat Galvin	✓		Sally Sandvig	✓	
Frank Klein	✓				
Chet Pollert	✓				
Todd Porter	✓				
Wayne Tieman	✓				
Dave Weiler	✓				
Robin Weisz	✓				

Total (Yes) 14 No 0

Absent 0

Floor Assignment Rep. Cleary

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2114, as engrossed and amended: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, *recommends* **DO PASS** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed SB 2114, as amended, was placed on the Sixth order on the calendar.

In addition to the amendments adopted by the House as printed on pages 960 and 961 of the House Journal, Reengrossed Senate Bill No. 2114 is further amended as follows:

Page 6, line 10, after the first comma insert "specialty practice registered nurse,"

Renumber accordingly

2001 TESTIMONY

SB 2114

Testimony on SB 2114
Senate Human Services Committee
January 22, 2001

included in Kalanek's draft of amendments

Chairman Lee and members of the Senate Human Services Committee, thank you for the opportunity to testify on SB 2114. My name is Shelly Peterson, President of the North Dakota Long Term Care Association. I am here today representing our members, nursing facilities, basic care facilities and assisted living facilities.

We are supportive of all aspects of SB 2114 and respectively request the Committee to consider amendments that will further strengthen the bill.

Prior to talking about the amendments or the bill draft I would like to briefly outline to the Committee why I am here today. Last fall the Chairman of our Association was asked by a legislator what our position was on the educational requirements for nurses. That question prompted statewide discussion.

We conducted discussion groups in six regions of the state, asked the National Association of Directors of Nursing Administration of North Dakota for their input and position, discussed it within our Resident Issues Committee and Legislative Committee, explored the topic with legislators, conducted a survey of long term care nurses and finally at our December 13, 2000 Membership Meeting formulated our position and solution. During this time I worked closely with Dr. Constance Kalanek, Executive Director of the North Dakota Board of Nursing, exploring options that might be acceptable to both parties. During our exploratory process we found the majority of respondents, including nurses supported repealing the current educational standards, however this position would be strongly opposed by the North Dakota Board of Nursing.

In the true spirit of working toward common ground, the North Dakota Board of Nursing and our Association reached a "third alternative" that I truly believe will benefit North Dakota, consumers of health care and the nursing profession. Our amendment allows North Dakota to continue to maintain their academic requirements for nurses but allows those nurses who hold an out-of-state license, who apply for licensure in North Dakota and find they don't meet the educational requirements, to have two options in order to be allowed to practice in North Dakota.

elimination educational requirements ✓ 416-No 568-Yes

Currently a nurse who does not meet the educational requirements applies for a transitional license. In order to obtain a transitional license, a nurse must show 1) completion of a nursing education program approved by another state's Board of Nursing; 2) a current license by examination, approved by the State's requirement for license by examination; and 3) an unencumbered license.

Our proposed amendment provides the nurse-applicant described above a second option. As you know the only option available now is the nurse applicant must obtain an Associate Degree (LPN) or Baccalaureate Degree (RN) with a major in nursing within eight years. North Dakota Long Term Care Association's amendment adds continuing education as the second option available to the nurse. So rather than having only one option of returning to school, the nurse would agree to 30 hours of continuing education every license renewal cycle. A renewal cycle is two years. The continuing education parameters would be set by the North Dakota Board of Nursing, and could be tailored to the area of nursing practice relevant to the transitional nurse's job duties, if they so choose.

As it stand, this amendment has no impact on the 400 nurses presently in transition, although it is anticipated the North Dakota Board of Nursing would address this issue by rule. The amendment further does not address the nurse whose license lapsed because they did not obtain the proper academic requirements within eight years, who may now wish to practice under the CEU provision. It would only be through rule promogation by the North Dakota Board of Nursing could these situations be addressed. Our amendment is simply allowing another option to those experienced nurses deemed competent by another state, who desire a North Dakota license to practice here.

As you may be aware, long term care is in a nursing crisis and if this amendment removes one barrier to employment in North Dakota, we believe it merits your serious consideration and adoption. Currently we have 1,000 open positions in nursing facilities across North Dakota. The top vacant position is CNA, with RN's and LPN's second. Two-thirds of the nursing facilities term themselves in a staffing crisis and in 2000, two out of every five nursing facilities voluntarily stopped admissions because of insufficient staff to care for residents.

For nursing facilities LPN turnover is 24% and RN turnover is 33%. With the average age of long term care LPN's at 43 years and RN's at 44 year, this problem will become even more acute in ten and fifteen years when nurses decide to retire.

This amendment may be unconstitutional by violating the equal protection clause of the U.S. Const. In state and out-of-state nurses are required to meet different educational requirements, (I wish I was allowed to talk)

We recognize we have many barriers to employment. Salary and benefits, demands of the job, working evenings and weekends, rural North Dakota etc. We believe our amendment will remove one of those barriers by allowing those nurses duly licensed by another state, to practice in North Dakota.

I have explained only one amendment related to the nurse licensed by another state, the other amendments are being brought forward by the North Dakota Board of Nursing and would be best explained by Dr. Constance Kalanek, Executive Director of the North Dakota Board of Nursing. Amendment language related to CEU option are the two definitions of "Transitional practical nurse license" and "Transitional registered nurse license" and on Page 8 where it addresses transitional license renewals, "thirty hours continuing education activity." Prior to giving the floor back to Dr. Kalanek, I have received testimony by a nurse in her last year of transition who will lose her license on December 31, 2001 because she will not have met the academic requirements. She is a Minnesota resident, and works in North Dakota at TBI STEPS Program of Personal Achievement, the skilled nursing facility in Grafton who serves adults with severe head injuries. She is unable to be present and asked me to bring her story to you this morning.

Thank you for your consideration of our amendment and our support of SB 2114. I would be happy to answer any questions you might have at this time.

Shelly Peterson, President
North Dakota Long Term Care Association
1900 North 11th Street
Bismarck, ND 58501
(701) 222-0660

1/20/01

To Chairman Lee, Members of the Senate Human Service Committee

Thank you for the opportunity to submit my testimony and discuss the impact that Senate Bill No. 2114 could have on me. My name is Christine Dahlman; I reside in rural Stephen, Minnesota and currently have a transitional license as a Registered Nurse. In 1987, I graduated from East Grand Forks Technical College with my Practical Nursing degree. In 1993, I pursued my education, and graduated from Northland Community College with an Associate in Science degree. I am currently pursuing my baccalaureate degree through Regents College, however; I will not complete my education by the end of the year.

I have been a North Dakota State employee for the past fifteen years in which I have held several positions, most currently, being Director of Nursing for the newly developed Traumatic Brain Injury Unit in Grafton, North Dakota. I am also employed part time as a Practical Nursing clinical instructor for North Dakota State College of Science, Wahpeton, North Dakota. I am on my fourth renewal cycle for my license, which means effective December 31, 2001; I will not be able to practice nursing in North Dakota. I have a strong commitment towards education and I support and commend the Board of Nursing on their regulatory process to deliver quality nursing care to the public, however; I feel that my situation, at best, describes the majority of transitional nurses in the rural healthcare setting. It has been difficult to obtain my baccalaureate degree in the required time frame. Several factors need to be taken into consideration such as: raising a family, financial support, accessibility to education in the rural setting, employee accommodation, and different life circumstances. I am in favor of lifting the current academic requirements and converting to continuing education requirements like the adjoining states. ***I am asking that you support SB 2114 and the amendment by the North Dakota Long Term Care Association on CEU's. I believe that this amendment, if passed, will benefit the state of North Dakota, the rural community healthcare crisis, and predominately the people that we serve. Again, thank you for allowing me to express my concerns.***

Respectfully submitted,

Christine Dahlman, RN

PROPOSED AMENDMENTS TO SENATE BILL NO. 2114

Page 2, after line 28, insert:

"10. "Transitional practical nurse license" means a license issued by the board to a person who meets all of the requirements for licensure by endorsement as a licensed practical nurse, except the educational requirements.

11. "Transitional registered nurse license" means a license issued by the board to a person who meets all of the requirements for licensure by endorsement as a registered nurse, except the educational requirements."

Page 4, line 23, replace "Staff" with "A person"

Page 4, line 28, replace "Group" with "Within group"

Page 5, line 1, replace "Human" with "Within human" and remove "A licensed nurse may"

Page 5, remove lines 2 and 3

Page 5, after line 8, insert:

"**SECTION 4. AMENDMENT.** Section 43-12.1-05 of the 1999 Supplement to the North Dakota Century Code is amended and reenacted as follows:

43-12.1-05. Board of nursing - Composition - Term of office. There is a state board of nursing whose members must be appointed by the governor which must consist of five registered nurses, three licensed practical nurses, and one public member. Each board member must be appointed for a term of four years. No appointee may be appointed for more than two consecutive terms. An appointment for an unexpired term of more than eighteen months will constitute a full term. Terms of nurse board members must be evenly distributed to allow two licensed nurse board members to be appointed or reappointed each year. ~~The members of the board holding office on August 1, 1995, may continue to serve as members for their respective terms.~~"

Page 8, line 7, remove the overstrike over "~~Renewal requires proof of progression towards~~"

Page 8, line 8, remove the overstrike over "~~meeting the~~", after "~~educational~~" insert "academic", remove the overstrike over "~~requirements~~" and insert immediately thereafter "thirty hours continuing education activity"

Page 9, line 11, after "nurse," insert "specialty practice registered nurse,"

Page 9, line 19, after "certification" insert "or evaluation"

Page 9, line 22, after "certification" insert "or evaluation"

Page 10, line 21, remove "probate,"

Page 10, line 23, after "reprimand" insert ", place on probation"

Page 12, after line 9, insert:

"**SECTION 13. AMENDMENT.** Section 43-12.1-16 of the 1999 Supplement to the North Dakota Century Code is amended and reenacted as follows:

43.12.1-16. ~~(Effective through July 31, 2001)~~ Delegation of medication administration. A licensed nurse may delegate medication administration to a person exempt under subsection 9 of section 43-12.1-04."

Renumber accordingly

Entry Into Practice
Survey Results From Nurses
December 2000

1. Should the educational requirements for RN's and LPN's be eliminated?

   Yes: 65 or 59%
   No: 46 or 41%

2. Should we support an endorsement process?

Yes:	90 or 67%
No:	28 or 21%
Did not answer:	17 or 12%

3. Should the North Dakota Long Term Care Association take a position on this issue?

Yes:	72 or 67%
No:	25 or 23%
Undecided or No Answer:	10 or 10%

62 members responded to the survey with multiple responses from Mott Good Samaritan Center, Trinity Homes and the Baptist Home.

<u>Resident Issues Committee Recommendation:</u>
Work with the North Dakota University System to increase access to education in non-traditional ways. If access to affordable and non-traditional education is not achieved repeal entry-into-practice in the 2003 session.

<u>Legislative Committee Recommendation:</u>
Support the multi-state licensure legislation and work with the Board of Nursing in reaching an agreement on an amendment that would acknowledge licensed nurses in other states who wish to practice in North Dakota without pursing additional education.

Fifty-seventh
Legislative Assembly
of North Dakota

_____ BILL NO. _____

Introduced by

North Dakota Board of Nursing

A BILL for an Act to allow certain administrative agencies to enter into licensing compacts with other states.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Administrative agency compacts. An administrative agency as defined in subsection 2 of 28-32-01 may establish, by administrative rule, procedures for licensees in another state to be licensed in this state pursuant to a written agreement with another state, written licensing compacts with other states, or any other method of license recognition that ensures the health, safety and welfare of the public. Any compact or agreement by an administrative agency does not become binding on this state until implemented by administrative rule under this section.

Chairman Senator Judy Lee and other Members of the Senate Human Services Committee.

Thank you for this opportunity to testify on the Senate Bill 2114 amendment proposed.

I am Glenice Darwin, a graduate of Dickinson State College in 1971, with an Associate Degree in Nursing. I have been a Registered Nurse in ND for 30 years this summer. I am certified as a Gerontological Nurse by the American Nurses Credentialing Center Commission on Certification. I am also a certified Directer of Nursing Administration in Long Term Care through the National Association Directors of Nursing Administration in Long Term Care. I received by Bachelors of Science Degree in Health Services Administration from the University of Minnesota, Moorhead, MN.

I have been the Director of Nursing Service at the Arthur Good Samaritan Center, in Arthur, North Dakota since 1992. On occasion over this period of time I have had nurses quit in Oct/Nov/Dec. to move out of state because they choose not to invest two more years of their lives at a college of nursing to earn their degree. It is not a problem for these nurses to obtain a transitional license to practice in the state of ND, the problem arises when the nurse realizes just how much time away from their families will be required, how much driving is required at attend some classes and their clinical days, the cost of each credit hour they will be required to take, the cost of motel rooms and the gas, plus the cost of books, supplies and other expenses, they consider the

total cost of going on for their degrees and many cases feel they just can't do it. They choose to leave the state or drive to MN or SD and not incur the debt.

A couple of situations I would like to share briefly with you. A LPN I hired from the state of Oregon had excellent references. A Physician I contacted regarding her, highly recommended her for hire in LTC. He wished he could have her back as an employee. He spoke highly about her skills and devotion to his patients at their clinic and hospital. I hired her, she orientated easily and ahead of schedule for most LPN's. She worked for me for a year and decided to move to MN. She wanted to stay in ND because she has family here, but didn't choose to continue for her degree as the current relicensure requires. She was an excellent LPN of a one-year program in Portland, Oregon. She has kept in contact with us at the center and requests us to let her know if the state changes their criteria for relicensure. She would love to come back to our center if she does not have to go back to college for a degree. CEU's would not be an undo hardship.

Another case, an excellent LPN, choosing to be an Registered Nurse. She went part-time for me and choose an out of state college to complete her Associate Degree for RN. She past her boards and than left our home to work at the VA hospital in Fargo, since they are governmental and except any state license without a BSN. She doesn't have to prepare a schedule to obtain her BSN at this time since she has three children at home and chooses not to incur further educational debts.

These are just two situations that resulted in additional expense for our center. There are many more nursing concerns for rural LTC facilities regarding the shortage of nursing staff. For example not admitting residents that want to come to our facility because we don't have the nurses to care for them in the manner I believe they deserve for quality of life. I have on more than one occasion denied admissions due to the shortage of nurses in the past year and other years. I have had to use contract nurses in the past. I don't believe the quality of care is the highest possible when you need to use contract staff. They don't know and love our residents as we do. The cost of contract LPN's is $30/hr and for RN's $40/hr.

We try desperately to keep all our nurses because we are 32 miles from Fargo and are in competition with three large hospitals and five LTC facilities and other care providing agencies. So when I lose a nurse to another state due to our current licensure requirements, this truly concerns me for ND. The state population is growing older and we need these nurses to stay and be employed here within the state.

The Evangelical Lutheran Good Samaritan Society is the nation's largest non-profit provider of long term care services. The Society has 240 facilities located in 25 states and serves approximately 25,000 residents. There are 15 facilities located in North Dakota.

The Good Samaritan Society has invested significant funds to build the technology infrastructure for learning, connection, and sharing of data and information between the facilities and its Central Office. The Society has established a Distance Learning Network that links the facilities by satellite to its Central Office in Sioux Falls.

Because of the Society's rural locations and the shortage of long-term care employees, especially nurses, the Society is developing academic partnerships to provide nursing education for Good Samaritan Society Staff. The University of SD and South Dakota State University are working together with the Good Samaritan Society to offer course work for an Associate Degree in Nursing (RN) and a Bachelors Degree in Nursing and an increasing number of CEU's for nurses. These academic programs will be rolled out this fall in Minnesota, Nebraska, and Iowa. North Dakota is not under consideration for these distance degree nursing programs because of the current licensure requirement.

The Society is extremely supportive of this bill because it is flexible and responsive to where the delivery of education is going. Also, it would allow our facilities in ND to take advantage of its technology by training and developing our own staff and community members and therefore addressing the workforce shortage.

Please consider the proposed amendment to Senate Bill 2114. This amendment would allow any nurse who does not meet the educational standards for the state of ND to have two options. They could enroll in a degree program or choose to do the 30 CEU's for four renewal periods and not consider moving to another state.

Thank you for your time and consideration of this amendment.

North Dakota Healthcare Association

Vision
The North Dakota Healthcare Association will take an active leadership role in major healthcare issues.

Mission
The North Dakota Healthcare Association exists to advance the health status of persons served by the membership

2001 Session

SB 2114

Madam Chairman, members of Health and Human Services Committee, my name is Arnold Thomas. I am President of the ND Healthcare Association and am here in support of SB 2114.

SB 2114 is the culmination of a work effort that included hospitals and hospital nurse leaders. We think the provisions in this bill will provide appropriate tools and policy guidelines for today's health care environment as the BD seeks to fulfill it purpose.

We especially commend the BD's leadership in supporting the expansion of options available for licensed nurses to sustain and engage their professional skills in ND. In addition to complimenting existing professional standards and professional competency expectations, we think the continuing education provision will enhance the practice attractiveness of ND for licensed nurses practicing in other jurisdictions, whose professional interests are primarily rural focused.

We ask adoption of the continuing education amendment and a "Do Pass" of SB 2114.

PO Box 7340 Bismarck, ND 58507-7340 Phone 701-224-9732 Fax 701-224-9529

On behalf of the board, I wish to offer testimony in support of SB 2114 relating to the Nurse Practices Act 43-12.1.

Chairperson Lee and members of the Human Services Committee, my
My name is Kirsten Friedt. I am a Registered Nurse employed by ABLE, Inc. of Dickinson. I urge you to place a DO PASS on Senate Bill 2114. ABLE provides services to people with Developmental Disabilities; we are licensed under chapter 25-16. I have been employed by ABLE, Inc. for almost 11 years. Medication administration and delegation of nursing tasks have long been a gray area for nurses employed by facilities such as ABLE, Inc. I can remember discussing this very issue at the first nurse's meeting for people with developmental disabilities that I attended, just a few short months after I started.

Today I would like to speak to the exemption portion of this bill included in section three, subsection 9 both with the exemption effective through July 31, 2001 and effective after July 31, 2001. During the last legislative session I was not in favor of the exemption as it is noted through July 31, 2001. The exemption through July 31, 2001 exempts the DD provider from having to place staff administering medications on the North Dakota Board of Nursing's Medication Assistant Registry. However, it does not exempt the nurses employed by the DD provider from having to comply with the Nurse Practice Act. What this did was take the nurse out of the task of administering medications. Unlicensed assistive personnel are able administer medications without the nurse being involved.

The exemption as written to be effective after July 31, 2001 states the nurse may delegate medication administration to a person exempt from the provisions of chapter 43-12.1. This keeps the nurse involved in the task of administering medications when it has been delegated to unlicensed assistive personnel. This provision is in fact a compromise reached by the North Dakota Board of Nursing and the Department of Human Services. I was a member of the committee that deliberated over this issue. Although it is not perfect by any means it is workable and rational at this point in time. It continues to allow me, the nurse, to delegate to the staff the duty of administering medications. This includes insuring the person administering medications meets competency standards.

Once again, I urge you to place a do pass on Senate Bill 2114. Thank you for your time and attention to my testimony.

Testimony Before the Human Services Committee

SB 2114

Chairperson: Senator Judy Lee

January 22, 2001

Chairperson Lee and members of the committee,

My name is Bonnie Seizler; I am the Assistant Director of Mental Health and represent the Department of Human Services on the Medication Administration Committee.

In response to HB 1403 of the 1999 legislative session, representatives from the Department of Human Services, the Board of Nursing, the North Dakota Medical Association, the North Dakota Nurses Association, the North Dakota Association of Community Facilities and other private providers met regularly to discuss the ramifications of unlicensed staff providing medication. The results of those efforts were previously reported to the Interim Budget Committee on Health Care as directed by HB 1403.

The changes detailed in subsection 9 of Section 3 of Senate Bill 2114 reflect the consensus of that group. However, the Department requests an amendment to the bill to clarify line 23 item 9 c to read:

Line 23 item "9. Group homes, residential child care facilities, and adult foster care facilities licensed under section 50-11, or"

The Department of Human Services supports Senate Bill 2114.

I am happy to answer any questions you may have.

NORTH DAKOTA BOARD OF NURSING

919 S 7th St., Suite 504, Bismarck, ND 58504-5881

Web Site Address: http://www.ndbon.org
Telephone # (701) 328-9777
Nurse Advocacy # (701) 328-9783
Fax # (701) 328-9785

HUMAN SERVICES COMMITTEE

TESTIMONY RELATED TO SB 2114

Chairperson Lee and members of the Human Services Committee, my name is Constance Kalanek, Executive Director of the North Dakota Board of Nursing.

On behalf of the board, I wish to offer testimony in support of SB 2114 relating to the Nurse Practices Act 43-12.1.

The North Dakota Board of Nursing works diligently to establish and maintain rules and regulations that protect and serve the public. In 1995, the Nurse Practices Act was subject to major revisions, which also resulted in several rule revisions.

The board currently licenses 8271 registered nurses of which 61% hold a bachelor's degree or higher, 3173 licensed practical nurses of which 48% hold an associate degree, and 443 advanced practice nurses. The board also maintains a nurse assistant registry of 2122 nurse assistants and 238 medication assistants.

The proposed revisions of the Nurse Practices Act 43-12.1 began with the first meeting of the Nurse Practice Committee established by the board in May 2000. This committee was established to provide expertise from areas of nursing practice not represented on the board and to make recommendations to the board on issues relevant to current practice. This committee comprised of 23 individuals, represents nursing practice, administration (hospital and LTC), ND Department of Health, North Dakota Licensed Practical Nurse Association and the North Dakota Nurses Association. The committee met in May, June, August, and September 2000.

The following is a section by section summary of the revisions made to the Nurse Practices Act 43-12.1 along with rationale for the changes.

Section-by-Section Summary of Proposed Revisions to Chapter 43-12.1 Nurse Practices Act

SECTION ONE: DEFINITIONS

The most important revision in this section is the definition of "**Unlicensed assistive person**". This proposed definition provides for utilization of an assistant to the nurse in a variety of roles in their field regardless of title. Unlicensed assistive person may include but are not limited to nurse assistant, surgical and dialysis technicians and medical assistants.

The proposed definition for "**specialty practice registered nurse**" will provide for recognition and licensure of nurses who practice a specialty but who do not meet the qualification for advanced practice. The specialty practice registered nurse must be currently licensed as a registered nurse, in good standing, and not be the subject of current disciplinary action. Examples include but are not limited to the registered nurse first assistant (RNFA), diabetic educator, or enterostomal therapist.

SECTION TWO: LICENSED REQUIRED

This section states that any person who provides nursing care to a resident of this state must hold a current license or registration issued by the board. The proposed revision inserts the category of specialty practice registered nurse and deletes the words "**a nurse assistant**" and replaces it with "**unlicensed assistive person**".

SECTION THREE: PERSONS EXEMPT

In this section the term **tasks** is replaced with the word **interventions**. This is congruent with the updated terminology used in the nursing profession. It is a broader term that encompasses more than the basic technical skills.

This section also provides for an **exemption for medication administration** for facilities licensed under chapter 25-03.2, chapter 25-16, and chapter 50-11. The 1995 Nurse Practices Act - NDCC 43-12.1-04(9) exempted DD provider agencies, foster care providers, and human service centers from registry of assistive personnel from medication administration. This exemption has continued and will sunset July 31, 2001.

A joint committee of the Department of Human Services and the Board of Nursing was established according to the requirements contained in HB 1403 during the 1999 Legislative Session. The committee met on September 9, September 22, October 12, November 10, December 16, 1999. Executive Summaries are available for your review.

The rationale for this exemption includes the following:

- The NDDHS facilities will monitor certified medication assistants through the use of the Medication Assistant Programs registry at Minot State University in conjunction with the Protection and Advocacy Program.
- This is not an exemption from the nurse assistant registry.
- Background checks are conducted on individuals employed by the facilities/agencies under the purview of the ND Department of Human Services.
- An up-to-date list of names of individuals successfully completing the Medication Assistant I Course is supplied to the North Dakota Board of Nursing beginning in May 1999.
- The Board of Nursing approves the Medication Assistant Courses I & II.
- NDDHS will include in contracts with providers or in a rule revision a requirement that employees of facilities administering medications complete a North Dakota Board of Nursing approved Medication I Course.
- NDDHS will be responsible to establish a standard reporting mechanism for providers on medication errors and will review the submitted reports with the BON.
- In an effort to provide quality nursing care in those facilities the Board has proposed a revision of the definition of consultative nurse and the addition of definitions for assisting with self-administration of regularly scheduled or routine medications and basic nursing interventions. (See attached)
- The revision of the definition of consultative nurse provides direction for nurses who are delegating to unlicensed personnel and is broad enough to cover consultative nursing regardless of employment setting.
- The nurse is accountable to the board of nursing and the facility to follow the standards of practice for an identified role, i.e. RN, LPN.

This section continues to provide protection to the nurse who delegates medication administration in the above settings. According to the **Attorney General's Opinion dated December 4, 2000,** "despite the limitation provided by NDAC 54-05-04-05(9), medication administration may be delegated to a person exempt under NDCC 43-12.1-04(9) pursuant to NDCC 43-12.1-16 until August 1, 2001. If this protection were not provided for the nurses providing consultative services to these facilities, they may indeed be in violation of NDCC 43-12.1. The opinion is attached.

SECTION THREE: EXEMPTIONS (CONT).

North Dakota practitioners must be licensed to practice nursing. This section (Page 5, Line 4, Subsection 10) would exempt individuals licensed in another jurisdiction with a ND employer to attend orientation, meetings, or required continuing education without obtaining a ND license. Specifically, health care facilities located on the ND, Minnesota, SD, and Montana borders have satellite clinics and smaller hospitals, which employ nurses licensed in Minnesota, Montana and SD.

Due to the significant changes in the health care environment and the establishment of large health care corporations across state borders, many nurses who reside in a

contiguous state must attend required inservices or orientation from the ND employer in the North Dakota work site. Also, a number of national corporations and organizations employ nurses strictly to provide either consultation or education in North Dakota for limited time frames.
Subsection 10 also specifically provides for nurse consultants to practice in the state on a limited basis. Examples include but are not limited to presenting in-services, reviewing policy and procedures; working as a sales representative. Guest lecturer, short-term consultant, and evaluation specifics will be further defined in the rules.

SECTION FOUR: COMPENSATION OF BOARD MEMBERS

This section deletes the current language and replaces it with language consistent with other regulatory boards in North Dakota. The proposed language is much more specific and more useful for budgetary purposes. The board of nursing is the only board to use the current language

SECTION FIVE: POWERS AND DUTIES OF THE BOARD

This section replaces the term nurse assistant with unlicensed assistive person to be consistent throughout the NDCC 43-12.1.

Subsection 12 (Page 6, line 22) addresses the **Nurse Advocacy Program (NAP).** The program addresses issues of impairment and is confidential in nature. Evaluation and treatment of NAP participants is obtained from programs and treatment professionals who are mandated by statutory confidentiality laws. The NAP records and program results that reflect such action should likewise be protected.
Subsection 13 (Page 6, line 24) adds the word applicants to provide for disciplinary action by the board for individuals who have a positive response to the licensure questions.

SECTION SIX: LICENSURE - REGISTRATION

This section deletes the requirement of proof of progression towards meeting the educational requirements for endorsed nurses that do not meet the educational requirements established by the board. The proposed amendment would re-instate this sentence.

Subsection six (Page 8, line 25) makes the editorial changes described in Sections one and two related to the nurse assistant. Also, added proof of certification as a mechanism for registry status.
Subsection seven (Page 8, line 30, Page 9, lines1-7) identifies the requirements for obtaining a specialty practice license for the registered nurse.

SECTION SEVEN: LICENSE-REGISTRATION-RENEWAL

This section eliminates the residency requirement and is a recommendation by legal counsel. It legally may be unconstitutional. ND is the only state with a residency requirement for nurses. Employment by a federal agency is addressed in NDCC 43-12.1-04 (3). Subsection 2 (Page 9, Line 17) clearly outlines the requirements for placement on the nurse assistant (unlicensed assistive person) registry.

SECTION EIGHT: DUTIES OF LICENSEES

This section adds "registrants" or "registered" to the current language. This will provide for the individuals on the nurse assistant registry to be held to the same standard as the licensee when asked to provide information to the board or to report potential violations. It also provides for consistency.

SECTION NINE: DISCIPLINARY PROCEEDINGS.

This section is intended to address the increased cost for legal services for complex cases. It also clarifies how the boards of nursing of other states are notified. Effective November 1999 federal law required reporting to national data banks.

