Alaska Board of Nursing

Agenda Item #1

Roll Call/Call to Order

ALASKA BOARD OF NURSING MEETING

AGENDA (DRAFT)

MAY 14 & 15, 2024

MISSON STATEMENT:

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

Meeting Details

Meeting Name:	Alaska Board of Nursing Meeting
Meeting Start Time:	9:00 AM (AKST)
Meeting Start Date:	May 15, 2024
Meeting End Time:	4:00 PM (AKST)
Meeting End Date:	May 16, 2024
Meeting Locations:	1. Board/Staff - Suite 1560, Atwood Building, Anchorage, AK 2. Zoom for Public Attendees (Limited In-Person Space)

Zoom Link:
https://us02web.zoom.us/j/83603003484?pwd=UnBvWXJtaG8veWJvdjFGZ1BYTm9KZz09
Meeting ID: 836 0300 3484
Passcode: 563959

Links

Board of Nursing: Nursing.Alaska.gov

Agenda

1. Roll Call/Call to Order (9:00 - 9:02)
2. Ethics Disclosures (9:02 – 9:03)
3. Consent Agenda Items (9:03 – 9:10)
   - Review/Approve Meeting Agenda
   - Report from CCNE
   - Letter from the NCSBN President
   - NCSBN Licensure Survey report
   - NCSBN National Nursing Education Database report 2021-2022 (published 2024)
4. BON Letters regarding legislation (9:15 – 09:30)
   - HB 314 and SB 225
   - SB 91
   - HB 175
5. UAF LPN Program (09:30-09:45)

   Presenter: Kimberlee Fontaine, UAF Community Technical College
   - Faculty waiver request
6. Presentation to the Board (0945- 10:15)

   Presenter: Jason Sauders, BSN, RN, Crossroads
   - Medication Administration Course Education approval
   - Clarifications and suggestions

Break (10:15-10:30)

7. APU Nursing Program update: NCLEX Passing Rates (10:30-10:50)

   Presenter: Marianne Murray DNP, RN, CHSE
8. Span Tran: Evaluation of Foreign-Educated Nurses (10:50- 11:10)
   Presenter: Jacob Malakoff, Senior Institutional Liaison
9. AK NLC Results (11:10-11:30)
   Presenter: Elizabeth Zhong, PhD, Senior Research Scientist
10. PDMP Update- (11:30-12:00)
    Presenter: Lisa Sherrell, PDMP Manager

Adjourn for Lunch (12:00 – 1:00)

11. 2024 BON Annual Report, complete the draft for submission (1:00-1:20)
    Presenter: Patty Wolf MSN, RNC-OB, Executive Administrator BON
12. Discussion: Notification for records subpoena requirements in statute (1:20-1:35)

    Presenter: April Erickson, DNP, CRNA

13. Regulation Project Updates-(1:35-1:55)

    Current Project status

    Regulation Clarification Proposal:

12 AAC 44.850. NURSE AIDE COMPETENCY EVALUATION.

14. Advisory Opinion updates (1:55- 2:15)

Break 2:15-2:30

15. Annual Review of National Certification Bodies per 12 AAC 44. 420. (2:30-3:00)
    - Review of Child/Adolescent Psychiatric-Mental Health, Clinical Nurse Specialist PMHCNS-BC ANCC Certification
16. CNA Abuse Registry Update- (3:00-3:15)

    Presenter: Patty Wolf, MSN, RNC-OB, Executive Administrator

17. Discussion: Request to consider a set number of CEU's for ACLS, PALS, and NRP with a valid card. (3:15-3:40)

    Presenter: Patty Wolf, MSN, RNC-OB, Executive Administrator

18. Review/Assign Action item Assignments and due dates for Board Members (3:40- 4:00)

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

    Adjourn

Wednesday, May 15, 2024

19. Call to Order/Roll Call (0900)

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

20. Deliberative Session (09:05)
21. Executive Session (09:50)

    Reading of orders

22. Investigative and Probation Reports

    Presenters: Investigations Team

Break 10:45-11:00

23. Reviewing Process Training for Board Members (11:00-11:35)

    Presenter: Joy Hartlieb Investigator III

24. Strategic Planning (11:35-12:00)

Review updated plan.

Adjourn for Lunch 12:00-1:00

25. Licensing Reports (1:00- 1:30)

    RN: Madeleine Henderson, Occupational Licensing Examiner

    CNA: Michelle Griffin, Occupational Licensing Examiner

    CNA Program updates: Kelly Olson, RN, Nursing Consultant

    Providence Medical Center CNA Program Application: Troy Larkin, PhD, RN

26. Division Updates (1:30 – 2:15)

    Legislative Update: Glenn Saviers, Deputy Director

    Financials: Melissa Dumas, Administrative Operations Manager

    Staffing: Patty Wolf, MSN, RNC-OB, Executive Administrator

27. Public Comment Period (2:15 – 2:45)

28. For the Good of the Order (2:45)

- Assign/Review action items.
- Any further topics to cover?
- Agenda ideas for future meetings
- Review and confirm the dates of the next meetings: August 7 & 8 and November 6 & 7.

29. Chair Final Comments (3:15)

    Adjourn

Alaska Board of Nursing

Agenda Item #2

Ethics Disclosures

Alaska Board of Nursing

Agenda Item #3

Consent Agenda Items

NCSBN
Leading Regulatory Excellence

Jan. 25, 2024

National Nursing Education Database: 2021–2022 Aggregate Data

Nancy Spector, PhD, RN, FAAN

Josephine Silvestre, MSN, RN

Qiana McIntosh, MBA

Nicole Kaminski-Ozturk, PhD, PMP

Introduction

In the fall of 2020 NCSBN launched the Annual Report Program, which is the first national program to collect annual education data from all nursing programs in participating U.S. nursing regulatory bodies (NRBs). This program is based on NCSBN's studies of quality indicators of nursing programs (Spector et al., 2020), where NCSBN's Annual Report team collects demographic data and evidence-based quality indicators of nursing programs for the NRBs. Most NRBs require nursing education annual data as part of their approval process of nursing programs.

Each nursing program in participating states/jurisdictions receives a report of their metrics and each participating NRB receives a report of all their programs' metrics, including how their programs are meeting the quality indicators. Annually NCSBN will disseminate a report of the aggregate data so that programs and NRBs can benchmark the program metrics. The NRBs and nursing programs can then work together to identify needed improvements – *before* NCLEX® Exam pass rates and other outcomes fall. It is important to remember that NCLEX pass rates are lagging indicators, meaning that they don't begin to fall until other key quality indicators have not been met (Spector et al., 2020).

Participating NRBs

While 20 U.S. NRBs participated in NCSBN's Annual Report Program in 2020–21 (NCSBN, 2023), 23 NRBs participated in 2021–2022. Table 1 illustrates how the participating jurisdictions in 2020–2021 compared to those in 2021–2022. A goal of the Annual Report Program is that all NRBs will participate, thus providing us with the first national nursing education database of all U.S. nursing programs.

Table 1. Participants in 2020–21 and 2021–22

	2020–2021	2021–2022
Participating NRBs	20	23
Number of Programs	843	972
Enrolled Students	112,147	124,912
Full-time Faculty	8,263	9,653
Part-time Faculty	3,104	4,402
Clinical Adjunct Faculty – Employed by Program	7,296	8,822
Clinical Adjunct Faculty – Not Employed by Program	472	837

Results

Table 2 illustrates program demographics. Similar to the 2020–2021 data, there are only five diploma programs and seven master's entry programs in this sample, which limits generalizations across those populations. As can be seen from Table 2, the majority of the bachelor's and accelerated bachelor's programs are urban, while the majority of licensed practical/vocational nurse (LPN/VN) and associate's programs are rural. These findings compare to the 2020–2021 data. The majority of LPN/VN, associate's and bachelor's programs are publicly owned, though 44.4% of the of the bachelor's programs are private not-for-profit, as are a majority of the master's entry programs. Of note, 24.1% of the 29 accelerated BSN programs are private for–profit programs. Of the LPN/VN programs and associate's programs, 12.4% and 12%, respectively, are private for–profit programs. These findings related to private for-profit programs are similar to those from 2020–2021. Regarding learning modalities, only 20.7% of the accelerated Bachelor of Science in Nursing (BSN) programs are in–person only, though the majority of the other program types are in-person-only (range from 56.8% to 80%). This compares to the 2020–2021 data, though the accelerated BSN programs had more in-person-only learning in 2020–2021 (39.1%). Similar to 2020–2021 data, online-only learning is present in associate's and accelerated BSN programs to a very limited extent and not at all in the other programs. Of the six program types evaluated, between 20% and 75.9% had some hybrid component. The literature often cites hybrid or blended education, when well implemented, to be beneficial in higher education (Müller & Mildenberger, 2021). Similar to 2020–2021 data most nursing program directors do not have administrative authority over allied health. In this 2021–2022 sample, most programs do not have an assistant/associate director, which is similar to the 2020–2021 data. However, nearly all the programs have dedicated administrative support for assisting with day-to-day activities of the nursing program. In accordance with 2020–2021 data, most programs implement formal orientation for adjunct faculty, full-time faculty and part-time faculty, as well as mentoring of full-time faculty. It should be noted, however, that while definitions of orientation and mentoring are provided, these data are self-reported.

Table 2. Program Demographics

	LPN/VN	Diploma	Associate's	Bachelor's	Accelerated BSN	Master's Entry
N	330	5	367	234	29	7
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Geographic Location						
Urban	90 (27.3%)	2 (40.0%)	109 (29.7%)	106 (45.3%)	19 (65.5%)	2 (28.6.0%)
Suburban	75 (22.7%)	2 (40.0%)	75 (20.4%)	57 (24.4%)	10 (34.5%)	4 (57.1%)
Rural	161 (48.8%)	1 (20.0%)	174 (47.4%)	65 (27.8%)	0 (0.0%)	1 (14.3%)
Other	4 (1.2%)	0 (0.0%)	9 (2.5%)	6 (2.6%)	0 (0.0%)	0 (0.0%)
Institutional Ownership						
Public	279 (84.5%)	2 (40.0%)	299 (81.5%)	107 (45.7%)	11 (37.9%)	3 (42.9%)
Private, Not-for-Profit	10 (3.0%)	2 (40.0%)	24 (6.5%)	104 (44.4%)	11 (37.9%)	4 (57.1%)
Private, For-Profit	41 (12.4%)	1 (20.0%)	44 (12.0%)	23 (9.8%)	7 (24.1%)	0 (0.0%)
Learning Modalities						
In-Person Only	250 (75.8%)	4 (80.0%)	209 (56.9%)	133 (56.8%)	6 (20.7%)	4 (57.1%)
Online Only	0 (0.0%)	0 (0.0%)	3 (0.8%)	0 (0.0%)	1 (3.4%)	0 (0.0%)
Hybrid	80 (24.2%)	1 (20.0%)	155 (42.2%)	101 (43.2%)	22 (75.9%)	3 (42.9%)
Simulated Clinical Experience Offered						
Yes	273 (82.7%)	5 (100.0%)	354 (96.5%)	226 (96.6%)	29 (100.0%)	7 (100.0%)
No	57 (17.3%)	0 (0.0%)	13 (3.5%)	8 (3.4%)	0 (0.0%)	0 (0.0%)

Table 2. Program Demographics						
	LPN/VN	Diploma	Associate's	Bachelor's	Accelerated BSN	Master's Entry
N	330	5	367	234	29	7
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Director Has Administrative Responsibility for Allied Health						
Yes	93 (28.2%)	1 (20.0%)	91 (24.8%)	22 (9.4%)	1 (3.4%)	0 (0.0%)
No	237 (71.8%)	4 (80.0%)	276 (75.2%)	212 (90.6%)	28 (96.6%)	7 (100.0%)
Program Has Assistant/Associate Director						
Yes	76 (23.0%)	2 (40.0%)	102 (27.8%)	98 (41.9%)	15 (51.7%)	3 (42.9%)
No	254 (77.0%)	3 (60.0%)	265 (72.2%)	136 (58.1%)	14 (48.3%)	4 (57.1%)
Director Has Dedicated Administrative Support						
Yes	274 (83.0%)	5 (100.0%)	336 (91.6%)	210 (89.7%)	23 (79.3%)	6 (85.7%)
No	56 (17.0%)	0 (0.0%)	31 (8.4%)	24 (10.3%)	6 (20.7%)	1 (14.3%)
Formal Orientation for New Adjunct Clinical Faculty						
Yes	279 (84.5%)	4 (80.0%)	341 (92.9%)	213 (91.0%)	28 (96.6%)	6 (85.7%)
No	51 (15.5%)	1 (20.0%)	26 (7.1%)	21 (9.0%)	1 (3.4%)	1 (14.3%)
Formal Orientation for New Full-Time Faculty						
Yes	317 (96.1%)	5 (100.0%)	361 (98.4%)	232 (99.1%)	29 (100.0%)	7 (100.0%)
No	13 (3.9%)	0 (0.0%)	6 (1.6%)	2 (0.9%)	0 (0.0%)	0 (0.0%)
Formal Orientation for New Part-Time Faculty						
Yes	275 (83.3%)	5 (100.0%)	328 (89.4%)	203 (86.8%)	25 (86.2%)	6 (85.7%)
No	55 (16.7%)	0 (0.0%)	39 (10.6%)	31 (13.2%)	4 (13.8%)	1 (14.3%)
Formal Mentoring for New Full-Time Faculty						
Yes	293 (88.8%)	5 (100.0%)	353 (96.2%)	217 (92.7%)	27 (93.1%)	7 (100.0%)
No	37 (11.2%)	0 (0.0%)	14 (3.8%)	17 (7.3%)	2 (6.9%)	0 (0.0%)

Table 3 illustrates the clinical hours (direct care, simulation and skills lab[1]) across the six program types, while Table 4 reports on the trend of direct care clinical hours (those hours where students take care of actual patients) in the U.S. between 2010 and 2022. While the mean of direct care clinical hours for bachelor's and Accelerated Bachelor of Science in Nursing (ABSN) programs decreased slightly from 2020-2021, the rest of the programs' direct care hours increased slightly. Nearly all programs have simulation (Table 2), though as can be seen in Table 3, the number of simulation hours being used is low (range: 46.96 to 93.31 hours). According to NCSBN's Member Board Profiles (NCSBN, 2022), 35 (61%) of the U.S. NRBs allow up to 50% of the clinical hours[2] to be replaced by simulation, as long as accepted simulation guidelines are used. Therefore, in most states and U.S. jurisdictions regulation is not a barrier to programs using simulation (NCSBN, 2022). Interestingly, all of the six program types use more skills lab hours than simulation hours.

1. Direct patient care, simulation, and skills lab are all defined in the survey.
2. 7 NRBs (12%) allow up to 25%; 1 (2%) NRB allows more than 75%; 1 (2%) NRB allows up to 30%; 2 (4%) NRBs allow no simulation to replace clinical experiences; and in 11 (19%) NRBs simulation is not addressed in the statute or rules.

Table 3. Breakdown of Program Hours by Program Type						
	LPN/VN	Diploma	Associate's	Bachelor's	Accelerated BSN	Master's Entry
N	330	5	367	234	29	7
Direct Patient Care Hours						
Mean	406.13	612.00	445.43	610.29	552.85	736.57
SD	±181.68	±392.98	±299.58	±240.2	±156.75	±155.14
Simulation Hours						
Mean	46.96	56.30	67.44	83.26	93.31	59.57
SD	±43.73	±32.75	±57.45	±62.29	±63.3	±26.92
Skills Lab Hours						
Mean	110.86	99.30	105.05	112.03	108.14	104.14
SD	±63.54	±59.20	±78.59	±69.71	±69.41	±56.73

Table 4 reports on the trend of direct care clinical experience hours from 2010 through 2022. The 2010 and 2017 data on direct care clinical experience hours were obtained in national studies by NCSBN (Smiley, 2019), while the 2020–2021 and 2021–2022 data are from the aggregate Annual Report data, from participating NRBs, for those years (NCSBN, 2023). As is apparent in Table 4, direct care clinical hours have decreased in U.S. nursing programs since 2010. When comparing direct care clinical hours across English speaking countries, Hungerford (2019) found in a scoping review exercise that the U.S. lags behind Australia, New Zealand and the United Kingdom[3]. The pandemic could be a reason for decreasing hours in 2020–2021 and 2021–2022, so we will see if this downward trend reverses with the 2022–2023 data. While direct care clinical hours are pivotal to positive outcomes in nursing education (Spector et al., 2020), at this time we do not have evidence on the specific numbers of clinical experience hours students should have. This is an important indicator to monitor.

Table 4. Trend of Direct Care Clinical Hours from 2010–2022				
	2010 (median hours)	2017 (median hours)	2020-21 (mean hours)	2021-22 (mean hours)
Master's Entry	770	780	665	736.57
Bachelor's	765	712	625.64	610.29
Associate's	628	573	437.61	445.43
Diploma	720	683	530.21	612.00
LPN/VN	(data not collected)	565	386.3	406.13

NCSBN's mixed-methods, national study of nursing education, followed by an analysis of the data by researchers, educators, attorneys and regulators, determined the key quality indicators of nursing education programs (Spector et al., 2020). It is crucial for nursing education programs and NRBs to identify any quality indicators that have not been met so that programs can be proactive in making improvements before their outcomes are adversely impacted. Therefore, the Annual Reports that the NRBs and nursing programs receive have a summary of the eight key quality indicators that need to be met. Table 5 illustrates the percentage of the 972 nursing programs, across program types, in the 2021–2022 Annual Report program that met, or did not meet, the quality indicators. Nursing programs can present these national data to their administrators to convince them that more resources and/or funding are needed so they will meet national standards.

3 Australia mandates 800 hours; New Zealand mandates 1100 hours; the United Kingdom mandates 2300 hours.

Compared to the 2020–2021 Annual Report aggregate data for programs meeting quality indicators (NCSBN, 2023), the 2021–2022 data are similar. For example, LPN/VN programs continue to lag behind other nursing programs for national nursing accreditation. The literature suggests that national nursing accreditation leads to better program outcomes (Spector et al., 2020). Another trend identified was that many programs experienced major organizational changes. Some of these changes include new director or assistant/associate director, staff or faculty layoff, changes in institutional leadership, collapsing programs, economic efficiencies which often lead to layoffs or cutting programs, etc. The research suggests that this lack of upper administrative support is associated with poorer outcomes (Spector et al., 2020). There were 26.4% (similar to the percentage in 2020–2021) of the programs in this database that had less than 35% full-time faculty, which is a major quality indicator and can lead to poorer outcomes (Spector et al., 2020). In the 2021–2022 database, we found that on-time graduation rates of 70% (used by the U.S. national nursing accreditors and the U.S. Department of Education) are not being met by programs. While graduation rates were not identified as a quality indicator in the NCSBN study (Spector et al., 2020), that may be because not all NRBs had been consistently collecting those data. However, we are now consistently collecting those data and will be statistically analyzing if on-time graduation rates are associated with better program outcomes. Indeed, 45.4% of the programs in the 2021–2022 database have less than 70% graduation rates.

Table 5. Key Quality Indicators Across Nursing Program Types

	LPN/VN	Diploma	Associate's	Bachelor's	Accelerated BSN	Master's Entry	Grand Total
N	330	5	367	234	29	7	972
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Accreditation Status							
Yes	42 (12.7%)	3 (60.0%)	283 (77.1%)	227 (97.0%)	29 (100.0%)	7 (100.0%)	591 (60.8%)
No	288 (87.3%)	2 (40.0%)	84 (22.9%)	7 (3.0%)	0 (0.0%)	0 (0.0%)	381 (39.2%)
Programs' Approval Status							
Fully Approved	303 (91.8%)	4 (80.0%)	326 (88.8%)	216 (92.3%)	26 (89.7%)	6 (85.7%)	881 (90.6%)
Not Approved/Conditional/ Probationary or Warning Status	27 (8.2%)	1 (20.0%)	41 (11.2%)	18 (7.7%)	3 (10.3%)	1 (14.3%)	91 (9.4%)
Experienced Major Organizational Changes							
Yes	144 (43.6%)	3 (60.0%)	166 (45.2%)	131 (56.0%)	21 (72.4%)	5 (71.4%)	470 (48.4%)
No	186 (56.4%)	2 (40.0%)	201 (54.8%)	103 (44.0%)	8 (27.6%)	2 (28.6%)	502 (51.6%)
Director Turnover							
Less than or Equal to Three Directors over the Past Five Years	308 (93.3%)	5 (100.0%)	328 (89.4%)	213 (91.0%)	23 (79.3%)	7 (100.0%)	884 (90.9%)
More than Three Directors over the Past Five Years	22 (6.7%)	0 (0.0%)	39 (10.6%)	21 (9.0%)	6 (20.7%)	0 (0.0%)	88 (9.1%)
Less Than 50% Direct Care Clinical Experience							
Greater than 50% Direct Care Clinical Experience	309 (93.6%)	5 (100.0%)	343 (93.5%)	226 (96.6%)	29 (100.0%)	7 (100.0%)	919 (94.5%)
Less than 50% Direct Care Clinical Experience	21 (6.4%)	0 (0.0%)	24 (6.5%)	8 (3.4%)	0 (0.0%)	0 (0.0%)	53 (5.5%)
Less Than 35% Full-Time Faculty							
Greater than 35% Full-Time Faculty	266 (80.6%)	3 (60.0%)	265 (72.2%)	163 (69.6%)	13 (44.8%)	5 (71.4%)	715 (73.6%)
Less than 35% Full-Time Faculty	64 (19.4%)	2 (40.0%)	102 (27.8%)	71 (30.3%)	16 (55.2%)	2 (28.6%)	257 (26.4%)

Table 5. Key Quality Indicators Across Nursing Program Types							
	LPN/VN	Diploma	Associate's	Bachelor's	Accelerated BSN	Master's Entry	Grand Total
N	330	5	367	234	29	7	972
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Less Than 70% Graduation Rate							
Greater than or Equal to 70% Graduation Rate	150 (45.5%)	0 (0.0%)	199 (54.2%)	159 (67.9%)	18 (62.1%)	5 (71.4%)	531 (54.6%)
Less than 70% Graduation Rate	180 (54.5%)	5 (100.0%)	168 (45.8%)	75 (32.1%)	11 (37.9%)	2 (28.6%)	441 (45.4%)
Programs Established 2017 or Before 2017/After 2017							
2017 or before	313 (94.9%)	5 (100.0%)	330 (89.9%)	209 (89.3%)	23 (79.3%)	3 (42.9%)	883 (90.8%)
After 2017	17 (5.1%)	0 (0.0%)	37 (10.1%)	25 (10.7%)	6 (20.7%)	4 (57.1%)	89 (9.2%)

Besides the key quality indicators, other quality indicators were identified by the NCSBN mixed-methods study (Spector et al., 2020) and these are highlighted in Table 6. While most programs provide disability support services, services for students with low socioeconomic statuses and formal remediation for students needing academic support, English as a second language (ESL) services/resources are missing in many nursing programs. While there is slight improvement from the 2020–2021 data, the majority of programs are not offering resources in ESL. Promoting more diversity in nursing education has become a major focus and providing these students with ESL resources has been shown to enhance outcomes (Sailsman, 2021; Spector et al., 2020). Therefore, nurse educators need to be more proactive with advocating for their ESL students, and the administrators should pay attention to this quality indicator. Of all the programs in the 2021–2022 database, 81.8% have remediation in place for students making errors or near misses in their clinical experiences, which means that 18.2% do not. These data are similar to 2020–2021 data, and this remains an area where improvements should be made. Similar to the 2020–2021 data, though even a little lower, only 4.1% of the simulation labs are accredited and 19.3% of simulation faculty are certified. With the advances being seen in simulation, this is an area where programs should focus in the future.

Table 6. Other Quality Indicators							
	LPN/VN	Diploma	Associate's	Bachelor's	Accelerated BSN	Master's Entry	Grand Total
N	330	5	367	234	29	7	972
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Disability Support Services							
Yes	322 (97.6%)	5 (100.0%)	365 (99.5%)	233 (99.6%)	29 (100.0%)	7 (100.0%)	961 (98.9%)
No	8 (2.4%)	0 (0.0%)	2 (0.5%)	1 (0.4%)	0 (0.0%)	0 (0.0%)	11 (1.1%)
ESL Services							
Yes	124 (37.6%)	2 (40.0%)	186 (50.7%)	99 (42.3%)	10 (34.5%)	4 (57.1%)	425 (43.7%)
No	206 (62.4%)	3 (60.0%)	181 (49.3%)	135 (57.7%)	19 (65.5%)	3 (42.9%)	547 (56.3%)
Services for Low Socioeconomic Class Students							
Yes	305 (92.4%)	4 (80.0%)	349 (95.1%)	214 (91.5%)	24 (82.8%)	6 (85.7%)	902 (92.8%)
No	25 (7.6%)	1 (20.0%)	18 (4.9%)	20 (8.5%)	5 (17.2%)	1 (14.3%)	70 (7.2%)
Formal Remediation Process for Students Needing Academic Support							
Yes	273 (82.7%)	4 (80.0%)	313 (85.3%)	198 (84.6%)	28 (96.6%)	6 (85.7%)	822 (84.6%)
No	57 (17.3%)	1 (20.0%)	54 (14.7%)	36 (15.4%)	1 (3.4%)	1 (14.3%)	150 (15.4%)

Table 6. Other Quality Indicators							
	LPN/VN	Diploma	Associate's	Bachelor's	Accelerated BSN	Master's Entry	Grand Total
N	275	7	326	208	23	4	843
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Formal Remediation Process for Students Committing Errors/Near Misses							
Yes	263 (79.7%)	3 (60.0%)	309 (84.2%)	188 (80.3%)	26 (89.7%)	6 (85.7%)	795 (81.8%)
No	67 (20.3%)	2 (40.0%)	58 (15.8%)	46 (19.7%)	3 (10.3%)	1 (14.3%)	177 (18.2%)
Certified Simulation Faculty							
Yes	29 (8.8%)	2 (40.0%)	70 (19.1%)	70 (29.9%)	13 (44.8%)	4 (57.1%)	188 (19.3%)
No	244 (73.9%)	3 (60.0%)	284 (77.4%)	155 (66.2%)	16 (55.2%)	3 (42.9%)	705 (72.5%)
Does not offer simulated clinical experience	57 (17.3%)	0 (0.0%)	13 (3.5%)	9 (3.8%)	0 (0.0%)	0 (0.0%)	79 (8.1%)
Accredited Simulation Lab							
Yes	7 (2.1%)	0 (0.0%)	10 (2.7%)	14 (6.0%)	8 (27.6%)	1 (14.3%)	40 (4.1%)
No	266 (80.6%)	5 (100.0%)	344 (93.7%)	211 (90.2%)	21 (72.4%)	6 (85.7%)	853 (87.8%)
Does not offer simulated clinical experience	57 (17.3%)	0 (0.0%)	13 (3.5%)	9 (3.8%)	0 (0.0%)	0 (0.0%)	79 (8.1%)

Conclusion

This 2021-2022 national report of 972 nursing education programs is provided for NRBs and nursing programs to benchmark nursing education metrics to these evidence-based quality indicators. Nurse regulators can work with nursing programs to identify deficiencies so that nursing programs can make improvements *before* outcomes (such as NCLEX pass rates) are adversely affected. These 2021–2022 data illustrate the nursing education trends:

- Clinical experience hours have decreased since 2010, though there has been a slight improvement since 2020–2021;
- More than 50% of the nursing programs have no resources and programs for ESL students;
- LPN/VN programs lag behind other nursing programs for being nationally nursing accredited;
- More than a quarter of all nursing programs have less than 35% of their faculty being full-time;
- Many nursing programs do not have a 70% on-time graduation rate;
- Higher administration is often not supportive of nursing education; and
- A majority of simulation labs are not accredited. Similarly a majority of simulation faculty are not certified.

More states are joining this Annual Report Program every year and our goal is for all NRBs to participate in the program. This database is a major contribution to nursing education and we are grateful to the NRBs and nursing programs that have participated.

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February 22, 2024 ***VIA EMAIL***

Memo from COA

To: *U.S. Department of Education*
Specialized Accrediting Agencies
California Bureau for Private Postsecondary Education
Regional Accrediting Agencies
Division of Nursing, HRSA
State Boards of Nursing
State Boards of Higher Education
International Federation of Nurse Anesthetists

From: *Francis Gerbasi, PhD, CRNA, FAAN*
Chief Executive Officer
Council on Accreditation of Nurse Anesthesia Educational Programs (COA)

Date: *February 22, 2024*

Subject: COA Report of Actions

Enclosed for your information is a report of the actions taken by the Council on Accreditation of Nurse Anesthesia Educational Programs (COA) at its January 25-27, 2024 meeting. In accordance with the regulations of the U.S. Department of Education, the accreditation actions have been submitted in the Department's Database of Accredited Postsecondary Institutions and Programs (DAPIP).

If you have any questions, or if we can be of further assistance, please do not hesitate to contact us. We can be reached by telephone (224-275-9130) or e-mail (accreditation@coacrna.org).
Sincerely,

Francis Gerbasi

Francis Gerbasi, PhD, CRNA, FAAN
Chief Executive Officer

FG/ta
https://coacrna1.sharepoint.com/sites/ACCRED/Agencies/USDE/CORRESP/2024/022224 - Accred and Related Decisions - Report of Actions - Community of Interest.docx

REPORT OF ACTIONS
Effective January 25, 2024 unless otherwise indicated

Initial Accreditation Granted

- New Mexico State University Nurse Anesthesiology DNP Program, Las Cruces, NM

  Public Disclosure Statement
  The New Mexico State University Nurse Anesthesiology DNP Program was granted initial accreditation effective November 9, 2023. The program was found in compliance with the *Standards for Accreditation of Nurse Anesthesia Programs – Practice Doctorate*. Given this action, the program will be scheduled for its next consideration of continued accreditation 5 years following the start of the program's first class of students. The COA may change this to an earlier time as a result of new or additional information, changes in the activities of the program, or changes needed in the accreditation review schedule.

- Roseman University of Health Sciences Nurse Anesthesiology Program, Las Vegas, NV

  Public Disclosure Statement
  The Roseman University of Health Sciences Nurse Anesthesiology Program was granted initial accreditation effective January 25, 2024. The program was found in compliance with the *Standards for Accreditation of Nurse Anesthesia Programs – Practice Doctorate*. Given this action, the program will be scheduled for its next consideration of continued accreditation 5 years following the start of the program's first class of students. The COA may change this to an earlier time as a result of new or additional information, changes in the activities of the program, or changes needed in the accreditation review schedule.

- The Ohio State University College of Nursing DNP Program—Nurse Anesthesia Track, Columbus, OH

  Public Disclosure Statement
  The Ohio State University College of Nursing DNP Program—Nurse Anesthesia Track was granted initial accreditation effective October 11, 2023. The program was found in compliance with the *Standards for Accreditation of Nurse Anesthesia Programs – Practice Doctorate*. Given this action, the program will be scheduled for its next consideration of continued accreditation 5 years following the start of the program's first class of students. The COA may change this to an earlier time as a result of new or additional information, changes in the activities of the program, or changes needed in the accreditation review schedule.

- The University of Texas Medical Branch School of Nursing Nurse Anesthesia Program, Galveston, TX

  The University of Texas Medical Branch School of Nursing Nurse Anesthesia Program was granted initial accreditation effective January 25, 2024. The program was found in compliance with the *Standards for Accreditation of Nurse Anesthesia Programs – Practice Doctorate*. Given this action, the program will be scheduled for its next consideration of

continued accreditation 5 years following the start of the program's first class of students. The COA may change this to an earlier time as a result of new or additional information, changes in the activities of the program, or changes needed in the accreditation review schedule.

Affirmation of Prior Continued Accreditation Decision

- Marian University Nurse Anesthesia Program Leighton School of Nursing Nurse Anesthesia Program, Indianapolis, IN

  Public Disclosure Statement
  The Marian University Nurse Anesthesia Program Leighton School of Nursing Nurse Anesthesia Program was granted continued accreditation for 10 years effective May 25, 2022. This decision was made on the basis of a March 2022 virtual accreditation review. Consistent with U.S. Department of Education requirements, the COA conducted a focused, in-person onsite review of the program in follow-up to the virtual accreditation review. The program was found in full compliance with the *Standards for Accreditation of Nurse Anesthesia Programs – Practice Doctorate* and the COA affirmed its June 21, 2022 continued accreditation decision. Given this action, the program will be scheduled for its next consideration of continued accreditation in Spring 2032. The COA may change this to an earlier time as a result of new or additional information or changes in the activities of the program.

Initial Accreditation – Decision Deferred

- Hunter-Bellevue School of Nursing Nurse Anesthesia Program, New York, NY

  The initial accreditation decision for the Hunter-Bellevue School of Nursing Nurse Anesthesia Program was deferred. Given this action, the program will be scheduled for its next consideration of initial accreditation in May 2024. The COA may change this to an earlier time as a result of new or additional information or changes in the activities of the program. The program must submit a progress report documenting actions taken to come into full compliance with the *Standards for Accreditation of Nurse Anesthesia Programs - Practice Doctorate* related to the adequacy of faculty and support personnel resources and the delivery of distance education.

Distance Education Offerings – Approved

- Fairfield University Nurse Anesthesia Program, Fairfield, CT
- New Mexico State University Nurse Anesthesiology DNP Program, Las Cruces, NM (effective November 9, 2023)
- Roseman University of Health Sciences Nurse Anesthesiology Program, Las Vegas, NV
- The Ohio State University College of Nursing DNP Program—Nurse Anesthesia Track, Columbus, OH (effective January 19, 2024)

- The University of Texas Medical Branch School of Nursing Nurse Anesthesia Program, Galveston, TX

Major Programmatic Change – Approved

- Fairfield University Nurse Anesthesia Program, Fairfield, CT
    - Additional Location [Texas]
- Rosalind Franklin University of Medicine and Science Nurse Anesthesia Program, North Chicago, IL
    - Additional Location [Colorado] (effective December 15, 2023)

Published: March 22, 2024

Show Cause Directive Issued

At its meeting on February 8, 2024, the CCNE Board of Commissioners directed the program below to "show cause" as to why adverse action should not be taken. Importantly, the issuance of a show cause directive is not an adverse action, but a statement of serious concern by the Board. In accordance with the Code of Federal Regulations, §602.26(b), CCNE is required to notify various entities of this action.

Accredited Program(s)	Effective Date	
Rowan University		*Stratford, NJ*
Baccalaureate	February 8, 2024	

At its meeting on March 13-14, 2024, the CCNE Board of Commissioners directed the programs below to "show cause" as to why adverse action should not be taken.

Accredited Program(s)	Effective Date	
Beckfield College		*Florence, KY*
Baccalaureate	March 14, 2024	
Roosevelt University		*Chicago, IL*
Baccalaureate	March 14, 2024	

Show Cause Directive Removed

At its meeting on March 13-14, 2024, the CCNE Board of Commissioners removed the show cause directive previously issued to the program below. This action to remove the show cause directive was taken following review of information provided by the program. This program remains accredited by CCNE.

Accredited Program(s)	Effective Date	
University of San Francisco		*San Francisco, CA*
DNP	March 14, 2024	

For Information on CCNE's Public Disclosure Decision-Making Process, go to https://www.aacnnursing.org/Portals/0/PDFs/CCNE/Board-Actions-Public-Disclosure-Spring2024.pdf

Letter FROM THE President

POST-BOARD MEETING UPDATE

Feb. 14, 2024

Greetings Colleagues:

The NCSBN Board of Directors (BOD) convened Feb. 6–7. Fortunately, the weather was warmer than usual for this time of year in Chicago.

A significant responsibility of the BOD is to consider the Finance Committee reports and receive the results of the annual fiscal audit. The audit firm RMS presented to the BOD in person. This was the first time that RMS had performed as NCSBN's auditing firm and they were found to be rigorous and collaborative in their approach. I am pleased to share that the RMS audit report yielded a clean audit with no deficiencies. My thanks to the treasurer, the Finance Committee and NCSBN's Finance staff for their attention to this important process.

As is customary at every meeting a verbal environmental scan was conducted which served to inform the BOD of regulatory issues and themes across our membership. At this time of year many legislatures are in session, so several BOD members reported both positive and concerning legislation, including nurse title protection, APRN bills, licensure, compacts, NRBs regulating other professions and workforce. The BOD agreed that NCSBN's tracking of legislation and communication to the membership was of value and appreciated. Examples of other regulatory matters discussed were Operation Nightingale, licensing issues, limits on NCLEX® testing, success of apprenticeship programs, work on NCSBN ID, medication aide testing, RN prescribing, use of Artificial Intelligence (AI) in the regulatory space and international applicants.

The BOD received an update on remote proctoring and the use of AI which will be presented at the Midyear Meeting. Staff also reported on the status of the Nursys® in Canada initiative. In November 2022, the British Columbia College of Nurses and Midwives (BCCNM) and the College of Nurses of Ontario (CNO) completed their initial licensure load and began submitting daily licensure update files to the Nursys in Canada system, which is separately kept in the Canadian CLOUD territory.

In January 2024, NCSBN launched the first phase that entails cross-system searching and cross-system Speed Memo capabilities between the two Nursys systems. The Nursys administrator will send notification when CNO and BCCNM are ready to start using Speed Memo function. This update ensures that each nurse has one unique nurse identifier (NCSBN ID), regardless of if the nurse is licensed in the U.S., Canada or both. NCSBN, BCCNM and CNO are developing the necessary legal agreements, policies, and procedures for the operationalization and expansion of Nursys in Canada to other Canadian NRBs. The BOD was pleased to learn of the progress related to this initiative.

Federal Affairs staff reported on efforts to build relationships with key individuals at federal agencies in furtherance of NCSBN strategic initiatives and objectives. The BOD also received a report on the status of federal legislation that may have implications for nursing regulation.

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Leading Regulatory Excellence

POST-BOARD MEETING UPDATE, CONTINUED

Midyear Area Meeting proposed agenda topics were discussed. The BOD provided input and direction regarding the topics for these meetings, being mindful not to duplicate Midyear Meeting presentations and to ensure we were responding to topics of interest to the membership.

In a follow-up to the monthly Operation Nightingale calls that NCSBN hosted in 2023 the BOD and legal counsel discussed and considered suggestions and requests from the membership for certain actions on the part of NCSBN. The BOD recognizes that the work associated with processing Operation Nightingale cases is complex and demands increased resources at the individual nurse regulatory boards. The BOD is committed to continuing efforts to assist boards and reduce state burdens while carefully considering the role of NCSBN in these activities. The BOD identified additional information and actions NCSBN could take to support boards, and this information will be communicated soon.

CEO Phil Dickison shared highlights of his first few months in his new role and provided his internal and external goals and progress towards those goals. It was evident to the BOD that Phil is leading with energy, commitment and passion focused on the mission of the organization, building for an even more positive future.

I look forward to seeing many of you in Atlanta at the Midyear Meeting where you will find information and opportunities for discussion on many of the topics that the BOD discussed at their meeting. I encourage you all to give some thought to solicitations from the Leadership Succession Committee and the Awards committee as these represent opportunities to encourage and recognize leaders in our midst. Safe travels to Atlanta.

Warm Regards,

Jay Douglas, MSM, RN, CSAC, FRE

President
804.516.9028
jay.douglas@dhp.virginia.gov

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NCSBN
MEMBER BOARD PROFILES

2023 Licensure Survey **Generated: 3/13/2024 2:44:40 PM**

59 Jurisdictions Included in the report:

Alabama (AL)	Alaska (AK)	American Samoa (AS)	Arizona (AZ)	Arkansas (AR)
California-RN (CA-RN)	California-VN (CA-VN)	Colorado (CO)	Connecticut (CT)	Delaware (DE)
District of Columbia (DC)	Florida (FL)	Georgia (GA)	Guam (GU)	Hawaii (HI)
Idaho (ID)	Illinois (IL)	Indiana (IN)	Iowa (IA)	Kansas (KS)
Kentucky (KY)	Louisiana-PN (LA-PN)	Louisiana-RN (LA-RN)	Maine (ME)	Maryland (MD)
Massachusetts (MA)	Michigan (MI)	Minnesota (MN)	Mississippi (MS)	Missouri (MO)
Montana (MT)	Nebraska-AP (NE-APRN)	Nebraska (NE)	Nevada (NV)	New Hampshire (NH)
New Jersey (NJ)	New Mexico (NM)	New York (NY)	North Carolina (NC)	North Dakota (ND)
Northern Mariana Islands (CNMI)	Ohio (OH)	Oklahoma (OK)	Oregon (OR)	Pennsylvania (PA)
Rhode Island (RI)	South Carolina (SC)	South Dakota (SD)	Tennessee (TN)	Texas (TX)
Utah (UT)	Vermont (VT)	Virgin Islands (VI)	Virginia (VA)	Washington (WA)
West Virginia-PN (WV-PN)	West Virginia-RN (WV-RN)	Wisconsin (WI)	Wyoming (WY)	

0 Jurisdictions not included in the report due to non-response:

Table of Contents

Survey Terminology

The following terms are used throughout all surveys:

***Board of Nursing*: Jurisdiction's governmental agency responsible for the regulation of nursing practice. Includes any other terminology to refer to the regulatory authority (i.e., commission, examiners, registration, jurisdiction). When referring to Board of Nursing, the reference collectively includes Board Members, Executive Officer and Staff.**

***Jurisdiction*: Refers to state, territory or district where a Board of Nursing is located. May also be used to refer generally to the Board of Nursing in a particular jurisdiction.**

***Board Staff*: Staff of the Board of Nursing**

***Executive Officer*: Person responsible for running the Board of Nursing. Includes any other terminology to refer to that authorized person (i.e., Executive Director)**

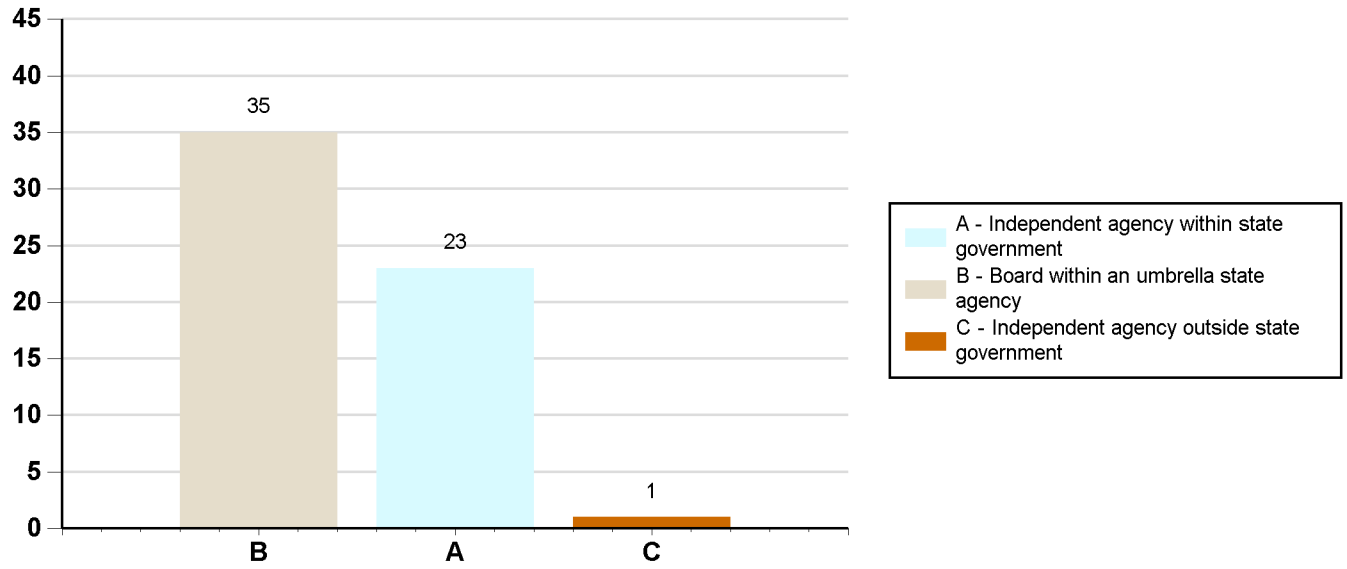
***Board Member*: Member of the governing body of the Board of Nursing as outlined by statute**

***Practical nurse or PN*: Licensed practical or vocational nurse (LPN/LVN)**

***Temporary Practice Permit: A* time limited permit that allows an applicant, who meets all qualifications for licensure, to practice while waiting for specific information regarding their application**

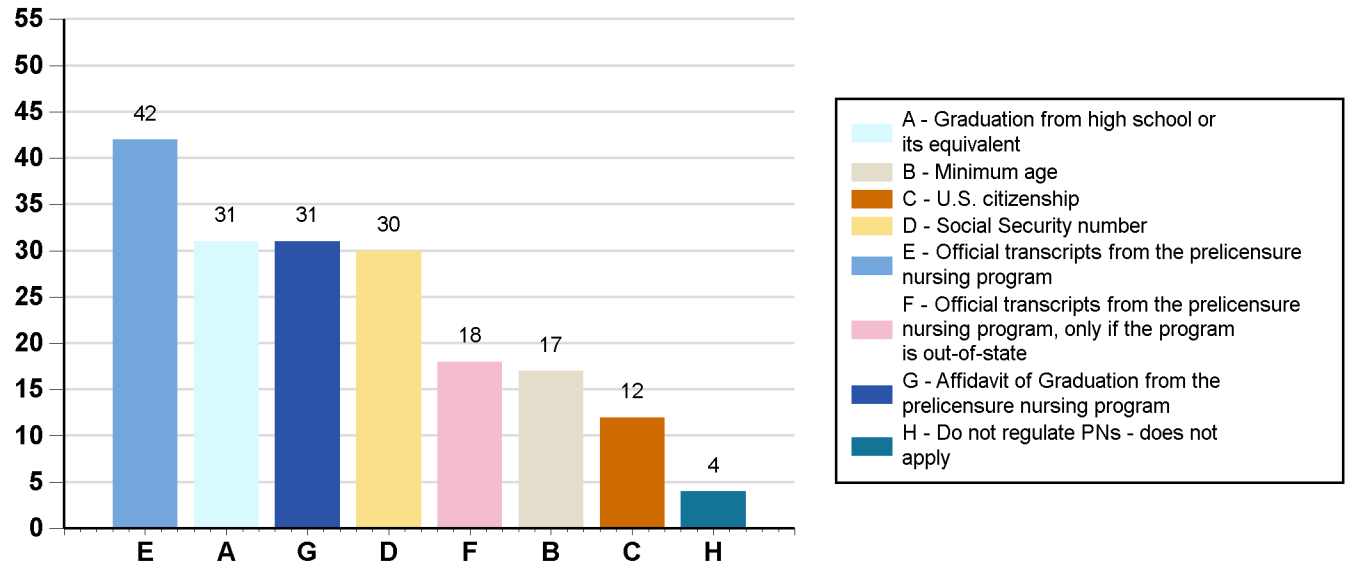
***Substance Use Disorder:* Encompasses a pattern of behaviors that range from misuse to dependency or addiction, whether the substance is alcohol, legal drugs or illegal drugs**

Agency Type:



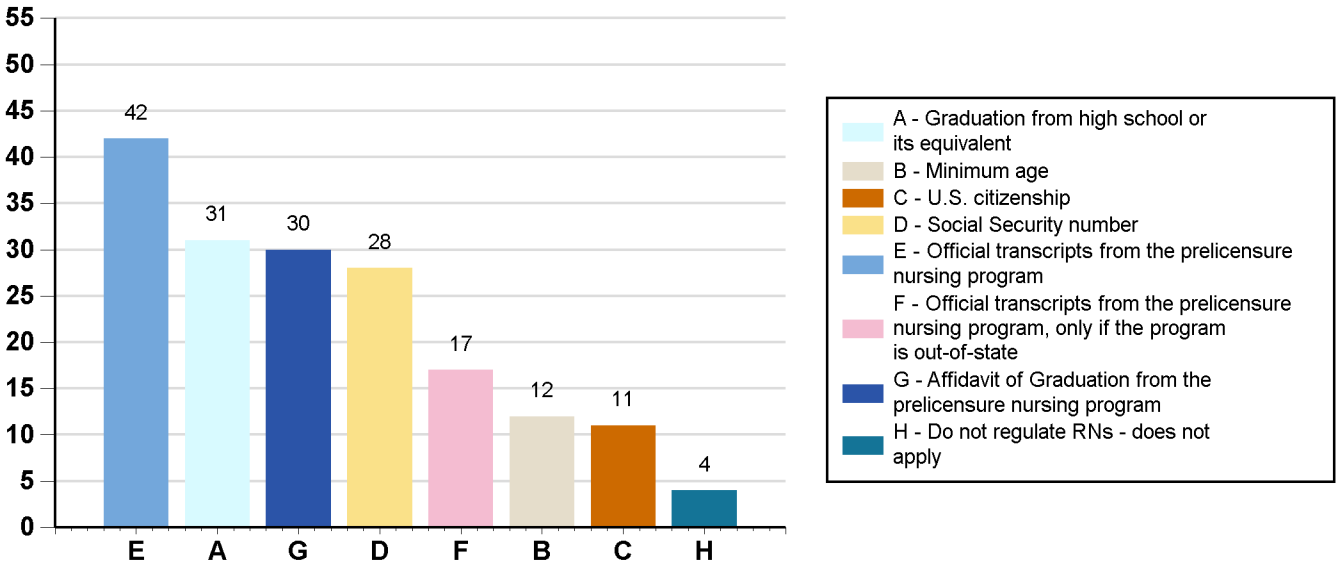
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Independent agency within state government	AL, AS, AZ, CNMI, KS, KY, LA-RN, MD, ME, MN, MO, MS, ND, NM, NV, OH, OK, OR, SD, TX, WV-PN, WV-RN, WY	23	39%
Board within an umbrella state agency	AK, AR, CA-RN, CA-VN, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, LA-PN, MA, MI, MT, NE, NE-APRN, NH, NJ, NY, PA, RI, SC, TN, UT, VA, VI, VT, WA, WI	35	59%
Independent agency outside state government	NC	1	2%

Q1. Which of the following are a requirement for initial PN licensure? (Check all that apply.)



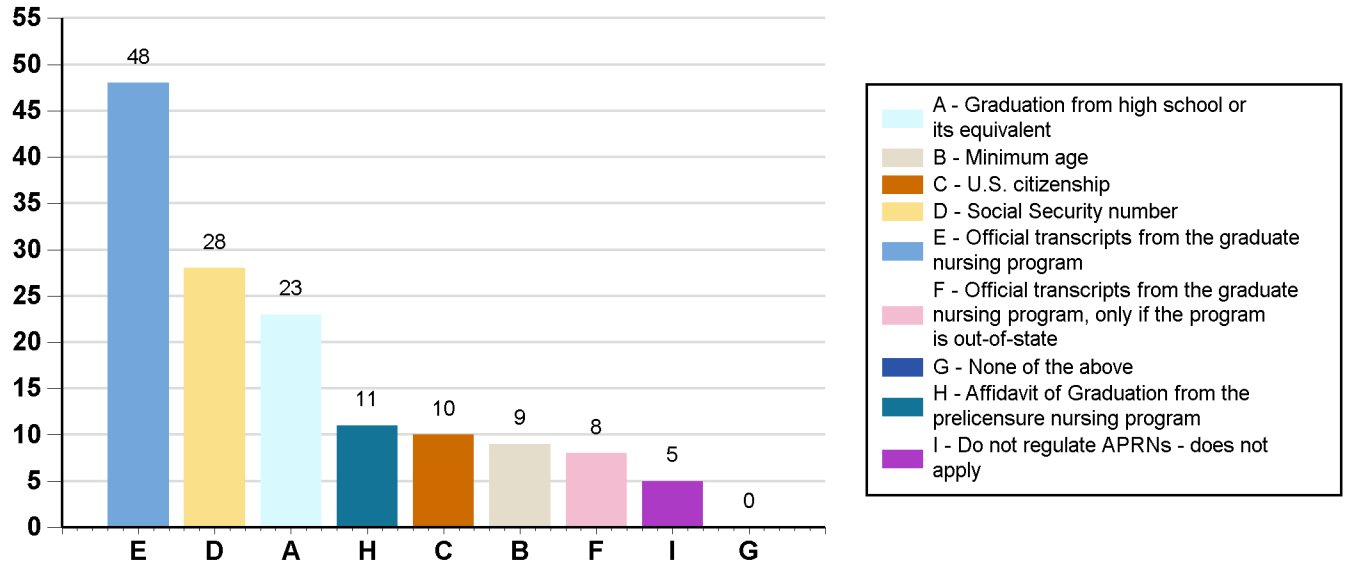
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Graduation from high school or its equivalent	AL, AR, AS, CA-VN, CNMI, DC, DE, FL, GA, GU, IA, IN, KY, LA-PN, MA, MD, ME, MT, NC, NE, NH, NJ, NV, NY, PA, RI, TN, UT, VA, VI, WV-PN	31	53%
Minimum age	AL, CA-VN, CNMI, DC, GA, HI, KY, MI, NJ, NV, NY, OK, PA, SC, UT, WI, WV-PN	17	29%
U.S. citizenship	AL, AZ, GU, HI, IA, MS, NE, OK, RI, VI, WV-PN, WY	12	20%
Social Security number	AL, AR, AZ, CA-VN, FL, GU, HI, IA, ID, IN, KS, KY, LA-PN, MA, ME, MS, NC, ND, NH, NV, OK, RI, SC, TN, UT, VA, VI, VT, WV-PN, WY	30	51%
Official transcripts from the prelicensure nursing program	AK, AL, AR, AS, AZ, CA-VN, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, KS, KY, LA-PN, MA, MD, MI, MN, MO, MS, MT, ND, NE, NH, NM, NV, NY, OK, RI, TN, UT, VI, WA, WV-PN, WY	42	71%
Official transcripts from the prelicensure nursing program, only if the program is out-of-state	AS, AZ, CA-VN, CNMI, FL, MD, ME, NC, NJ, OH, OR, PA, SC, SD, UT, VA, VT, WI	18	31%
Affidavit of Graduation from the prelicensure nursing program	AK, AL, AR, AZ, CA-VN, DE, FL, ID, IN, KY, LA-PN, MA, MD, ME, MI, MN, MS, NC, NJ, NM, OH, OR, PA, SC, SD, TX, UT, VA, VT, WA, WV-PN	31	53%
Do not regulate PNs - does not apply	CA-RN, LA-RN, NE-APRN, WV-RN	4	7%

Q2. Which of the following are a requirement for initial RN licensure? (Check all that apply.)



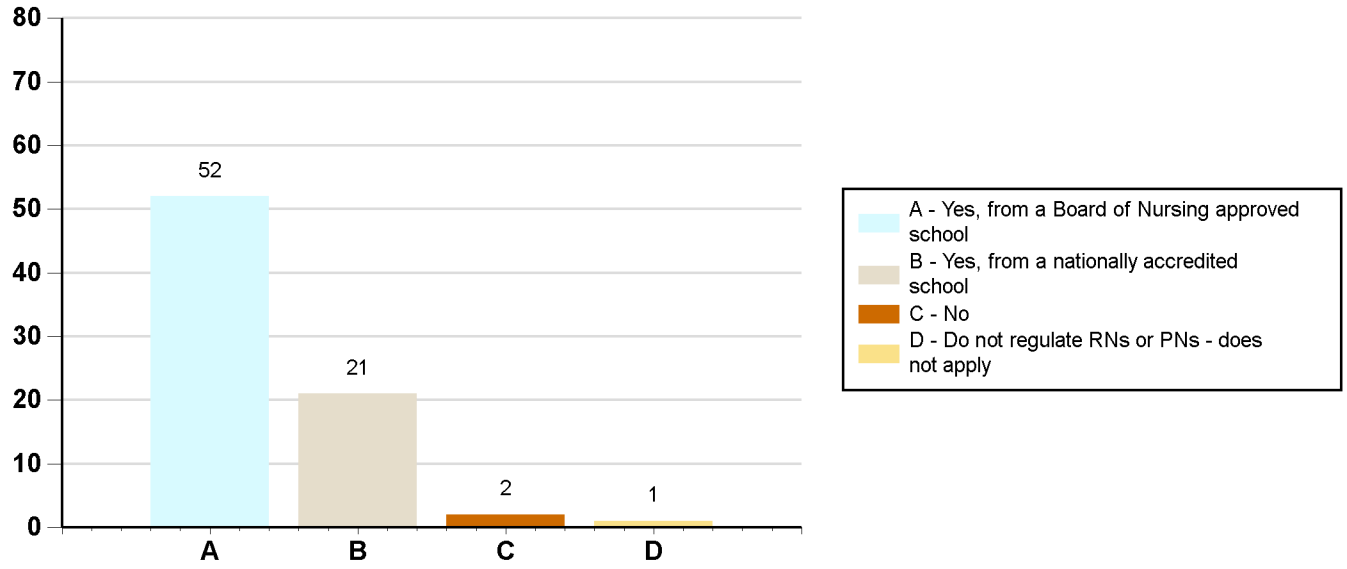
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Graduation from high school or its equivalent	AL, AR, AS, CA-RN, CNMI, DC, DE, FL, GU, IA, IN, KY, LA-RN, MA, MD, ME, MO, MT, NC, NE, NH, NJ, NY, PA, RI, TN, UT, VA, VI, WI, WV-RN	31	53%
Minimum age	AL, CNMI, DC, HI, KY, MI, NJ, NY, OK, SC, UT, WV-RN	12	20%
U.S. citizenship	AL, AZ, GU, HI, IA, MS, NE, OK, RI, VI, WY	11	19%
Social Security number	AL, AR, AZ, FL, GU, HI, IA, ID, IN, KS, KY, LA-RN, MA, ME, MS, NC, ND, NH, NV, OK, RI, SC, TN, UT, VA, VI, VT, WY	28	47%
Official transcripts from the prelicensure nursing program	AK, AL, AR, AS, AZ, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, KS, KY, LA-RN, MA, MD, MI, MN, MO, MS, MT, ND, NE, NH, NM, NV, NY, OK, RI, SC, TN, UT, VI, WA, WV-RN, WY	42	71%
Official transcripts from the prelicensure nursing program, only if the program is out-of-state	AS, CA-RN, CNMI, FL, MD, ME, NC, NJ, OH, OR, PA, SC, SD, UT, VA, VT, WI	17	29%
Affidavit of Graduation from the prelicensure nursing program	AK, AL, AR, AZ, CA-RN, DE, FL, ID, IN, KY, LA-RN, MA, MD, ME, MI, MN, MS, NC, NJ, NM, OH, OR, PA, SD, TX, UT, VA, VT, WA, WV-RN	30	51%
Do not regulate RNs - does not apply	CA-VN, LA-PN, NE-APRN, WV-PN	4	7%

Q3. Which of the following are a requirement for initial APRN licensure? (Check all that apply.)



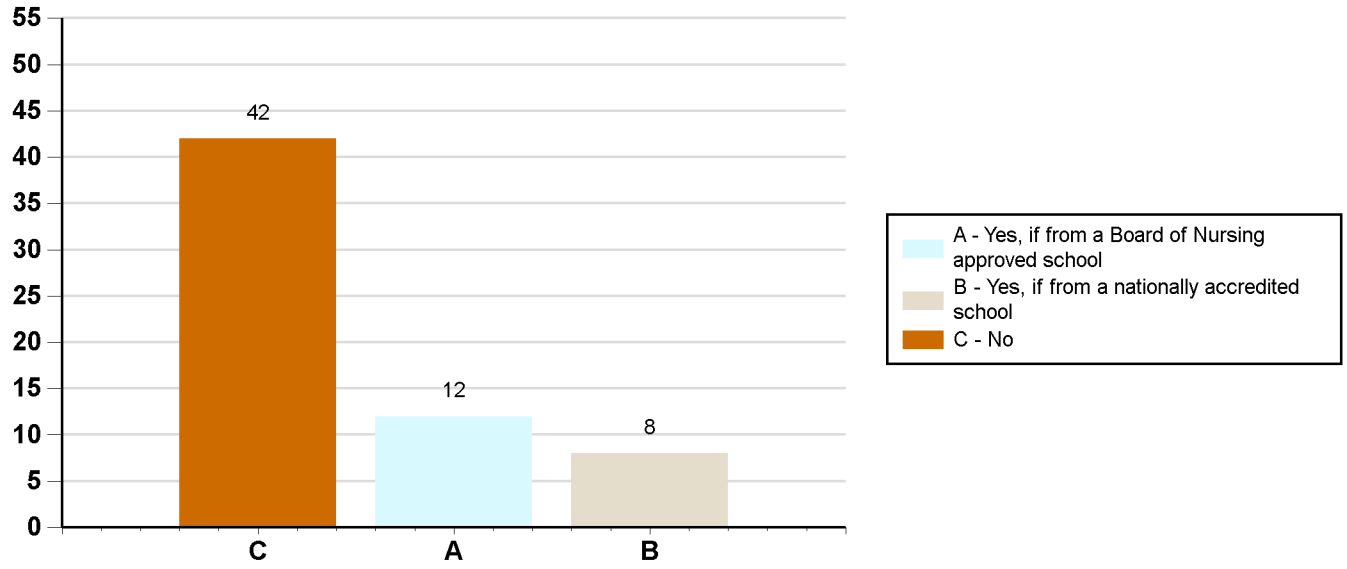
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Graduation from high school or its equivalent	AL, AR, AS, CA-RN, CNMI, DC, DE, GU, IA, IN, KY, LA-RN, MA, MD, ME, NH, NJ, NY, RI, TN, UT, VA, VI	23	39%
Minimum age	AL, DC, HI, KY, MI, NJ, NY, SC, UT	9	15%
U.S. citizenship	AL, AZ, GU, HI, IA, MS, OK, RI, VI, WY	10	17%
Social Security number	AL, AR, AZ, FL, GU, HI, IA, ID, IN, KS, KY, LA-RN, MA, ME, MO, MS, ND, NH, NV, OK, RI, SC, TN, UT, VA, VI, VT, WY	28	47%
Official transcripts from the graduate nursing program	AK, AL, AR, AS, AZ, CNMI, CO, CT, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-RN, MA, MD, ME, MI, MS, MT, NC, ND, NE-APRN, NH, NJ, NM, NV, NY, OH, OK, OR, RI, SC, SD, TN, TX, UT, VA, VI, WA, WV-RN, WY	48	81%
Official transcripts from the graduate nursing program, only if the program is out-of-state	AS, CA-RN, CNMI, MD, NJ, PA, UT, VT	8	14%
None of the above		0	0%
Affidavit of Graduation from the prelicensure nursing program	AL, CA-RN, ID, MD, MI, MN, MS, NJ, PA, UT, VT	11	19%
Do not regulate APRNs - does not apply	CA-VN, LA-PN, NE, WI, WV-PN	5	8%

Q4. Is graduation from a nursing education program a requirement for initial RN or PN licensure? (Check all that apply.)



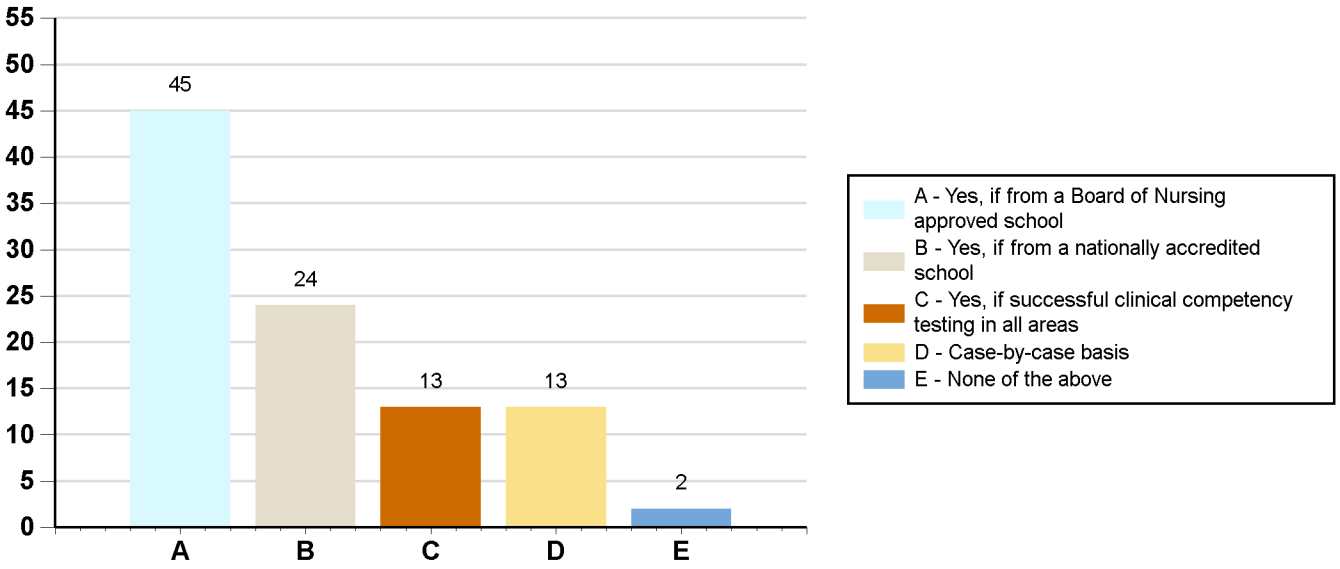
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Yes, from a Board of Nursing approved school	AK, AL, AR, AS, AZ, CNMI, CO, CT, DC, DE, FL, GA, HI, IA, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	52	88%
Yes, from a nationally accredited school	AK, AL, CNMI, CT, DC, FL, GU, HI, ID, MA, MD, ME, MS, MT, NH, NY, RI, UT, VT, WV-PN, WV-RN	21	36%
No	CA-RN, CA-VN	2	3%
Do not regulate RNs or PNs - does not apply	NE-APRN	1	2%

Q5. Are graduates from a prelicensure nursing program without a clinical component allowed licensure? (Check all that apply.)



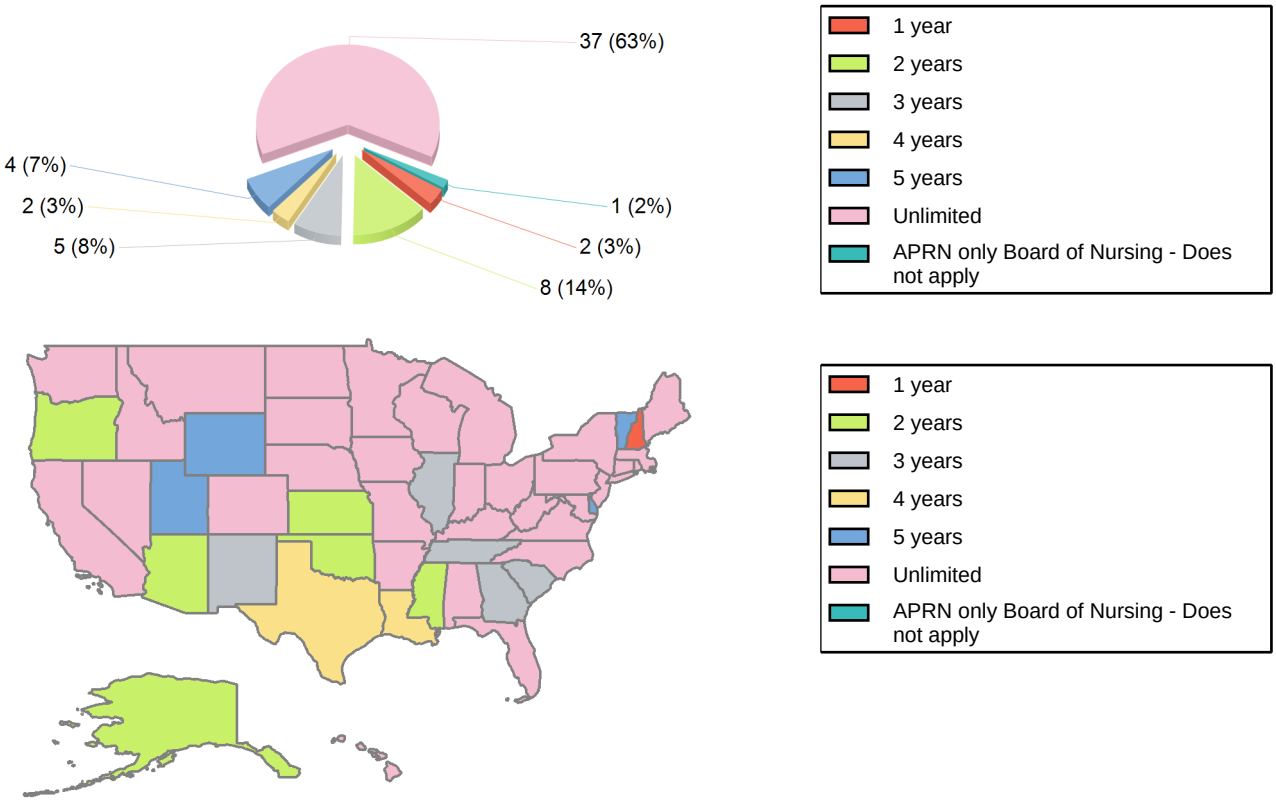
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Yes, if from a Board of Nursing approved school	AR, GA, HI, IA, MO, MT, NC, OR, SC, WA, WV-RN, WY	12	21%
Yes, if from a nationally accredited school	AK, HI, ID, MT, NV, SC, UT, WV-RN	8	14%
No	AL, AS, AZ, CA-RN, CA-VN, CNMI, CO, CT, DC, DE, FL, GU, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MS, ND, NE, NH, NJ, NM, NY, OH, OK, PA, RI, SD, TN, TX, VA, VI, VT, WI, WV-PN	42	72%

Q6. Are graduates of a prelicensure distance education program allowed licensure? (Check all that apply.)



Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Yes, if from a Board of Nursing approved school	AK, AR, AS, AZ, CA-RN, CNMI, CO, CT, DE, FL, GA, HI, IA, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MS, MT, ND, NE, NH, NJ, NM, OH, OK, OR, PA, SC, SD, TN, TX, VA, VI, VT, WI, WV-PN, WV-RN, WY	45	78%
Yes, if from a nationally accredited school	AK, AS, CA-RN, CNMI, CT, FL, GU, HI, ID, KS, MA, MD, ME, MS, MT, NE, NH, NV, UT, VI, VT, WI, WV-PN, WV-RN	24	41%
Yes, if successful clinical competency testing in all areas	AS, CA-RN, CNMI, DE, GU, HI, IL, KS, LA-RN, ME, OK, VI, VT	13	22%
Case-by-case basis	AL, DC, DE, FL, LA-PN, LA-RN, MD, ME, NC, NY, VI, WA, WV-PN	13	22%
None of the above	CA-VN, RI	2	3%

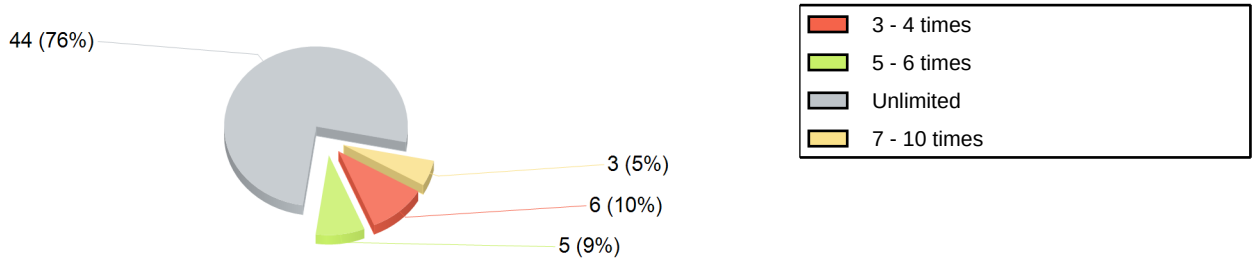
Q7. What is the time limit for applicants to pass the NCLEX after graduation?

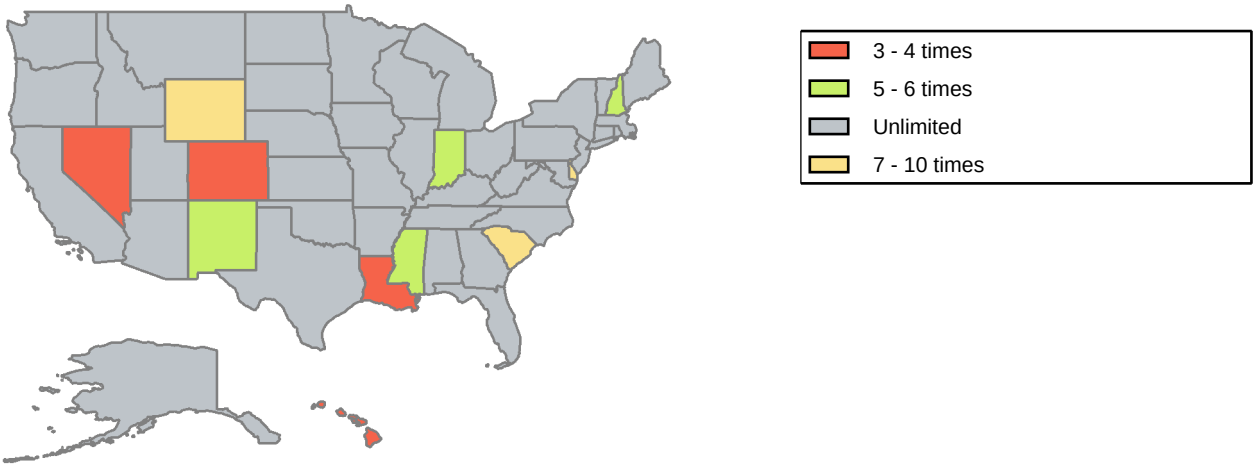


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
1 year	DC, NH	2	3%
2 years	AK, AZ, GU, KS, LA-PN, MS, OK, OR	8	14%
3 years	GA, IL, NM, SC, TN	5	8%
4 years	LA-RN, TX	2	3%
5 years	DE, UT, VT, WY	4	7%
Unlimited	AL, AR, AS, CA-RN, CA-VN, CNMI, CO, CT, FL, HI, IA, ID, IN, KY, MA, MD, ME, MI, MN, MO, MT, NC, ND, NE, NJ, NV, NY, OH, PA, RI, SD, VA, VI, WA, WI, WV-PN, WV-RN	37	63%
APRN only Board of Nursing - Does not apply	NE-APRN	1	2%

Q8. What is the total number of times an initial applicant can take the NCLEX?

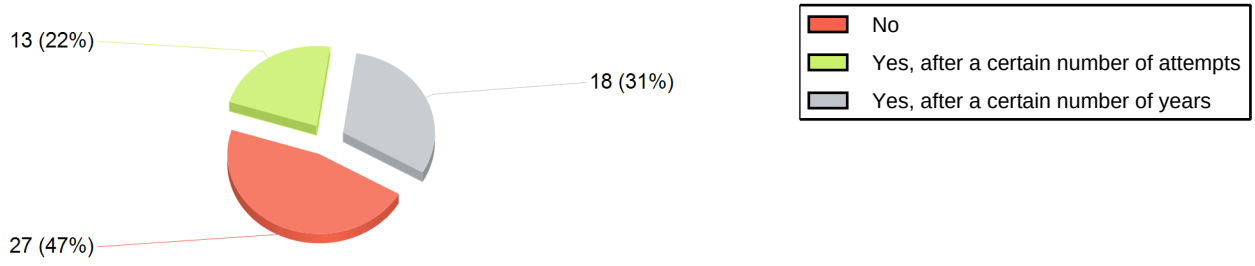


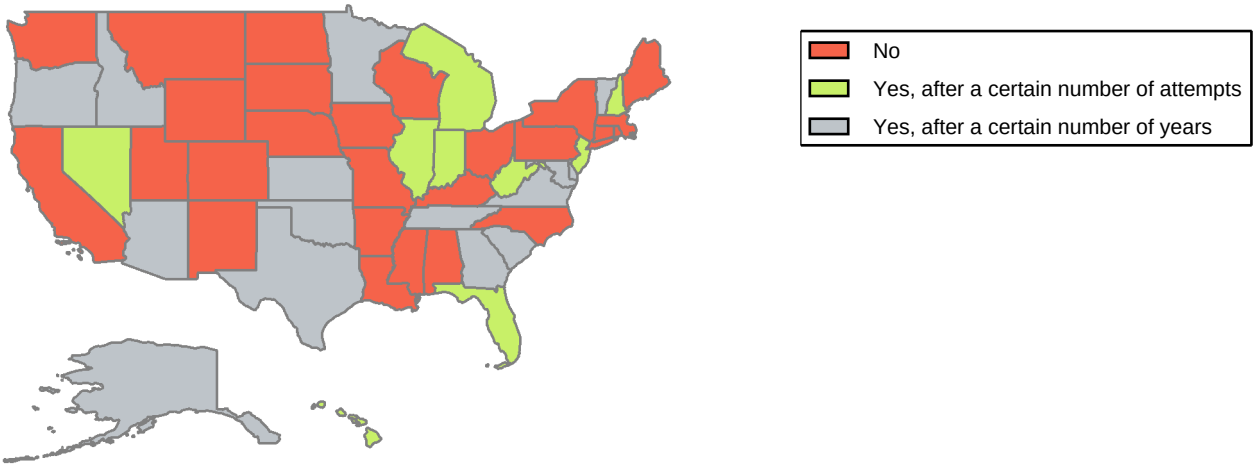


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
3 - 4 times	CO, HI, LA-PN, LA-RN, NV, VI	6	10%
5 - 6 times	GU, IN, MS, NH, NM	5	9%
Unlimited	AK, AL, AR, AS, AZ, CA-RN, CA-VN, CNMI, CT, DC, FL, GA, IA, ID, IL, KS, KY, MA, MD, ME, MI, MN, MO, MT, NC, ND, NE, NJ, NY, OH, OK, OR, PA, RI, SD, TN, TX, UT, VA, VT, WA, WI, WV-PN, WV-RN	44	76%
7 - 10 times	DE, SC, WY	3	5%

Q9. Does the Board of Nursing require remediation after a certain number of failed NCLEX attempts?

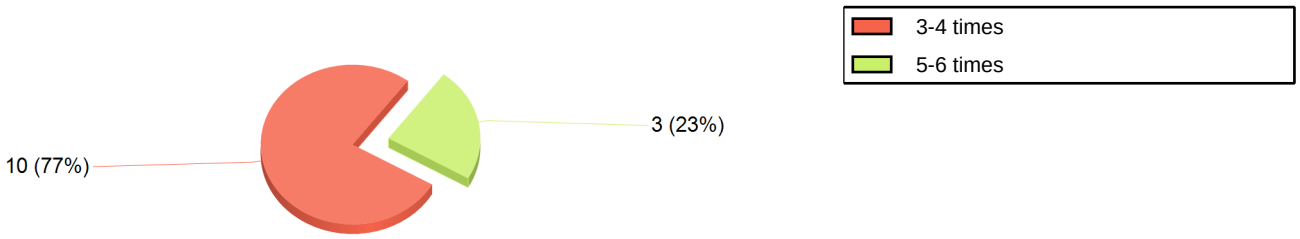


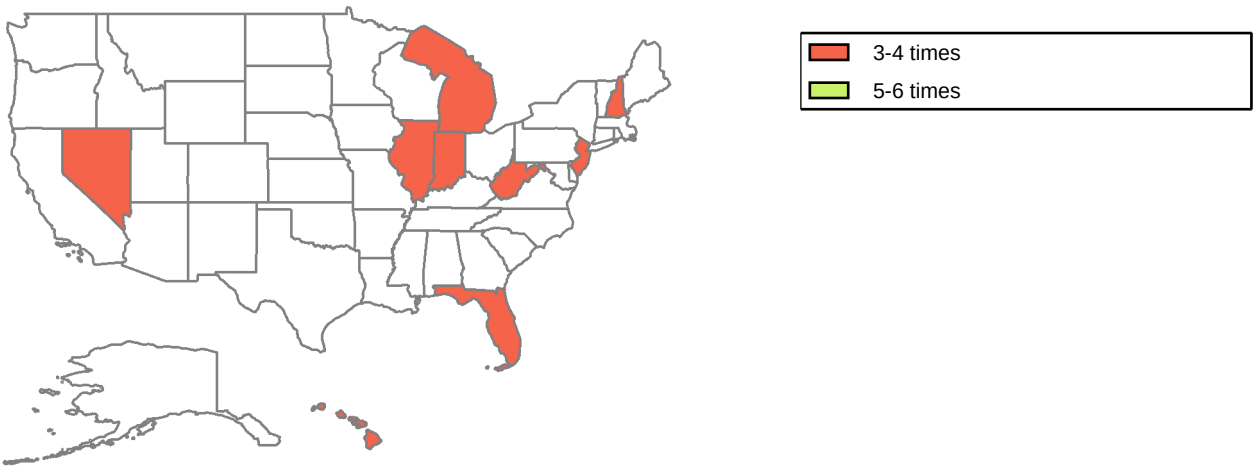


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AL, AR, CA-RN, CA-VN, CO, CT, IA, KY, LA-RN, MA, ME, MO, MS, MT, NC, ND, NE, NM, NY, OH, PA, RI, SD, UT, WA, WI, WY	27	47%
Yes, after a certain number of attempts	CNMI, DC, FL, GU, HI, IL, IN, MI, NH, NJ, NV, VI, WV-RN	13	22%
Yes, after a certain number of years	AK, AS, AZ, DE, GA, ID, KS, LA-PN, MD, MN, OK, OR, SC, TN, TX, VA, VT, WV-PN	18	31%

Q10. How many failed NCLEX attempts require an applicant to complete remediation before another NCLEX attempt?

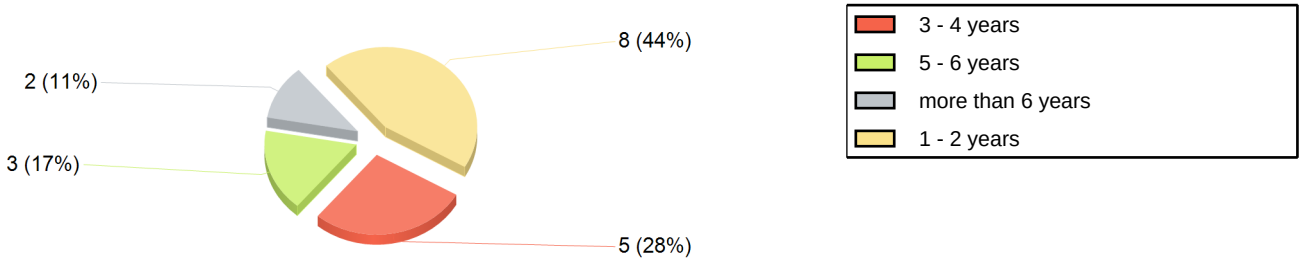


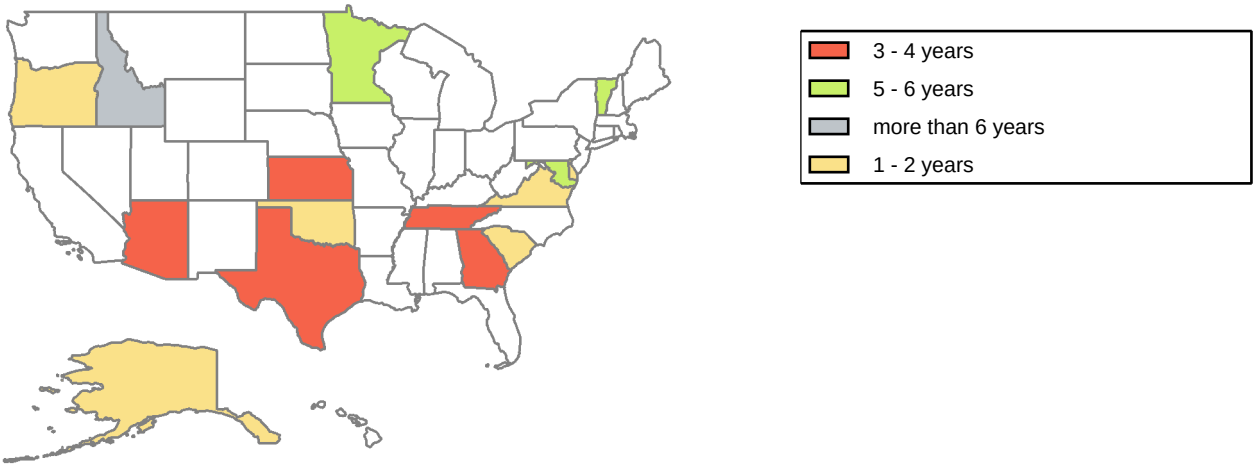


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
3-4 times	FL, HI, IL, IN, MI, NH, NJ, NV, VI, WV-RN	10	77%
5-6 times	CNMI, DC, GU	3	23%

Q11. How many years of failed NCLEX attempts require an applicant to complete remediation before another NCLEX attempt?

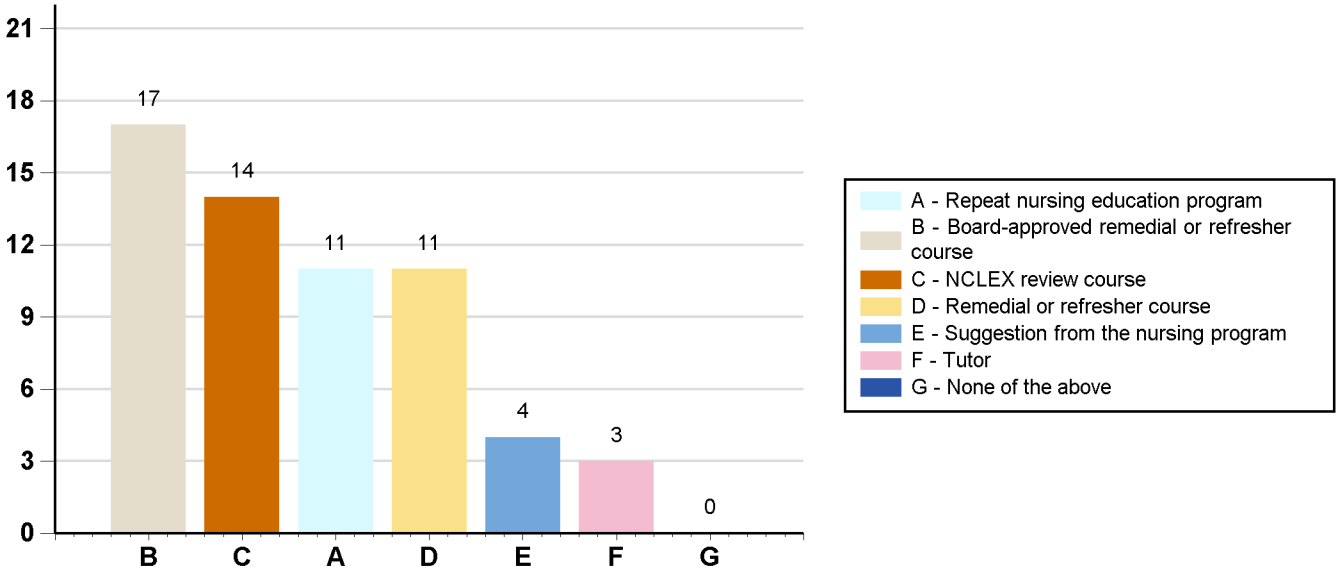




*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

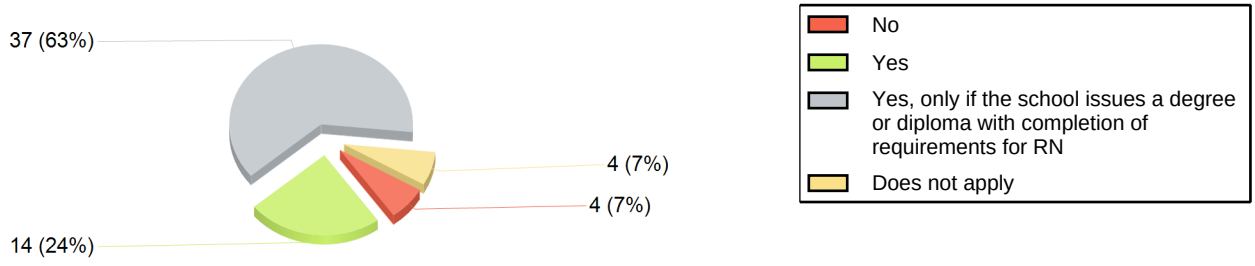
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
3 - 4 years	AZ, GA, KS, TN, TX	5	28%
5 - 6 years	MD, MN, VT	3	17%
more than 6 years	ID, WV-PN	2	11%
1 - 2 years	AK, AS, DE, LA-PN, OK, OR, SC, VA	8	44%

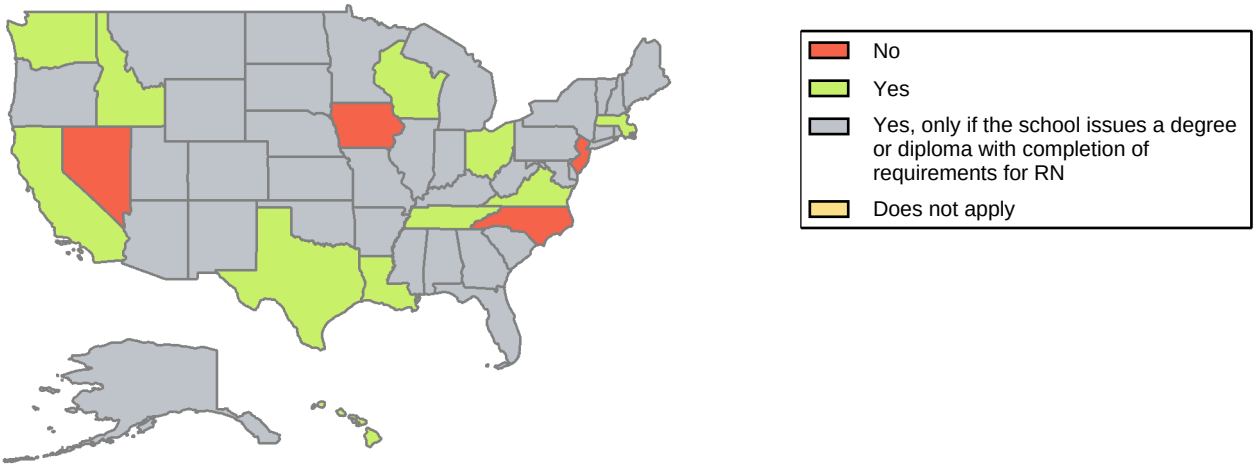
Q12. Are any of the following included as possible remediation after specific number of attempts/years of failed NCLEX attempts? (Check all that apply)



Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Repeat nursing education program	AK, GA, GU, KS, LA-PN, MI, OR, TN, TX, VT, WV-PN	11	37%
Board-approved remedial or refresher course	AZ, CNMI, DC, FL, GU, HI, ID, IN, KS, MD, MI, NJ, NV, OK, SC, VI, WV-PN	17	57%
NCLEX review course	AS, CNMI, DE, GU, ID, IL, KS, MI, MN, NH, NJ, NV, SC, WV-PN	14	47%
Remedial or refresher course	AK, AZ, CNMI, DC, GU, ID, IN, KS, MI, NH, WV-PN	11	37%
Suggestion from the nursing program	AZ, GU, KS, WV-PN	4	13%
Tutor	NH, WV-PN, WV-RN	3	10%
None of the above		0	0%

Q13. Are applicants in a graduate entry-level nursing degree program eligible to take the NCLEX-RN examination following completion of the Board of Nursing's educational requirements for a RN?

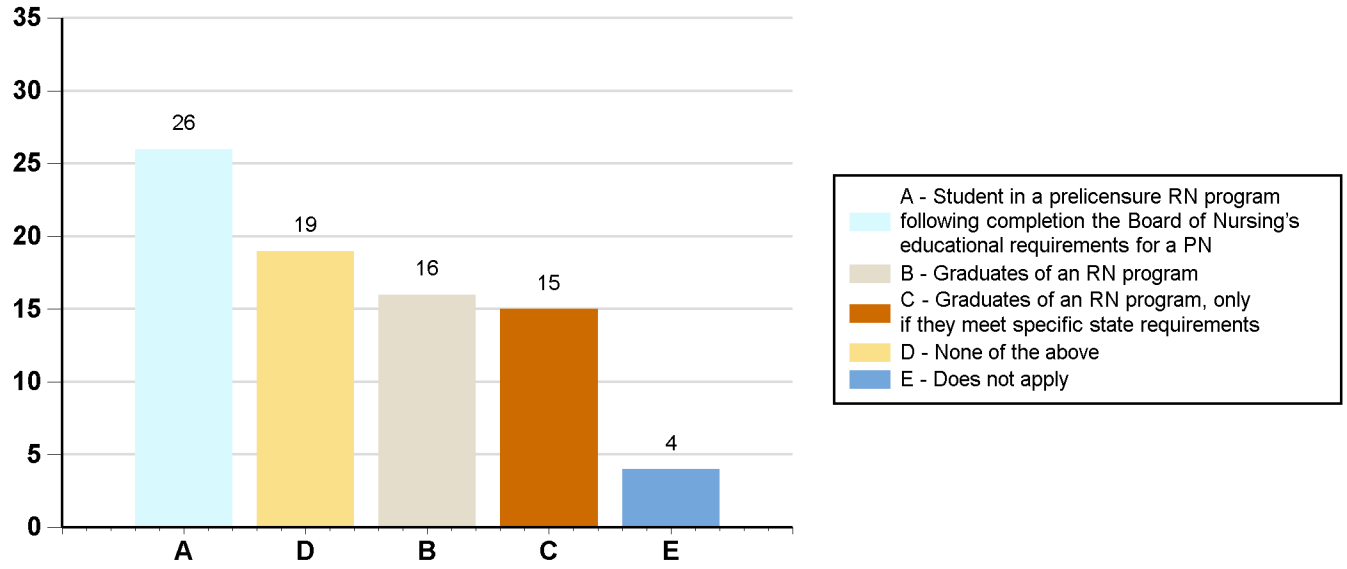




*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

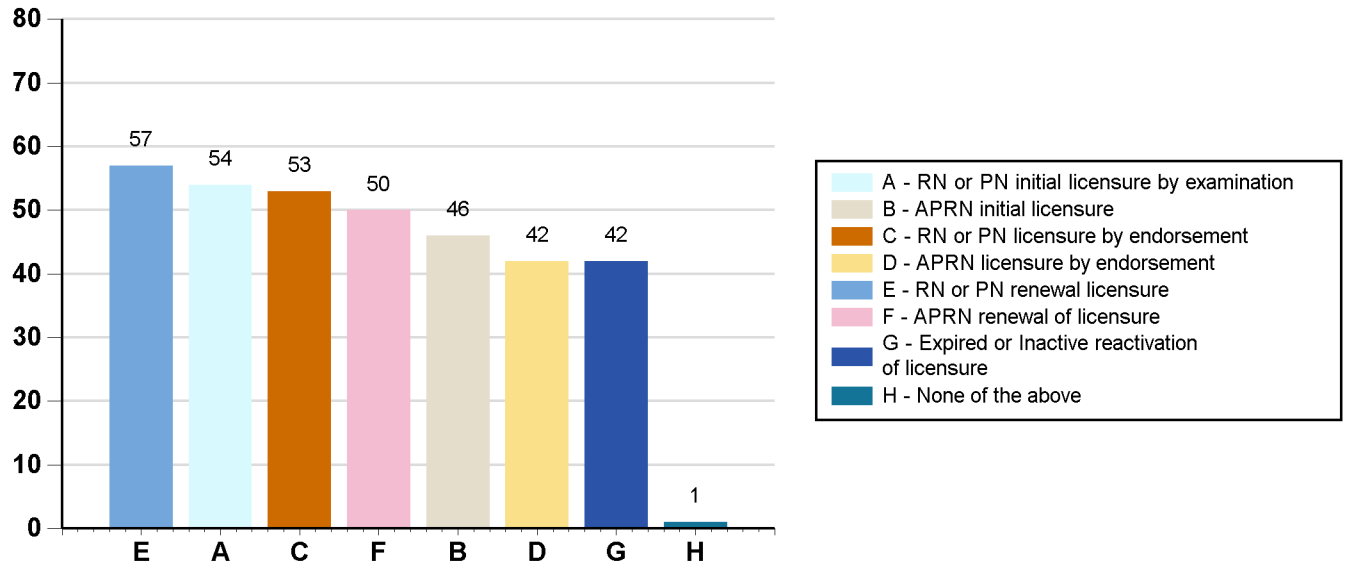
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	IA, NC, NJ, NV	4	7%
Yes	CA-RN, CNMI, GU, HI, ID, LA-RN, MA, OH, TN, TX, VA, VI, WA, WI	14	24%
Yes, only if the school issues a degree or diploma with completion of requirements for RN	AK, AL, AR, AS, AZ, CO, CT, DC, DE, FL, GA, IL, IN, KS, KY, MD, ME, MI, MN, MO, MS, MT, ND, NE, NH, NM, NY, OK, OR, PA, RI, SC, SD, UT, VT, WV-RN, WY	37	63%
Does not apply	CA-VN, LA-PN, NE-APRN, WV-PN	4	7%

Q14. Are any of the following eligible to take the NCLEX-PN? (Check all that apply.)



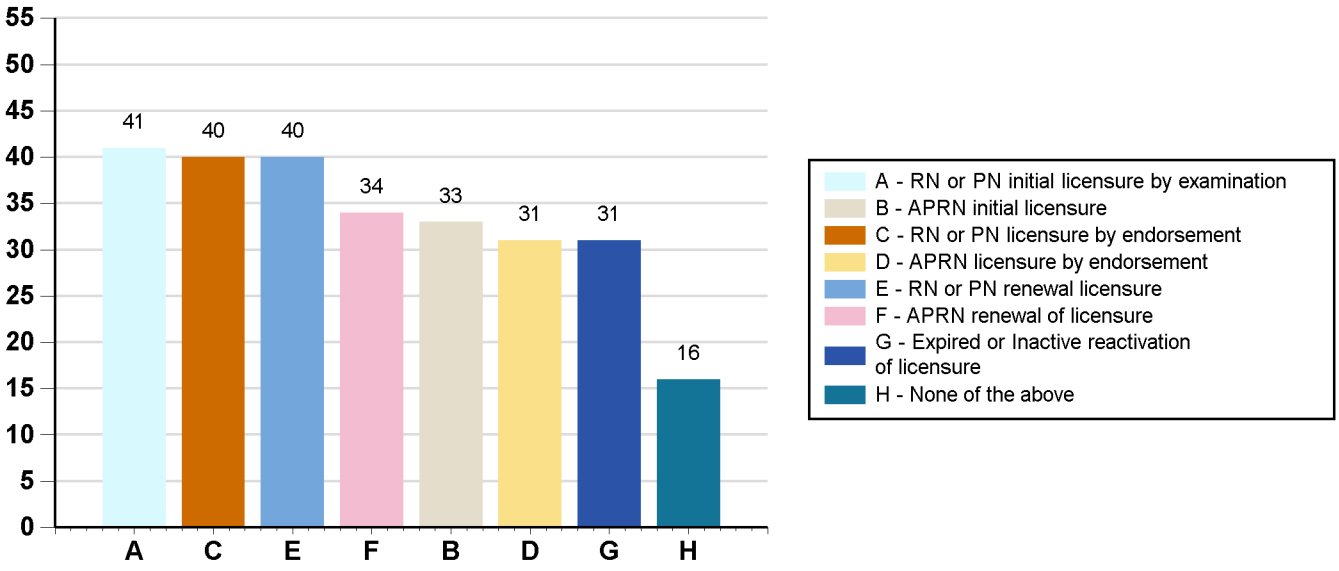
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Student in a prelicensure RN program following completion the Board of Nursing's educational requirements for a PN	AL, AS, AZ, CA-VN, CNMI, CO, FL, GU, HI, ID, IN, KY, MA, MD, MT, NH, NM, OK, RI, SC, SD, UT, VT, WA, WI, WY	26	44%
Graduates of an RN program	AR, AS, AZ, CNMI, CO, FL, HI, MD, MI, NE, NH, NV, NY, OK, OR, SC	16	27%
Graduates of an RN program, only if they meet specific state requirements	AL, AZ, CA-VN, GU, ID, KS, MD, MI, MO, MS, NC, NM, SD, UT, WA	15	25%
None of the above	AK, CT, DC, DE, GA, IA, IL, LA-PN, ME, MN, ND, NJ, OH, PA, TN, TX, VA, VI, WV-PN	19	32%
Does not apply	CA-RN, LA-RN, NE-APRN, WV-RN	4	7%

Q15. Can licensure applications be submitted online? (Check all that apply)



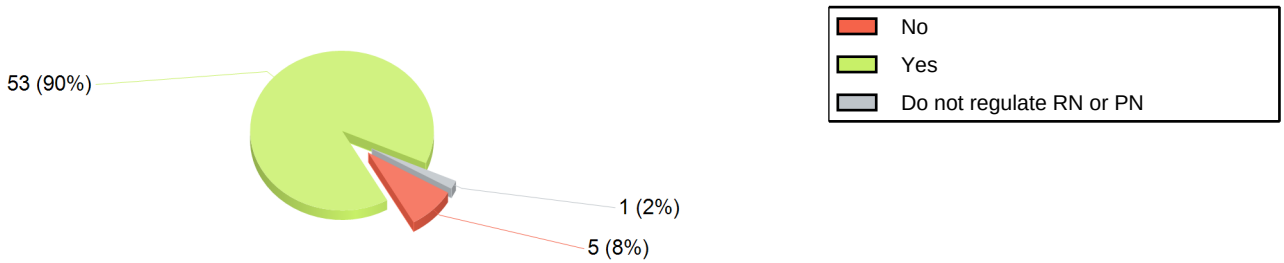
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
RN or PN initial licensure by examination	AK, AL, AR, AZ, CA-RN, CA-VN, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MS, MT, NC, ND, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV-PN, WV-RN, WY	54	92%
APRN initial licensure	AK, AL, AR, AZ, CA-RN, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-RN, MA, ME, MI, MN, MS, MT, NC, NH, NJ, NM, NV, NY, OH, OK, OR, PA, SC, TN, TX, UT, VA, VT, WA, WV-RN, WY	46	78%
RN or PN licensure by endorsement	AK, AL, AR, AZ, CA-RN, CA-VN, CNMI, CO, CT, DC, DE, FL, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MS, MT, NC, ND, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV-PN, WV-RN, WY	53	90%
APRN licensure by endorsement	AK, AL, AR, AZ, CA-RN, CNMI, CO, CT, DC, DE, FL, GU, HI, IA, IL, IN, KS, KY, LA-RN, MA, ME, MI, MN, MS, MT, NH, NJ, NM, NV, NY, OH, OK, OR, PA, SC, TX, UT, VA, VT, WA, WV-RN, WY	42	71%
RN or PN renewal licensure	AK, AL, AR, AZ, CA-RN, CA-VN, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	57	97%
APRN renewal of licensure	AK, AL, AR, AZ, CA-RN, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-RN, MA, MD, ME, MI, MN, MS, MT, NC, ND, NE-APRN, NH, NJ, NM, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, UT, VA, VT, WA, WV-RN, WY	50	85%
Expired or Inactive reactivation of licensure	AL, AR, AZ, CA-RN, CA-VN, CNMI, CO, CT, DC, DE, FL, GU, IA, ID, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MS, MT, NC, ND, NM, NV, NY, OH, OK, OR, PA, TN, TX, VT, WI, WV-PN, WV-RN, WY	42	71%
None of the above	AS	1	2%

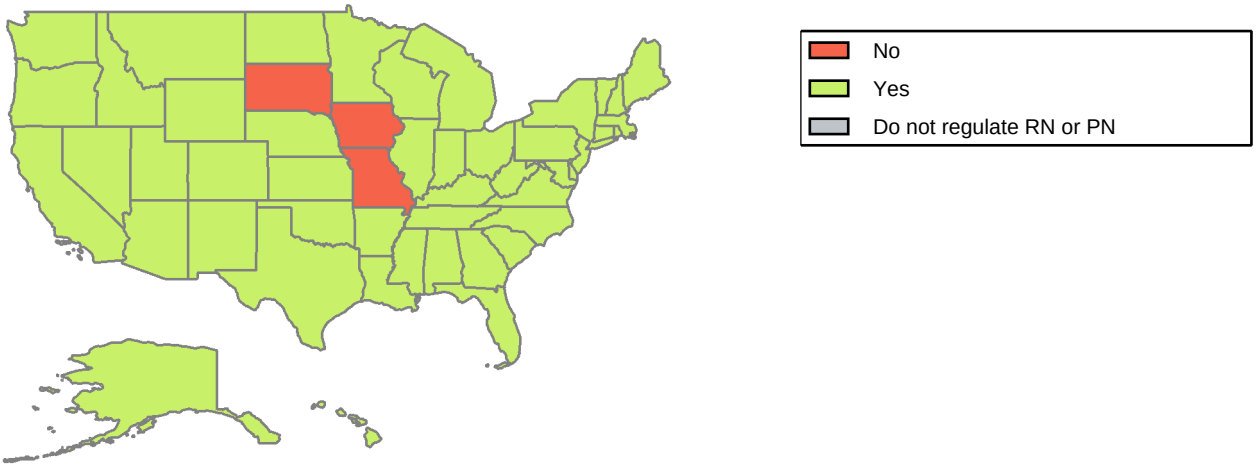
Q16. Are licensure applications required to be submitted online? (Check all that apply)



Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
RN or PN initial licensure by examination	AL, AR, AZ, CA-RN, CNMI, CO, CT, DC, DE, GU, ID, IL, IN, KY, LA-PN, LA-RN, MA, MD, ME, MI, MS, NC, ND, NH, NJ, NM, NV, OH, OR, PA, RI, SC, SD, TN, TX, VA, VT, WI, WV-PN, WV-RN, WY	41	71%
APRN initial licensure	AL, AR, AZ, CA-RN, CNMI, CO, CT, DC, DE, GU, ID, IL, IN, KY, LA-RN, MA, ME, MI, MS, NC, NH, NJ, NM, NV, OH, OR, PA, TN, TX, VA, VT, WV-RN, WY	33	57%
RN or PN licensure by endorsement	AL, AR, AZ, CA-RN, CNMI, CO, CT, DC, DE, GU, ID, IL, IN, KY, LA-PN, LA-RN, MA, MD, ME, MI, MS, NC, ND, NH, NJ, NM, NV, OH, OR, PA, RI, SD, TN, TX, VA, VT, WI, WV-PN, WV-RN, WY	40	69%
APRN licensure by endorsement	AL, AR, AZ, CA-RN, CNMI, CO, CT, DC, DE, GU, IL, IN, KY, LA-RN, MA, ME, MI, MS, NH, NJ, NM, NV, OH, OR, PA, TN, TX, VA, VT, WV-RN, WY	31	53%
RN or PN renewal licensure	AL, AR, AZ, CA-RN, CNMI, CO, CT, DC, DE, GU, ID, IL, IN, KY, LA-PN, LA-RN, MD, ME, MI, MS, NC, ND, NH, NJ, NM, NV, OH, OR, PA, RI, SD, TN, TX, VA, VI, VT, WI, WV-PN, WV-RN, WY	40	69%
APRN renewal of licensure	AL, AR, AZ, CA-RN, CNMI, CO, CT, DC, DE, GU, ID, IL, IN, KY, LA-RN, MD, ME, MI, MS, NC, ND, NH, NM, NV, OH, OR, PA, SD, TN, TX, VA, VT, WV-RN, WY	34	59%
Expired or Inactive reactivation of licensure	AL, AR, AZ, CA-RN, CNMI, CO, CT, DC, DE, GU, ID, IN, KY, LA-RN, ME, MI, MS, NC, ND, NM, NV, OH, OR, PA, TN, TX, VT, WI, WV-PN, WV-RN, WY	31	53%
None of the above	AK, CA-VN, FL, GA, HI, IA, KS, MN, MO, MT, NE, NE-APRN, NY, OK, UT, WA	16	28%

Q17. Do initial licensure-by-examination applications address the request for special accommodations during administration of the NCLEX-RN/PN?





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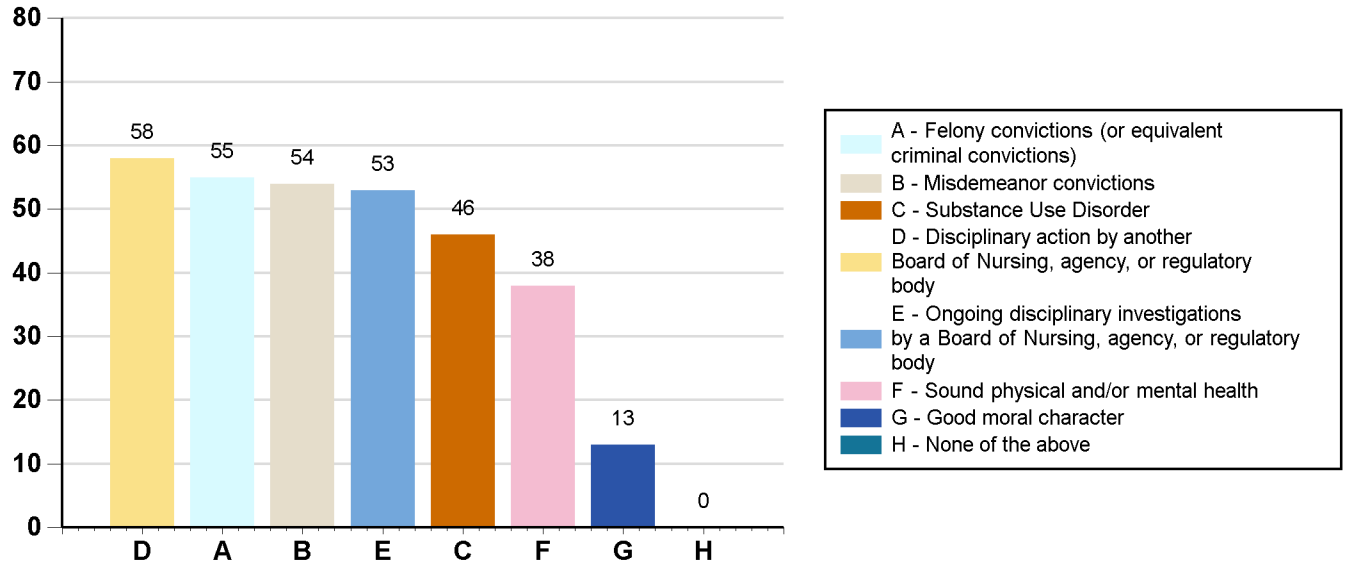
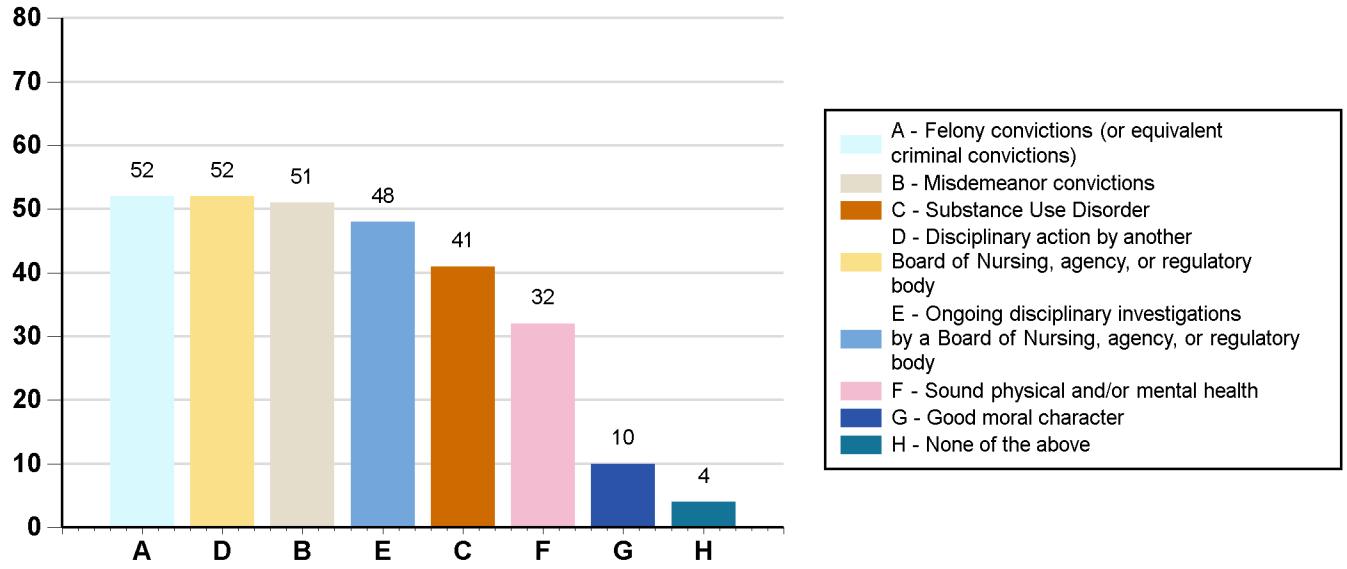
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AS, CNMI, IA, MO, SD	5	8%
Yes	AK, AL, AR, AZ, CA-RN, CA-VN, CO, CT, DC, DE, FL, GA, GU, HI, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	53	90%
Do not regulate RN or PN	NE-APRN	1	2%

Q18. Do RN or PN initial licensure applications contain questions regarding any of the following? (Check all that apply.)



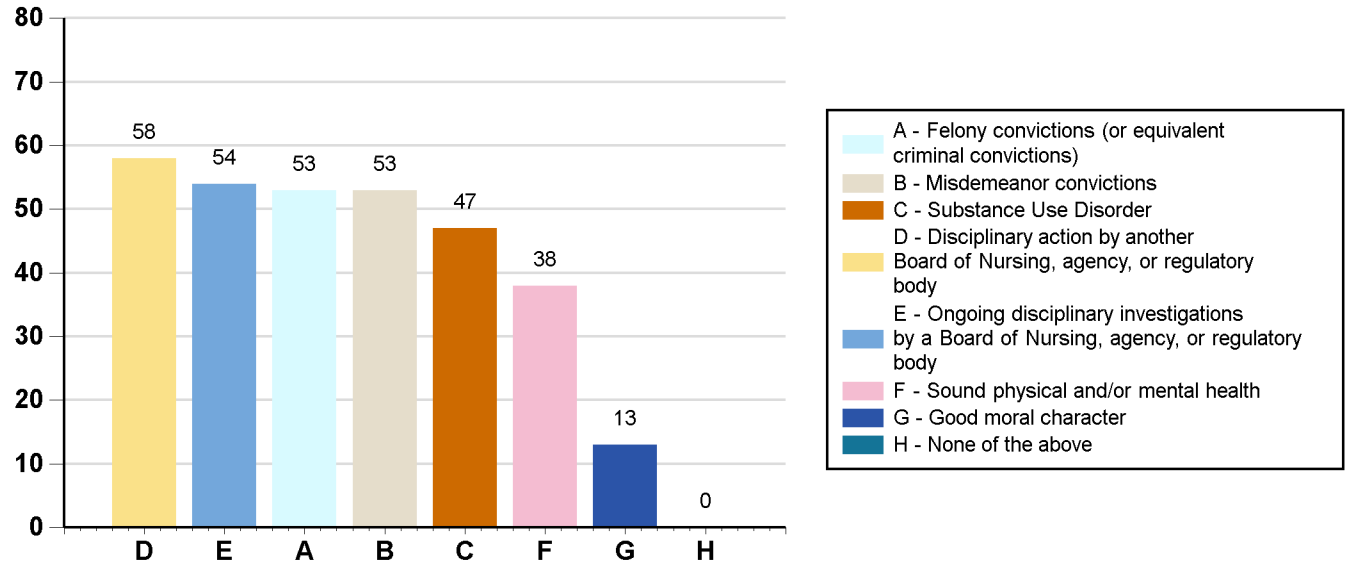
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Felony convictions (or equivalent criminal convictions)	AK, AL, AR, AS, AZ, CA-VN, CNMI, CO, CT, DC, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	55	95%
Misdemeanor convictions	AK, AL, AR, AS, AZ, CA-VN, CNMI, CO, DC, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	54	93%
Substance Use Disorder	AK, AL, AR, AS, AZ, CO, DC, DE, FL, GA, GU, IA, ID, IL, KS, KY, LA-PN, LA-RN, MD, ME, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OR, PA, RI, SC, SD, TN, TX, VI, VT, WA, WI, WV-PN, WV-RN, WY	46	79%
Disciplinary action by another Board of Nursing, agency, or regulatory body	AK, AL, AR, AS, AZ, CA-RN, CA-VN, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	58	100%
Ongoing disciplinary investigations by a Board of Nursing, agency, or regulatory body	AK, AL, AR, AZ, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	53	91%
Sound physical and/or mental health	AK, AL, AR, AZ, CO, DC, FL, GA, GU, ID, IL, KS, LA-PN, LA-RN, MN, MO, MS, MT, NC, ND, NH, NM, NV, OH, OR, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	38	66%
Good moral character	AL, GU, KS, LA-PN, MA, MD, MI, MO, NY, OH, SC, TN, VI	13	22%
None of the above		0	0%

Q19. Do RN or PN renewal licensure applications contain questions regarding any of the following? (Check all that apply.)



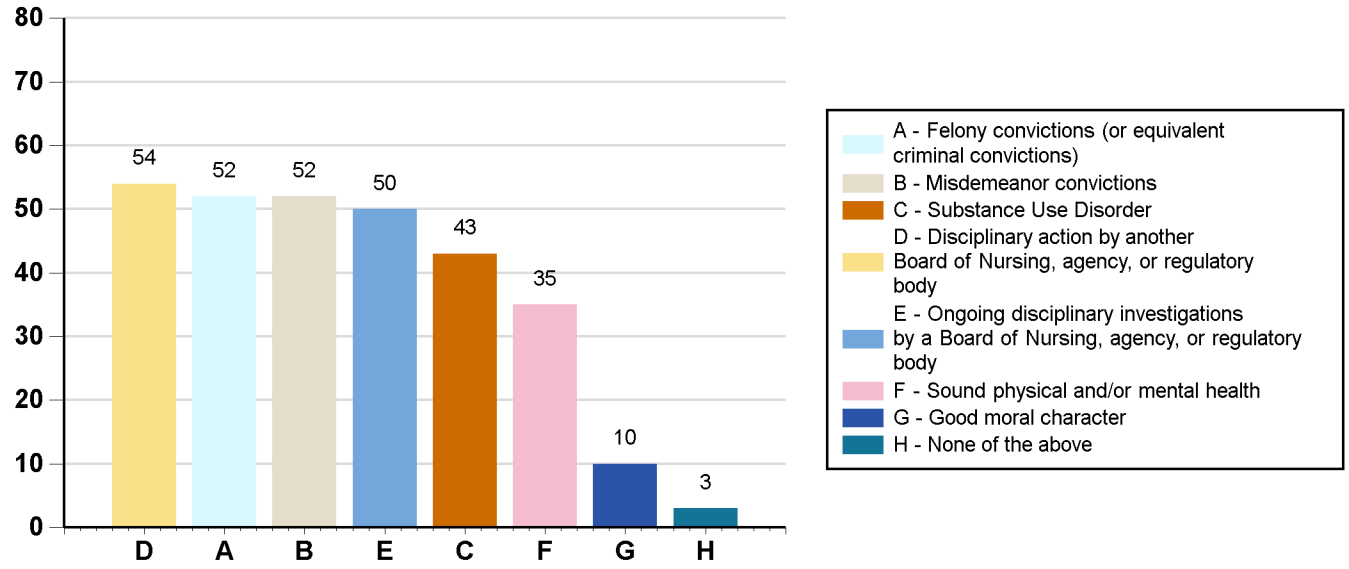
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Felony convictions (or equivalent criminal convictions)	AK, AL, AR, AZ, CA-RN, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, RI, SC, SD, TN, TX, UT, VI, VT, WI, WV-PN, WV-RN, WY	52	90%
Misdemeanor convictions	AK, AL, AR, AZ, CA-RN, CNMI, CO, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, RI, SC, SD, TN, TX, UT, VI, VT, WI, WV-PN, WV-RN, WY	51	88%
Substance Use Disorder	AK, AL, AR, AZ, CO, DC, DE, GA, GU, IA, ID, IL, KS, KY, LA-PN, LA-RN, MD, ME, MN, MO, MS, NC, ND, NE, NH, NJ, NM, NV, OH, OR, PA, RI, SC, SD, TN, TX, VI, VT, WV-PN, WV-RN, WY	41	71%
Disciplinary action by another Board of Nursing, agency, or regulatory body	AK, AL, AR, AZ, CA-RN, CA-VN, CNMI, CO, CT, DC, DE, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VI, VT, WV-PN, WV-RN, WY	52	90%
Ongoing disciplinary investigations by a Board of Nursing, agency, or regulatory body	AK, AL, AR, AZ, CNMI, CO, CT, DC, DE, GA, GU, HI, ID, IL, IN, KS, KY, LA-PN, LA-RN, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VI, VT, WV-PN, WV-RN, WY	48	83%
Sound physical and/or mental health	AK, AL, AR, AZ, CO, DC, GA, GU, ID, IL, KS, LA-PN, LA-RN, MN, MS, NC, ND, NH, NM, NV, OH, OR, SC, SD, TN, TX, UT, VI, VT, WV-PN, WV-RN, WY	32	55%
Good moral character	AL, GU, KS, LA-PN, MI, MO, NY, OH, TN, VI	10	17%
None of the above	AS, MA, VA, WA	4	7%

Q20. Do RN or PN endorsement licensure applications contain questions regarding any of the following? (Check all that apply.)



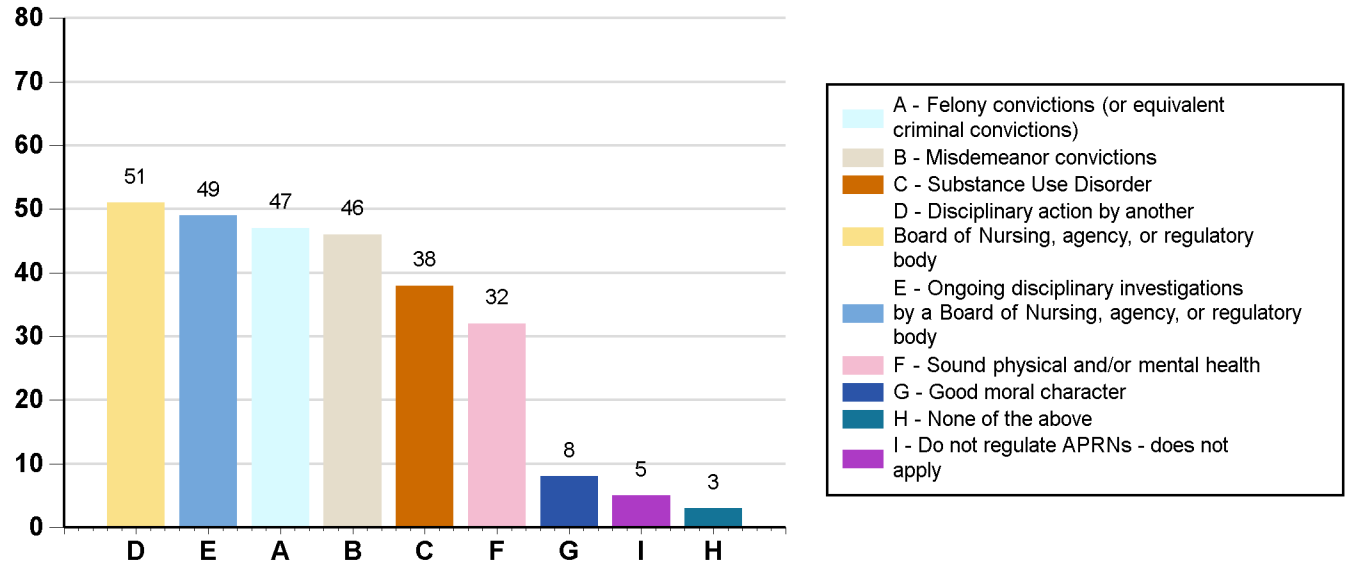
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Felony convictions (or equivalent criminal convictions)	AK, AL, AR, AS, AZ, CNMI, CO, CT, DC, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, RI, SC, SD, TN, TX, UT, VI, VT, WA, WI, WV-PN, WV-RN, WY	53	91%
Misdemeanor convictions	AK, AL, AR, AS, AZ, CNMI, CO, DC, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	53	91%
Substance Use Disorder	AK, AL, AR, AS, AZ, CO, DC, DE, FL, GA, GU, IA, ID, IL, KS, KY, LA-PN, LA-RN, MD, ME, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OR, PA, RI, SC, SD, TN, TX, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	47	81%
Disciplinary action by another Board of Nursing, agency, or regulatory body	AK, AL, AR, AS, AZ, CA-RN, CA-VN, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	58	100%
Ongoing disciplinary investigations by a Board of Nursing, agency, or regulatory body	AK, AL, AR, AS, AZ, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	54	93%
Sound physical and/or mental health	AK, AL, AR, AZ, CO, DC, FL, GA, GU, ID, IL, KS, LA-PN, LA-RN, MN, MO, MS, MT, NC, ND, NH, NM, NV, OH, OR, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	38	66%
Good moral character	AL, GU, KS, LA-PN, MA, MD, MI, MO, NY, OH, OR, TN, VI	13	22%
None of the above		0	0%

Q21. Do RN or PN expired or inactive licensure applications contain questions regarding any of the following? (Check all that apply.)



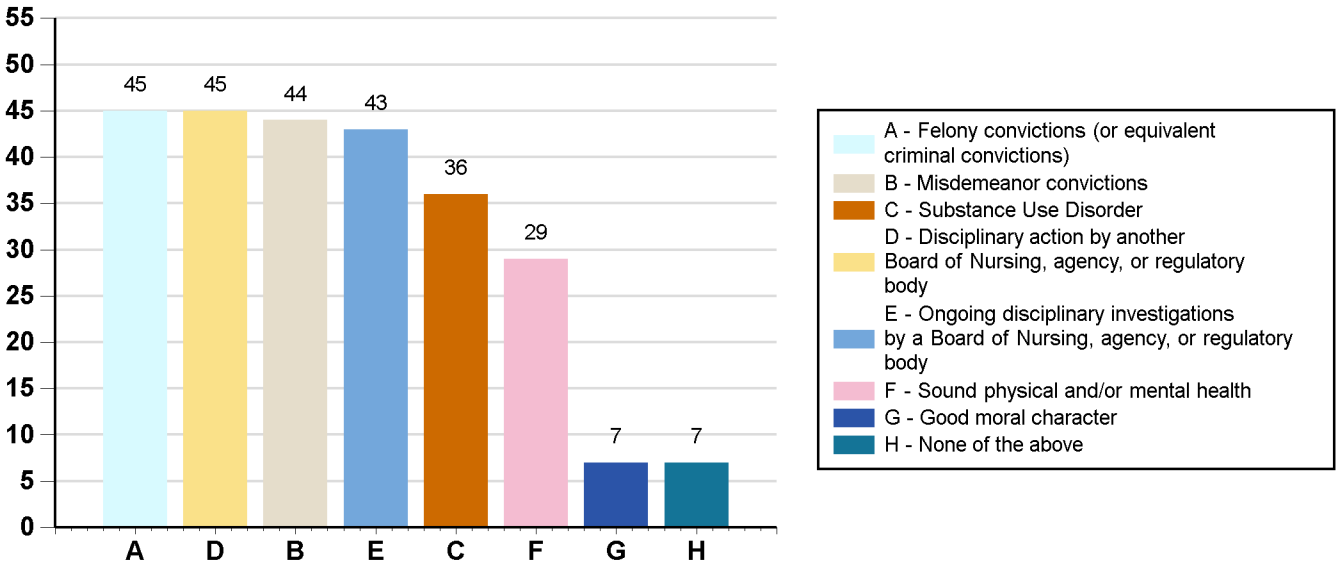
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Felony convictions (or equivalent criminal convictions)	AK, AL, AR, AZ, CA-RN, CNMI, CO, CT, DC, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, RI, SC, SD, TN, TX, UT, VI, VT, WA, WI, WV-PN, WV-RN, WY	52	90%
Misdemeanor convictions	AK, AL, AR, AZ, CA-RN, CNMI, CO, DC, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	52	90%
Substance Use Disorder	AK, AL, AR, AZ, CO, DC, GA, GU, IA, ID, IL, KS, KY, LA-PN, LA-RN, MD, ME, MN, MO, MS, NC, ND, NE, NH, NJ, NM, NV, OH, OR, PA, RI, SC, SD, TN, TX, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	43	74%
Disciplinary action by another Board of Nursing, agency, or regulatory body	AK, AL, AR, AZ, CA-RN, CA-VN, CNMI, CO, CT, DC, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	54	93%
Ongoing disciplinary investigations by a Board of Nursing, agency, or regulatory body	AK, AL, AR, AZ, CNMI, CO, CT, DC, GA, GU, HI, ID, IL, IN, KS, KY, LA-PN, LA-RN, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	50	86%
Sound physical and/or mental health	AK, AL, AR, AZ, CO, DC, GA, GU, ID, IL, KS, LA-PN, LA-RN, MN, MO, MS, NC, ND, NH, NM, NV, OH, OR, SC, SD, TN, TX, UT, VA, VI, VT, WA, WV-PN, WV-RN, WY	35	60%
Good moral character	AL, GU, KS, LA-PN, MI, MO, NY, OH, TN, VI	10	17%
None of the above	AS, DE, MA	3	5%

Q22. Do APRN initial licensure applications contain questions regarding any of the following? (Check all that apply.)



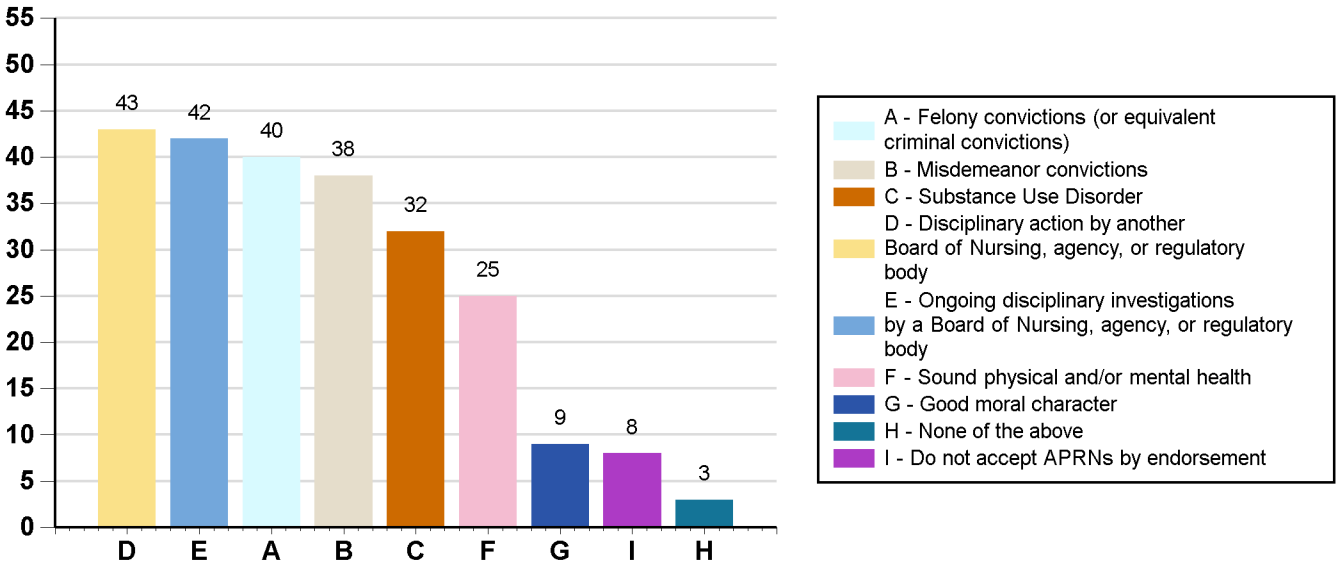
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Felony convictions (or equivalent criminal convictions)	AL, AR, AS, AZ, CNMI, CT, DC, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-RN, MA, MD, ME, MI, MN, MS, MT, NC, ND, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WV-RN, WY	47	80%
Misdemeanor convictions	AL, AR, AS, AZ, CNMI, DC, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-RN, MA, MD, ME, MI, MN, MS, MT, NC, ND, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WV-RN, WY	46	78%
Substance Use Disorder	AL, AR, AS, AZ, DC, DE, FL, GA, GU, IA, ID, IL, KS, KY, LA-RN, MD, ME, MN, MS, MT, NC, ND, NH, NJ, NM, NV, OH, OR, PA, SC, SD, TN, TX, VI, VT, WA, WV-RN, WY	38	64%
Disciplinary action by another Board of Nursing, agency, or regulatory body	AL, AR, AS, AZ, CA-RN, CNMI, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WV-RN, WY	51	86%
Ongoing disciplinary investigations by a Board of Nursing, agency, or regulatory body	AL, AR, AS, AZ, CNMI, CT, DC, DE, FL, GA, GU, HI, ID, IL, IN, KS, KY, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WV-RN, WY	49	83%
Sound physical and/or mental health	AL, AR, AZ, DC, FL, GA, GU, ID, IL, KS, LA-RN, MN, MS, MT, NC, ND, NH, NM, NV, OH, OR, SC, SD, TN, TX, UT, VA, VI, VT, WA, WV-RN, WY	32	54%
Good moral character	AL, GU, KS, MA, MI, OH, TN, VI	8	14%
None of the above	AK, CO, NY	3	5%
Do not regulate APRNs - does not apply	CA-VN, LA-PN, NE, WI, WV-PN	5	8%

Q23. Do APRN renewal licensure applications contain questions regarding any of the following? (Check all that apply.)



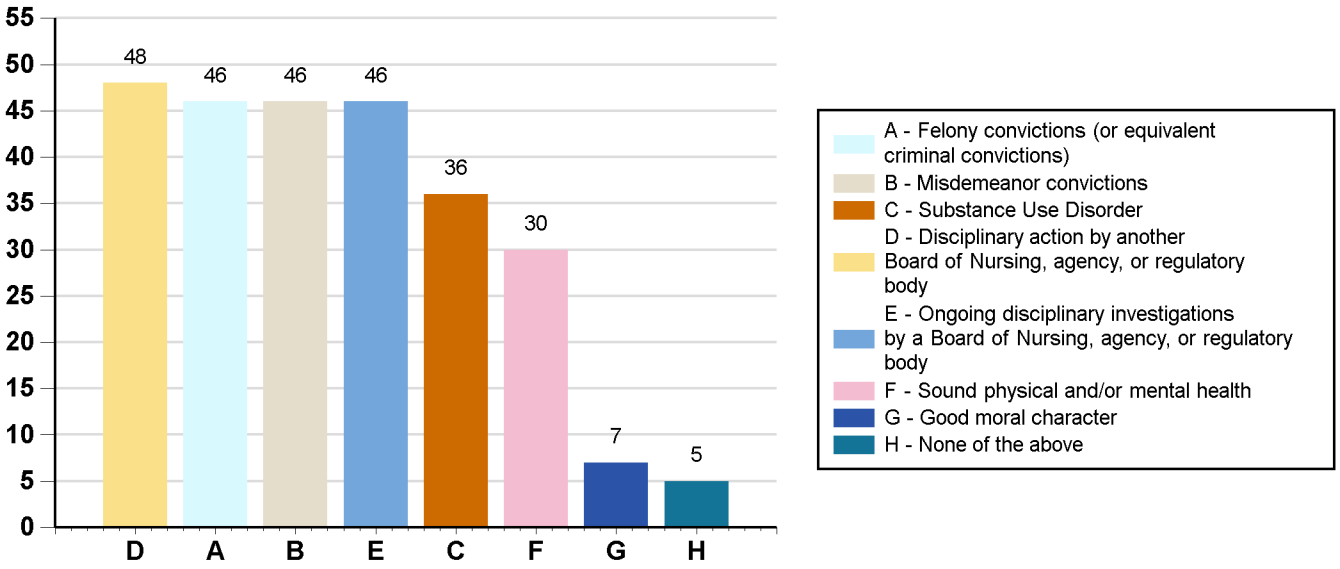
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Felony convictions (or equivalent criminal convictions)	AL, AR, AZ, CA-RN, CNMI, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-RN, MD, ME, MI, MN, MS, MT, NC, ND, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, RI, SC, SD, TN, TX, UT, VI, VT, WV-RN, WY	45	83%
Misdemeanor convictions	AL, AR, AZ, CA-RN, CNMI, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-RN, MD, ME, MI, MN, MS, MT, NC, ND, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, RI, SC, SD, TN, TX, UT, VI, VT, WV-RN, WY	44	81%
Substance Use Disorder	AL, AR, AZ, CNMI, DC, DE, GA, GU, IA, ID, IL, KS, KY, LA-RN, MD, ME, MN, MS, NC, ND, NH, NJ, NM, NV, OH, OR, PA, SC, SD, TN, TX, VA, VI, VT, WV-RN, WY	36	67%
Disciplinary action by another Board of Nursing, agency, or regulatory body	AL, AR, AZ, CA-RN, CNMI, CT, DC, DE, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-RN, MD, ME, MI, MN, MS, MT, NC, ND, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VI, VT, WV-RN, WY	45	83%
Ongoing disciplinary investigations by a Board of Nursing, agency, or regulatory body	AL, AR, AZ, CNMI, CT, DC, DE, GA, GU, HI, ID, IL, IN, KS, KY, LA-RN, MD, ME, MI, MN, MS, MT, NC, ND, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VI, VT, WV-RN, WY	43	80%
Sound physical and/or mental health	AL, AR, AZ, DC, DE, GA, GU, ID, IL, KS, LA-RN, MN, MS, NC, ND, NH, NM, NV, OH, OR, SC, SD, TN, TX, UT, VI, VT, WV-RN, WY	29	54%
Good moral character	AL, GU, KS, MI, OH, TN, VI	7	13%
None of the above	AK, AS, CO, MA, MO, NY, WA	7	13%

Q24. Do APRN endorsement licensure applications contain questions regarding any of the following? (Check all that apply.)



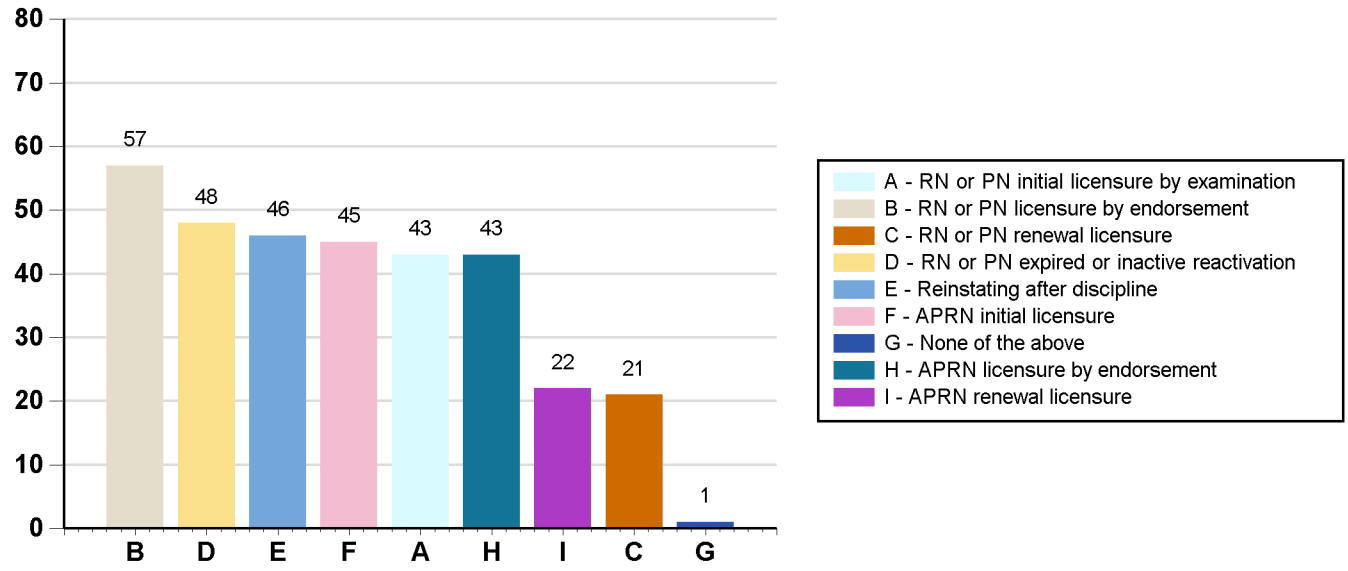
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Felony convictions (or equivalent criminal convictions)	AL, AR, AS, AZ, CNMI, CT, DC, GU, HI, IA, IL, IN, KS, KY, LA-RN, MA, MD, MI, MS, MT, ND, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, RI, SC, SD, TX, UT, VA, VI, VT, WA, WV-RN, WY	40	74%
Misdemeanor convictions	AL, AR, AS, CNMI, DC, GU, HI, IA, IL, IN, KS, KY, LA-RN, MA, MD, MI, MS, MT, ND, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, RI, SC, SD, TX, UT, VA, VI, VT, WA, WV-RN, WY	38	70%
Substance Use Disorder	AL, AR, AS, AZ, DC, DE, GU, IA, IL, KS, KY, LA-RN, MD, MS, MT, ND, NH, NJ, NM, NV, OH, OR, PA, SC, SD, TX, VA, VI, VT, WA, WV-RN, WY	32	59%
Disciplinary action by another Board of Nursing, agency, or regulatory body	AL, AR, AS, AZ, CNMI, CT, DC, DE, GU, HI, IA, IL, IN, KS, KY, LA-RN, MA, MD, MI, MO, MS, MT, ND, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TX, UT, VA, VI, VT, WA, WV-RN, WY	43	80%
Ongoing disciplinary investigations by a Board of Nursing, agency, or regulatory body	AL, AR, AS, AZ, CNMI, CT, DC, DE, GU, HI, IL, IN, KS, KY, LA-RN, MA, MD, MI, MO, MS, MT, ND, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TX, UT, VA, VI, VT, WA, WV-RN, WY	42	78%
Sound physical and/or mental health	AL, AR, AZ, DC, GU, IL, KS, LA-RN, MS, MT, ND, NM, NV, OH, OR, SC, SD, TX, UT, VA, VI, VT, WA, WV-RN, WY	25	46%
Good moral character	AL, AZ, GU, KS, MA, MI, OH, SC, VI	9	17%
None of the above	AK, CO, NY	3	6%
Do not accept APRNs by endorsement	CA-RN, FL, GA, ID, ME, MN, NC, TN	8	15%

Q25. Do APRN expired or inactive licensure applications contain questions regarding any of the following? (Check all that apply.)



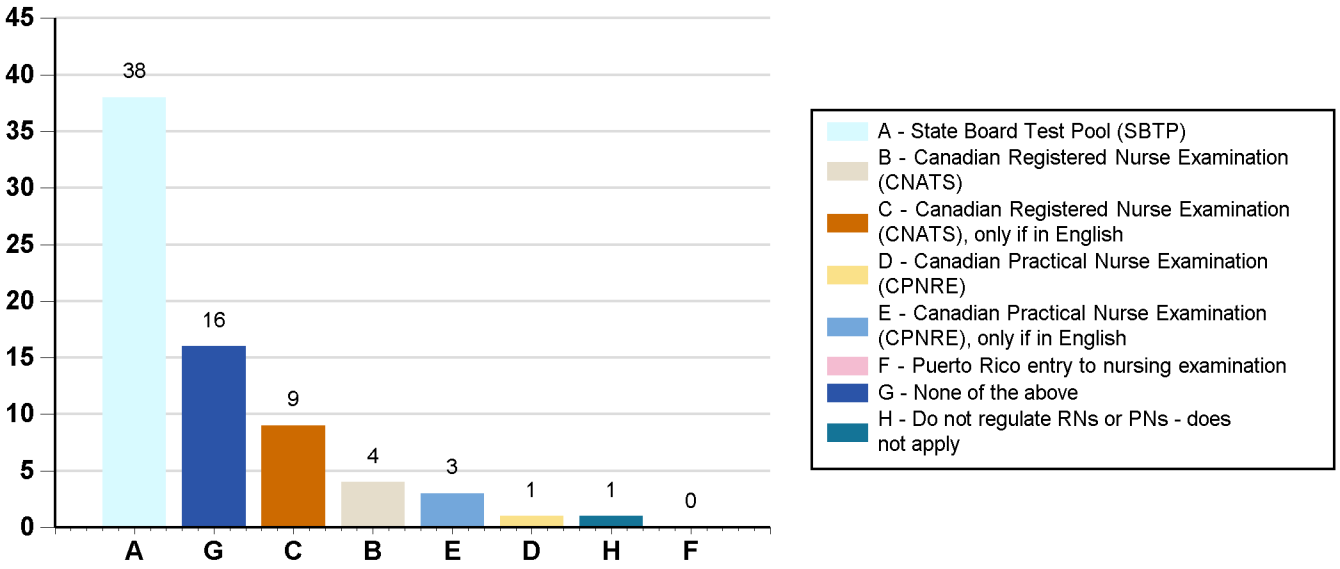
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Felony convictions (or equivalent criminal convictions)	AL, AR, AS, AZ, CA-RN, CNMI, CT, DC, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-RN, MD, ME, MN, MS, MT, NC, ND, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WV-RN, WY	46	85%
Misdemeanor convictions	AL, AR, AS, AZ, CA-RN, CNMI, DC, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-RN, MD, ME, MI, MN, MS, MT, NC, ND, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WV-RN, WY	46	85%
Substance Use Disorder	AL, AR, AS, AZ, DC, GA, GU, IA, ID, IL, KS, KY, LA-RN, MD, ME, MN, MS, NC, ND, NH, NJ, NM, NV, OH, OR, PA, SC, SD, TN, TX, VA, VI, VT, WA, WV-RN, WY	36	67%
Disciplinary action by another Board of Nursing, agency, or regulatory body	AL, AR, AS, AZ, CA-RN, CNMI, CT, DC, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-RN, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WV-RN, WY	48	89%
Ongoing disciplinary investigations by a Board of Nursing, agency, or regulatory body	AL, AR, AS, AZ, CNMI, CT, DC, GA, GU, HI, ID, IL, IN, KS, KY, LA-RN, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WV-RN, WY	46	85%
Sound physical and/or mental health	AL, AR, AZ, DC, GA, GU, ID, IL, KS, LA-RN, MN, MS, NC, ND, NH, NM, NV, OH, OR, SC, SD, TN, TX, UT, VA, VI, VT, WA, WV-RN, WY	30	56%
Good moral character	AL, GU, KS, MI, OH, TN, VI	7	13%
None of the above	AK, CO, DE, MA, NY	5	9%

Q26. Is the presence/absence of disciplinary action on a nursing license verified via NURSYS at any of the following stages of licensure? (Check all that apply.)



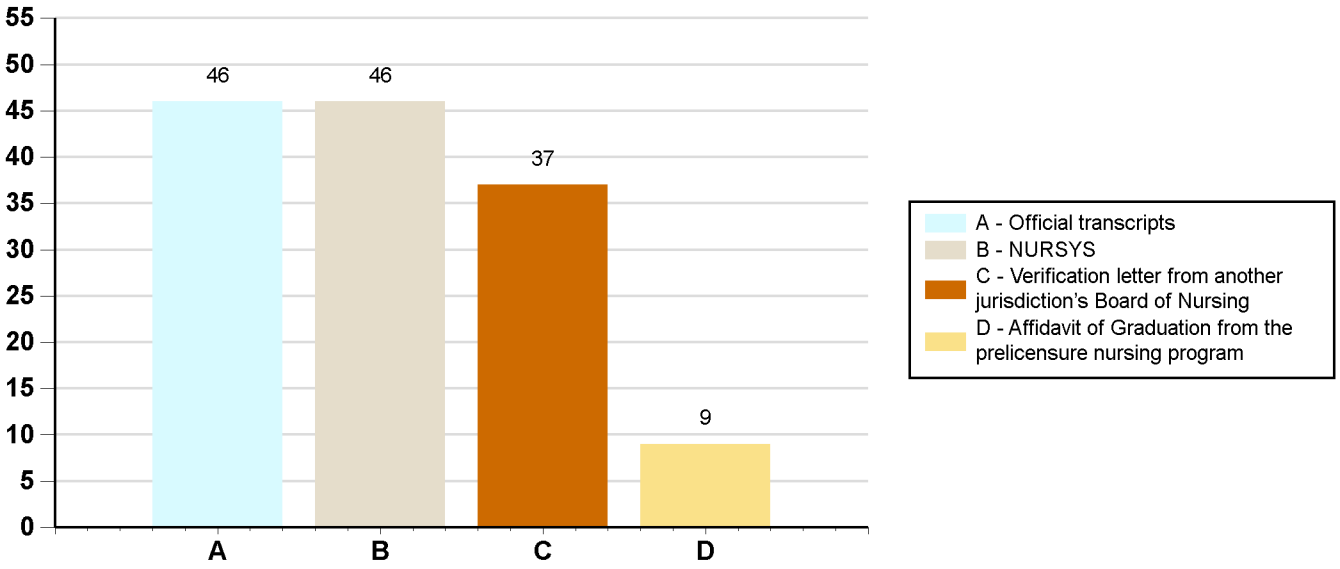
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
RN or PN initial licensure by examination	AK, AL, AR, AS, AZ, CA-VN, CNMI, CO, CT, DE, FL, GA, GU, IA, ID, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, NY, OK, SC, SD, TN, TX, UT, VA, VT, WV-RN, WY	43	73%
RN or PN licensure by endorsement	AK, AL, AR, AS, AZ, CA-RN, CA-VN, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-RN, WY	57	97%
RN or PN renewal licensure	AS, AZ, CA-VN, CNMI, GU, IA, IN, KS, LA-PN, ME, MI, MS, NC, NE, NJ, NM, OR, SC, SD, UT, VT	21	36%
RN or PN expired or inactive reactivation	AK, AL, AR, AS, AZ, CA-VN, CNMI, CO, CT, DC, DE, FL, GA, GU, IA, ID, IL, KS, KY, LA-PN, LA-RN, MD, ME, MI, MO, MS, NC, ND, NE, NH, NJ, NM, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VI, VT, WA, WI, WV-RN, WY	48	81%
Reinstating after discipline	AK, AL, AR, AS, AZ, CA-VN, CNMI, CO, CT, DC, FL, GA, GU, IA, ID, IL, IN, KS, LA-RN, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, VA, VT, WA, WY	46	78%
APRN initial licensure	AK, AL, AR, AS, AZ, CA-RN, CNMI, CO, DC, DE, FL, GA, GU, HI, IA, ID, KS, KY, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE-APRN, NH, NJ, NM, NV, OK, RI, SC, SD, TN, TX, UT, VA, VT, WV-RN, WY	45	76%
None of the above	WV-PN	1	2%
APRN licensure by endorsement	AK, AL, AR, AS, AZ, CNMI, CO, DC, DE, GU, HI, IL, IN, KS, KY, LA-RN, MA, MD, ME, MI, MS, MT, ND, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TX, UT, VA, VI, VT, WA, WV-RN, WY	43	73%
APRN renewal licensure	AS, AZ, CNMI, GU, IA, IN, KS, MD, ME, MI, MS, NC, NE-APRN, NJ, NM, OR, RI, SC, SD, UT, VI, VT	22	37%

Q27. Which examinations, other than NCLEX, are accepted for licensure by endorsement? (Check all that apply.)



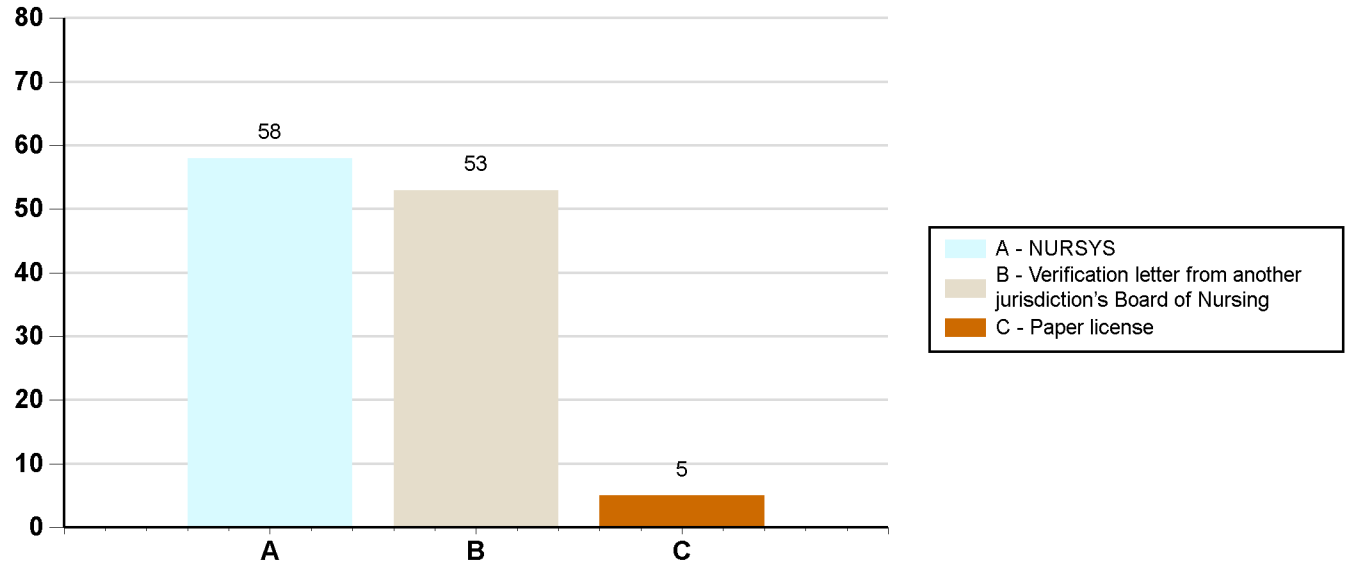
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
State Board Test Pool (SBTP)	AK, AR, AZ, CA-RN, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA-RN, MA, ME, MO, MT, NC, ND, NE, NM, NV, NY, OH, OK, OR, PA, SD, TN, TX, VA, WA, WY	38	64%
Canadian Registered Nurse Examination (CNATS)	CT, MA, MI, VA	4	7%
Canadian Registered Nurse Examination (CNATS), only if in English	AK, DE, IN, ME, NC, NE, NH, VT, WI	9	15%
Canadian Practical Nurse Examination (CPNRE)	CT	1	2%
Canadian Practical Nurse Examination (CPNRE), only if in English	IN, NE, WI	3	5%
Puerto Rico entry to nursing examination		0	0%
None of the above	AL, AS, CA-VN, CNMI, GU, LA-PN, MD, MN, MS, NJ, RI, SC, UT, VI, WV-PN, WV-RN	16	27%
Do not regulate RNs or PNs - does not apply	NE-APRN	1	2%

Q28. How is nursing education verified for licensure by endorsement applicants? (Check all that apply.)



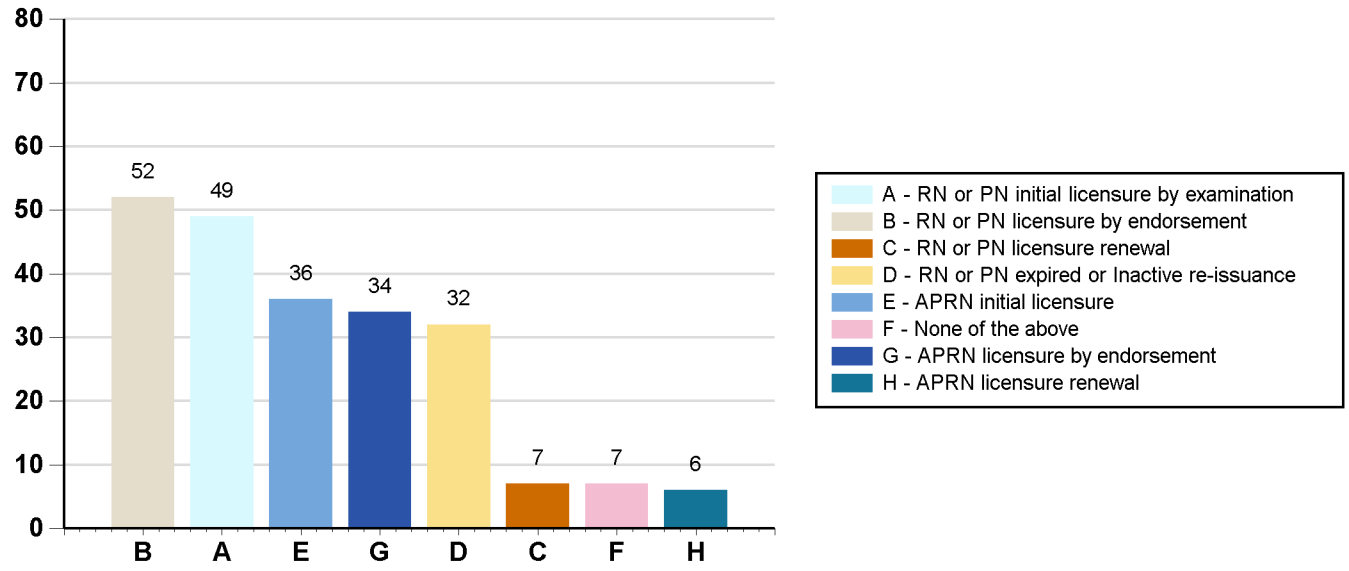
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Official transcripts	AK, AL, AS, AZ, CA-RN, CA-VN, CNMI, CT, DE, FL, GA, GU, IA, ID, IL, IN, KS, KY, LA-PN, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NE-APRN, NH, NJ, NM, NV, NY, OH, OK, OR, PA, SC, SD, UT, VI, WA, WI, WY	46	78%
NURSYS	AK, AR, AS, AZ, CA-VN, CNMI, CO, CT, DC, DE, FL, GU, HI, IA, ID, KY, LA-RN, MD, ME, MN, MO, MS, MT, NC, NE, NE-APRN, NH, NJ, NM, NV, OH, OK, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN	46	78%
Verification letter from another jurisdiction's Board of Nursing	AK, AL, AR, AS, CA-VN, CNMI, CO, DC, DE, FL, ID, KY, LA-RN, MD, ME, MN, MO, MS, MT, NC, NE, NE-APRN, NJ, NM, NV, NY, OH, OK, PA, RI, SD, TX, UT, VA, WI, WV-PN, WV-RN	37	63%
Affidavit of Graduation from the prelicensure nursing program	AK, CA-VN, ID, IN, MD, MI, NJ, OH, VI	9	15%

Q29. How are licenses verified for licensure by endorsement applicants? (Check all that apply.)



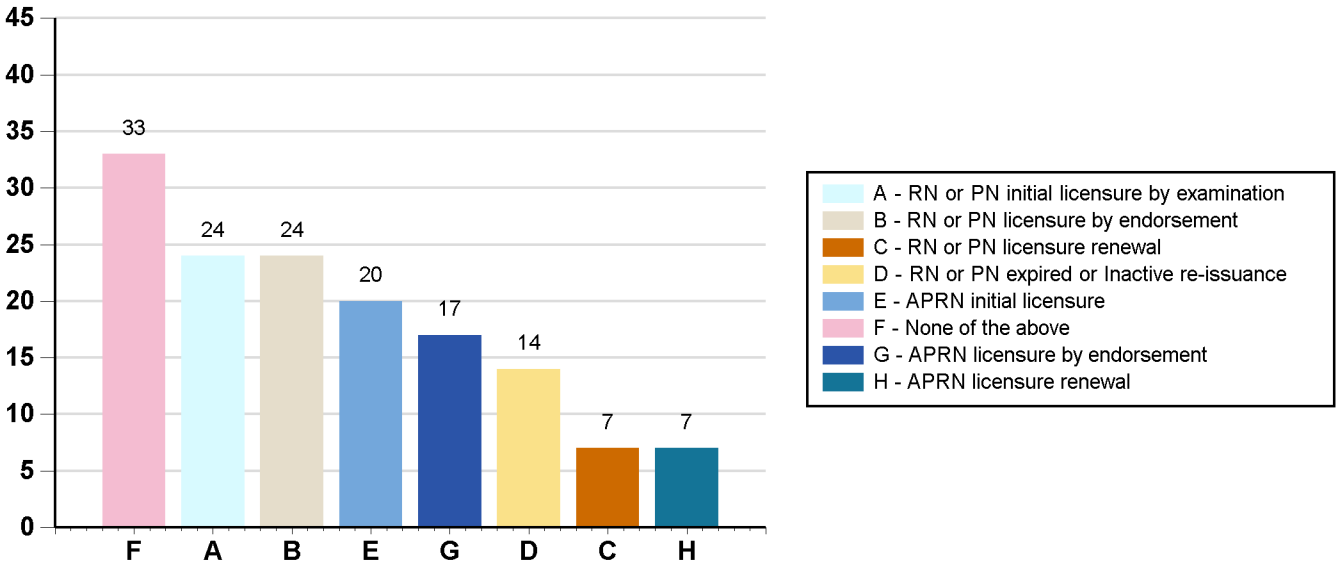
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
NURSYS	AK, AL, AR, AS, AZ, CA-RN, CA-VN, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NE-APRN, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VI, VT, WA, WI, WV-PN, WV-RN, WY	58	98%
Verification letter from another jurisdiction's Board of Nursing	AK, AL, AR, AS, CA-RN, CA-VN, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, KS, KY, LA-PN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NE-APRN, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TX, UT, VA, VI, WA, WI, WV-PN, WV-RN, WY	53	90%
Paper license	AS, ID, MI, NH, VI	5	8%

Q30. What type of licensure applications require a fingerprint-based/biometric criminal background check? (Check all that apply.)



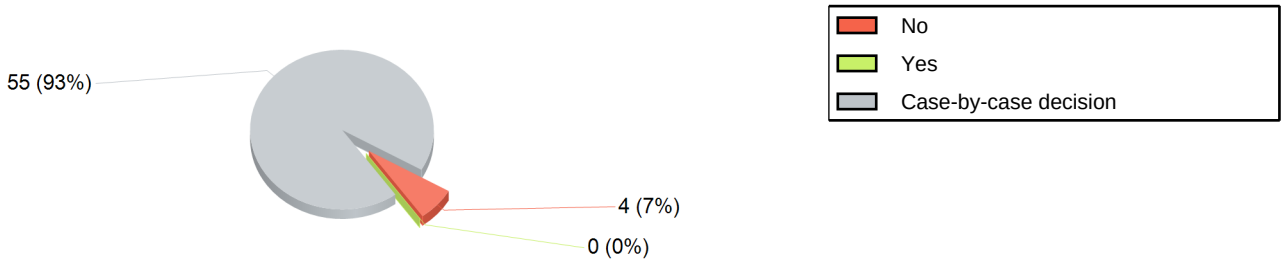
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
RN or PN initial licensure by examination	AK, AR, AZ, CA-RN, CA-VN, CO, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, RI, SC, SD, TN, TX, UT, VA, VI, VT, WV-PN, WV-RN, WY	49	83%
RN or PN licensure by endorsement	AK, AL, AR, AZ, CA-RN, CA-VN, CO, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WV-PN, WV-RN, WY	52	88%
RN or PN licensure renewal	GU, HI, MD, NJ, NV, VI, VT	7	12%
RN or PN expired or Inactive re-issuance	AK, AZ, CO, DC, GA, GU, HI, IA, ID, IL, KY, LA-RN, MD, MI, MO, MS, NC, ND, NE, NJ, OH, OR, SC, SD, TN, TX, UT, VI, VT, WV-PN, WV-RN, WY	32	54%
APRN initial licensure	AK, AL, AR, AZ, DC, DE, FL, GU, HI, ID, IL, IN, KS, KY, LA-RN, MD, ME, MI, MN, MS, MT, ND, NE-APRN, NH, NJ, NM, NV, OK, OR, RI, SC, SD, UT, VI, VT, WY	36	61%
None of the above	AS, CNMI, CT, MA, NY, PA, WI	7	12%
APRN licensure by endorsement	AK, AL, AR, AZ, DC, DE, GU, HI, IL, IN, KS, KY, LA-RN, MD, MI, MS, MT, ND, NE-APRN, NH, NJ, NM, NV, OK, OR, RI, SC, SD, UT, VA, VI, VT, WA, WY	34	58%
APRN licensure renewal	GU, MD, NJ, NV, VI, VT	6	10%

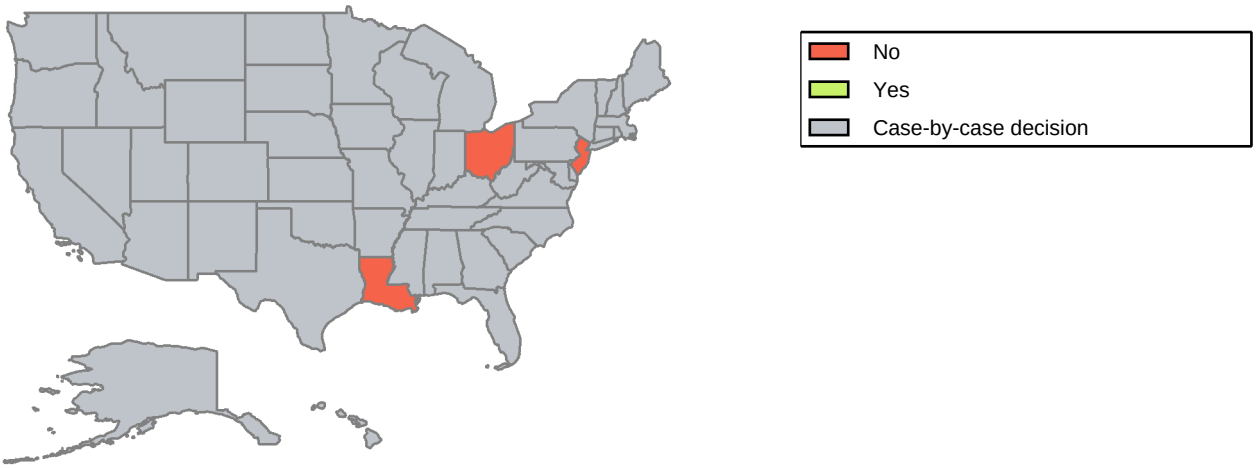
Q31. What type of licensure applications require a name-based criminal background check (state police/patrol)? (Check all that apply.)



Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
RN or PN initial licensure by examination	AK, AL, AR, AZ, CA-VN, DE, FL, GU, IA, IN, KY, LA-PN, MD, ME, MI, MN, NE, NH, NJ, PA, RI, UT, VI, WA	24	41%
RN or PN licensure by endorsement	AK, AL, AR, AZ, CA-VN, DE, FL, GU, IA, IN, KY, LA-PN, MD, ME, MI, MN, NE, NH, NJ, PA, RI, UT, VI, WA	24	41%
RN or PN licensure renewal	DC, FL, GU, MD, NJ, OR, VI	7	12%
RN or PN expired or Inactive re-issuance	AK, AL, AZ, GU, IA, KY, LA-PN, MD, MI, NE, NJ, UT, VI, WA	14	24%
APRN initial licensure	AK, AL, AR, AZ, DE, FL, GU, IN, KY, MD, ME, MI, MN, NH, NJ, PA, RI, UT, VI, WA	20	34%
None of the above	AS, CA-RN, CNMI, CO, CT, GA, HI, ID, IL, KS, LA-RN, MA, MO, MS, MT, NC, ND, NE-APRN, NM, NV, NY, OH, OK, SC, SD, TN, TX, VA, VT, WI, WV-PN, WV-RN, WY	33	56%
APRN licensure by endorsement	AK, AL, AR, AZ, DE, GU, IN, KY, MD, MI, NH, NJ, PA, RI, UT, VI, WA	17	29%
APRN licensure renewal	DC, FL, GU, MD, NJ, OR, VI	7	12%

Q32. Are applicants with a restricted license for practice eligible for licensure by endorsement?

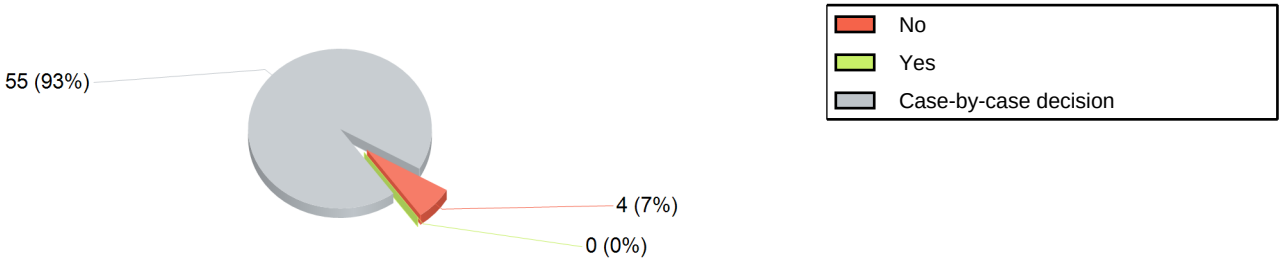


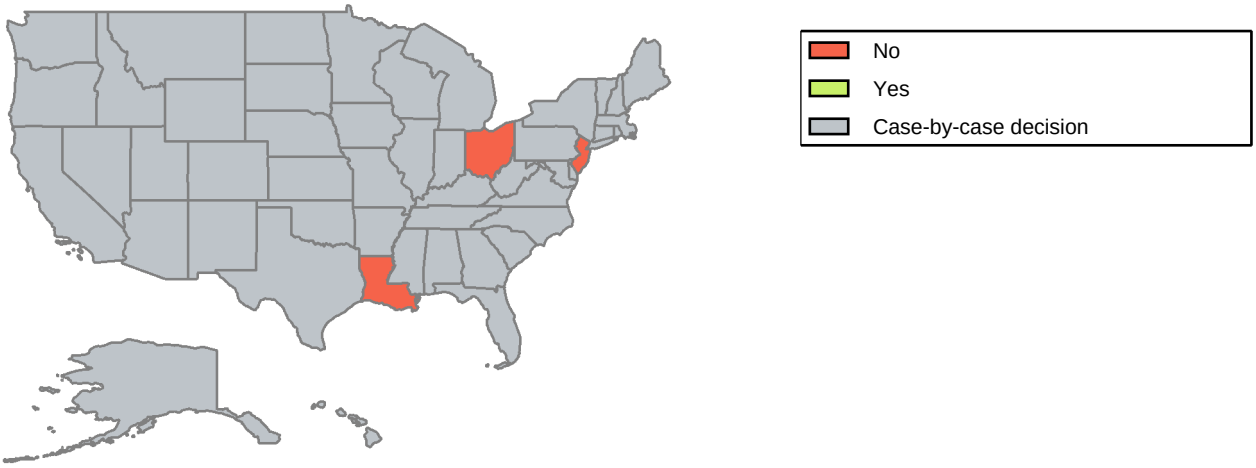


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	LA-PN, LA-RN, NJ, OH	4	7%
Yes		0	0%
Case-by-case decision	AK, AL, AR, AS, AZ, CA-RN, CA-VN, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NE-APRN, NH, NM, NV, NY, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	55	93%

Q33. Are applicants whose license is encumbered by probation eligible for licensure by endorsement?

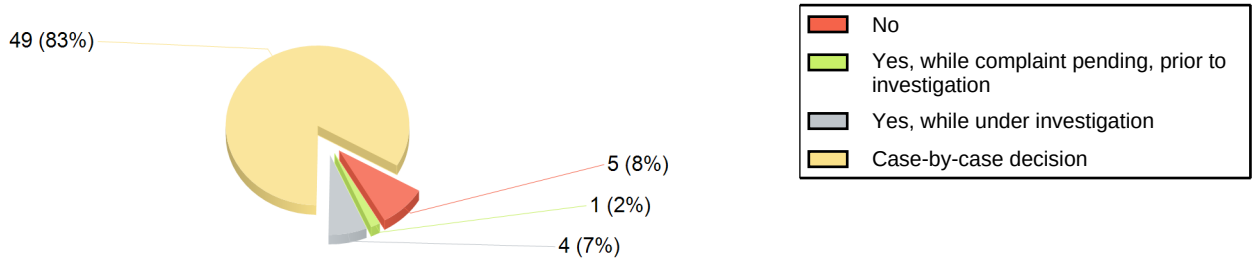


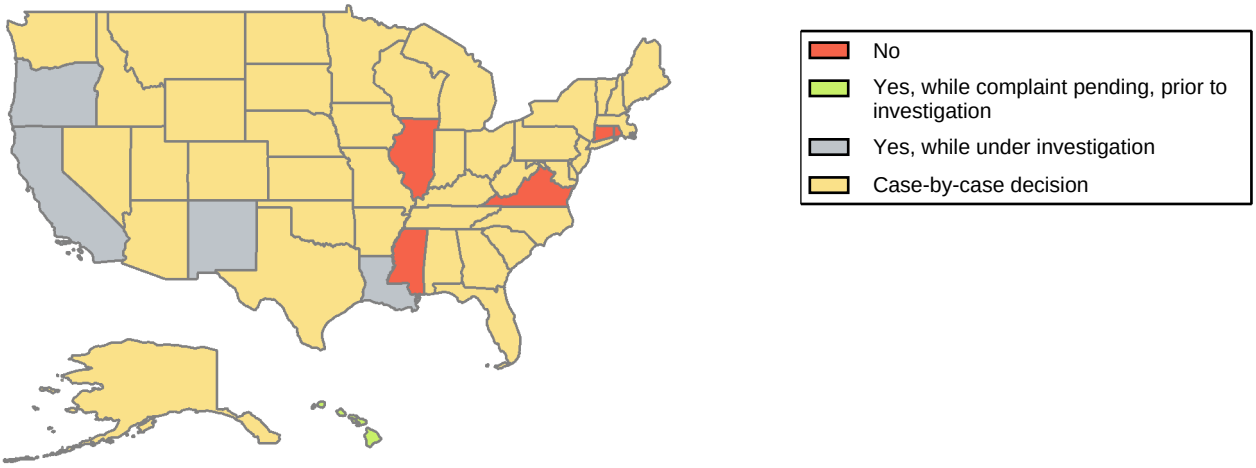


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	LA-PN, LA-RN, NJ, OH	4	7%
Yes		0	0%
Case-by-case decision	AK, AL, AR, AS, AZ, CA-RN, CA-VN, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NE-APRN, NH, NM, NV, NY, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	55	93%

Q34. Are applicants whose license is under investigation or have an open complaint eligible for licensure by endorsement? (Check all that apply.)

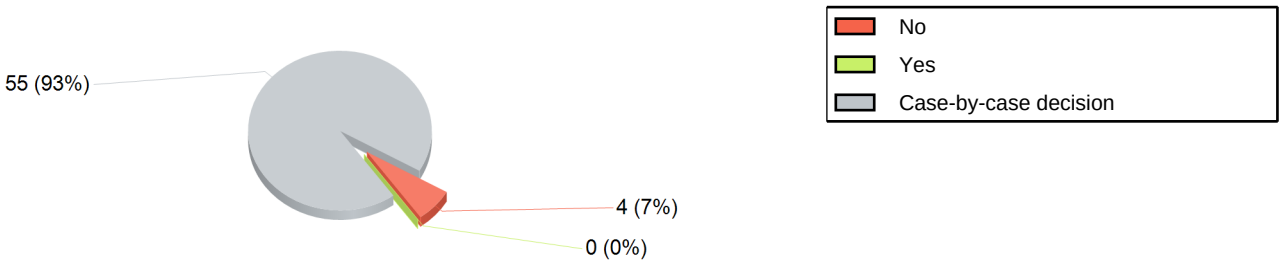


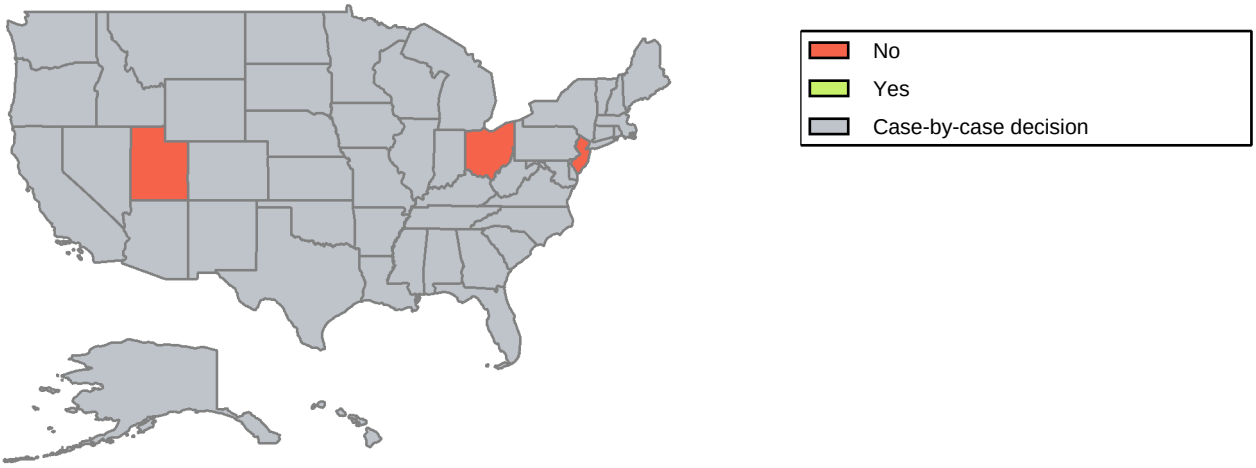


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	CT, IL, MS, RI, VA	5	8%
Yes, while complaint pending, prior to investigation	HI	1	2%
Yes, while under investigation	CA-RN, LA-RN, NM, OR	4	7%
Case-by-case decision	AK, AL, AR, AS, AZ, CA-VN, CNMI, CO, DC, DE, FL, GA, GU, IA, ID, IN, KS, KY, LA-PN, MA, MD, ME, MI, MN, MO, MT, NC, ND, NE, NE-APRN, NH, NJ, NV, NY, OH, OK, PA, SC, SD, TN, TX, UT, VI, VT, WA, WI, WV-PN, WV-RN, WY	49	83%

Q35. Are applicants who are participating in an alternative to discipline program eligible for licensure by endorsement?

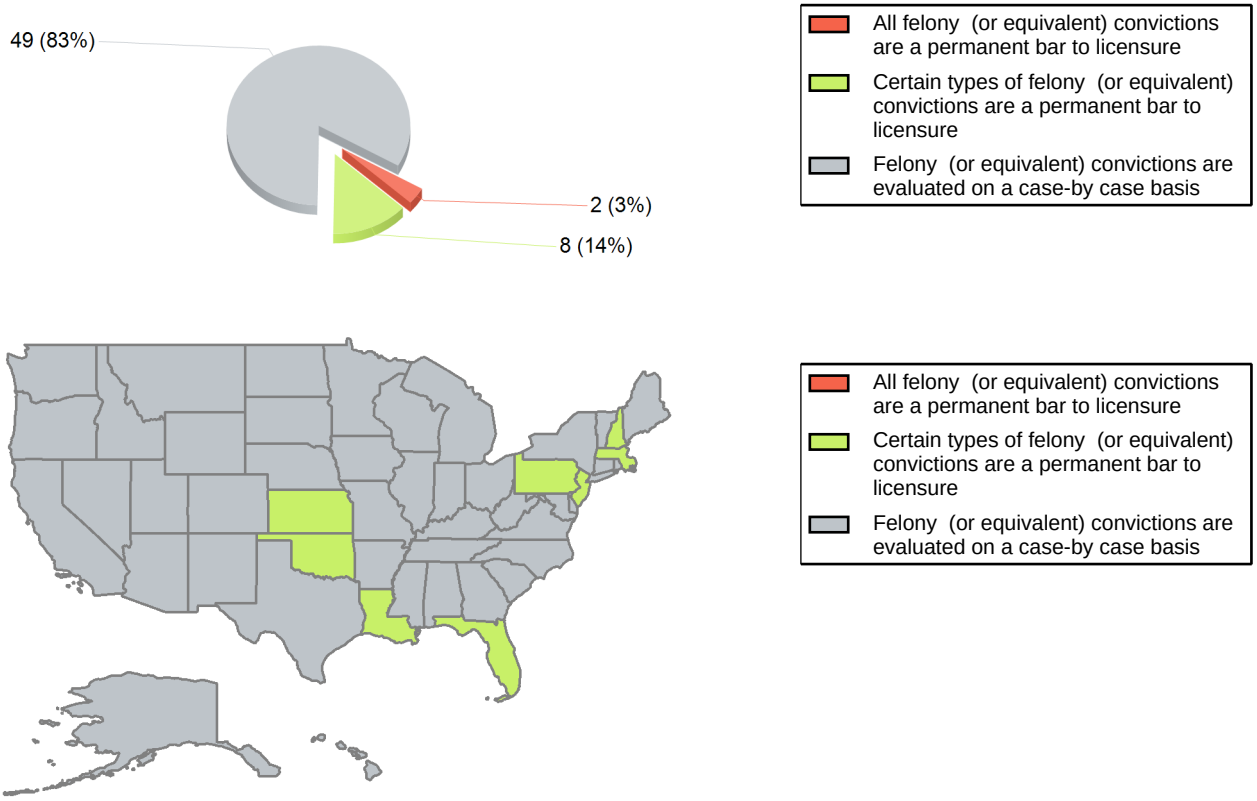




*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	LA-PN, NJ, OH, UT	4	7%
Yes		0	0%
Case-by-case decision	AK, AL, AR, AS, AZ, CA-RN, CA-VN, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NE-APRN, NH, NM, NV, NY, OK, OR, PA, RI, SC, SD, TN, TX, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	55	93%

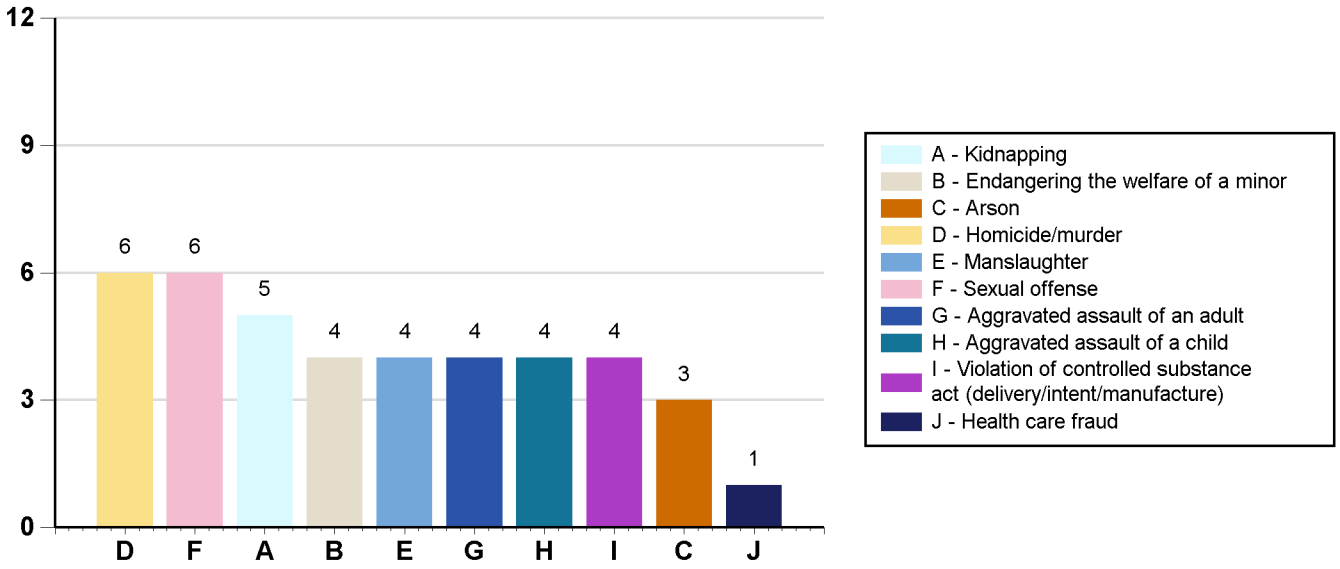
Q36. Which of the following is true regarding applicants with felony (or equivalent) convictions?



*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

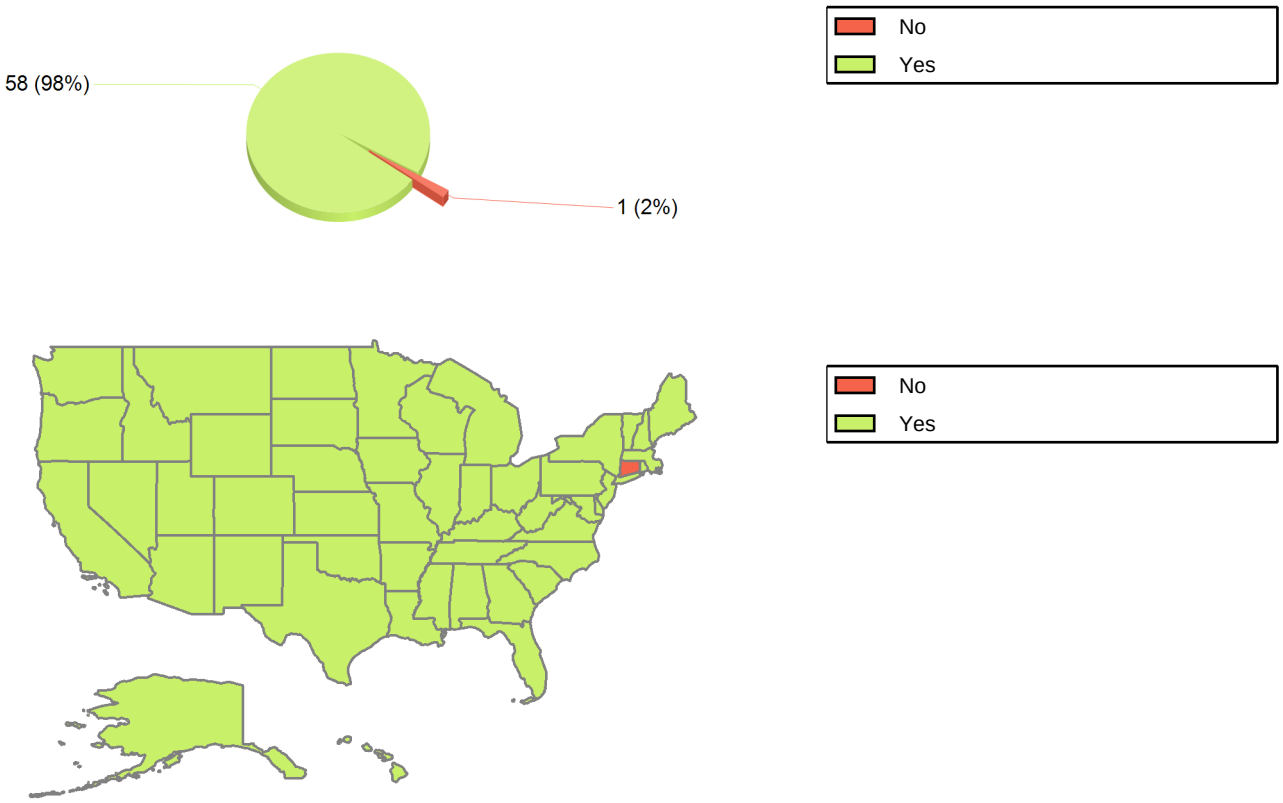
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
All felony (or equivalent) convictions are a permanent bar to licensure	CNMI, VI	2	3%
Certain types of felony (or equivalent) convictions are a permanent bar to licensure	FL, KS, LA-RN, MA, NH, NJ, OK, PA	8	14%
Felony (or equivalent) convictions are evaluated on a case-by case basis	AK, AL, AR, AS, AZ, CA-RN, CA-VN, CO, CT, DC, DE, GA, GU, HI, IA, ID, IL, IN, KY, LA-PN, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NE-APRN, NM, NV, NY, OH, OR, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV-PN, WV-RN, WY	49	83%

Q37. Which of the following felony level convictions (or equivalent criminal convictions) are permanent bars to licensure? (Check all that apply.)



Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Kidnapping	KS, MA, NH, NJ, OK	5	62%
Endangering the welfare of a minor	MA, NH, NJ, OK	4	50%
Arson	KS, MA, OK	3	38%
Homicide/murder	KS, LA-RN, MA, NH, NJ, OK	6	75%
Manslaughter	KS, MA, NH, OK	4	50%
Sexual offense	LA-RN, MA, NH, NJ, OK, PA	6	75%
Aggravated assault of an adult	KS, MA, NH, OK	4	50%
Aggravated assault of a child	KS, MA, NH, OK	4	50%
Violation of controlled substance act (delivery/intent/manufacture)	FL, MA, NJ, OK	4	50%
Health care fraud	FL	1	12%

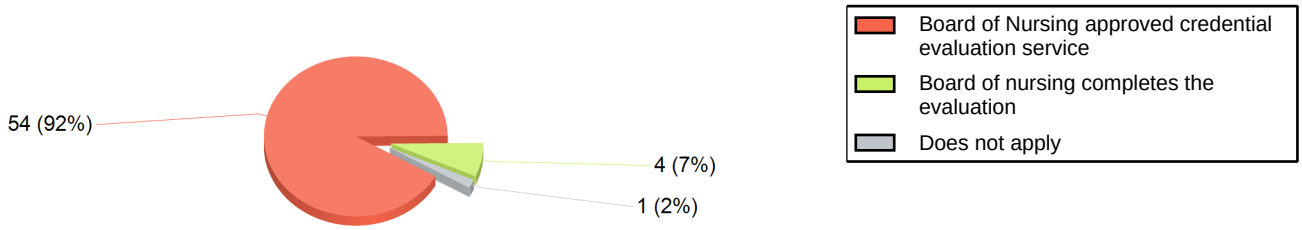
Q38. Are misdemeanor convictions (or equivalent criminal convictions) evaluated prior to licensure?

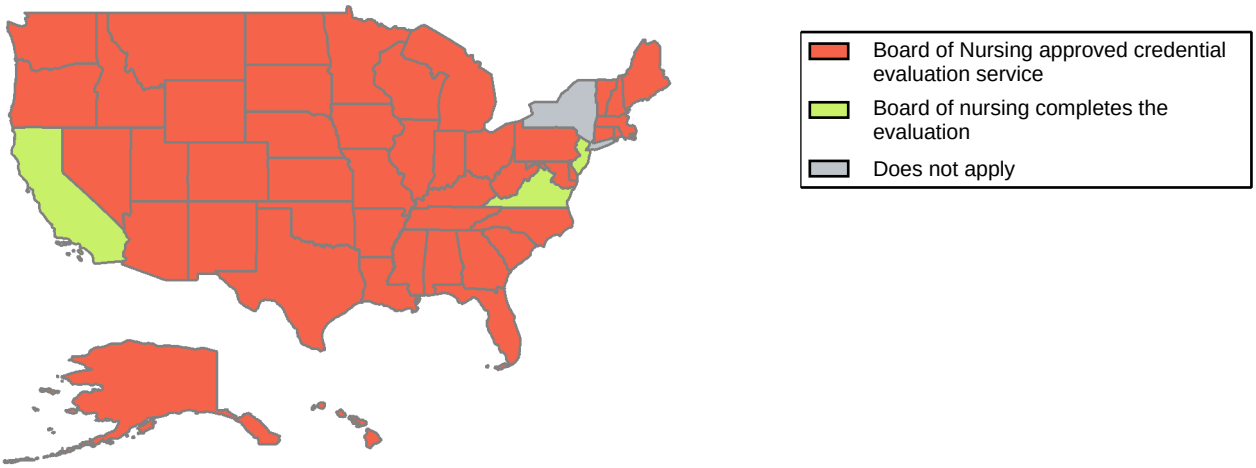


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	CT	1	2%
Yes	AK, AL, AR, AS, AZ, CA-RN, CA-VN, CNMI, CO, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NE-APRN, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	58	98%

Q39. How are education credential evaluations completed for an internationally educated applicant?

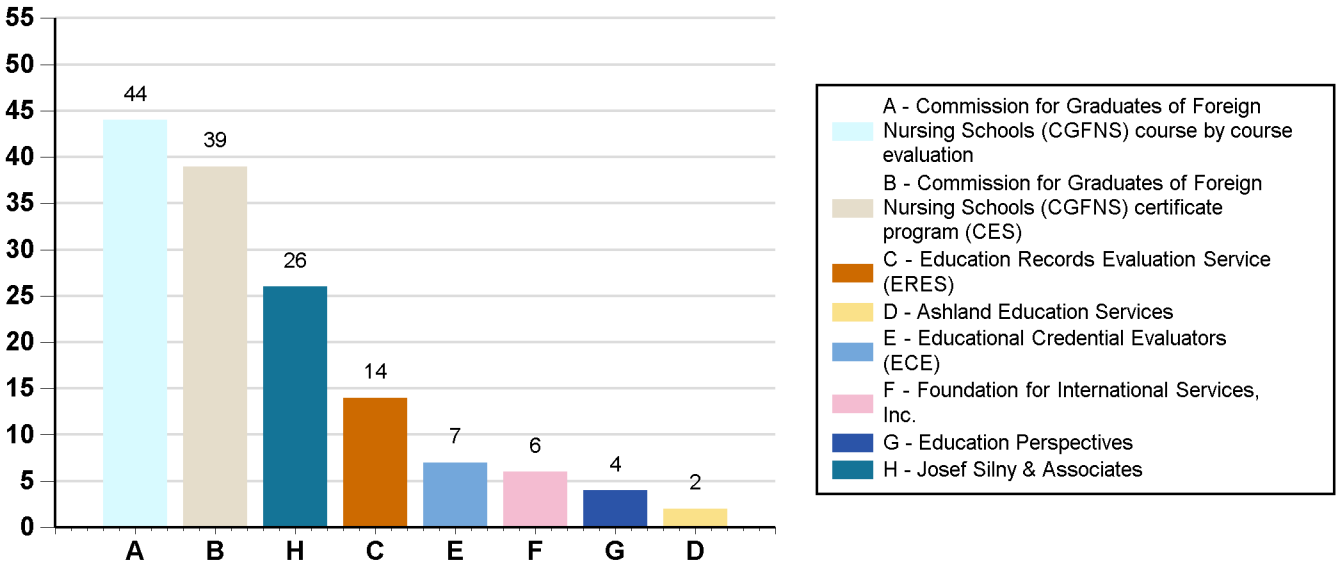




*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

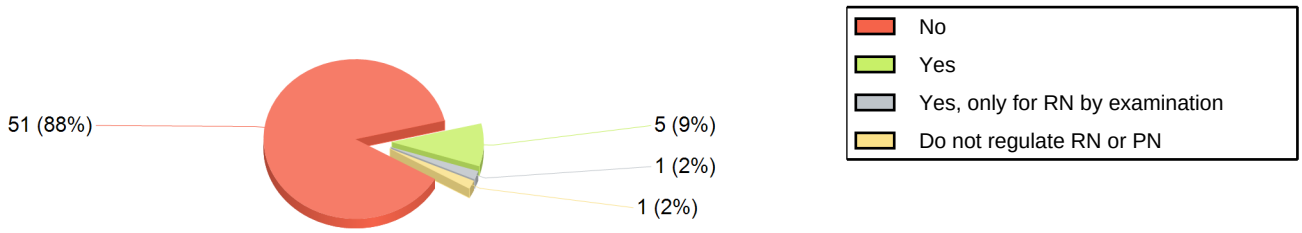
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Board of Nursing approved credential evaluation service	AK, AL, AR, AZ, CA-VN, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NE-APRN, NH, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VI, VT, WA, WI, WV-PN, WV-RN, WY	54	92%
Board of nursing completes the evaluation	AS, CA-RN, NJ, VA	4	7%
Does not apply	NY	1	2%

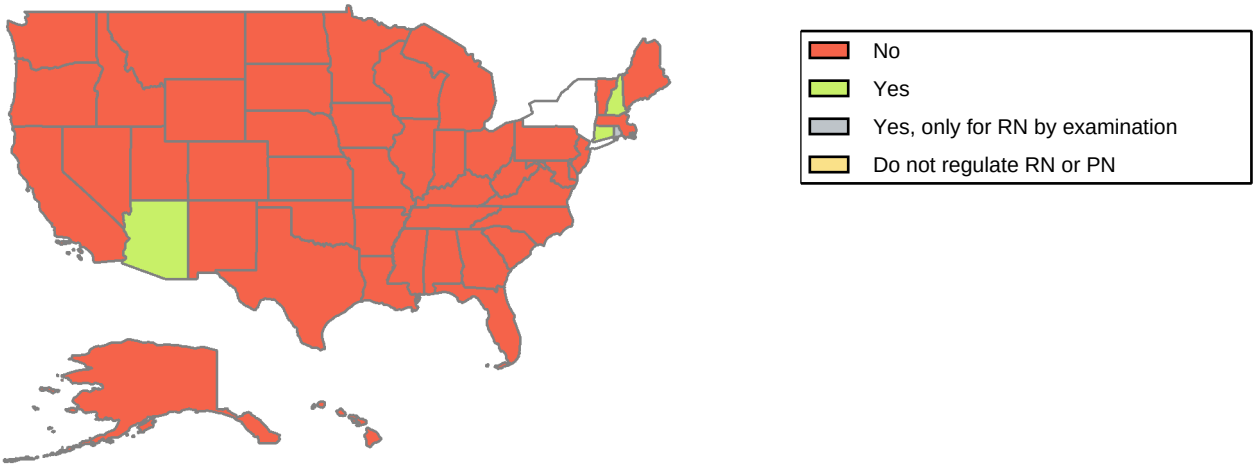
Q40. Which of the following credential evaluation services can be used? (Check all that apply)



Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Commission for Graduates of Foreign Nursing Schools (CGFNS) course by course evaluation	AK, AL, AR, AZ, CA-VN, CNMI, CO, DC, FL, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, NC, ND, NE, NE-APRN, NH, NM, NV, OH, OR, PA, RI, TX, UT, VI, VT, WI, WV-PN, WY	44	81%
Commission for Graduates of Foreign Nursing Schools (CGFNS) certificate program (CES)	AK, AL, AZ, CA-VN, CNMI, CO, CT, DC, DE, GA, HI, IA, ID, IL, IN, LA-RN, MA, MD, ME, MI, MS, MT, NC, ND, NE, NH, NM, OK, RI, SC, SD, TN, UT, VI, WA, WI, WV-PN, WV-RN, WY	39	72%
Education Records Evaluation Service (ERES)	AL, AZ, CA-VN, CO, FL, IL, ND, NE, NE-APRN, OR, SC, TX, UT, WY	14	26%
Ashland Education Services	CO, FL	2	4%
Educational Credential Evaluators (ECE)	AL, CO, KY, ND, SC, UT, WA	7	13%
Foundation for International Services, Inc.	AL, CO, KY, ND, SC, UT	6	11%
Education Perspectives	CO, OR, SC, UT	4	7%
Josef Silny & Associates	AL, AR, AZ, CNMI, FL, HI, ID, IL, KY, LA-RN, MI, MO, MT, ND, NE, NE-APRN, NM, NV, OK, OR, PA, SC, TX, UT, WA, WY	26	48%

Q41. Does the Board of Nursing require the internationally educated applicant to pass a credential evaluation service's NCLEX-RN/PN predictor exam?

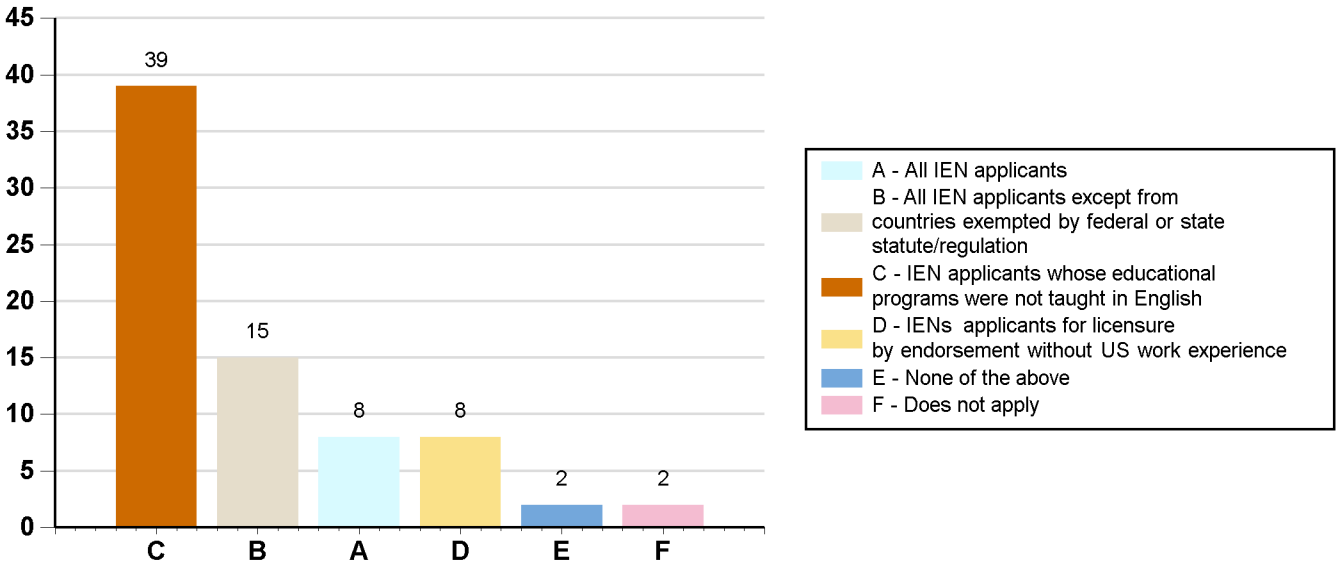




*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

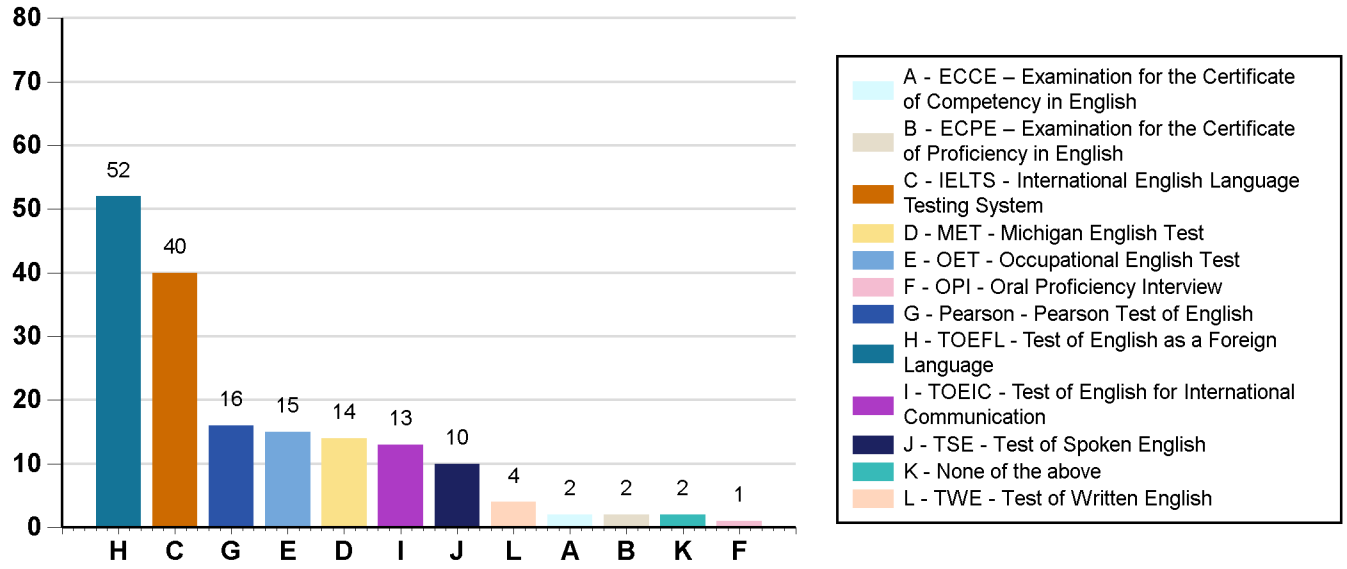
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AK, AL, AR, CA-RN, CA-VN, CNMI, CO, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NJ, NM, NV, OH, OK, OR, PA, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV-PN, WV-RN, WY	51	88%
Yes	AS, AZ, CT, NH, VI	5	9%
Yes, only for RN by examination	RI	1	2%
Do not regulate RN or PN	NE-APRN	1	2%

Q42. Do you require proof of passage of an English proficiency examination from any of the following internationally educated applicants (IENs)? (Check all that apply.)



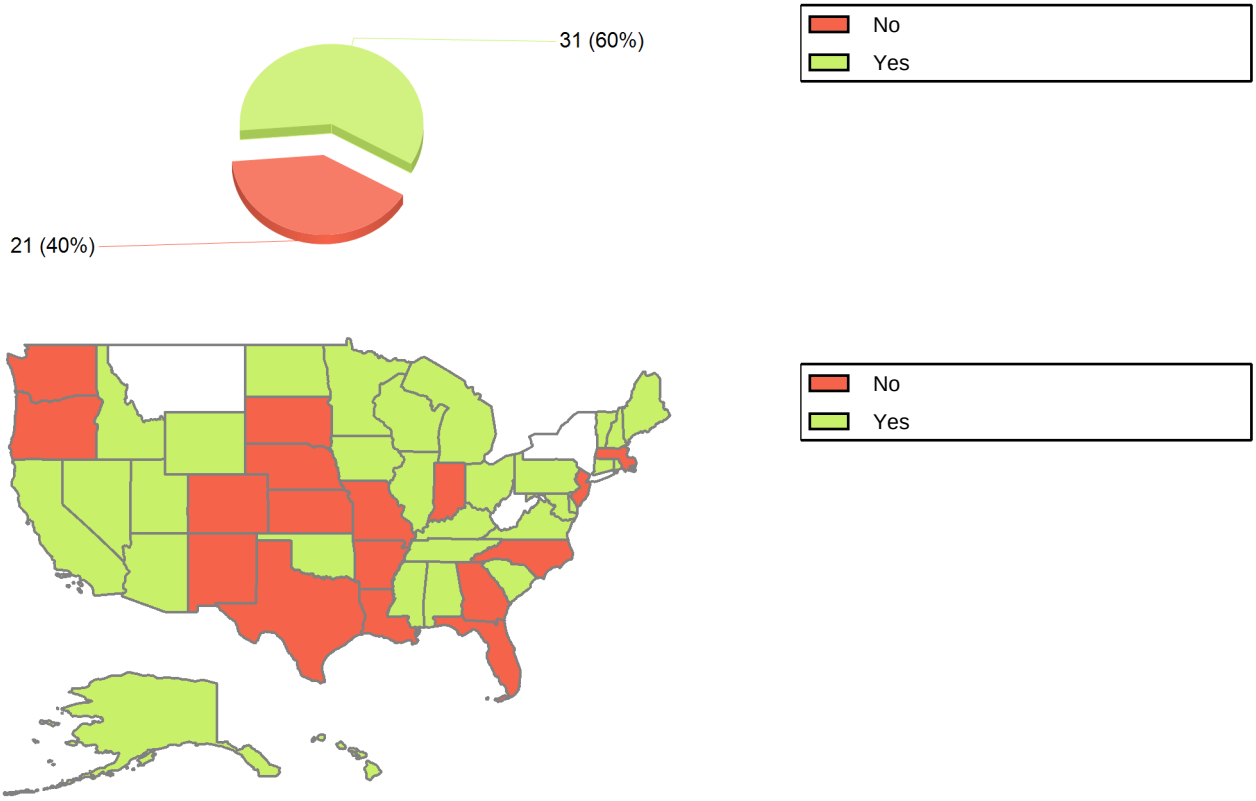
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
All IEN applicants	AS, GU, IN, MI, MS, RI, UT, WV-PN	8	14%
All IEN applicants except from countries exempted by federal or state statute/regulation	AK, AR, IA, MD, MO, NC, NH, NV, OH, OK, VA, VT, WA, WV-RN, WY	15	26%
IEN applicants whose educational programs were not taught in English	AK, AL, AZ, CA-RN, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, KS, KY, LA-RN, MA, MD, ME, MI, MN, MO, ND, NE, NE-APRN, NH, NJ, NM, OR, PA, SC, SD, TN, TX, VI, VT, WI, WY	39	67%
IENs applicants for licensure by endorsement without US work experience	GA, MD, NE, NE-APRN, NJ, NV, OK, WA	8	14%
None of the above	LA-PN, MT	2	3%
Does not apply	CA-VN, CNMI	2	3%

Q43. Which English proficiency exam is acceptable? (Check all that apply.)



Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
ECCE – Examination for the Certificate of Competency in English	MI, UT	2	4%
ECPE – Examination for the Certificate of Proficiency in English	MI, UT	2	4%
IELTS - International English Language Testing System	AK, AL, AR, AZ, CA-RN, CO, DC, DE, FL, IA, ID, IL, IN, KS, KY, LA-RN, MA, MD, MI, MN, MO, NC, ND, NE, NE-APRN, NH, NV, OK, OR, PA, SC, SD, TN, TX, UT, VA, VI, WA, WI, WY	40	74%
MET - Michigan English Test	DE, FL, KY, LA-RN, MA, MD, MI, NE, NE-APRN, OK, TN, UT, WA, WY	14	26%
OET - Occupational English Test	DE, FL, KY, MA, MD, MI, ND, NE, NE-APRN, NJ, OR, TN, UT, VI, WA	15	28%
OPI - Oral Proficiency Interview	UT	1	2%
Pearson - Pearson Test of English	DE, FL, ID, KY, LA-RN, MA, NE, NE-APRN, NV, OK, PA, RI, SC, TX, UT, WY	16	30%
TOEFL - Test of English as a Foreign Language	AK, AL, AR, AZ, CA-RN, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-RN, MA, MD, ME, MI, MN, MO, MS, NC, ND, NE, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WY	52	96%
TOEIC - Test of English for International Communication	AZ, DE, KY, LA-RN, MI, MO, NE, NE-APRN, NM, OK, SD, UT, VA	13	24%
TSE - Test of Spoken English	AR, AZ, DC, FL, HI, ID, NE, SC, TX, UT	10	19%
None of the above	AS, WV-RN	2	4%
TWE - Test of Written English	AZ, HI, SC, UT	4	7%

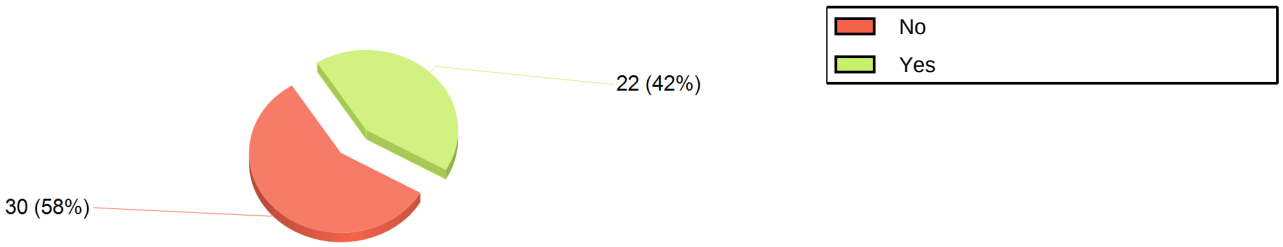
Q44. Does the Board of Nursing accept English proficiency examination scores that are greater than 2 years old?