SECTION TEN: GROUNDS FOR DISCIPLINE-PENALTIES

This section specifically outlines board authority. The BON has conducted an alternative to discipline program entitled the Nurse Advocacy Program for nurses with identified impairments of chemical dependency, psychiatric impairments, and or physical disorders. It has been in operation for 10 years and has had a total of 92 participants (57 RNs, 35 LPNs) since its inception. The change in this section gives the board the authority to ask for evaluation and treatment when impairment is reported to the board.

The other revisions would allow for voluntary surrender or emergency suspension of one's license to practice nursing. The revisions would be further defined in the rules.

Subsection 2 (Page 11,Line 1) adds registration and assist in the practice of nursing for inclusion of the unlicensed assistive person (nurse assistant). **Restricted** is replaced with **sanctioned** is a broader term to encompass other jurisdiction's terminology.

Subsection 5 (Page 11, Line 9) has been clarified by inserting the language of professional misconduct which would be further defined in the rules as it is for the deleted terms. Examples of professional misconduct include, but are not limited to a departure or failure to conform to standards of practice; endangering a patient's life, health, or safety; misconduct could include non-payment of medications; non-payment of Nursing Education Loan; patient abandonment; negligence; or failure to adhere to professional code of ethics.

Subsection 6 (Page 11, Line 13-14) has been revised to include supplies and equipment and drug diversion for personal use is more specific.
Subsection 9 (Page 11, Line 19-21) specifically identifies responsibilities of licensee; Globally identifies any violation within the authority of the board.

SECTION ELEVEN: VIOLATION – PENALTIES.
Refer to Sections one and two.

AMENDMENTS
The board proposes the following amendments. See handcut.

CONCLUSIONS

Individual licensed nurses are accountable for their actions. This includes the performance of or supervision of the performance of activities and functions requiring the knowledge, skills and abilities currently ascribed to the licensed nurse. The Board of Nursing will continue to evaluate nursing practice according to the provisions of the Nurse Practices Act, the legal standards of nursing as promulgated through the Administrative Rules of the Board of nursing, and collective wisdom of the appointed board members. The board will continue to carry out its mission as to the safety of the specific nursing practices, protection of the public and the provision of competent practitioners. Thank you for giving me the opportunity to provide testimony on behalf of the North Dakota Board of Nursing.

I am now open for questions.

STATE OF NORTH DAKOTA
OFFICE OF ATTORNEY GENERAL
STATE CAPITOL
600 E BOULEVARD AVE
BISMARCK ND 58505-0040
(701) 328-2210 FAX (701) 328-2226

Heidi Heitkamp
ATTORNEY GENERAL

DEC 1 2

December 4, 2000

Honorable Judy L. DeMers
State Senator
2200 South 29th Street, Apt. 92N
Grand Forks, ND 58201-5869

Dear Senator DeMers:

Thank you for your letter inquiring about the delegation authority of licensed nurses under North Dakota's Nurse Practices Act, N.D.C.C. ch. 43-12.1.

The Nurse Practices Act defines nursing to include "[a]dministration, teaching, supervision, delegation, and evaluation of health and nursing practices." N.D.C.C. § 43-12.1-02(6). The authority of a nurse to delegate to nurse assistants is necessarily implied from the definition of "nurse assistant" as "a person who is authorized by the board to perform nursing tasks delegated and supervised by a licensed nurse." N.D.C.C. § 43-12.1-02(5). "Nurse" is defined in N.D.C.C. § 43-12.1-02(4) as "any person currently licensed as an advanced practice registered nurse, registered nurse, or licensed practical nurse."

N.D.C.C. ch. 43-12.1 only authorizes delegation by a nurse to a person exempt from the Nurse Practices Act pursuant to N.D.C.C. § 43-12.1-16. "A licensed nurse may delegate medication administration to a person exempt under subsection 9 of section 43-12.1-04." N.D.C.C. § 43-12.1-16 (effective through July 31, 2001). 1999 N.D. Sess. Laws. ch. 376, § 4. Subsection 9 of section 43-12.1-04 exempts from the Nurse Practices Act "[a] person who provides medication administration according to individual needs and as part of an individual habilitation or case plan within a residential treatment center for children licensed under chapter 25-03.2, a treatment or care center for developmentally disabled persons licensed under chapter 25-16, or a residential child care facility licensed under chapter 50-11."

Pursuant to the authority provided to the Board of Nursing in N.D.C.C. § 43-12.1-08(2), the Board has adopted rules to define delegation and regulate its use . See, for example, N.D.A.C. § 54-05-00.1-01(6) and chs. 54-05-04, 54-07-05, and 54-07-08. N.D.A.C. § 54-05-04-05 prohibits delegation by a licensed nurse for nine listed activities. Subsection 9 of that section prohibits delegation of medication administration unless it is to a nurse assistant who has met the requirements of N.D.A.C. ch.

54-07-05. That subsection also provides an exception to its own limitation for specific delegation to a specific nurse assistant for the administration of a specific medication to a specific client.

The Legislature grants rulemaking authority to administrative agencies by statutory delegation. However, the Legislature may also retract authority previously delegated to an agency. Trinity Medical Center v. North Dakota Board of Nursing, 399 N.W.2d 835, 848 (N.D. 1987). Therefore, under the circumstances provided for delegation under N.D.C.C. § 43-12.1-16 to those persons identified in N.D.C.C. § 43-12.1-04(9), the Legislature has, for the period of effectiveness of those statutes, overridden the rules of the Board of Nursing that are contrary to those sections. Therefore, it is my opinion that despite the limitation provided by N.D.A.C. § 54-05-04-05(9), medication administration may be delegated to a person exempt under N.D.C.C. § 43-12.1-04(9) pursuant to N.D.C.C. § 43-12.1-16 until August 1, 2001, when that statute expires. It is my further opinion that except for delegation pursuant to N.D.C.C. § 43-12.1-16, licensed nurses may only delegate to a nurse assistant.

Sincerely,

Heidi Heitkamp
Attorney General

rel/pg

PROPOSED REVISIONS TO NDAC TITLE 54
RULE REVSION

Definitions.

Current:

54-07-01-02(5) "Consultative Nurse" means a licensed nurse who provides guidance and information as a participant of the interdisciplinary team but is not individually responsible to direct the plan of care for the client.

Suggested Replacement 54-07-01-02(5)

"Consultative Nurse" means a licensed nurse who provides guidance and information related to nursing procedures and interventions to the facility or agency but is not individually responsible to provide or direct the plan of care for the client.

Suggested addition to Article 54-07-01-02 Nurse Assistant: (revision to Unlicensed Assistive Person after Nurse Practices Act enacted)

54-07-01-02. Definitions.

2. "Activities of daily living" includes transferring, ambulating, repositioning, exercising, toileting, feeding, and assistance with self-administered of regularly scheduled or routine medications and personal cares. Personal care includes but is not limited to bathing, hair care, nail care, shaving, dressing, ~~and~~ oral care, and maintenance of a safe environment. Basic interventions vary from setting to setting depending on the client population served and the acuity and complexity of the client's care needs.

3. "Assisting with Self Administration of Regularly Scheduled or Routine Medications" means helping the client with one or more steps in the process of taking medications but does not mean "administration of medication" as defined in the rules. Examples of "assisting" include, but are not limited to opening the medication container or reminding the client of the proper time to take the medication. Assisting with the administration of medication may be a delegated intervention.

RNFA Responsibilities

Along with first assisting the surgeon, RNFA responsibilities include:

- Evaluating the needs of the patient and of the surgical team on a continuum throughout the surgical experience.
- Collaborating with the surgeons and other health care professionals for an optimal surgical outcome.
- Performing followup care to evaluate the patient's condition.
- Participating in discharge planning and post-operative teaching.

Who recognizes RNFA practice?

First assisting is within the scope of nursing practice of all fifty state boards of nursing. Many major professional organizations recognize the RNFA role, including

- The Association of periOperative Registered Nurses, Inc (AORN),
- The American College of Surgeons (ACS),
- National League of Nursing (NLN),
- The American Nurses Association (ANA), and
- The National Association of Orthopedic Nurses (NAON).

Why does my doctor choose an RNFA?

In this age of skyrocketing health care costs, RNFAs are a cost-effective surgical assistant provider. Decreasing costs is an important issue to both doctors and patients. RNFA's help to make this possible without compromising patient safety or quality of care. Their experience, knowledge, skills and qualifications make them a valuable member of the health care team.

As a concerned health care consumer, you can empower and "assist" YOURSELF by requesting your surgeon employ the services of an RNFA.

Registered Nurse First Assistant:

"Combining knowledge and skill for assistive solutions!"

For further information regarding Registered Nurse First Assistants contact:

AORN, Inc
RN First Assistant Specialty Assembly
2170 South Parker Road, Suite 300
Denver, CO 80231-5711
http://www.aorn.org/groups/sa/RNFA.htm
http://www.aorn.org/patient/index.htm
http://www.aorn.org/patient/rnfafact.htm

REGISTERED NURSE FIRST ASSISTANT

You are having surgery.

Your doctor says an assistant is needed for your surgical procedure.

Your assistant will be an RNFA . . .

RN FIRST ASSISTANTS

"A quality, cost-effective alternative for the surgical patient"

Amid America's inevitable health care reform changes and insurance cutbacks, the nationally recognized profession of Registered Nurse First Assistant (RNFA's) is proud to announce its unique position to offer cost-effective, quality first assisting and nursing care for the surgical patient with education and support for the family.

As an educated, board certified, and licensed professional, the RNFA can provide a multiple-role solution to our health care crisis that is in alignment with today's health care reform philosophy.

As a provider of surgical assisting, the RNFA is often reimbursed by insurance companies for services rendered at a significantly lower cost to the consumer and insurance industry while providing safe quality patient care.

What is an RNFA?

RNFA stands for Registered Nurse First Assistant. This is a registered nurse who through additional education and training has obtained the necessary technical skills and knowledge to function as the assistant to the surgeon during an operation.

Additionally, the RNFA is competent to perform individualized nursing care management before and after surgery.

How does a Registered Nurse become a first assistant?

An experienced RN attends a formal RNFA education program offered by many colleges throughout the country. This involves one academic year of both classroom and supervised clinical training overseen by a surgeon preceptor. Upon completion, the RN is awarded a certificate signifying RNFA status indicating the ability to assist the surgeon at the operating field as well as the bedside.

To be accepted to an RNFA program, the RN must have at least two years of professional nursing experience in an operating room environment and the CNOR designation or have an advanced practice degree.

To achieve national certification, represented by the CNOR credential, the RN must successfully complete a nationally recognized exam. CNOR status indicates the RN's proficiency in the practice of caring for patients perioperatively (before, during, and after surgery). This certification provides a credential from the Certification Board of Perioperative Nursing and is recognized by the Association of periOperative Registered Nurses (AORN) as documentation of professional achievement based on AORN standards of practice.

Certification as a RN First Assistant (CRNFA) can be achieved after completing a specified number of hours as a first assistant and passing a nationally recognized exam. CRNFA status documents validation of the professional achievement of identified standards of practice by an individual Registered Nurse First Assistant providing perioperative care.

Where do RNFAs practice?

RNFAs are employed by hospitals, surgery centers, clinics, physicians, or self-employed independent providers. They also practice as educators and administrators. The duties performed depend on the practice setting, experience, individual state laws, institutional regulations, and specialty areas in which they practice.

Susan McMahon

Senate Bill 2114

Specialization in nursing practice has been a major advancement in nursing over the last few decades. Three forces initiate movement toward specialization:
New knowledge pertinent to the field
Technological advance
And response to public need.

The development of the Registered Nurse First Assistant is the result of changes in the health care delivery system and insurers' greater attention to cost-effectiveness.

The scope of practice for the Registered Nurse First Assistant is a part of the specialized practice of perioperative nursing. The RNFA assists the surgeon in the performance of the surgical procedure, from the preoperative assessment through thesurgical intervention, recovery, and discharge of the patient.

Currently the board of nursing in all fifty states recognizes the RNFA role as being within the scope of nursing practice. The Association of periOperative Registered Nurses, the American College of Surgeons, the American Nurses Association, and the National Association of Orthopedic Nurses also recognize RNFAs.

To be eligible for certification the Registered Nurse First Assistant must:

1. be currently licensed as a registered nurse , without provision or condition
2. must be a Certified Nurse Operating Room (CNOR) and must maintain that status throughout the entire period of CRNFA certification
   The CNOR itself involves two years of perioperative experience, current licensure as a registered nurse, and successful completion of the certification exam.
3. must have a BSN degree as of January 1,2000
4. must have completed 2000 documented hours of practice as an RNFA
5. must have completed a formal RNFA program follow standards of ARN

The category of Specialty Practice Registered Nurse recognizes the experience and expertise of the CRNFA. Our education is extensive and is a definite benefit to our patients, the citizens of North Dakota.

REGISTERED NURSE FIRST ASSISTANT
CONSUMER FACT SHEET

Registered Nurse First Assistant (RNFA)
A quality, cost-effective alternative for the surgical patient

Amid America's inevitable health care reform changes and insurance cutbacks the nationally recognized profession of Registered Nurse First Assistant (RNFA) is proud to announce their unique position to offer cost effective quality first assisting and nursing care for the surgical patient.

As an educated, licensed professional, the RNFA can provide a multiple-role solution to our health care crisis, which is in alignment with today's health care reform philosophy.

As a provider of surgical assisting, insurance companies may reimburse the RNFA for services rendered at a significantly lower cost to the consumer and insurance industry without compromising the quality of patient care.

The RNFA is a Registered Nurse with a minimum of five years clinical/didactic education, certification, and experience. These five years include the following chronological requisites:

- At least two years secondary education for Registered Nurse (RN) licensure.
- At least two years practicing professional nursing in the operating milieu
- Achievement of national Certification in Operating Room Nursing (CNOR) which indicates:
  - satisfactory completion of two years perioperative nursing
  - proficiency in the practice of caring for patients perioperatively
  - documented validation of professional achievement of identified standards of practice as
  - defined by the national Association of periOperative Registered Nurses (AORN)
  - extraordinary concern for accountability to the general public for nursing practice

- Education for the RNFA indicates the ability to assist the surgeon at the operating room table as well as the "bedside", evidenced by:
  - competency in performing individualized surgical nursing care management before, during, and after surgery
  - competency in recognizing surgical anatomy and physiology and operative technique related to first assist
  - competency in carrying out intraoperative nursing behaviors of handling tissue, providing exposure, using surgical instruments, suturing, and controlling blood loss
  - competency in recognizing surgical hazards and initiating appropriate corrective and preventative action including but not limited to recognizing abnormal lab values and diagnostic test results
  - achievement of Basic Cardiac Life Support

The RNFA is responsible preoperatively for:

- Interviewing the surgical patient for a comprehensive health history
- Performing nursing physical assessments
- Educating the patient and offering emotional support
- Evaluating the needs of the patient and of the surgical team on a continuum throughout the surgical intervention

The RNFA is responsible intraoperatively for:

- Collaborating with the surgeon and the other health care professionals for an optimal surgical outcome
- Assisting the anesthesiologist when applicable
- Assisting with patient positioning, skin preparation, and draping
- Providing wound exposure
- Handling tissue appropriately to reduce the potential for injury
- Using and manipulating surgical instruments skillfully
- Controlling blood loss
- Suturing tissue

The RNFA is responsible postoperatively for:

- Assisting in the safe delivery of the patient to the recovery room
- Communicating to appropriate health care personnel and family members
- Performing follow-up care to evaluate patient condition
- Participating in discharge planning and postoperative teaching

REGISTERED NURSE FIRST ASSISTANT

Combining knowledge and skill for assistive solutions

COMMONLY ASKED QUESTIONS ABOUT REGISTERED NURSE FIRST ASSISTANTS (RNFA'S) AND REIMBURSEMENT

Who are the members of the surgical team?

The members of the surgical team are the surgeon, the anesthesiologist, the registered nurse who functions in the circulating nurse role, the registered nurse or a surgical technologist who functions in the scrub nurse role and the registered nurse who functions in the role as the first assistant to the surgeon.

What is the role of the RN First Assistant?

The role of the Registered Nurse First Assistant (RNFA), as reflected in the RNFA Consumer Fact Sheet, is collaborative with the surgeon. It begins when the need for surgical intervention is identified, continues through the surgical procedure and is completed when the patient is discharged from the surgeon's care. The unique role of the Registered Nurse First Assistant (RNFA) has emerged out of changes in the health care delivery system and insurance cutbacks. The RNFA is the only licensed alternative to the MD assistant in surgery and can provide cost-effective, knowledgeable, educated surgical assisting without reducing the quality of patient care.

Are RNFA's recognized on a state and national level?

Yes. RNFA's are recognized by the

- American College of Surgeons (ACS)
- Association of Operating Room Nurses (AORN)
- American Nurses Association (ANA)
- National Association of Orthopedic Nurses (NAON)

Do all surgical procedures require two surgeons?

No. Most procedures require only one primary surgeon with an educationally prepared nonphysician first assistant, such as the RNFA.

In conclusion,

With their time at a premium and decreasing reimbursement, surgeons are increasing the utilization of the RNFA's services. Health care reform is a virtual reality. Reimbursement of a qualified, educationally prepared, licensed nonphysician can serve the public's health care needs at a substantial cost savings to the insurance carrier and to the consumer.

RNFA's are credible alternatives for providing surgical assistance throughout all phases of a patient's surgical experience. With today's trend to reduce health care spending, the role of the RNFA is viewed as a safeguard against any reduction in quality or continuity of health care.

CERTIFICATION PROGRAM FOR REGISTERED NURSE FIRST ASSISTANTS OFFERED BY THE CERTIFICATION BOARD PERIOPERATIVE NURSING

Definition

Certification is defined as: The documented validation of the professional achievement of identified standards of practice by an individual registered nurse providing care for patients before, during and after surgery.

Objectives of the Certification Program

- Recognizes the individual registered nurse who is proficient in practice.
- Strengthens conscious use of theory in planning and implementing patient care.
- Enhances professional growth through continued learning that results in broader knowledge and expanded skills.

Purposes of Certification

- Demonstrate concern for accountability to the general public for nursing practice.
- Enhance quality patient care.
- Identify RNFA's who have demonstrated professional achievement in providing care for patients during surgical intervention.
- Provide employing agencies with a means of identifying professional achievement of an individual RNFA.
- Identify professional nurses practicing in an expanded role.

Eligibility

Any registered nurse who meets the following requirements may apply for certification. **EVERY REQUIREMENT MUST BE MET AT THE TIME OF APPLICATION.**

1. The applicant must be currently licensed as a registered nurse, without provision or condition, in the country where currently practicing.
2. The applicant must be a CNOR at the time of application and must maintain CNOR status during the entire period of CRNFA certification.
3. The applicant must have successfully completed a structured educational course based on the core curriculum for the RNFA.
4. The applicant must have completed at least 2000 hours of practice as an RNFA. This practice includes pre and postoperative patient care as well as practice within the operating room. It may include hours of practice in an RNFA internship or practicum. It does not include attendance of classes, programs or seminars. **Written documentation of the 2000 hours of practice must accompany this application.**
4. The applicant must have completed at least 500 of the required practice hours within the two years prior to application.

The CBPN (Certification Board Perioperative Nursing) recently included, as part of its strategic plan, the BSN or MSN as a criterion for certification. This plan will be implemented in the year 2000. This change reflects the Board's decision to support a professional standard. This criterion brings certification in accordance with its purpose. Meanwhile, the time frame provides sufficient notification for those nurses without plans for further education to become certified. It is not the Board's wish to penalize nurses without nurses degrees, but to encourage them to meet this professional standard.

Those who are already certified will not need a BSN or MSN as long as CNOR certification does not lapse.

Recertification

CRNFA certification is conferred for a period of five years. To recertify, CRNFA's must either:

1. Achieve a passing score on the examination; or
2. Provide written documentation of 100 acceptable contact hours related to RNFA practice (over and above the CNOR contact hours)

Documentation of 2000 practice hours as an RNFA will be required as part of the eligibility criteria.

REGISTERED NURSE FIRST ASSISTANT
EDUCATIONAL COURSE

The Registered Nurse First Assistant program is designed to provide the experienced perioperative nurse with the advanced preparation necessary to assume the role of first assistant. The nursing process is utilized as the basis for providing nursing care to patients requiring surgical intervention. The program is based on the Core Curriculum for the RNFA.

Prerequisites

A. Two years of recent perioperative experience in scrubbing and circulating, and/or first assisting.

B. Must be CNOR or CNOR eligible with CNOR status obtained before a certificate of program completion is awarded. Verification of current RN license and CNOR status must be submitted.

C. CPR certification required.

D. Must submit two letters:

1. One of recommendation validating:
   a. Proficiency in the roles of scrubbing, circulating, or first assisting
   b. Ability to perform effectively in stressful and emergency situations
   c. Ability to perform effectively and harmoniously as a team member
   d. Ability to perform effectively as a leader
2. One from surgeon/physician agreeing to fulfill the preceptor role during the independent clinical internship.

The program consists of three components:

A. Preclassroom Component - Consists of reading assignments with accompanying feedback analysis to be complete prior to the one week didactic session. Begins approximately six weeks prior to didactic component.

These texts are required:

1. Core Curriculum for the RNFA - (from AORN)
2. Rothrock, J. (1993). THE FIRST RN ASSISTANT; AN EXPANDED PERIOPERATIVE ROLE. J. B. Lippincott: Philadelphia
3. Clinical surgical text of choice
4. Also suggested:
   Current AORN standards
   Bates, B. (1987 or most recent edition). A GUIDE TO PHYSICAL EXAMINATION AND HISTORY TAKING. 4th edition. J. B. Lippincott: Philadelphia
   Zollinger. ATLAS OF SURGICAL PROCEDURES. Anatomy and Physiology.
   Brown. Physical Assessment Text

B. The Didactic Learning Session - The classroom component is designed to provide the RNFA

candidate with the intellectual concepts and manual techniques necessary to first assisting. This session includes 48 hours of lectures and manual dexterity laboratory sessions on knot tying and suturing. The objectives are based on the Core Curriculum for RN First Assistants.

1. Discuss the evolution of the RN as a first assistant and their role as a surgical team member
2. Identify behaviors of the RN first assistant
3. Describe factors influencing scope of practice
4. Discuss legal issues and documents that delineate legal responsibilities for the RN first assistant
5. List methods of providing exposure, hemostasis, and safe tissue handling
6. Demonstrate basic knots with modifications and combinations of same
7. Demonstrate basic suturing methods for wound closure
8. Recognize proper techniques of asepsis, infection control, and wound healing.
9. Describe the anatomy, physiology, and disease processes as they relate to each of the specialty areas and specific operations
10. Recognize surgical hazards and identify appropriate nursing actions
11. Discuss types of job descriptions, personnel scheduling systems and implement evaluation systems within a hospital facility
12. Identify and demonstrate knowledge of drugs used in pre and postop care, OR and anesthesia
13. Discuss current credentialing processes available to the RNFA's
14. Discuss application methods for practice privileges and reimbursement

C. Independent Clinical Internship - This component is designed to practice the necessary clinical learning experiences for the perioperative nurse who wishes to function in the expanded role of an RNFA. The internship will be supervised and mutually planned by the physician preceptor and the RNFA student. Each student will actively participate in determining their objectives, identifying learning resources, and evaluating attainment of goals for their individual learning needs. The physician preceptor will assist the student in learning independent intraoperative behavior necessary for the RNFA role. These include:

- tissue handling
- suturing and knot tying
- providing hemostasis and exposure
- use of surgical instruments

The RNFA student will consult with the program faculty coordinator and function under the direct supervision of the surgeon preceptor during the entire clinical internship. The independent structure of the clinical internship component demands the student to be highly disciplined, motivated, and self-directed with attention directed toward goal setting and achievement. The internship will be 120 hours specific to the role of the RNFA. This component must be completed within the maximum time frame of twelve months. A certificate of program completion will be issued after successful completion of all components.

CNOR EXAM OFFERED BY CERTIFICATION BOARD PERIOPERATIVE NURSING

Definition

CNOR certification is defined as: The documented validation of the professional achievement of identified standards of practice by an individual registered nurse providing care for patients before, during and after surgery.

Objectives of the Certification Program

- Recognizes the individual registered nurse who is proficient in practice.
- Strengthens conscious use of theory in assessing, planning, implementing, and evaluating patient care.
- Enhances professional growth through continued learning that results in broader knowledge and expanded skills.

Purposes of Certification

- Demonstrate concern for accountability to the general public for nursing practice.
- Enhance quality patient care.
- Identify registered nurses who have demonstrated professional achievement in providing preioperative nursing care.
- Provide employing agencies with a means of identifying professional achievement of an individual perioperative nurse.
- Provide personal satisfaction for practitioners.

Eligibility

Any registered nurse who meets the following requirements may apply for certification. **EVERY REQUIREMENT MUST BE MET AT THE TIME OF APPLICATION.**

1. The applicant must be currently licensed as a registered nurse, without provision or condition, in the country where currently practicing.
2. The applicant must have completed a minimum of two year perioperative practice as a registered nurse in an administrative, teaching, research, or general staff capacity. The practice may be full or part time. There must be at least 2400 hours during that two year period.
3. The applicant must have been employed at some time within the last two years prior to application, either full or part time, in an administrative, teaching, research, or general staff capacity in perioperative nursing as a registered nurse.

Recertification

1. Achieve a passing score on the program.
2. Provide written documentation of 100 acceptable contact hours.

January 22, 2001

Testimony : To Senate Human Services Committee

Chairperson Lee and Committee Members:
My name is Mary Smith. I am testifying on behalf of the North Dakota Nurses Association on SB 2114.

The Nurses Association commends the Board of Nursing for their work and for the process of open communication and for involving nurses from numerous practice areas in making decisions regarding needed changes in the Practices Act.

Highlights of the proposed changes we view as strengthening and clarifying the "practice of nursing" include:

In Section One The proposed definition of "Unlicensed Assistive Personnel" provides for utilization of an assistant to the nurse in a variety of roles regardless of title. The proposed definition of "Specialty Practice Registered Nurse" provides recognition and licensure for nurses who practice in a specialty area but do not have a Masters Degree.

In Section Three The proposed revision of an exemption for individuals licensed in another jurisdiction with a ND employer allows for the nurses to attend orientation, meetings, or required continuing education without obtaining a ND license. Specifically, health care facilities located on the ND, Minnesota, SD and Montana borders have satellite clinics and smaller hospitals, which employ nurses licensed in these states. Due to changes in the health care environment, and the establishment of large health care corporations across state borders, many nurses who reside in a contiguous state must attend required inservices or orientation from the ND employer at the ND worksite. This exemption also specifically provides for nurse consultants to practice in the state on a limited basis.

In Section Seven The proposed elimination of residency requirements for nurses to practice.

Section Ten The proposed revisions provide for an alternative to discipline such as the Nurse Advocacy Program for impaired nurses and increases clarity. It gives the board the authority to ask for an evaluation and treatment when impairment is reported to the board. The other revisions would allow for voluntary surrender of one's license to practice nursing. It also, provides for the burden of proof on the licensee to submit evidence of safe practice. Subsection 5 has been clarified by inserting the language of professional misconduct which would be further defined in the rules. Examples of professional misconduct would be a departure or failure to conform to standards of practice, endangering a patient's life or safety, non-payment of Nursing Education Loan, and failure to adhere to professional code of ethics.

The Nurses Association, however does have one area of non-agreement with the revisions. We have met with the Board regarding this issue and have not been able to reach resolution. We have in effect agreed to disagree and a member of our Board will be presenting that issue this morning.

Thank you for this opportunity to testify and for your support of nurses in North Dakota.

Mary Smith MS,RN
President, NDNA

TESTIMONY ON SB 2114
NORTH DAKOTA NURSES ASSOCIATION

Chairperson Lee and members of the Senate Human Services Committee. My name is Penni Weston. I am a Registered Nurse and a board member of the North Dakota Nurses Association (NDNA), an organization representing professional nurses in ND.

NDNA has been a participant in the workgroups responsible for formulating the revisions to the Nurse Practice Act. We appreciated the opportunity to be involved in this process and support the revisions with one exception. We are not supportive of the exemption for those individuals who provide medications in specific settings (developmentally disabled treatment centers, human service centers, etc.). NDNA is fully aware that this exemption has been agreed upon as a compromise, however we have grave concerns for the safety of the clients receiving medications as a result of this compromise. The dictionary defines compromise as conceding, giving in or making a deal. The other definition of compromise is to compromise care. We believe this is the applicable definition in this exemption for the following reasons:

1. This exemption allows the least trained individual to administer medications to some of our least capable citizens. Medication administration is a complex skill that requires a broad base of knowledge to prevent undesired consequences. It is much more involved than simply "handing out pills". The individual administering medication must have knowledge of anatomy and physiology (which organs will the medication affect), microbiology (what diseases or infections is the medication intended to treat), pharmacology (what are the potential side effects and allergic reactions), mathematics (what is the correct dosage) and medical and legal principles. These must be understood before the actual manual skill of giving the medication can be mastered. At the very least, licensed nurses should be involved in determining which medications can be safely administered by someone with only the completion of a self-study program.