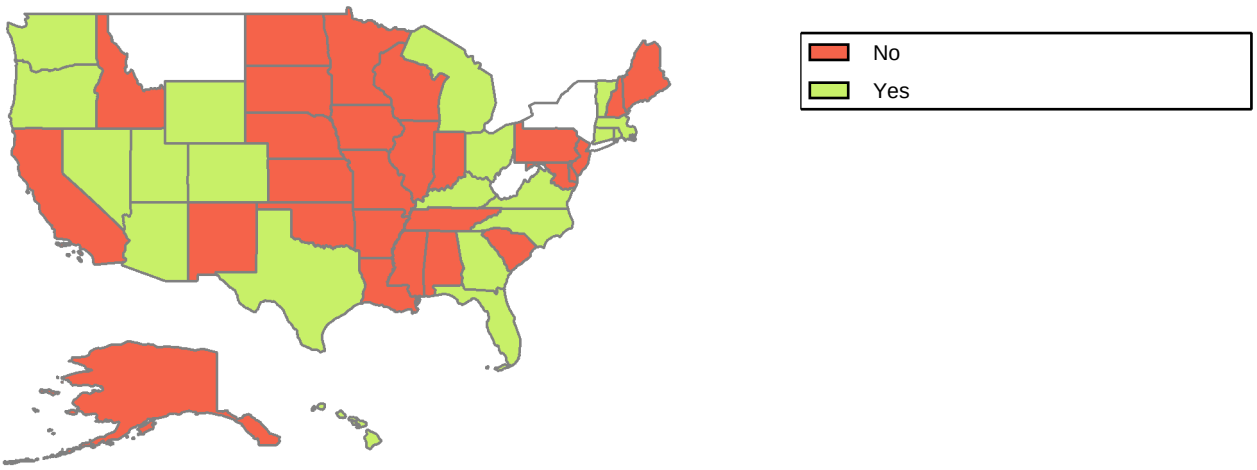


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AR, CO, FL, GA, GU, IN, KS, LA-RN, MA, MO, NC, NE, NE-APRN, NJ, NM, OR, SD, TX, VI, WA, WV-PN	21	40%
Yes	AK, AL, AZ, CA-RN, CT, DC, DE, HI, IA, ID, IL, KY, MD, ME, MI, MN, MS, ND, NH, NV, OH, OK, PA, RI, SC, TN, UT, VA, VT, WI, WY	31	60%

Q45. Does the Board of Nursing accept results of English proficiency examinations that are offered virtually?

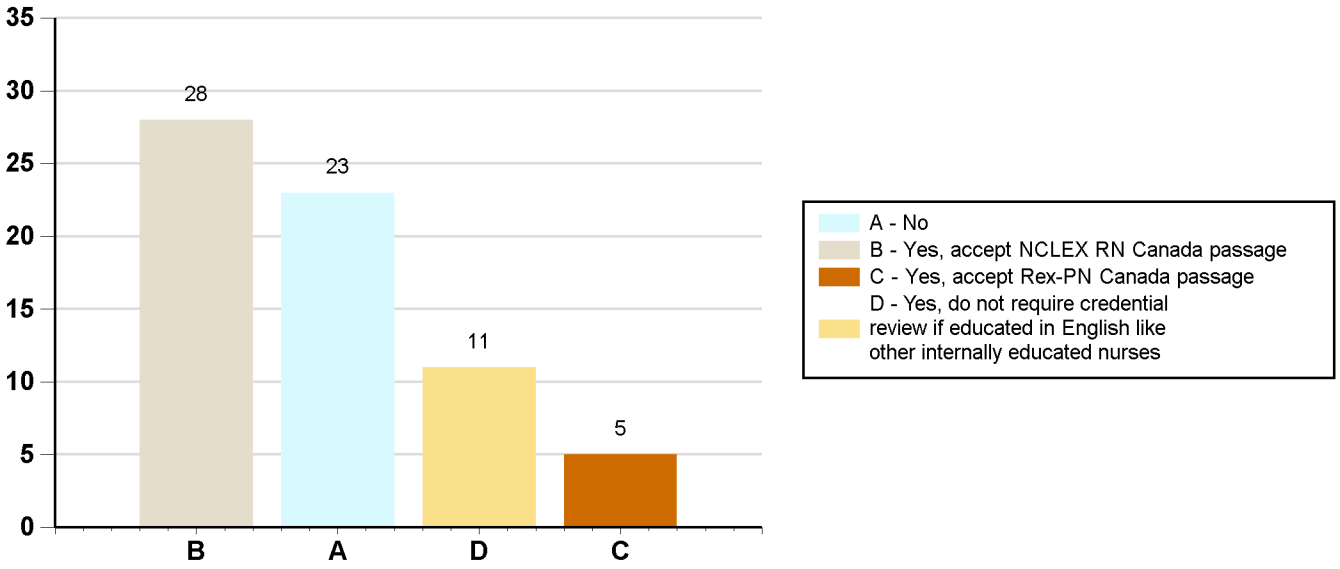




*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

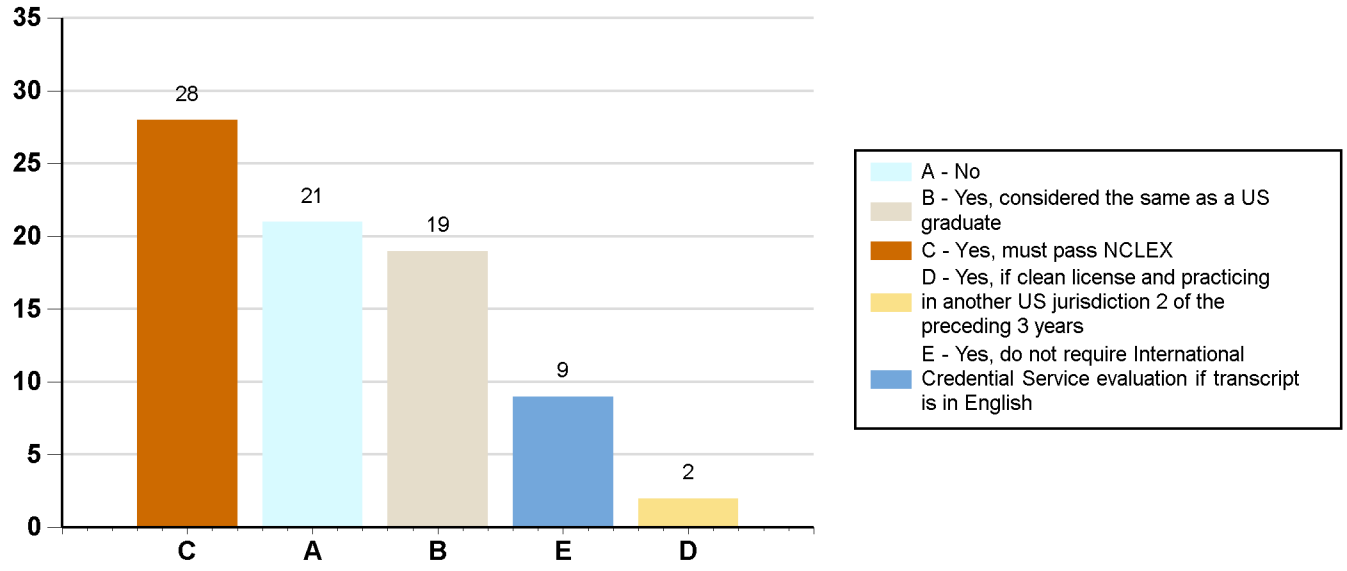
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AK, AL, AR, CA-RN, DE, GU, IA, ID, IL, IN, KS, LA-RN, MD, ME, MN, MO, MS, ND, NE, NE-APRN, NH, NJ, NM, OK, PA, SC, SD, TN, VI, WI	30	58%
Yes	AZ, CO, CT, DC, FL, GA, HI, KY, MA, MI, NC, NV, OH, OR, RI, TX, UT, VA, VT, WA, WV-PN, WY	22	42%

Q46. Does the Board of Nursing have specific procedures for licensure of nurses educated in Canada which are different from the usual procedures for internationally Educated nurses? (Check all that apply.)



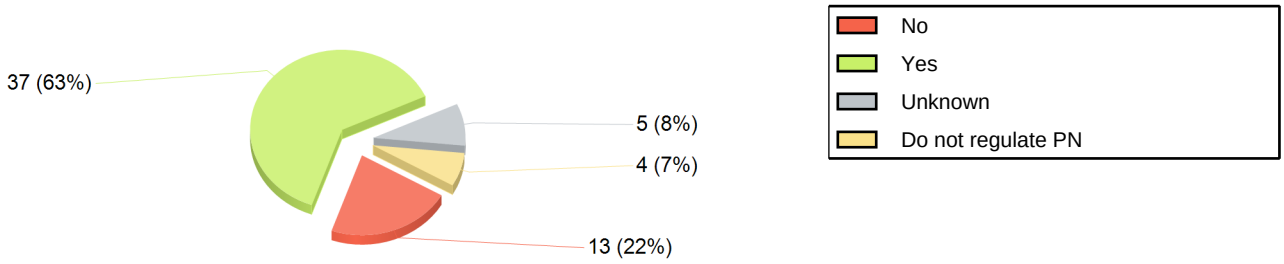
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AR, AS, CA-VN, DE, FL, GA, GU, IA, ID, KS, MA, MD, MI, MO, MS, NC, NH, OK, RI, SC, WV-PN, WV-RN, WY	23	40%
Yes, accept NCLEX RN Canada passage	AL, AZ, CA-RN, CNMI, CO, CT, DC, HI, IL, KY, MN, MT, ND, NE, NE-APRN, NJ, NM, NV, OH, OR, PA, TN, TX, UT, VI, VT, WA, WI	28	48%
Yes, accept Rex-PN Canada passage	AZ, IN, LA-PN, VT, WI	5	9%
Yes, do not require credential review if educated in English like other internally educated nurses	AK, DC, LA-RN, ME, MN, NE, NE-APRN, SD, VA, VT, WA	11	19%

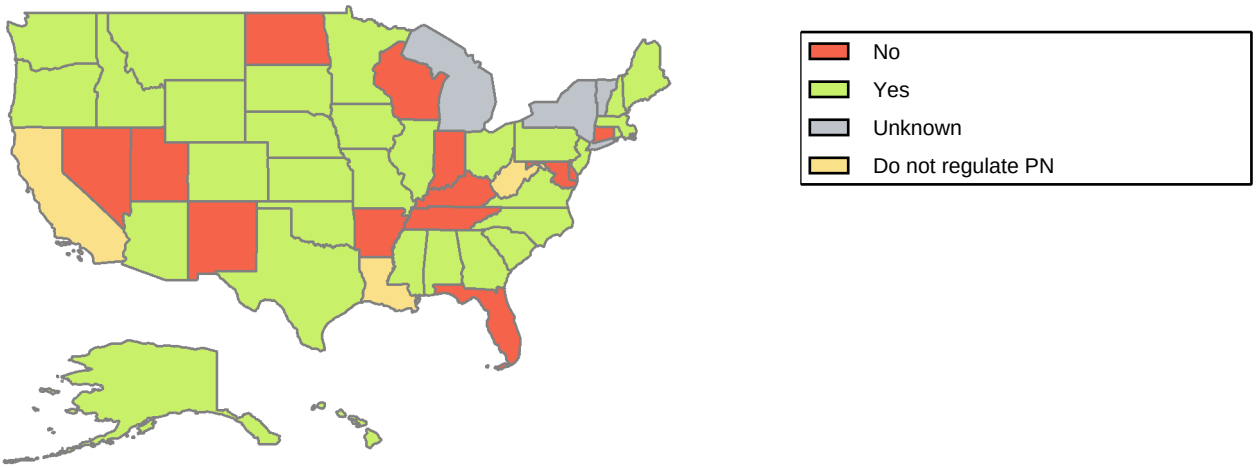
Q47. Does the Board of Nursing have specific procedures for licensure of nurses educated in Puerto Rico which are different from the usual procedures for Internationally Educated nurses? (Check all that apply.)



Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AK, CA-RN, DE, GA, GU, IA, ID, IN, LA-RN, MA, MN, MO, NC, NH, OK, RI, SD, TX, UT, VT, WA	21	36%
Yes, considered the same as a US graduate	AL, AR, CA-VN, CO, CT, DC, HI, IL, MD, MI, MS, MT, ND, NV, PA, TN, WI, WV-RN, WY	19	33%
Yes, must pass NCLEX	AL, AS, AZ, CA-VN, CNMI, CT, DC, HI, KS, KY, LA-PN, MD, ME, MI, MS, MT, NE, NE-APRN, NJ, NM, OH, OR, PA, SC, TN, VA, VI, WV-PN	28	48%
Yes, if clean license and practicing in another US jurisdiction 2 of the preceding 3 years	CA-VN, FL	2	3%
Yes, do not require International Credential Service evaluation if transcript is in English	AL, AZ, DC, KS, MD, ME, MI, ND, NE-APRN	9	16%

Q48. Is a graduate of the ARMY 68WM6 LPN program permitted to take the NCLEX-PN?

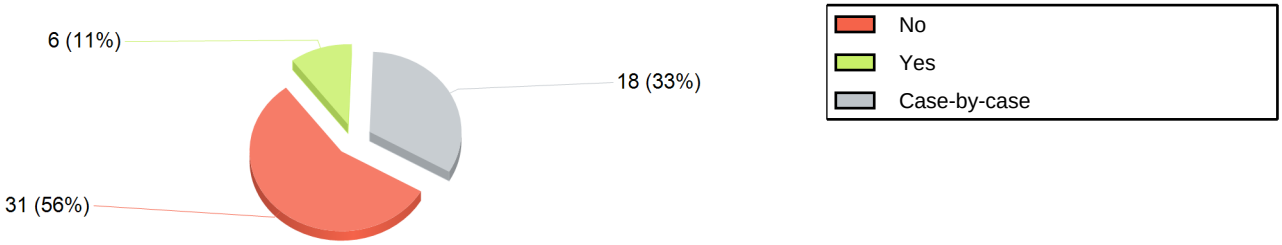


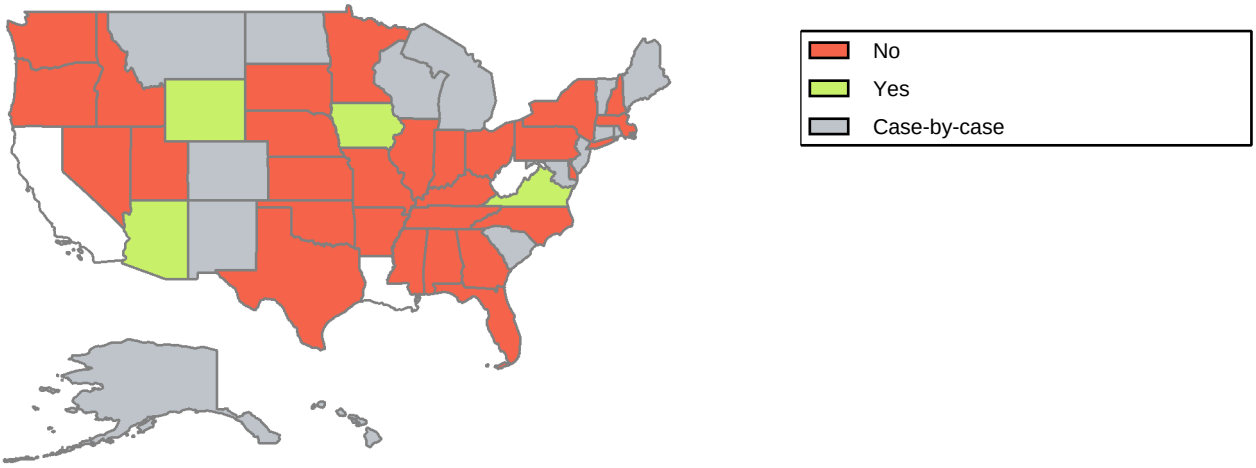


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AR, CT, DE, FL, IN, KY, MD, ND, NM, NV, TN, UT, WI	13	22%
Yes	AK, AL, AZ, CA-VN, CO, DC, GA, GU, HI, IA, ID, IL, KS, LA-PN, MA, ME, MN, MO, MS, MT, NC, NE, NH, NJ, OH, OK, OR, PA, RI, SC, SD, TX, VA, VI, WA, WV-PN, WY	37	63%
Unknown	AS, CNMI, MI, NY, VT	5	8%
Do not regulate PN	CA-RN, LA-RN, NE-APRN, WV-RN	4	7%

Q49. Is a graduate of an Army occupation specialist training program permitted to take the NCLEX-PN?

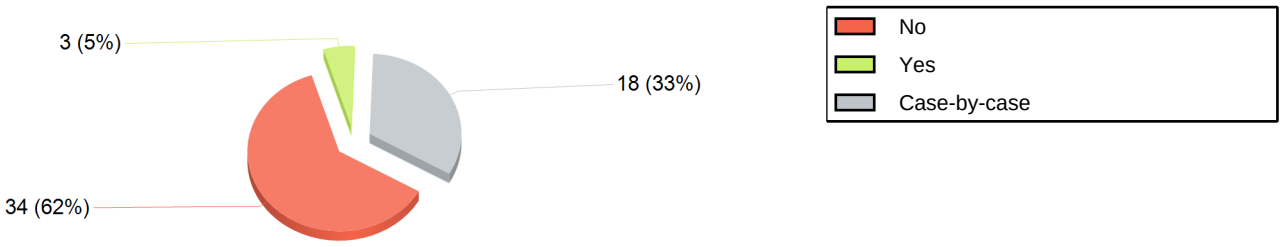


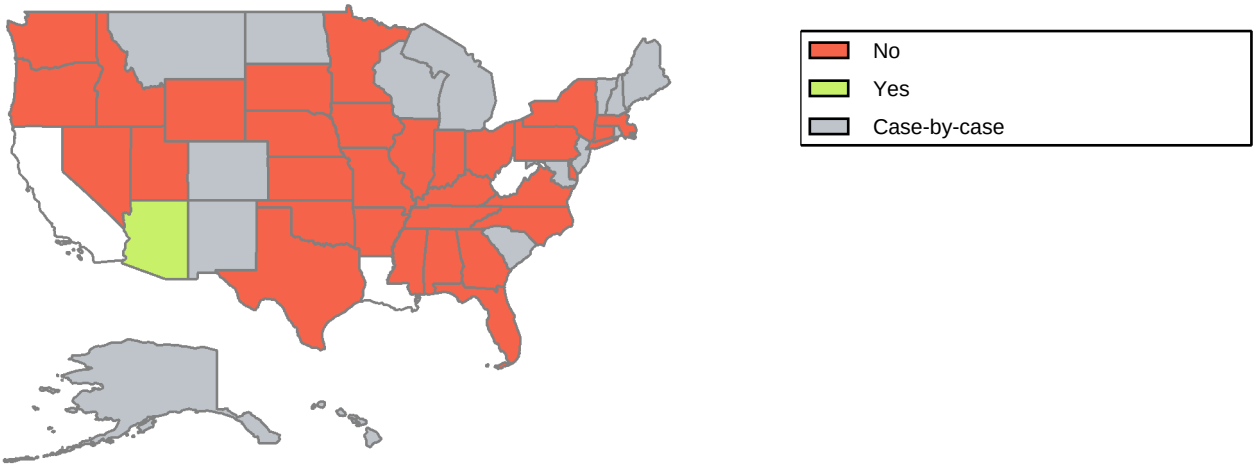


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AL, AR, AS, DC, DE, FL, GA, ID, IL, IN, KS, KY, MA, MN, MO, MS, NC, NE, NH, NV, NY, OH, OK, OR, PA, SD, TN, TX, UT, VI, WA	31	56%
Yes	AZ, IA, LA-PN, VA, WV-PN, WY	6	11%
Case-by-case	AK, CA-VN, CNMI, CO, CT, GU, HI, MD, ME, MI, MT, ND, NJ, NM, RI, SC, VT, WI	18	33%

Q50. Is a graduate of a Navy occupation specialist training program permitted to take the NCLEX-PN?

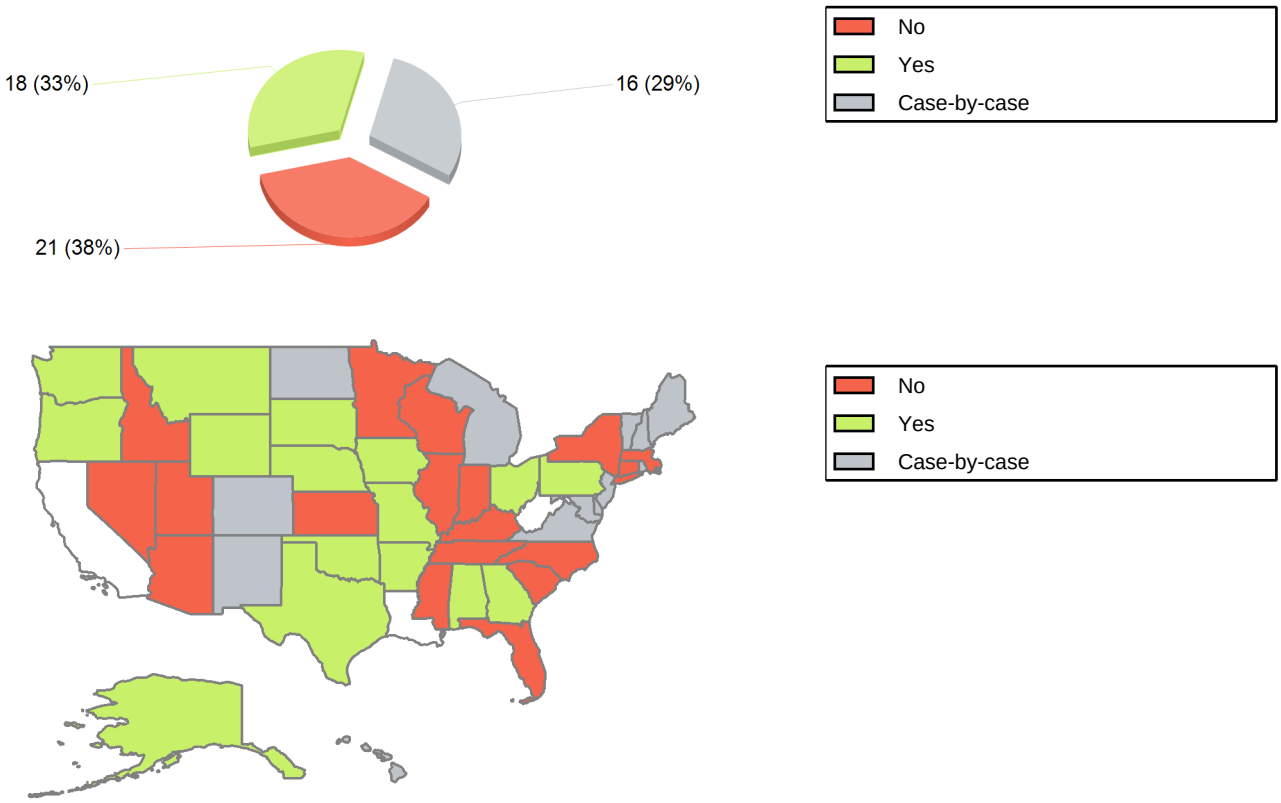




*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AL, AR, AS, CT, DC, DE, FL, GA, IA, ID, IL, IN, KS, KY, MA, MN, MO, MS, NC, NE, NV, NY, OH, OK, OR, PA, SD, TN, TX, UT, VA, VI, WA, WY	34	62%
Yes	AZ, LA-PN, WV-PN	3	5%
Case-by-case	AK, CA-VN, CNMI, CO, GU, HI, MD, ME, MI, MT, ND, NH, NJ, NM, RI, SC, VT, WI	18	33%

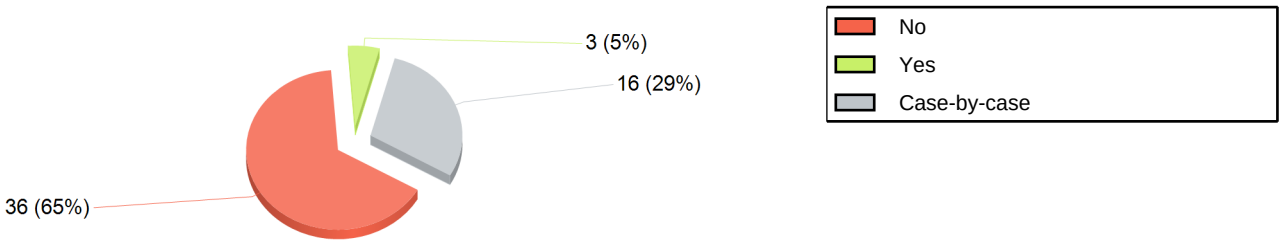
Q51. Is a graduate of an AIR FORCE BMTCP 4N051 (5 SKILL LEVEL) program permitted to take the NCLEX-PN?

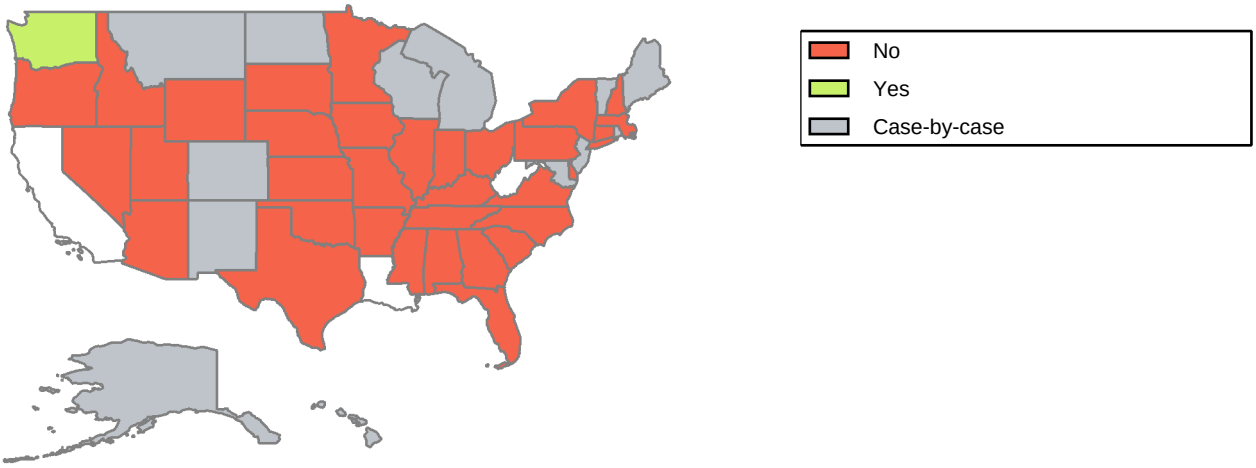


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AS, AZ, CT, DC, FL, ID, IL, IN, KS, KY, MA, MN, MS, NC, NV, NY, SC, TN, UT, VI, WI	21	38%
Yes	AK, AL, AR, GA, IA, LA-PN, MO, MT, NE, OH, OK, OR, PA, SD, TX, WA, WV-PN, WY	18	33%
Case-by-case	CA-VN, CNMI, CO, DE, GU, HI, MD, ME, MI, ND, NH, NJ, NM, RI, VA, VT	16	29%

Q52. Is a graduate of a Marine Corps occupation specialist training program permitted to take the NCLEX-PN?

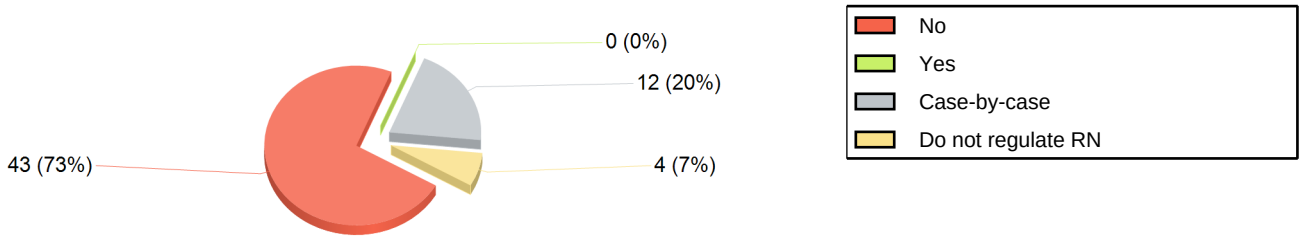


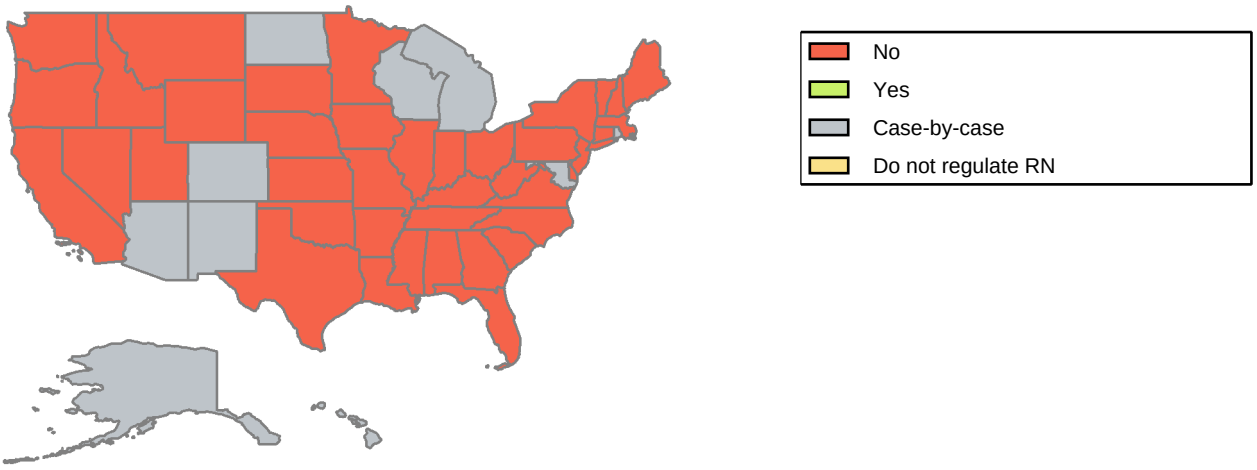


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AL, AR, AS, AZ, CT, DC, DE, FL, GA, IA, ID, IL, IN, KS, KY, MA, MN, MO, MS, NC, NE, NH, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, UT, VA, VI, WY	36	65%
Yes	LA-PN, WA, WV-PN	3	5%
Case-by-case	AK, CA-VN, CNMI, CO, GU, HI, MD, ME, MI, MT, ND, NJ, NM, RI, VT, WI	16	29%

Q53. Is a graduate of an Army occupation specialist training program permitted to take the NCLEX-RN?

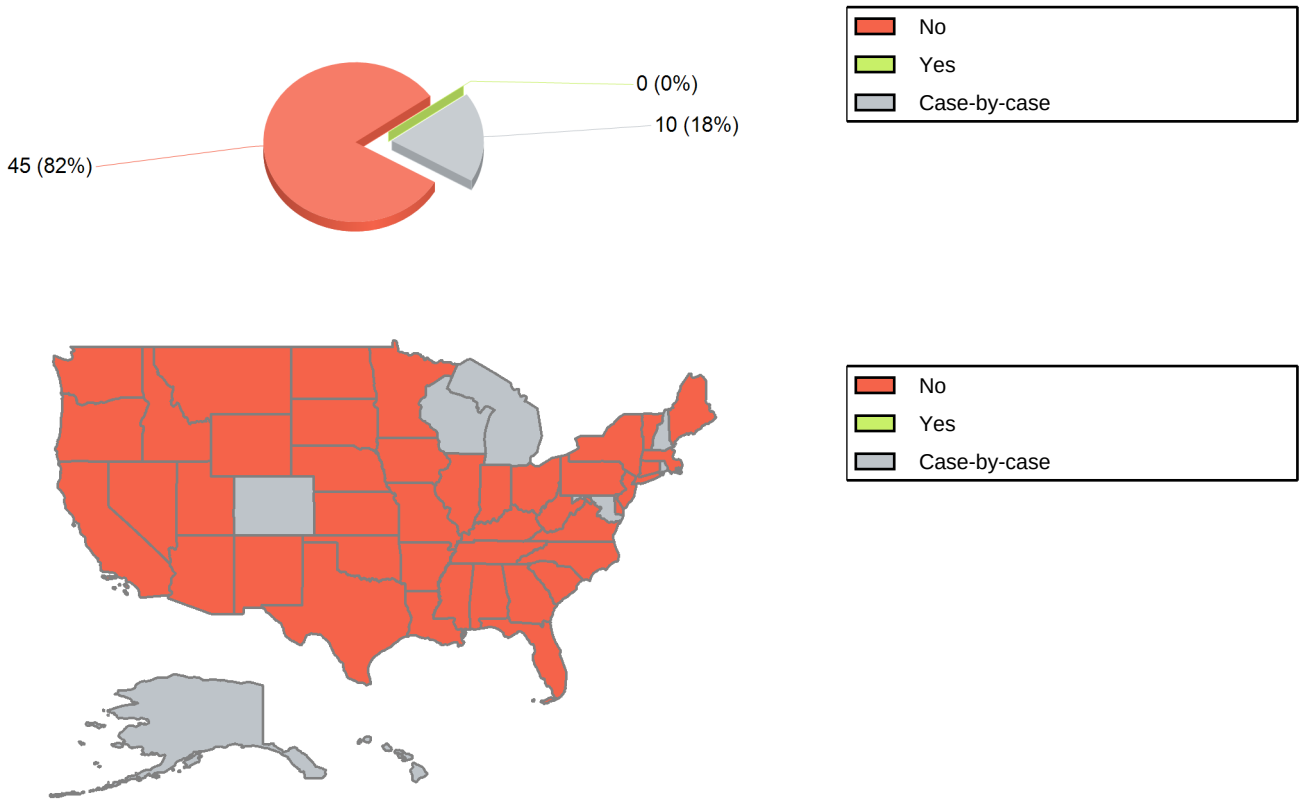




*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AL, AR, AS, CA-RN, CT, DC, DE, FL, GA, IA, ID, IL, IN, KS, KY, LA-RN, MA, ME, MN, MO, MS, MT, NC, NE, NH, NJ, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, UT, VA, VI, VT, WA, WV-RN, WY	43	73%
Yes		0	0%
Case-by-case	AK, AZ, CNMI, CO, GU, HI, MD, MI, ND, NM, RI, WI	12	20%
Do not regulate RN	CA-VN, LA-PN, NE-APRN, WV-PN	4	7%

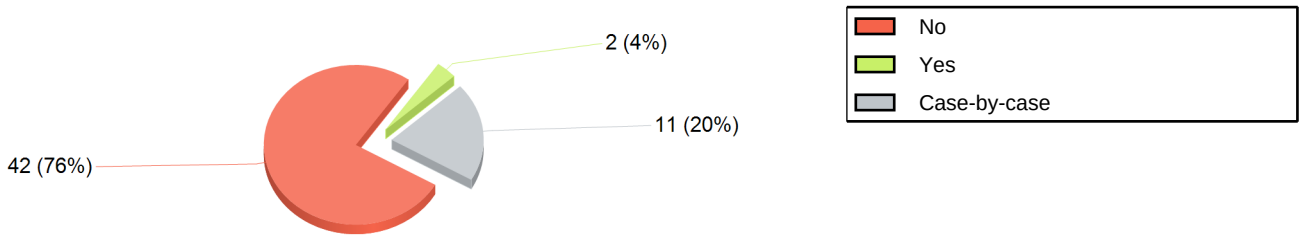
Q54. Is a graduate of a Navy occupation specialist training program permitted to take the NCLEX-RN?

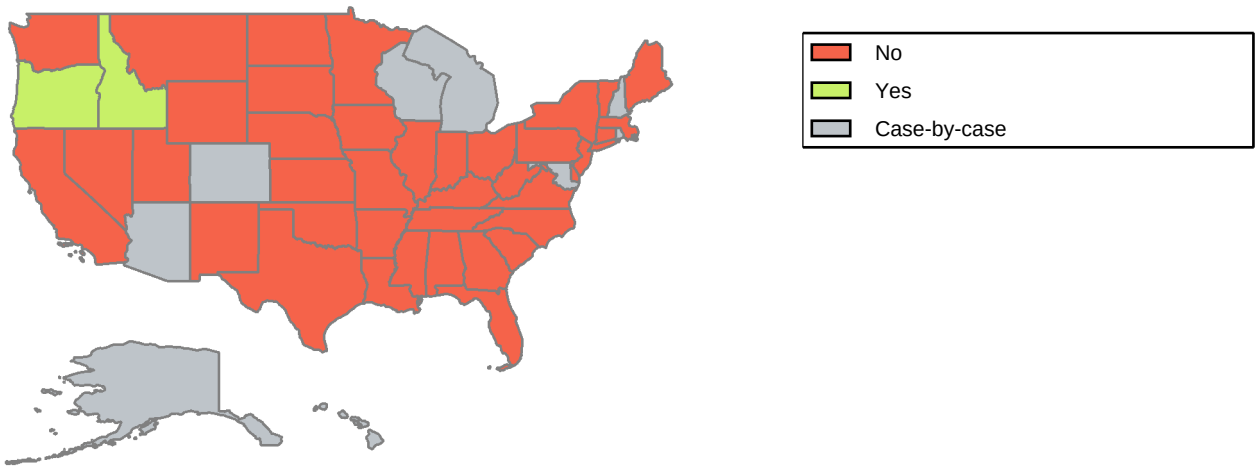


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AL, AR, AS, AZ, CA-RN, CT, DC, DE, FL, GA, IA, ID, IL, IN, KS, KY, LA-RN, MA, ME, MN, MO, MS, MT, NC, ND, NE, NJ, NM, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, UT, VA, VI, VT, WA, WV-RN, WY	45	82%
Yes		0	0%
Case-by-case	AK, CNMI, CO, GU, HI, MD, MI, NH, RI, WI	10	18%

Q55. Is a graduate of an Air Force occupation specialist training program permitted to take the NCLEX-RN?

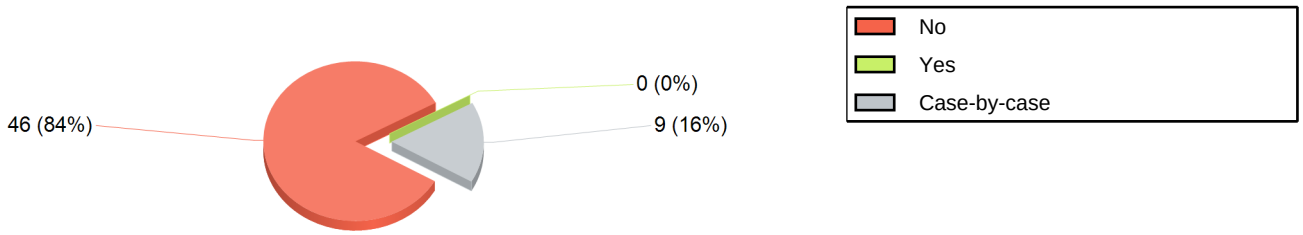


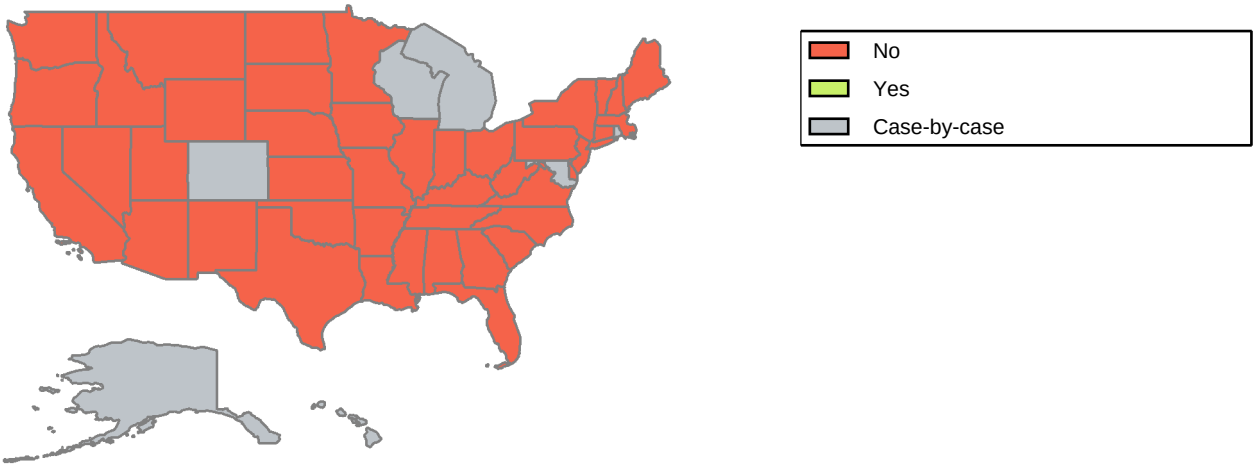


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AL, AR, AS, CA-RN, CT, DC, DE, FL, GA, IA, IL, IN, KS, KY, LA-RN, MA, ME, MN, MO, MS, MT, NC, ND, NE, NJ, NM, NV, NY, OH, OK, PA, SC, SD, TN, TX, UT, VA, VI, VT, WA, WV-RN, WY	42	76%
Yes	ID, OR	2	4%
Case-by-case	AK, AZ, CNMI, CO, GU, HI, MD, MI, NH, RI, WI	11	20%

Q56. Is a graduate of a Marine Corps occupation specialist training program permitted to take the NCLEX-RN?

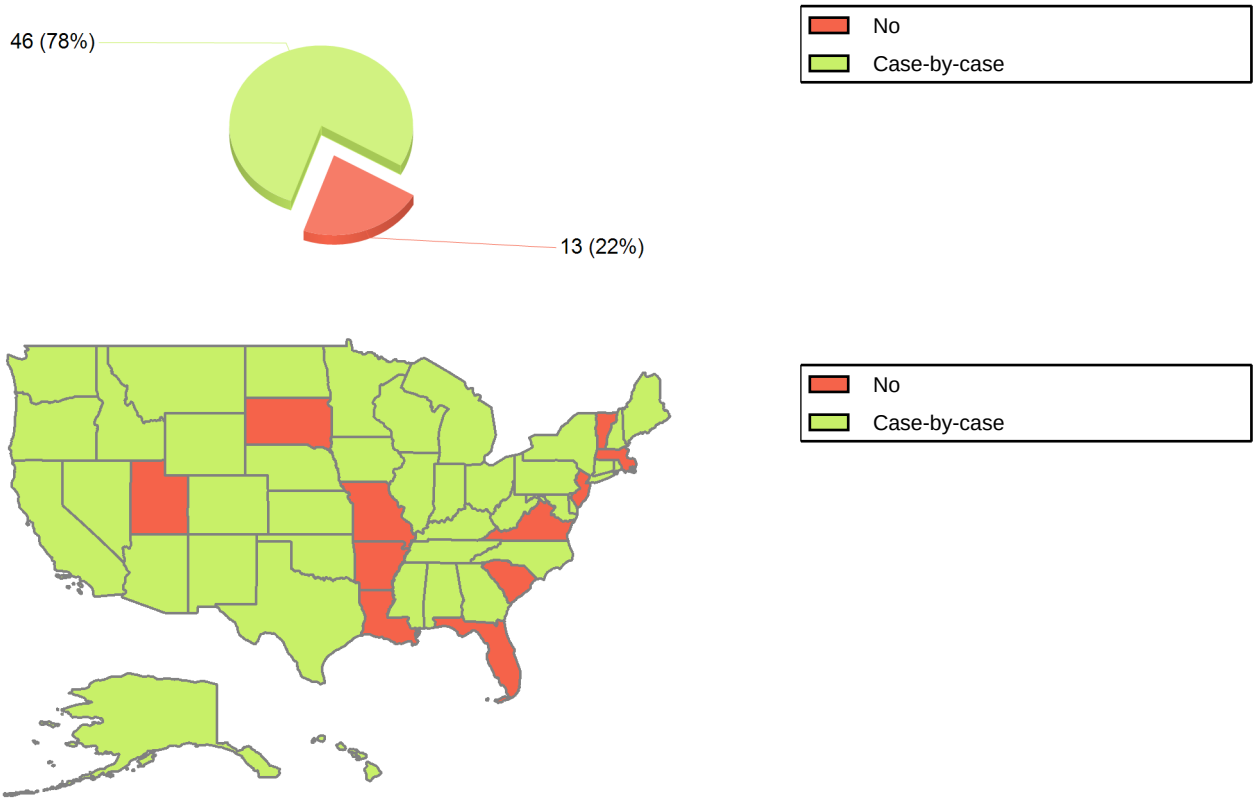




*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AL, AR, AS, AZ, CA-RN, CT, DC, DE, FL, GA, IA, ID, IL, IN, KS, KY, LA-RN, MA, ME, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, UT, VA, VI, VT, WA, WV-RN, WY	46	84%
Yes		0	0%
Case-by-case	AK, CNMI, CO, GU, HI, MD, MI, RI, WI	9	16%

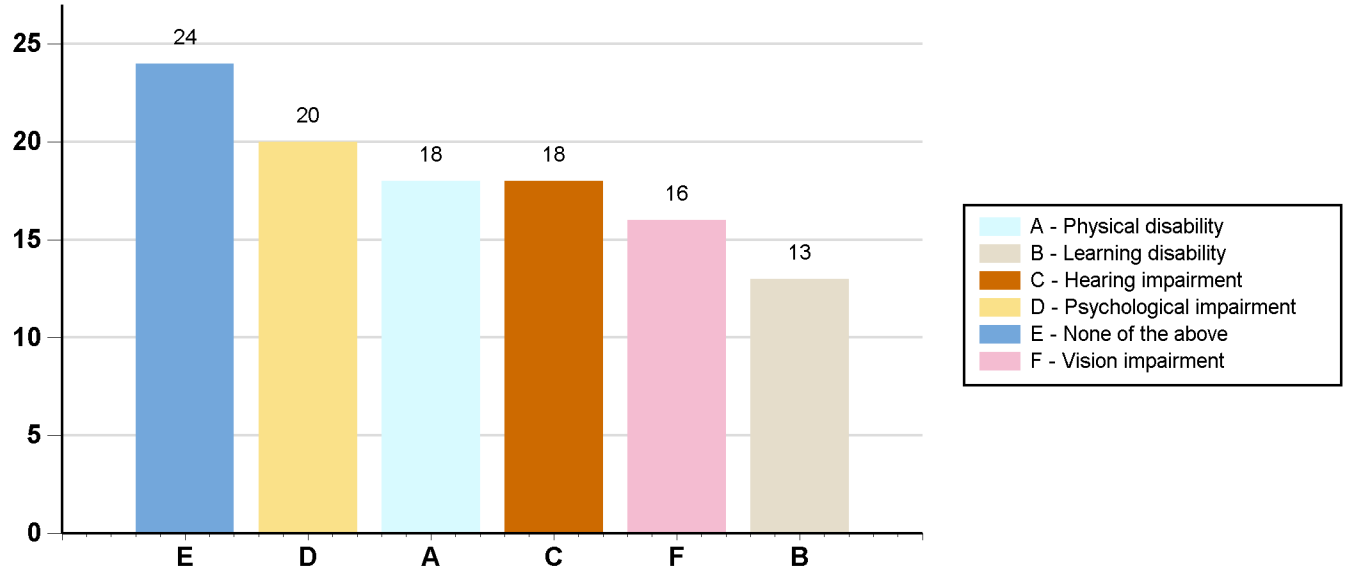
Q57. Can an individual with a physical or mental health impairment/handicap be issued a license with limitations/conditions?



*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

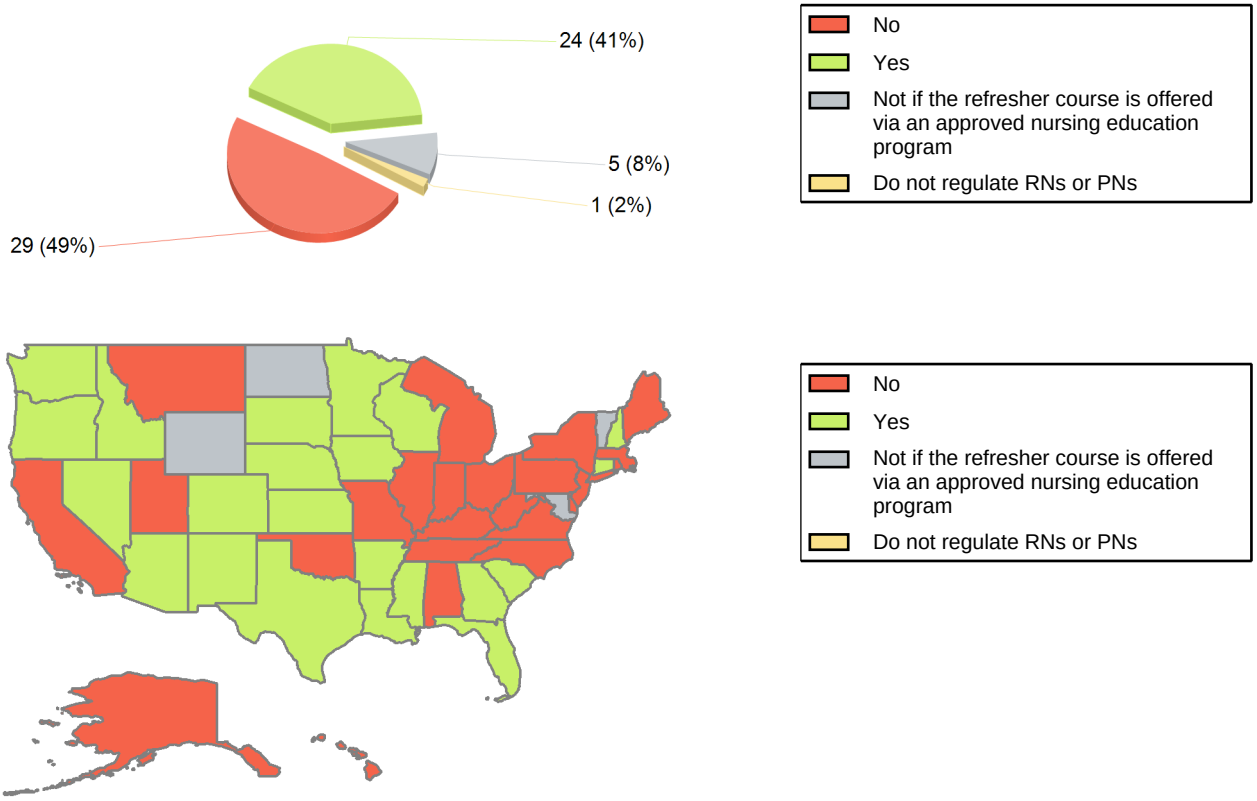
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AR, AS, CA-VN, FL, LA-RN, MA, MO, NJ, SC, SD, UT, VA, VT	13	22%
Case-by-case	AK, AL, AZ, CA-RN, CNMI, CO, CT, DC, DE, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, MD, ME, MI, MN, MS, MT, NC, ND, NE, NE-APRN, NH, NM, NV, NY, OH, OK, OR, PA, RI, TN, TX, VI, WA, WI, WV-PN, WV-RN, WY	46	78%

Q58. Which of the following impairments/disabilities can be a cause for issuing a license with limitations? (Check all that apply)



Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Physical disability	AZ, CNMI, CO, CT, GU, ID, KS, LA-PN, ME, MN, MS, NC, ND, RI, VI, WA, WI, WY	18	39%
Learning disability	CNMI, CO, CT, ID, KS, LA-PN, MN, NC, ND, VI, WA, WI, WY	13	28%
Hearing impairment	AZ, CNMI, CO, CT, GU, ID, KS, LA-PN, MN, MS, NC, ND, OR, RI, VI, WA, WI, WY	18	39%
Psychological impairment	AZ, CNMI, CO, CT, GU, ID, KS, LA-PN, ME, MN, NC, ND, NM, OR, PA, TX, VI, WA, WI, WY	20	43%
None of the above	AK, AL, CA-RN, DC, DE, GA, HI, IA, IL, IN, KY, MD, MI, MT, NE, NE-APRN, NH, NV, NY, OH, OK, TN, WV-PN, WV-RN	24	52%
Vision impairment	CNMI, CO, CT, GU, ID, KS, LA-PN, MN, NC, ND, OR, RI, VI, WA, WI, WY	16	35%

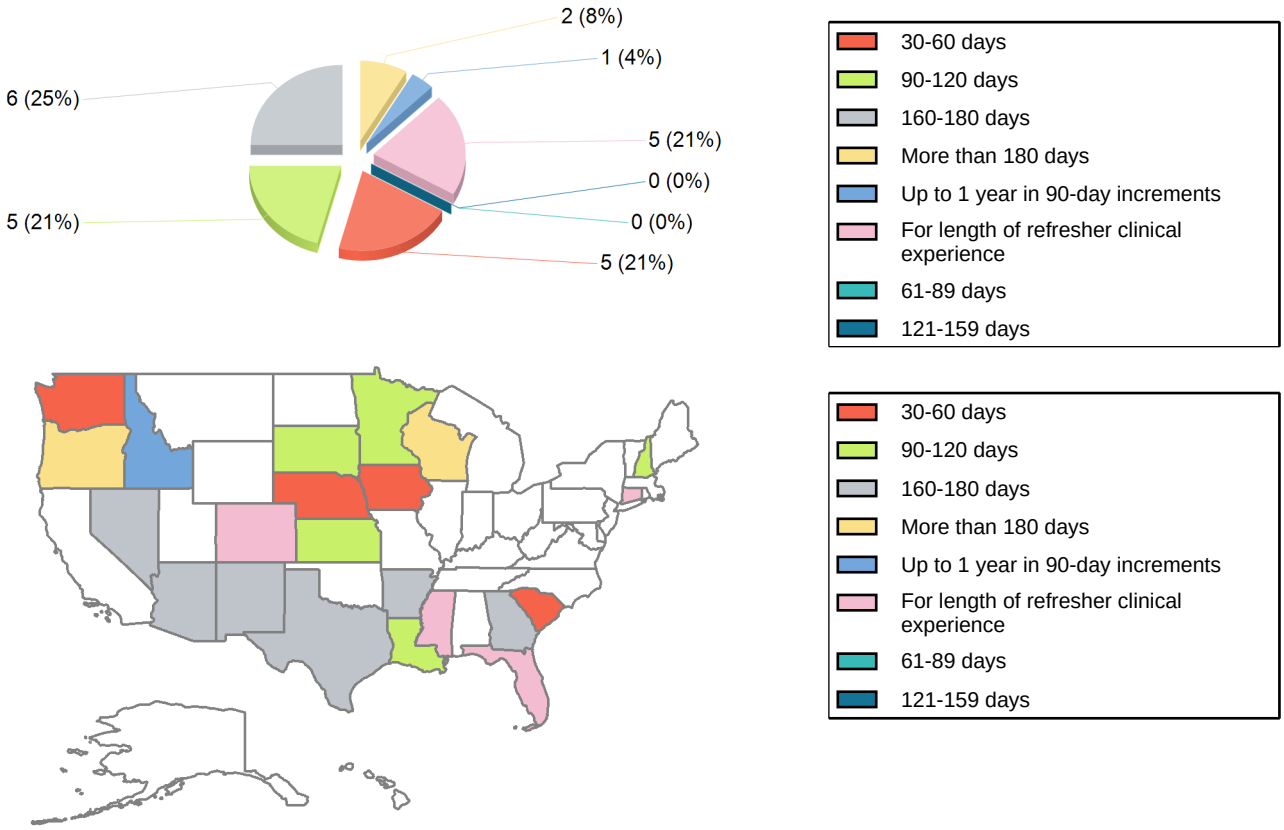
Q59. Is a limited education license or authorization issued allowing clinical practice during a refresher program?



*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AK, AL, CA-RN, CA-VN, CNMI, DC, DE, HI, IL, IN, KY, MA, ME, MI, MO, MT, NC, NJ, NY, OH, OK, PA, RI, TN, UT, VA, VI, WV-PN, WV-RN	29	49%
Yes	AR, AZ, CO, CT, FL, GA, GU, IA, ID, KS, LA-PN, LA-RN, MN, MS, NE, NH, NM, NV, OR, SC, SD, TX, WA, WI	24	41%
Not if the refresher course is offered via an approved nursing education program	AS, MD, ND, VT, WY	5	8%
Do not regulate RNs or PNs	NE-APRN	1	2%

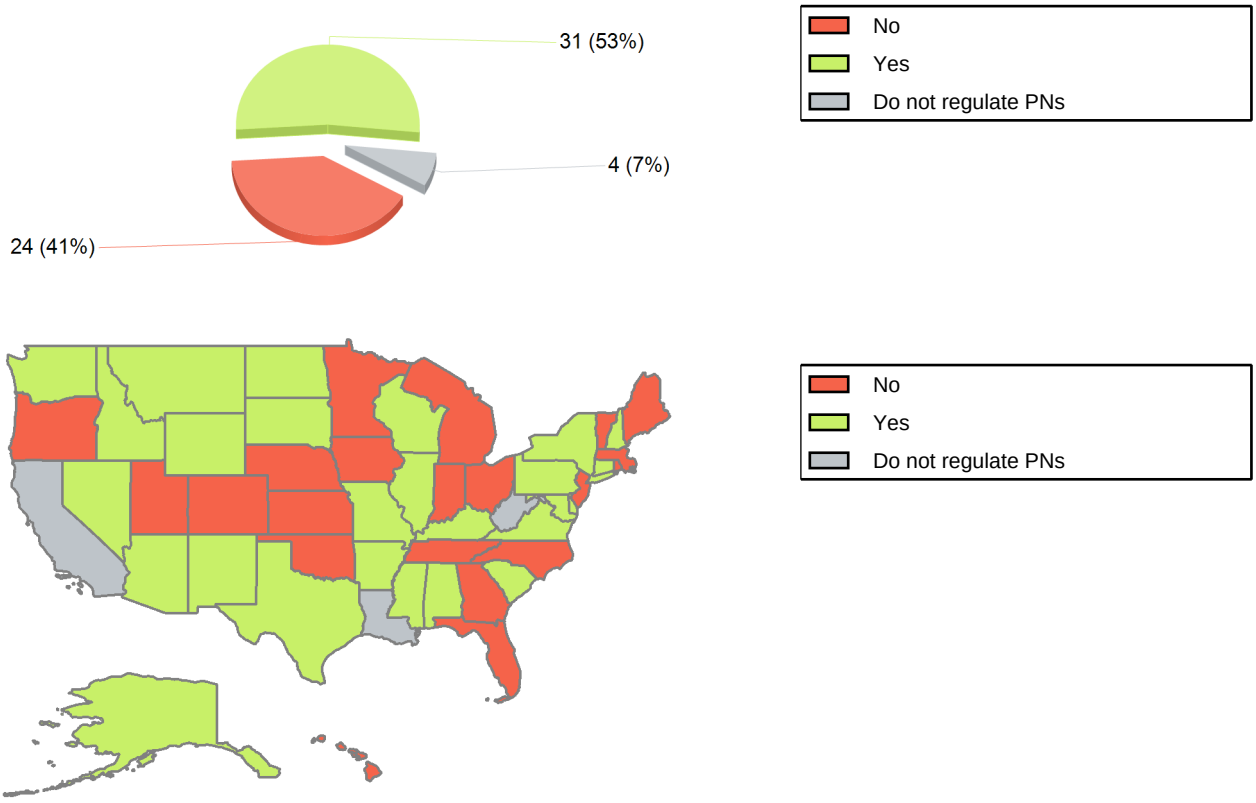
Q60. How long is limited license or authorization valid?



*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
30-60 days	IA, LA-PN, NE, SC, WA	5	21%
90-120 days	KS, LA-RN, MN, NH, SD	5	21%
160-180 days	AR, AZ, GA, NM, NV, TX	6	25%
More than 180 days	OR, WI	2	8%
Up to 1 year in 90-day increments	ID	1	4%
For length of refresher clinical experience	CO, CT, FL, GU, MS	5	21%
61-89 days		0	0%
121-159 days		0	0%

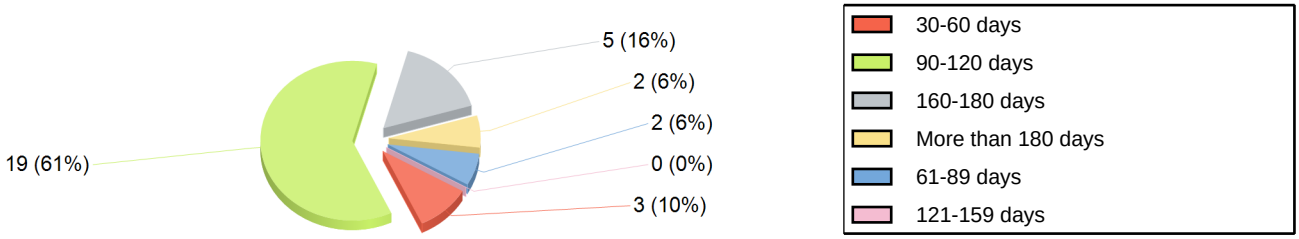
Q61. Are temporary practice permits available for applicants applying for PN licensure by examination?

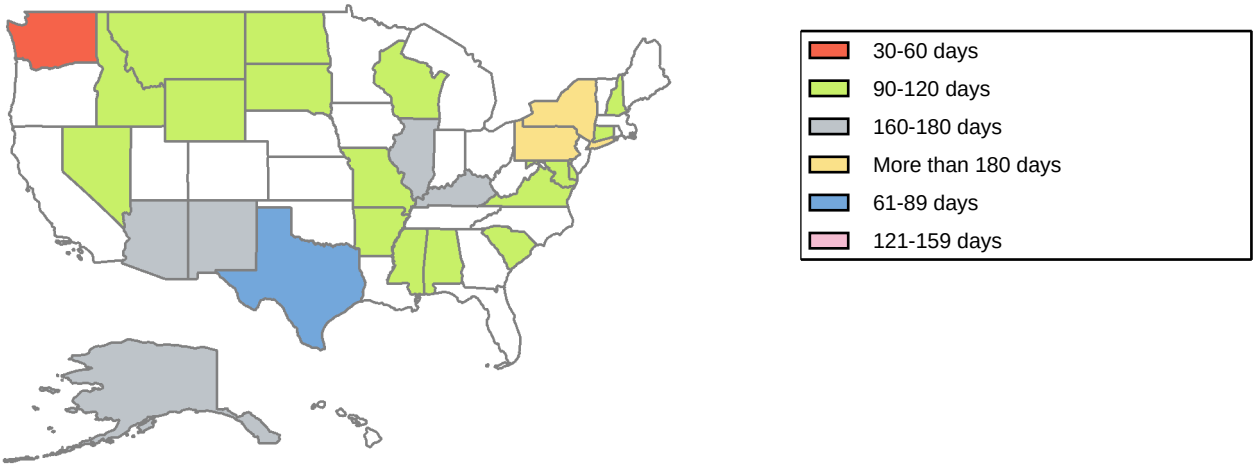


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AS, CNMI, CO, DC, FL, GA, HI, IA, IN, KS, MA, ME, MI, MN, NC, NE, NJ, OH, OK, OR, RI, TN, UT, VT	24	41%
Yes	AK, AL, AR, AZ, CA-VN, CT, DE, GU, ID, IL, KY, LA-PN, MD, MO, MS, MT, ND, NH, NM, NV, NY, PA, SC, SD, TX, VA, VI, WA, WI, WV-PN, WY	31	53%
Do not regulate PNs	CA-RN, LA-RN, NE-APRN, WV-RN	4	7%

Q62. How long is the temporary practice permit valid for PN licensure by examination applicant?

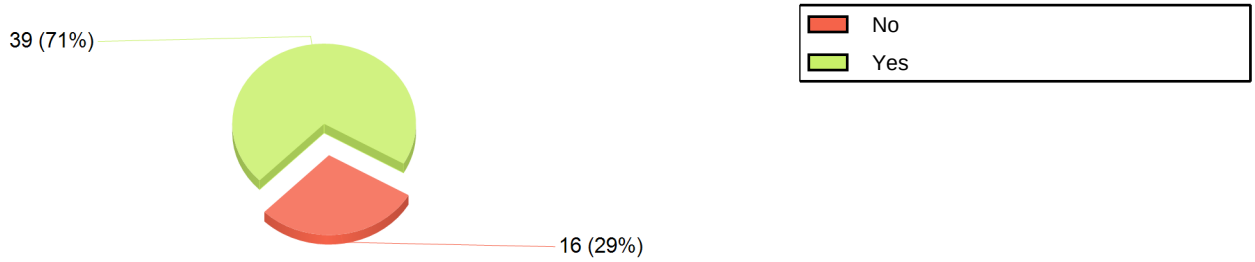


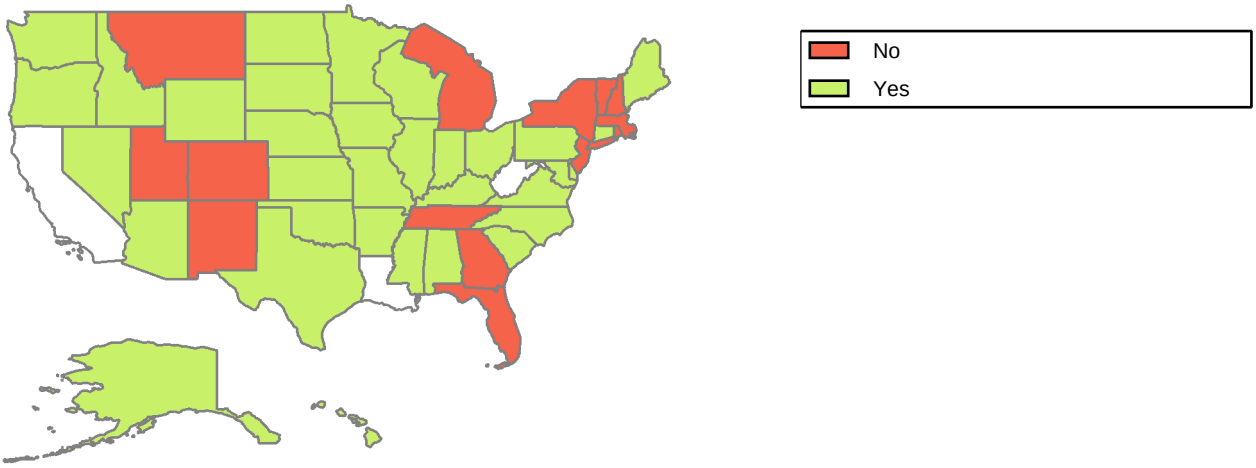


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
30-60 days	CA-VN, LA-PN, WA	3	10%
90-120 days	AL, AR, CT, DE, GU, ID, MD, MO, MS, MT, ND, NH, NV, SC, SD, VA, WI, WV-PN, WY	19	61%
160-180 days	AK, AZ, IL, KY, NM	5	16%
More than 180 days	NY, PA	2	6%
61-89 days	TX, VI	2	6%
121-159 days		0	0%

Q63. Are temporary practice permits available for applicants applying for PN licensure by endorsement?

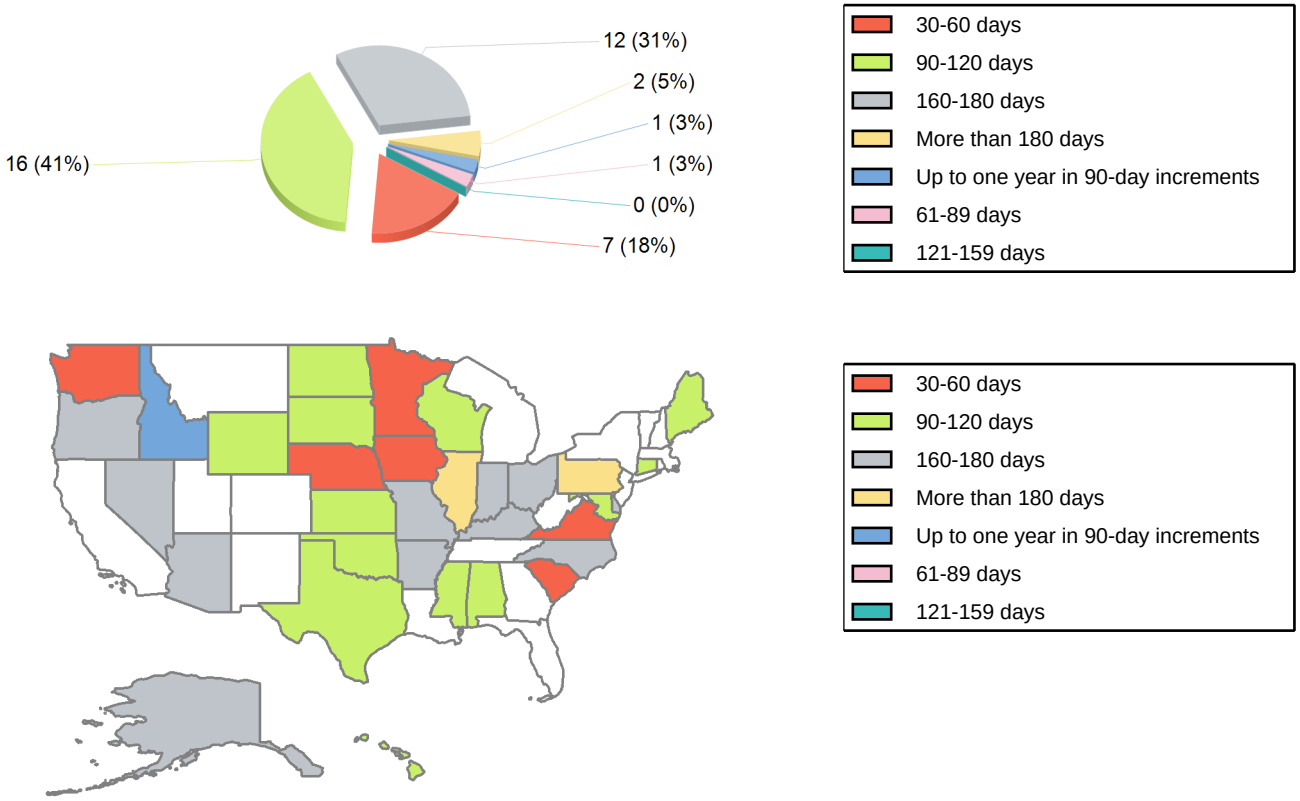




*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AS, CA-VN, CO, FL, GA, MA, MI, MT, NH, NJ, NM, NY, RI, TN, UT, VT	16	29%
Yes	AK, AL, AR, AZ, CNMI, CT, DC, DE, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, MD, ME, MN, MO, MS, NC, ND, NE, NV, OH, OK, OR, PA, SC, SD, TX, VA, VI, WA, WI, WV-PN, WY	39	71%

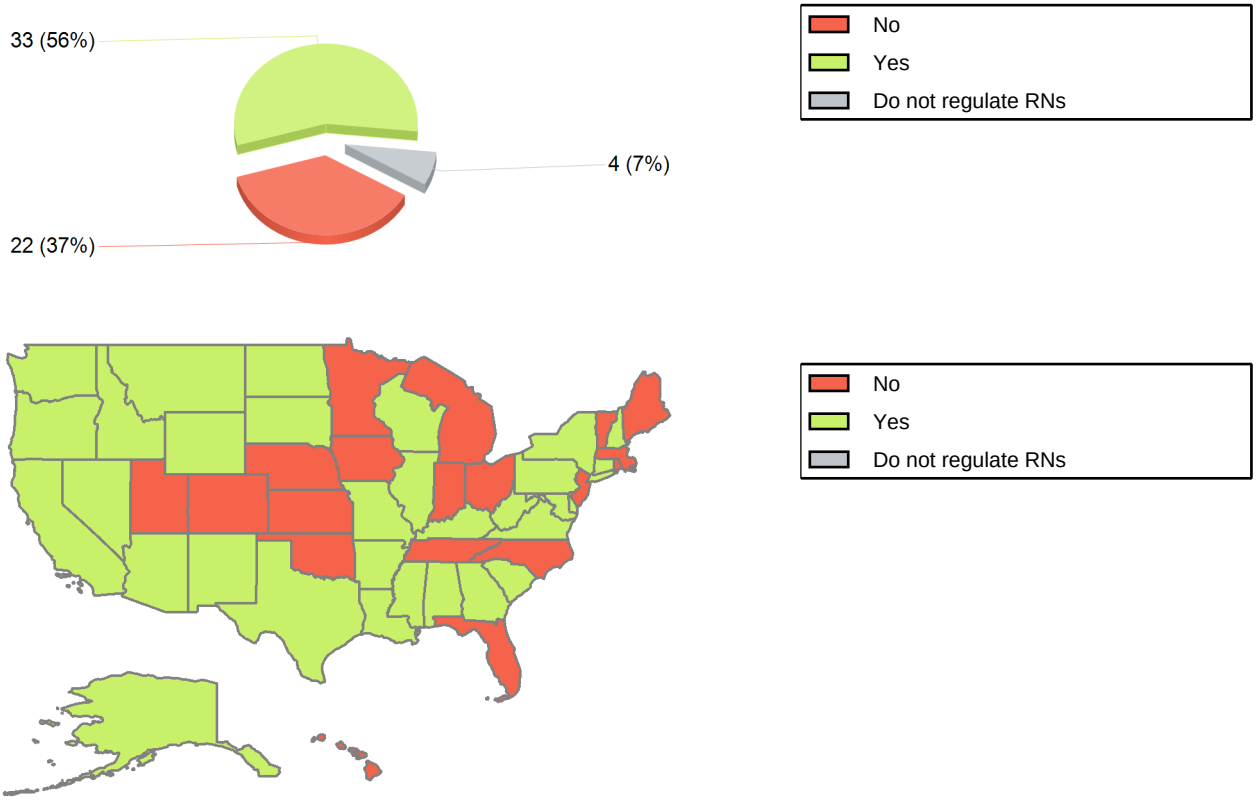
Q64. How long is the temporary practice permit valid for PN licensure by endorsement applicants?



*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
30-60 days	IA, LA-PN, MN, NE, SC, VA, WA	7	18%
90-120 days	AL, CNMI, CT, DC, GU, HI, KS, MD, ME, MS, ND, OK, SD, TX, WI, WY	16	41%
160-180 days	AK, AR, AZ, DE, IN, KY, MO, NC, NV, OH, OR, WV-PN	12	31%
More than 180 days	IL, PA	2	5%
Up to one year in 90-day increments	ID	1	3%
61-89 days	VI	1	3%
121-159 days		0	0%

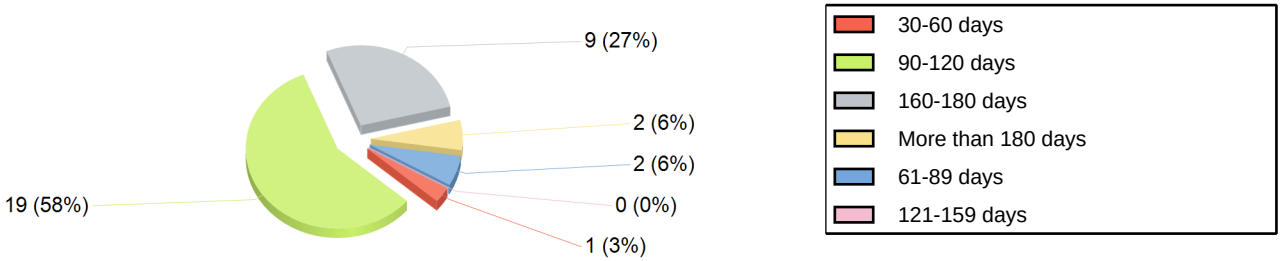
Q65. Are temporary practice permits available for applicants applying for RN licensure by examination?

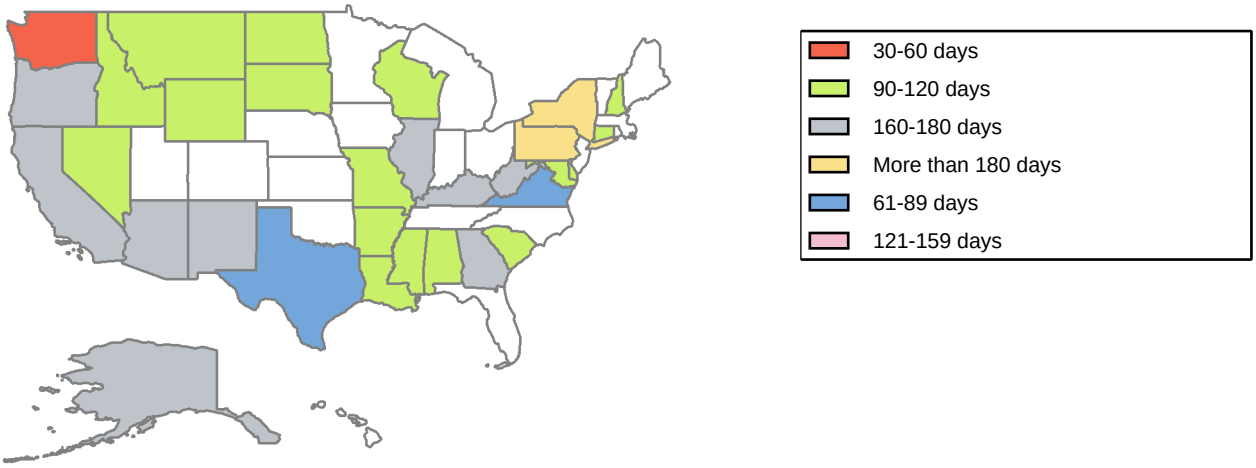


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AS, CNMI, CO, FL, HI, IA, IN, KS, MA, ME, MI, MN, NC, NE, NJ, OH, OK, RI, TN, UT, VI, VT	22	37%
Yes	AK, AL, AR, AZ, CA-RN, CT, DC, DE, GA, GU, ID, IL, KY, LA-RN, MD, MO, MS, MT, ND, NH, NM, NV, NY, OR, PA, SC, SD, TX, VA, WA, WI, WV-RN, WY	33	56%
Do not regulate RNs	CA-VN, LA-PN, NE-APRN, WV-PN	4	7%

Q66. How long is the temporary practice permit valid for RN licensure by examination applicant?

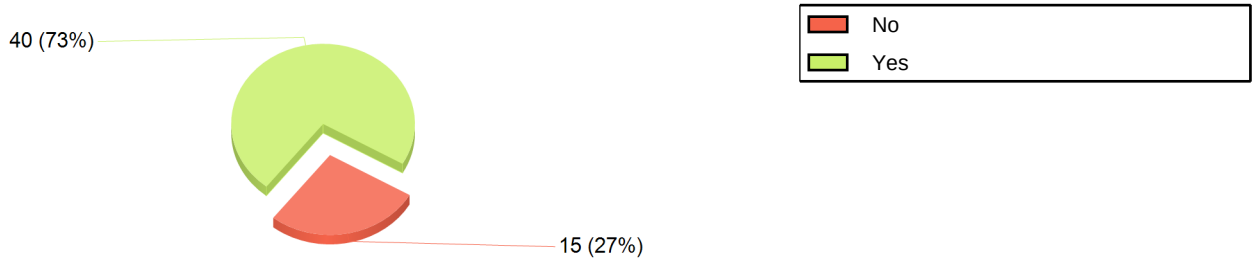


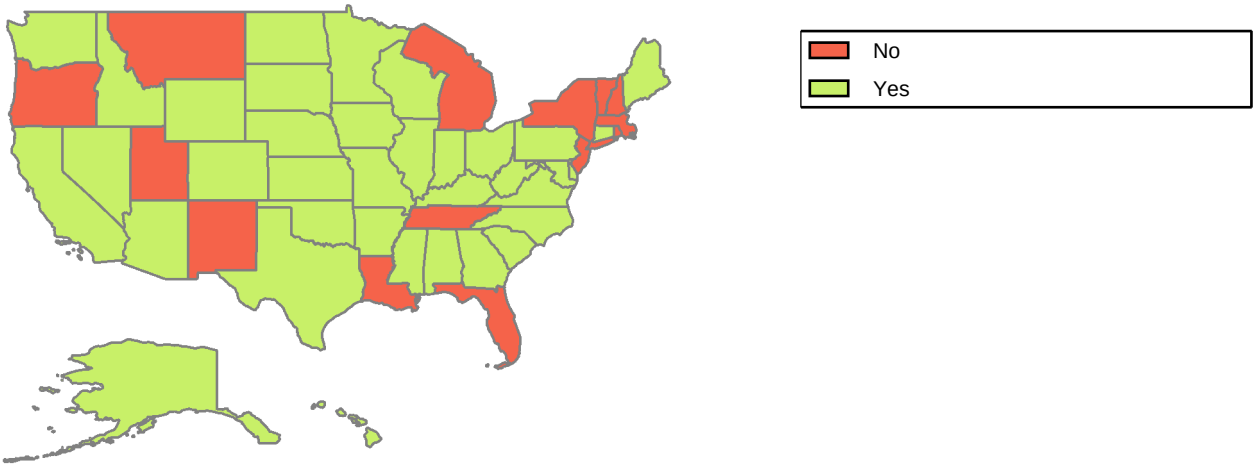


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
30-60 days	WA	1	3%
90-120 days	AL, AR, CT, DC, DE, GU, ID, LA-RN, MD, MO, MS, MT, ND, NH, NV, SC, SD, WI, WY	19	58%
160-180 days	AK, AZ, CA-RN, GA, IL, KY, NM, OR, WV-RN	9	27%
More than 180 days	NY, PA	2	6%
61-89 days	TX, VA	2	6%
121-159 days		0	0%

Q67. Are temporary practice permits available for applicants applying for RN licensure by endorsement?

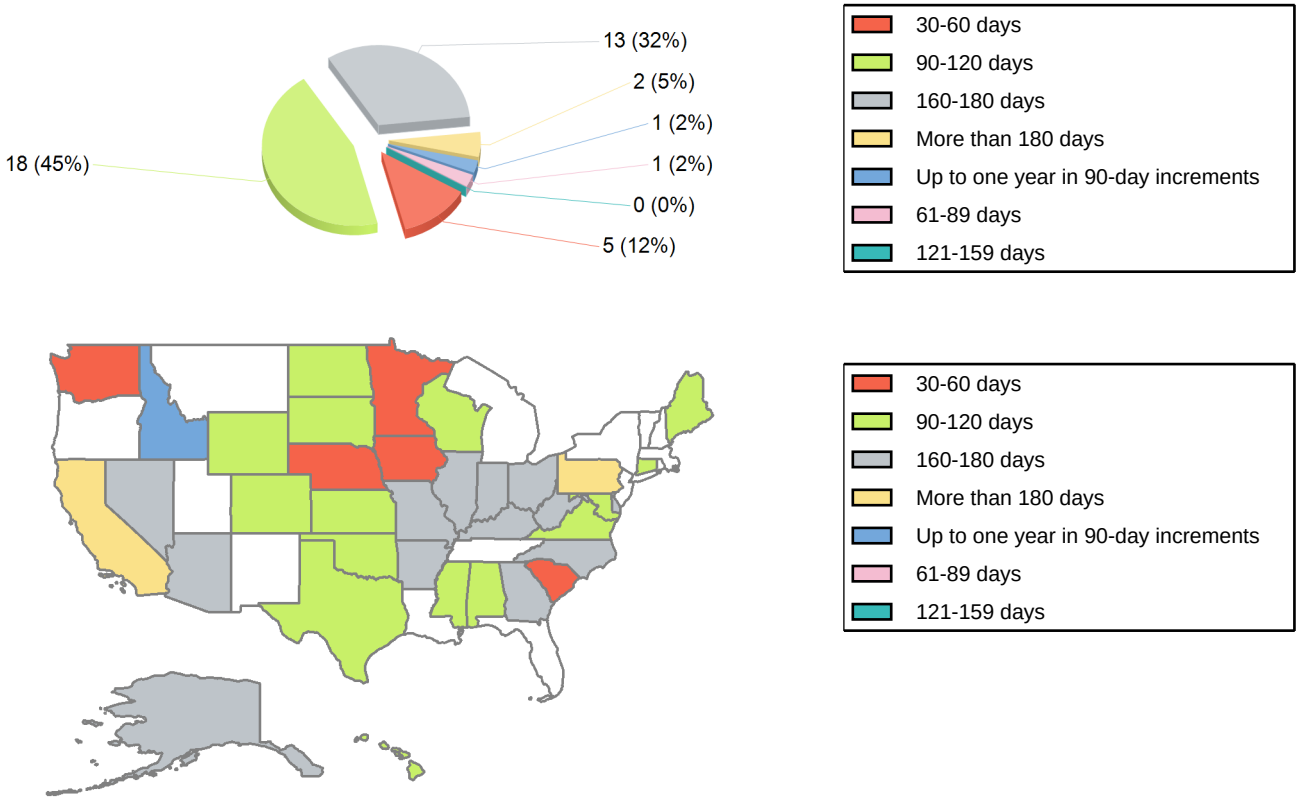




*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AS, FL, LA-RN, MA, MI, MT, NH, NJ, NM, NY, OR, RI, TN, UT, VT	15	27%
Yes	AK, AL, AR, AZ, CA-RN, CNMI, CO, CT, DC, DE, GA, GU, HI, IA, ID, IL, IN, KS, KY, MD, ME, MN, MO, MS, NC, ND, NE, NV, OH, OK, PA, SC, SD, TX, VA, VI, WA, WI, WV-RN, WY	40	73%

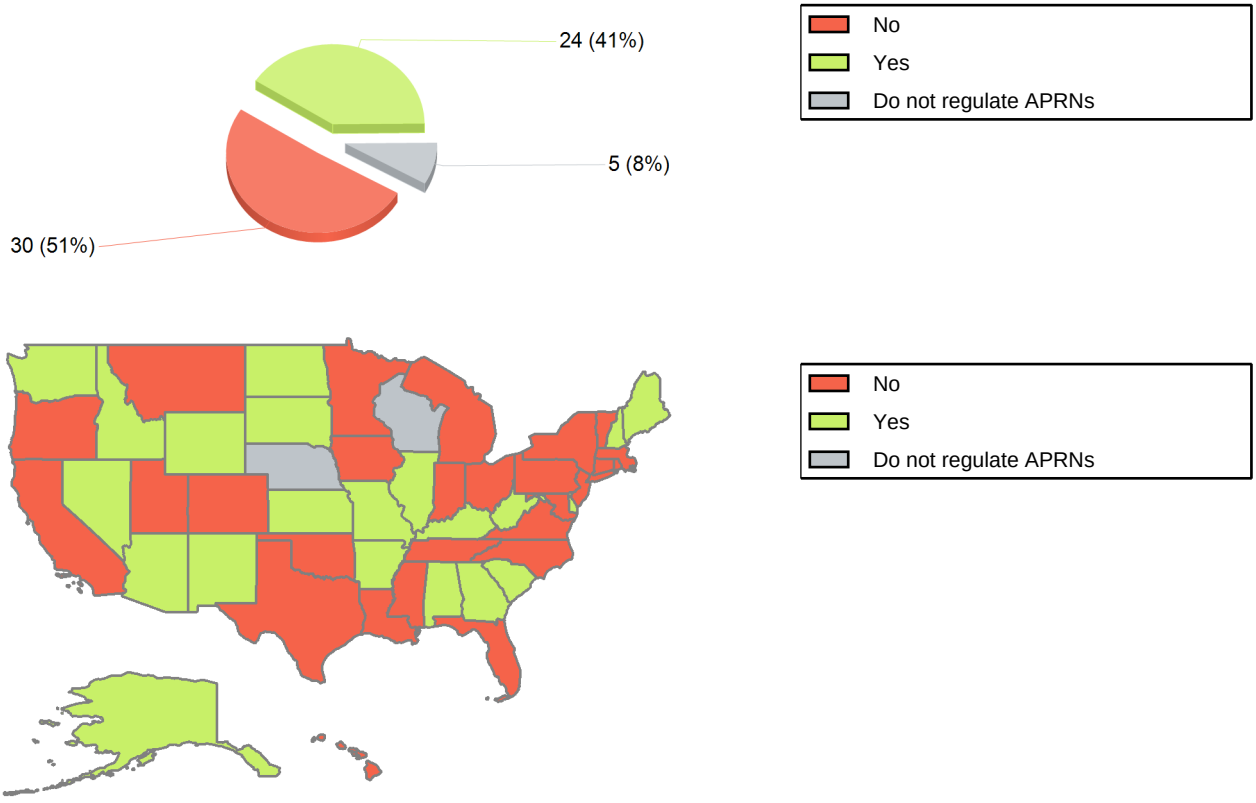
Q68. How long is the temporary practice permit valid for RN licensure by endorsement applicants?



*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
30-60 days	IA, MN, NE, SC, WA	5	12%
90-120 days	AL, CNMI, CO, CT, DC, GU, HI, KS, MD, ME, MS, ND, OK, SD, TX, VA, WI, WY	18	45%
160-180 days	AK, AR, AZ, DE, GA, IL, IN, KY, MO, NC, NV, OH, WV-RN	13	32%
More than 180 days	CA-RN, PA	2	5%
Up to one year in 90-day increments	ID	1	2%
61-89 days	VI	1	2%
121-159 days		0	0%

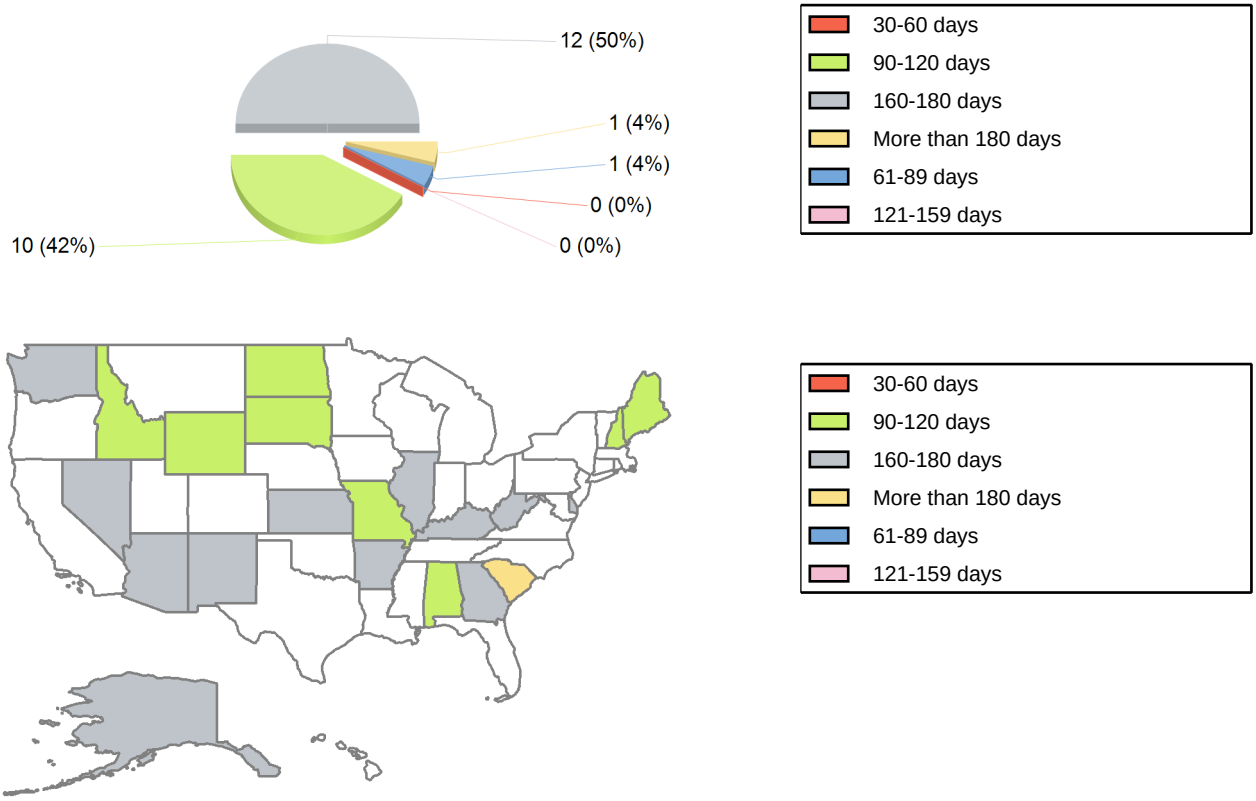
Q69. Are temporary practice permits available for applicants applying for APRN initial licensure?



*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AS, CA-RN, CNMI, CO, CT, FL, HI, IA, IN, LA-RN, MA, MD, MI, MN, MS, MT, NC, NE-APRN, NJ, NY, OH, OK, OR, PA, RI, TN, TX, UT, VA, VT	30	51%
Yes	AK, AL, AR, AZ, DC, DE, GA, GU, ID, IL, KS, KY, ME, MO, ND, NH, NM, NV, SC, SD, VI, WA, WV-RN, WY	24	41%
Do not regulate APRNs	CA-VN, LA-PN, NE, WI, WV-PN	5	8%

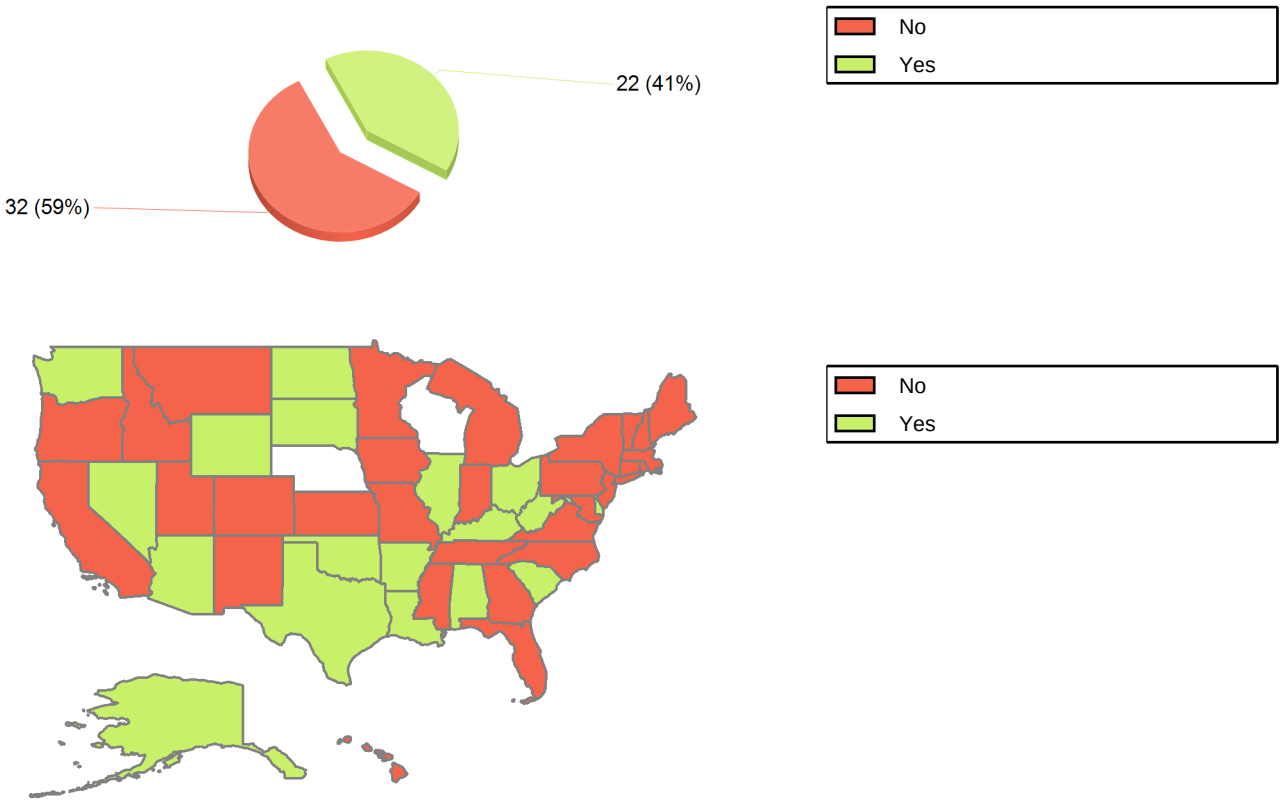
Q70. How long is the temporary practice permit valid for APRN initial licensure applicant?



*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
30-60 days		0	0%
90-120 days	AL, DC, GU, ID, ME, MO, ND, NH, SD, WY	10	42%
160-180 days	AK, AR, AZ, DE, GA, IL, KS, KY, NM, NV, WA, WV-RN	12	50%
More than 180 days	SC	1	4%
61-89 days	VI	1	4%
121-159 days		0	0%

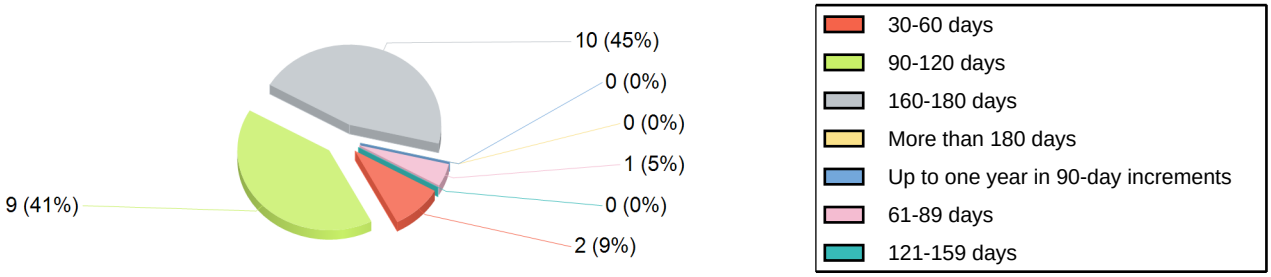
Q71. Are temporary practice permits available for applicants applying for APRN licensure by endorsement?

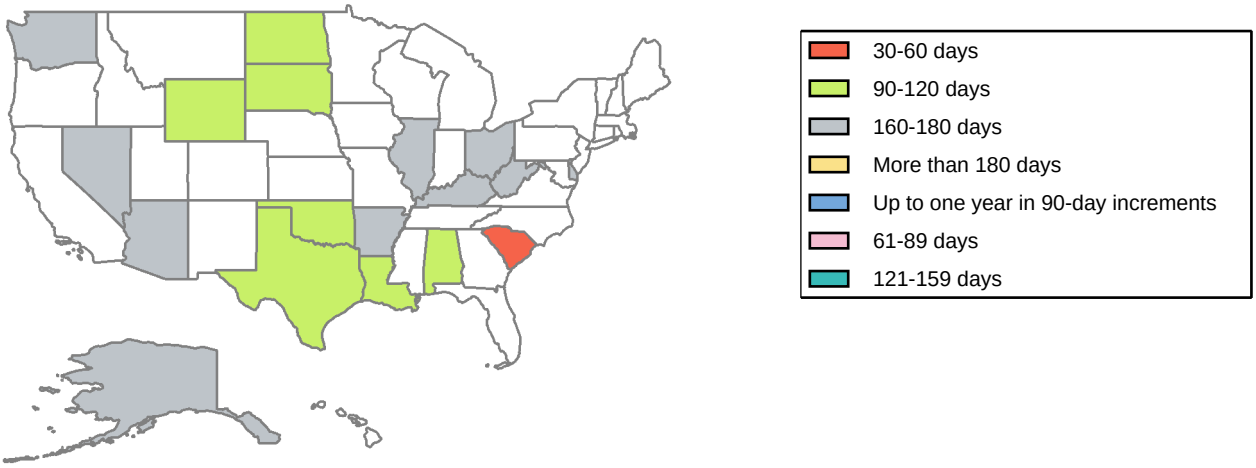


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AS, CA-RN, CO, CT, DC, FL, GA, HI, IA, ID, IN, KS, MA, MD, ME, MI, MN, MO, MS, MT, NC, NH, NJ, NM, NY, OR, PA, RI, TN, UT, VA, VT	32	59%
Yes	AK, AL, AR, AZ, CNMI, DE, GU, IL, KY, LA-RN, ND, NE-APRN, NV, OH, OK, SC, SD, TX, VI, WA, WV-RN, WY	22	41%

Q72. How long is the temporary practice permit valid for APRN licensure by endorsement applicants?

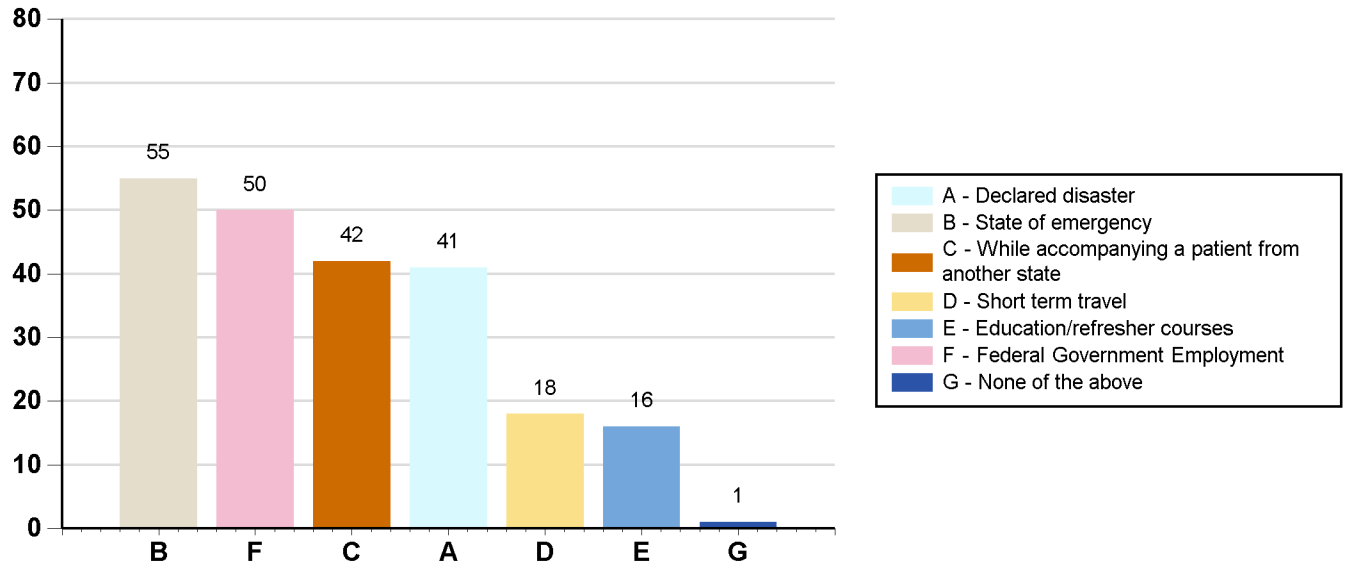




*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

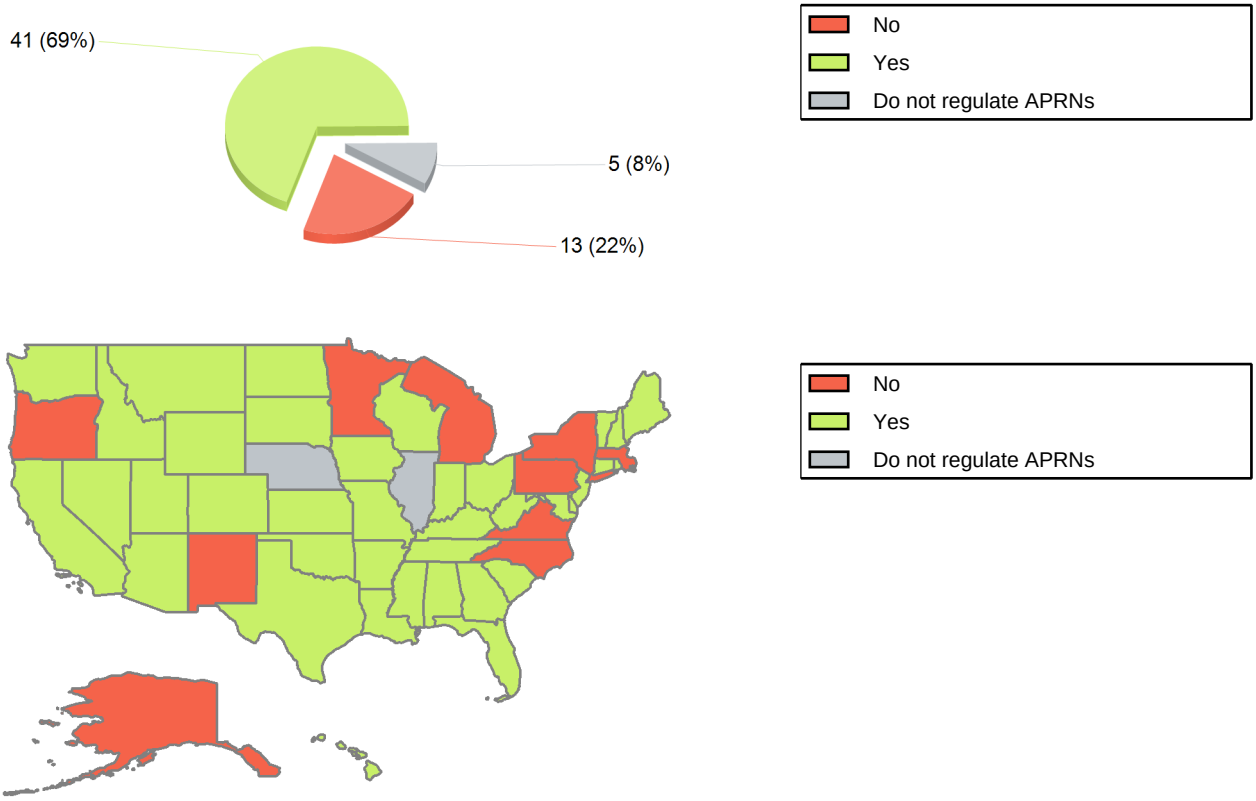
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
30-60 days	NE-APRN, SC	2	9%
90-120 days	AL, CNMI, GU, LA-RN, ND, OK, SD, TX, WY	9	41%
160-180 days	AK, AR, AZ, DE, IL, KY, NV, OH, WA, WV-RN	10	45%
More than 180 days		0	0%
Up to one year in 90-day increments		0	0%
61-89 days	VI	1	5%
121-159 days		0	0%

Q73. Are exemptions to licensure requirements allowed for nurses in any of the following situations? (Check all that apply.)



Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Declared disaster	AK, AL, AR, AS, AZ, CA-RN, CNMI, DC, DE, FL, GU, IA, ID, IL, KS, LA-PN, LA-RN, MD, MI, MN, MO, MS, MT, NC, ND, NJ, NY, OH, OK, OR, RI, SC, TN, TX, UT, VA, VI, VT, WA, WV-PN, WY	41	69%
State of emergency	AK, AL, AR, AS, AZ, CA-RN, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NE-APRN, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WV-PN, WY	55	93%
While accompanying a patient from another state	AK, AL, AR, AZ, CA-RN, CO, CT, DC, DE, FL, GA, IA, IL, LA-PN, LA-RN, MA, MD, ME, MN, MO, MS, MT, ND, NE, NH, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, WA, WI, WV-PN, WV-RN, WY	42	71%
Short term travel	AK, CT, DC, DE, IL, LA-PN, LA-RN, MD, ND, NE-APRN, OH, OK, TN, UT, VA, WI, WV-PN, WY	18	31%
Education/refresher courses	AL, CO, FL, IA, LA-PN, MI, MN, MT, ND, OH, OK, SD, TN, UT, WI, WY	16	27%
Federal Government Employment	AK, AL, AR, AZ, CA-RN, CO, DC, DE, FL, GA, GU, HI, IA, ID, IL, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NE-APRN, NH, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, WA, WI, WV-PN, WV-RN, WY	50	85%
None of the above	CA-VN	1	2%

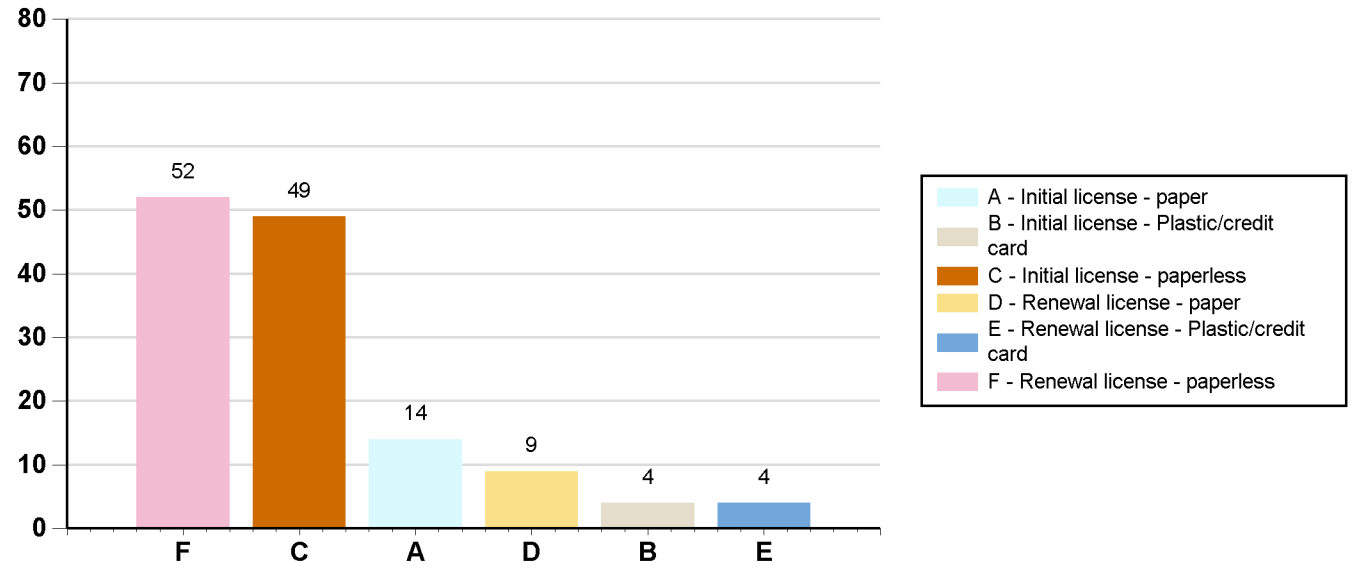
Q74. Is in-state or compact licensure required for graduate nursing clinical practicum within the jurisdiction?



*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

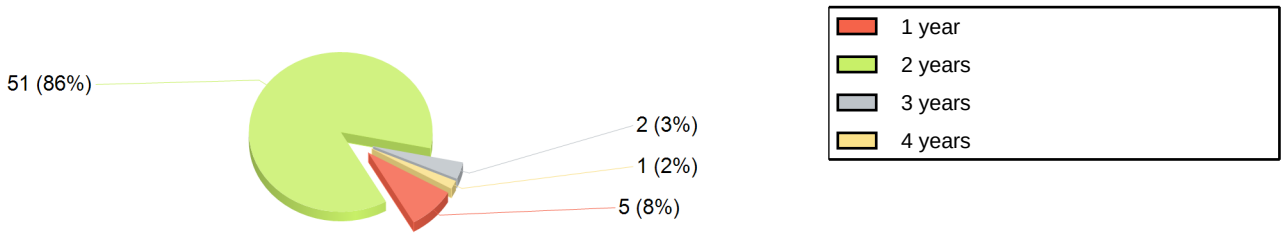
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AK, AS, GU, MA, MI, MN, NC, NM, NY, OR, PA, VA, VI	13	22%
Yes	AL, AR, AZ, CA-RN, CNMI, CO, CT, DC, DE, FL, GA, HI, IA, ID, IN, KS, KY, LA-RN, MD, ME, MO, MS, MT, ND, NE-APRN, NH, NJ, NV, OH, OK, RI, SC, SD, TN, TX, UT, VT, WA, WI, WV-RN, WY	41	69%
Do not regulate APRNs	CA-VN, IL, LA-PN, NE, WV-PN	5	8%

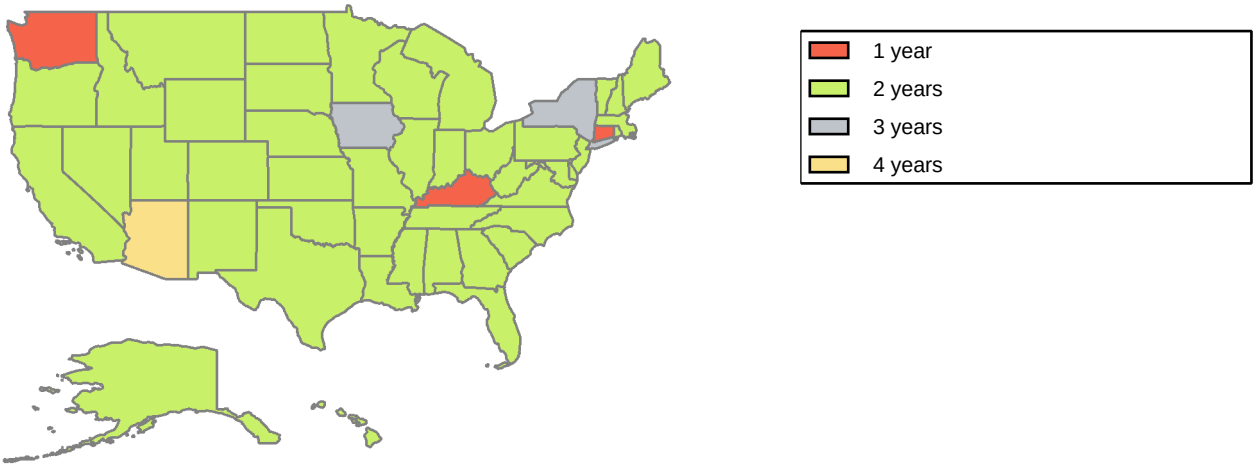
Q75. How does the Board of Nursing issue licenses? (Check all that apply.)



Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Initial license - paper	CA-VN, GA, MN, NE, NE-APRN, NJ, NY, PA, SD, TN, UT, VA, WA, WI	14	24%
Initial license - Plastic/credit card	AS, CNMI, GU, UT	4	7%
Initial license - paperless	AK, AL, AR, AZ, CA-RN, CA-VN, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NE-APRN, NH, NM, NV, NY, OH, OK, OR, RI, SC, TX, UT, VI, VT, WI, WV-PN, WV-RN, WY	49	83%
Renewal license - paper	CA-VN, GA, NJ, NY, PA, SD, TN, UT, WI	9	15%
Renewal license - Plastic/credit card	AS, CNMI, GU, UT	4	7%
Renewal license - paperless	AK, AL, AR, AZ, CA-RN, CA-VN, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NE-APRN, NH, NM, NV, NY, OH, OK, OR, RI, SC, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	52	88%

Q76. How long is a nursing license valid?

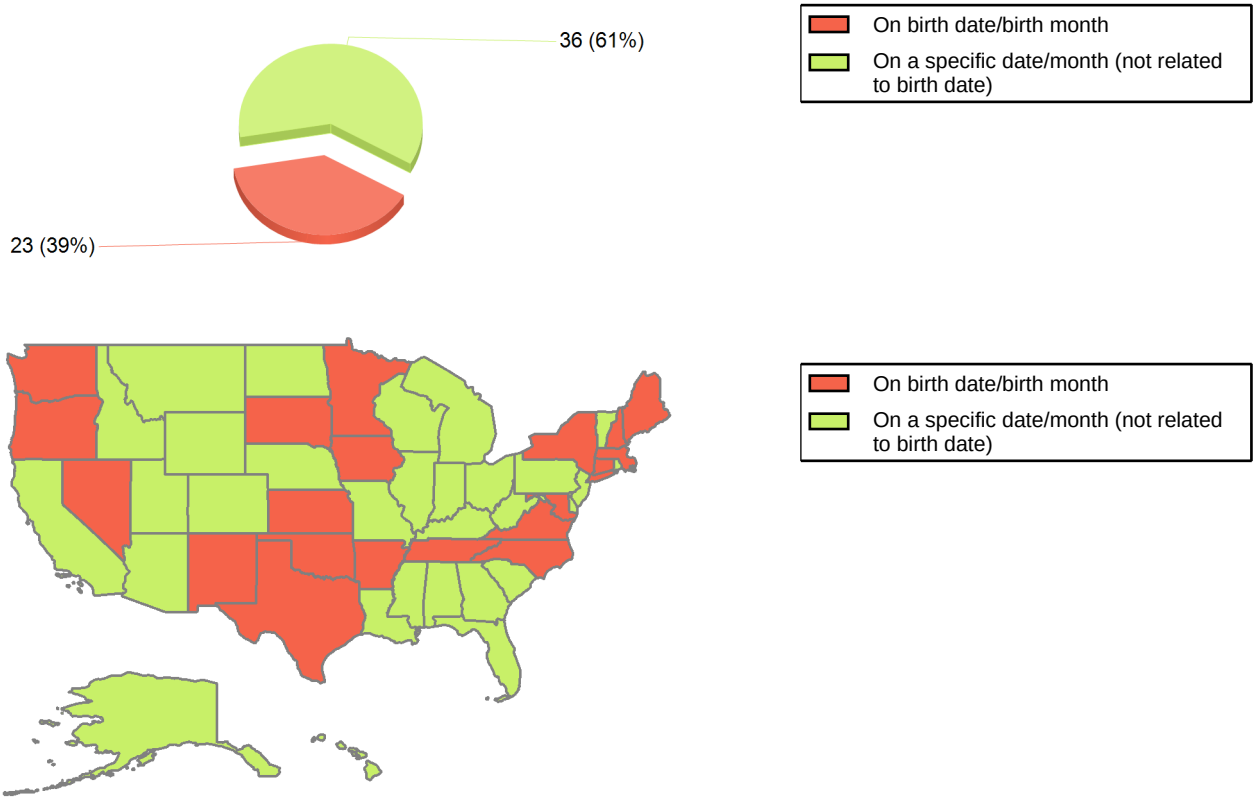




*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
1 year	CT, KY, LA-PN, WA, WV-PN	5	8%
2 years	AK, AL, AR, AS, CA-RN, CA-VN, CNMI, CO, DC, DE, FL, GA, GU, HI, ID, IL, IN, KS, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WI, WV-RN, WY	51	86%
3 years	IA, NY	2	3%
4 years	AZ	1	2%

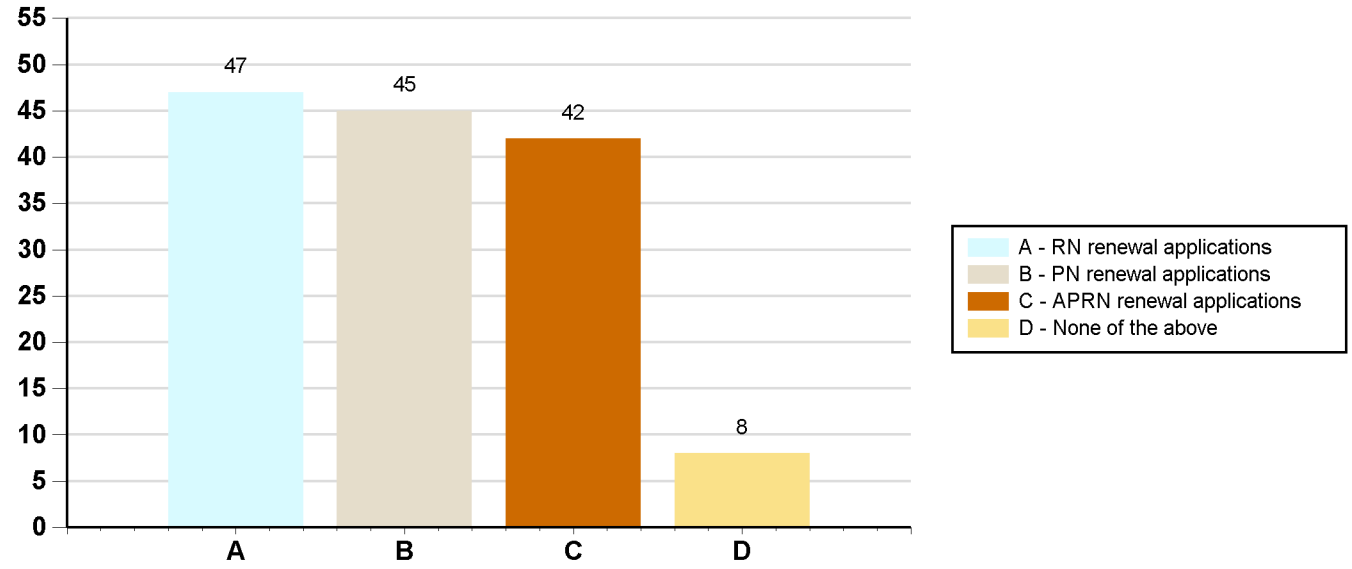
Q77. When are renewals processed?



*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

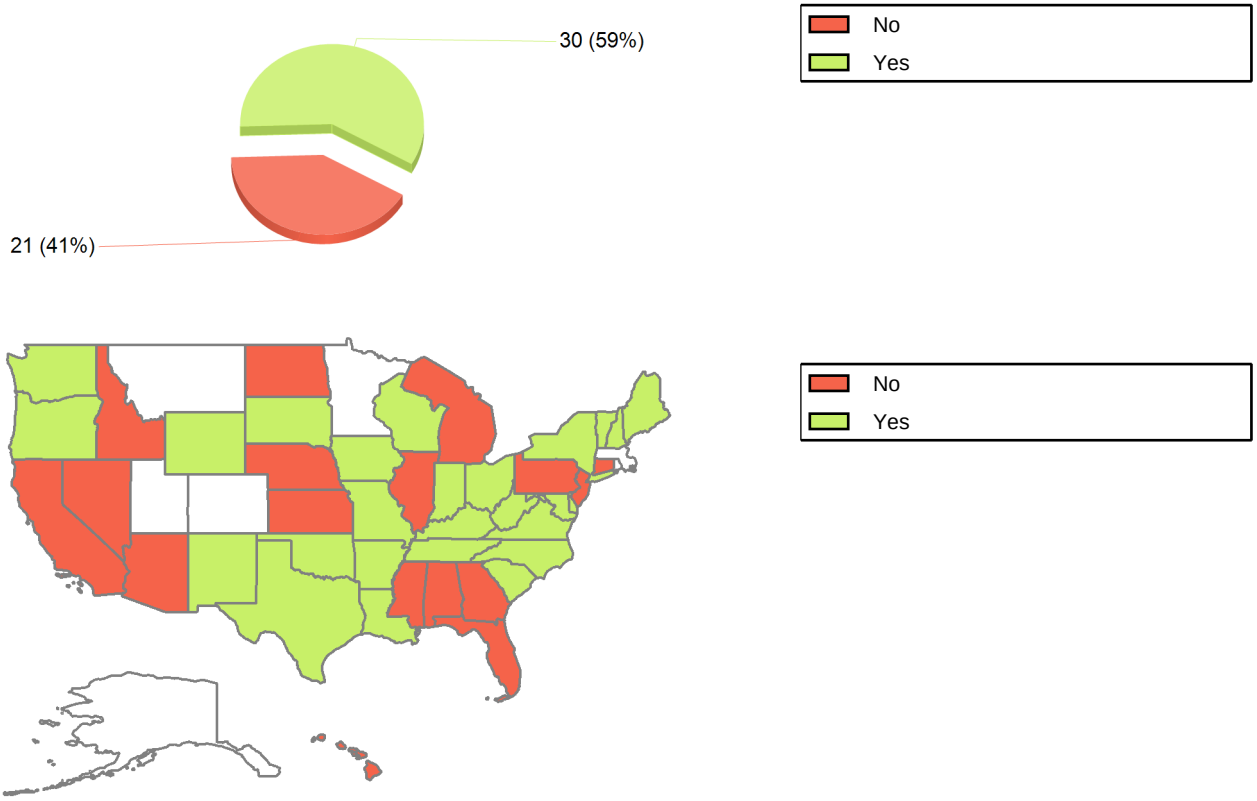
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
On birth date/birth month	AR, CA-VN, CNMI, CT, IA, KS, MA, MD, ME, MN, NC, NH, NM, NV, NY, OK, OR, SD, TN, TX, VA, VI, WA	23	39%
On a specific date/month (not related to birth date)	AK, AL, AS, AZ, CA-RN, CO, DC, DE, FL, GA, GU, HI, ID, IL, IN, KY, LA-PN, LA-RN, MI, MO, MS, MT, ND, NE, NE-APRN, NJ, OH, PA, RI, SC, UT, VT, WI, WV-PN, WV-RN, WY	36	61%

Q78. Do licensure renewal applications collect workforce data? (Check all that apply.)



Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
RN renewal applications	AL, AR, AZ, CA-RN, CNMI, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-RN, MD, ME, MI, MO, MS, NC, ND, NE, NE-APRN, NJ, NM, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, VA, VI, VT, WA, WI, WV-RN, WY	47	80%
PN renewal applications	AL, AR, AZ, CA-VN, CNMI, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, MD, ME, MI, MO, MS, NC, ND, NE, NE-APRN, NJ, NM, NV, OH, OK, PA, SC, SD, TN, TX, VA, VI, VT, WA, WI, WV-PN, WY	45	76%
APRN renewal applications	AL, AR, AZ, CA-RN, CNMI, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-RN, MD, ME, MI, MS, NC, ND, NH, NJ, NM, NV, NY, OH, OK, OR, SC, SD, TN, TX, VA, VI, VT, WA, WY	42	71%
None of the above	AK, AS, CO, MA, MN, MT, RI, UT	8	14%

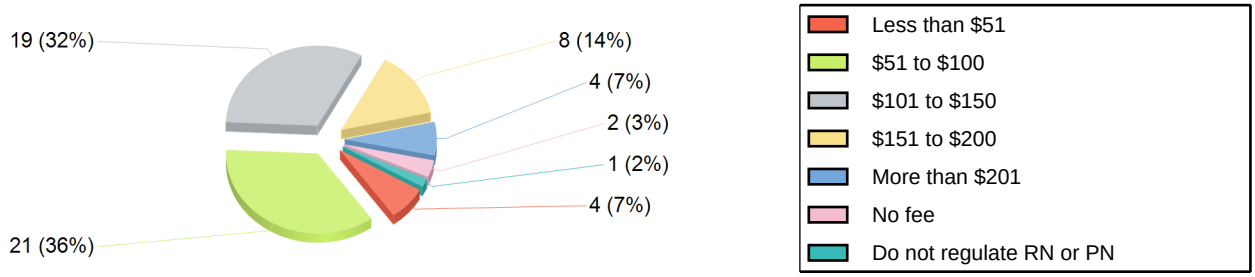
Q79. Is completion of workforce data questions mandatory for the licensure renewal process?

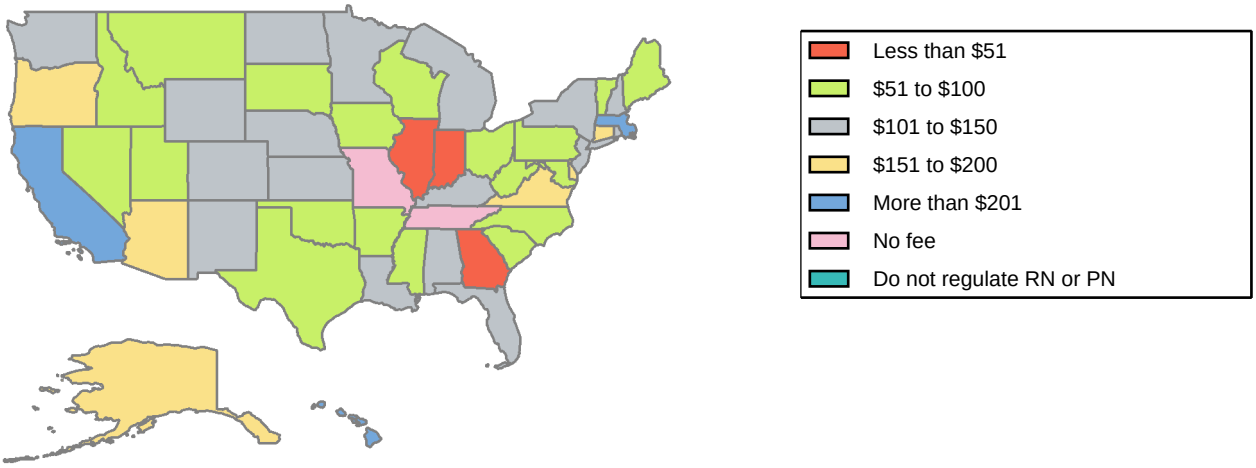


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AL, AZ, CA-RN, CA-VN, CNMI, CT, FL, GA, HI, ID, IL, KS, LA-PN, MI, MS, ND, NE, NE-APRN, NJ, NV, PA	21	41%
Yes	AR, DC, DE, GU, IA, IN, KY, LA-RN, MD, ME, MO, NC, NH, NM, NY, OH, OK, OR, SC, SD, TN, TX, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	30	59%

Q80. Which of the following amounts is closest to the RN/PN initial licensure by examination fee (including application fee if applicable, but not to include NCLEX or CBC fee)?

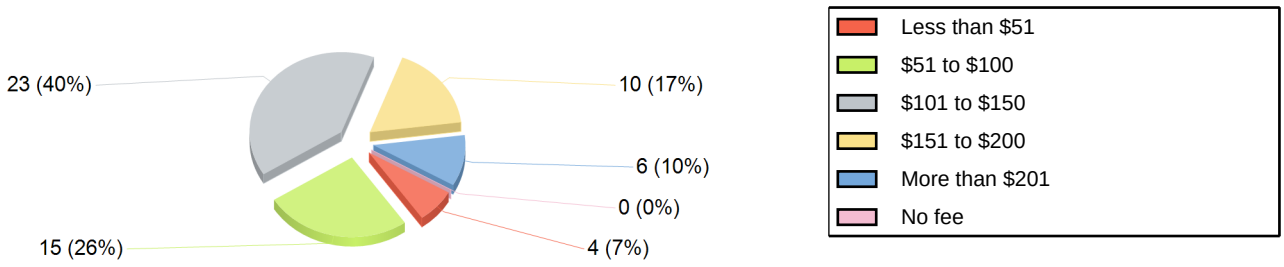


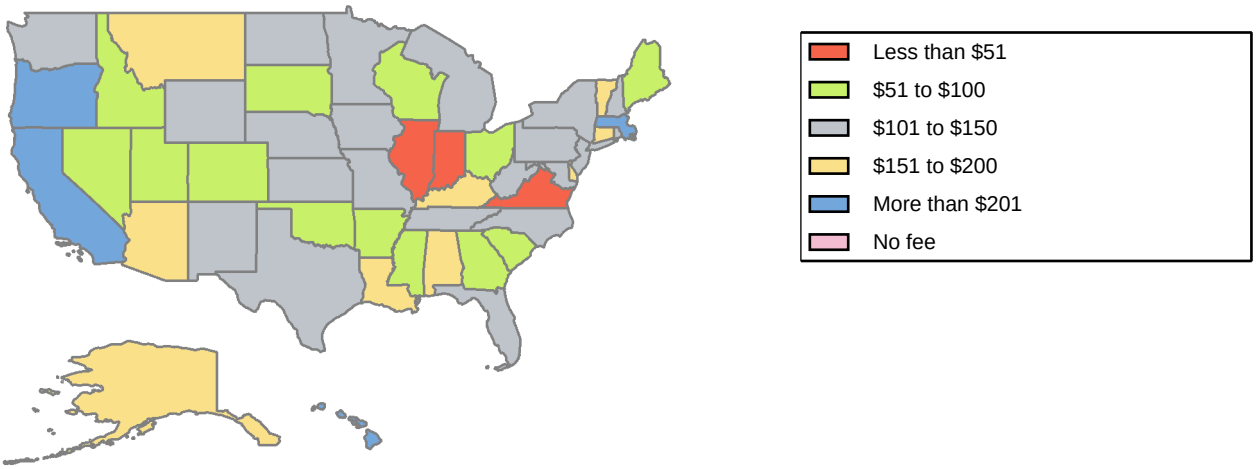


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Less than $51	AS, GA, IL, IN	4	7%
$51 to $100	AR, IA, ID, LA-PN, MD, ME, MS, MT, NC, NV, OH, OK, PA, SC, SD, TX, UT, VT, WI, WV-PN, WV-RN	21	36%
$101 to $150	AL, CO, FL, GU, KS, KY, LA-RN, MI, MN, ND, NE, NH, NJ, NM, NY, RI, VI, WA, WY	19	32%
$151 to $200	AK, AZ, CNMI, CT, DC, DE, OR, VA	8	14%
More than $201	CA-RN, CA-VN, HI, MA	4	7%
No fee	MO, TN	2	3%
Do not regulate RN or PN	NE-APRN	1	2%

Q81. Which of the following amounts is closest to the RN/PN initial licensure by endorsement fee (including application fee if applicable, but not to include CBC fee)?

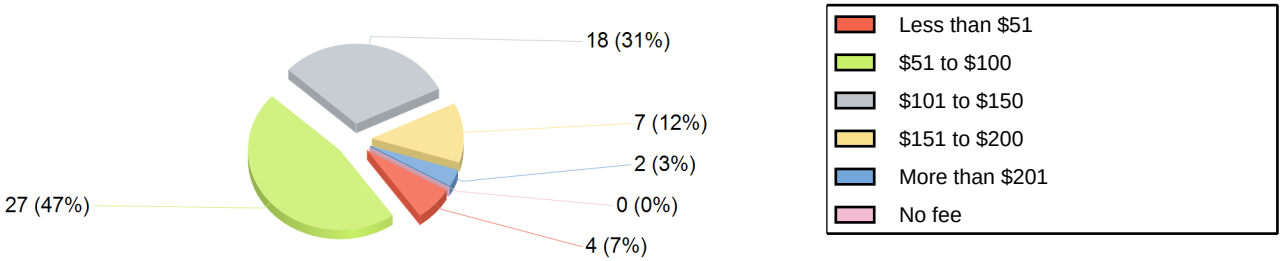


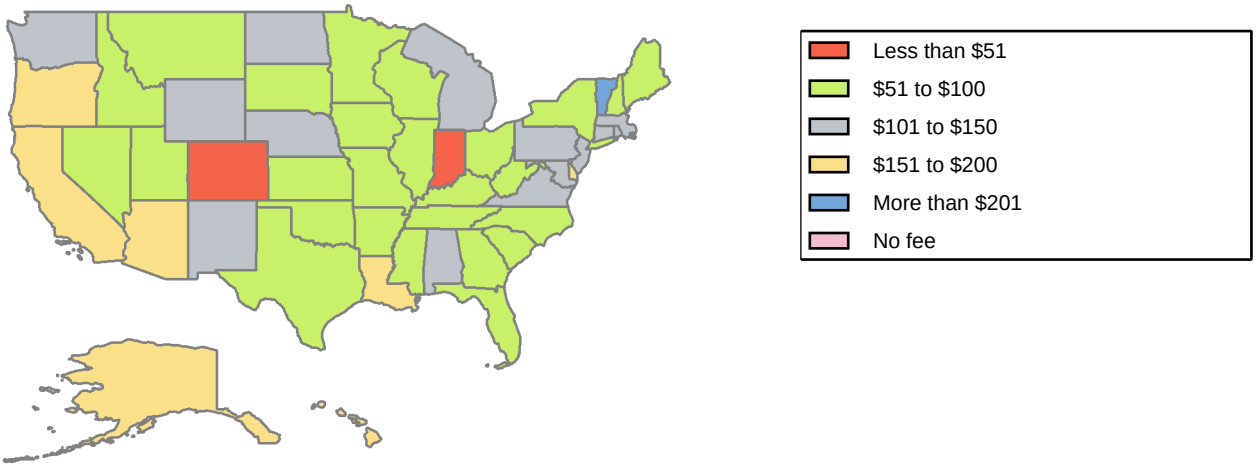


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Less than $51	AS, IL, IN, VA	4	7%
$51 to $100	AR, CO, GA, ID, LA-PN, ME, MS, NV, OH, OK, SC, SD, UT, WI, WV-PN	15	26%
$101 to $150	FL, GU, IA, KS, MD, MI, MN, MO, NC, ND, NE, NH, NJ, NM, NY, PA, RI, TN, TX, VI, WA, WV-RN, WY	23	40%
$151 to $200	AK, AL, AZ, CNMI, CT, DE, KY, LA-RN, MT, VT	10	17%
More than $201	CA-RN, CA-VN, DC, HI, MA, OR	6	10%
No fee		0	0%

Q82. Which of the following amounts is closest to the RN/PN renewal fee (not to include CBC fee)?

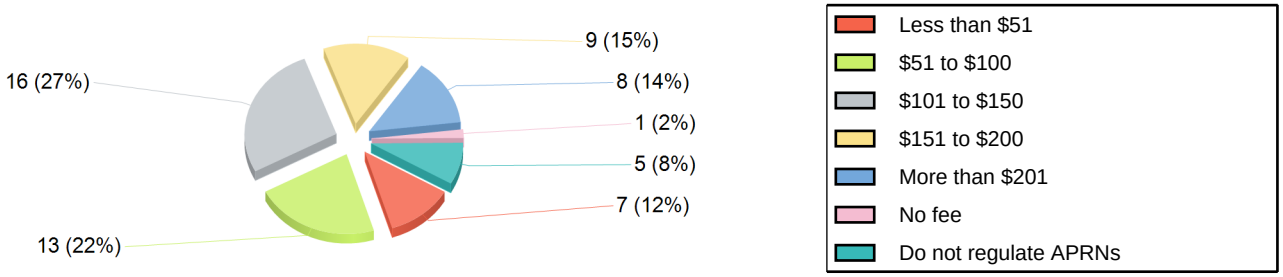


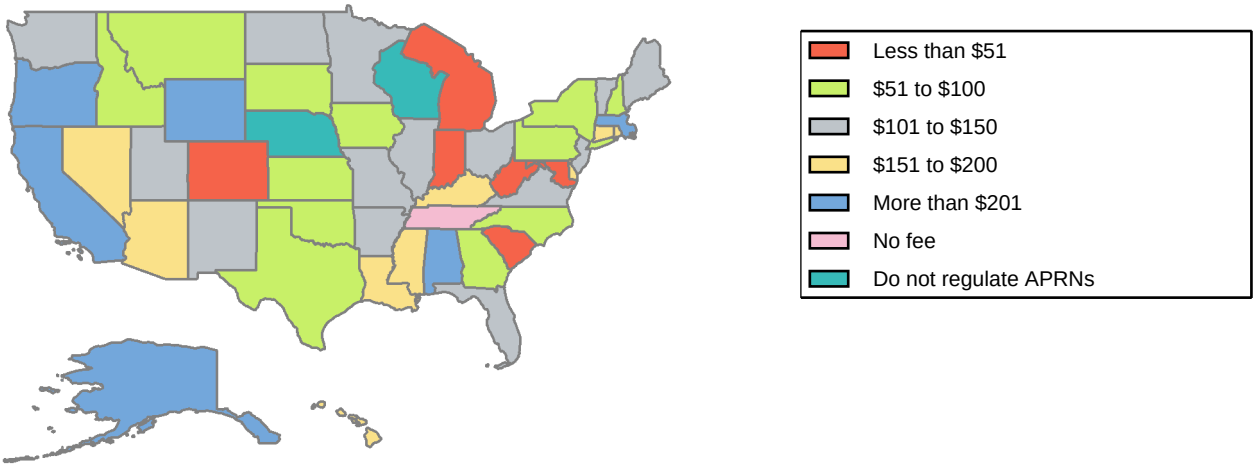


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Less than $51	AS, CO, IN, WV-PN	4	7%
$51 to $100	AR, FL, GA, IA, ID, IL, KS, KY, LA-PN, ME, MN, MO, MS, MT, NC, NH, NV, NY, OH, OK, SC, SD, TN, TX, UT, WI, WV-RN	27	47%
$101 to $150	AL, CNMI, CT, DC, GU, MA, MD, MI, ND, NE, NJ, NM, PA, RI, VA, VI, WA, WY	18	31%
$151 to $200	AK, AZ, CA-RN, DE, HI, LA-RN, OR	7	12%
More than $201	CA-VN, VT	2	3%
No fee		0	0%

Q83. Which of the following amounts is closest to the APRN initial licensure fee (including application fee if applicable, but not to include CBC fee)?