2. Client safety is our major concern with this exemption. Who will be monitoring medication administration to assure that the client's safety and well being is protected? The client will go to a health care provider who will issue a prescription and then will have no further responsibility to the client. The prescription will then go to a pharmacist who will fill place the pills in the bottle and label the container. This pharmacist will

also have no further responsibility or interaction with the client. The medication is then delivered to the client's care setting. Who then, will be responsible to make sure the medication is given at the appropriate time, in the right amount and to the right client?

A recent report from the IOM (Institute of Medicine) demonstrates that errors are being made at alarming rates. Medication errors are one of the areas that have surfaced as being one of the most troublesome. Note that this report indicates patient safety is being jeopardized in health care settings where licensed nurses are administering medications. Common sense would tell us that if medication errors were jeopardizing patient safety where licensed nurses are involved in the process of medication administration, not having a licensed nurse involved would seem to indicate almost sure danger.

3. This legislative body is deliberating a bill, which would allow pharmacists with a doctorate degree (7 years of formal education) to administer flu vaccines to adults. This same legislation (SB 2364) was defeated last session with the rationale given by legislators that it was "unsafe" and that medication administration, particularly to pediatric patients, must be done by nurses. It seems inconsistent and illogical to think then, that someone with less education should be allowed to administer medications such as anticonvulsants (prevent seizures), psychotropics (mood altering), antihypertensives (blood pressure and heart medications), and oral hypoglycemics (diabetes medications). Medical symptoms may not have been the reason for someone entering these settings, however, as the aging process occurs and medical problems arise, so does the need for nursing care; particularly medication administration. The person who administers these medications should know about drug toxicities, side effects, drug/drug interactions and other potential problems that may arise as a result of the client requiring medication for treatment of a medical problem. If the individual administering the medications does not have this knowledge, then the person who is supervising the medication administration must know this in order to safely delegate this task.

As previously stated, NDNA does not support this exemption, however, we are offering an amendment for the committee to consider. The premise of professional licensing is to protect the public from unscrupulous providers. Exemptions to a practice act serve only to weaken the protection of the public.

When this exemption was temporary, the last sentence, "A licensed nurse may delegate medication administration to a person exempt from the provisions of Chapter 43-12.1 under this subsection" may have been important. With the exemption potentially becoming permanent, we ask that it be eliminated.

Families who give nursing care to a family member are exempted, but a licensed nurse is often involved through home care or hospice services. Individuals rendering assistance in a disaster are exempt, but licensed nurses have always been involved such as providing leadership and direction for care in the shelters.

Because this sentence is in one of the exemptions, it may prevent licensed nurses from being involved in the other exemptions as well.

PROPOSED AMENDMENT TO SB 2114

Delete the last sentence of Section 3, 43-12.1-04, subsection 9, d. to read:

~~d.~~ Human service centers licensed under chapter 50-06. ~~A licensed nurse may delegate medication administration to a person exempt from the provisions of Chapter 43-12.1 under this subsection.~~

In closing, NDNA believes licensed nurses should be and must be involved in any setting where nursing care is rendered, either through direct care or delegation. Delegation implies licensed nurse responsibility, which cannot be permissive under the law.

To: Senate Human Services Committee
Judy Lee, chair

From: Melana Howe, RN
Director of Patient Care Services
Hettinger, North Dakota

I am a registered nurse and work in healthcare administration.

As an employer of healthcare personnel with West River Regional Medical Center and President of the North Dakota Organization of Nurse Executives (the clinical supportive entity of the North Dakota Healthcare Association), I am speaking in support of Senate Bill 2114 and specifically Sections One and Three as they relate to supervision through delegation and licensure.

First, North Dakota is unique in its standards for assignment and delegations. The nurse's role and accountability for care are defined by the following questions:

1. Who is directing the care?
2. From whom does the unlicensed assistive personnel get the authority to act?
3. What are the nursing activities for which the nurse is held accountable?

In numerous healthcare facilities across ND, individuals, regardless of title or education, are performing interventions delegated and supervised by a licensed nurse. These individuals are assistive to the nurse, regardless of title. The desired change in the Practice Act recognizes the individual's education, training, and competency. It also recognizes those individuals' scope of practice that overlaps with nursing. It sets the stage for mutual respect between professionals. An assistant to the nurse is not a nursing assistant, but may be another recognized professional, such as medical assistant, surgical technician, dialysis technician, or medical technicians.

Secondly, ND practitioners must be licensed to practice nursing. This section would exempt individuals licensed in another jurisdiction with a ND employer to attend orientation, meetings, or required continuing education without obtaining a ND License. Specifically, healthcare facilities located on the North Dakota, Minnesota, South Dakota, and Montana borders have satellite clinics and smaller hospitals, which employ nurses licensed in Minnesota, Montana, and South Dakota.

Due to the significant changes in the healthcare environment and the establishment of large healthcare corporations across state borders, many nurses who reside in a border state must attend required in-services or orientation in ND. Also, a number of national corporations and organizations employ nurses strictly to provide either consultation or education in ND for limited time frames. This exemption also specifically provides for nurse consultants to practice in the state on limited basis. Examples include but are not limited to, presenting in-services, reviewing policy and procedures, working as a sole representative, guest lecturer, short-term consultant.

The ND BON should be commended on their collaboration with nursing executives, such as myself, to prepare for the desired revisions of the Standards of Practice for nursing. Healthcare is changing rapidly and drastically. The proposed revisions are timely, practical, and make good sense. Thank you.

NDNA
NORTH DAKOTA NURSES ASSOCIATION

649 Airport Rd. • Bismarck, ND 58504 • Phone: (701) 223-1385 • Fax: (701) 223-0575

January 25, 2001

Members of the Senate Human Services Committee:

I have attached a summary and supporting data from HRSA Bureau of Health Professions regarding:

- numbers of nurses,
- changes in numbers of nursing degrees awarded,
- educational levels of nurses, and
- various employment indicators for nurses

for North Dakota and the surrounding states of Minnesota, Montana and South Dakota as well as national averages.

This data supports that North Dakota's educational requirements have not negatively impacted the numbers of nurses in the state. In most areas, including numbers of RNs, LPNs and numbers of students graduating from LPN programs, North Dakota "outranks" neighboring state that have lower educational standards and the national averages.

Thank you for your consideration of this material and please feel free to contact me at any time with questions or concerns regarding nursing issues.

Sharon Moos, Executive Administrator
North Dakota Nurses Association

SUMMARY OF ATTACHED RN/LPN DATA FOR NORTH DAKOTA AND SURROUNDING STATES

State	Number of RNs per 100,000 Population	National Rank
North Dakota	1069	3/50
Minnesota	945	12/50
Montana	764	34/50
South Dakota	1049	5/50
U.S.	798	---

Source: Division for Nursing; Bureau of the Census 1996

State	Number of LPNs per 100,000 Population
North Dakota*	434
Minnesota	353
Montana	268
South Dakota	254
U.S.	249

**North Dakota has 1.5 times the national rate of LPNs and ranks 2nd highest in 50 states*

Source: Bureau of Labor Statistics; Bureau of the Census; Division for Nursing 1998

Percentage Change in RN Program Degrees Awarded 1991-2 to 1996-7*

State	
North Dakota	-8%
Minnesota	10%
Montana	-5%
South Dakota	-43%
U.S.	12%

Source: National Center for Educational Statistics; Bureau of the Census

**Data not adjusted for growth of states overall population during 1991-1997*

Percentage Change in LPN Program Degrees Awarded 1991-2 to 1996-7*

State	
North Dakota	18%
Minnesota	-3%
Montana	-47%
South Dakota	4%
U.S.	12%

Source: National Center for Education Statistics; Bureau of the Census

**Data not adjusted for growth of states overall population during 1991-1997*

Highest Nursing Related Educational Attainment of RNs Employed in Nursing 1996

State	Diploma	Associate Degree	Baccalaureate	Masters/Doc.
North Dakota	28%	15%	49%	8%
Minnesota	24%	37%	32%	7%
Montana	21%	33%	40%	6%
South Dakota	23%	38%	33%	5%
U.S.	24%	35%	32%	10%

Source: Division for Nursing

Number of LPNs per 100 RNs	
North Dakota	40
Minnesota	37
Montana	35
South Dakota	24
National Average	32

Source: Bureau of Labor Statistics; Bureau of the Census; Division for Nursing 1998
Data for RNs drawn from the 1996 National Sample Survey

Percent Change in FTE Hospital RN Employment 1992-1998

State	% of Change
North Dakota	21%
Minnesota	12%
Montana	13%
South Dakota	-3%
U.S.	9%

Source: American Hospital Association

Percent RNs Employed Full Time 1996

State	% RNs Employed Full Time	National Rank
North Dakota	65%*	43/50
Minnesota	55%	48/50
Montana	65%	41/50
South Dakota	73%	21/50
U.S.	71%	

Source: Division for Nursing; Bureau of the Census

- *Review of 1999 ND Board of Nursing Data indicates 52% of RNs now employed full time in North Dakota*

NURSING

- √ There were 7,248 licensed registered nurses (RNs) in North Dakota in 1996; 6,902 were employed in nursing.
- √ There were 1068.9 RNs per 100,000 population in North Dakota in 1996, significantly more than the national average of 798.
- √ The RN workforce in the West North Central Census Division aged significantly between 1988 and 1996. The percentage of RNs 40 years and older increased from 44% in 1988 to 59% in 1996.
- √ In 1996, the majority of RNs employed in nursing in the West North Central Census Division were non-Hispanic white (96.6%). Only 1% were Black/African American, less than their percentage in the general population (5.3%).
- √ The number of RNs in North Dakota increased 11% between 1988 and 1996 while the state's population declined 1%. The result was a 12% growth in RNs per capita, compared to a 20% growth nationwide.
- √ The majority (60%) of RNs in the West North Central Census Division who were employed worked in hospitals in 1996. As a result, metropolitan areas with a concentration of hospital beds were likely to have a relatively high ratio of RNs per capita.
- √ In North Dakota, the number of full-time equivalent RNs working in hospitals increased 21% between 1992 and 1998 while the number of inpatient days declined 17%. The result was a 45% increase in the ratio of full-time equivalent RNs to inpatient days, compared to a 26% increase in the ratio nationwide.
- √ In 1996, 49% of RNs employed in nursing in North Dakota had a Baccalaureate degree; 28% had a Nursing diploma; 15% had an Associate degree; and 8% had a Masters/ Doctoral degree.
- √ Between 1991-92 and 1996-97, the vast majority of nursing degrees awarded in North Dakota were Baccalaureate degrees and there were no Associate degrees awarded in nursing in the state during that period.
- √ In 1996-97, 95.9% of the RN degree recipients in North Dakota were non-Hispanic white. Approximately 3% were American Indian/Alaskan Native, slightly less than the percentage in the state's general population (4.6%).

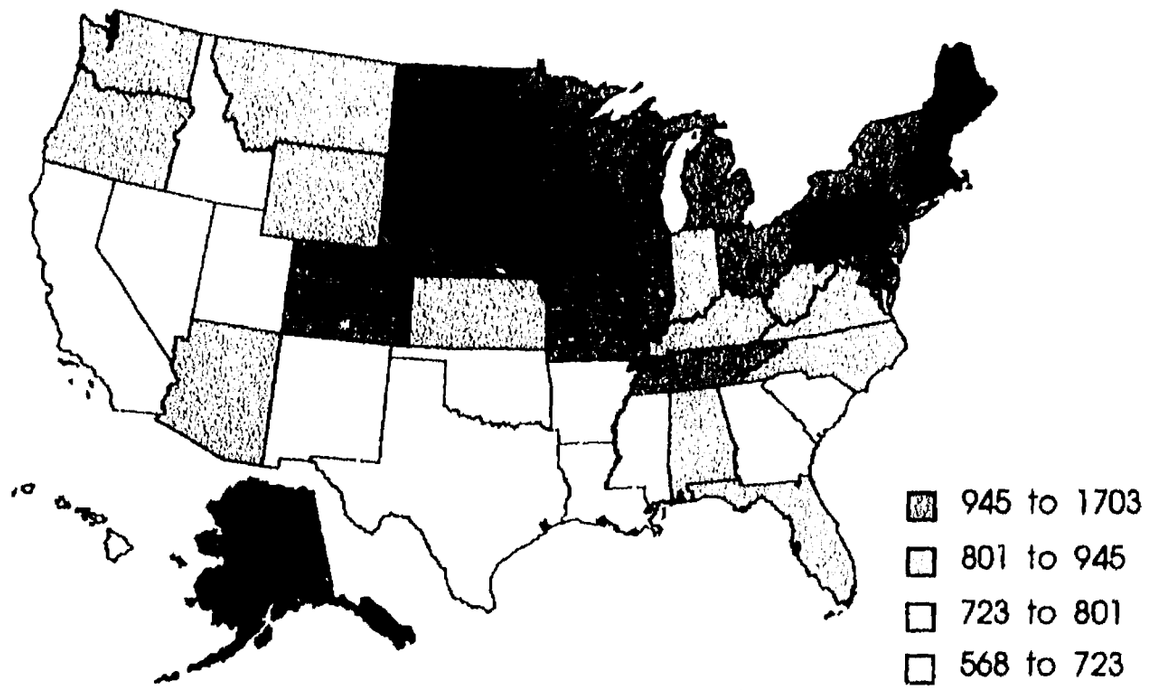
Registered Nurses

Registered Nurses - Total & RNs employed in nursing, 1996

	North Dakota	Region VIII	US	Rank
Registered nurses - total	7,248	80,560	2,658,874	47/50
Registered nurses employed in nursing (RNs)	6,902	68,680	2,116,816	46/50
Per 100,000 population	1,068.9	798.4	797.7	3/50
Percent employed full time	65%	69%	71%	43/50
Percent female	-	-	95%	-
Percent minority	-	-	10%	-

Source: Division for Nursing; Bureau of the Census.
Note: Unless otherwise indicated, 'Registered Nurses' and 'RNs' designate Registered Nurses employed in nursing

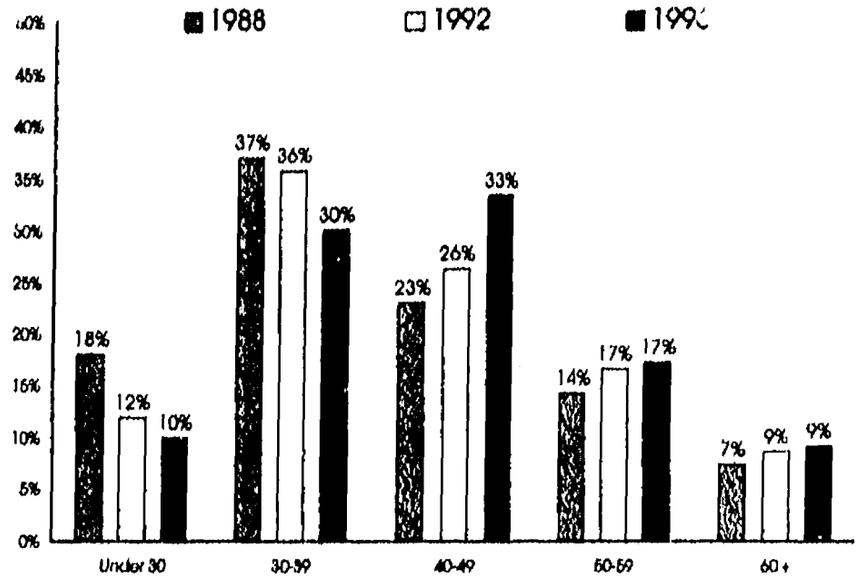
RNs per 100,000 population, 1996



US	797.7
Region VIII	798.4
North Dakota	1,068.9

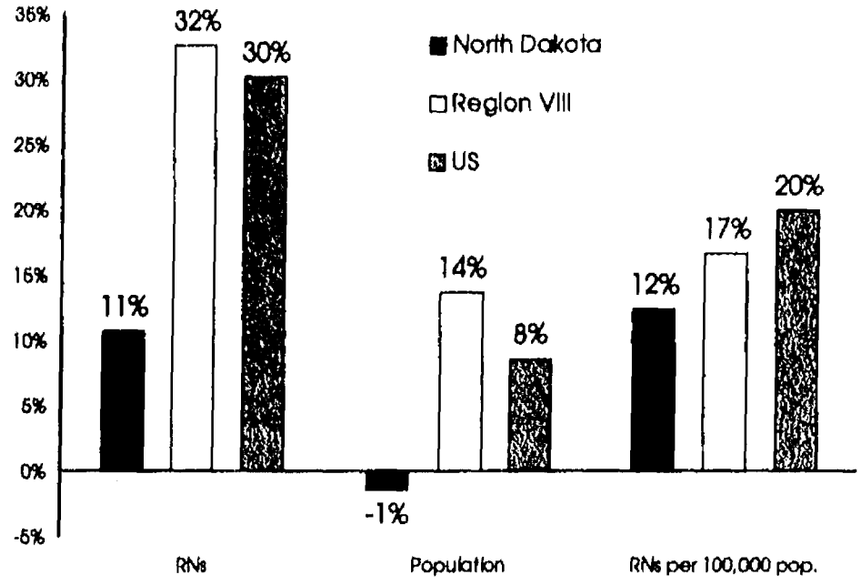
Source: Division for Nursing; Bureau of the Census.

Age distribution of RNs employed in nursing, West North CentralCensus Division, 1988-1996



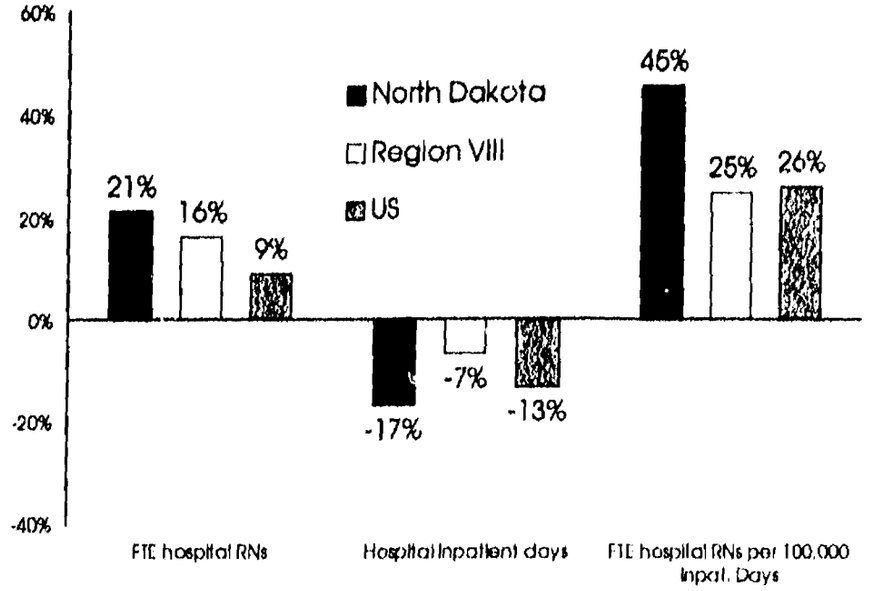
Source: Division for Nursing.

Percent change in RNs, population & RNs per 100,000 population, 1988-1996



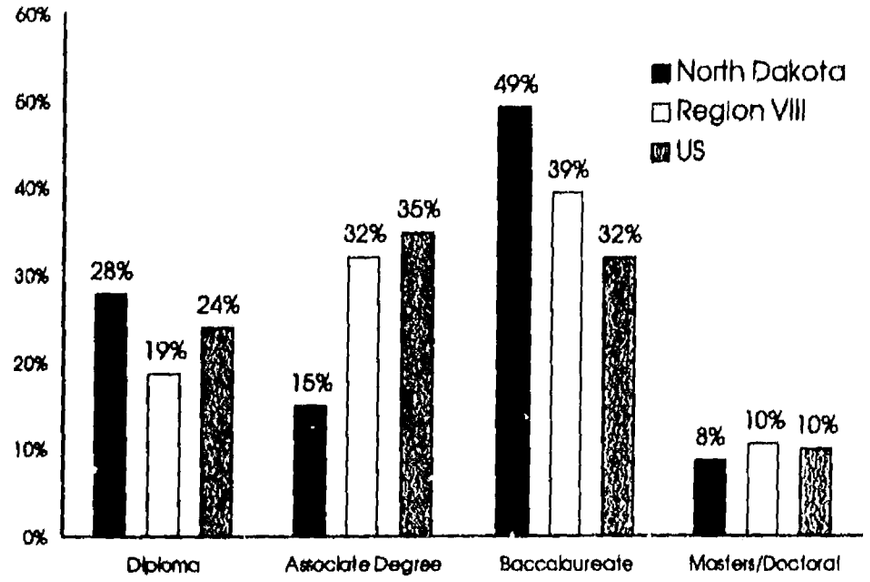
Source: Division for Nursing; Bureau of the Census.

Percent change in FTE hospital RN employment, hospital inpatient days & FTE hospital RN employment per inpatient day, 1992-1998



Source: American Hospital Association.

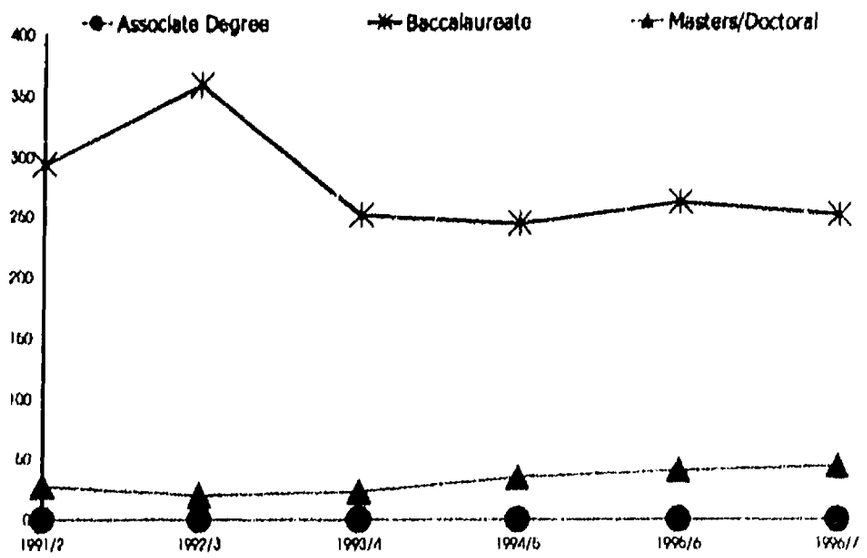
Highest nursing-related educational attainment of RNs employed in nursing, 1996



Source: Division for Nursing.

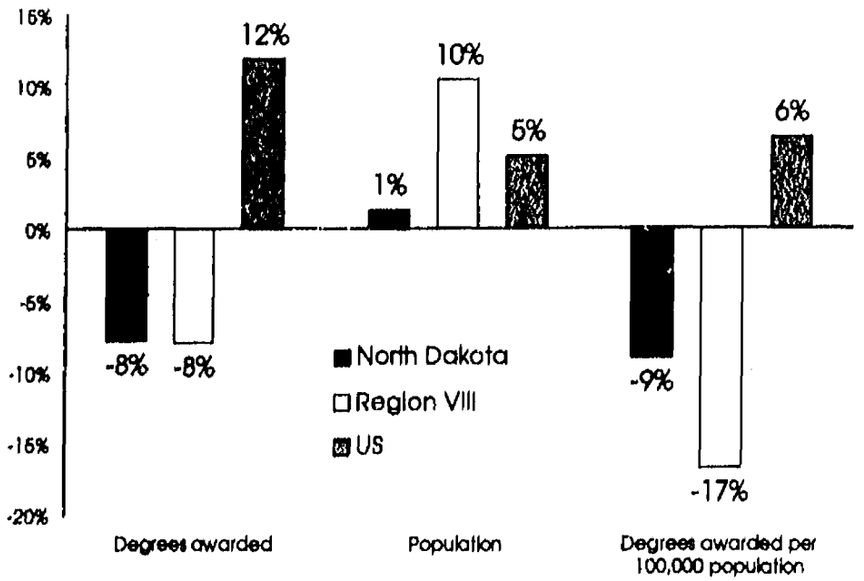
RN EDUCATION

RN education program degrees received by award level, 1991-92 to 1996-97



Source: National Center for Education Statistics; Bureau of the Census.

Percentage change in RN program degrees awarded, population & RN program degrees awarded per 100,000 population, 1991-2 to 1996-7



Source: National Center for Education Statistics; Bureau of the Census.

LICENSED PRACTICAL/VOCATIONAL NURSES (LPNs)

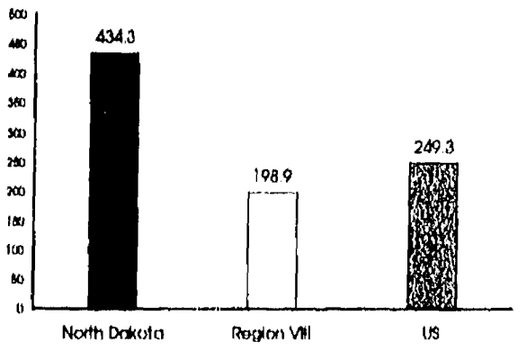
- √ North Dakota ranked 2nd highest among the states in the per capita employment of Licensed Practical/Vocational Nurses (LPNs), with 434.3 LPNs per 100,000 population which is more than 1.5 times the national rate of 249.3 per 100,000. North Dakota ranked 38th in the number of LPNs employed in 1998 with 2,770 workers.
- √ Over two thirds of all LPNs in the United States in 1999 worked in institutional settings (35.9% working in hospitals and 34.8% working in nursing and personal care facilities).
- √ The vast majority of LPNs in the United States were non-Hispanic white (73% in 1999) and female (94.9% in 1998). Nationally, Black/African Americans were over represented in the profession (18%) compared to their presence in the population as a whole (12%). By contrast, Hispanic/Latinos were underrepresented (5%) compared to their presence in the population (11% in 1999).
- √ Most recipients of LPN degrees in North Dakota in 1997 were non-Hispanic white (94%) and female (93%).
- √ In North Dakota, there were 40 LPNs for every 100 RNs employed in the state. This is significantly higher than the national ratio of 32 LPNs employed for every 100 RNs.

LPNs, 1998

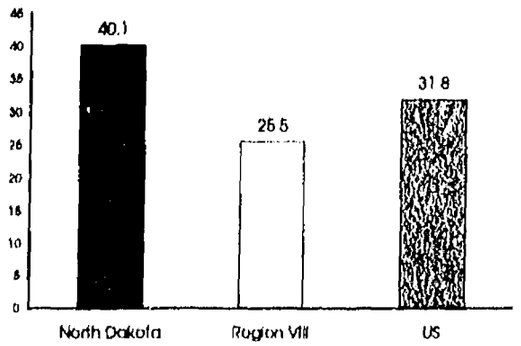
	North Dakota	Region VIII	US	ND rank
LPNs	2,770	17,500	673,790	38/50
Per 100,000 population	434.3	198.9	249.3	02/50
Per 100 RNs	40.1	25.5	31.8	11/50
Percent female	-	-	94.9%	-

Source: Bureau of Labor Statistics; Bureau of the Census; Division for Nursing.
Note: Data for RNs drawn from the 1996 National Sample Survey.
The abbreviation LPN, or Licensed Practical Nurse, is used herein to refer to both LPNs and LVNs, or Licensed Vocational Nurses.