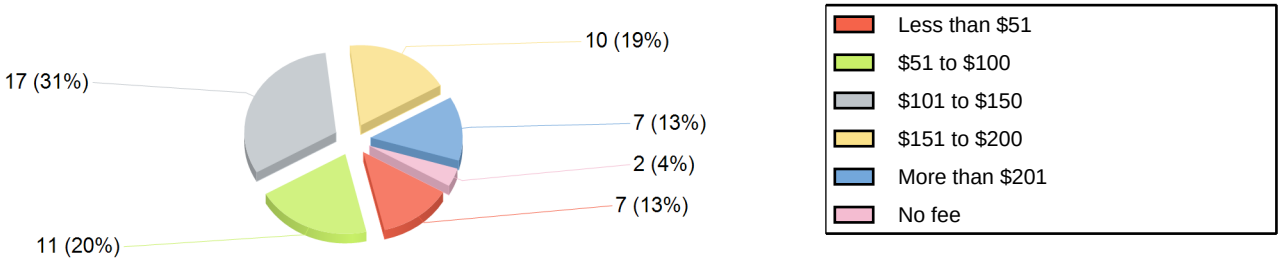


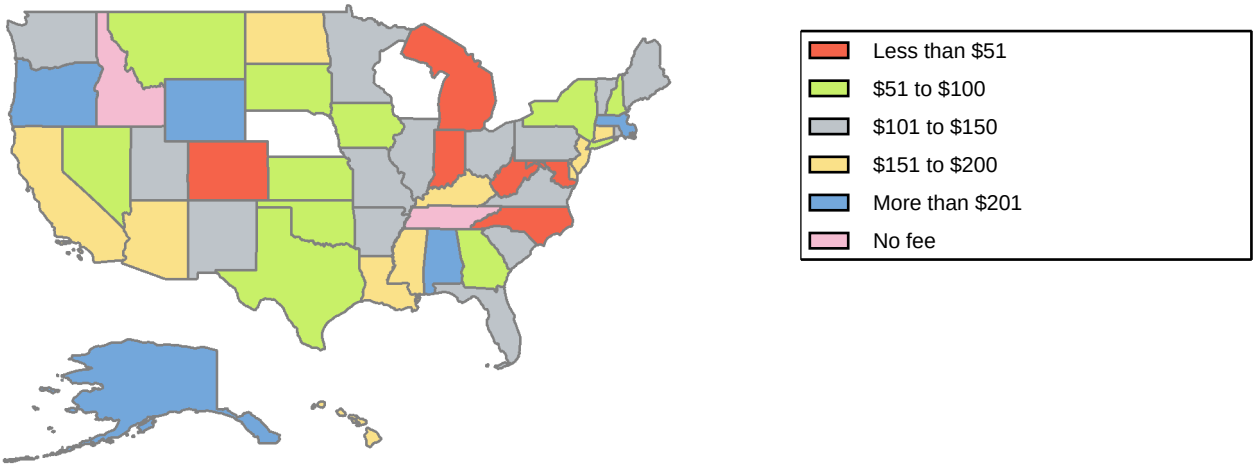


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Less than $51	CO, IN, MD, MI, NE-APRN, SC, WV-RN	7	12%
$51 to $100	AS, GA, IA, ID, KS, MT, NC, NH, NY, OK, PA, SD, TX	13	22%
$101 to $150	AR, FL, GU, IL, ME, MN, MO, ND, NJ, NM, OH, UT, VA, VI, VT, WA	16	27%
$151 to $200	AZ, CT, DE, HI, KY, LA-RN, MS, NV, RI	9	15%
More than $201	AK, AL, CA-RN, CNMI, DC, MA, OR, WY	8	14%
No fee	TN	1	2%
Do not regulate APRNs	CA-VN, LA-PN, NE, WI, WV-PN	5	8%

Q84. Which of the following amounts is closest to the APRN initial licensure by endorsement fee (including application fee if applicable, but not to include CBC fee)?

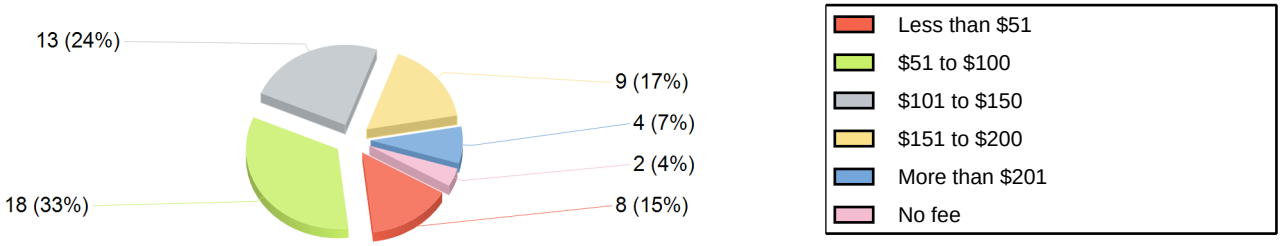


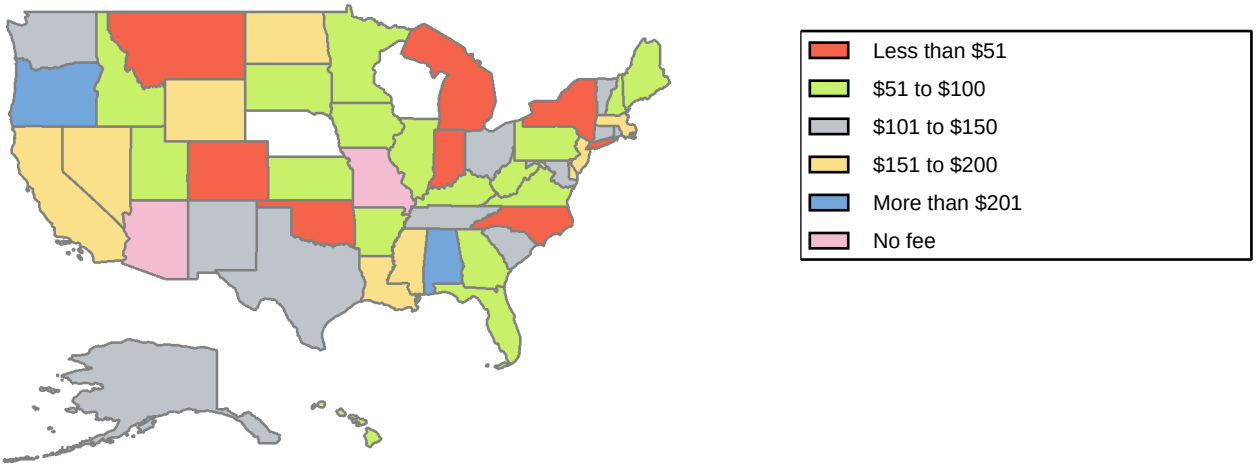


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Less than $51	CO, IN, MD, MI, NC, NE-APRN, WV-RN	7	13%
$51 to $100	AS, GA, IA, KS, MT, NH, NV, NY, OK, SD, TX	11	20%
$101 to $150	AR, FL, GU, IL, ME, MN, MO, NM, OH, PA, RI, SC, UT, VA, VI, VT, WA	17	31%
$151 to $200	AZ, CA-RN, CT, DE, HI, KY, LA-RN, MS, ND, NJ	10	19%
More than $201	AK, AL, CNMI, DC, MA, OR, WY	7	13%
No fee	ID, TN	2	4%

Q85. Which of the following amounts is closest to the APRN renewal fee?

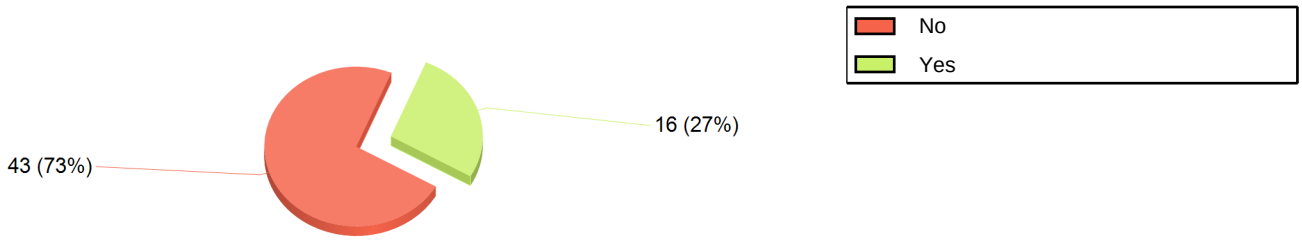


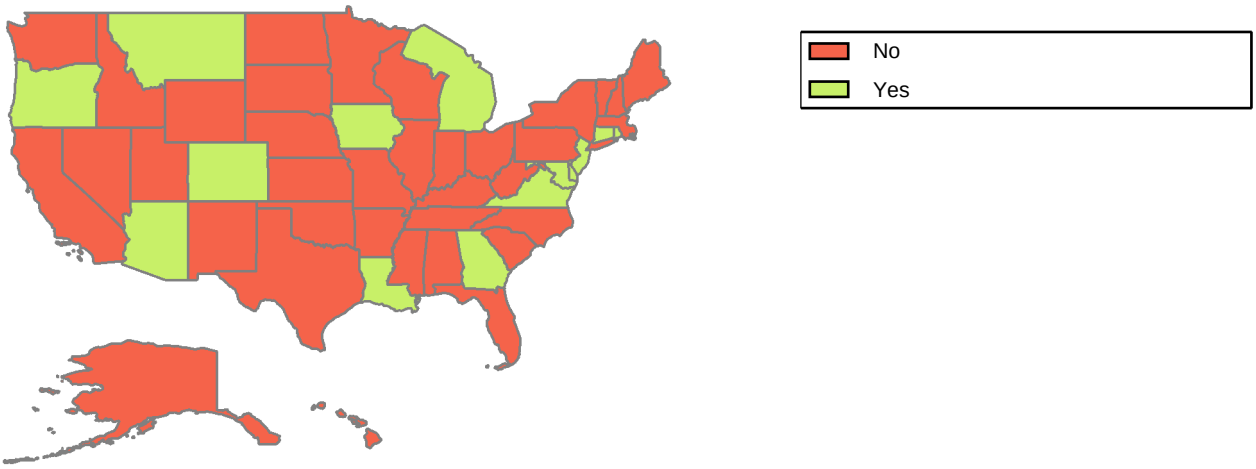


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Less than $51	CO, IN, MI, MT, NC, NE-APRN, NY, OK	8	15%
$51 to $100	AR, AS, FL, GA, HI, IA, ID, IL, KS, KY, ME, MN, NH, PA, SD, UT, VA, WV-RN	18	33%
$101 to $150	AK, CT, GU, MD, NM, OH, RI, SC, TN, TX, VI, VT, WA	13	24%
$151 to $200	CA-RN, DE, LA-RN, MA, MS, ND, NJ, NV, WY	9	17%
More than $201	AL, CNMI, DC, OR	4	7%
No fee	AZ, MO	2	4%

Q86. If not renewed on time, is there a grace period for renewal of license?

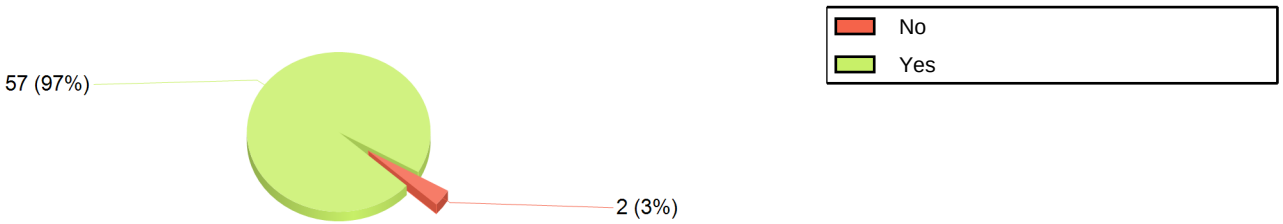


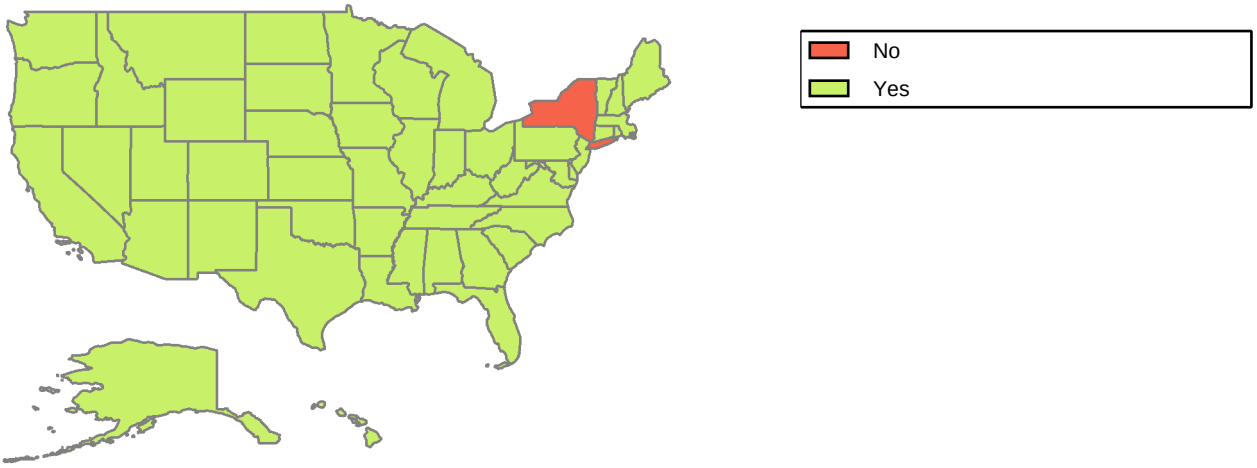


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AK, AL, AR, CA-RN, CA-VN, CNMI, FL, GU, HI, ID, IL, IN, KS, KY, LA-PN, MA, ME, MN, MO, MS, NC, ND, NE, NE-APRN, NH, NM, NV, NY, OH, OK, PA, SC, SD, TN, TX, UT, VI, VT, WA, WI, WV-PN, WV-RN, WY	43	73%
Yes	AS, AZ, CO, CT, DC, DE, GA, IA, LA-RN, MD, MI, MT, NJ, OR, RI, VA	16	27%

Q87. Does a license expire if not renewed on time?

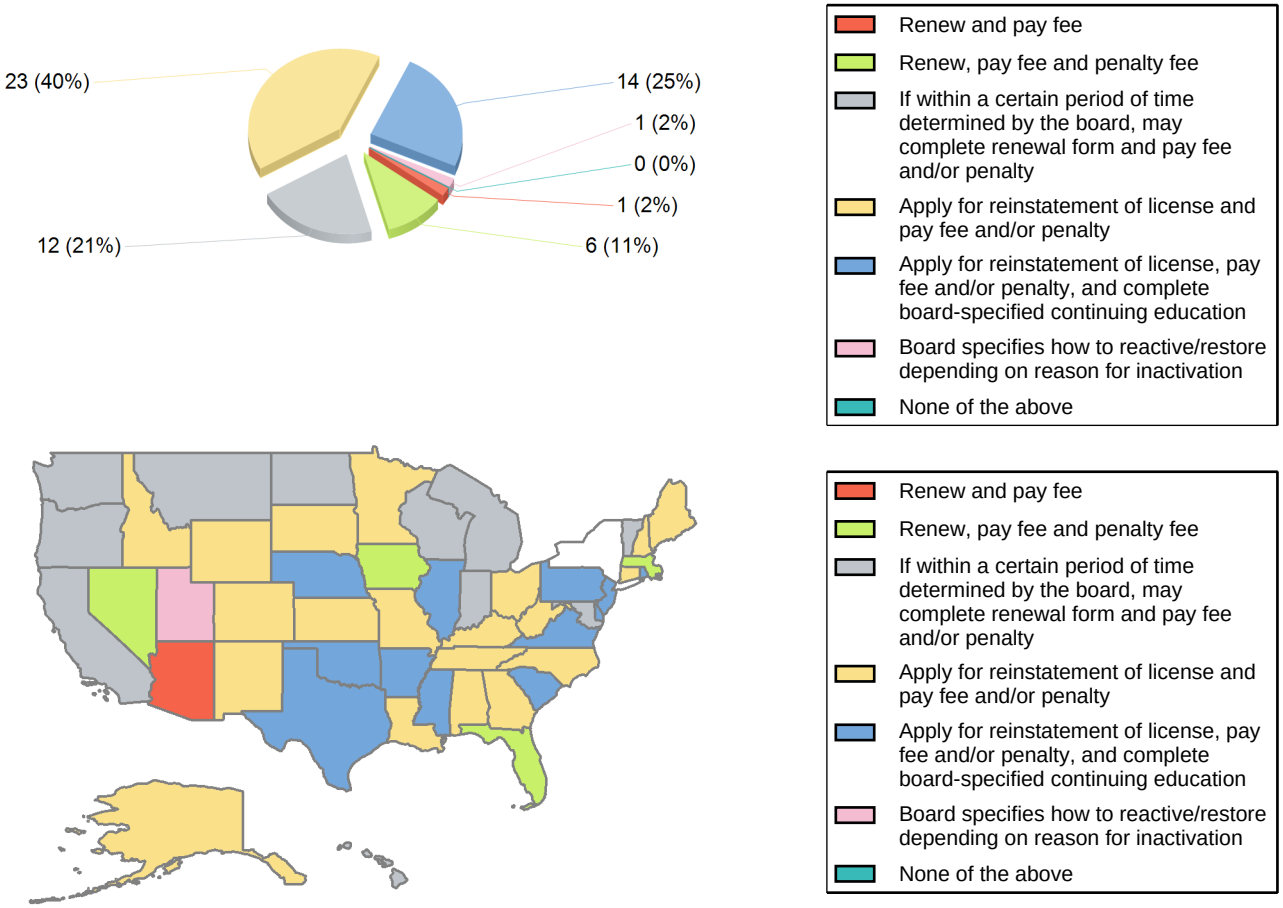




*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AS, NY	2	3%
Yes	AK, AL, AR, AZ, CA-RN, CA-VN, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	57	97%

Q88. How does the licensee reactivate/restore an expired license?

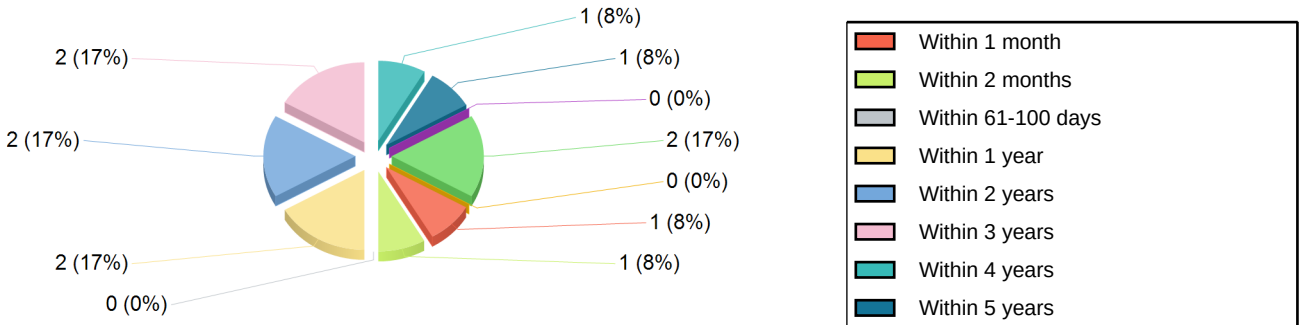


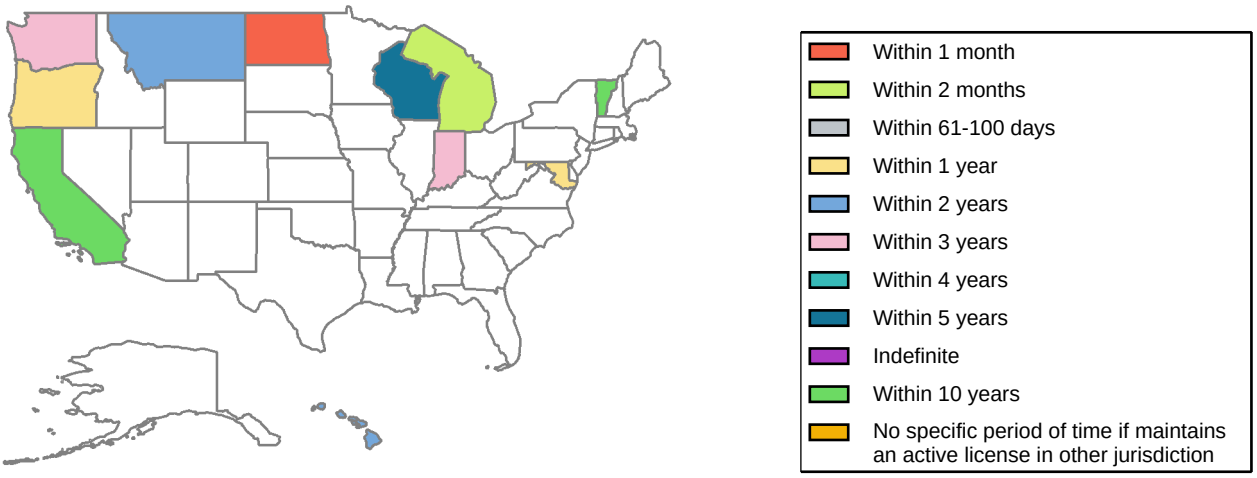
*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Renew and pay fee	AZ	1	2%
Renew, pay fee and penalty fee	CA-VN, FL, IA, MA, NV, VI	6	11%
If within a certain period of time determined by the board, may complete renewal form and pay fee and/or penalty	CA-RN, HI, IN, LA-PN, MD, MI, MT, ND, OR, VT, WA, WI	12	21%
Apply for reinstatement of license and pay fee and/or penalty	AK, AL, CO, CT, DC, GA, GU, ID, KS, KY, LA-RN, ME, MN, MO, NC, NE-APRN, NH, NM, OH, SD, TN, WV-RN, WY	23	40%

Apply for reinstatement of license, pay fee and/or penalty, and complete board-specified continuing education	AR, CNMI, DE, IL, MS, NE, NJ, OK, PA, RI, SC, TX, VA, WV-PN	14	25%
Board specifies how to reactive/restore depending on reason for inactivation	UT	1	2%
None of the above		0	0%

Q89. What is the certain period of time determined by the board, the licensee may complete renewal form and pay fee and/or penalty to reactivate/restore an expired license?

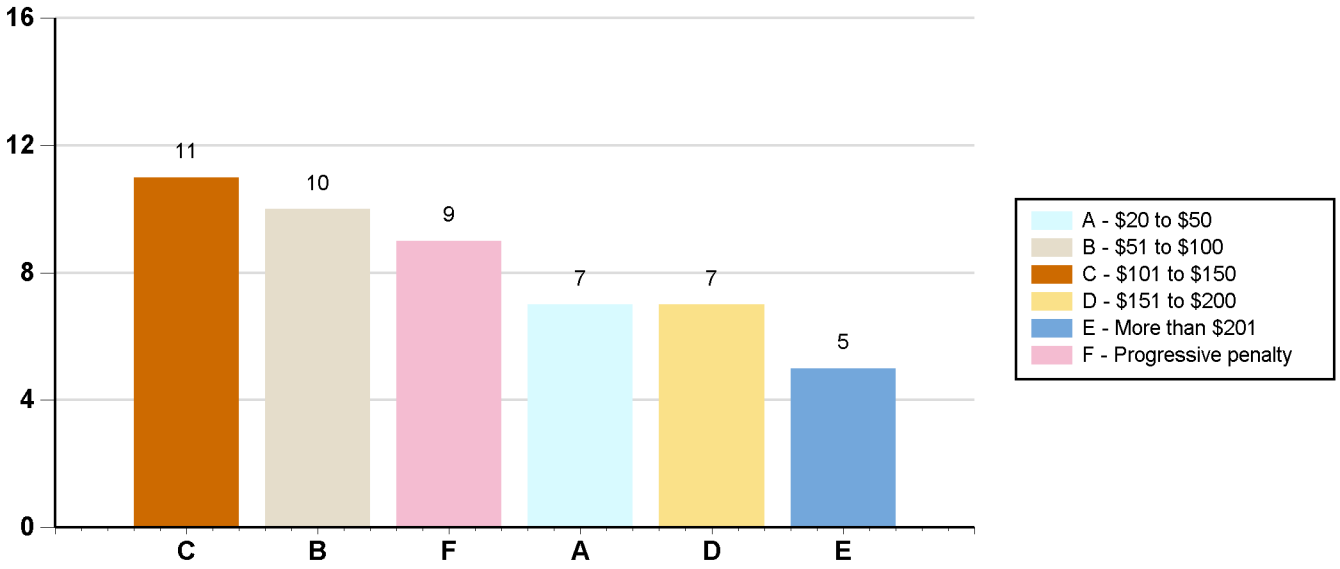




*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

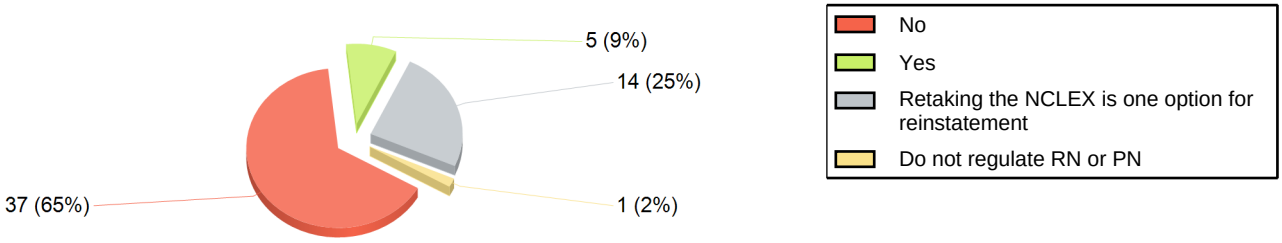
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Within 1 month	ND	1	8%
Within 2 months	MI	1	8%
Within 61-100 days		0	0%
Within 1 year	MD, OR	2	17%
Within 2 years	HI, MT	2	17%
Within 3 years	IN, WA	2	17%
Within 4 years	LA-PN	1	8%
Within 5 years	WI	1	8%
Indefinite		0	0%
Within 10 years	CA-RN, VT	2	17%
No specific period of time if maintains an active license in other jurisdiction		0	0%

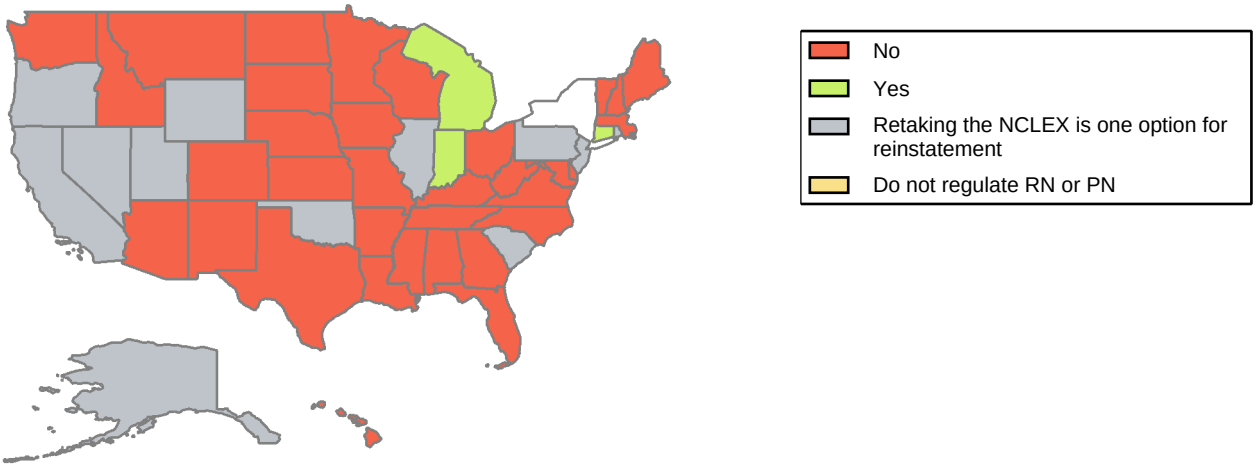
Q90. Which of the following amounts is closest to the license restoration or late renewal financial penalty? (Check all that apply)



Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
$20 to $50	CO, HI, LA-RN, MD, MO, WA, WI	7	17%
$51 to $100	CA-RN, FL, GA, GU, IN, MA, MT, NE-APRN, NV, OH	10	24%
$101 to $150	AL, DC, ID, KS, LA-PN, MI, MN, ND, VT, WV-RN, WY	11	26%
$151 to $200	AK, IA, LA-PN, NC, ND, NM, VI	7	17%
More than $201	CA-VN, KY, LA-PN, ME, VT	5	12%
Progressive penalty	AZ, CT, LA-PN, MN, NH, OR, SD, TN, VT	9	21%

Q91. Is there a requirement to retake the NCLEX if a RN or PN license has been expired for a certain period of time in order to reinstate/reactivate the license?

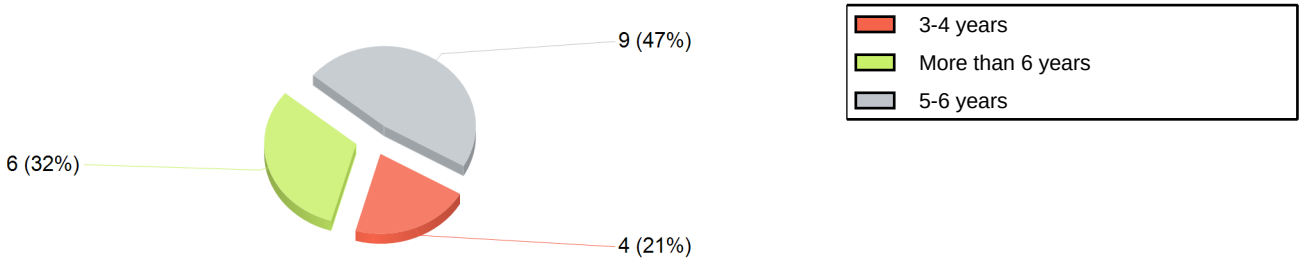


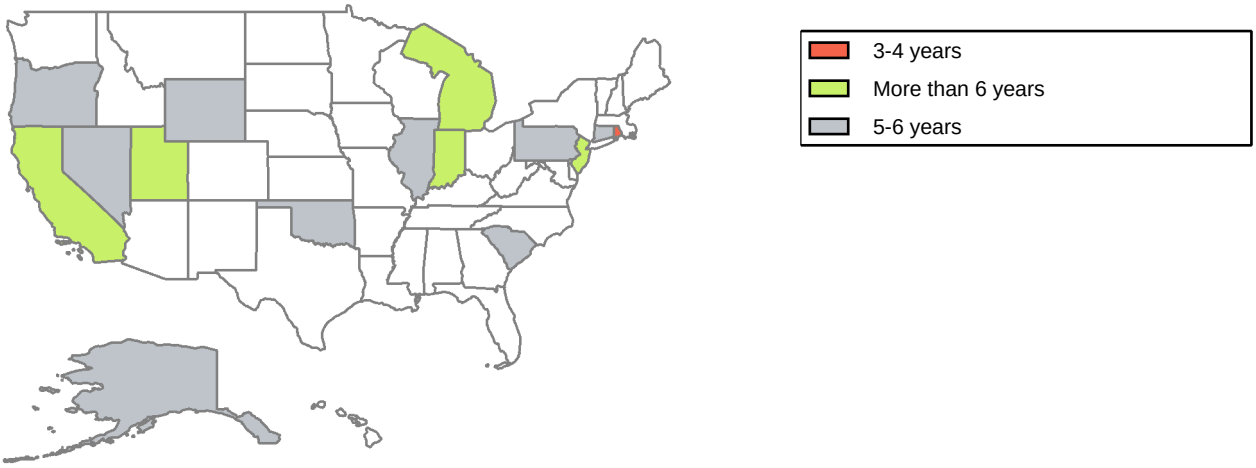


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AL, AR, AZ, CO, DC, DE, FL, GA, GU, HI, IA, ID, KS, KY, LA-PN, LA-RN, MA, MD, ME, MN, MO, MS, MT, NC, ND, NE, NH, NM, OH, SD, TN, TX, VA, VT, WA, WI, WV-RN	37	65%
Yes	CA-VN, CT, IN, MI, VI	5	9%
Retaking the NCLEX is one option for reinstatement	AK, CA-RN, CNMI, IL, NJ, NV, OK, OR, PA, RI, SC, UT, WV-PN, WY	14	25%
Do not regulate RN or PN	NE-APRN	1	2%

Q92. What is the time period expired for which retaking the NCLEX is an option to reinstate the license?

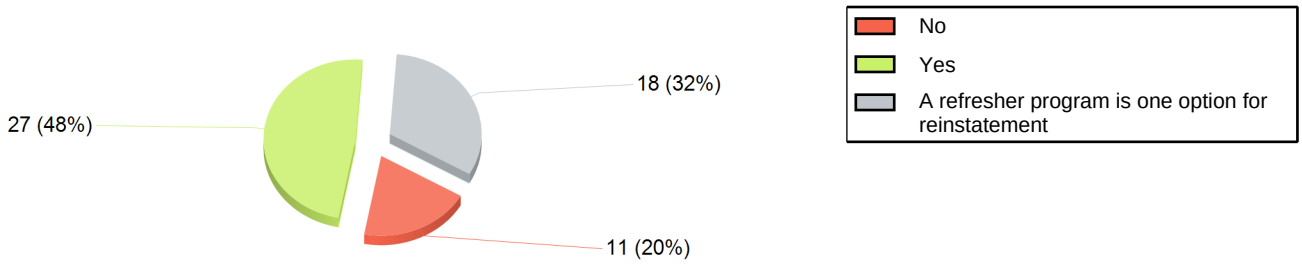


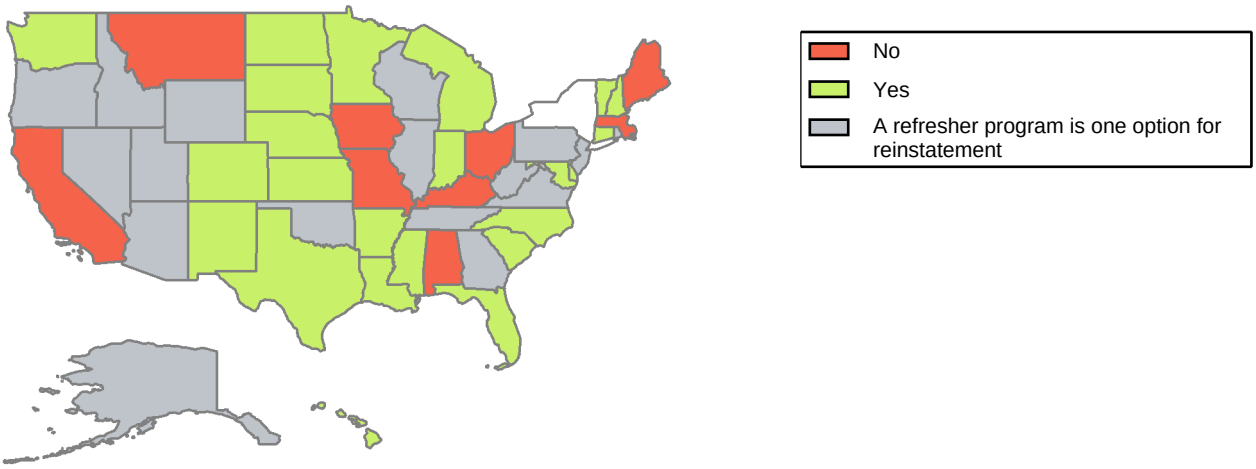


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
3-4 years	CA-VN, CNMI, RI, WV-PN	4	21%
More than 6 years	CA-RN, IN, MI, NJ, UT, VI	6	32%
5-6 years	AK, CT, IL, NV, OK, OR, PA, SC, WY	9	47%

Q93. Is there a requirement to take an approved refresher program if a RN or PN license has been expired for a certain period of time in order to reinstate the license?

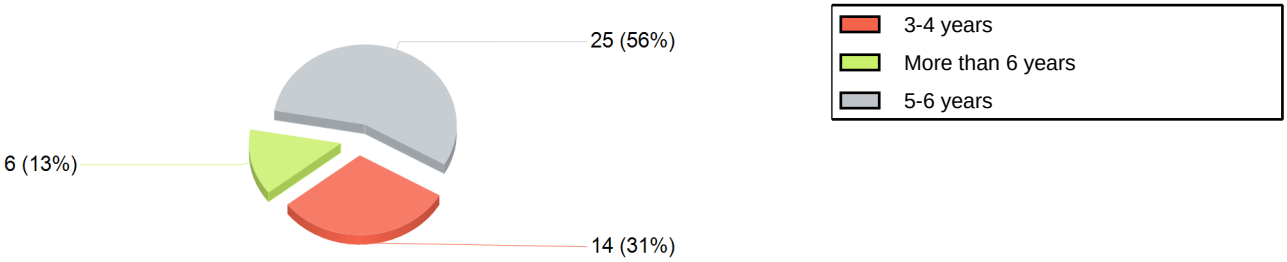


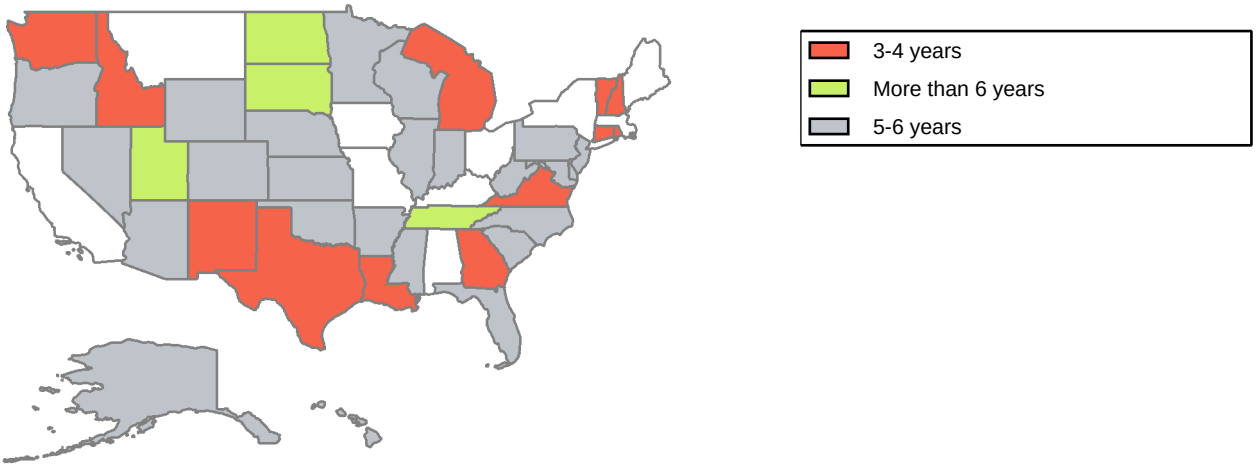


*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
No	AL, CA-RN, CA-VN, CNMI, IA, KY, MA, ME, MO, MT, OH	11	20%
Yes	AR, CO, CT, DC, DE, FL, GU, HI, IN, KS, LA-PN, LA-RN, MD, MI, MN, MS, NC, ND, NE, NH, NM, SC, SD, TX, VI, VT, WA	27	48%
A refresher program is one option for reinstatement	AK, AZ, GA, ID, IL, NJ, NV, OK, OR, PA, RI, TN, UT, VA, WI, WV-PN, WV-RN, WY	18	32%

Q94. What is the time period expired for which taking an approved refresher course is an option to reinstate the license?

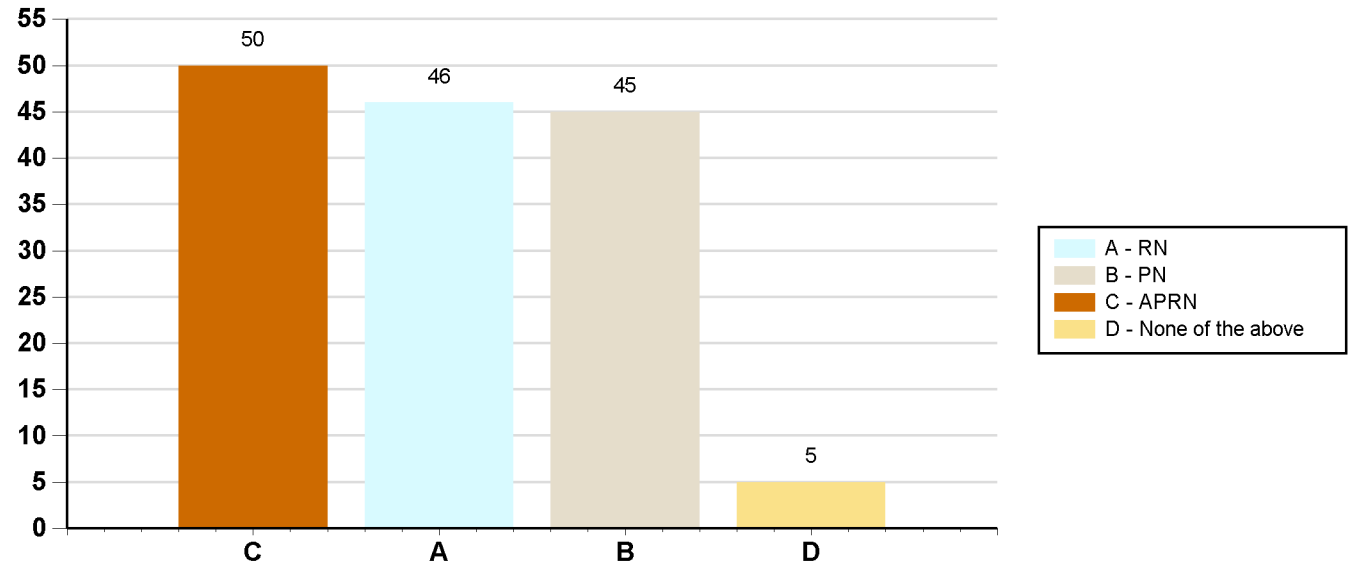




*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

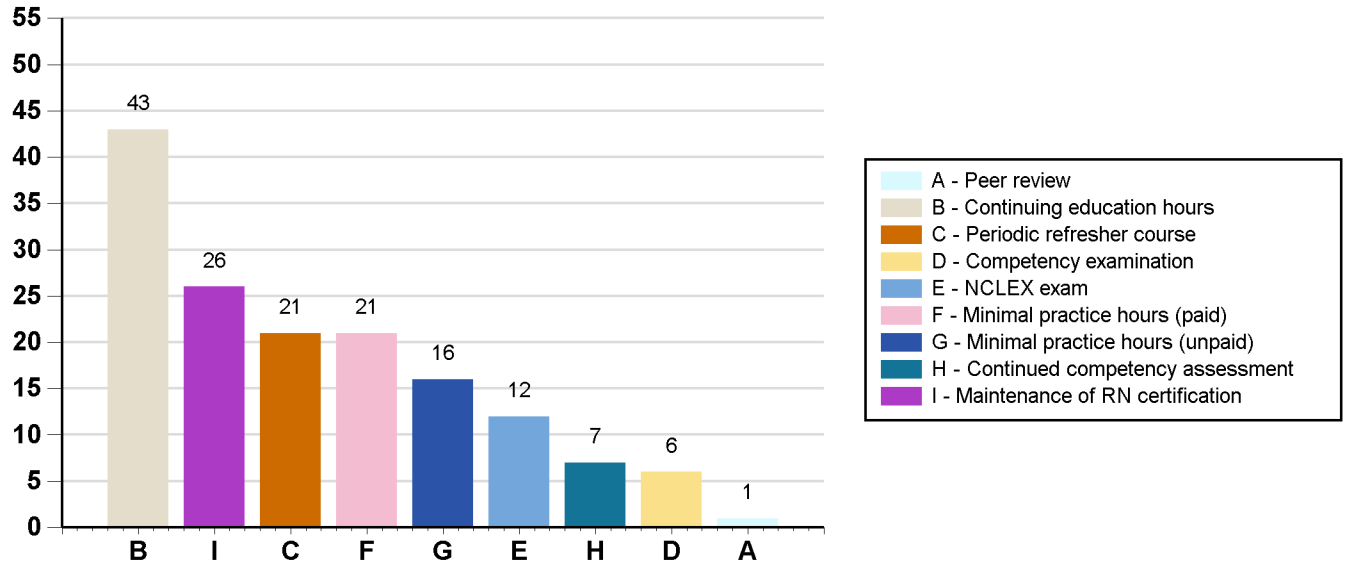
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
3-4 years	CT, GA, ID, LA-PN, LA-RN, MI, NH, NM, RI, TX, VA, VT, WA, WV-PN	14	31%
More than 6 years	GU, ND, SD, TN, UT, VI	6	13%
5-6 years	AK, AR, AZ, CO, DC, DE, FL, HI, IL, IN, KS, MD, MN, MS, NC, NE, NJ, NV, OK, OR, PA, SC, WI, WV-RN, WY	25	56%

Q95 Which professions require continued competency for renewal of license? (Check all that apply.)



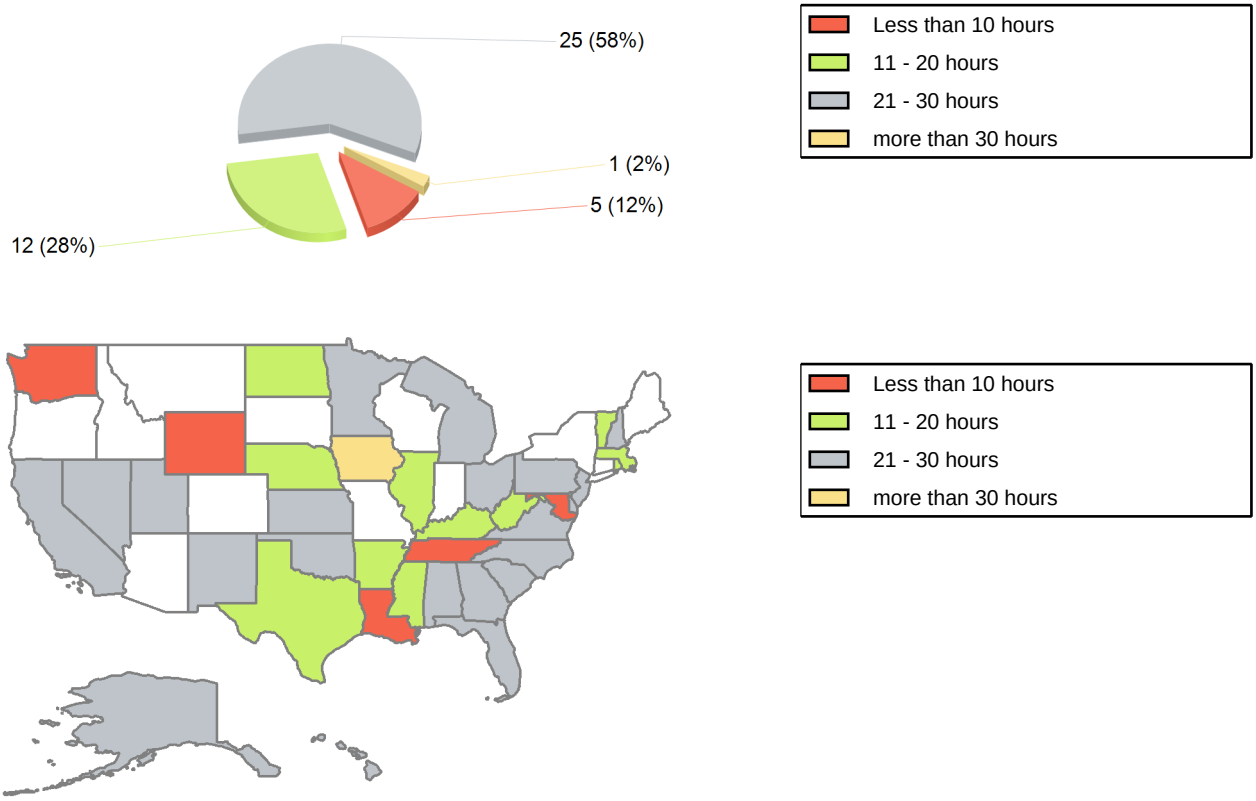
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
RN	AK, AL, AR, AS, AZ, CA-RN, CNMI, DC, DE, FL, GA, GU, HI, IA, IL, KS, KY, LA-RN, MA, MD, MI, MN, MS, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WV-RN, WY	46	78%
PN	AK, AL, AR, AS, AZ, CA-VN, CNMI, DC, DE, FL, GA, GU, HI, IA, IL, KS, KY, MA, MD, MI, MN, MS, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WV-PN, WY	45	76%
APRN	AK, AL, AR, AS, AZ, CNMI, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-RN, MA, MD, ME, MI, MN, MO, MS, NC, ND, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WV-RN, WY	50	85%
None of the above	CO, LA-PN, MT, NY, WI	5	8%

Q96. Which of the following methods can be used to meet continued competency requirements for RNs? (Check all that apply)



Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Peer review	TN	1	2%
Continuing education hours	AK, AL, AR, AS, CA-RN, CNMI, DC, DE, FL, GA, GU, HI, IA, IL, KS, KY, LA-RN, MA, MD, MI, MN, MS, NC, ND, NE, NH, NJ, NM, NV, OH, OK, PA, RI, SC, TN, TX, UT, VA, VI, VT, WA, WV-RN, WY	43	93%
Periodic refresher course	AK, AZ, CNMI, DC, GA, GU, IA, LA-RN, MI, MS, NC, ND, NE, NH, NV, OK, SC, TN, VA, WA, WY	21	46%
Competency examination	AK, AZ, GU, KY, LA-RN, TN	6	13%
NCLEX exam	AK, CNMI, GU, HI, ND, NV, OK, PA, SC, TN, VI, WY	12	26%
Minimal practice hours (paid)	AK, AZ, DE, GA, LA-RN, MD, NC, ND, NE, NH, NV, OK, OR, SD, TN, UT, VA, VI, VT, WA, WY	21	46%
Minimal practice hours (unpaid)	AK, AZ, DE, NC, ND, NH, NV, OR, SD, TN, UT, VA, VI, VT, WA, WY	16	35%
Continued competency assessment	AZ, GU, KY, LA-RN, MI, SC, TN	7	15%
Maintenance of RN certification	AK, AR, CNMI, DC, FL, GA, GU, HI, IA, KY, LA-RN, MD, MS, NE, NH, NM, OK, SC, TN, TX, VA, VI, VT, WA, WV-RN, WY	26	57%

Q97. How many continuing education hours are required for RNs?



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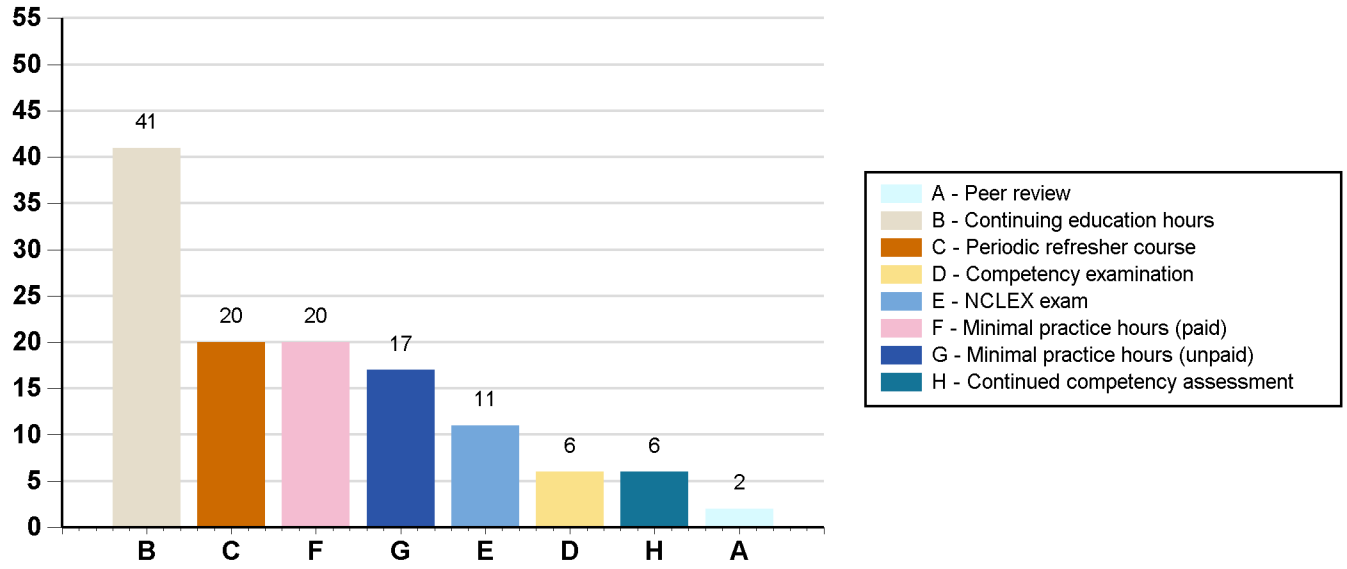
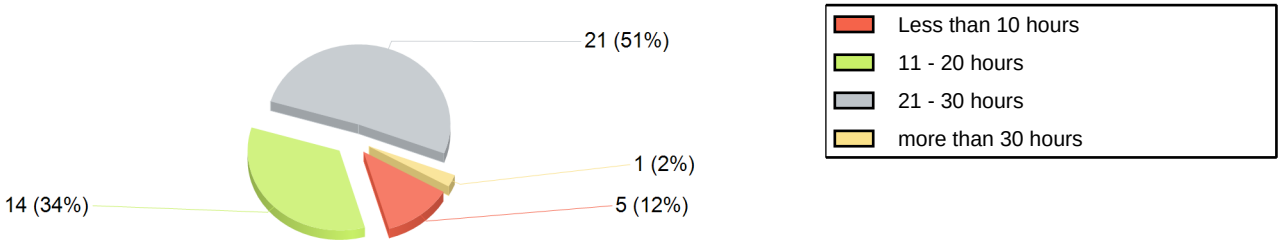
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Less than 10 hours	LA-RN, MD, TN, WA, WY	5	12%
11 - 20 hours	AR, IL, KY, MA, MS, ND, NE, RI, TX, VI, VT, WV-RN	12	28%
21 - 30 hours	AK, AL, AS, CA-RN, CNMI, DC, DE, FL, GA, GU, HI, KS, MI, MN, NC, NH, NJ, NM, NV, OH, OK, PA, SC, UT, VA	25	58%
more than 30 hours	IA	1	2%

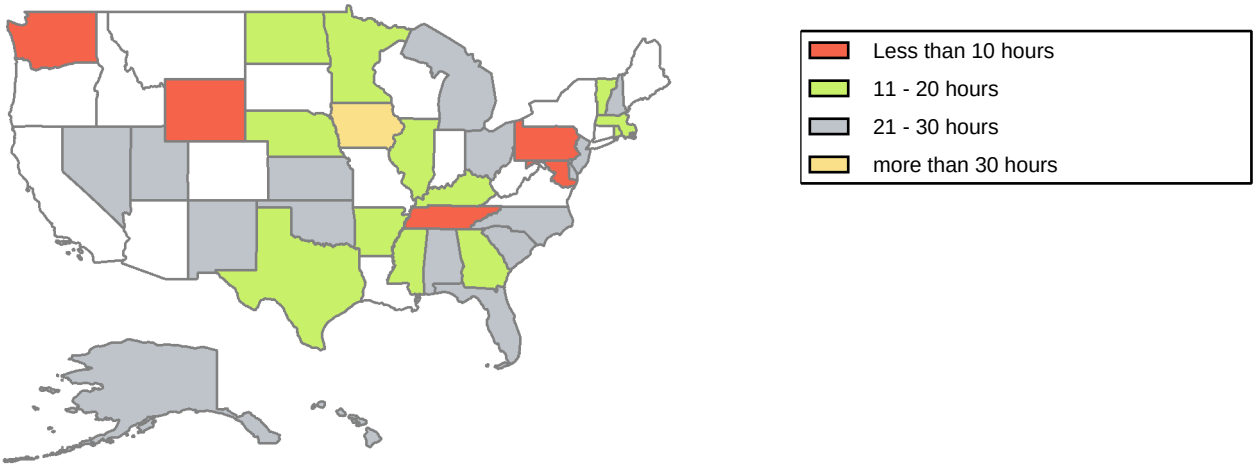
Q98. Which of the following methods can be used to meet continued competency requirements for PNs? (Check all that apply)



Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Peer review	AL, TN	2	4%
Continuing education hours	AK, AL, AR, AS, CA-VN, CNMI, DC, DE, FL, GA, GU, HI, IA, IL, KS, KY, MA, MD, MI, MN, MS, NC, ND, NE, NH, NJ, NM, NV, OH, OK, PA, RI, SC, TN, TX, UT, VI, VT, WA, WV-PN, WY	41	91%
Periodic refresher course	AK, AL, AZ, CNMI, DC, GU, IA, MI, MS, NC, ND, NE, NH, NV, OK, SC, TN, VA, WA, WY	20	44%
Competency examination	AK, AL, AZ, GU, KY, TN	6	13%
NCLEX exam	AK, CNMI, GU, HI, ND, NV, OK, PA, SC, TN, WY	11	24%
Minimal practice hours (paid)	AK, AZ, DE, MD, NC, ND, NE, NH, NV, OK, OR, SD, TN, UT, VA, VI, VT, WA, WV-PN, WY	20	44%
Minimal practice hours (unpaid)	AK, AZ, DE, NC, ND, NH, NV, OR, SD, TN, UT, VA, VI, VT, WA, WV-PN, WY	17	38%
Continued competency assessment	AZ, GU, KY, MS, SC, TN	6	13%

Q99. How many continuing education hours are required for PNs?

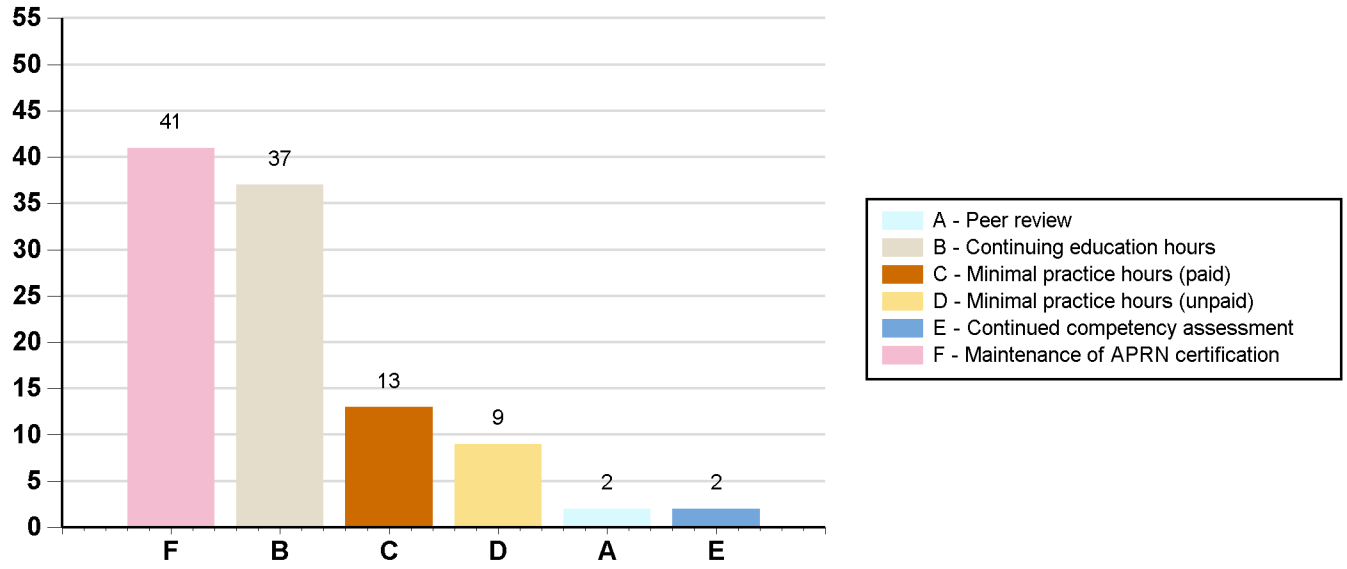




*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

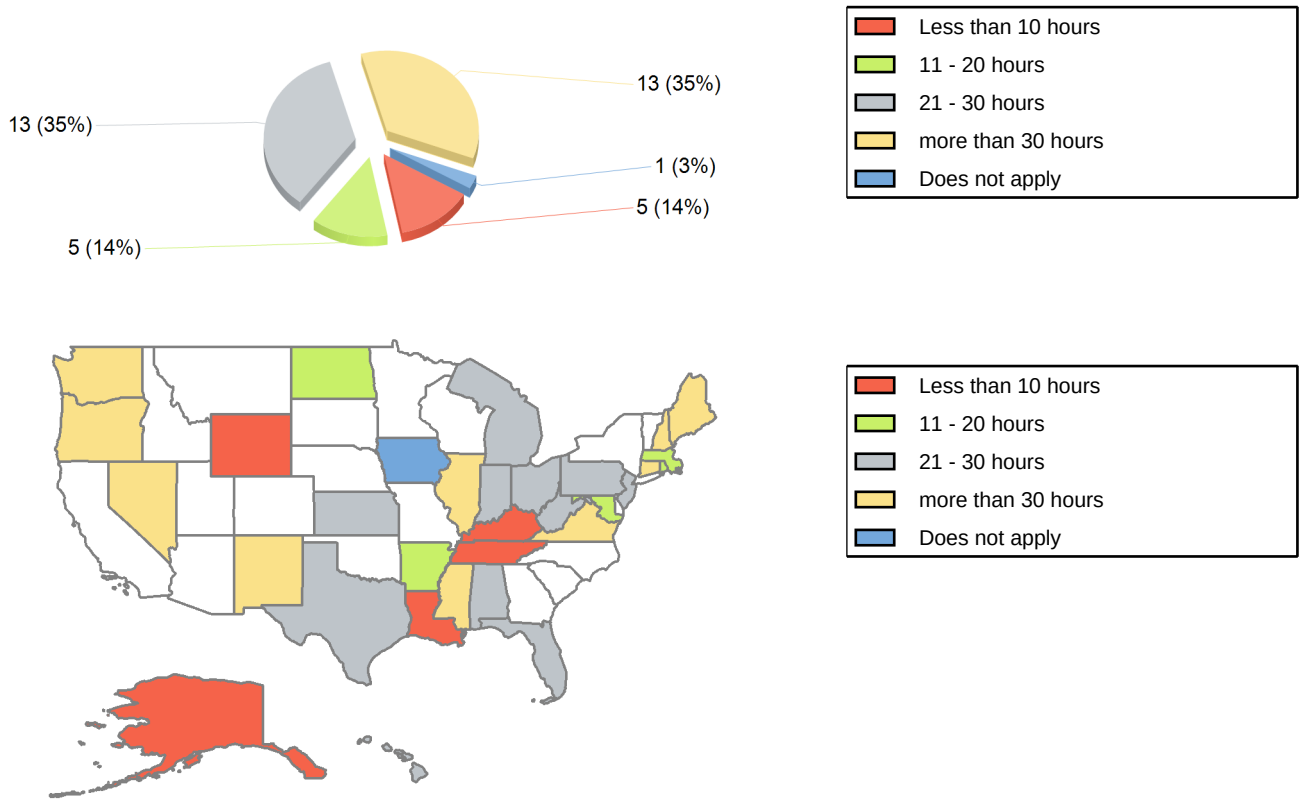
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Less than 10 hours	MD, PA, TN, WA, WY	5	12%
11 - 20 hours	AR, DC, GA, IL, KY, MA, MN, MS, ND, NE, RI, TX, VI, VT	14	34%
21 - 30 hours	AK, AL, AS, CA-VN, CNMI, DE, FL, GU, HI, KS, MI, NC, NH, NJ, NM, NV, OH, OK, SC, UT, WV-PN	21	51%
more than 30 hours	IA	1	2%

Q100. Which of the following methods can be used to meet continued competency requirements for APRNs? (Check all that apply.)



Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Peer review	ID, ME	2	4%
Continuing education hours	AK, AL, AR, AS, CNMI, CT, DC, FL, GU, HI, IA, IL, IN, KS, KY, LA-RN, MA, MD, ME, MI, MS, ND, NH, NJ, NM, NV, OH, OR, PA, RI, TN, TX, VA, VI, WA, WV-RN, WY	37	74%
Minimal practice hours (paid)	AZ, DE, LA-RN, MD, ME, ND, NH, NV, OR, TX, VI, VT, WA	13	26%
Minimal practice hours (unpaid)	AZ, DE, ND, NH, OR, TX, VI, VT, WA	9	18%
Continued competency assessment	GU, KY	2	4%
Maintenance of APRN certification	AK, AR, AZ, CNMI, CT, DC, DE, FL, GA, GU, HI, IA, ID, KY, LA-RN, MD, ME, MI, MN, MO, MS, NC, ND, NE-APRN, NH, NM, NV, OK, OR, PA, SC, SD, TN, TX, UT, VA, VI, VT, WA, WV-RN, WY	41	82%

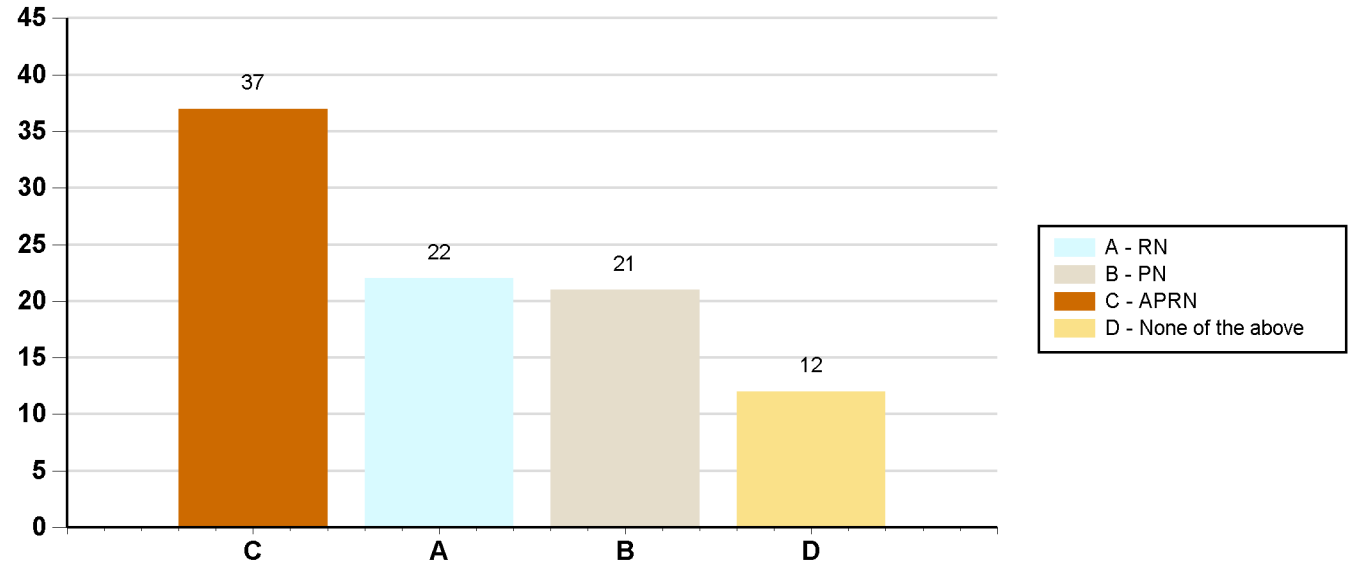
Q101. How many continuing education hours are required for APRNs?



*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

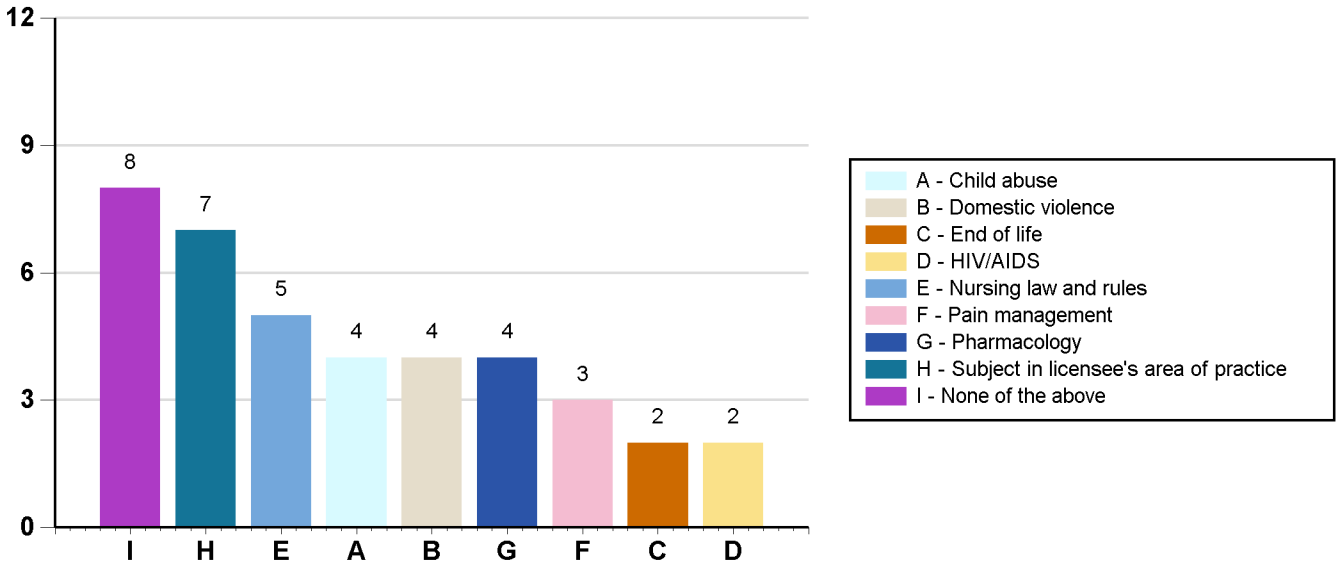
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Less than 10 hours	AK, KY, LA-RN, TN, WY	5	14%
11 - 20 hours	AR, MA, MD, ND, RI	5	14%
21 - 30 hours	AL, CNMI, DC, FL, HI, IN, KS, MI, NJ, OH, PA, TX, WV-RN	13	35%
more than 30 hours	AS, CT, GU, IL, ME, MS, NH, NM, NV, OR, VA, VI, WA	13	35%
Does not apply	IA	1	3%

Q102. Is continuing education by subject matter required as part of licensure maintenance?



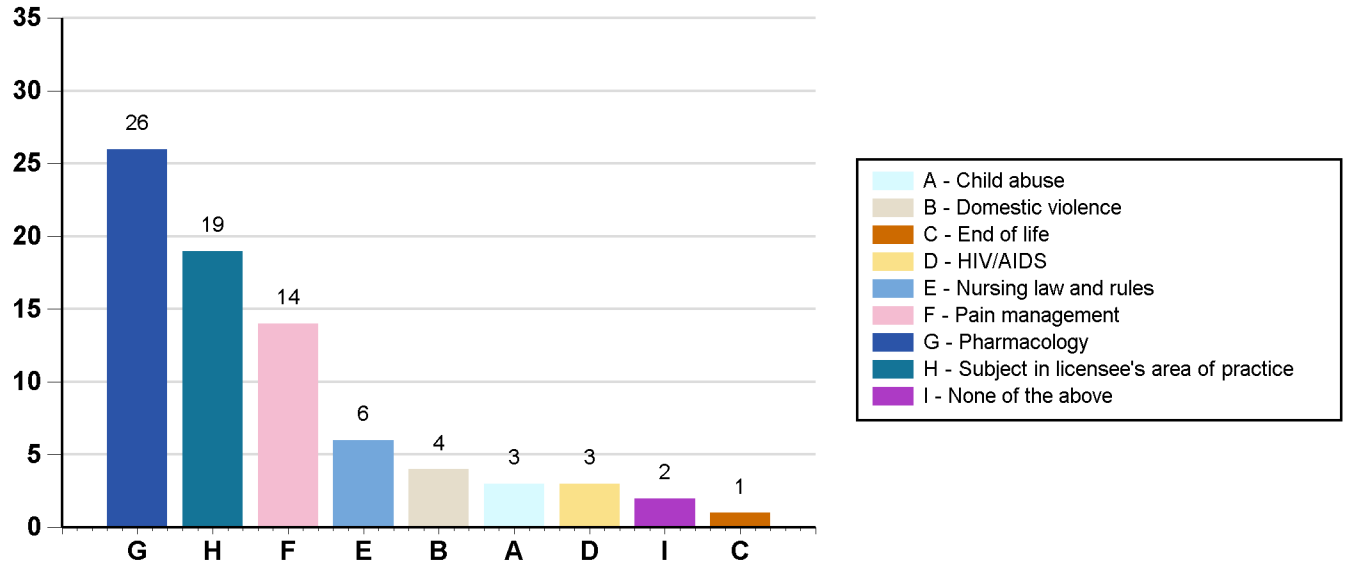
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
RN	AR, AS, CA-RN, CNMI, CT, DC, DE, FL, GU, IA, IL, KY, MA, MI, NV, OH, PA, RI, TX, UT, VA, VI	22	41%
PN	AR, AS, CNMI, DC, DE, FL, GU, IA, IL, KY, MA, MI, NC, NV, OH, PA, RI, TX, UT, VI, WV-PN	21	39%
APRN	AK, AL, AR, AS, CA-RN, CNMI, CT, DC, FL, GU, HI, IA, IL, IN, KY, LA-RN, MA, MD, ME, MS, ND, NH, NJ, NM, NV, OH, OK, OR, PA, RI, TN, TX, VA, VI, VT, WA, WY	37	69%
None of the above	AZ, CA-VN, GA, ID, KS, MN, MO, NE, NE-APRN, SC, SD, WV-RN	12	22%

Q103. Which subject matter topics are required for continuing education for RN or PN licensure maintenance? (Check all that apply.)



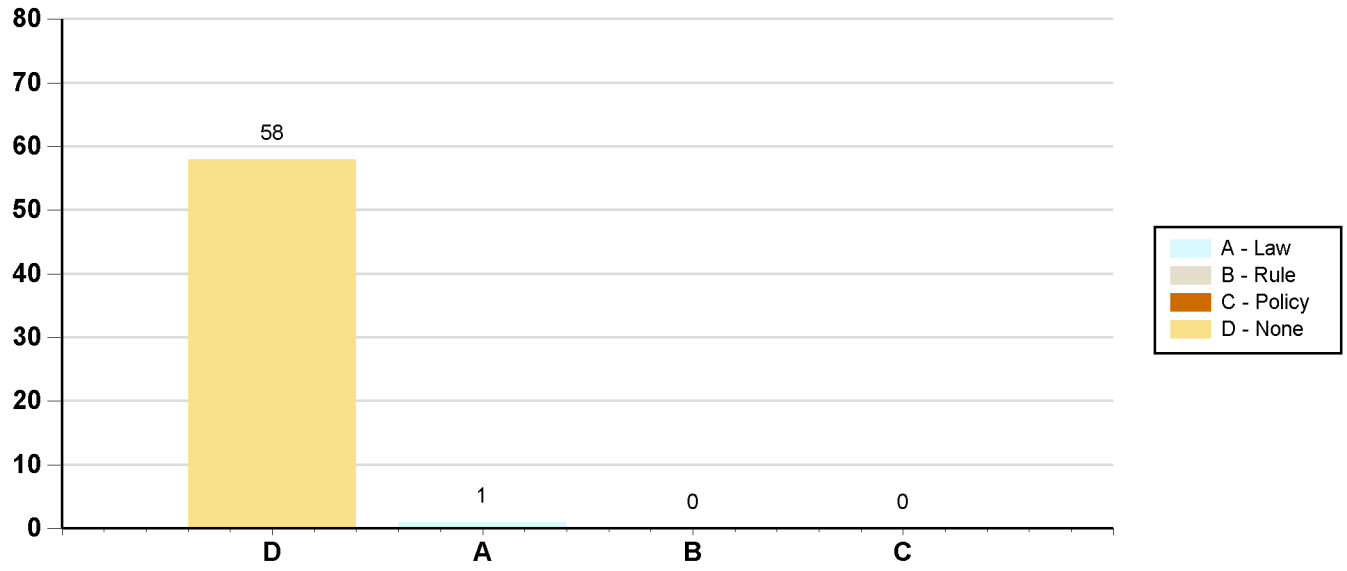
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Child abuse	AS, IA, KY, PA	4	17%
Domestic violence	AS, FL, KY, MA	4	17%
End of life	AS, WV-PN	2	8%
HIV/AIDS	AS, DC	2	8%
Nursing law and rules	AS, CNMI, FL, OH, TX	5	21%
Pain management	AS, MI, WV-PN	3	12%
Pharmacology	AS, CNMI, VI, WV-PN	4	17%
Subject in licensee's area of practice	AR, AS, CNMI, DC, RI, TX, UT	7	29%
None of the above	CA-RN, CT, DE, GU, IL, NC, NV, VA	8	33%

Q104. Which subject matter topics are required for continuing education for APRN licensure maintenance? (Check all that apply.)



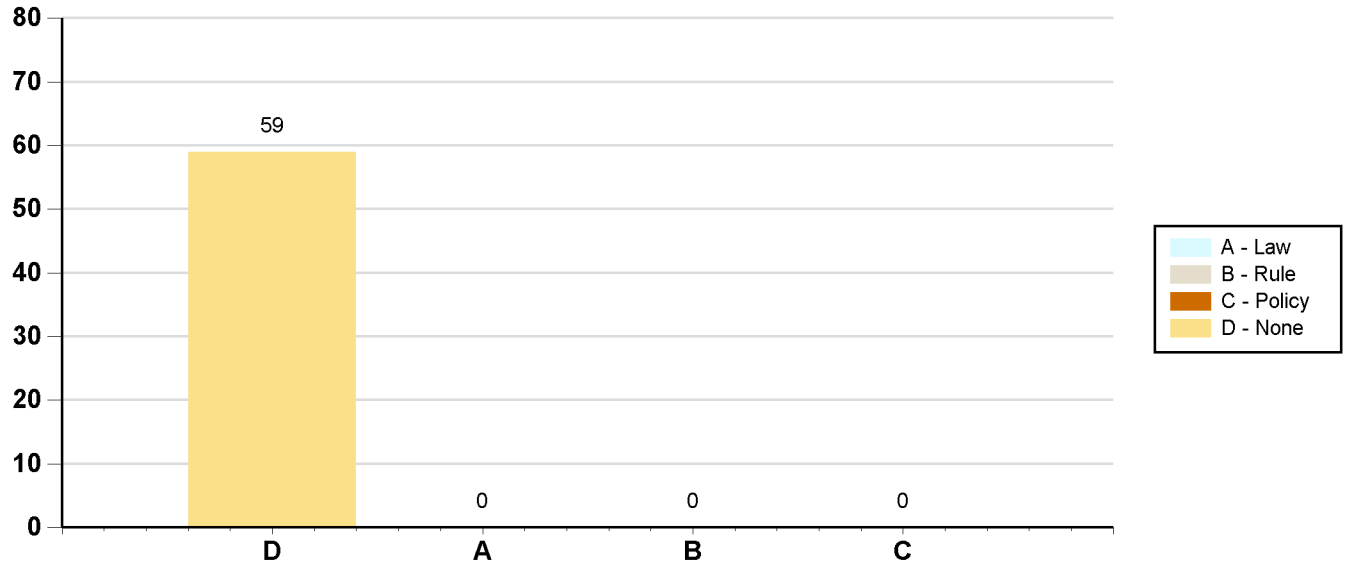
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Child abuse	AS, IA, PA	3	8%
Domestic violence	AS, CT, FL, MA	4	11%
End of life	AS	1	3%
HIV/AIDS	AS, CT, DC	3	8%
Nursing law and rules	AL, AR, AS, CNMI, FL, TX	6	16%
Pain management	AK, AS, CT, IA, MA, ME, NM, OR, PA, RI, TN, VA, VT, WA	14	38%
Pharmacology	AL, AR, AS, CA-RN, CNMI, CT, DC, FL, HI, IL, IN, KY, LA-RN, ME, MS, ND, NH, NJ, NM, OH, PA, TX, VA, VI, WA, WY	26	70%
Subject in licensee's area of practice	AL, AR, AS, CNMI, CT, DC, HI, KY, LA-RN, MD, NJ, NM, NV, OR, PA, RI, TX, VA, WA	19	51%
None of the above	GU, OK	2	5%

Q105. Does your jurisdiction have a state law, rule or policy that expressly prohibits eligibility to take the NCLEX for an otherwise qualified Licensure and Deferred Action for Childhood Arrival (DACA) recipient?



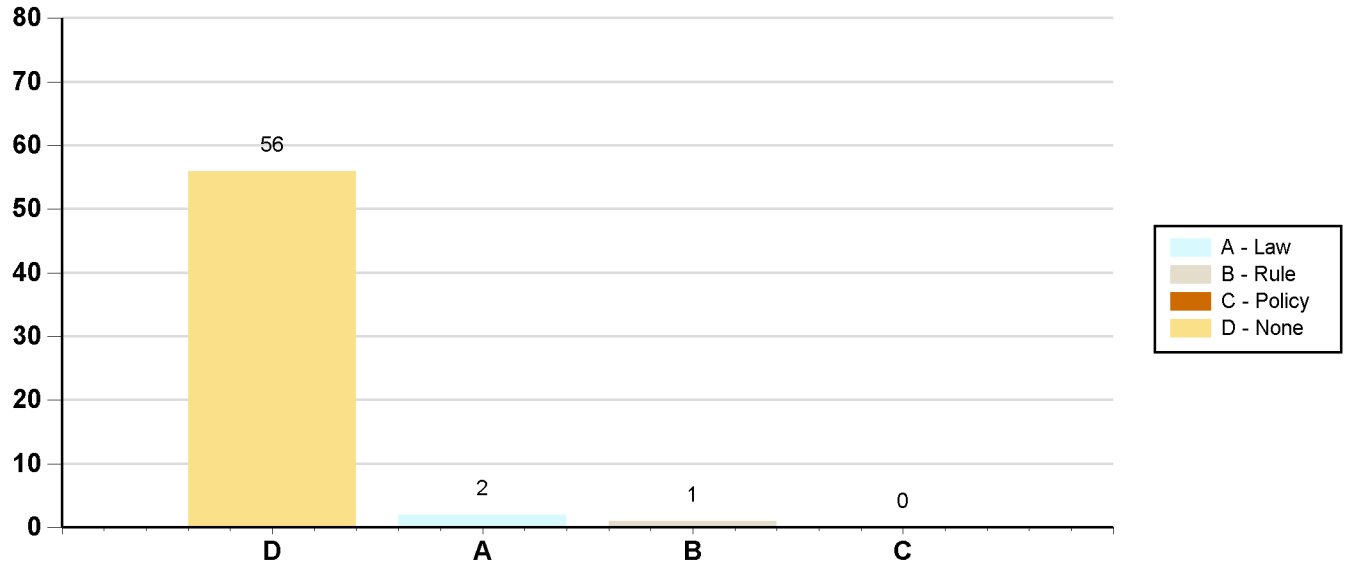
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Law	AZ	1	2%
Rule		0	0%
Policy		0	0%
None	AK, AL, AR, AS, CA-RN, CA-VN, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NE-APRN, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	58	98%

Q106. Does your jurisdiction have a proposed state law, rule or policy that expressly prohibits eligibility to take the NCLEX for an otherwise qualified Licensure and Deferred Action for Childhood Arrival (DACA) recipient?



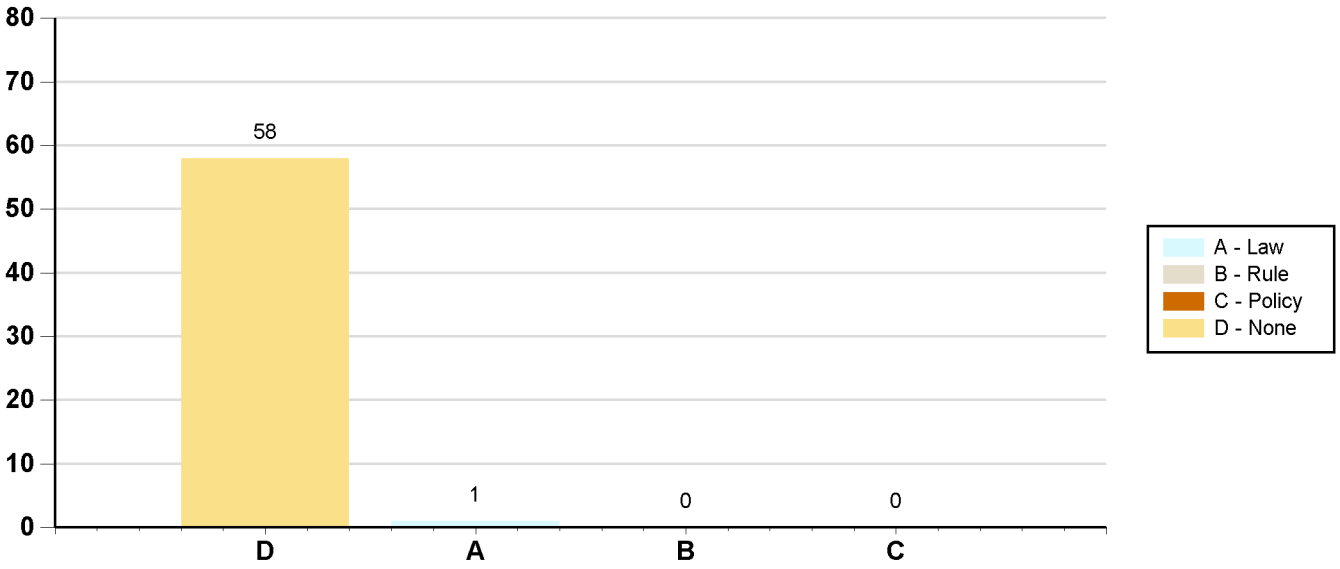
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Law		0	0%
Rule		0	0%
Policy		0	0%
None	AK, AL, AR, AS, AZ, CA-RN, CA-VN, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NE-APRN, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	59	100%

Q107. Does your jurisdiction have a state law, rule or policy that expressly allows eligibility to take the NCLEX for an otherwise qualified Licensure and Deferred Action for Childhood Arrival (DACA) recipient?



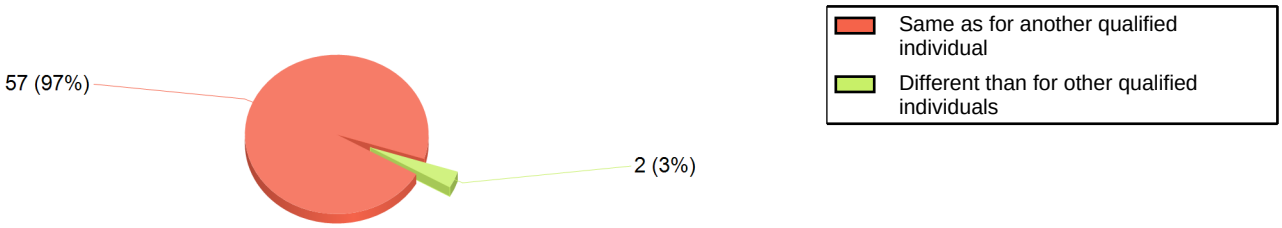
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Law	AR, OR	2	3%
Rule	VA	1	2%
Policy		0	0%
None	AK, AL, AS, AZ, CA-RN, CA-VN, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NE-APRN, NH, NJ, NM, NV, NY, OH, OK, PA, RI, SC, SD, TN, TX, UT, VI, VT, WA, WI, WV-PN, WV-RN, WY	56	95%

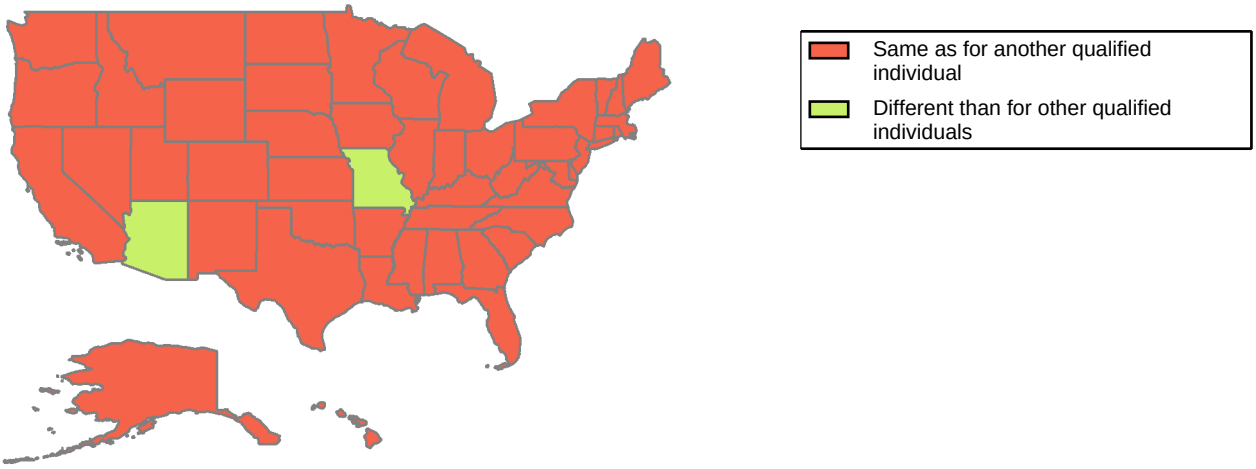
Q108. Does your jurisdiction have a proposed state law, rule or policy that expressly allows eligibility to take the NCLEX for an otherwise qualified Licensure and Deferred Action for Childhood Arrival (DACA)recipient?



Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Law	VA	1	2%
Rule		0	0%
Policy		0	0%
None	AK, AL, AR, AS, AZ, CA-RN, CA-VN, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NE-APRN, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VI, VT, WA, WI, WV-PN, WV-RN, WY	58	98%

Q109. If, your jurisdiction does not have a state law, rule or policy, how does the jurisdiction determine eligibility to take the NCLEX for an otherwise qualified Licensure and Deferred Action for Childhood Arrival (DACA) recipient?

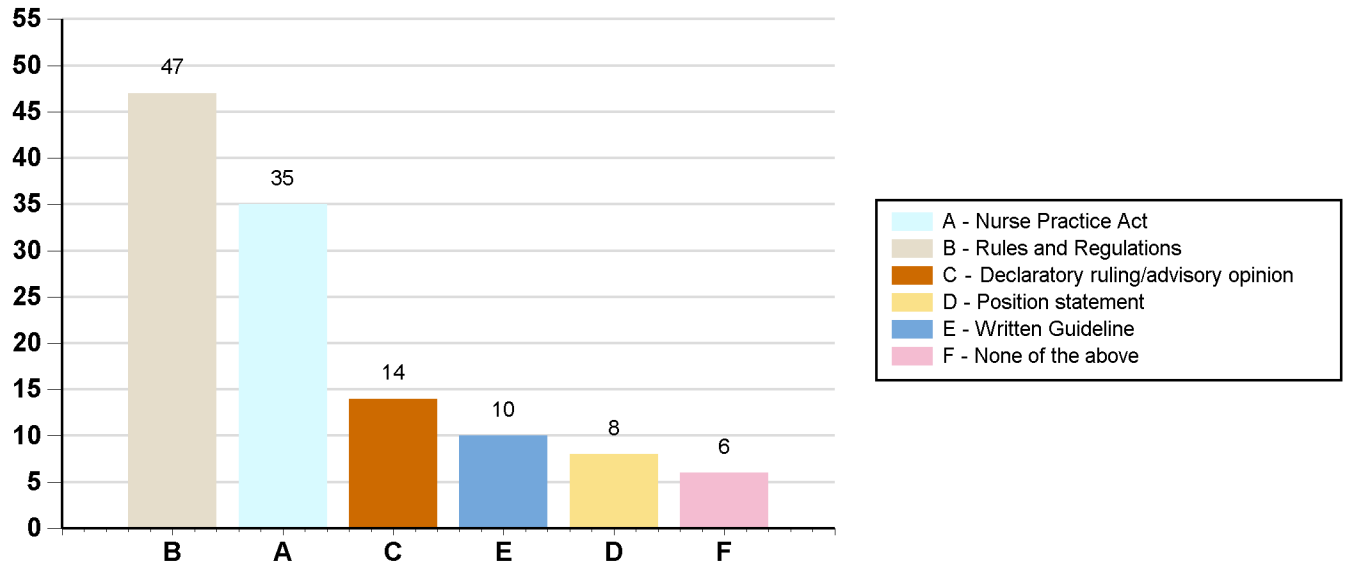




*PN BONs and US Territories are not displayed on the map. For detailed information, please see the text responses below.

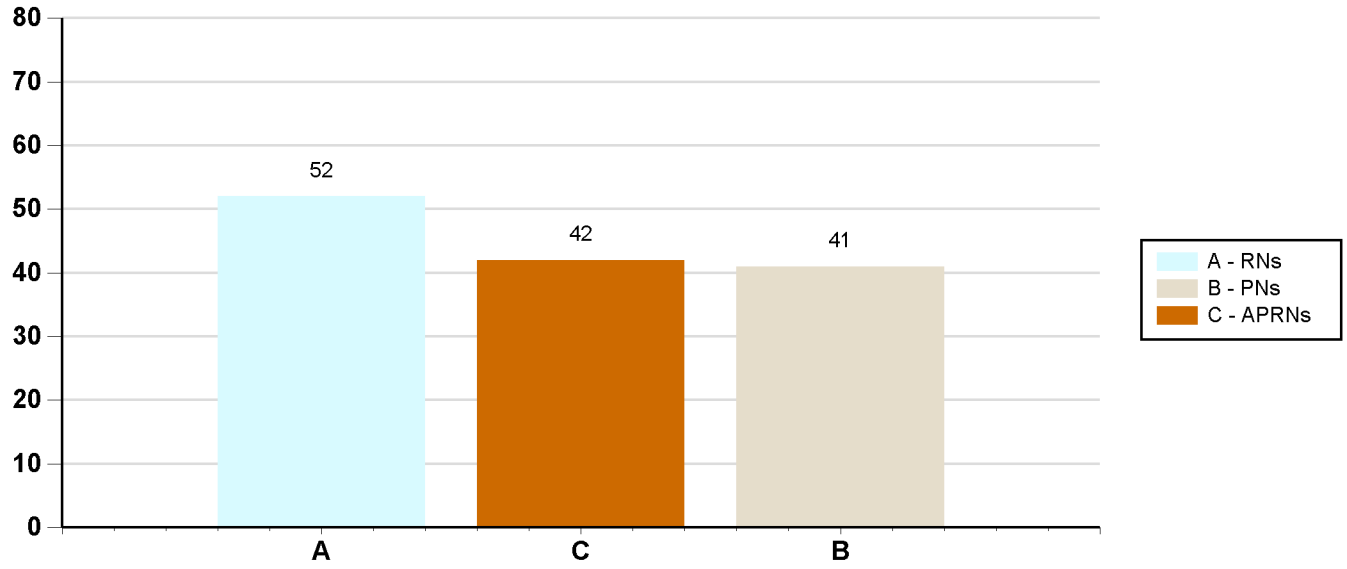
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Same as for another qualified individual	AK, AL, AR, AS, CA-RN, CA-VN, CNMI, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, IN, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MS, MT, NC, ND, NE, NE-APRN, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	57	97%
Different than for other qualified individuals	AZ, MO	2	3%

Q110. Are there specific references to delegation in any of the following: (Check all that apply.)



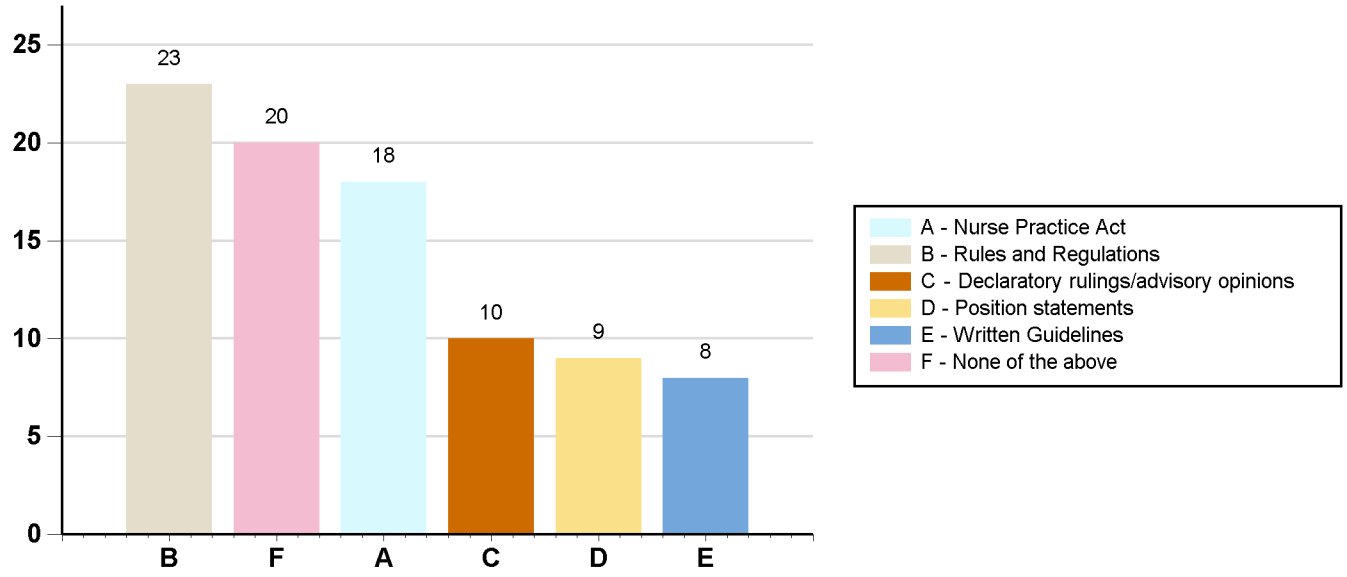
Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Nurse Practice Act	AK, AR, AZ, CA-RN, CO, DC, FL, GA, GU, HI, IA, IL, KS, LA-RN, MA, MD, ME, MN, MO, MT, NE, NE-APRN, NH, NV, OH, OK, OR, SC, SD, UT, VA, VI, WA, WV-PN, WY	35	59%
Rules and Regulations	AK, AL, AR, AZ, CA-RN, CO, DC, DE, FL, GA, GU, IA, ID, IL, KS, KY, LA-RN, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NE-APRN, NH, NJ, NM, OH, OK, OR, RI, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-PN, WV-RN, WY	47	80%
Declaratory ruling/advisory opinion	AK, AL, AZ, CT, KY, LA-RN, MA, MD, ND, NE-APRN, SC, SD, WA, WY	14	24%
Position statement	AL, MO, MS, NE, SC, SD, TN, WV-PN	8	14%
Written Guideline	CA-RN, IA, LA-PN, MN, NV, OK, SD, VT, WV-PN, WV-RN	10	17%
None of the above	AS, CA-VN, CNMI, IN, NY, PA	6	10%

Q111. Do the references to delegation apply to RNs, PNs or APRNs? (Check all that apply).



Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
RNs	AK, AL, AR, AZ, CA-RN, CO, CT, DC, DE, FL, GA, GU, HI, IA, ID, IL, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NE-APRN, NH, NJ, NM, NV, OH, OK, OR, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV-RN, WY	52	98%
PNs	AK, AL, AR, AZ, CA-RN, CO, CT, DC, FL, GA, IA, ID, KS, KY, LA-PN, MA, MD, ME, MI, MO, MS, MT, ND, NE, NH, NJ, NM, NV, OH, OK, RI, SC, SD, TN, UT, VA, VI, VT, WA, WV-PN, WY	41	77%
APRNs	AK, AR, AZ, CA-RN, CO, CT, DC, FL, GA, GU, IA, ID, IL, KS, KY, LA-PN, LA-RN, MA, MD, ME, MI, MN, MO, MS, MT, ND, NH, NJ, NM, NV, OH, OK, OR, RI, SC, SD, TX, UT, VT, WA, WV-RN, WY	42	79%

Q112. Are there specific references to telenursing, telehealth or other terms referring to electronic practice in any of the following? (Check all that apply):



Responses	Jurisdictions	Number of Boards	Percentage of Boards Responding
Nurse Practice Act	AK, AR, CA-RN, DE, FL, HI, IA, LA-RN, MD, ME, MO, NH, NV, OK, SC, UT, VA, WV-PN	18	31%
Rules and Regulations	AK, AL, AR, FL, IA, IN, KY, LA-RN, MA, MD, ME, MI, MO, MT, NH, OK, SD, TX, UT, VA, VT, WA, WV-RN	23	39%
Declaratory rulings/advisory opinions	AK, GU, KY, LA-RN, MA, NV, SC, SD, WA, WY	10	17%
Position statements	AR, AZ, GA, GU, ID, ND, OR, SC, WA	9	15%
Written Guidelines	CO, GU, IA, ID, LA-PN, MN, OK, VA	8	14%
None of the above	AS, CA-VN, CNMI, CT, DC, IL, KS, MS, NC, NE, NE-APRN, NJ, NM, NY, OH, PA, RI, TN, VI, WI	20	34%

BOISE STATE UNIVERSITY
COLLEGE OF HEALTH SCIENCES
School of Nursing

Patty Wolf, MSN, RNC-OB
Executive Director of the Alaska SARA Council
Alaska Board of Nursing
patty.wolf@alaska.gov

To Whom it May Concern:

Boise State University's School of Nursing recently received approval to launch BS-DNP degree tracks, which will offer streamlined pathways for nurses who hold a bachelor's degree to earn their Doctorate of Nursing Practice with a Family of Nurse Practitioner emphasis or an Adult Gerontology Acute Care Nurse Practitioner emphasis. The new tracks are part of Boise State's response to our accrediting body, the National Organization of Nurse Practitioner Faculties' (NONPF) commitment for entry level Nurse Practitioner programs to be doctorally prepared by 2025.

Currently, Boise State partners with the Alaska Board of Nursing in an effort to educate nurses where they live and practice. We are writing to request that the Alaska Board of Nursing recognize Boise State University's BS-DNP Adult Gerontology Acute Care Nurse Practitioner (AGNP-AC) and Family Nurse Practitioner (FNP) program as a distance nursing education program in Alaska. Since we currently partner with this state, please let us know if there's anything we need to do on our end to ensure a smooth transition from Master's level educational practice to the doctoral level.

Thank you for your guidance. Please do not hesitate to reach out with any questions.

Sincerely,

Dr. Amy Spurlock
Associate Division Dean and Chief Nursing Administrator
School of Nursing
Boise State University

Alaska Board of Nursing

Agenda Item #4

BON Legislative Letters

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Commerce, Community, and Economic Development

BOARD OF NURSING

P.O. Box 110806
Juneau, Alaska 99811-0806
Main: 907.465.2550
Fax: 907.465.2974

February 28, 2024

The Honorable Jesse Bjorkman
Chair, Senate Labor & Commerce Committee
Alaska State Capitol, Room 9
Juneau, Alaska 99801

The Honorable Jesse Sumner
Chair, House Labor & Commerce Committee
Alaska State Capitol, Room 421
Juneau, Alaska 99801

RE: Support for HB 314 & SB 225 – Occupational Licensing Fees

Dear Chair Bjorkman and Chair Sumner,

The Alaska Board of Nursing supports HB 314 and SB 225 introduced by Governor Dunleavy.

This legislation would remove investigation, hearing, and legal costs from the regulatory costs that must currently be covered by professional license fees due to AS 08.01.065. As a result, law-abiding professional licensees would no longer have to pay fees to cover the costs of investigation for professionals potentially violating Alaska laws or individuals operating without a license. This is a change that would better support Alaska's licensed professionals, including APRN's, RN's, LPN's, and CNA's.

Sincerely,

DocuSigned by:
Danette Schloeder
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Danette Schloeder, DNP, RNC-OB, C-EFM, C-ONQS
Chair, Alaska Board of Nursing

THE STATE of ALASKA
GOVERNOR MICHAEL J. DUNLEAVY

Department of Commerce, Community, and Economic Development
BOARD OF NURSING

550 West Seventh Avenue, Suite 1500
Anchorage, AK 99501-3567
Main: 907.269.8161
Toll free fax: 907.269.8156

April 12, 2024

The Honorable Bryce Edgmon, Neal Foster, and DeLena Johnson
Co-Chairs, House Finance Committee
Alaska State Capitol. Rooms 410, 511, and 505
Juneau, Alaska 99801

RE: Concerns Regarding House Bill 175: Board of Licensed Midwives

Dear Co-Chairs, Edgmon, Foster, and Johnson:

The Board of Nursing has determined an ethical responsibility to voice concerns with some of the provisions in House Bill 175: Board of Licensed Midwives. The Board of Nursing has not taken a position on this legislation but would like to ensure the Legislature is aware of some matters that could have a significant impact on public safety.

Changing the title from Certified Direct Entry Midwives to Licensed Midwives. Currently Certified Nurse Midwives (CNM) are licensed and Certified Direct Entry Midwives are issued a certificate; changing their title to licensed would increase confusion to the public.
The Board of Nursing would like to clarify the distinctions among professional midwifery credentials in the United States. In Alaska, a Certified Nurse Midwife (CNM) is an Advanced Practice Registered Nurse, educated by an accredited graduate program, Certified in Midwifery granted by a national certification body, and licensed by the State Board of Nursing. A Certified Direct-Entry Midwife (CDM) has a minimum of a high school education or equivalent, may or not be educated by an accredited educational program, has a current certified professional midwife certification, and receives a certificate as a Direct Entry Midwife from the board of Certified Direct Entry Midwives. We have supplied an attached reference or you can access the document here. Additionally, here is a document, located on the Midwifery Education Accreditation Council (MEAC) that describes the essential competencies for Midwifery practice.

The Board of Nursing is supportive of the midwifery profession working within their scope of practice, and as stated are not opposed to HB 175 or the midwife laws being more modernized. We ask that the Legislature carefully consider whether removing all public safety parameters from statute is in the best interest of Alaskans.

Sincerely,

DocuSigned by:
Danette Schloeder
7C5E12B02F9C4E8...

Danette Schloeder, DNP, RNC-OB, C-EFM, C-ONQS
Board Chair, Alaska Board of Nursing

Cc: The Honorable Jamie Allard, Alaska House of Representatives
Lizzie Kubitz, Legislative Liaison, DCCED
Sylvan Robb, Division Director, DCCED-CBPL

Comparison of Certified Nurse Midwives, Certified Midwives, and Certified Professional Midwives

Clarifying the distinctions among professional midwifery credentials in the United States

International Confederation of Midwives' Definition of MIDWIFE	**While the profession of midwifery has developed differently in each country, we share a common understanding of the midwife internationally. The International Confederation of Midwives' definition is:** The midwife is recognized as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labor, and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counseling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and childcare. A midwife may practice in any setting including the home, community, hospitals, clinics, or health units.

NATIONAL MIDWIFERY CREDENTIALS IN THE UNITED STATES OF AMERICA	CERTIFIED NURSE-MIDWIFE (CNM)	CERTIFIED MIDWIFE (CM)	CERTIFIED PROFESSIONAL MIDWIFE (CPM)
EDUCATION			
Minimum Degree Required for Certification	Graduate Degree		Certification does not require an academic degree but is based on demonstrated competency in specified areas of knowledge and skills.
Minimum Education Requirements for Admission to Midwifery Education Program	Bachelor's Degree or higher from an accredited college or university AND		High School Diploma or equivalent
	Earn RN license prior to or within midwifery education program.	Successful completion of required science & health courses and related health skills training prior to or within midwifery education program.	Prerequisites for accredited programs vary, but typically include specific courses such as statistics, microbiology, anatomy and physiology, and experience such as childbirth education or doula certification. There are no specified requirements for entry to the North American Registry of Midwives (NARM) Portfolio Evaluation Process (PEP) pathway: an apprenticeship process that includes verification of knowledge and skills by qualified preceptors.
Clinical Experience Requirements	Attainment of knowledge, skills, and professional behaviors as identified by the American College of Nurse-Midwives (ACNM) Core Competencies for Basic Midwifery Education.		Attainment of knowledge and skills, identified in the periodic job analysis conducted by NARM.

NATIONAL MIDWIFERY CREDENTIALS IN THE UNITED STATES OF AMERICA	CERTIFIED NURSE-MIDWIFE (CNM)	CERTIFIED MIDWIFE (CM)	CERTIFIED PROFESSIONAL MIDWIFE (CPM)
	Clinical education must occur under the supervision of an American Midwifery Certification Board (AMCB)-certified CNM/CM or other qualified preceptor who holds a graduate degree, has preparation for clinical teaching, and has clinical expertise and didactic knowledge commensurate with the content taught; >50% of clinical education must be under CNM/CM supervision.		NARM requires that the clinical component of the educational process must be at least two years in duration and include a minimum of 55 births in three distinct categories. Clinical education must occur under the supervision of a midwife who must be nationally certified, legally recognized and who has practiced for at least three years and attended 50 out-of-hospital births post certification. CPMs certified via the PEP may earn a Midwifery Bridge Certificate (MBC) to demonstrate they meet the International Confederation of Midwives (ICM) standards for minimum education.
EDUCATION PROGRAM ACCREDITING ORGANZATION			
	The Accreditation Commission for Midwifery Education (ACME) is authorized by the U.S. Department of Education to accredit midwifery education programs and institutions. Midwifery education programs must be located within or affiliated with a regionally accredited institution.		The Midwifery Education Accreditation Council (MEAC) is authorized by the U.S. Department of Education to accredit midwifery education programs and institutions. The scope of recognition includes certificate and degree-granting institutions, programs within accredited institutions, and distance education programs.
SCOPE OF PRACTICE			
Range of care provided	Midwifery as practiced by CNMs and CMs encompasses the independent provision of care during pregnancy, childbirth, and the postpartum period; sexual and reproductive health; gynecologic health; and family planning services, including preconception care. Midwives also provide primary care for individuals from adolescence throughout the lifespan as well as care for the healthy newborn during the first 28 days of life. Midwives provide care for all individuals who seek midwifery care, inclusive of all gender identities and sexual orientations. CNMs/CMs provide initial and ongoing comprehensive assessment, diagnosis, and treatment. They conduct physical examinations; independently prescribe medications including but not limited to controlled substances, treatment of substance use disorder, and expedited partner therapy; admit, manage, and discharge patients; order and interpret laboratory and diagnostic tests; and order medical devices, durable medical equipment, and home health services. Midwifery care as practiced by CNMs and CMs includes health promotion, disease prevention, risk assessment and management, and individualized wellness education and counseling. These services are provided in partnership with individuals and families in diverse settings such as ambulatory care clinics, private offices, telehealth and other methods of remote care delivery, community and public health systems, homes, hospitals, and birth centers.		Midwifery as practiced by CPMs offers care, education, counseling and support to women and their families throughout the caregiving partnership, including pregnancy, birth and the postpartum period. CPMs provide on-going care throughout pregnancy and continuous, hands-on care during labor, birth and the immediate postpartum period, as well as maternal and well-baby care through the 6-8 week postpartum period. CPMs provide initial and ongoing comprehensive assessment, diagnosis, and treatment. CPMs are trained to recognize abnormal or dangerous conditions requiring consultation with and/or referral to other healthcare professionals. They conduct physical examinations, administer medications, and use devices as allowed by state law, order and interpret laboratory and diagnostic tests.
Practice Settings	All settings - hospitals, homes, birth centers, and offices. The majority of CNMs and CMs attend births in hospitals.		Homes, birth centers, and offices. The majority of CPMs attend births in homes and/or birth centers.

Prescriptive Authority	All US jurisdictions	Maine, Maryland, New York, Rhode Island, Virginia, and Washington, DC	CPMs do not maintain prescriptive authority; however, they may obtain and administer certain medications in select states.
Third Party Reimbursement	Most private insurance; Medicaid coverage mandated in all states; Medicare, TRICARE	Most private insurance; Medicaid coverage in Maine, Maryland, New York, Rhode Island, and Washington, DC	Private insurance mandated in 6 states; coverage varies in other states; 13 states include CPMs in state Medicaid plans
CERTIFICATION			
NATIONAL MIDWIFERY CREDENTIALS IN THE UNITED STATES OF AMERICA	**CERTIFIED NURSE-MIDWIFE (CNM)**	**CERTIFIED MIDWIFE (CM)**	**CERTIFIED PROFESSIONAL MIDWIFE (CPM)**
Certifying Organization	American Midwifery Certification Board (AMCB)		North American Registry of Midwives (NARM)
	AMCB and NARM are accredited by the National Commission for Certifying Agencies		
Requirements Prior to Taking National Certification Exam	Graduation from a midwifery education program accredited by the Accreditation Commission for Midwifery Education (ACME); AND Verification by program director of completion of education program AND Verification of master's degree or higher **CNMs must also submit evidence of an active RN license at time of initial certification*		Graduation from a midwifery education program accredited by the Midwifery Education Accreditation Council (MEAC) OR Completion of NARM's Portfolio Evaluation Process (PEP) OR AMCB-Certified CNM/CM with at least ten community-based birth experiences OR Completion of an equivalent state licensure program All applicants must also submit evidence of current adult CPR and neonatal resuscitation certification or course completion
Recertification Requirement	Every 5 years		Every 3 years
LICENSURE			
Legal Status	Licensed in 50 states plus the District of Columbia and U.S. territories as midwives, nurse-midwives, advanced practice registered nurses, or nurse practitioners.	Licensed in Delaware, Hawaii, Maine, Maryland, New Jersey, New York, Oklahoma, Rhode Island, Virginia, and the District of Columbia.	Licensed in 35 states and the District of Columbia.
Licensure Agency	Boards of Midwifery, Medicine, Nursing or Departments of Health	Boards of Midwifery, Medicine, Nursing, Complementary Health Care Providers or Departments of Health	Boards of Midwifery, Medicine, Nursing, Complementary Health Care Providers; Departments of Health or Departments of Professional Licensure or Regulation
PROFESSIONAL ASSOCIATION			
	American College of Nurse-Midwives (ACNM		National Association of Certified Professional Midwives (NACPM)
Note: This document does not address individuals who are not certified and may attend births with or without legal recognition.			

Updated: ACNM Government Affairs | April 2022

Essential Competencies

for Midwifery Practice

2018 UPDATE

Final version published January 2019

1. GENERAL COMPETENCIES

- **1.a** Assume responsibility for own decisions and actions as an autonomous practitioner
- **1.b** Assume responsibility for self-care and self-development as a midwife
- **1.c** Appropriately delegate aspects of care and provide supervision
- **1.d** Use research to inform practice
- **1.e** Uphold fundamental human rights of individuals when providing midwifery care
- **1.f** Adhere to jurisdictional laws, regulatory requirements, and codes of conduct for midwifery practice
- **1.g** Facilitate women to make individual choices about care
- **1.h** Demonstrate effective interpersonal communication with women and families, health care teams, and community groups
- **1.i** Facilitate normal birth processes in institutional and community settings, including women's homes
- **1.j** Assess the health status, screen for health risks, and promote general health and well-being of women and infants
- **1.k** Prevent and treat common health problems related to reproduction and early life
- **1.l** Recognize conditions outside midwifery scope of practice and refer appropriately.
- **1.m** Care for women who experience physical and sexual violence and abuse

2. PRE-PREGNANCY AND ANTENATAL

- **2.a** Provide pre-pregnancy care
- **2.b** Determine health status of woman
- **2.c** Assess fetal well-being
- **2.d** Monitor the progression of pregnancy
- **2.e** Promote and support health behaviours that improve well being
- **2.f** Provide anticipatory guidance related to pregnancy, birth, breastfeeding, parenthood, and change in the family
- **2.g** Detect, manage, and refer women with complicated pregnancies
- **2.h** Assist the woman and her family to plan for an appropriate place of birth
- **2.i** Provide care to women with unintended or mistimed pregnancy

3. CARE DURING LABOUR AND BIRTH

- **3.a** Promote physiologic labour and birth
- **3.b** Manage a safe spontaneous vaginal birth and prevent complications
- **3.c** Provide care of the newborn immediately after birth

4. ONGOING CARE OF WOMEN AND NEWBORNS

- **4.a** Provide postnatal care for the healthy woman
- **4.b** Provide care to healthy newborn infant
- **4.c** Promote and support breastfeeding
- **4.d** Detect and treat or refer postnatal complications in woman
- **4.e** Detect and manage health problems in newborn infant
- **4.f** Provide family planning services

THE STATE of ALASKA
GOVERNOR MICHAEL J. DUNLEAVY

Department of Commerce, Community, and Economic Development

BOARD OF NURSING

550 West Seventh Avenue, Suite 1500
Anchorage, AK 99501-3567
Main: 907.269.8161
Toll free fax: 907.269.8156

April 12, 2024

The Honorable Bryce Edgmon, Neal Foster, and DeLena Johnson
Co-Chairs, House Finance Committee
Alaska State Capitol. Rooms 410, 511, and 505
Juneau, Alaska 99801

RE: Concerns Regarding SB 91: An Act relating to telehealth relating to multidisciplinary care teams and relating to the practice of medicine.

Dear Co-Chairs, Edgmon, Foster, and Johnson:

The Board of Nursing supports Advanced Practice Registered Nurses (APRN) as independent practitioners and leaders of multidisciplinary care teams. Therefore, should not be constrained to being a member of a team "coordinated by a physician" to deliver telehealth services. An APRN may practice telehealth per the following nursing regulation 12 AAC 44.925. STANDARDS OF PRACTICE FOR TELEHEALTH.

Sincerely,

DocuSigned by:
Danette Schloeder
7C5E12B02F9C4E8...

Danette Schloeder, DNP, RNC-OB, C-EFM, C-ONQS
Board Chair
Alaska Board of Nursing

Cc: The Honorable Matt Claman, Alaska Senate
Lizzie Kubitz, Legislative Liaison, DCCED
Sylvan Robb, Division Director, DCCED-CBPL

Alaska Board of Nursing

Agenda Item #5

UAF Technical College

Allied Health
604 Barnette Street
Fairbanks, AK 99701
907.455.2823 PH
907.455.2865 FAX
www.ctc.uaf.edu

Alaska Board of Nursing

Division of Occupational Licensing

P.O. Box 110806

Juneau, AK 99811

March 27, 2024

Dear Ms. Wolf,

I am following up our email conversation with a written request to be added to the agenda for the May Board of Nursing meeting. We will be requesting a waiver to allow our LPN students to receive training from other working LPN's at clinical sites. We don't have any person in mind so I don't have a resume for you. We hope to see you in May.

With warmest regards,

Kim Frontain MSN, RN

CURRICULUM VITAE Betty **J.**
(B.J.) Aldrich MD **210**

[redacted]

EMPLOYMENT

University of **Alaska** Community **and** Technical College
Fairbanks, Alaska
January, 2019 **- current**
Position: **Assistant** Professor, **Allied** Health Program

University of **Alaska** Fairbanks Student Health and Counseling Center
Fairbanks, Alaska
January, **2002 - January**, 2019
Position: Director; **staff** physician

Tanana Valley Clinic
Fairbanks, **Alaska**
August, **2000- January**, 2002 (contracted to UAF **from 9/**01– 1/02**)**
Position: Staff physician

EDUCATION

Alaska Family Practice Residency Program
Anchorage,
Alaska
July, 1997 **- June**, **2000**
Family Practice Board Certification

University of Washington School of Medicine

Seattle, Washington
August, 1992 **- May**, 1996
MD degree

University of Alaska
Fairbanks
Fairbanks**, Alaska**
September, 1988-**May**, 1992 **-** pre-med **courses**
September, 1980 **-** May 1983 **- BBA** in Accounting and Economics

San Diego State University**,** San Diego CA
September, 1978 **- May**, 1980- general **coursework**

TEACHING EXPERIENCE – Adjunct and **Assistant Professor** roles
Methods: Online, **Distance**, and Face to Face

Medical Law and Ethics **- HLTH F118**, UAF CRCD/eCampus. 2007 **- current** Human Diseases - HLTH F208, UAF CRCD/eCampus and CTC. **2008-** current **Human Behavior in** Health Care - HLTH F106, UAF CTC. 2016 **– 2020 Medical Office** Technology HLTH F130, UAF CTC. 2020 **- current** Anatomy and Physiology - HLTH F114, UAF CTC. Fall 2017
Introduction to Pharmacology **-** MA 247, UAF **CTC**.
Fall 2021 - current
Clinical **Procedures I - MA** 142 (co-taught), UAF CTC. **Fall** 2019
Clinical Procedures II – **MA** 244 (co-**taught**), UAF CTC. Spring 2020, 2021, 2022

PROFESSIONAL ORGANIZATIONS

Past member of American Academy of Family Physicians
Past member of Alaska Academy of Family Physicians

MEDICAL LICENSE

Alaska - Meds 4140; retired **status 2020**

HOSPITAL PRIVILEGES

Fairbanks Memorial **Hospital** - Community **Based Medical Staff status (retired 2020)**

REFERENCES

Available upon request

Alaska Board of Nursing

Break

Alaska Board of Nursing

Agenda Item #6

Medication Course approval request

and topics for the Board.

Crossroads Counseling and Training Services

Medication Management Manual

Purpose and Plan:

Crossroads Counseling and Training Services (CCATS) maintains multiple homes licensed to provide services under either Section 7 of the Alaska Administrative Code 130 (7 AAC 130) or Alaska Statute Title 47, Chapter 33 (AS 47.33).

This manual contains all educational material necessary for CCATS staff at all levels to understand their role in aiding clients to self-administer medications safely. In addition to compiling relevant legal guidelines, this book will include information and education about understanding medication safety, monitoring for adverse side effects and reactions, proper documentation, incident reporting for medication errors, safe storage and handling of medications (including controlled substances), and medication disposal.

Scope and limits of this training:

CCATS provides **Supervision of Self Administration** in licensed Assisted Living homes as defined in 7 AAC 10.1070 and AS 47.33.020. In all other licensed community based service waiver homes managed by CCATS, **Assistance with Self Administration of Medications** is provided as defined in 7 AAC 130.227. This Medication Management program will define all state requirements for Supervision and Assistance with Self Administration of Medications and will include all training material necessary to meet or exceed those requirements. Once staff has completed this training, they will be able to safely supervise the self-administration of medications in CCATS assisted living homes and assist with the self-administration of medications in any CCATS residential habilitation homes.

Alaska law defines **Medication Administration** as a task of nursing which must be delegated to unlicensed assistive personnel by a licensed Registered Nurse. At this time CCATS does not provide Medication Administration Services to any customers and does not maintain any staff delegated for Medication Administration tasks. CCATS does employ a registered nurse licensed in the state of Alaska and will be able to provide training to meet all requirements for Medication Administration with the intent of maintaining continuity of care in case a need arises with a current client. (*This training manual is not considered valid training for **Medication Administration** until it has been approved by the Alaska state board of nursing. Until this training has been approved, CCATS will utilize an approved Medication administration training provided on the Board of Nursing website as needed.*) While this training will allow staff to be delegated to administer medications, it does not include the delegation itself. Staff will not be authorized to administer medications until they have been delegated by the RN.

A Registered Nurse will review the Medication Management program at least once per calendar year to ensure it continues to meet all legal requirements and will review any changes with the Administrator.

Understanding your role in Self Administration, Assisting and Administering Medications

After completing this training, a Direct Service Provider will be able to safely provide individuals with **Supervision of Self Administration of Medications** in an assisted living setting or **Assist with Self Administration of Medications** in other licensed home settings. The ability to provide **Medication Administration** services to an individual requires additional training and delegation by a Licensed Registered Nurse and is not covered in this training.

Providing **Supervision of Self Administration of Medications in an assisted living setting** involves the following:

- reminding a resident to take medication;
- opening a medication container or prepackaged medication for a resident;
- reading a medication label to a resident;
- observing a resident while the resident takes medication;
- checking a resident's self-administered dosage against the label of the medication container;
- reassuring a resident that the resident is taking the dosage as prescribed; and
- directing or guiding, at the request of the resident, the hand of a resident who is administering the resident's own medications.

Providing **Assistance with Self Administration of Medications** can involve the following tasks:

- reminding the recipient to take medication;
- opening a medication container or prepackaged medication for the recipient;
- reading a medication label to the recipient;
- providing food or liquids if the medication label instructs the recipient to take the medication with food or liquids;
- observing the recipient while the recipient takes medication;
- checking the recipient's self-administered dosage against the label of the medication container;
- reassuring the recipient that the recipient is taking the dosage as prescribed; or
- directing or guiding the hand of the recipient, at the recipient's request, while the recipient administers medication;

An individual who requires full **Medication Administration** needs someone else to directly deliver or apply oral, nasal, ophthalmic, otic, topical, vaginal, or rectal medication to or into their body because they are unable to administer medication independently. <u>Additional steps are required before staff may complete Medication Administration.</u>

7 AAC 130.227 - Home and Community-Based Waiver Services -Administration of medication and assistance with self-administration of medication.

(a) Except as provided in (i) of this section, a provider shall offer administration of medication and assistance with self-administration of medication as integral parts of the following home and community-based waiver services:

(1) adult day services under 7 AAC 130.250;
(2) day habilitation services under 7 AAC 130.260;
(3) residential habilitation services under 7 AAC 130.265;
(4) employment services under 7 AAC 130.270;
(5) intensive active treatment services under 7 AAC 130.275;
(6) respite care services under 7 AAC 130.280.

(b) A provider of the services listed in (a) of this section shall be responsible for administration of medication or assistance with self-administration of medication if

(1) a medication is
(A) time-sensitive and may not be delayed; or
(B) required as needed by a recipient;
(2) the recipient or the recipient's representative requests assistance with the recipient's self-administration of medication or requests administration of medication by the provider;
(3) the recipient's support plan developed in accordance with 7 AAC 130.217 and 7 AAC 130.218 specifies that the recipient needs
(A) assistance with self-administration of medication; or
(B) administration of medication by the provider;
(4) no individual otherwise responsible for administration of medication or assistance with self-administration of medication for that recipient is available at the time when the recipient requires medication; and
(5) the individual that provides administration of medication or assistance with self-administration of medication has completed the training requirements of (f) of this section.

(c) The provider may employ, or make arrangements with, a registered nurse with an active license under AS 08.68 to

(1) administer medications to a recipient or to delegate administration of medication in accordance with 12 AAC 44.950 - 12 AAC 44.990 and this section; and
(2) provide the training specified in (f) of this section.

(d) A provider listed in (a) of this section shall develop and implement written policies and procedures that address

(1) administration of medication and assistance with self-administration of medication while a recipient is in the care of and receiving services from the provider;
(2) training in administration of medication and assistance with self-administration of medication under (f) of this section;
(3) documentation under (g) of this section;

(4) supervision of individuals that provide assistance with administration of medication or assistance with self-administration of medication;

(5) monitoring and evaluation of

(A) administration of medication; or

(B) assistance with self-administration of medication; and

(6) requirements for reporting medication errors.

(e) Before a provider may provide administration of medication or assistance with self-administration of medication under this section, the provider must

(1) have a written delegation for administration of medication or assistance with self-administration of medication from the recipient or recipient's representative, or a delegation in accordance with 12 AAC 44.965 or another applicable statute or regulation;

(2) have written information that identifies

(A) how to store each medication;

(B) the route of administration for each medication;

(C) potential interaction for each medication with other medications the recipient is taking;

(D) potential side effects of each medication;

(E) the individual to notify in the event of the recipient's adverse reaction to a medication; and

(F) if the medication is to be taken as needed,

(i) the circumstances in which the medication is to be administered; and

(ii) whether the delegating authority must be notified before the medication is administered or before assistance with self-administration is provided.

(f) Each individual that provides administration of medication or assistance with self-administration of medication must have on file, with the provider, written verification of attendance and successful completion of the following training appropriate to the task:

(1) if the individual is to provide assistance with the recipient's self-administration of medication, the individual must successfully complete training that addresses the activities listed in (j)(2) of this section;

(2) if the individual is to administer medication to a recipient without the assistance of the recipient, the individual must successfully complete training that has been approved under 12 AAC 44.965(c).

(g) An individual providing administration of medication or assistance with self-administration of medication under this section must document, in the recipient's record for all medication taken by the recipient while the recipient is in the care of the individual,

(1) the name of the medication;

(2) the dosage administered;

(3) the time of administration;

(4) the name of the individual that assisted the recipient with the recipient's self-administration of medication or administered medication to the recipient; and

(5) the written delegation under (e)(1) of this section authorizing administration of medication or assistance with self-administration of medication.

(h) A provider of the services listed in (a) of this section shall develop and implement a system to manage and report medication errors that includes

(1) a plan for documenting and tracking medication errors;

(2) a requirement for reporting, as a critical incident under 7 AAC 130.224, any medication error that results in medical intervention;

(3) a protocol for analyzing medication errors each quarter;

(4) a procedure for taking corrective action based upon that analysis; and

(5) a process for summarizing the quarterly analyses and corrective action conducted under this subsection, and submitting that summary to the department with the application to renew certification under 7 AAC 130.220 or upon request.

(i) The requirements of this section do not apply if

(1) the services are provided in a foster home or assisted living home licensed under AS 47.32, and medications are provided in accordance with 7 AAC 10.1070;

(2) the recipient administers the recipient's own medication without assistance; or

(3) the recipient or the recipient's representative gives the provider written notice designating an individual that will be responsible for administration of medication or assistance with self-administration of medication for the recipient, and the provider arranges with that individual to administer the medication or assist with self-administration at the time medication is required by the recipient.

(j) In this section,

(1) "administration of medication" means the direct delivery or application of an oral, nasal, ophthalmic, otic, topical, vaginal, or rectal medication by a provider to or into the body of a recipient that is unable to administer medication independently, and the use of an epinephrine auto-injector for a severe allergic reaction;

(2) "assistance with self-administration of medication" means

(A) reminding the recipient to take medication;

(B) opening a medication container or prepackaged medication for the recipient;

(C) reading a medication label to the recipient;

(D) providing food or liquids if the medication label instructs the recipient to take the medication with food or liquids;

(E) observing the recipient while the recipient takes medication;

(F) checking the recipient's self-administered dosage against the label of the medication container;

(G) reassuring the recipient that the recipient is taking the dosage as prescribed; or

(H) directing or guiding the hand of the recipient, at the recipient's request, while the recipient administers medication;

(3) "medication" means a drug or product, including an over-the-counter product, that is intended to be taken by the recipient at a scheduled time or as needed, and that is prescribed for a recipient by an individual

(A) with an active license under AS 08 to practice as

(i) an advanced practice registered nurse;

(ii) a physician, including an osteopath;

(iii) a physician assistant; or

(iv) a dentist; or

(B) who is an employee of the federal government assigned to a tribal health care program, and who has an active license from a jurisdiction in the United States to practice as

(i) an advanced practice registered nurse;

(ii) a physician, including an osteopath;

(iii) a physician assistant; or

(iv) a dentist;

(4) repealed 7/1/2015;

(5) "medication error" means

(A) a failure to document medication administration;

(B) a failure to provide medication administration at, or within one hour before or one hour after, the scheduled time;

(C) the delivery of medication

(i) at a time other than when a medication was scheduled, if the time was outside the acceptable range in (B) of this paragraph;

(ii) other than by the prescribed route;

(iii) other than in the prescribed dosage;

(iv) not intended for the recipient; or

(v) intended for the recipient, but given to another individual.

AS 47.33.020 - Health-Related Services Allowed in Assisted Living Homes

(a) This chapter does not prohibit the resident of an assisted living home from self-administering the resident's own medications, unless the resident's assisted living plan specifically provides otherwise.
(b) An assisted living home may provide, obtain, or offer to provide or obtain the health-related services described in (c) - (i) of this section. A service under (c) - (i) of this section may only be provided or obtained in addition to, and as a supplemental service to, the long-term provision by the home to the resident of assistance with the activities of daily living or personal assistance.
(c) If self-administration of medications is included in a resident's assisted living plan, the assisted living home may supervise the resident's self-administration of medications, notwithstanding a limitation imposed by AS 08 or by a regulation adopted under AS 08. The supervision may be performed by any home staff person and may include

(1) reminding a resident to take medication;
(2) opening a medication container or prepackaged medication for a resident;
(3) reading a medication label to a resident;
(4) observing a resident while the resident takes medication;
(5) checking a resident's self-administered dosage against the label of the medication container;
(6) reassuring a resident that the resident is taking the dosage as prescribed; and
(7) directing or guiding, at the request of the resident, the hand of a resident who is administering the resident's own medications.

(d) An assisted living home may provide intermittent nursing services to a resident who does not require 24-hour nursing services and supervision. Intermittent nursing services may be provided only by a nurse licensed under AS 08.68 or by a person to whom a nursing task has been delegated under (e) of this section.
(e) A person who is on the staff of an assisted living home and who is not a nurse licensed under AS 08.68 may perform a nursing task in that home if

(1) the authority to perform that nursing task is delegated to that person by a nurse licensed under AS 08.68; and
(2) that nursing task is specified in regulations adopted by the Board of Nursing as a task that may be delegated.

(f) A resident who needs skilled nursing care may, with the consent of the assisted living home, arrange for that care to be provided in the home by a nurse licensed under AS 08.68 if that arrangement does not interfere with the services provided to other residents.
(g) As part of a plan to avoid transfer of a resident from the home for medical reasons, the home may provide, through the services of a nurse who is licensed under AS 08.68, 24-hour skilled nursing care to the resident for not more than 45 consecutive days.
(h) If a resident has received 24-hour skilled nursing care for the 45-day limit set by (g) of this section, the resident or the resident's representative may elect to have the resident remain in the home without continuation of 24-hour skilled nursing care if the home agrees to retain the resident after

(1) the home and either the resident or the resident's representative have consulted with the resident's physician;

(2) the home and either the resident or the resident's representative have discussed the consequences and risks involved in the election to remain in the home; and

(3) the portion of the resident's assisted living plan that relates to health-related services has been revised to provide for the resident's health-related needs without the use of 24-hour skilled nursing care, and the revised plan has been reviewed by a registered nurse licensed under AS 08.68 or by the resident's attending physician.

(i) A terminally ill resident may remain in the home if (1) the home and either the resident or the resident's representative agree that the resident may remain in the home; and (2) the resident is under the care of a physician who certifies that the needs of the resident are being met in the home. The time limitation of (g) of this section does not apply in the case of a terminally ill resident.

7 AAC 10.1070 - Medications - Assisted living homes under 7 AAC 10.1000(b)(6)

(a) Subject to 12 AAC 44.965, or another applicable statute or regulation, an entity listed in 7 AAC 10.1000(b) shall meet each applicable requirement of this section unless the entity has an onsite pharmacist and consequently follows a more stringent procedure for that requirement, including a procedure required under 12 AAC 52, or by federal law, and the department has been informed in writing of the more stringent procedure and has approved its use for purposes of this section.

(b) If, as part of health-related services provided in an assisted living home, the home supervises the self-administration of medications, supervision must be performed in accordance with AS 47.33.020.

(c) Except as provided in (d) and (g)(4) of this section, an entity subject to this section shall

(1) ensure that each stored medication, including each nonprescription medication, is in its original container and properly labeled with the name of the adult or child for whom it is intended, the name of the medication, the dosage, expiration date, and directions for administration; except as provided in 7 AAC 10.1000(c), the requirements of this paragraph do not apply to nonprescription medication used communally in a foster home or foster group home;

(2) store medications in a manner that prevents access by unauthorized persons;

(3) store controlled substances in a locked, permanently affixed storage container; for a controlled substance that requires refrigeration, the storage container must be locked; the entity shall establish written procedures for maintaining a record that accurately accounts for the receipt and each use of each controlled substance, and for periodically reconciling the record; except as provided in 7 AAC 10.1000(c), the requirements of this paragraph do not apply to a child care facility;

(4) store medications, including controlled substances, in accordance with the manufacturer's recommendations; and

(5) ensure that nonprescription medications and health products, including nonaspirin fever reducers, naturopathic remedies, vitamin and mineral supplements, diaper ointments and powders, sunscreen, and insect repellent, are used only at the dose, duration, or method of administration specified on the manufacturer's label.

(d) The provisions of (c) of this section do not apply to a medication that a resident of an assisted living home is allowed to keep in that resident's room.

(e) The following entities subject to this chapter may be delegated the task of administration of medicine under 12 AAC 44.965:

(1) a foster home for an adult;

(2) a foster group home for adults;

(3) an assisted living home.

(f) An entity not listed in (e) of this section may administer medication if

(1) within the scope of the person's own license;

(2) under other legal authority; or

(3) under the supervision of another licensed health care provider.

(g) An entity authorized to administer medication may do so only under the following conditions:

(1) the entity must first obtain written permission for the administration of prescription medication from the adult or that adult's representative, or the parent of a child in care upon admission into the entity, or when a new medication is prescribed; if the department is the child's legal guardian, the entity must first obtain written permission from the department;

(2) the entity may administer prescription medication and special medical procedures only in the dosage, at the intervals, or in the manner prescribed by a physician or other person legally authorized to prescribe medication or medical procedures;

(3) if an entity providing care for children has not obtained written permission from the child's parent for the administration of a commonly used nonprescription medication or medication contained in the first aid kit required by 7 AAC 10.1075, the entity shall document telephone permission to administer that medication; a foster home, a foster group home, or an entity providing care for a child for whom the department is the legal guardian is not required to obtain permission from the child's parent for the administration of nonprescription medication, but shall administer nonprescription medication as authorized by the department in the placement agreement;

(4) the entity shall have a written policy for the use of any commonly used nonprescription medication for oral or topical use kept on hand by the entity for the communal use of any adult or child in care for whom the medication may be indicated; the requirements of this paragraph do not apply to an assisted living home serving two or fewer residents;

(5) prescription medicine must be kept in

(A) the original container showing the date filled, the expiration date, instructions, and the physician's or other medical professional's name; or

(B) medicine sets filled by a pharmacist, a licensed medical professional, or a resident's representative; the prescription date filled, the expiration date, instructions, and the physician's or other medical professional's name must be affixed to or stored with each medicine set;

(6) in an entity with one or more employees, only one designated employee in each shift may administer medication, the designated employee shall record and initial the time each dose is administered;

(7) unused medication must be returned to the parent of a child in care when the medication is no longer needed, except that an entity providing care for a child for whom the department is the legal guardian shall discard the unused medication

(A) in a manner that prevents access by children in care; and

(B) in accordance with instructions from the manufacturer, if any;

(8) an assisted living home shall ensure that unused medication is properly discarded and shall notify the resident or resident's representative of the disposal of the medication.

(h) The entity shall ensure that medication requiring refrigeration is grouped together, stored in a manner to prevent contamination of food, and labeled as required by this section. A

residential child care facility or an assisted living home that provides care for six or more residents shall keep medication in a separate refrigeration unit that is not used to store food.

(i) In addition to complying with the other requirements of this section, a residential psychiatric treatment center

(1) shall ensure that the record of the prescription and administration of prescription and nonprescription medications is kept in each child's files and in another master medications file arranged to show in chronological order the prescription and administration of medications to each child, with records sorted by each child's name, showing each diagnosis for each child;

(2) shall make the records described in (1) of this subsection available for department review for the purpose of identifying and preventing abuse, or inappropriate or unnecessary use of prescription or nonprescription medications;

(3) may not use a medication for the purpose of sedating or controlling the behavior of a child; however, subject to 7 AAC 50.870, a medication may be used for chemical restraint in a residential psychiatric treatment center; in this paragraph, "chemical restraint" has the meaning given in 7 AAC 50.990;

(4) may not administer a psychotropic or neuroleptic class medication to a child unless the use of the medication is part of the child's treatment plan developed under 7 AAC 50.840 and use of the medication has been consented to by the child's parent, Indian custodian, or guardian after both the clinical director and the prescribing physician have given sufficient information and counseling to the parent, Indian custodian, or guardian to ensure that the parent, Indian custodian, or guardian can give an informed consent to or refusal of the use of the medication; the information and counseling must discuss the option of not using the medication, the potential benefits and disadvantages of the medication, and alternative medications or therapies that might reasonably be used to treat the same condition; and

(5) may not discharge or threaten to discharge a child because the child's parent, Indian custodian, or guardian declines to give consent to the use of any recommended medication.

(j) In this section,

(1) "controlled substance" means a drug, substance, or immediate precursor included in the schedules set out in AS 11.71.140-11.71.190;

(2) "Indian custodian" has the meaning given in 25 U.S.C. 1903(6).