LPNs per 100,000 population, 1998

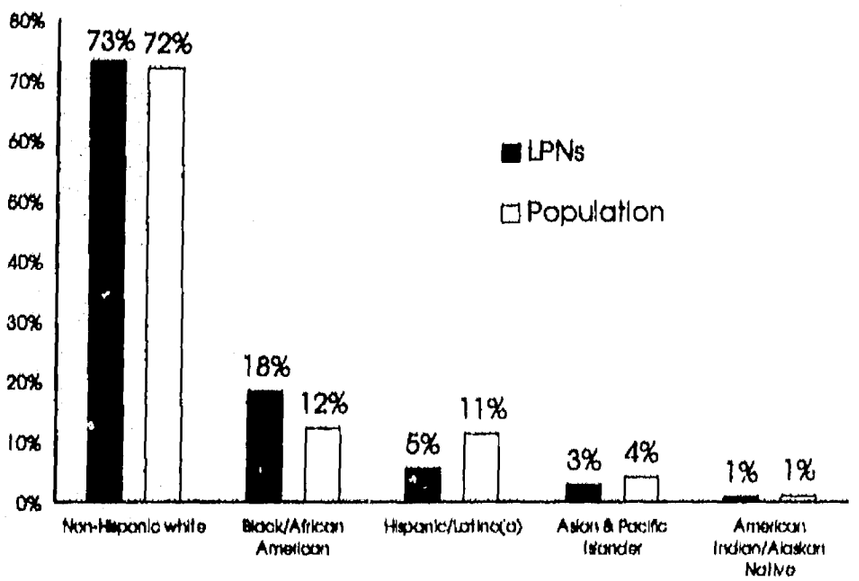


LPNs per 100 RNs, 1998



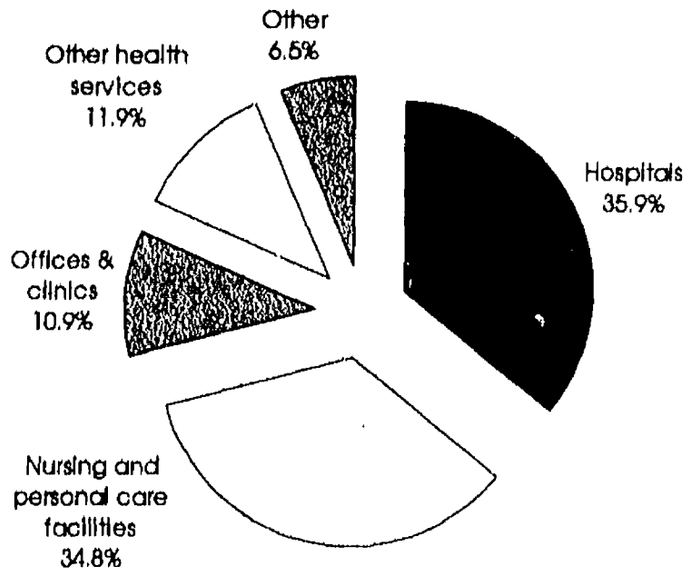
Source: Bureau of Labor Statistics; Bureau of the Census; Division for Nursing.
Note: Data for RNs drawn from the 1996 National Sample Survey.

Race/ethnicity of LPNs and the population, U.S., 1999



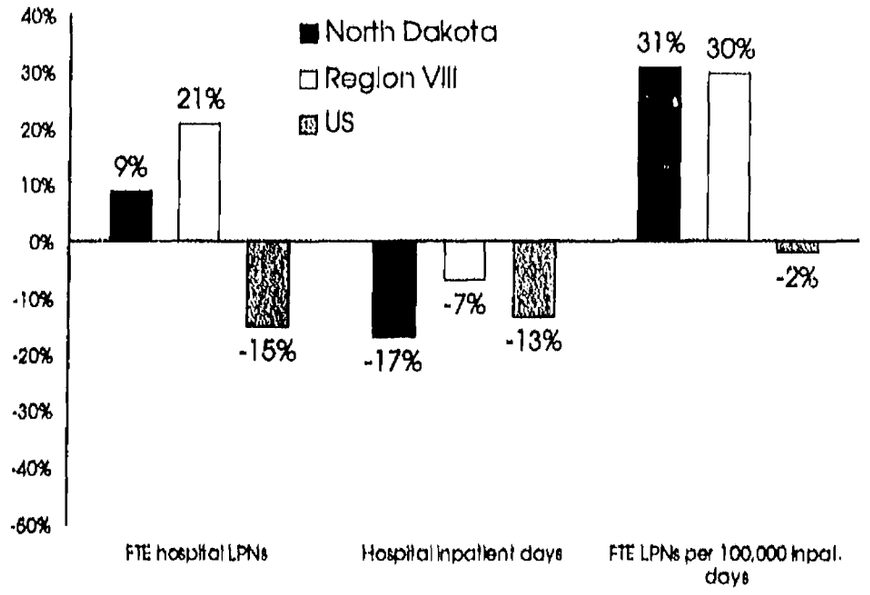
Source: Bureau of Labor Statistics.

LPNs by place of work, U.S., 1999



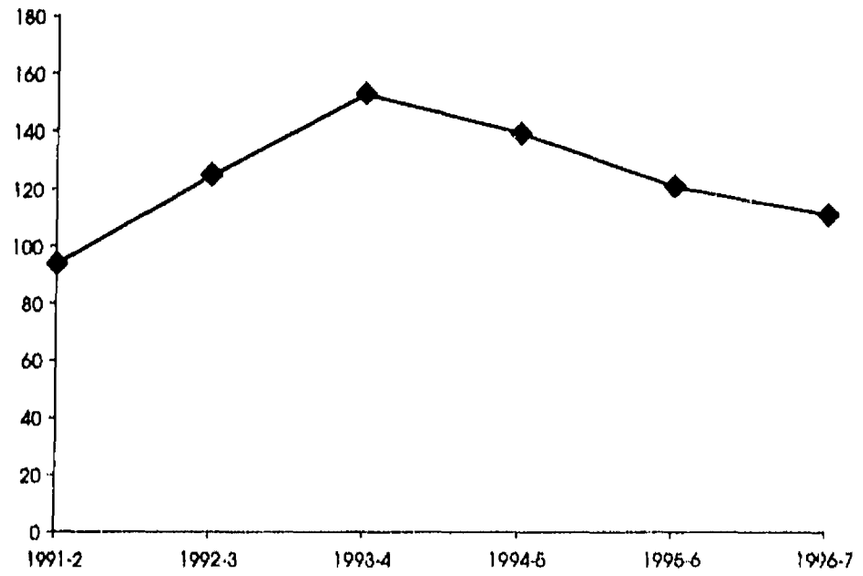
Source: Bureau of Labor Statistics.

Percentage change in FTE hospital LPN employment, inpatient days & FTE hospital LPN employment per inpatient day, 1992-1998



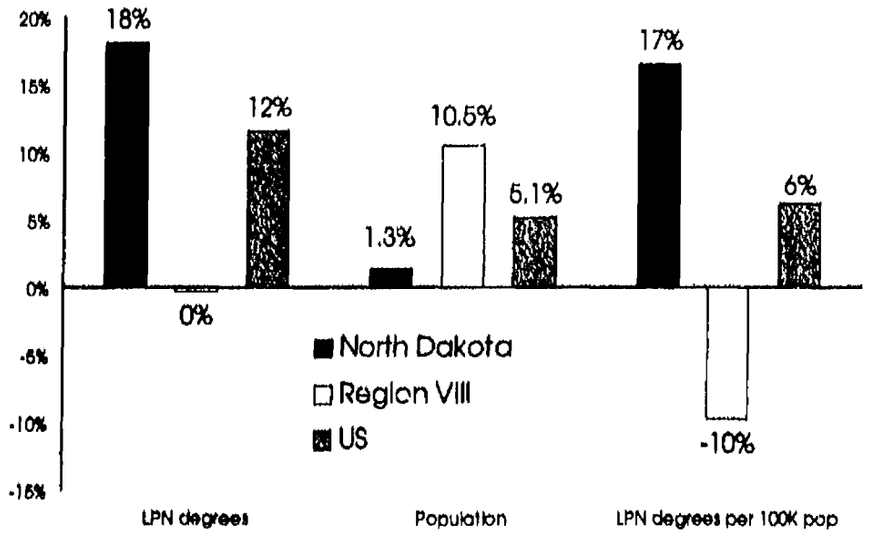
Source: American Hospital Association; Bureau of the Census.

LPN education program degrees awarded, 1992-3 to 1996-7



Source: National Center for Education Statistics.

Percentage change in LPN degrees awarded, population & LPN degrees per 100,000 population, 1992-3 to 1996-97



Source: National Center for Education Statistics; Bureau of the Census.

NURSING

- √ There were 50,909 licensed registered nurses (RNs) in Minnesota in 1996; 44,015 were employed in nursing.
- √ There were 945.2 RNs per 100,000 population in Minnesota in 1996, more than the national average of 798.
- √ The RN workforce in the West North Central Census Division aged significantly between 1988 and 1996. The percentage of RNs 40 years and older increased from 44% in 1988 to 59% in 1996.
- √ In 1996, the majority of RNs employed in nursing in the West North Central Census Division were non-Hispanic white (96.6%). Only 1% were Black/African American, less than their percentage in the general population (5.3%).
- √ The number of RNs in Minnesota increased 30% between 1988 and 1996 while the state's population only grew 8%. The result was a 20% growth in RNs per capita, the same as the growth nationwide.
- √ The majority (60%) of RNs in the West North Central Census Division who were employed worked in hospitals in 1996. As a result, metropolitan areas with a concentration of hospital beds were likely to have a relatively high ratio of RNs per capita.
- √ In Minnesota, the number of full-time equivalent RNs working in hospitals increased 12% between 1992 and 1998 while the number of inpatient days declined 11%. The result was a 25% increase in the ratio of full-time equivalent RNs to inpatient days, compared to a 26% increase in the ratio nationwide.
- √ In 1996, 37% of RNs employed in nursing in Minnesota had an Associate degree; 32% had a Baccalaureate degree; 24% had a Nursing diploma; and 7% had a Masters/Doctoral degree.
- √ Between 1991-92 and 1996-97, the number of Associate degrees awarded in nursing in Minnesota remained relatively stable while the number of Baccalaureate degrees awarded increased slightly.
- √ In 1996-97, 94.9% of the RN degree recipients in Minnesota were non-Hispanic white.

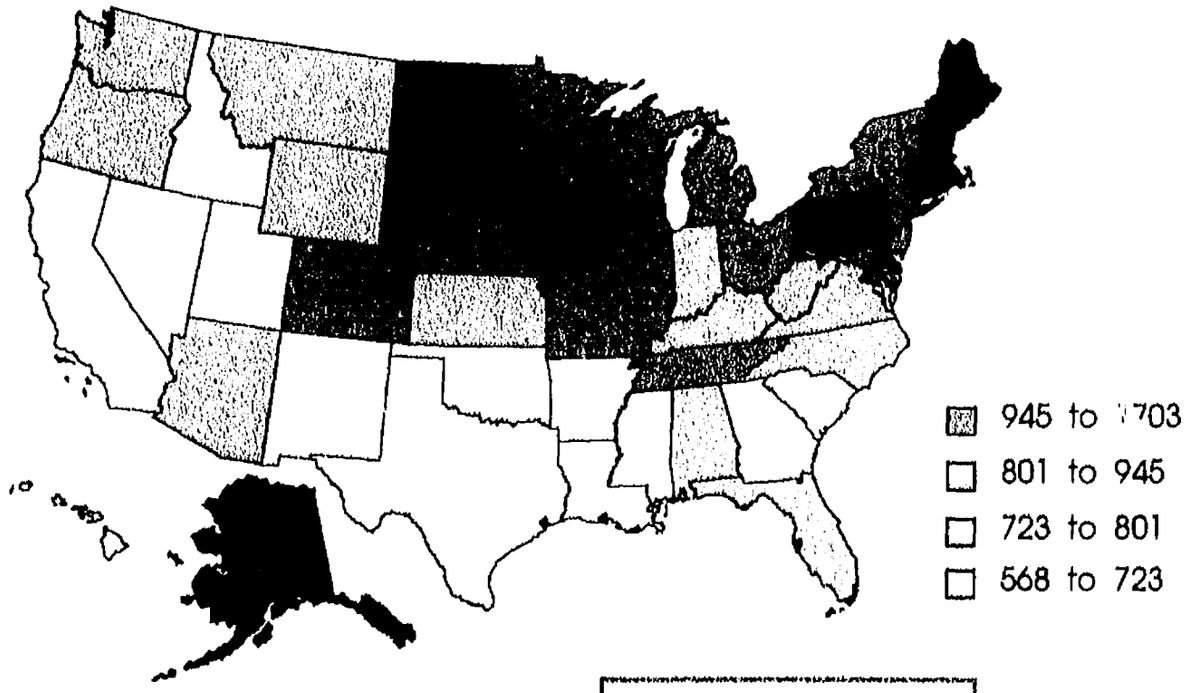
Registered Nurses

Registered Nurses - Total & RNs employed in nursing, 1996

	Minnesota	Region V	US	Rank
Registered nurses - total	50,909	502,989	2,558,874	19/50
Registered nurses employed in nursing (RNs)	44,015	415,036	2,115,815	18/50
Per 100,000 population	945.2	858.8	797.7	12/50
Percent employed full time	55%	65%	71%	48/50
Percent female	-	-	95%	-
Percent minority	-	-	10%	-

Source: Division for Nursing; Bureau of the Census.
Note: Unless otherwise indicated, 'Registered Nurses' and 'RNs' designate Registered Nurses employed in nursing.

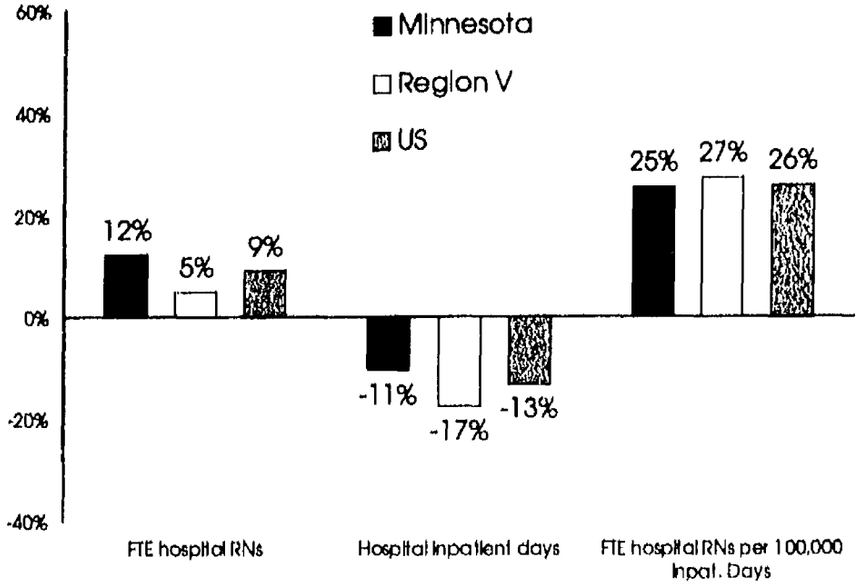
RNs per 100,000 population, 1996



US	797.7
Region V	858.8
Minnesota	945.2

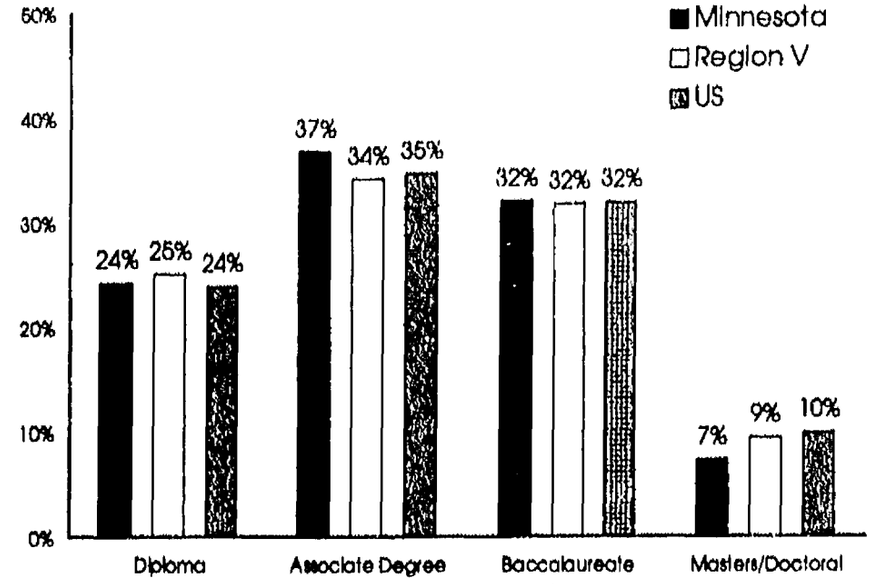
Source: Division for Nursing; Bureau of the Census.

Percent change in FTE hospital RN employment, hospital inpatient days & FTE hospital RN employment per inpatient day, 1992-1998



Source: American Hospital Association.

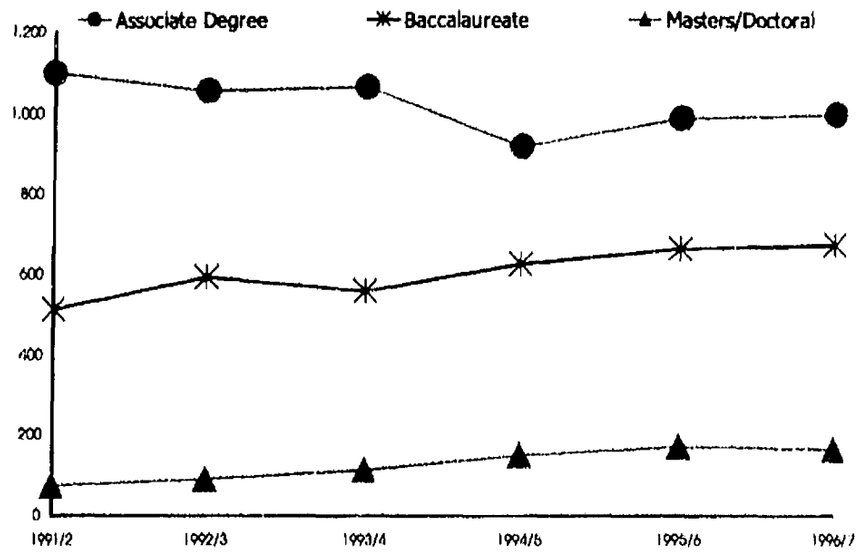
Highest nursing-related educational attainment of RNs employed in nursing, 1996



Source: Division for Nursing.

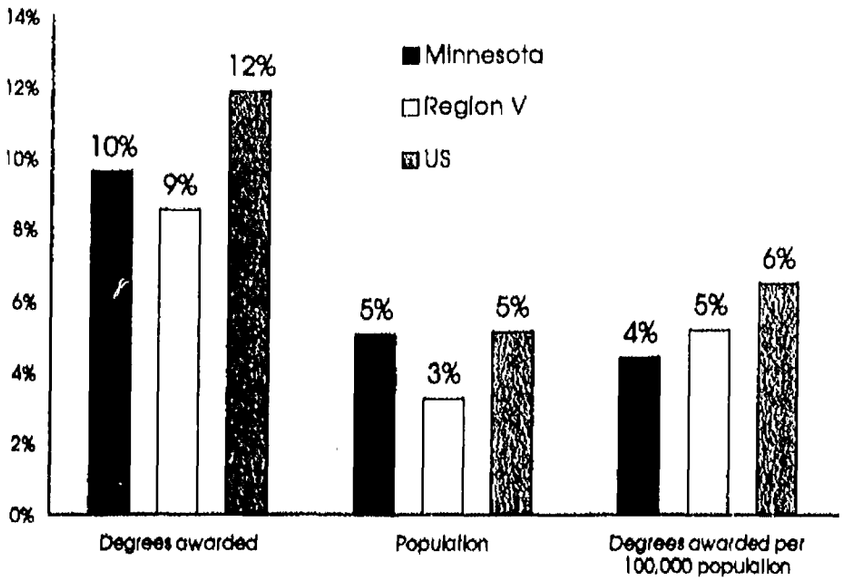
RN EDUCATION

RN education program degrees received by award level, 1991-92 to 1996-97



Source: National Center for Education Statistics; Bureau of the Census.

Percentage change in RN program degrees awarded, population & RN program degrees awarded per 100,000 population, 1991-2 to 1996-7



Source: National Center for Education Statistics; Bureau of the Census.

Licensed Practical/Vocational Nurses (LPNs)

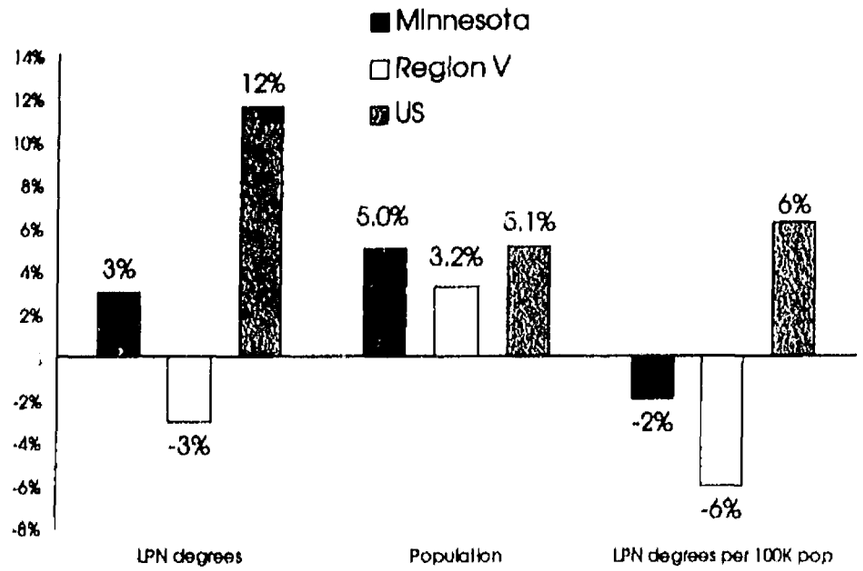
- √ Minnesota ranked 8th highest among the states in the per capita employment of Licensed Practical/ Vocational Nurses (LPNs), with 353.1 LPNs per 100,000 population as compared to the national rate of 249.3 per 100,000. Michigan ranked 15th in the number of LPNs employed in 1998 with 16,690 workers.
- √ Over two thirds of all LPNs in the United States in 1999 worked in institutional settings (35.9% working in hospitals and 34.8% working in nursing and personal care facilities).
- √ The vast majority of LPNs in the United States were non-Hispanic white (73% in 1999) and female (94.9% in 1998). Nationally, Blacks/African Americans were over represented in the profession (18%) compared to their presence in the population as a whole (12%). By contrast, Hispanic/Latinos were underrepresented (5%) compared to their presence in the population (11% in 1999).
- √ Most recipients of LPN degrees in Minnesota in 1997 were non-Hispanic white (89%) and female (90%).
- √ In Minnesota, there were 38 LPNs for every 100 RNs employed in the state. This is higher than the national ratio of 32 LPNs employed for every 100 RNs.

LPNs, 1998

	Minnesota	Region V	US	MN rank
LPNs	16,690	121,110	673,790	15/50
Per 100,000 population	353.1	247.2	249.3	08/50
Per 100 RNs	37.9	29.2	31.8	13/50
Percent female	-	-	94.9%	-

Source: Bureau of Labor Statistics; Bureau of the Census; Division for Nursing.
Note: Data for RNs drawn from the 1996 National Sample Survey.
The abbreviation LPN, or Licensed Practical Nurse, is used herein to refer to both LPNs and LVNs, or Licensed Vocational Nurses.

Percentage change in LPN degrees awarded, population & LPN degrees per 100,000 population, 1992-3 to 1996-97



Source: National Center for Education Statistics; Bureau of the Census.

Race/ethnicity & gender of LPN program degree recipients & the population, 1996-97

	LPN education program degree recipients	Population
Race/ethnicity		
Non-Hispanic white	89.6%	92.1%
Black/African American	4.3%	2.7%
Hispanic/Latino(a)	2.0%	1.6%
Asian & Pacific Islander	2.0%	2.6%
American Indian/Alaskan Native	2.3%	1.2%
Total	100.0%	100.0%
Gender		
Female	90.3%	50.7%
Male	9.7%	49.3%
Total	100.0%	100.0%

Source: National Center for Education Statistics; Bureau of the Census.

NURSING

- √ There were 8,417 licensed registered nurses (RNs) in Montana in 1996; 6,774 were employed in nursing.
- √ There were 763.7 RNs per 100,000 population in Montana, less than the national average of 798.
- √ The RN workforce in the Mountain Census Division aged significantly. The percentage of RNs 40 years and older increased from 50% in 1988 to 67% in 1996.
- √ In 1996, the majority of RNs employed in nursing in the Mountain Census Division were non-Hispanic white (92.4%). Fewer than 3% were /Latino, significantly less than the percentage in the general population (15.7%).
- √ The number of RNs in Montana increased 28% between 1988 and 1996 while the state's population only grew 11%. The result was a 16% growth in RNs per capita, compared to a 20% growth nationwide.
- √ The majority (60%) of RNs who are employed in the Mountain Census Division worked in hospitals. As a result, metropolitan areas with a concentration of hospital beds were likely to have a relatively high ratio of RNs per capita.
- √ In Montana, the number of full-time equivalent RNs working in hospitals increased 13% between 1992 and 1998 while the number of inpatient days only increased 7%. The result was a 6% increase in RNs per capita, compared to a 26% increase nationwide.
- √ In 1996, 40% of RNs employed in nursing in Montana had a Baccalaureate degree; 33% had an Associate degree; 21% had a Nursing diploma; and 6% had a Masters/ Doctoral degree.
- √ Between 1991-92 and 1996-97, the number of Baccalaureate degrees awarded in nursing declined slightly in Montana while the number of Associate degrees awarded remained relatively stable.
- √ In 1996-97, 92.9% of the RN degree recipients in Montana were non-Hispanic white, approximately the same as the percentage in the state's population.

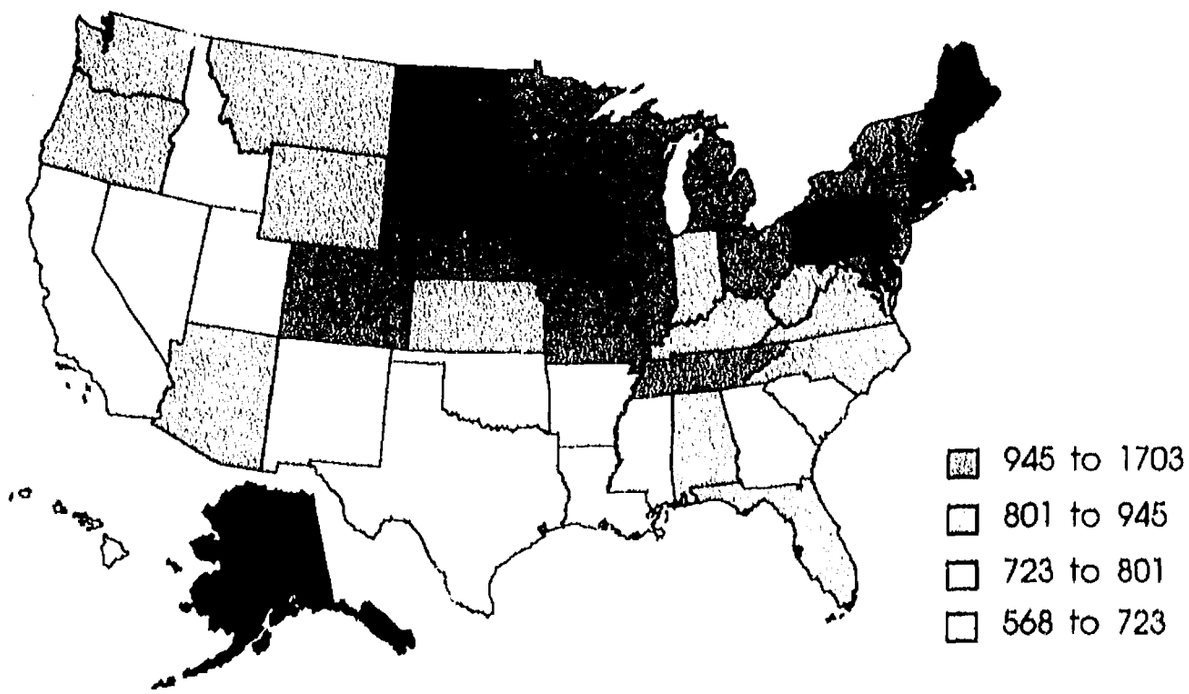
Registered Nurses

Registered Nurses - Total & RNs employed in nursing, 1996

	Montana	Region VIII	US	Rank
Registered nurses - total	8,417	80,560	2,558,874	46/50
Registered nurses employed in nursing (RNs)	6,774	68,680	2,115,815	47/50
Per 100,000 population	763.7	798.4	797.7	34/50
Percent employed full time	65%	69%	71%	41/50
Percent female	-	-	95%	-
Percent minority	-	-	10%	-

Source: Division for Nursing; Bureau of the Census.
Note: Unless otherwise indicated, 'Registered Nurses' and 'RNs' designate Registered Nurses employed in nursing.

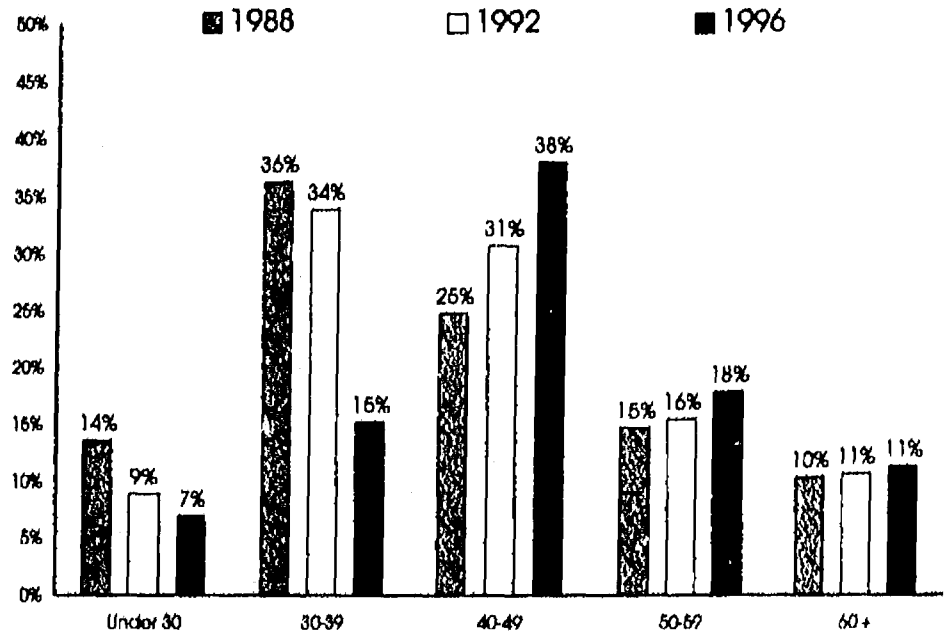
RNs per 100,000 population, 1996



US	797.7
Region VIII	798.4
Montana	763.7

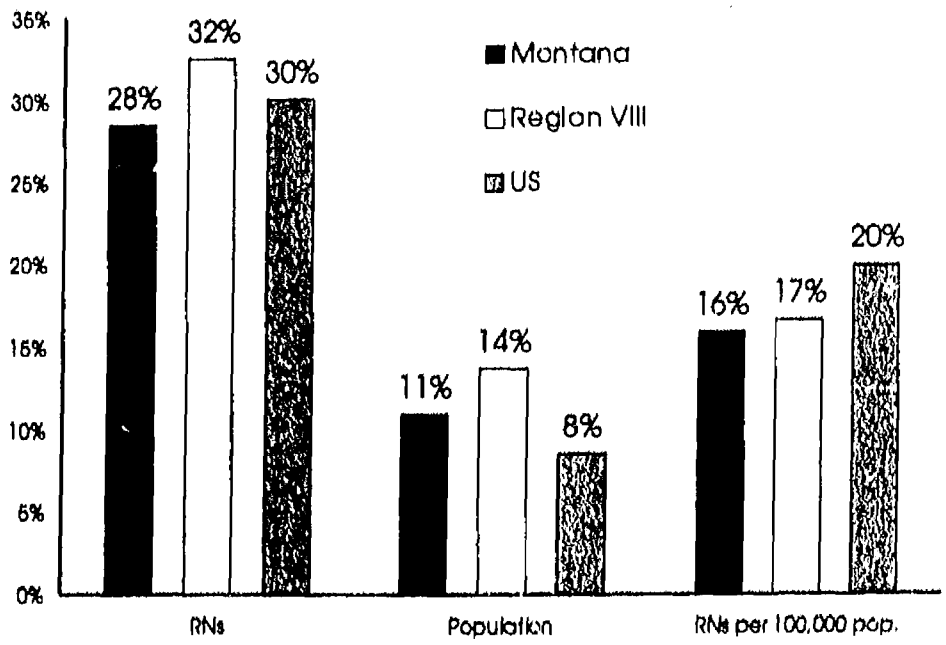
Source: Division for Nursing; Bureau of the Census.

Age distribution of RNs employed in nursing, Mountain Census Division, 1988-1996



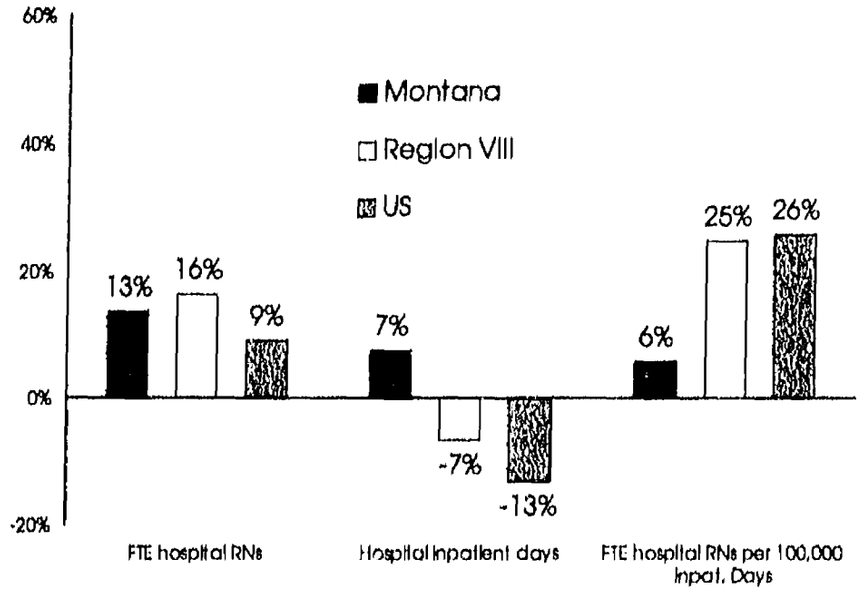
Source: Division for Nursing.

Percent change in RNs, population & RNs per 100,000 population, 1988-1996



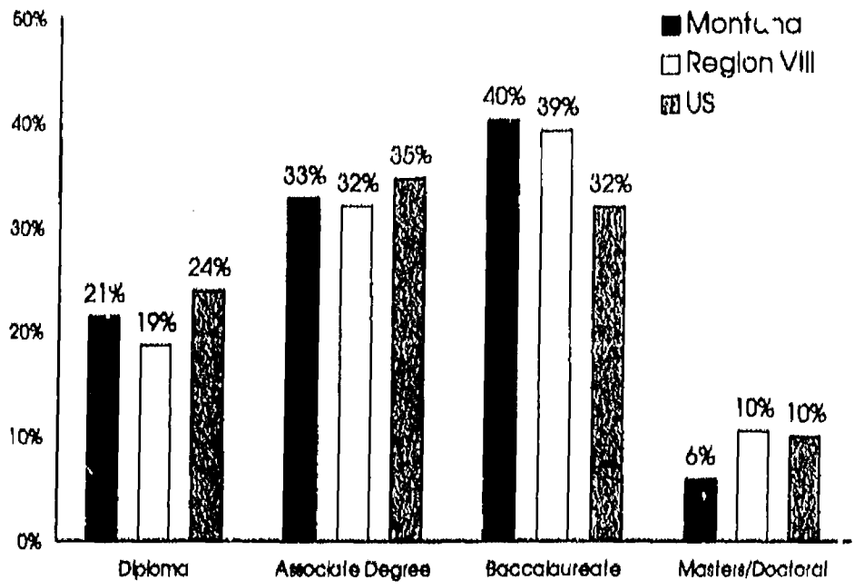
Source: Division for Nursing; Bureau of the Census.

Percent change in FTE hospital RN employment, hospital inpatient days & FTE hospital RN employment per inpatient day, 1992-1998



Source: American Hospital Association.

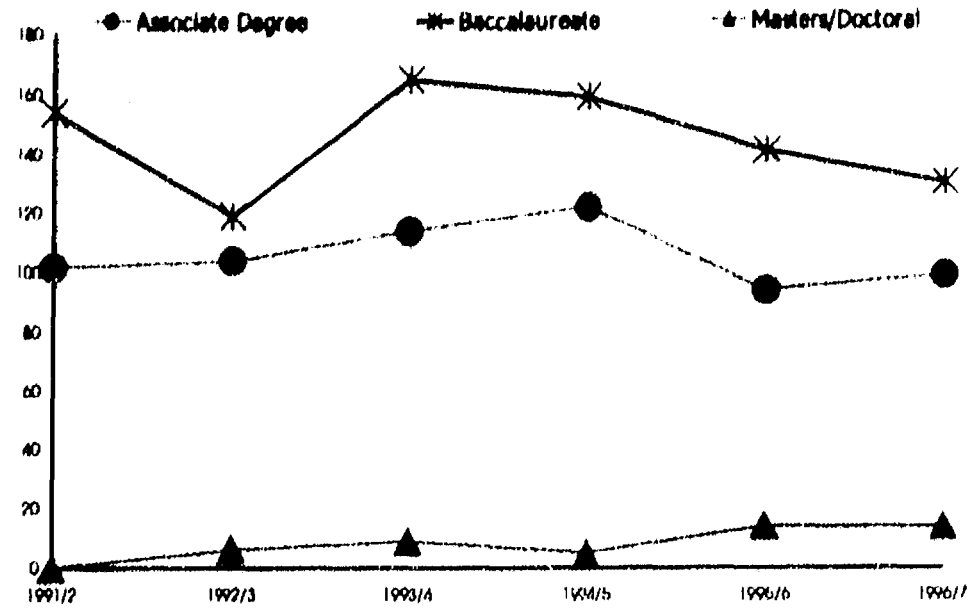
Highest nursing-related educational attainment of RNs employed in nursing, 1996



Source: Division for Nursing.

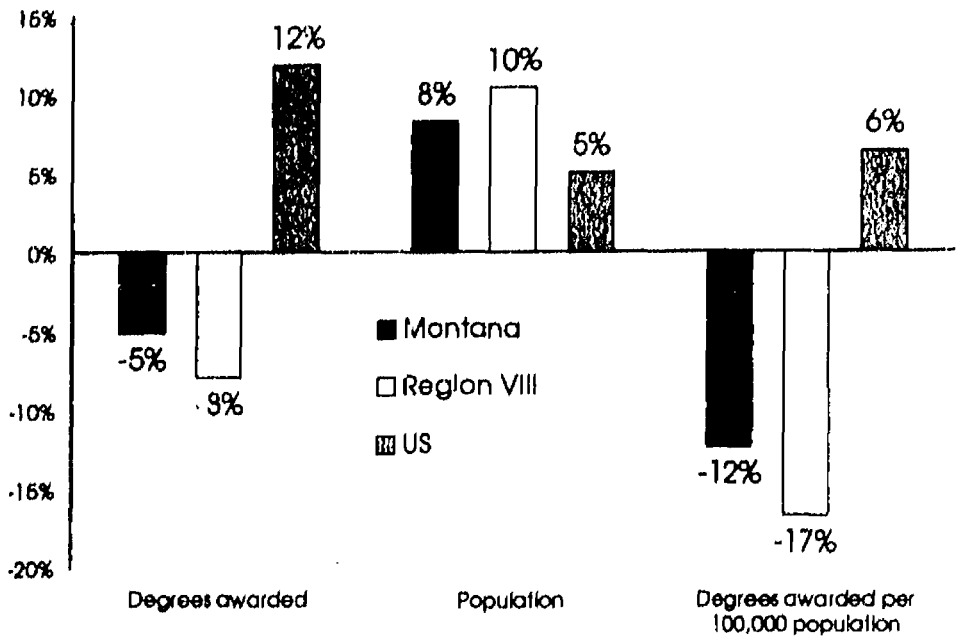
RN EDUCATION

RN education program degrees received by award level, 1991-92 to 1996-97



Source: National Center for Education Statistics; Bureau of the Census.

Percentage change in RN program degrees awarded, population & RN program degrees awarded per 100,000 population, 1991-2 to 1996-7



Source: National Center for Education Statistics; Bureau of the Census.

Licensed Practical/Vocational Nurses (LPNs)

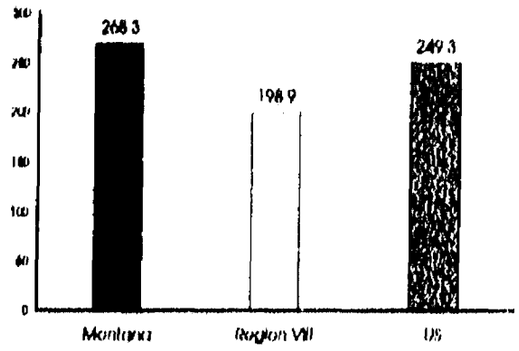
- √ Montana ranked 23rd among the states in the per capita employment of Licensed Practical/Vocational Nurses (LPNs), with 268.3 LPNs per 100,000 population as compared to the national rate of 249.3 per 100,000. Montana ranked 43rd in the number of LPNs employed in 1998 with 2,360 workers.
- √ Over two thirds of all LPNs in the United States in 1999 worked in institutional settings (35.9% working in hospitals and 34.8% working in nursing and personal care facilities).
- √ The vast majority of LPNs in the United States were non-Hispanic white (73% in 1999) and female (94.9% in 1998). Nationally, Black/African Americans were over represented in the profession (18%) compared to their presence in the population as a whole (12%). By contrast, Hispanic/Latinos were underrepresented (5%) compared to their presence in the population (11% in 1999).
- √ Most recipients of LPN degrees in Montana in 1997 were non-Hispanic white (97%) and female (96%). American Indian/Alaskan Natives were underrepresented among degree recipients, earning 2% of all degrees while constituting 6% of the state's population.
- √ In Montana, there were 35 LPNs for every 100 RNs employed in the state. This is comparable to the national ratio of 32 LPNs employed for every 100 RNs.

LPNs, 1998

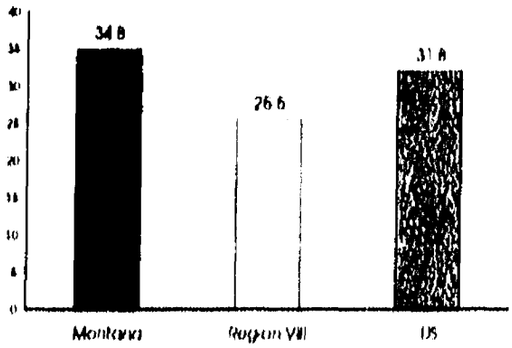
	Montana	Region VIII	US	MT rank
LPNs	2,360	17,500	673,790	43/50
Per 100,000 population	268.3	198.9	249.3	23/50
Per 100 RNs	34.8	25.5	31.8	19/50
Percent female	-	-	94.9%	-

Source: Bureau of Labor Statistics; Bureau of the Census; Division for Nursing.
Note: Data for RNs drawn from the 1996 National Sample Survey.
The abbreviation LPN, or Licensed Practical Nurse, is used herein to refer to both LPNs and LVNs, or Licensed Vocational Nurses.

LPNs per 100,000 population, 1998

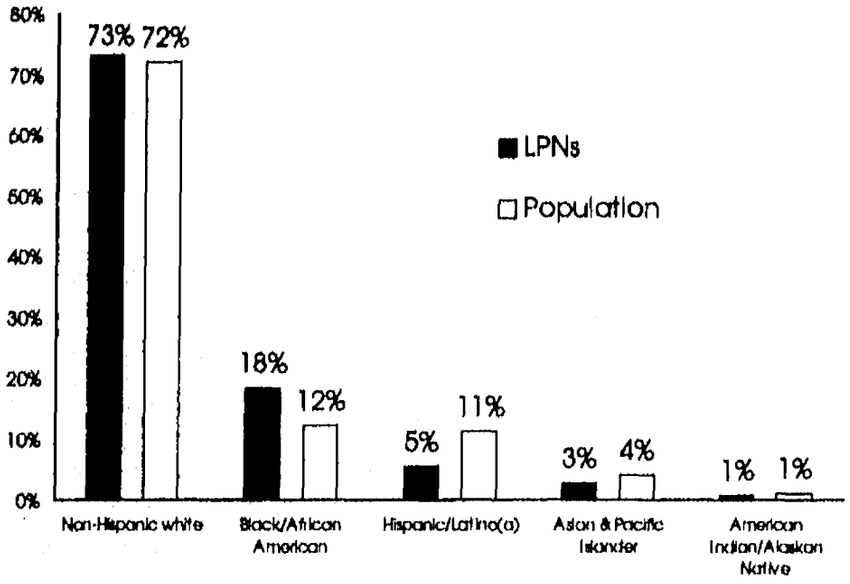


LPNs per 100 RNs, 1998



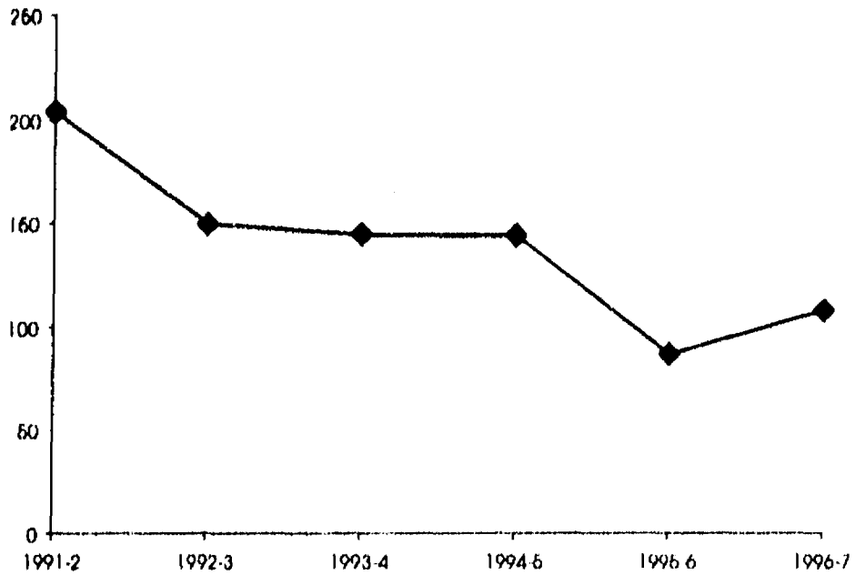
Source: Bureau of Labor Statistics; Bureau of the Census; Division for Nursing
Note: Data for RNs drawn from the 1996 National Sample Survey.

Race/ethnicity of LPNs and the population, U.S., 1999



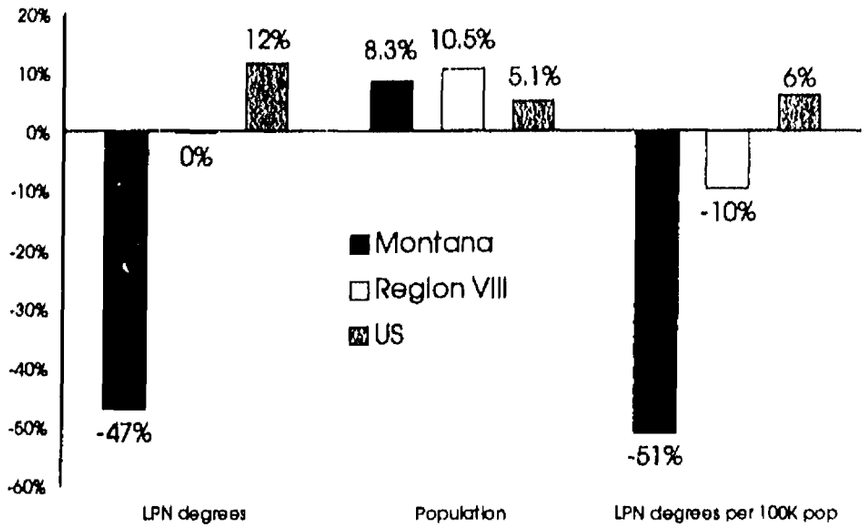
Source: Bureau of Labor Statistics.

LPN education program degrees awarded, 1992-3 to 1996-7



Source: National Center for Education Statistics.

Percentage change in LPN degrees awarded, population & LPN degrees per 100,000 population, 1992-3 to 1996-97



Source: National Center for Education Statistics; Bureau of the Census.

NURSING

- √ There were 9,035 licensed registered nurses (RNs) in South Dakota in 1996; 7,752 were employed in nursing.
- √ There were 1,048.6 RNs per 100,000 population in South Dakota in 1996, significantly more than the national average of 798.
- √ The RN workforce in the West North Central Census Division aged significantly between 1988 and 1996. The percentage of RNs 40 years and older increased from 44% in 1988 to 59% in 1996.
- √ In 1996, the majority of RNs employed in nursing in the West North Central Census Division were Non-Hispanic white (96.6%). Only 1% were Black/African American, less than their percentage in the general population (5.3%).
- √ The number of RNs in South Dakota increased 34% between 1988 and 1996 while the State's population only grew 6%. The result was a 27% growth in RNs per capita, compared to a 20% growth nationwide.
- √ The majority (60%) of RNs in the West North Central Census Division who were employed worked in hospitals in 1996. As a result, metropolitan areas with a concentration of hospital beds were likely to have a relatively high ratio of RNs per capita.
- √ In South Dakota, the number of full-time equivalent RNs working in hospitals declined 3% between 1992 and 1998 while the number of inpatient days rose 6%. The result was a 9% decrease in the ratio of full-time equivalent RNs to inpatient days, compared to a 26% increase in the ratio nationwide.
- √ In 1996, 38% of RNs employed in nursing in South Dakota had an Associate degree; 33% had a Baccalaureate degree; 23% had a Nursing diploma; and 5% had a Masters/Doctoral degree.
- √ Between 1991-92 and 1996-97, the number of Associate and Baccalaureate degrees awarded in nursing decreased in South Dakota. In 1996, the number of Associate degrees awarded in nursing was higher than the number of Baccalaureate degrees awarded.
- √ In 1996-97, 94.3% of the RN degree recipients in South Dakota were non-Hispanic white. Nearly 5% were American Indian/Alaskan Native, less than the percentage in the state's general population (7.8%).

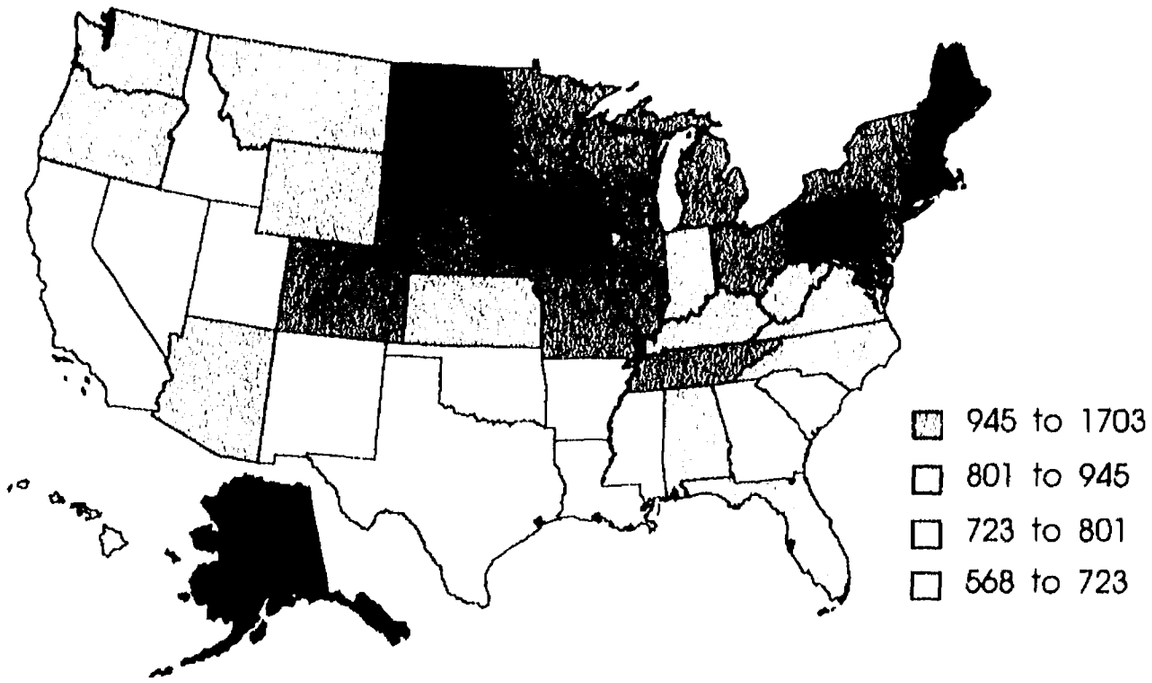
Registered Nurses

Registered Nurses - Total & RNs employed in nursing, 1996

	South Dakota	Region VIII	US	Rank
Registered nurses - total	9,035	80,660	2,558,874	44/60
Registered nurses employed in nursing (RNs)	7,762	68,680	2,116,816	43/60
Per 100,000 population	1,048.6	798.4	797.7	6/60
Percent employed full time	73%	69%	71%	21/60
Percent female	-	-	96%	-
Percent minority	-	-	10%	-

Source: Division for Nursing; Bureau of the Census.
Note: Unless otherwise indicated, 'Registered Nurses' and 'RNs' designate Registered Nurses employed in nursing.

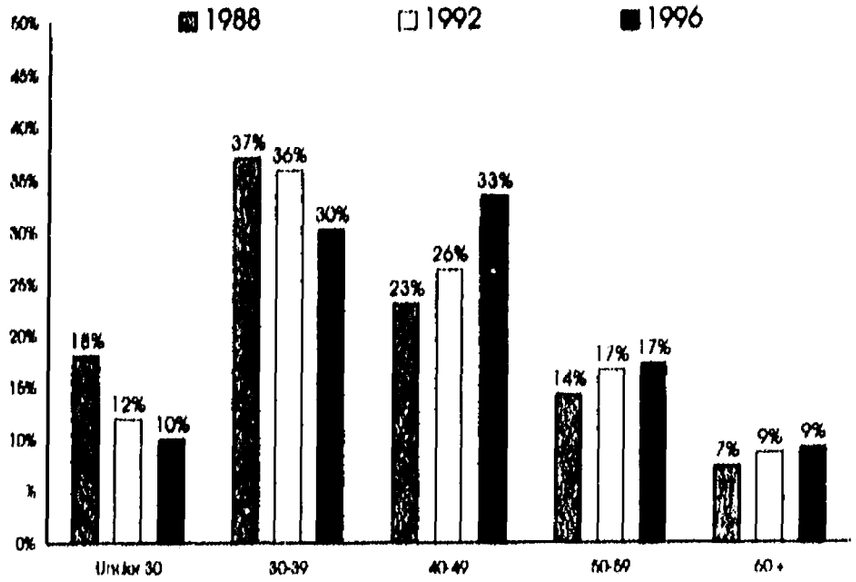
RNs per 100,000 population, 1996



US	797.7
Region VIII	798.4
South Dakota	1,048.6

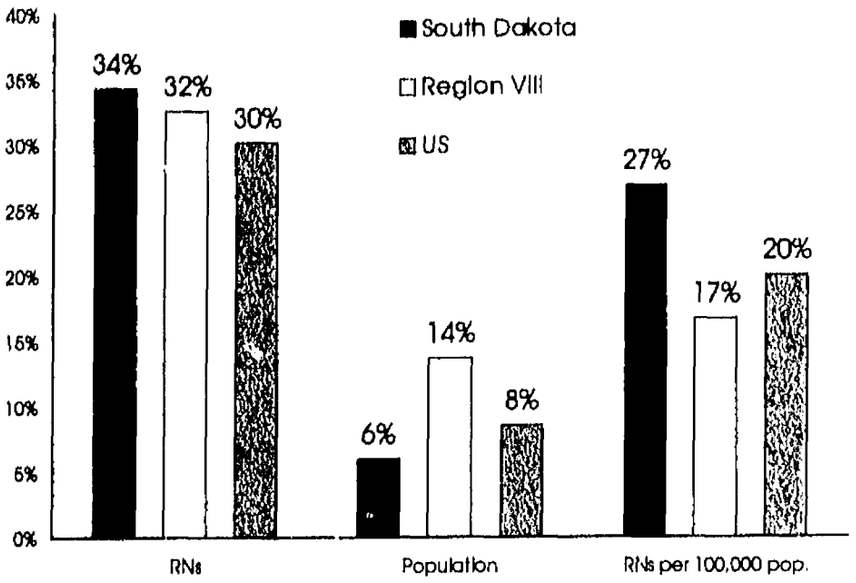
Source: Division for Nursing; Bureau of the Census.

Age distribution of RNs employed in nursing, West North CentralCensus Division, 1988-1996



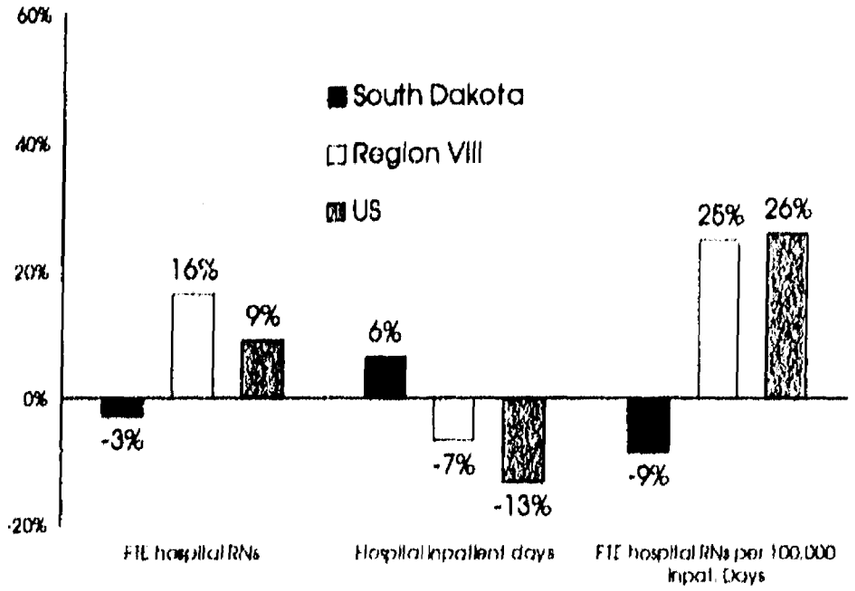
Source: Division for Nursing.

Percent change in RNs, population & RNs per 100,000 population, 1988-1996



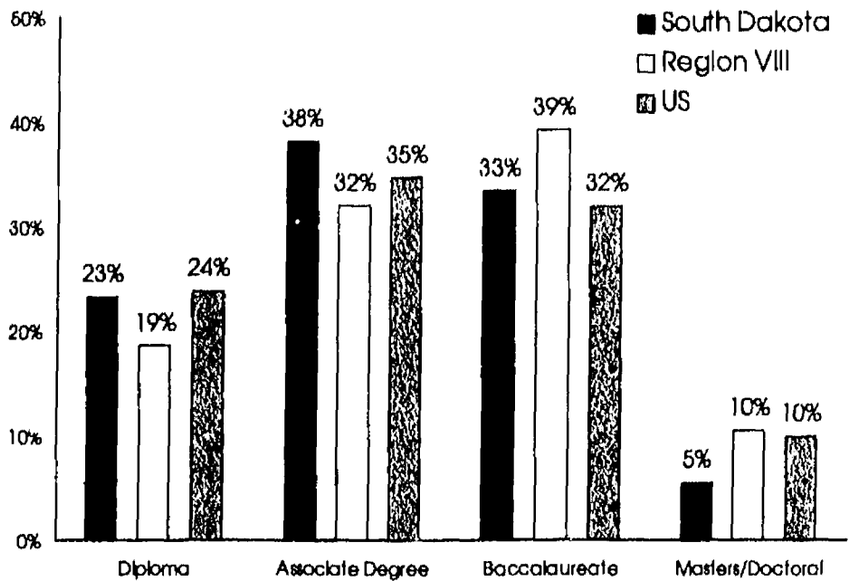
Source: Division for Nursing; Bureau of the Census.

Percent change in FTE hospital RN employment, hospital inpatient days & FTE hospital RN employment per inpatient day, 1992-1998



Source: American Hospital Association.

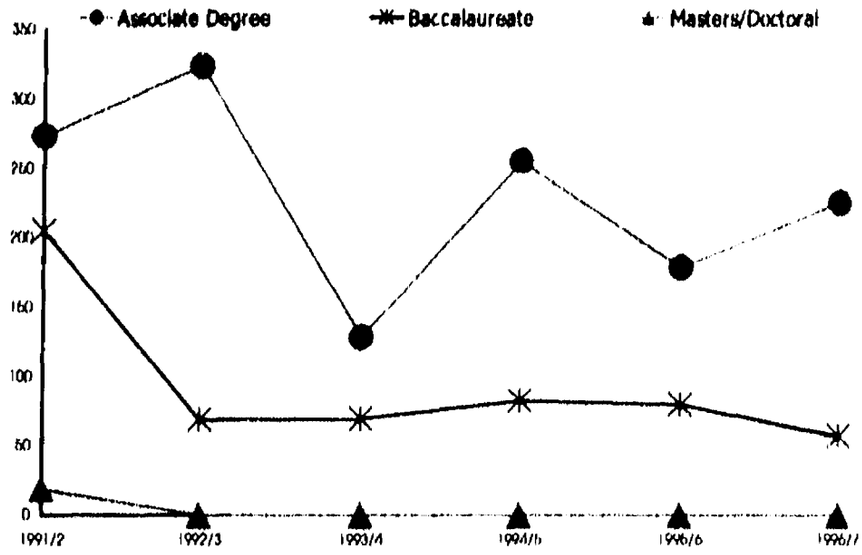
Highest nursing-related educational attainment of RNs employed in nursing, 1996



Source: Division for Nursing.

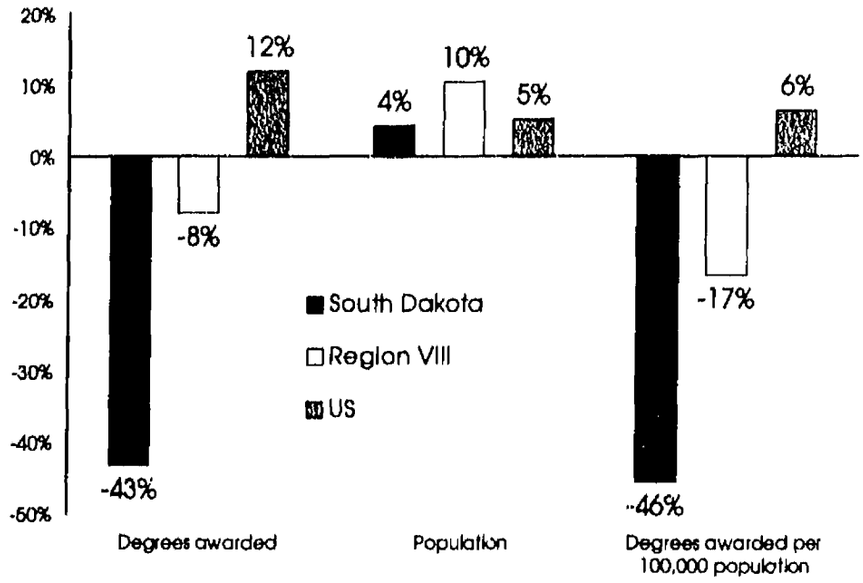
RN EDUCATION

RN education program degrees received by award level, 1991-92 to 1996-97



Source: National Center for Education Statistics; Bureau of the Census.

Percentage change in RN program degrees awarded, population & RN program degrees awarded per 100,000 population, 1991-2 to 1996-7



Source: National Center for Education Statistics; Bureau of the Census.

LICENSED PRACTICAL/VOCATIONAL NURSES (LPNs)

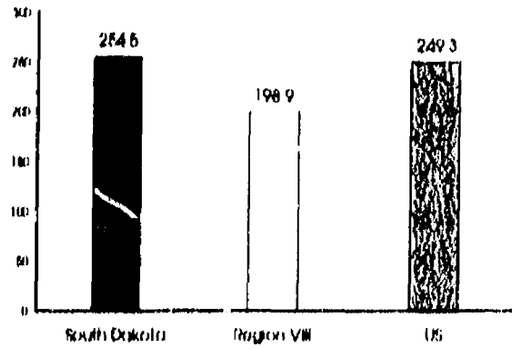
- √ South Dakota ranked 26th among the states in per capita employment of Licensed Practical/Vocational Nurses (LPNs), with 254.5 LPNs per 100,000 population as compared to the national rate of 249.3 per 100,000. South Dakota ranked 46th in the number of LPNs employed in 1998 with 1,860 workers.
- √ Over two thirds of all LPNs in the United States in 1999 worked in institutional settings (35.9% working in hospitals and 34.8% working in nursing and personal care facilities).
- √ The vast majority of LPNs in the United States were non-Hispanic white (73% in 1999) and female (94.9% in 1998). Nationally, Black/African Americans were over represented in the profession (18%) compared to their presence in the population as a whole (12%). By contrast, Hispanic/Latinos were underrepresented (5%) compared to their presence in the population (11% in 1999).
- √ Most recipients of LPN degrees in South Dakota in 1997 were non-Hispanic white (98%) and female (92%). American Indian/Alaskan Natives were not among the recipients of these degrees although they represent 8% of the state population.
- √ In South Dakota, there were 24 LPNs for every 100 RNs employed in the state. This is lower than the national ratio of 32 LPNs employed for every 100 RNs.

LPNs, 1998

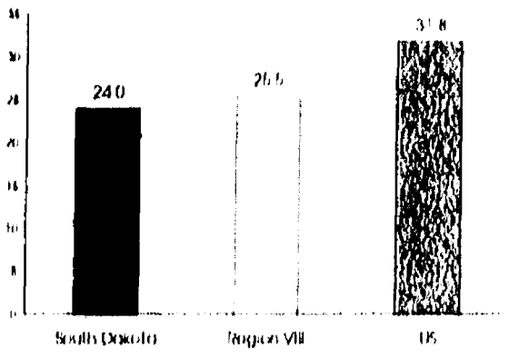
	South Dakota	Region VIII	US	SD rank
LPNs	1,860	17,500	673,790	46/50
Per 100,000 population	254.5	198.9	249.3	26/50
Per 100 RNs	24.0	25.5	31.8	35/50
Percent female	-	-	94.9%	-

Source: Bureau of Labor Statistics; Bureau of the Census; Division for Nursing.
Note: Data for RNs drawn from the 1996 National Sample Survey.
The abbreviation LPN, or Licensed Practical Nurse, is used herein to refer to both LPNs and LVNs, or Licensed Vocational Nurses.

LPNs per 100,000 population, 1998

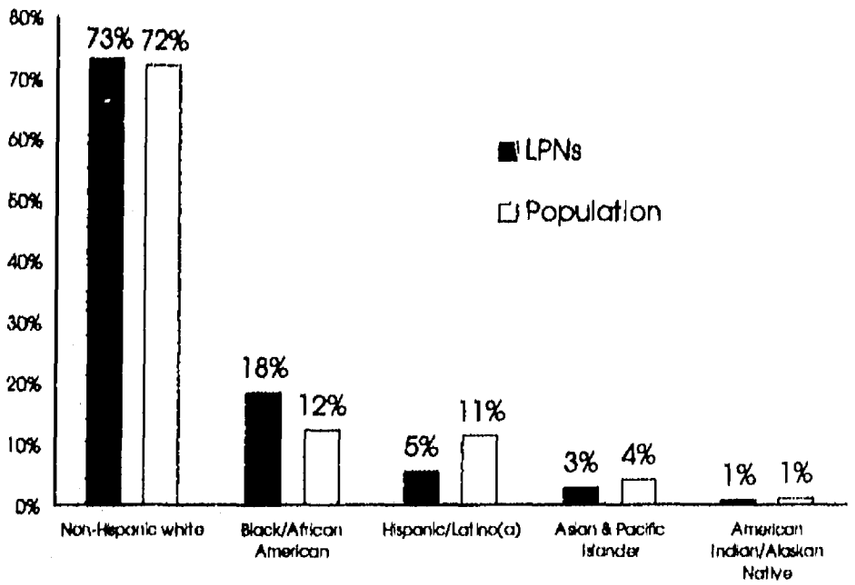


LPNs per 100 RNs, 1998



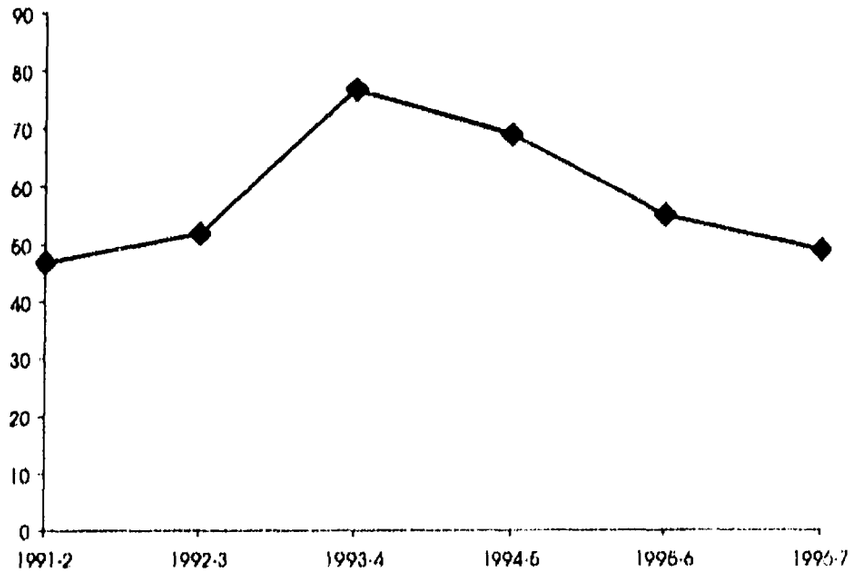
Source: Bureau of Labor Statistics; Bureau of the Census; Division for Nursing
Note: Data for RNs drawn from the 1996 National Sample Survey

Race/ethnicity of LPNs and the population, U.S., 1999



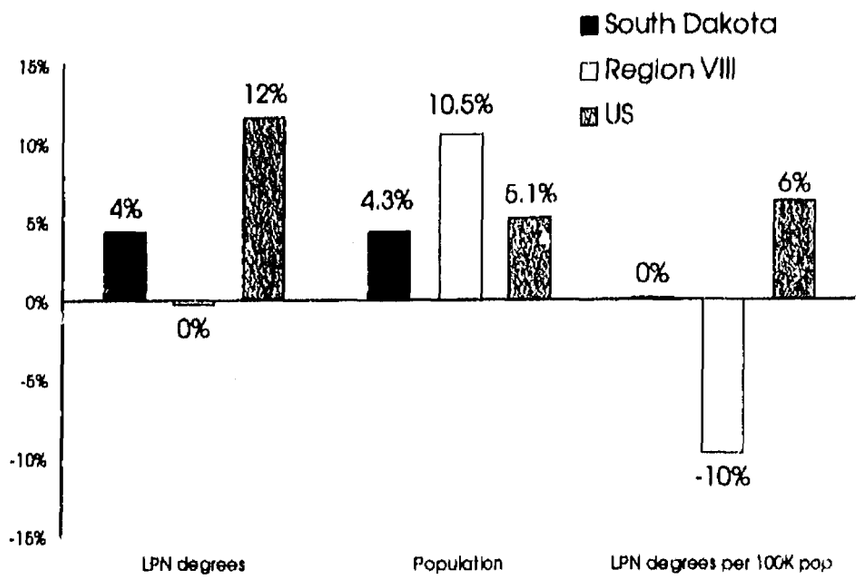
Source: Bureau of Labor Statistics.

LPN education program degrees awarded, 1992-3 to 1996-7



Source: National Center for Education Statistics.

Percentage change in LPN degrees awarded, population & LPN degrees per 100,000 population, 1992-3 to 1996-97



Source: National Center for Education Statistics; Bureau of the Census.

HOUSE HUMAN SERVICES COMMITTEE

TESTIMONY RELATED TO SB 2114

Chairperson Price and members of the Human Services Committee, my name is Constance Kalanek, Executive Director of the North Dakota Board of Nursing.

On behalf of the board, I wish to offer testimony in support of SB 2114 relating to the Nurse Practices Act 43-12.1.

The North Dakota Board of Nursing works diligently to establish and maintain rules and regulations that protect and serve the public. In 1995, the Nurse Practices Act was subject to major revisions, which also resulted in several rule revisions.

The board currently licenses 8271 registered nurses of which 61% hold a bachelor's degree or higher, 3173 licensed practical nurses of which 48% hold an associate degree, and 443 advanced practice nurses. The board also maintains a nurse assistant registry of 2122 nurse assistants and 238 medication assistants.

The proposed revisions of the Nurse Practices Act 43-12.1 began with the first meeting of the Nurse Practice Committee established by the board in May 2000. This committee was established to provide expertise from areas of nursing practice not represented on the board and to make recommendations to the board on issues relevant to current practice. This committee comprised of 23 individuals, represents nursing practice, administration (hospital and LTC), ND Department of Health, North Dakota Licensed Practical Nurse Association and the North Dakota Nurses Association. The committee met in May, June, August, and September 2000.

The following is a section by section summary of the revisions made to the Nurse Practices Act 43-12.1 along with rationale for the changes.

Section-by-Section Summary of Proposed Revisions to Chapter 43-12.1 Nurse Practices Act

SECTION ONE: DEFINITIONS

The most important revision in this section is the definition of "**Unlicensed assistive person**". This proposed definition provides for utilization of an assistant to the nurse in a variety of roles in their field regardless of title. Unlicensed assistive person may include but are not limited to nurse assistant, surgical and dialysis technicians and medical assistants.

The proposed definition for "**specialty practice registered nurse**" will provide for recognition and licensure of nurses who practice a specialty but who do not meet the qualification for advanced practice. The specialty practice registered nurse must be currently licensed as a registered nurse, in good standing, and not be the subject of current disciplinary action. Examples include but are not limited to the registered nurse first assistant (RNFA), diabetic educator, or enterostomal therapist.

The definitions for transitional practical nurse license and transitional registered nurse license were amended into the act in the Senate. The definition existed in the rules and on the advise of counsel they were amended into the Nurse Practices Act.

SECTION TWO: LICENSED REQUIRED

This section states that any person who provides nursing care to a resident of this state must hold a current license or registration issued by the board. The proposed revision inserts the category of specialty practice registered nurse and deletes the words "**a nurse assistant**" and replaces it with "**unlicensed assistive person**".

SECTION THREE: PERSONS EXEMPT

In this section the term **tasks** is replaced with the word **interventions**. This is congruent with the updated terminology used in the nursing profession. It is a broader term that encompasses more than the basic technical skills.

This section also provides for an **exemption for medication administration** for facilities licensed under chapter 25-03.2, chapter 25-16, chapter 50-11 and chapter 50-06. The 1995 Nurse Practices Act - NDCC 43-12.1-04(9) exempted DD provider agencies, foster care providers, and human service centers from registry of assistive personnel from medication administration. This exemption has continued and will sunset July 31, 2001.

A joint committee of the Department of Human Services and the Board of Nursing was established according to the requirements contained in HB 1403 during the 1999 Legislative Session. The committee met on September 9, September 22,

October 12, November 10, December 16, 1999. Executive Summaries are available for your review.

The rationale for this exemption includes the following:

- The NDDHS facilities will monitor certified medication assistants through the use of the Medication Assistant Programs registry at Minot State University in conjunction with the Protection and Advocacy Program.
- This is not an exemption from the nurse assistant registry.
- Background checks are conducted on individuals employed by the facilities/agencies under the purview of the ND Department of Human Services.
- An up-to-date list of names of individuals successfully completing the Medication Assistant I Course is supplied to the North Dakota Board of Nursing beginning in May 1999.
- The Board of Nursing approves the Medication Assistant Courses I & II.
- NDDHS will include in contracts with providers or in a rule revision a requirement that employees of facilities administering medications complete a North Dakota Board of Nursing approved Medication I Course.
- NDDHS will be responsible to establish a standard reporting mechanism for providers on medication errors and will review the submitted reports with the BON.
- In an effort to provide quality nursing care in those facilities the Board has proposed a revision of the definition of consultative nurse and the addition of definitions for assisting with self-administration of regularly scheduled or routine medications and basic nursing interventions. (See attached)
- The revision of the definition of consultative nurse provides direction for nurses who are delegating to unlicensed personnel and is broad enough to cover consultative nursing regardless of employment setting.
- The nurse is accountable to the board of nursing and the facility to follow the standards of practice for an identified role, i.e. RN, LPN.

This section continues to provide protection to the nurse who delegates medication administration in the above settings. According to the **Attorney General's Opinion dated December 4, 2000,** "despite the limitation provided by NDAC 54-05-04-05(9), medication administration may be delegated to a person exempt under NDCC 43-12.1-04(9) pursuant to NDCC 43-12.1-16 until August 1, 2001. If this protection were not provided for the nurses providing consultative services to these facilities, they may indeed be in violation of NDCC 43-12.1.

SECTION THREE: EXEMPTIONS (CONT).

North Dakota practitioners must be licensed to practice nursing. This section (Page 5, Line 9, Subsection 10) would exempt individuals licensed in another jurisdiction with a ND employer to attend orientation, meetings, or required continuing education without obtaining a ND license. Specifically, health care facilities located on the ND, Minnesota,

SD, and Montana borders have satellite clinics and smaller hospitals, which employ nurses licensed in Minnesota, Montana and SD.
Due to the significant changes in the health care environment and the establishment of large health care corporations across state borders, many nurses who reside in a contiguous state must attend required inservices or orientation from the ND employer in the North Dakota work site. Also, a number of national corporations and organizations employ nurses strictly to provide either consultation or education in North Dakota for limited time frames.
Subsection 10 also specifically provides for nurse consultants to practice in the state on a limited basis. Examples include but are not limited to presenting in-services, reviewing policy and procedures; working as a sales representative. Guest lecturer, short-term consultant, and evaluation specifics will be further defined in the rules.

SECTION FIVE: COMPENSATION OF BOARD MEMBERS

This section deletes the current language and replaces it with language consistent with other regulatory boards in North Dakota. The proposed language is much more specific and more useful for budgetary purposes. The board of nursing is the only board to use the current language

SECTION SIX: POWERS AND DUTIES OF THE BOARD

This section replaces the term nurse assistant with unlicensed assistive person to be consistent throughout the NDCC 43-12.1.

Subsection 12 (Page 7, line 8) addresses the **Nurse Advocacy Program (NAP).** The program addresses issues of impairment and is confidential in nature. Evaluation and treatment of NAP participants is obtained from programs and treatment professionals who are mandated by statutory confidentiality laws. The NAP records and program results that reflect such action should likewise be protected.
Subsection 13 (Page 7, line 10) adds the word applicants to provide for disciplinary action by the board for individuals who have a positive response to the licensure questions.

SECTION SEVEN: LICENSURE - REGISTRATION

This section requires proof of progression towards meeting the educational requirements for endorsed nurses that do not meet the educational requirements established by the board. The amendment approved in the Senate would also provide for another track for the experienced transitional licensee to select continuing education requirement to renew their license. A typographical error occurred on page 8, line 24—the word of should be deleted and replaced with or. See attached.

Subsection six (Page 9, line 11) makes the editorial changes described in Sections one and two related to the nurse assistant. Also, added proof of certification as a mechanism for registry status.

Subsection seven (Page 9, line 16-23) identifies the requirements for obtaining a specialty practice license for the registered nurse.

SECTION EIGHT: LICENSE-REGISTRATION-RENEWAL

This section eliminates the residency requirement and is a recommendation by legal counsel. It legally may be unconstitutional. ND is the only state with a residency requirement for nurses. Employment by a federal agency is addressed in NDCC 43-12.1-04 (3). Subsection 2 (Page 10, Line 3-9) clearly outlines the requirements for placement on the nurse assistant (unlicensed assistive person) registry.

SECTION NINE: DUTIES OF LICENSEES

This section adds "registrants" or "registered" to the current language. This will provide for the individuals on the nurse assistant registry to be held to the same standard as the licensee when asked to provide information to the board or to report potential violations. It also provides for consistency.

SECTION TEN: DISCIPLINARY PROCEEDINGS.

This section is intended to address the increased cost for legal services for complex cases. It also clarifies how the boards of nursing of other states are notified. Effective November 1999 federal law required reporting to national data banks.

SECTION TEN: GROUNDS FOR DISCIPLINE-PENALTIES

This section specifically outlines board authority. The BON has conducted an alternative to discipline program entitled the Nurse Advocacy Program for nurses with identified impairments of chemical dependency, psychiatric impairments, and or physical disorders. It has been in operation for 10 years and has had a total of 92 participants (57 RNs, 35 LPNs) since its inception. The change in this section gives the board the authority to ask for evaluation and treatment when impairment is reported to the board.

The other revisions would allow for voluntary surrender or emergency suspension of one's license to practice nursing. The revisions would be further defined in the rules.

Subsection 2 (Page 11,Line 19) adds registration and assist in the practice of nursing for inclusion of the unlicensed assistive person (nurse assistant). **Restricted** is replaced with **sanctioned** is a broader term to encompass other jurisdiction's terminology.

Subsection 5 (Page 11, Line 27) has been clarified by inserting the language of professional misconduct which would be further defined in the rules as it is for the deleted terms. Examples of professional misconduct include, but are not limited to a departure or failure to conform to standards of practice; endangering a patient's life, health, or safety;

misconduct could include non-payment of medications; non-payment of Nursing Education Loan; patient abandonment; negligence; or failure to adhere to professional code of ethics.

Subsection 6 (Page 11, Line 30-31) has been revised to include supplies and equipment and drug diversion for personal use is more specific.
Subsection 9 (Page 12, Line 5-7) specifically identifies responsibilities of licensee; Globally identifies any violation within the authority of the board.

SECTION ELEVEN: VIOLATION – PENALTIES.
Refer to Sections one and two.

SECTION 12. AMENDMENTS
On page 12, the board proposes the addition of specialty practice registered nurse in lines 15 and 19. See attachment.

CONCLUSIONS

Thank you for giving me the opportunity to provide testimony on behalf of the North Dakota Board of Nursing.

I am now open for questions.

PROPOSED AMENDMENTS TO SENATE BILL NO. 2114

Page 8, line 24, remove "of thirty hours of" replace with "or"

Page 8, line 25 remove "activity" and replace with "requirements as established by the board.

Page 12, line 15, after "an advanced practice registered nurse" insert "a specialty practice registered nurse,"

Page 12, line 19, after "an advanced practice registered nurse" insert "a specialty practice registered nurse,"

PROPOSED REVISIONS TO NDAC TITLE 54
RULE REVSION

Definitions.

Current:

54-07-01-02(5) "Consultative Nurse" means a licensed nurse who provides guidance and information as a participant of the interdisciplinary team but is not individually responsible to direct the plan of care for the client.

Suggested Replacement 54-07-01-02(5)

"**Consultative Nurse**" means a licensed nurse who provides guidance and information related to nursing procedures and interventions to the facility or agency but is not individually responsible to provide or direct the plan of care for the client.

Suggested addition to Article 54-07-01-02 Nurse Assistant: (revision to Unlicensed Assistive Person after Nurse Practices Act enacted)

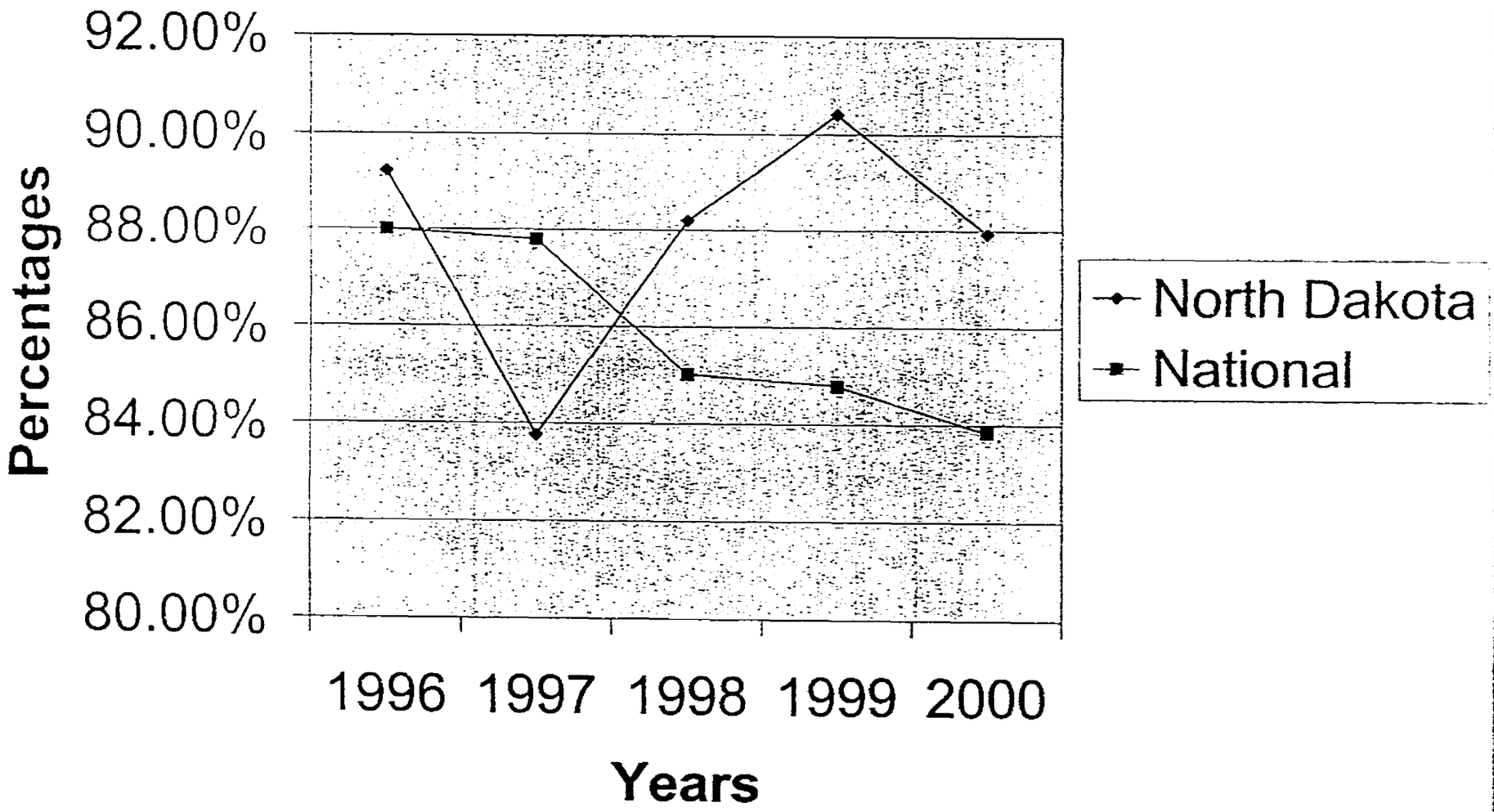
54-07-01-02. Definitions.

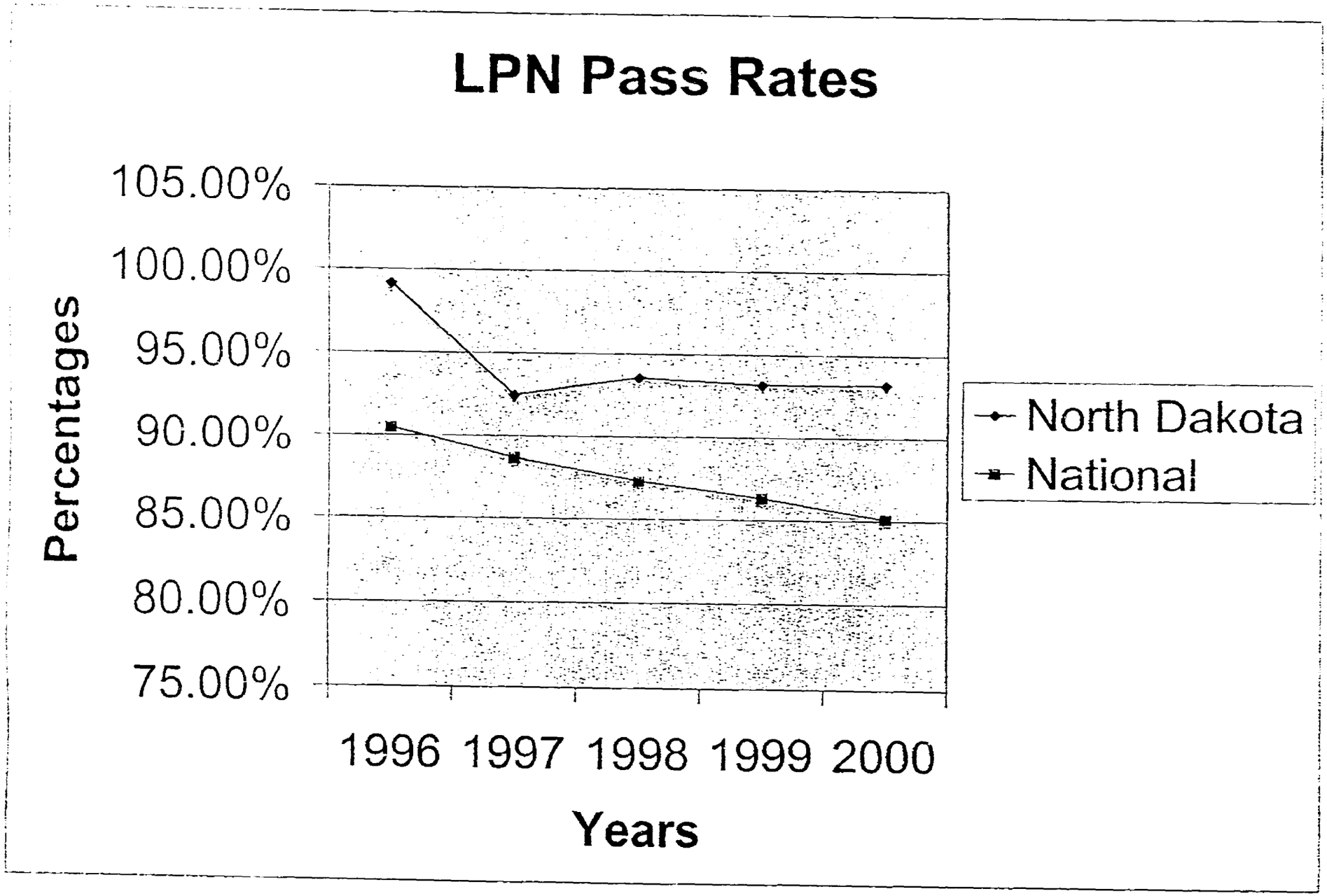
2. "Activities of daily living" includes transferring, ambulating, repositioning, exercising, toileting, feeding, and assistance with self-administered **of regularly scheduled or routine** medications and personal cares. Personal care includes **but is not limited to** bathing, hair care, nail care, shaving, dressing, ~~and~~ oral care, **and maintenance of a safe environment**. **Basic interventions vary from setting to setting depending on the client population served and the acuity and complexity of the client's care needs.**

3. **"Assisting with Self Administration of Regularly Scheduled or Routine Medications" means helping the client with one or more steps in the process of taking medications but does not mean "administration of medication" as defined in the rules. Examples of "assisting" include, but are not limited to opening the medication container or reminding the client of the proper time to take the medication. Assisting with the administration of medication may be a delegated intervention.**

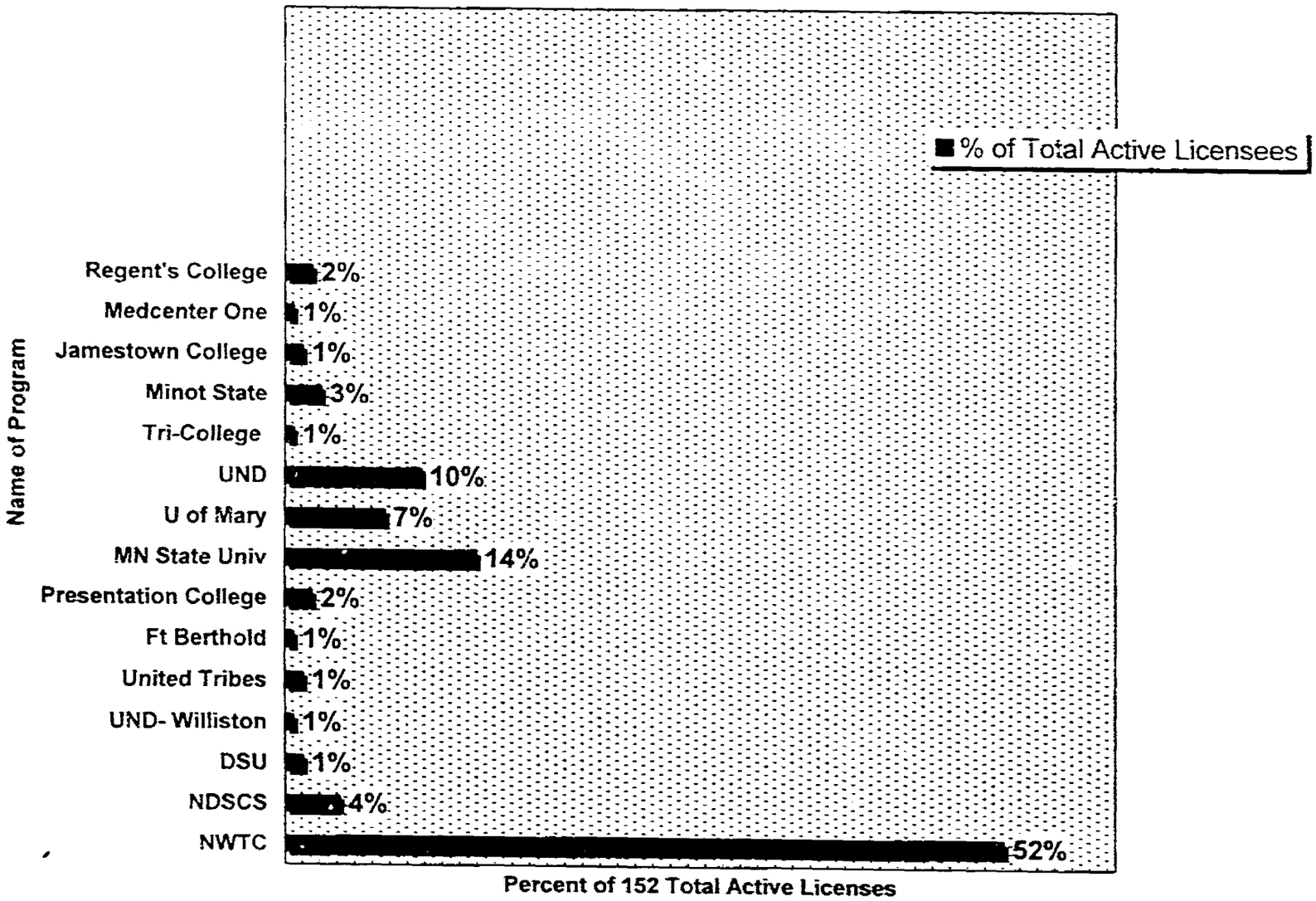
SB 2114

RN Pass Rates

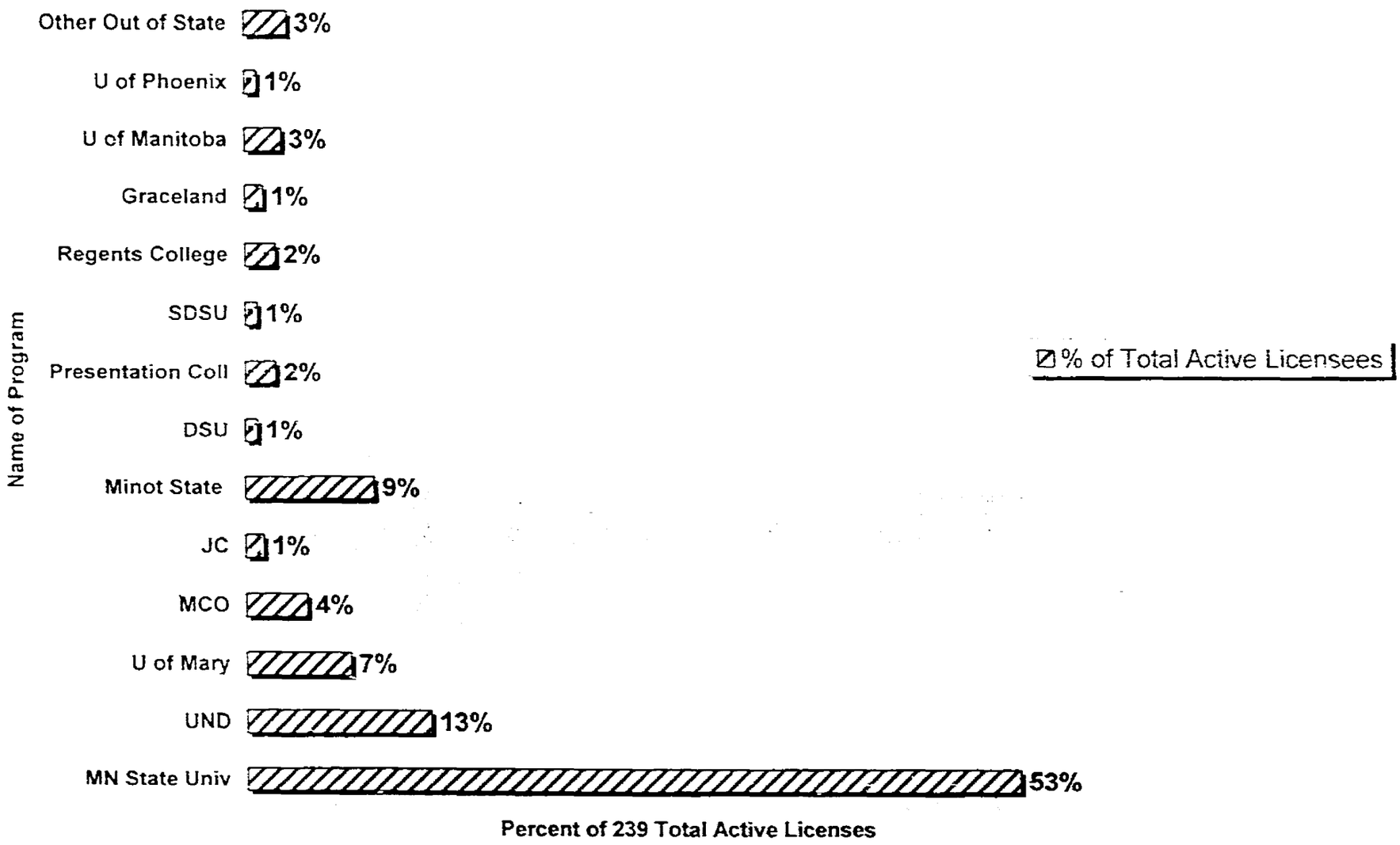



LPN Pass Rates
105.00%
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
Percentages
1996 1997 1998 1999 2000
Years
North Dakota
National

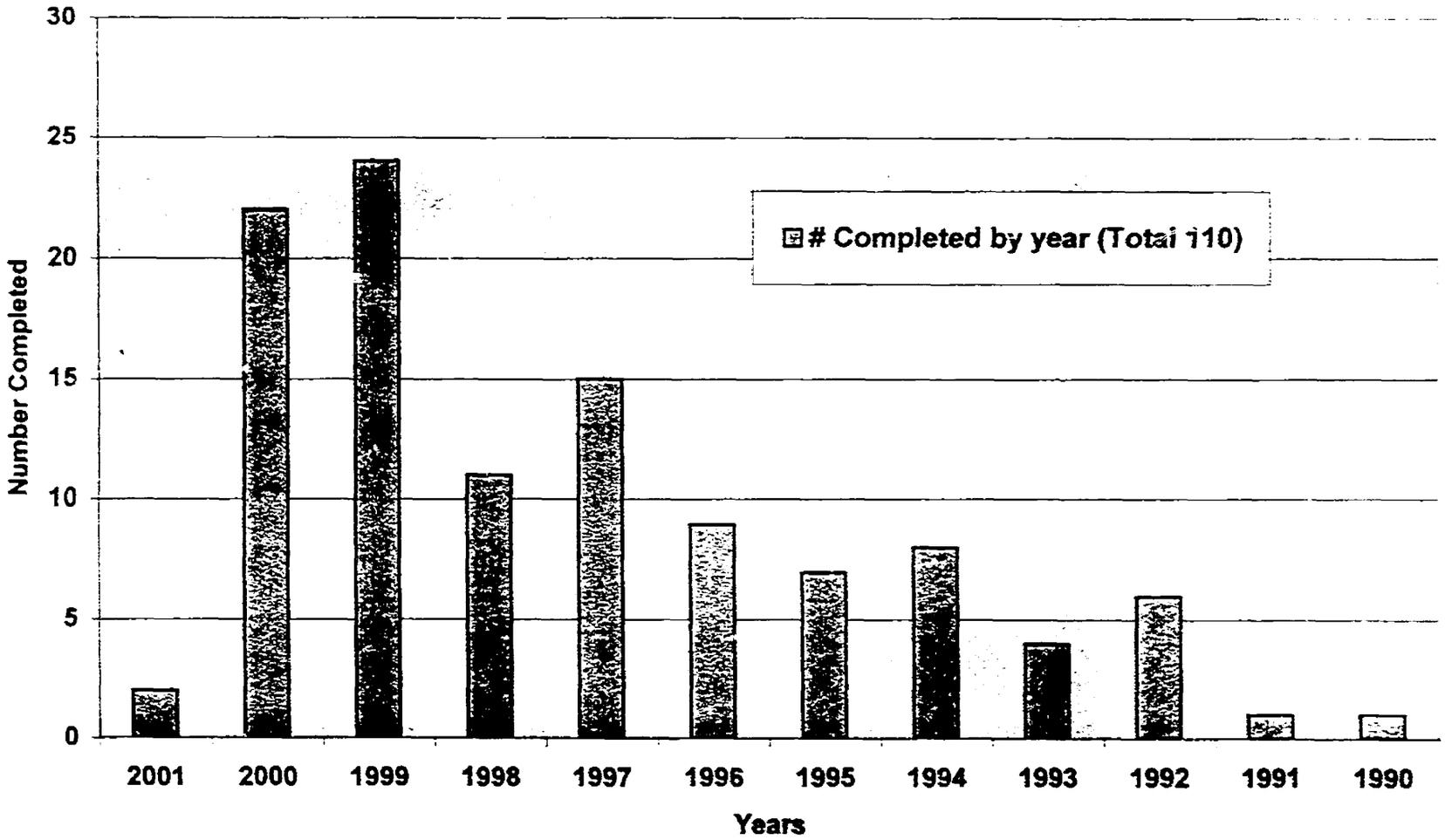
Program of Study Schools - Transitional LPN



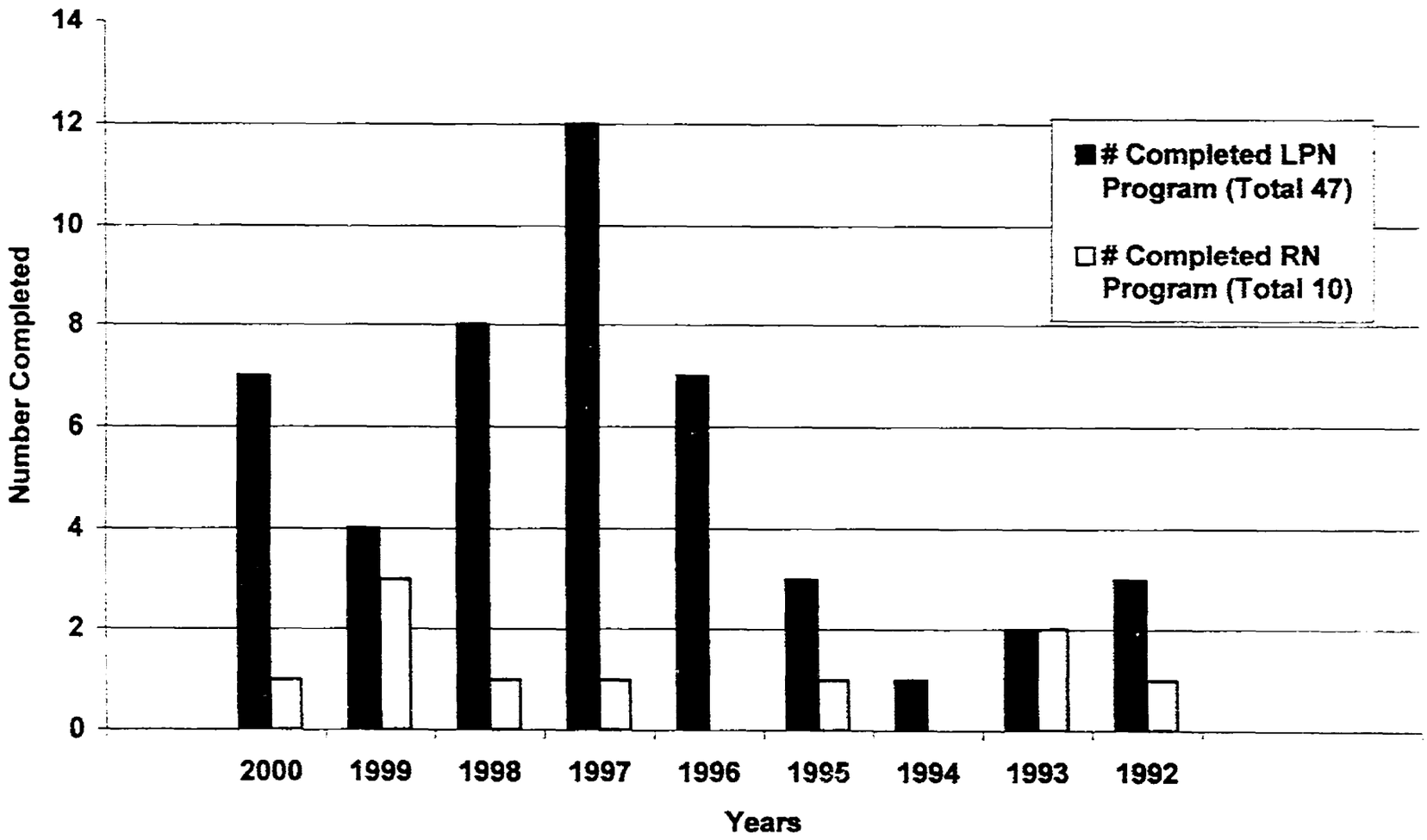
Program of Study Schools - Transitional RN



Number of Transitional RNs Completed RN Program



Number of Transitional LPNs Completed



Testimony Before the Human Services Committee

SB 2114

Chairperson: Representative Clara Sue Price

March 7, 2001

Chairperson Price and members of the committee,

My name is Bonnie Selzler. I am the Assistant Director of Mental Health Services and represent the Department of Human Services on the Medication Administration Committee.

In response to HB 1403 of the 1999 legislative session, representatives from the Department of Human Services, the Board of Nursing, the North Dakota Medical Association, the North Dakota Nurses Association, the North Dakota Association of Community Facilities and other private providers met regularly to discuss the ramifications of unlicensed staff providing medication. The results of those efforts were previously reported to the Interim Budget Committee on Health Care as directed by HB 1403.

The changes detailed in subsection 9 of Section 3 of Senate Bill 2114 reflect the consensus of that group.

The Department of Human Services supports Senate Bill 2114.

I am happy to answer any questions you may have.

On behalf of the board, I wish to offer testimony in support of SB 2114 relating to the Nurse Practices Act 43-12.1.

Chairperson Price and members of the Human Services Committee, my
My name is Kirsten Friedt. I am a Registered Nurse employed by ABLE, Inc. of Dickinson. I urge you to place a DO PASS on Senate Bill 2114. ABLE provides services to people with Developmental Disabilities; we are licensed under chapter 25-16. I have been employed by ABLE, Inc. for almost 12 years. Medication administration and delegation of nursing tasks have long been a gray area for nurses employed by facilities such as ABLE, Inc. I can remember discussing this very issue at the first nurse's meeting for people with developmental disabilities that I attended, just a few short months after I started.

Today I would like to speak to the exemption portion of this bill included in section three, subsection 9 both with the exemption effective through July 31, 2001 and effective after July 31, 2001. During the last legislative session I was not in favor of the exemption as it is noted through July 31, 2001. The exemption through July 31, 2001 exempts the DD provider from having to place staff administering medications on the North Dakota Board of Nursing's Medication Assistant Registry. However, it does not exempt the nurses employed by the DD provider from having to comply with the Nurse Practice Act. What this did was take the nurse out of the task of administering medications. Unlicensed assistive personnel are able administer medications without the nurse being involved.

The exemption as written to be effective after July 31, 2001 states the nurse may delegate medication administration to a person exempt from the provisions of chapter 43-12.1. This keeps the nurse involved in the task of administering medications when it has been delegated to unlicensed assistive personnel. This provision is in fact a compromise reached by the North Dakota Board of Nursing and the Department of Human Services. I was a member of the committee that deliberated over this issue. Although it is not perfect by any means it is workable and rational at this point in time. It continues to allow me, the nurse, to delegate to the staff the duty of administering medications. This includes insuring the person administering medications meets competency standards.

Once again, I urge you to place a do pass on Senate Bill 2114. Thank you for your time and attention to my testimony.

Senate Bill 2114

Greetings Chairman Price and members of the Committee. My name is Susan McNaboe. I am a registered nurse (RN), a Certified Nurse Operating Room (CNOR) and a Certified Registered Nurse First Assistant (CRNFA). I have lived in ND for 25 years and have been employed in Operative Services of Mercy Medical Center, Williston throughout that time.

I am speaking today in support of SB2114, specifically to section 1. Item 8.

Specialization in nursing practice has been a major advancement in nursing over the last few decades. Three forces initiate movement toward specialization:
New knowledge pertinent to the field
Technological advance
And response to public need.

The development of the Registered Nurse First Assistant is the result of changes in the health care delivery system and insurers' greater attention to cost-effectiveness.

The scope of practice for the Registered Nurse First Assistant is a part of the specialized practice of perioperative nursing. The RNFA assists the surgeon in the performance of the surgical procedure, from the preoperative assessment through the surgical intervention, recovery, and discharge of the patient.

Currently the board of nursing in all fifty states recognizes the RNFA role as being within the scope of nursing practice. The Association of periOperative Registered Nurses, the American College of Surgeons, the American Nurses Association, and the National Association of Orthopedic Nurses also recognize RNFAs.

A CRNFA is a registered nurse first assistant (RNFA) who obtains national certification, a voluntary process. An RNFA already is a technically skilled, highly educated nursing professional who renders direct patient care as part of the perioperative nursing process. The certification process raises an already high quality standard and recognizes those RNFAs who have achieved excellence in patient care.

The RNFA seeking certification must meet rigid requirements before applying, including:

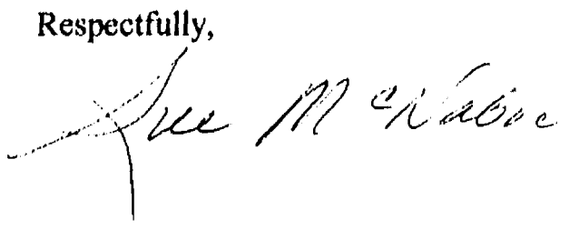
1. current licensure as a registered nurse , without provision or condition
2. must be a Certified Nurse Operating Room (CNOR) and must maintain that status throughout the entire period of CRNFA certification
   The CNOR itself involves two years of perioperative experience, current licensure as a registered nurse, and successful completion of the certification exam.
3. must have completed 2000 documented hours of practice as an RNFA
4. Must have completed a formal RNFA program that meets criteria established by the Certification Board Perioperative Nursing including training equivalent to one-year comprehensive post-graduate program involving both classroom and clinical studies.
5. Must have a Bachelor and/or Master of Science Degree in Nursing after January 1,2000.

Ideally a physician would provide first assistant services. In rural areas such as ours this is simply not always possible. In our situation we have no Advanced Practice Nurses or Physicians Assistants that are available. It quickly became apparent who would be fulfilling the first assistant role. Thus, remembering the words of my parents—"If you are going to do it, do it right" and knowing the way to do it right is through the appropriate education, I went back to school. CRNFAs receive more advanced education and training in first assisting than any other non-physician provider who first assists.

The category of Specialty Practice Registered Nurse recognizes the experience and expertise of the CRNFA. Our education is extensive and is a definite benefit to our patients, the citizens of North Dakota.

Thank you

Respectfully,



SUPPORT MEDICARE REIMBURSEMENT FOR CERTIFIED REGISTERED NURSE FIRST ASSISTANTS

AORN (the Association of periOperative Registered Nurses) is seeking Medicare reimbursement for the surgical first assisting services of Certified Registered Nurse First Assistants (CRNFAs) at a rate of 13.6 percent of the surgeon's fee. As first assistants, CRNFAs provide high-quality cost-effective care and perform the same tasks and duties as surgeons, physicians, physician assistants (PAs), and some nurse practitioners (NPs) who may currently receive Medicare reimbursement for first assisting services. Reimbursing CRNFAs for their surgical first assisting services would address this fundamental inequity.

WHAT IS A CRNFA?

A CRNFA is a registered nurse first assistant (RNFA) who obtains national certification, a voluntary process. An RNFA already is a technically skilled and highly educated nursing professional who renders direct patient care as part of the perioperative nursing process. The RNFA possesses the skills, knowledge, and judgment necessary to assist the surgeon in performing a safe operation that yields optimal results for the patient. The certification process raises an already high quality standard and recognizes those RNFAs who have achieved excellence in patient care.

The RNFA seeking certification must meet rigid requirements before applying, including:

1. Current licensure as an RN, without provision or condition, in the United States;

2. Certification in perioperative nursing (CNOR);

3. Completion of a minimum of 2000 hours of practice as an RNFA[1] that includes preoperative, intraoperative, and postoperative patient care;

4. Completion of a formal RNFA program that meets criteria established by the Certification Board Perioperative Nursing, including training equivalent to a one-year comprehensive post-graduate program involving both classroom and clinical studies in anatomy and physiology, assessment skills, asepsis/infection control, and an extensive surgical assisting curriculum. During the required clinical internship, the prospective RNFA spends a minimum number of clinical hours under the supervision of a surgeon preceptor; and

5. Hold a B.S.N. or M.S.N as of January 1, 2000.

CRNFAs are recognized by the American College of Surgeons, the American Nurses Association, the National League for Nursing, the National Association of Orthopedic Nurses, and the 50 state boards of nursing.

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[1] There are approximately 4,000 RNFAs in the United States. According to a 1995 survey of the Specialty Assembly, RNFAs are employed by hospitals and physicians, as well as being self-employed as independently contracted health care providers. In addition:

- The average age of an RNFA is 42 years old.
- The average length of time as an RN is 17 years.
- The average length of time in the operating room is 15 years.
- The average length of time as an RNFA is 4.62 years.
- Thirty percent of RNFAs have CRNFA credentials.

WHAT MAKES CRNFAs SPECIAL?

CRNFAs bring the patient-centered perspective of nursing into the operating room, continuously utilizing critical thinking skills and assessing patient health in order to ensure optimal patient outcomes. Further, CRNFAs have received more advanced education and training in surgical first assisting than any other non-physician provider who first assists. For example, PAs commonly complete much less than the 2,000 hours of surgical assisting currently required before RNFAs may take the CRNFA certification exam. NPs are not required to have any extensive training in first assisting and yet receive direct reimbursement. In addition, CRNFAs and RNFAs are the only providers -- aside from the rare physician making house calls -- who sometimes provide post-operative care by actually visiting patients at home following surgery. Thus, not only do CRNFAs have more clinical experience and education but they also provide continuity of care to patients enabling higher quality and better patient outcomes.

HOW WOULD CRNFAs SAVE THE HEALTH CARE SYSTEM MONEY?

Heath claims data from the Health Care Financing Administration (HCFA) reveal that physicians file more than 90 percent of the first assistant at surgery claims for Medicare reimbursement. Physicians receive 16 percent of the surgeon's fee for first assisting. **CRNFAs are requesting only 13.6 percent of the surgeon's fee for their first assisting services.** Use of CRNFAs would therefore be a high quality yet cost-effective alternative for the nation's health care delivery system, affording additional flexibility to surgeons, hospitals and ambulatory surgery centers.

Further, CRNFAs are equally as cost-effective as other non-physician providers (PAs and some NPs) who currently are reimbursed at 13.6 percent of the surgeon's fee for first assisting. Moreover, CRNFAs have more rigorous training in first assisting, which likely would result in positive patient outcomes such as lower recidivism rates, decreased complications from surgery, higher patient satisfaction levels and overall lower expected costs per patient. Until CRNFAs can receive direct reimbursement, however, there is no incentive to use these high quality, cost-effective providers for first assisting in surgery.

WHO CURRENTLY REIMBURSES CRNFAs?

- Though some commercial insurers provide coverage for the services of CRNFAs, reimbursement is inconsistent and variable on a state-by-state and even a case-by-case basis.
- Payment by BlueCross/BlueShield plans vary by state; however, generally, if the CRNFA is not a contracted provider, BlueCross/BlueShield will pay the patient directly for CRNFA services.
- Many Medicaid plans provide direct reimbursement.

COST ESTIMATE

An independent cost estimate by Muse & Associates determined that coverage eligibility for CRNFAs under Part B of the Medicare program would cost $7.2 million in 2000, increasing to $25.1 million in 2004. The total cost over a five-year period would be $84.6 million.

SUMMARY

As a provider of health care, the CRNFA is a viable solution for controlling rising health care costs. Working in collaborative practice with surgeons, CRNFAs are cost-effective to the patient and to the health care delivery system. The AORN proposal would extend Medicare coverage eligibility to CRNFAs for their surgical first assisting services. Because CRNFAs would be reimbursed under Medicare at a lower rate than physicians who first assist, and because CRNFAs routinely provide much-needed patient education and counseling, use of CRNFAs could well decrease the frequency and length of hospital stays.

North Dakota Licensed Practical Nurses' Association

CHAIRMAN PRICE,MEMBERS OF THE HUMAN SERVICES COMMITTEE, LADIES AND GENTLEMEN,

MY NAME IS ELAINE D. TAYLOR LPN. I AM HERE AS A REPRESENTATIVE AND PRESIDENT OF THE NORTH DAKOTA LICENSED PRACTICAL NURSES ASSOCIATION. I ALSO COME TO YOU AS A LPN OF 37 YEARS IN THIS MY CHOSEN PROFESSION.

NDLPNA WISHES TO SPEAK IN FAVOR OF SB 2114 AND TO THANK YOU FOR THIS OPPORTUNITY HERE TODAY.

MEMBERS OF NDLPNA FEEL THAT THE CHOICE TO WORK IN THE MEDICAL ARENA CARRIES WITH IT RESPONSIBILITES AND ACCOUNTABILITY.THERE ARE THOSE OUT THERE WHO SAY THAT ACCOUNTABILITY IS A "TURF" ISSUE OF THE PROFESSIONALS MAKING ONLY,BUT WE SAY,NOT SO! ACCOUNTABILITY IS ALL AROUND US. IT IS IN THE DUTY THAT YOU THE ELECTED OFFICIAL HAS TO US THE PUBLIC,THAT ELECTED YOU, CHILDREN TO PARENT,WIFE TO HUSBAND,WE AS TAXPAYERS TO THE US GOVERNMENT,THE LIST GOES ON AND ON.PERHAPS AS PROFESSIONALS IT ENTAILS MORE,BUT HOWEVER THE ISSUE STANDS.IT IS THEREFORE NECESSARY TO SEE THAT THE PROPER EDUCATION,TRAINING,CERTIFICATION AND LICENSING ARE IN PLACE AND THAT THERE IS A ENVIRONMENT SO THAT CONTINUED EDUCATION AND LEARNING IS MET.

SPEAKING FROM PERSONAL EXPERIENCE OF 35 YEARS IN THE ACUTE CARE,TO MY LATEST EXPERIENCE OF 2 YEARS IN LONG TERM CARE. THE MEDICAL PICTURE HAS GREATLY BROADENED.EVEN THOUGH VARIOUS FACILITIES HAVE DOWNSIZED,RIGHTSIZED;WHAT WE SEE NOW ARE EVEN MORE ACUTELY ILL CLIENTS AND THERE IS A SEVERITY OF DISABILITIES AND TRAGEDIES THAT REQUIRE MUCH MORE CARE AND EVEN GREATER NEED FOR THE LTC ADMISSION.IT IS NO LONGER A CASE OF CARING FOR MOM,OR DAD IN A GOOD FACILITY,BUT YOUNGER AND MORE ACUTE CASES NEED THAT CONTINUED CARE.THEREFORE NDLPNA IMPLORES THESE AGENCIES TO USE THEIR STAFF TO THE FULLEST OF THEIR CAPABILITIES AND TO THE EXTENT THAT THEIR SCOPE OF PRACTICE ALLOWS.

THIS BRINGS US TO ANOTHER ISSUE THAT NEEDS ADDRESSING.NOT JUST HERE IN ND ,BUT EVERYWHERE WE ARE LOOKING AT A SHORTAGE OF NURSES. TEN YEARS AGO WHEN WE MET HERE ON ISSUES,THE AVERAGE AGE(LPN) WAS 41 - 44,WE ARE NOW LOOKING AT A POPULATION OF 51 - 55 YEARS AND OLDER.THERE IS ALSO A GROUP OUT THERE THAT CHOOSE NOT TO WORK AND PRACTICE THEIR PROFESSION BECAUSE,FACE IT;SALARIES AND BENEFITS ARE NOT THE GREATEST,HOURS ARE LONG AND GETTING LONGER,FOR LACK OF STAFFING BEING COMPLETE;THEN YOU HAVE THE DILEMA OF CONCERNS OVER SAFETY,NOT ONLY FOR THE PUBLIC,BUT NURSES CONCERNS OVER LICENSURE PROTECTION. WHAT ABOUT THOSE WHO DESIRE TO WORK HERE IN ND ,BUT CANNOT,WE TELL THEM THAT THEIR YEARS OF EXPERIENCE,KNOWLEDGE,SKILLS AND ABILITIES COUNT FOR NAUGHT.CAN WE AFFORD TO LOSE MORE PROFESSIONAL CARE GIVERS? WE OF NDLPNA ALSO FEEL THAT ND HAS MET THOSE CRITERIA AND STANDARDS SET BY OUTSIDE ENTITIES,ALL WE NEED DO IS LOOK

TESTIMONY ON SB 2114
NORTH DAKOTA NURSES ASSOCIATION

Chairman Price and members of the House Human Services Committee. My name is Penni Weston. I am a Registered Nurse and a board member of the North Dakota Nurses Association (NDNA), an organization representing professional nurses in ND.

NDNA has been a participant in the workgroups responsible for formulating the revisions to the Nurse Practice Act. We appreciated the opportunity to be involved in this process and support the revisions with one exception. We are not supportive of the exemption for those individuals who provide medications in specific settings (developmentally disabled treatment centers, human service centers, etc.). NDNA is fully aware that this exemption has been agreed upon as a compromise, however we have grave concerns for the safety of the clients receiving medications as a result of this compromise. The dictionary defines compromise as conceding, giving in or making a deal. Another definition of compromise is to compromise care. We believe this is the applicable definition in this exemption for the following reasons:

1. This exemption allows the least trained individual to administer medications to some of our least capable citizens. Medication administration is a complex skill that requires a broad base of knowledge to prevent undesired consequences. It is much more involved than simply "handing out pills". The individual administering medication must have knowledge of anatomy and physiology (which organs will the medication affect), microbiology (what diseases or infections is the medication intended to treat), pharmacology (what are the potential side effects and allergic reactions), mathematics (what is the correct dosage) and medical and legal principles. These must be understood before the actual manual skill of giving the medication can be mastered. At the very least, licensed nurses should be involved in determining which medications can be safely administered by someone who has only completed a self-study program.

2. Client safety is our major concern and objection to this exemption. Who will be monitoring medication administration to assure that the client's safety and well being is protected? The client will go to a health care provider who will issue a prescription. This provider will have no further responsibility to the client. The prescription is then taken to a pharmacist who will place the pills in the bottle and label the container. This

pharmacist will also have no further responsibility or interaction with the client. The pharmacist has no opportunity to provide education to the client or the person administering the medication about the intended use and/or side effects of the prescribed medication. The medication is then delivered to the client's care setting. Who then, will be responsible to make sure the medication is given at the appropriate time, in the right amount and to the right client? Who will educate the staff as to what side effects to watch for and under what conditions it would not be appropriate to give the medication?

A recent report from the IOM (Institute of Medicine) demonstrates that errors are being made at alarming rates. Medication errors are one of the areas that have surfaced as being one of the most troublesome. Note that this report indicates patient safety is being jeopardized in health care settings where licensed nurses are administering medications. Common sense would tell us that if medication errors were jeopardizing patient safety where licensed nurses are involved in the process of medication administration, not having a licensed nurse involved would seem to indicate almost sure danger.

3. The ND Board of Nursing has defined medication administration as a nursing task. The board has also defined feeding as a nursing task. Feeding assistants have been utilized in the long term care setting to assist with this nursing task. The Health Care Financing Administration (HCFA) has taken the position that anyone that performs the "simple task" of feeding must complete the CNA course. This course includes content on how to take a blood pressure, pulse, report signs of infection and many other topics. It seems inconsistent and illogical to think then, that someone with less training should be allowed to administer medications such as anticonvulsants (prevent seizures), psychotropics (mood altering), antihypertensives (blood pressure and heart medications), and oral hypoglycemics (diabetes medications).

4. Medical symptoms may not have been the primary reason for someone entering these settings, however, as the aging process occurs and medical problems arise, so does the need for nursing care; particularly medication administration. The individual who administers these medications should know about drug toxicities, side effects, drug/drug interactions and other potential problems that may arise as a result of the client requiring medication for treatment of a medical problem. If the individual administering the medications does not have this knowledge, then the

person who is supervising the medication administration must know this in order to safely delegate this task.

As previously stated, NDNA does not support this exemption. The premise of professional licensing is to protect the public from unscrupulous providers. Exemptions to a practice act serve only to weaken the protection of the public.

There are currently exemptions to the practice act, however, there is usually still a nurse involved in some way. Families who give nursing care to a family member are exempted, but a licensed nurse is often involved through home care or hospice services. Individuals rendering assistance in a disaster are exempt, but licensed nurses have always been involved such as providing leadership and direction for care in the shelters.

In closing, NDNA believes licensed nurses should be and must be involved in any setting where nursing care is rendered, either through direct care or delegation. Delegation implies licensed nurse responsibility, which cannot be permissive under the law.

Thank you for the opportunity to testify on SB 2114 and I would be happy to answer any questions committee members might have.

To: House Human Service Committee
Representative-Clara Sue Price

From: Melana Howe, RN
Dir. of Patient Care Services
Hettinger, North Dakota

I am a registered nurse, and work in healthcare administration.

As an employer of healthcare personnel with West River Regional Medical Center and President of the North Dakota Organization of Nurse Executives (the clinical supportive entity of the North Dakota Healthcare Association), I am speaking in support of Senate Bill 2114 and specifically Sections One and Three as they relate to supervision through delegation and licensure.

First, North Dakota is unique in its' standards for assignment and delegations. The nurse's role and accountability for care are defined by the following questions:

1. Who is directing the care?
2. From whom does the unlicensed assistive personnel get the authority to act?
3. What are the nursing activities for which the nurse is held accountable?

In numerous healthcare facilities across ND, individuals, regardless of title or education, are performing interventions delegated and supervised by a licensed nurse. These individuals are assistive to the nurse, regardless of title. The desired change in the Practice Act recognizes the individual's education, training, and competency. It also recognizes those individuals' scope of practice that overlaps with nursing. It sets the stage for mutual respect between professionals, such as medical assistant, surgical technician, dialysis technician, or medical technicians. As Director of Patient Care, I do hiring, delegating to supervising, disciplining of RTs, EMS, Medical Assistants, and midlevels.

Secondly, ND practitioners must be licensed to practice nursing. This section would exempt individuals licensed in another jurisdiction with a ND employer to attend orientation, meetings, or required continuing education without obtaining a ND License. Specifically, healthcare facilities located on the North Dakota, Minnesota, South Dakota and Montana borders have satellite clinics and smaller hospitals, which employ nurses licensed in Minnesota, Montana, and South Dakota.

The ND BON should be commended on their collaboration with nursing executives, such as myself, to prepare for the desired revisions of the Standards of Practice for nursing. Healthcare is changing rapidly and drastically. The proposed revisions are timely, practical, and make good sense. Thank you.

Testimony on SB 2114
House Human Services Committee
March 7, 2001

Chairman Price and members of the House Human Services Committee, thank you for the opportunity to testify on SB 2114. My name is Shelly Peterson, President of the North Dakota Long Term Care Association. I am here today representing our members; nursing facilities, basic care facilities and assisted living facilities.

We are supportive of all aspects of SB 2114 and respectively request your support.

Prior to talking about SB 2114 I would like to briefly outline to the Committee why I am here today. Last fall the Chairman of our Association was asked by a legislator what our position was on the educational requirements for nurses. That question prompted statewide discussion.

We conducted discussion groups in six regions of the state, asked the National Association of Directors of Nursing Administration of North Dakota for their input and position, discussed it within our Resident Issues Committee and Legislative Committee, explored the topic with legislators, conducted a survey of long term care nurses and finally at our December 13, 2000 Membership Meeting formulated our position and solution. During this time I worked closely with Dr. Constance Kalanek, Executive Director of the North Dakota Board of Nursing, exploring options that might be acceptable to both parties. During our exploratory process we found the majority of respondents, including nurses supported repealing the current educational standards, however this position would be strongly opposed by the North Dakota Board of Nursing.

In the true spirit of working toward common ground, the North Dakota Board of Nursing and our Association reached a "third alternative" that I truly believe will benefit North Dakota, consumers of health care and the nursing profession. Section 7, under item 3 on page 8 of SB 2114 allows North Dakota to continue to maintain their academic requirements for nurses but allows those nurses who hold an out-of-state license, who apply for licensure in North Dakota and find they don't meet the educational requirements, to have two options in order to be allowed to practice in North Dakota.

Currently a nurse who does not meet the educational requirements applies for a transitional license. In order to obtain a transitional license, a nurse must show 1) completion of a nursing education program approved by another state's Board of Nursing; 2) a current license by examination, approved by the State's requirement for license by examination; and 3) an unencumbered license.

Section 7 provides the nurse-applicant described above a second option. As you know the only option available now is the nurse applicant must obtain an Associate Degree (LPN) or Baccalaureate Degree (RN) with a major in nursing within eight years. This section adds continuing education as the second option available to the nurse. So rather than having only one option of returning to school, the nurse would agree to 30 hours of continuing education every license renewal cycle. A renewal cycle is two years. The continuing education parameters would be set by the North Dakota Board of Nursing, and could be tailored to the area of nursing practice relevant to the transitional nurse's job duties, if they so choose.

As it stand, this bill has no impact on the 400 nurses presently in transition, although it is anticipated the North Dakota Board of Nursing would address this issue by rule. SB 2114 further does not address the nurse whose license lapsed because they did not obtain the proper academic requirements within eight years, who may now wish to practice under the CEU provision. It would only be through rule promogation by the North Dakota Board of Nursing could these situations be addressed. SB 2114 simply allows another option to those nurses deemed competent by another state, who desire a North Dakota license to practice here.

As you may be aware, long term care is in a nursing crisis and if this bill removes one barrier to employment in North Dakota, we believe it merits your serious consideration and adoption. Currently we have 1,000 open positions in nursing facilities across North Dakota. The top vacant position is CNA, with RN's and LPN's second. Two-thirds of the nursing facilities term themselves in a staffing crisis and in 2000, two out of every five nursing facilities voluntarily stopped admissions because of insufficient staff to care for residents.

For nursing facilities LPN turnover is 24% and RN turnover is 33%. With the average age of long term care LPN's at 43 years and RN's at 44 year, this problem will become even more acute in ten and fifteen years when nurses decide to retire.

We recognize we have many barriers to employment. Salary and benefits, demands of the job, working evenings and weekends and rural North Dakota are a few of the barriers. We believe SB 2114 will remove one barrier by allowing nurses duly licensed by another state, to practice in North Dakota.

I would like to bring to your attention a small error on page 8, related to the CEU provision. On line 24 "of" should be replaced with "or". The sentence should read "Renewal requires proof of progression towards meeting the ~~educational~~ - academic requirements or thirty hours of continuing education activity."

Thank you for your consideration of SB 2114. I would be happy to answer any questions you might have at this time.

Shelly Peterson, President
North Dakota Long Term Care Association
1900 North 11th Street
Bismarck, ND 58501
(701) 222-0660

MeritCare

March 5, 2001

From: Roger Gilbertson, MD,
President and CEO, MeritCare
North Dakota Registered Lobbyist Badge Number 207

Evelyn Quigley, MN, RN
Senior Executive and Chief Nursing Officer, MeritCare
North Dakota Registered Lobbyist Badge Number 214

To: Honorable Representative Clara Sue Price, Chairperson
Members of the House Human Services Committee
Fifty-Seventh Legislative Assembly
State of North Dakota

Re: **SB 2114 – Nursing Practice Standards**

Dear Honorable Representative Price and Members of the House Human Services Committee:

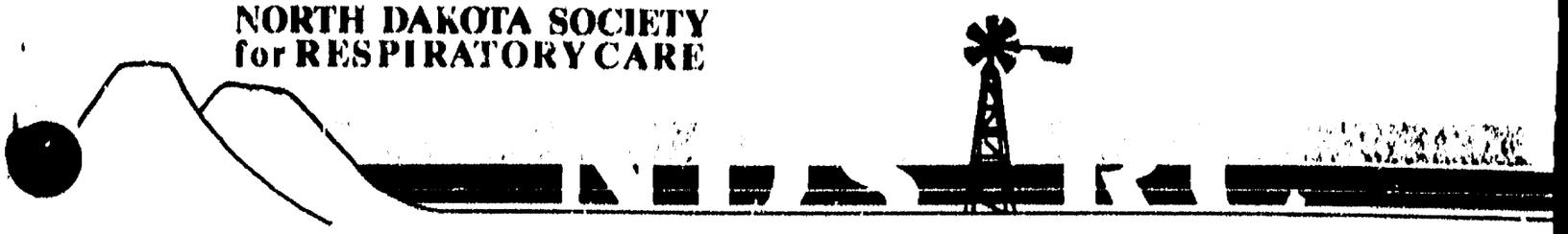
The purpose of this letter is to encourage a **DO PASS for SB 2114**. We respectfully request this document be filed with the House Human Services Committee proceedings.

MeritCare Health System is committed to the health of individuals and communities we serve by providing excellence in healthcare. As a health system, MeritCare represents 335 physicians, 49 physician assistants and 63 advanced practice registered nurses (nurse practitioners, certified registered nurse anesthetists, and clinical nurse specialists) in 68 specialty fields of medicine. Some 830 registered nurses and 355 licensed practical nurses provide compassionate care as MeritCare associates to the patients and families in the region we are privileged to serve. Over 18,000 people are admitted annually to MeritCare Hospital. More than 1.2 million clinical office visits are provided in 34 clinical settings throughout a 150-mile geographic radius of Fargo/Moorhead including smaller communities in eastern and central North Dakota. MeritCare partners with communities by providing clinical services to eleven community clinics and providing services to six nursing homes in North Dakota.

It is our belief that a **DO PASS VOTE** on **SB 2114** would provide for the **transitional licensure needed to provide incentive for nurses in border communities to begin practicing in North Dakota. It would allow time to address the long-term need for solutions rather than a dramatic dismantling of a system of excellence in nursing.**

MeritCare is willing to work with leaders across the state to design, test, and implement creative solutions to the shared crisis for nurses to provide the much needed care in various settings, both urban and rural, long term care, clinical, home care, or hospital setting. Please feel free to contact Ev Quigley, MN, RN, at (701)234-6953 or evquigley@meritcare.com or Susan Bosak, Public Policy and Government Relations, at (701)234-6332 or susanbosak@meritcare.com for further discussion of this or any health-related issues.

NORTH DAKOTA SOCIETY for RESPIRATORY CARE



"A BREATH OF FRESH CARE"

March 7, 2001

Testimony of: Glenn Thom, BS, MMgt, RRT
President, North Dakota Society for Respiratory Care (NDSRC)

Regarding: SB 2114, Reengrossed

As President of the NDSRC, I register these comments in relation to Reengrossed SB 2114, a bill concerned with the nurse practice act.

As respiratory therapists licensed to deliver patient care alongside the nurses in the state of North Dakota, we feel the amendments made in Reengrossed SB 2114 are positive changes to the North Dakota Century Code, with one notable exception.

Lines 3 and 4 of page 5 should be deleted. Rule 54-05-04-03 of the North Dakota Nursing Board's *Nursing Standards and Delegation: A Guide to North Dakota Board of Nursing Rules* indicates that criteria for nursing interventions that may be delegated includes "a standard and unchangeable procedure which does not require any exercise of independent nursing judgment."

Essential requisites of any health care practitioner being allowed to provide medication to chronically or acutely compromised clients include:

a) Knowledge of a medication's actions ("why it does what it does").
b) Knowledge of a medication's interactions ("how does it affect other medications' actions")
c) Knowledge of side effects ("what are common and not-so-common deleterious reactions to this medication?").
d) Interventions required for any adverse reactions to either the medication or method by which the medication is administered.
e) Interventions required for lack of response to the medication's intended effect.

The clients described in lines 3 and 4 of page 5 do not fall into the category of persons which can safely be covered by the services of "unlicensed assistive personnel".

We recommend that unlicensed assistive personnel be excluded from the delivery of medications to residents of facilities licensed under Chapter 25-16.

Thank you for your time and consideration.

54-05-04-03. Delegation process for nursing interventions. A licensed nurse may delegate a nursing intervention to a competent nurse assistant if the licensed nurses utilizes a decisionmaking process to delegate in a manner that protects public health, welfare, and safety. Such a process must include:

1. **Assessment** of clients and human and material resources by
   a. Identifying the needs of the client;
   b. Consulting the plan of care,
   c. Considering the circumstances and setting; and
   d. Assuring the availability of adequate resources, including supervision.
2. Planning for delegation that must include:
   a. Criteria for nursing interventions that may be delegated and includes:
      (1) The nature of the specific nursing intervention, its complexity, and the knowledge and skills required to perform the intervention.
      (2) The results of the intervention are predictable;
      (3) A determination that the potential risk to client is minimal; and
      (4) A standard and unchangeable procedure which does not require any exercise of independent nursing judgment
   b. Selection and identification of nurse assistants to whom nursing interventions may be delegated. Licensed nurses who assess and identify the nurse assistant's training, experience, and competency to provide a selected nursing intervention shall:
      (1) Teach the nursing interventions;
      (2) Observe the nurse assistant's demonstration of current competence to perform the nursing intervention, and
      (3) Document the nurse assistant's competency to perform the nursing intervention.
   c. Selection and identification of the methods of supervision and the licensed nurses responsible to provide supervision. The method of supervision and the frequency of assessment, inspection, and evaluation must be determined by:
      (1) The willingness and ability of the client to be involved in the management of the client's own care;
      (2) The stability of the client's condition;
      (3) The experience and competency of the nurse assistant providing the nursing intervention, and
      (4) The level of nursing judgment required for the delegated nursing intervention.
3. **Implementation** of the delegated nursing interventions by providing direction and supervision.
   a. Direction must include:
      (1) The nurse assistant's access to written instructions on how the nursing intervention is to be performed including
         (a) Reasons why the nursing intervention is necessary.
         (b) Methods used to perform the nursing intervention,
         (c) Documentation of the nursing intervention, and
         (d) Observation of the client's response
      (2) The licensed nurse's:
         (a) Monitoring to assure compliance with established standards of practice and policies; and
         (b) Evaluating client responses and attainment of goals related to the delegated nursing intervention.
   b. Supervision may be provided by the delegating licensed nurse or by other licensed nurses. The degree and method of supervision required must be determined by the licensed nurse after an evaluation of the appropriate factors involved including:
      (1) The number of clients for whom nursing interventions are delegated,
      (2) The stability of the condition of the client;
      (3) The training and capability of the nurse assistant to whom the nursing intervention was delegated.
      (4) The nature of the nursing intervention delegated; and
      (5) The proximity and availability of the licensed nurse when the nursing intervention is performed
4. **Evaluation** of the delegated nursing interventions through:
   a. Measurement of the client's response and goal attainment related to the delegated interventions,
   b. Modification of nursing interventions as indicated by client's response;
   c. Evaluation of the performance of the intervention by the nurse assistant,
   d. Feedback from nurse assistant; and
   e. Provision of feedback to nurse assistant

54-05-04-05. Interventions that may not be delegated. Interventions that require nursing knowledge, skill, and judgment may not be delegated by the licensed nurse to a nurse assistant. These activities include:

1. Physical, psychological, and social assessment which requires professional nursing judgment, intervention, referral, or followup
2. Development of nursing diagnosis and care goals.
3. Formulation of the plan of nursing care.
4. Evaluation of the effectiveness of the nursing care provided.
5. Teaching except for that related to promoting independence in activities of daily living.
6. Counseling, except that the nurse assistant may be instructed to recognize and report basic deviations from healthy behavior and communication patterns and may provide listening, empathy, and support.
7. Coordination and management of care including collaborating, consulting, and referring
8. Triage.
9. Medication administration may not be delegated unless the nurse assistant has met the requirements of NDAC chapter 54-07-05. The exception is when a licensed nurse specifically delegates to a specific nurse assistant the administration of a specific medication for a specific client