12 AAC 44.950 - Standard for Delegation of Nursing Duties to other Persons

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

(1) the nursing duty to be delegated must be within the scope of practice of the delegating nurse;

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

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

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

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

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

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

(A) a clear description of the procedure to follow to perform each task in the delegated duty;

(B) the predicted outcomes of the delegated nursing task;

(C) how the person is to observe and report side effects, complications, or unexpected outcomes in the patient, and the actions appropriate to respond to any of these; and

(D) the procedure to document the performance of the nursing duty in the patient's record.

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

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

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

12 AAC 44.965 - Delegation of the Administration of Medication

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

(1) “home and community-based services provider” as defined in 7 AAC 43.1110(8);
(2) “residential supported living services provider” as defined in 7 AAC 43.1110(15);
(3) school setting provider; in this paragraph, “school setting provider” means a person who is employed at a school that provides educational services to students age 21 or younger; or
(4) certified nurse aide employed by a long-term care facility licensed and certified by the Health Facilities Licensing and Certification section of the Department of Health.

(c) The person to whom the administration of medication is to be delegated must successfully complete a training course in administration of medication approved by the board. The training course in administration of medication approved by the board in this subsection will be reviewed by the board every two years.
(d) To delegate to another person the administration of routinely scheduled oral, topical, transdermal, nasal, inhalation, optic, otic, vaginal, or rectal medications to a patient the written instructions provided to the person under 12 AAC 44.950(a)(7) must also include

(1) directions for the storage and administration of medication, including the brand and generic name of the medication, the dosage amount and proper measurement, timing of the administration, recording the administration, the expected outcome of administration, and any contraindications to administration;
(2) possible interactions of medications;
(3) how to observe and report side effects, complications, errors, missed doses, or unexpected outcomes of the medications and appropriate response to such developments; and
(4) if the delegating nurse is not available on-site, the action that the person must take when medications are changed by order of a health care provider, including how to notify the delegating nurse of the change, how the delegating nurse will receive verification from the health care provider of the medication change, and how the nurse is to notify the other person if the administration of the change of medication is delegated.

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

(1) when to administer the PRN medication to the patient;
(2) the procedure to follow for the administration of the PRN medication, including dosage amount, frequency, and duration; and
(3) the circumstances under which the person should contact the delegating nurse.

AS 47.33.300 - Assisted Living Residents' rights

(a) Subject to (c) of this section, a resident of an assisted living home has the right to

(1) live in a safe and sanitary environment free from abuse and discrimination;

(2) be treated with consideration and respect for personal dignity, individuality, and the need for privacy, including privacy in

(A) a medical examination or health-related consultation;

(B) the resident's room or portion of a room;

(C) bathing and toileting, except for any assistance in those activities that is specified in the resident's assisted living plan; and

(D) the maintenance of personal possessions and the right to keep at least one cabinet or drawer locked;

(3) possess and use personal clothing and other personal property, unless the home can demonstrate that the possession or use of certain personal property would be unsafe or an infringement of the rights of other residents;

(4) engage in private communications, including

(A) receiving and sending unopened correspondence;

(B) having access to a telephone, or having a private telephone at the resident's own expense;

(C) visiting with persons of the resident's choice, subject to visiting hours established by the home and consistent with AS 47.33.060; and

(D) having access to the Internet provided by the home, subject to availability to the home in the community, and having a private device to access the Internet at the resident's own expense;

(5) close the door of the resident's room at any time, including during visits in the room with guests or other residents;

(6) at the resident's own expense unless otherwise provided in the residential services contract, participate in and benefit from community services and activities to achieve the highest possible level of independence, autonomy, and interaction with the community;

(7) manage the resident's own money;

(8) participate in the development of the resident's assisted living plan;

(9) share a room with a spouse if both are residents of the home;

(10) have a reasonable opportunity to exercise and to go outdoors at regular and frequent intervals, when weather permits;

(11) exercise civil and religious liberties;

(12) have access to adequate and appropriate health care and health care providers of the resident's own choosing, consistent with established and recognized standards within the community;

(13) self-administer the resident's own medications, unless specifically provided otherwise in the resident's assisted living plan;

(14) receive meals that are consistent with cultural preferences and religious or health-related restrictions;

(15) receive the prior notice of relocation of the home or the home's intent to terminate the residential services contract of the resident required by AS 47.33.080 and 47.33.360, respectively;
(16) present to the home grievances and recommendations for change in the policies, procedures, or services of the home without fear of reprisal or retaliation;
(17) at the resident's own expense unless otherwise provided in the residential services contract, have access to and participate in advocacy or special interest groups;
(18) at the resident's own expense unless otherwise provided in the residential services contract, intervene or participate in, or refrain from participating in, adjudicatory proceedings held under this chapter, unless provided otherwise by other law;
(19) reasonable access to home files relating to the resident, subject to the constitutional right of privacy of other residents of the home;
(20) receive information in a language the resident understands; and
(21) receive quality care; in this paragraph, "quality care" means care of a resident in accordance with the resident's assisted living plan, plan of care, personal preferences, and health care providers' recommendations.

(b) An assisted living home may not establish or apply a policy, procedure, or rule that is inconsistent with or contrary to a right provided by this section or by other law.

(c) The rights set out in (a)(3), (4), (7), (12), and (14) of this section do not create an obligation for an assisted living home to expend money for the specified rights unless otherwise provided in the residential services contract.

Maintaining Client Confidentiality and Privacy

The HIPAA Privacy Rule legally limits access to medical records and information to only those who have a NEED to know. Those who have the need to know have this need because they need some data and information about the client so that they can perform some indirect or direct client care. For example, nurses and care staff have a need to know information about the patient so that they can provide the patient with quality care. Dietitians have a need to know some information about the patient so that they can assess and plan care for the patient based on their nutritional needs and status.

All staff must be aware of the implications of and the possible consequences for violations relating to the Health Insurance Portability and Accountability Act and the HIPAA Privacy Rule.

Few staff violate client confidentiality intentionally. It is often momentary lapses of judgment that lead to these breaches so staff must consciously think before they act or speak.

Staff should never discuss clients with others who do not have the "need to know". They must protect and secure client written records and they must also secure electronic records by protecting and not sharing their password and logging off after each entry. It is important to identify what information is protected health information (PHI) and ensure that information can't be accessed by unauthorized individuals.

Other things that protect client privacy and confidentiality include not responding to any telephone or email inquiries about patients unless the inquiring person states a unique identifier for the patient such as a secret code number or word. Lastly, clients should not be discussed on any form of social media, and it is better to avoid taking photos in the client's home.

All care settings have regulations, policies and procedures related to confidentiality and accessing client records. All staff, and other healthcare providers, have the responsibility to be knowledgeable about these regulations, policies and procedures and adhere to them at all times without any breaches.

Personal privacy, including privacy during visits and during conversations as well as when they are getting personal care such as hygiene must also be upheld and maintained.

You will complete additional Confidentiality HIPAA compliance training at another time.

Infection Control and Safety

Universal and Standard Precautions

Universal and Standard Precautions are a set of infection control practices that care staff use to reduce transmission of microorganisms in the care setting. Together they dictate that we treat all body fluids as potentially infectious and describe how we can protect ourselves and our clients. We not only use these precautions when we might encounter body fluids including blood, urine, saliva, etc., but also when we are handling medication.

- Universal precautions (UP) were originally recommended by the CDC in the 1980s. They were introduced as an approach to infection control to protect workers from HIV, HBV, and other bloodborne pathogens in human blood and certain other body fluids, regardless of a patients' infection status. UP does not pertain to feces, nasal secretions, sputum, sweat, tears, urine, and vomitus unless they contain visible blood.

- Standard precautions (SP), were introduced in 1996 in the CDC/Healthcare Infection Control and Prevention Advisory Committee's "1996 Guideline for Isolation Precautions in Hospitals," and added additional infection prevention elements to UP in order to protect healthcare workers not only from pathogens in human blood and certain other body fluids, but also pathogens present in body fluids, non-intact skin and mucus membranes to which UP does not apply. SP includes hand hygiene; the use of certain types of PPE based on anticipated exposure; safe injection practices; and safe management of contaminated equipment and other items in the patient environment. SP is applied to all patients even when they are not known or suspected to be infectious.

Crossroads' infection control policy implements protections from both Universal and Standard precautions to ensure the safety of all clients and staff. These precautions should be used by all assistive personnel at all times when caring for clients regardless of their diagnosis and whether or not they are known to have a communicable infection. The key tenets are:

- Completing hand hygiene appropriately (handwashing with soap and water or use of an alcohol-based hand sanitizer)
    - Before and after patient contact
    - After contact with the immediate patient care environment.

- Appropriate use of personal protective equipment (PPE) when exposure to blood, body fluids, excretions, secretions (except sweat), mucous membranes, or non-intact skin is anticipated. PPE includes:
    - Gloves – when hand contamination is anticipated.
    - Masks and eye protection – when splashes may occur.
    - Gowns – when soiling of clothes may occur.

- Cleaning and sanitizing surfaces that staff or client's may come in contact with such as food prep surfaces, bathroom areas and common use areas.

Hand hygiene: hand washing and hand rub

Germs are most often spread by our hands because hands touch everything. Effective hand washing is one of the easiest and most effective means of preventing infections. There are two key methods for cleaning hands: hand washing and the hand rub sanitizer. Each method has benefits and drawbacks so staff need to be aware of which method they use depending on the situation:

Hand washing with soap and water is the only way to effectively clean visibly soiled hands however it can dry/irritate/damage skin after multiple uses which can break down our best defense against infection, our skin. Additionally, sinks may be less accessible and there may be a greater need for supplies such as paper towels or lotions.

The CDC recommends using an alcohol-based (60% or more) hand rub in all situations, except for when your hands are visibly dirty or contaminated. It is more effective for killing germs, quicker to use, is less damaging to the skin after multiple uses and is usually easier to access. The drawbacks of hand sanitizer use is that it is not appropriate for use when hands are visibly soiled and some sanitizers have additives like aloe which can leave a residue on hands after multiple uses.

Staff should clean their hands using one of these methods in the following circumstances:

- Whenever hands are visibly dirty or contaminated.

- Before:
    - having contact with clients
    - putting on gloves
    - handling food
    - handling medications
    - Using the toilet

- After:
    - having physical contact with a client
    - having contact with bodily fluids or excretions, non-intact skin, wound dressings or contaminated items (even your own)
    - toileting
    - handling inanimate objects in the client's room
    - Handling food
    - handling medications
    - removing gloves

The procedure for **hand rub** is:

1. Apply the foam or gel to the palm of one hand (usually about a quarter sized amount).
2. Rub hands together, making sure to apply friction to all surfaces and focusing in particular on the fingertips and fingernails, until dry.
3. Use enough rub to require at least 15 seconds to dry.
    a. Don't wipe away excess sanitizer, it must dry on your hands to be reliably successful.

The procedure for **hand washing** is:

1. Wet hands with water.
2. Apply soap.
3. Rub hands together for <u>at least</u> 15 seconds, covering all surfaces, including fingertips and fingernails.
4. Rinse under running water and dry with a disposable paper towel.
5. Use the towel to turn off the faucet.
6. Dispose of the paper towel, do not re-use it.

Other things to be aware of with hand hygiene:

- **Nail care**: If you are ever providing hands-on care to a client, long or artificial nails may not be appropriate. It is safest to clip nails to about ¼ inch. Be careful of shortening nails too much as this may cause injuries which open a pathway for infection. Longer artificial nails should not be used because they may risk scratching a client's skin while assisting with personal care, may be more difficult to clean, they may damage or reduce the effectiveness of protective gloves and acrylic surfaces allow bacteria to grow more than natural nails.

- **Hand jewelry (rings, bracelets, etc.)**: It is important to be aware of any jewelry you may be wearing on you hands when providing personal care. Jewelry can reduce the effectiveness of hand hygiene because bacteria may survive between jewelry and skin during hand hygiene. Taking off jewelry during hand hygiene then replacing it after can recontaminate hands. Jewelry with stones or other protrusions can cause scratches or skin tears and may damage protective gloves.

- **Skin care**: Repeated hand washing can cause skin dryness, irritation and breakdown, especially in Alaska's already dry climate. Because healthy, intact skin is our greatest barrier against infection avoiding dry and cracked skin is essential. Lotions are important to prevent skin dryness and irritation but may pose other risks by making hand hygiene less effective and potentially causing breakdown of protective gloves. To reduce these problems, it is important to only use non-greasy, non-residue lotions and look for products that are recommended for use in a healthcare setting

- **Modeling positive behaviors**: Adherence to good hand hygiene can influence others to be better with hand hygiene. Colleagues, trainees, and other staff watch what others do and research has shown that the actions of care staff influence the behavior of others. Clients are also often aware of what steps staff take when assisting them so, in addition to having healthy behaviors modeled for them, clients can recognize the actions taken to protect their health and well being.

Personal Protective Equipment (PPE)

A wide variety of Personal Protective Equipment can be found in more complex healthcare settings like the hospital or care facilities. The nature of care in assisted living and residential habilitation homes means that we do not require the same extent of personal protective equipment but that doesn't mean PPE isn't used at all. The most commonly used PPE in our setting are masks, gloves and gowns. Other items may be needed for special circumstances and Crossroads will provide additional training as needed.

Masks: Since the pandemic masks have become a part of day to day life for some people. They are one method to reduce the transmission of illness from coughing or sneezing. While N-95 filtration masks are recommended for people working in high risk situations, even simple disposable masks or re-usable cloth masks can reduce exposure in low risk situations. For the most part, the use of a mask is a personal choice for each individual and they may have many reasons for choosing to wear a mask from personal preference to compromised immunity.

To put on (don) a mask

1. Perform hand hygiene.
2. When using a face mask with ear loops, secure an ear loop over an ear.
3. Then place the other ear loop over the other ear.
4. Then grasp the nose piece of the mask and bring it to cover the bridge of the nose.
5. Mold the nose piece of the face mask with the fingertips of both hands by starting at the bridge of the nose and work outward toward the cheekbones.
6. Then grasp the nose piece of the face mask.
7. Then pull the bottom of the mask under chin

Image from: https://www.registerednursern.com/face-mask-how-to-put-on-don-and-take-off-doff-ppe/

To take off (doff) a mask:

1. Take the index finger of each hand and grasp the ear loops from behind the ears.
2. Pull the face mask forward off the face to remove the face mask.
3. Dispose or clean/reuse the face mask per your facility's protocol.
4. Perform hand hygiene

Image from: https://www.registerednursern.com/face-mask-how-to-put-on-don-and-take-off-doff-ppe/

When utilizing cloth or disposable masks, the CDC makes the following recommendations:

- For reusable cloth masks
    - If your cloth mask is wet or dirty, put it in a sealed plastic bag until you can wash it. This will keep it from getting moldy
    - If your cloth mask is dry and clean, you can store it in a breathable bag (like a paper or mesh fabric bag) to keep it clean between uses in the same day
    - Cloth masks should be washed at least once a day
    - Wash or sanitize your hands after removing any mask

- For disposable masks or respirators:
    - Disposable masks should be thrown away after they're worn once.
    - If you use respirators, check the manufacturer's instructions to learn how long they can be worn before they should be thrown away.
    - Disposable masks and respirators that become wet or dirty should be thrown away in the trash right away. Do not continue to wear a wet or dirty mask. Replace it with a dry, clean mask.

Here are some some situations when a staff person might be instructed to wear a mask while working in a client's home:

- When entering the room or assisting with personal care of someone who is ill
- When COVID-19 safety protocols are active
- When recovering from an illness but continue to have lingering coughing or sneezing
    - Staff should not go to work sick as this significantly increases the risk of transmission to clients
    - But many respiratory illnesses (flu, covid, etc) can have lingering symptoms after the the risk of transmission has passed
    - We still utilize PPE as part of Universal/Standard Precautions and treat all body fluids, even our own, as potentially infectious.

Even if you're not ill, cover your cough/sneeze!

- Coughing into the hand
    - Reduces the dispersal of aerosolized particles
    - Requires immediate hand hygiene after a cough or sneeze
- Coughing into a handkerchief or tissue
    - Reduces the dispersal of aerosolized particles
    - A tissue should not be re-used and may require hand hygiene after use
    - The handkerchief becomes soiled and may infect anything it touches after use
- Coughing into a sleeved elbow
    -
    - Reduces the dispersal of aerosolized particles
    - Doesn't require immediate hand hygiene after a cough or sneeze

Gloves should be used anytime you are handling potentially dangerous substances such as medications or cleaning supplies and when providing any hands-on assistance for your client where you may encounter body fluids or excretions such as saliva, urine, feces, vomit or blood. Even when not providing hands-on care, gloves should also be worn if there is a potential to encounter body fluids (emptying personal garbage cans, assisting with laundry, cleaning bathrooms). It is also important to change gloves after any task where they may have been contaminated.

Best practice for the use of gloves includes the following:

- Perform hand hygiene before using gloves and after removing them
- Wear gloves during contact with bodily fluids or excretions
- Wear gloves when handling medications
- Do not wear the same gloves for more than one client
- Do not reuse or wash gloves

Procedure for putting gloves on (Donning):

1. Perform hand hygiene before putting gloves on
2. Select the appropriately sized gloves
3. Hold the glove at the cuff with one hand and insert the other hand
4. When the base of the thumb reaches the cuff of the glove begin to spread fingers and insert hand into glove
5. Pull the glove cuff towards the wrist to cover as much skin as possible
6. Check to make sure there are no holes or tears.
7. Repeat steps 3-5 for your other hand

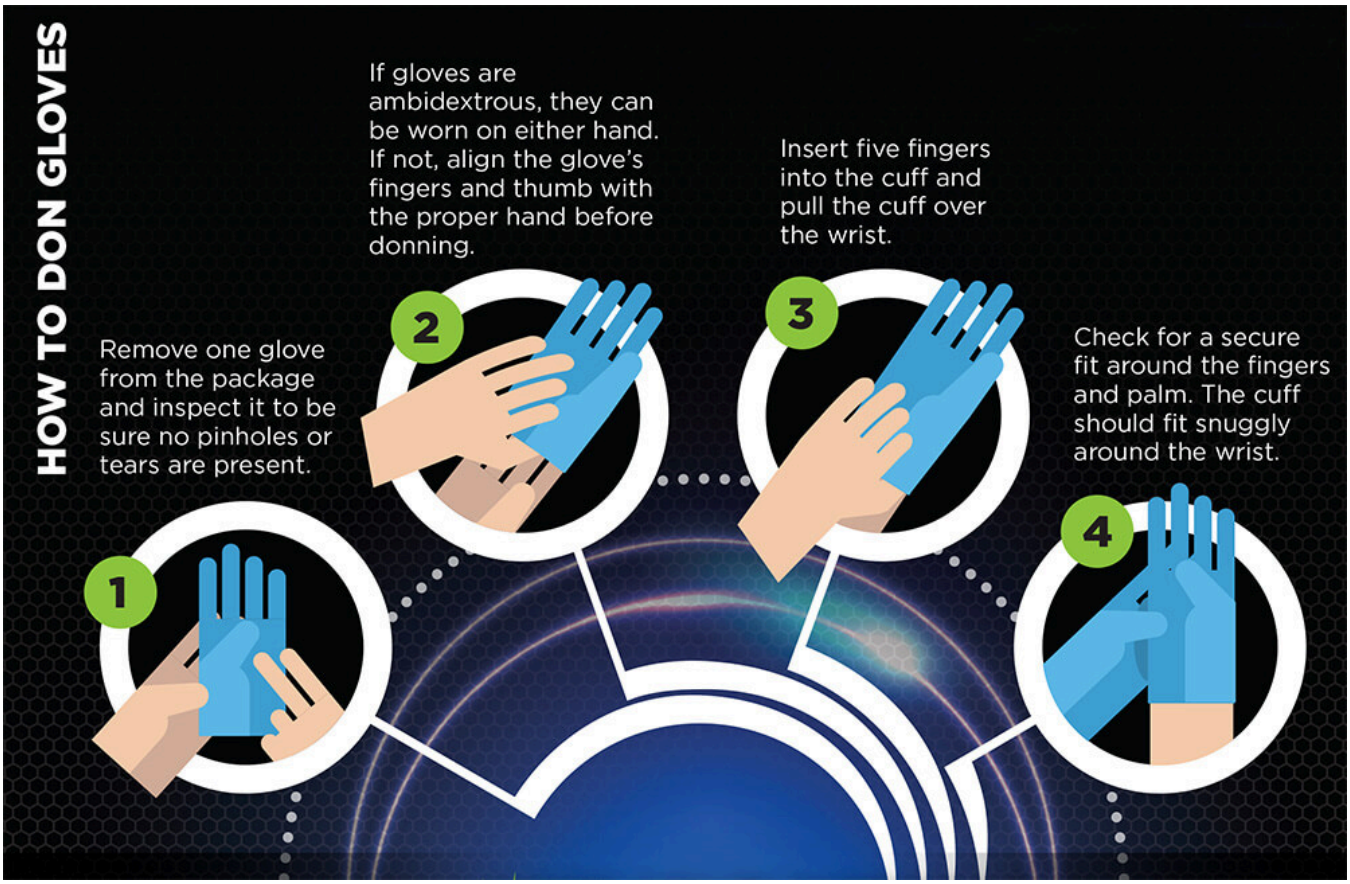


Image from
https://www.showagroup.com/us-en/newsroom/how-to-don-and-doff-disposable-gloves-correctly

Procedure for taking gloves off (Doffing):

1. Pinch one glove at the wrist cuff
2. Remove glove by pulling away from the body
3. Continue holding the removed glove in the gloved hand. Slide a few fingers of the bare hand inside the cuff of the glove that is still being worn
4. Pulling away from the body, peel off the second glove, turning it inside out and leaving the first glove wrapped inside as it is removed
5. Dispose of gloves safely and wash hands before touching any other surfaces.

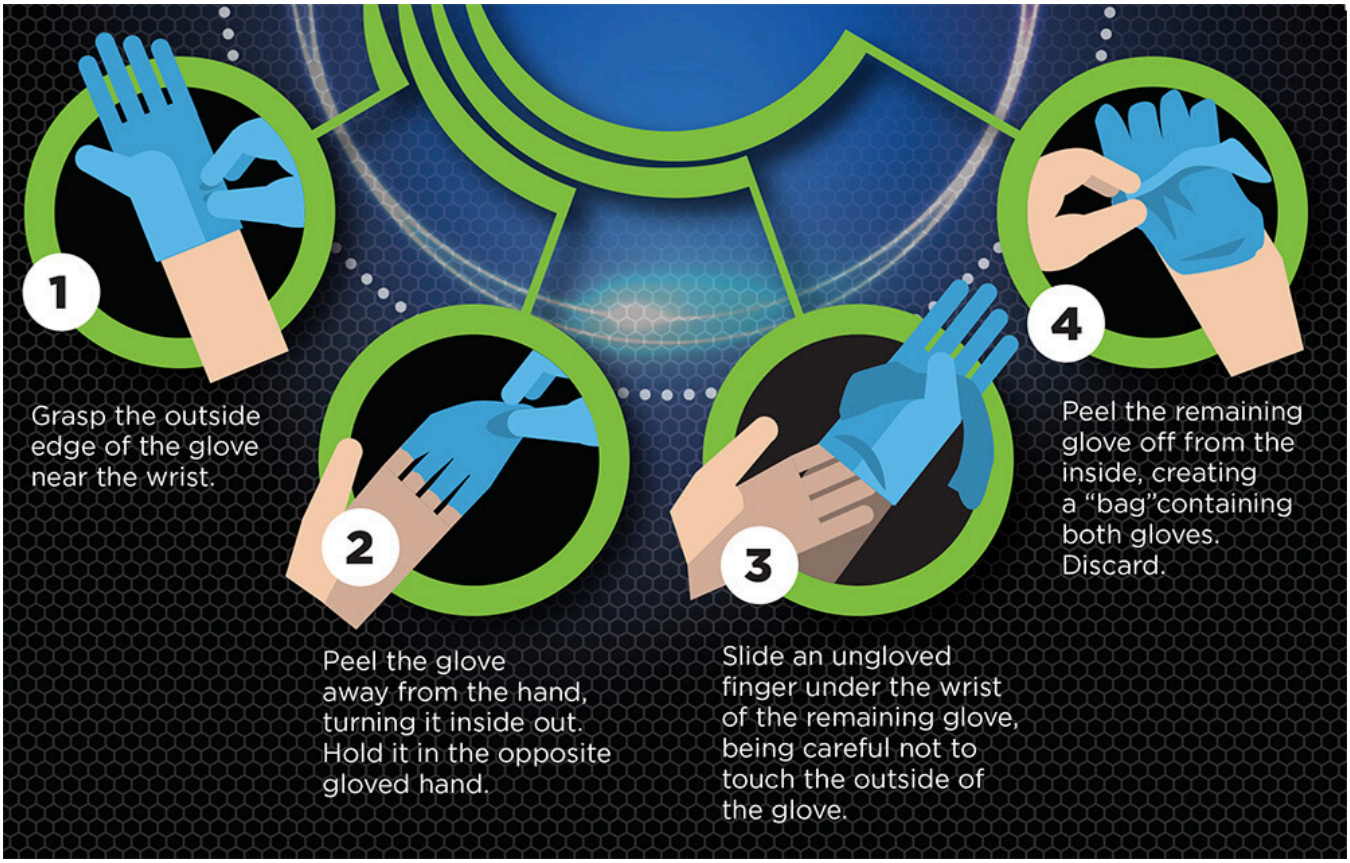


Image from
https://www.showagroup.com/us-en/newsroom/how-to-don-and-doff-disposable-gloves-correctly

Gowns

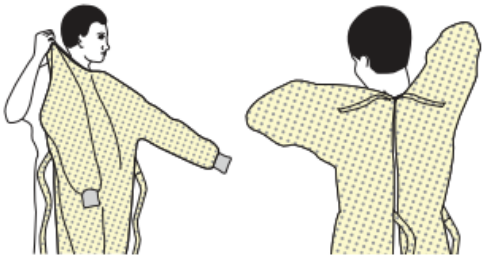
In the home setting gowns are less likely to be used than other forms of PPE but it is still valuable to understand how and when to utilize them. Gowns are primarily used during procedures and resident-care activities when contact of clothing/exposed skin with blood/body fluids, secretions and excretions is anticipated. These situations are quite rare as our clients often require little to no extensive personal care assistance and any instance with blood will likely involve immediate calls to 911 rather than direct care from staff. Any situation requiring a gown will also require gloves and masking.

Crossroads will primarily use disposable gowns which should be placed into the garbage after one use and should not be reused.

The procedure for donning a disposable gown is:

1. GOWN

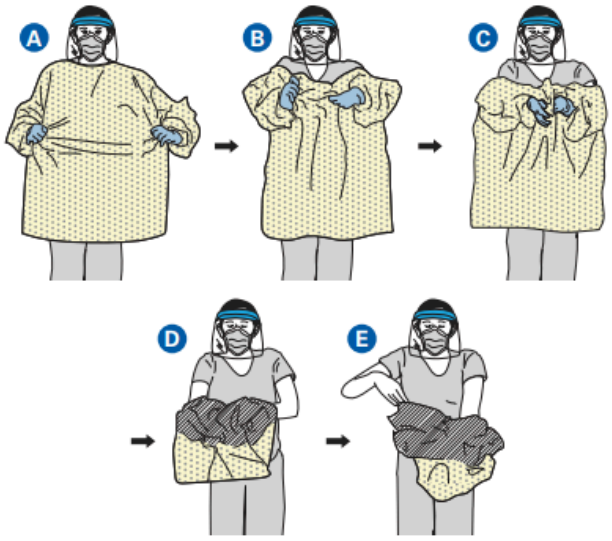
- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



The procedure for doffing a disposable gown is:

1. GOWN AND GLOVES

- Gown front and sleeves and the outside of gloves are contaminated!
- If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands
- While removing the gown, fold or roll the gown inside-out into a bundle
- As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container



You may find full procedures from the CDC here.

Cleaning, Sanitizing and Disinfecting Surfaces

Even if we do everything right with hand hygiene and use of PPE, we must still ensure that we are managing the cleanliness of the environment where we work. There are three levels of intervention that we can control in the home environment (Cleaning, Sanitizing and Disinfecting) and one intervention that requires a very controlled environment like a hospital operating room (sterilizing).

Some bacteria and viruses can survive for anywhere between a few hours to a month or more on tables, counters, durable medical equipment (walkers, wheel chairs, hospital beds, etc) and other surfaces. When people come in contact with these microbes, they may unknowingly be exposed to the illnesses that are present. For this reason, staff and clients need to stay vigilant when maintaining the home by completing the following tasks:

- Cleaning removes dirt, dust and other soils from surfaces.
    - Not reliably effective against bacteria or viruses
    - Cleaners include: Dish soap, laundry soap, Simple Green, Mrs. Meyer's, Bar Keeper's friend, Original Windex, Scrubbing Bubbles
    - Less likely to irritate skin than stronger products
- Sanitizing may or may not kill bacteria but does remove them from surfaces
    - Not reliably effective against viruses
    - Often requires friction to properly remove bacteria
    - May be more harsh than cleaners
    - Look for "Sanitize" or "Sanitizing" on the label
- Disinfecting kills harmful bacteria and viruses from surfaces
    - Effective against bacteria and viruses if used as directed
    - Often requires that it be left on a surface for a specific amount of time
    - Can often be harsh on skin and mucus membranes, may cause dangerous fumes
    - Look for "Disinfects" or "Disinfecting"

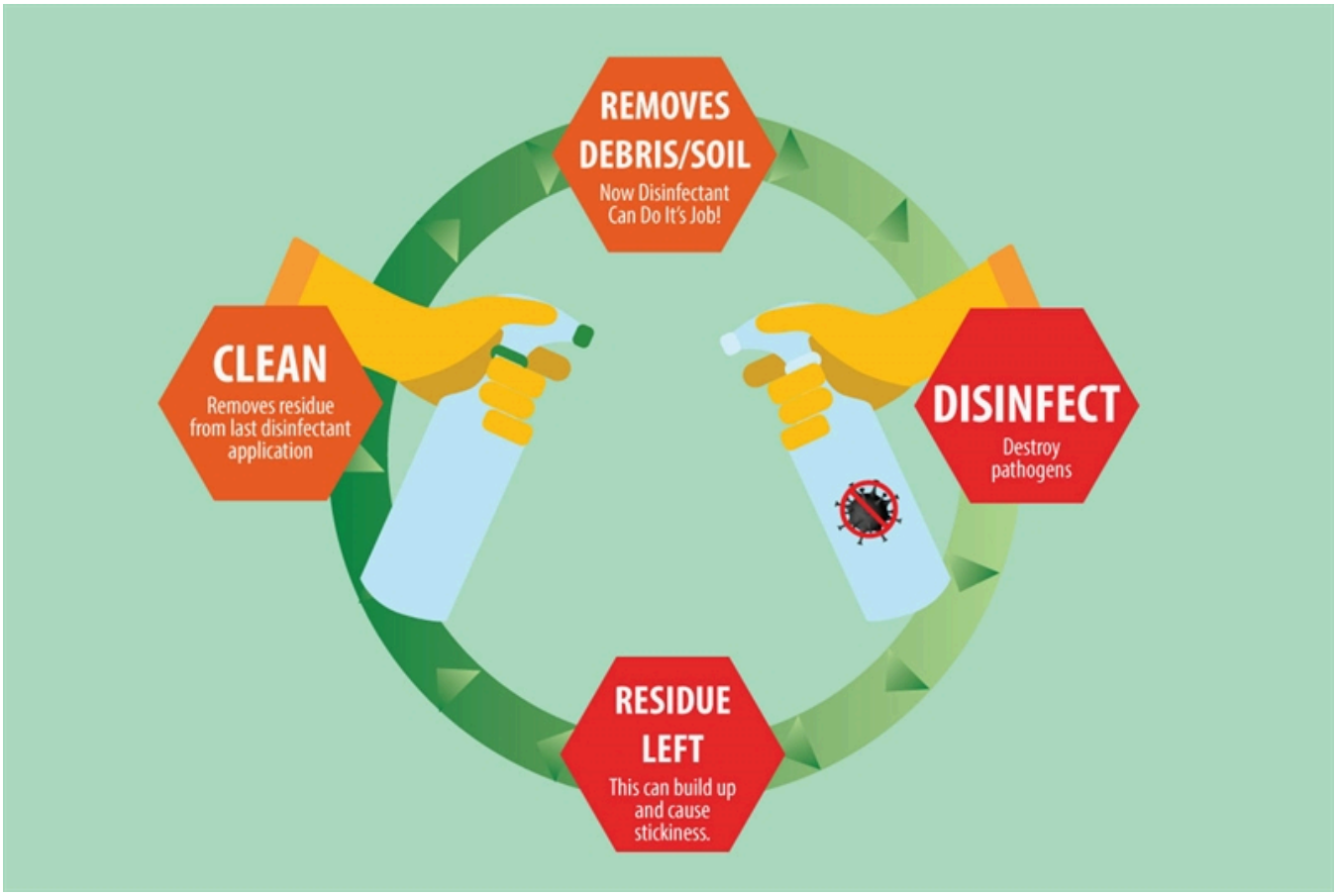
NOTE: Never mix any chemicals without clear instructions from the manufacturer and direction from your supervisor. Some of these substances can have serious reactions which can lead to hospitalization or death. In addition, state regulations prohibit the storage of disinfectants, bleach, household cleaning supplies, etc. with food products or medications.

Cleaning and Disinfection of surfaces in the Home:

The nature of a group assisted living home is that multiple people are utilizing many parts of the home throughout the day. It is important to try to maintain a clean environment throughout the day either with or without the assistance of the client's of the home. Common areas such as the kitchen, dining room, medication room and living room should be a main focus for staff. Lower traffic areas such as individuals' rooms may be more of a focus for those individuals unless staff enter the rooms for care on a regular basis. Sanitizing and disinfecting should be done on a daily basis in high traffic areas or where medications are handled. Follow manufacturer instructions for all disinfectants to ensure they are effective.

If specific disinfecting supplies are not available, staff may use a mixture of water and bleach following this procedure:

1. Obtain a plastic spray bottle that has been cleaned and rinsed thoroughly
2. Move to a well ventilated area
3. Mix 1 part Chlorine Bleach with 10 parts cool water (ex: 1 oz Bleach to 10 oz water) to create a 1:10 Bleach Solution
4. Allow the solution to sit on surfaces until it dries completely
5. Clean any residue away with a disposable towel or disinfected sponge or cloth
6. You may use or store the solution for up to 24 hours
7. Use Masking tape to mark the date and time it was filled



Sharps Safety and Management

The FDA defines a sharp as a device with sharp points or edges that can puncture or cut skin. They may be used at home, at work, and while traveling to manage the medical conditions of people or their pets, including allergies, arthritis, cancer, diabetes, hepatitis, HIV/AIDS, infertility, migraines, multiple sclerosis, osteoporosis, blood clotting disorders, and psoriasis. Examples include insulin syringes and blood sugar lancets for diabetic individuals.

While it is extremely unlikely that you will encounter sharps in a Crossroads Home, it is still important to know how to safely manage them. Alaska state law limits how staff can assist a client using any device that punctures the skin, it is possible that clients may have difficulty safely disposing of sharps and may require our assistance. Understanding the ways to keep oneself safe when encountering sharps is essential knowledge.

Standard Precautions with Sharps

It is possible to accidentally puncture your own skin or the skin of someone else when handling sharps. For this reason, it is important to treat any sharp you encounter as potentially infectious unless you have removed it from sterile packaging yourself. Even with a sterile sharp, if you accidentally touch or poke yourself or someone else, it should be treated as contaminated and disposed of, it should not be used by the client.

Bloodborne Pathogens

There are three major Bloodborne pathogens or illnesses that are most common in the healthcare setting and it is important to be aware of them. They are Hepatitis B Virus (HBV), Human Immunodeficiency virus (HIV) and Hepatitis C virus (HCV).

HBV and HCV affect the liver and can cause long term health issues including illness or death. There is a vaccine for HBV that you have access to through your employer but it requires multiple injections over a three month period so it is important to receive all doses for immunity. While HIV, a virus which attacks the body's ability to fight off other illnesses, was once considered a terminal condition but advances in medications and treatments have moved it to the category of Chronic condition along with hypertension or diabetes. While it is possible for someone to live a full and happy life with any of these conditions, it is still better to avoid them.

In the past, there have been significant stigmas associated with these illnesses and some people may feel shame or fear of reprisal from others if they knew their health status. Because of this, it is possible that we may not know the illness status of the client's we work with and in many cases, it may not be medically necessary for us to know. However, if we follow Standard Precautions and treat all substances as potentially infectious, we can do our best to ensure the health and safety of our clients and staff.

Safe Disposal of Sharps
All sharps should be disposed of in a designated Sharps container immediately after use. Sharps containers most often appear as a red or orange opaque plastic container with lid which limits the ability to reach in or remove sharps once they have been inserted. They most often have a large biohazard symbol on them as well. It is best practice to ensure the sharps container is close to the area where the sharp will be used. This reduces the time and distance a used sharp needs to travel, thus reducing the risk of a sharps stick.

If you ever notice improperly disposed of sharps (they are left on a table, using any container other than a designated sharps container, etc.) notify your supervisor immediately.

Safe Handling of Sharps
Because our role limits our ability to assist with sharps, it is rare that we will encounter them however it is not impossible. If it is known that a client uses sharps for their personal care needs, it is always best to have them handle any of their sharps rather than having staff handle them. If staff do need to handle any sharps, it is best to follow this procedure:

1. Report any improperly disposed of sharps to your supervisor
2. Treat any sharp as potential infectious.
3. Wear gloves before picking up any sharps.
4. Move the sharps container to the sharp rather than bringing the sharp to the container.
5. Make sure the area is calm and clear of people, don't handle sharps in high traffic areas
6. Only pick up the sharp at the point that is furthest from the sharp end
7. Do not attempt to recap or cover a sharp, just place it into the sharps container
8. If the sharps container is ⅔ or more full, report to your supervisor for disposal

Sharps Exposure
However unlikely, it is possible that you may experience a needle stick while working in a setting with sharps. If you are ever poked by a potentially contaminated sharp, do not panic.

- Immediately dispose of the sharp in a sharps container
- Clean the exposed area with soap and running water for at least 20-30 seconds.
    - You may use rubbing alcohol or hand sanitizer if a sink is not available
- Report to your supervisor immediately
- Your supervisor will help to make sure you are able to get to an urgent care or emergency department within 24 hours of the exposure
- There are medications that can be given at the hospital which can significantly reduce the risk of contracting a bloodborne illness if given within 24 hours of an exposure.
- In all needle stick cases, the health care provider will make a plan to monitor a person who has potentially been exposed. Staff will need to work with the provider to ensure all follow ups appointments are attended to ensure personal safety.

Understanding Medication Basics

Medications (or drugs) are substances utilized to Prevent illnesses (like vaccines), Eliminate infections (like antibiotics), Reduce symptoms (like a cold medicine or pain killer), or Replace something that the body is lacking (like vitamins or insulin). Some drugs are commonly available and used without medical supervision such as using caffeine to reduce the symptoms of fatigue or chocolate to improve one's mood. Other medications are strictly controlled due to the risk of injury related to misuse or the high risk of addiction or dependence. It is important to understand that medications affect different people in different ways.

The interplay between different medications can be extremely complicated and require years of education and experience to understand. Add in the personal factors listed in the next section and one can start to understand just how complex medication management can be. This is why staff are limited in what and how they are able to work with medications for their clients. It is only by working with physicians, pharmacists, nurses, and clients that we can ensure the safest possible interventions for care. Understanding our role in the team and maintaining those boundaries are also essential.

Benefits and limitations of medications

Medications are an important part of quality care but they are not the solution to every problem. They have their own limitations and may not work for everyone in the same way. In addition, they may cause undesired side effects or adverse reactions and may interact with other foods or medications in an unexpected way.

Personal factors that may affect the efficacy of medications include:

- Age: As a person grows older, their body changes so that interventions for an infant might be different from a child, a teen, an adult, and into old age. Body composition, organ function and other age-related factors can significantly change the impact medications have on a person.

- Body weight/size: the presence of more or less fat or muscle can affect the absorption and metabolization of medications.

- Sex: Body composition and water distribution can vary significantly by sex, most often related to the hormones released by the ovaries or testes. People with a menstrual cycle may find that medications may affect them differently at different points in their cycle. Additionally a person who is pregnant may require different medications or may have to choose to stop taking some medications that might have negative affects on their fetus.

- Genetic factors: Certain genetic conditions can affect the way a person's body responds to medications. For example: Downs Syndrome tends to cause premature aging so that a person in their 40's might experience conditions that are more typical for someone in their 60's. Others may have conditions where their cells or organ respond differently to medications.

- Psychological factors: Stress, confusion and other psychological factors can change the way the body absorbs and distributes nutrients. Additionally, a person who is stressed may be more likely to forget medications and some people who experience paranoia or delusions may avoid certain medications because they don't believe they are safe.

- Illnesses and Injury: Certain diseases and illnesses can affect the organs that process and distribute medications. Additionally, symptoms of stroke or strep throat may affect a persons ability to swallow medications. A person with significant nausea may have difficulty keeping medications down long enough for them to be absorbed.

- Allergies: Many people experience some kind of food or drug allergy which can limit which medications they may safely use in some situations.

Types and classifications of medications

There are over 20,000 different medications so it is unnecessary to know and recognize all medications. However, many medications can be grouped based on what conditions they help to treat or manage OR how they affect the body. Some groupings of medications for a specific condition may contain other groupings that affect that condition in different ways.

For example, Antihypertensives are a group of medications that help to reduce high blood pressure (hypertension). On closer inspection of the antihypertensives, however, you will find other, more specific groups of medications that reduce Hypertension in different ways:

- Diuretics work by removing fluid from the body which can reduce blood pressure but may also reduce swelling or shift electrolyte balances which affect how many systems in the body work efficiently.
- ACE Inhibitors affect a specific process in the body which changes the way blood vessels open and close but it also affects a process in the lungs which can sometimes cause a harmless but annoying dry cough.
- Beta Blockers change the strength and speed at which the heart beats. They can be used to help manage hypertension but may also be used for people with major heart conditions.

There are two groups of medications which you will be most likely to encounter when providing care with Crossroads: Medications for Chronic Conditions and Psychotropic Medications. While you don't need to memorize this, it is valuable to be aware of them!

Examples of Medications for Chronic Conditions

Chronic conditions are long lasting conditions (as opposed to Acute or short term conditions) that a person will likely be managing for a significant portion of time. They tend to become more numerous as a person gets older.

- Analgesics - help relieve pain such as from injury or arthritis (Acute or Chronic)
- Antibiotics - inhibit or kill bacterial infections (Usually Acute)
- Antifungal - inhibit or kill yeast/fungus (Usually Acute)
- Antidiabetics - help manage blood sugar for diabetes (Chronic)
- Anticoagulants - prevent blood from clotting reducing risk of stroke or deep vein blood clots (Chronic)
- Antihypertensives - lower blood pressure (Usually Chronic)
- Anti-Asthmatics - reduce the number of attacks (chronic) and severity (acute)
- Antihyperlipidemics - help to reduce the buildup of cholesterol in blood vessels (chronic)

Examples of Psychotropic Medications

Psychotropics are a special set of medications used to manage or treat both acute and chronic mental health disorders.

- Antidepressants - treat or manage depression
- Anti-anxiety - treat or manage anxiety disorders (panic attacks, phobias, anxiety and anxiety related symptoms
- Stimulants - help manage unorganized behavior (ADD/ADHD) by improving concentration and having a calming effect
- Antipsychotics - help manage psychosis where people become separated from their reality and may experience delusions or hallucinations.
- Mood Stabilizers - help regulate extreme emotions related to Bipolar disorder or extreme mood swings

Prescription and Over the Counter (OTC) Medications

Many, but not all, of the medications we assist clients with have been prescribed by a licensed medical practitioner such as a Medical Doctor, Psychiatrist, Physicians Assistant, Nurse Practitioner or dentist. Before prescribing any medication, they must understand the health needs of the individual and understand any other medications they may be taking to avoid interactions.

Once the medication has been prescribed, the Medication order or Prescription is sent to the Pharmacy to be reviewed and filled. The pharmacist is responsible for doing a second review of medications to ensure there will not be any significant interactions. If there is a concern, the pharmacist is responsible for communicating with the prescriber and seeking further

clarification. At that point the medication will be filled for pick up or delivery. As a final step, the pharmacist will provide written information about the medication and provide consultation with the client about any new medications.

Over the counter medications do not require the same level of scrutiny to obtain and can usually be bought at any pharmacy, drug store or grocery store. Just because OTCs are not as regulated as prescriptions doesn't mean there aren't still risks for misuse or potentially dangerous interactions with other medications. For this reason, all client medications should be approved by a licensed medical practitioner before using regardless of whether they are prescription or OTC.

Controlled Substances

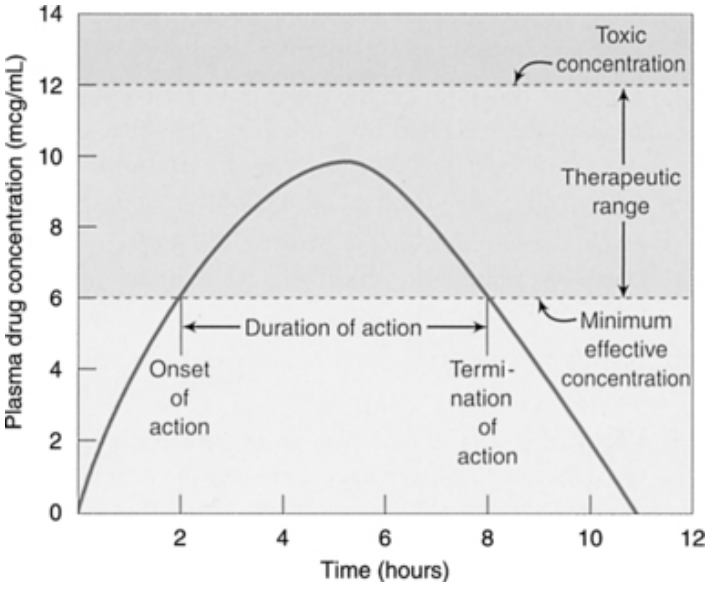
Federal and State governments have established a list of medications, called a schedule, that includes any medication that poses a higher risk of harm or abuse. These medications are known as controlled substances and require a greater degree of oversight than non controlled substances. Some examples include opioid pain medications (Morphine, Oxycodone, Oxycontin), benzodiazepines (Clonazepam, Lorazepam, Midazolam) for seizure and anxiety and stimulants for ADHD (Ritalin, Aderall). Controlled substances are required to be locked up and Crossroads requires that staff perform a controlled substance count daily for each of these medications to ensure that we are able to keep track of them.

The state of Alaska allows staff to assist clients to self-administer their own controlled substances but does not allow delegated staff to administer them. There are specific procedures for handling controlled medications which you will learn later in this manual.

Time Sensitive (Scheduled) vs. PRN (As Needed) Medications

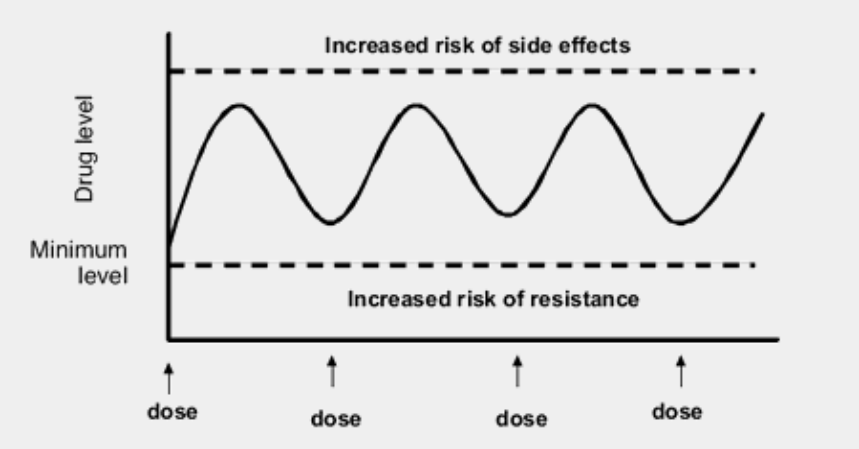
When a practitioner orders or prescribes a medication they will determine when that medication should be given. Some medications will have very specific times, others may be schedule for a more general time period and some may be listed as PRN or "as needed" (*Pro Re Nata* is Latin for As needed).

Every medication has a duration of action, a period between when you first take a medication to when it starts to have an effect to when it reaches its highest level of effect (the peak), to when it is no longer acting on the body to when it is fully processed out of the body.



The duration of action varies from medication to medication and person to person. As mentioned earlier, many personal factors from age, weight, sex, and health can affect the duration of action for an individual. Important medications are usually scheduled to maintain a continuous effect for the period of time it is most needed without increasing the risk of side effects. For example:

- Antibiotics are usually scheduled to maintain a 24 hour effect through the whole course of medication.
- Parkinson's medications are usually scheduled to maintain effect while the person is awake.
- Insulin is usually scheduled to manage blood sugar levels around meal times.
- Sleep aids are usually scheduled at bed time.



With all time sensitive or scheduled medications it is extremely important that they be administered at the right time!

PRN medications, on the other hand, are often used to manage an acute or short term condition and are usually taken whenever the need arises. PRNs can either be prescribed or OTC. Because a person usually doesn't know when they might develop a headache or heartburn, it is better for medications that help those conditions not to be scheduled for a specific time but rather "as needed." When a practitioner orders or prescribes a PRN medication, they will list an indication rather than a time. For example:

- As needed for headache or muscle aches
- As needed for heartburn
- As needed for seizure lasting more than 3 minutes

In a care setting such as homes managed by Crossroads, it is important for these indications to be met before the medication can be used. For people Administering medications, they will usually need to document the indications they observed in addition to documenting the administration.

How medications affect the body

While it is important to understand how medications affect ourselves and the clients we work with, it is not necessary for us to delve into the biochemical processes of each medication. Instead, we can focus on key aspects of medications such as understanding the desired effect, possible side effects and possible adverse or dangerous reactions. This section will also touch on the ways medications may interact with other medications or food and how that may change the desired effect. More specific information about the medications you encounter with your clients can be obtained from the pharmacy, referenced in home medication books or reviewed in print or electronic drug guides.

Expected or Desired Effects

Medications affect the body in so many different ways that it is common for some medications to be used to treat several different kinds of conditions. The US Food and Drug Administration approves each medication and designates what conditions each medication is indicated to treat, however there are times when a medication's side effect becomes the desired effect so a doctor may prescribe an "off label" use. Sometimes these "off label" uses become the most desired treatment.

- Viagra is most commonly used to manage erectile dysfunction but was developed as a medication for hypertension and chest pain
- Ozempic/Wegovy, a popular medication used for weight loss was originally approved to help manage type-2 diabetes
- Iproniazid was originally designed to treat tuberculosis but then became one of the world's first antidepressants
    - It was later discovered that this medication caused liver damage and was removed from the market

Because medications have so many different effects on the body, it is extremely important to be aware of changes that occur with our clients as these may be caused by or affected by their medications.

Side effects

Side effects are known and expected reactions to a medication which are not the originally intended therapeutic effect. Not all side effects affect a person the same way so some people may experience less or more effects from the same dose as others. Any side effects that may cause a health risk related to particular activities (using heavy equipment, going out in the sun, eating certain foods) will be noted on the medication label. Other side effects will be listed in the medication information you will have access to. Some medications may actually be used for their side effects rather than their originally intended effects.

Examples of side effects include:

- Headache (Some Heart Medications- Vasodilators)
- Nausea (Opioids, Antibiotics)
- Dangerously low blood sugar (insulin)
- Diarrhea (Antibiotics)
- Constipation (Opioids)
- Weight loss or gain (Antipsychotics)
- Sleepiness (Opioids, Benadryl)
- Dizziness (Opioids, Anti-hypertensives)
- Increased sensitivity to the sun (some antibiotics)

When side effects are understood, staff can help their clients to plan their days to avoid disruptions or problems. A medication that causes drowsiness probably shouldn't be given before the client goes out for a meal with friends or family, if they are taking a medication that causes constipation, they may need additional medications to help avoid constipation they should avoid fast acting laxatives before going on a hike.

It is especially important to be aware of possible side effects when a person first starts a medication. Staff should always watch for new or problematic side effects when they start a medication or have a change to their dosage, especially in the first few days. Any physical or behavioral changes should be reported to a supervisor immediately. Some medications might take days or weeks before side effects occur so it is important for staff to watch for changes any time they are working.

Managing side effects for someone who takes a lot of different medications can become quite complicated and may disrupt their lives to an extent that they would rather not take a particular medication. If this situation occurs, it is important to advocate for your client to discuss the problem with their doctor. It is possible that there are medications that might have less or different side effects than the medication they are currently taking. Medications should never be stopped or started without discussing with a physician first as there may be dangerous side effects from suddenly stopping certain medications.

Extrapyramidal symptoms

Extrapyramidal symptoms (EPS) are a specific group of symptoms caused by the long term side effects of certain medications on the Extrapyramidal system. This system is an area of the brain that controls involuntary muscle function (muscles you don't have to think about using like the muscles that help you to digest food or that help you maintain balance). Certain medications, mostly antipsychotics and some types of antidepressants, can potentially cause these symptoms over the course of their use.

These symptoms include parkinsons-like symptoms (slowing of movement, stooped posture, shuffling walk, mild tremors), muscle spasms in the head and neck called acute dystonia, a sense of restlessness called akathisia and involuntary muscle movement of the face (grimacing, lip smacking or puckering, chewing motions or rapid eye blinking) called tardive dyskinesia. These symptoms can range from being a slight annoyance to causing significant difficulties for a person and will often increase over time. When these symptoms are noticed, they should be reported to the client's physician.

The client and physician will need to review the symptoms and the efficacy of the medications that may be causing them. In some cases they may decide to continue with a medication because the EPS are easier to manage than the condition which the medication actually treats. In other situations, they may decide to discontinue the medications or trade them out for alternative medications that treat the same diagnosis in a different way. There are some newer medications that have been developed because they have a lower risk of causing EPS. There are also a few medications that have come out in the last decade which can be used to treat EPS to some degree.

Oversedation, Confusion and Falls

There are a broad variety of medications which can have a mild to significant sedating effect, leading to a client feeling tired, drowsy or sleepy. While some of these medications, like sleep aids, are intended to induce this effect, others have sedation as a side effect. While a mild sedating effect from a single medication may be easy to manage when planning a person's day, taking multiple medications with a sedating effect can have a greater effect on a person leading to increased sleeping or oversedation, increased risk for confusion and increased risk for falls.

Oversedation is a condition, usually caused by medications, where a person has a reduction in cognition, reduction in consciousness to the point of deep sleep and at the extreme, a reduction in breathing (respiratory depression). This can sometimes lead to the point of suffocation and death. When oversedation induces sleep, a client may become difficult to rouse, not responding to talking, touch or even gentle shaking to wake them. Their breathing may become more shallow and slow significantly from the average number of breaths per minute (around 12-20) down to 7 breaths per minute or less. The reduced breathing could lead to lips and nail beds turning blue from lack of oxygen. Call 911 immediately if you notice signs of respiratory depression.

A person who remains awake but is oversedated could appear confused, "out of it," or "zombie-like." Oversedation is often associated with confusion or delirium and can significantly increase the risk for injury through lack of judgment and falls. Especially with older adults, falls can lead to significant injuries including broken bones, internal injuries and even death. It is important for a DSP to be able to recognize the signs of oversedation and report it immediately to a supervisor for the safety of the client.

Adverse reactions, anaphylaxis and response

Adverse Reactions are an unexpected or unintended negative response to a medication. Medication allergies are the most common kind of adverse reactions but they are not the only ones. A medication prescribed to manage constipation but which causes worse constipation for some reason would be an example of an adverse reaction but because they are, by definition, unexpected, this manual will primarily focus on allergic reactions.

Allergic reactions happen when the immune system mistakenly recognizes a medication as if it were a bacteria or other harmful organism and enacts an immune response. People can develop allergies to medications at any time, not just when they first start taking a medication. Allergies can cause skin inflammation (rash, itching, hives), affect the digestive system (nausea, diarrhea) or cause dangerous swelling in the sinuses and airways. Some medication allergies may only be unpleasant or uncomfortable and can be reversed by stopping the medication and managing the symptoms. However, a more dangerous allergic reaction, also known as Anaphylaxis, can affect the respiratory system, potentially blocking the airway and can be deadly.

In addition to causing risk of death due to blocked airway, anaphylaxis can lead to anaphylactic shock, a rare situation where the person's blood pressure drops and the body loses its ability to maintain circulation to the heart and brain. Some people that know they have allergies may have access to an Epinephrine Pen (EpiPen), an emergency device that injects a dose of epinephrine (adrenaline) which causes the body to open airways and increases blood pressure. Staff will receive additional training for use of an epipen in homes where they are present.

If a client ever has difficulty breathing or collapses do not wait to see if symptoms improve, call 911 immediately! As soon as it is possible, staff must also notify the supervisor. After the immediate danger has passed, you will work with your supervisor to ensure that an incident report/GER is completed to document the event. Follow all guidance from your GER training to make sure all important details from before, during and after the event are included.

Drug interactions

Because of the diverse ways medications affect the body, it is possible for certain drugs or foods to interact with each other to increase, decrease or otherwise change the effect of the medications. The changes are called Drug to Drug or Drug to Food interactions.

Drug to drug interactions can either be desirable or undesirable effects. As mentioned previously, there are many types of antihypertensive medications for people with high blood pressure. The client's physician might prescribe more than one different medication specifically because they are more effective together than each would be on its own. This is called an additive or synergistic effect. On the other hand, some medications might counteract or reduce

the effectiveness of other medications either by having an opposite effect or changing the way the body absorbs and processes the other medications. This is called an antagonistic effect. Sometimes these synergistic or antagonistic effects are intentional and planned by a physician but other times, especially when a client is taking a larger number of medications, they may be unintentional.

Drug to food interactions occur when a medication interacts with something the client eats or drinks. As with drug to drug interactions, these may be either desirable or undesirable. Examples of some drug to food interactions include:

- Opioid medications plus alcohol can have a dangerous additive effect on sedation which can potentially lead to death
- Warfarin, a common blood thinner, can either have an increased or decreased effect if the client changes how many servings of leafy greens (rich in vitamin K) they eat in a week.
- Many Cholesterol medications are antagonistically affected by grapefruit or grapefruit juice because an enzyme in the fruit reduces the body's ability to absorb the medication

Medication labels will usually list the most important drug to drug and drug to food interactions but there may be other interactions that aren't listed. For this reason, staff should always try to observe changes in their clients, especially when they start, stop or change dosages of a medication as this information can be valuable for the client and their physician.

Toxicity

Some medications can cause injury, illness or death if they reach a high concentration in the system, this is called toxicity. The most common form of toxicity is overdose, taking more of the medication than instructed, but toxicity can also be caused by medication interactions or diseases of organs in the body which normally filter or break down substances in the body (liver and kidneys, for example).

A few specific examples of toxicity include:

- Warfarin was originally used at a much higher dose as rat poison. Warfarin toxicity can be deadly and cause uncontrolled bleeding inside and outside of the body. This most often occurs when a person takes too much but can also happen if a person significantly changes the amount of leafy greens they eat!
- Lithium is an older medication used for a variety of psychiatric disorders which has only a small variation between an amount that is therapeutic and an amount that is toxic. Because of this, people who use lithium have to have regular blood checks to ensure it is staying at safe levels. Lithium is filtered out of the body by the kidneys so they are also checked to make sure they are functioning properly because they might allow lithium levels to build up in the body if they are not.

- Opioid medications have a high risk for overdose due to the high occurrence of opioid abuse. Opioid toxicity leads to increased sedation and a possible stopping of breathing which can lead to death. A recent nasal spray medication called Narcan has become available to help fight Opioid overdose. It blocks the opiod's effect for a short time but it is possible for the person to shows signs of overdose again after it wears off. Anytime Narcan is administered, 911 should be called!

No matter what causes the toxicity, staff should treat any strange symptoms as a possible sign of toxicity and potentially dangerous. A supervisor should be notified in these instances. If a client ever becomes unconscious and unrousable (you can't wake them up) or if they ever have difficulty breathing, call 911 immediately.

Addiction

Care staff working with people who receive controlled substances on a regular basis may become worried that their clients may become addicted to those medications. But by understanding what addiction is and what one's own biases are, it may be easier for care staff to meet their clients where they live and provide support in as safe a way as possible.

While addiction is a very negatively weighted word in our society, if a person is closely following their doctor's orders when taking addictive medications, they can still be therapeutic. The national institute of health defines addiction as the "chronic, relapsing disorder characterized by compulsive drug seeking and use despite adverse consequences." Though some of our clients may experience difficulties with impulse control related to their diagnoses and may exhibit signs and symptoms of addiction to medications or substances, staff can still provide safe and supportive boundaries for those clients. It is okay to ask questions and gather more information from supervisors or medical professionals working with your client about their needs. On the other hand, it is not okay to ignore doctors orders because of your own worries about a client's medications. This can be a difficult situation, especially for staff who have experienced or been exposed to addiction in the past, but, as with all biases, it is important to control them while working in a care setting.

Drug Tolerance

Oftentimes the medications that are the easiest to become addicted to are also the ones that a person may become tolerant of or become dependent on. Drug tolerance is the change in how one's body processes medications over time, and often requires an increasing dosage to maintain the same effect. Drug dependence, on the other hand, involves the body changing over time because of a medication or substance so that it becomes difficult or dangerous to stop that medication or substance immediately.

It is important to understand that drug tolerance is not the same as addiction. A person can become tolerant of many different kinds of medications but this does not mean their use is

becoming problematic. An example of this is the Parkinson's medication Sinemet. Over time as parkinson's symptoms progress and the body becomes more tolerant of the medication, the dosage needs to be increased to continue to manage symptoms. A person who has been taking the medication for a long time (drug tolerant) might end up taking more than 10 times the dosage that a person new to the medication (drug naive) might take. People with a history of drug abuse may be at a greater risk for toxicity or overdose after stopping a drug because they might try to take the amount they were used to when they had a higher tolerance.

Drug Dependence

Drug dependency is also not the same as addiction though many people who are addicted to a substance will likely also develop a physical or psychological dependence. A physical dependence involves the body changing over time to adjust to the medication's presence. So if a medication replaces a substance that the body might normally make itself, the body may adjust and make less of the chemical naturally. In this case, if the person stops taking that medication, there will be a time where the body doesn't have enough of that chemical which can lead to negative symptoms. A psychological dependence involves the emotional or mental processes that are associated with the medications. A person may find they miss a drug because it gave them positive effects, made them feel good or even helped fight boredom. Psychological dependence can last far longer than physical dependence and may require assistance from a counselor to help build healthy behaviors. An example of this involves ex smokers who will be hit with a cigarette craving some times decades after they quit smoking.

In some cases a physician and client may decide to stop or reduce a medication to reduce the person's tolerance to a medication, this is called a drug holiday or medication vacation. This process should only be done with guidance from a physician and there may be risks to reducing or stopping medications. For people dealing with an addiction, they may try to quit "cold turkey" which has the potential to cause serious and even potentially fatal consequences. Oftentimes it may be necessary to work with a physician to reduce the risks of stopping an addictive substance such as alcohol or opioids.

An example of Addiction, Tolerance and Dependence

A huge population of people around the world use caffeine in the form of coffee, tea, energy drinks and chocolate covered coffee beans to help them stay awake and more focused throughout the day. Because it is readily available and minimally disruptive to a person's life, it may or not be described as an addiction based on our definition above (it also avoids the same stigma because it is so socially acceptable). Despite that fact, Caffeine absolutely can become tolerated in the body and can cause both physical and psychological dependence.

Many seasoned caffeine consumers no longer settle for a simple 6 oz cup of coffee (71 mg of caffeine) but tend towards multiple cups per day or they purchase the huge 20 oz cup (227 mg of caffeine). For some, that's not enough and they order additional shots of concentrated

espresso bringing the cup up to 410 mg of caffeine for one cup. There are, of course, some people who order more than one of these in a day. They have to consume more caffeine to achieve the desired effect. This is tolerance.

For anyone who has consumed caffeine products for a long enough period, it can be difficult to miss their morning cup. In addition to the psychological dependence, the desire to feel the effects of it like wakefulness or improved focus, there can also be symptoms of physical dependency such as headache, irritability, drowsiness, brain fog, decreased energy and depressed mood. These symptoms can make it very difficult to stop caffeine completely but may be reduced by gradually reducing the amount of caffeine consumed to allow the body to adjust.

Understanding these mechanisms can potentially help people to better serve their clients by understanding the difficulties they experience related to addiction, tolerance and dependence.

Managing medications

Forms of medications

Medications can be manufactured in many different forms based on the type of medication, intended use, route of administration and other factors. The form of medication may impact how it is stored, handled and administered. For example, insulin must be stored in a refrigerator, transdermal patches can transfer medication to the DSP if handled incorrectly and bisacodyl comes in both an oral tablet and a rectal suppository and it is best not to mix them up. The primary forms of medications are:

- **Tablets:** A medication, usually mixed with a binder powder, molded into a circular, oval/oblong or other shape.
    - May have an imprint stamped onto it to help with identification
    - May have a coating called Enteric Coating which protects medication from being dissolved before it can be absorbed
    - **DSPs a not allowed to crush or split tablets**
- **Capsules:** A hard or soft dissolvable container enclosing a dose of medicine, usually a powder or enteric coated beads. They are usually taken by mouth but not always- check administration instructions (Spiriva, an inhaled respiratory medication, is packaged in a capsule but has no effect if swallowed).
    - Some capsules are made of gelatin and may not be suitable for Vegetarian or Vegan clients
    - **DSPs are not allowed to open or crush capsules**
- **Gel Capsules:** A special kind of capsule that usually contain liquids.
    - Some gel capsules are made of gelatin and may not be suitable for Vegetarian or Vegan clients
    - **DSPs are not allowed to open gel capsules**
- **Liquid Medications:** Either an elixir (a solution that doesn't require mixing) or a suspension (a solution that needs to be mixed before administration). May be given via multiple routes.
    - Oral- cough syrups, pepto bismol, maalox, liquid tylenol
    - Ocular- Eye drops
    - Otic- ear drops or cleansers
    - Nasal- antihistamine or steroid nasal sprays
    - Subcutaneous- Insulin
- **Topical medications:** Absorbed through the skin and usually take the form of a cream (water-soluble, usually fully absorbed so non-greasy) or ointment (oil-based, tend to remain on the skin longer).
    - DSPs should wear gloves while handling topical medications
- **Transdermal Patch:** A small or large adhesive patch applied to the skin to deliver a measured amount of medication over a set period of time.
    - May leave a residue that should be cleaned when removed as medication can remain on the skin or skin irritation may occur

    - DSPs should wear gloves while handling transdermal patches
    - Used patches should be folded on themselves or attached to the glove then wrapped in the gloves to prevent exposure after it has been removed
- **Inhaler:** A device used to provide aerosolized liquid or powder medication by inhalation. May use an aerosolizer chamber to improve absorption of liquids.
    - Rinse mouth after use as some medication may remain in the mouth after use.
    - Some inhalers require multiple steps to use so always review instructions before assisting
- **Suppository:** Used for rectal or vaginal administration of medications, a suppository is most often a measured amount of medication mixed with a substance like glycerin or cocoa butter that melts at body temperature.
    - Needs to be in place at least 5-10 minutes for full absorption
    - Client may feel like they need to use the toilet shortly after insertion, encourage them to wait.
    - **DSPs may not insert a suppository when assisting with self-administration.**
- **Enema:** Enemas are injections of fluids used to cleanse or stimulate the emptying of your bowel.
    - Needs to be in place at least 5 minutes for full effect
    - Client may feel like they need to use the toilet shortly after insertion, encourage them to wait.
    - **DSPs may not insert an enema when assisting with self-administration.**

<u>Measurements and metrics</u>

DSPs are not allowed to pour liquid medications when assisting with self-administration, the client must do so for themselves. However part of the role of assisting involves checking that a dose of medication matches the prescription label which means staff need to understand the best practices for working with liquid medications:

- Only use labeled measuring devices specifically dedicated to that medication
    - Most liquid medication come with a measuring cup with marked dosages
- Measuring containers should be rested on a clean flat surface when pouring and reading them
    - If the cup is being held up, it may not be level and could be misread
    - DSP should get down to surface level to verify the amount of medication
- It is important to be aware of certain measurements that may be used commonly
    - Teaspoon (tsp) = 5ml
    - Tablespoon (tbsp) = 15ml
    - 1 ounce = 30ml
- Clean up any spilled medications immediately using gloves and report the spill if necessary.

Medical abbreviations

In fast paced medical settings, shortening commonly used words when communicating important concepts can be essential. Unfortunately, using abbreviations can lead to difficulties due to lack of understanding so it is better to avoid abbreviations whenever possible. Nonetheless, abbreviation use does happen so it is beneficial to be able to recognize them when they do occur. Below is a table of the most commonly encountered abbreviations and an explanation.

Abbreviation	Explanation	Abbreviation	Explanation
ADL	Activity of Daily Living	NKA	No known allergies
AM	Morning (Latin: *ante meridium*, before noon)	NKDA	No known drug allergies
ASAP	As Soon As Possible	NOC	Night time (Latin: *nocturnal*, night time)
BID	Twice per day (Latin: *bis in die*, twice a day)	NPO	Nothing by mouth (Latin: *nil per os*, nothing by mouth)
BM	Bowel Movement	N/V	Nausea and vomiting
BP	Blood Pressure	NVD	Nausea, vomiting, diarrhea
BPM	Heartbeats per minute or Breaths per minute	OTC	Over the counter
c	With (Latin: *cum*, with)	oz	Ounce
C	Celcius	p	After (Latin: *post*, after)
Cap	Capsule	PM	Afternoon/Evening (Latin: *post meridium*, after noon)
DC or D/C	Discontinue or stop	PO	By mouth (Latin: *per os*, by mouth)
Dx	Diagnosis	PRN	As Needed (Latin: *pro re nata*, as needed)
etc	And so on (Latin: *et cetera*, and so on)	Q	Every (Latin: *quaque*, every)
F	Fahrenheit	QH	Every hour (Latin: *quaque hora*, every hour)
FU or F/U	Follow up	Q4H, Q6H, Q8H	Every X hours (Latin: *quaque X hora*, every X hours)
GI	Gastrointestinal or Digestive Tract	R	Right
gm	Gram	ROM	Range of motion
gt or gtt	Drops (Latin: *guttae*, drops)	Rx	Prescription (Latin: *recipe*, recipe or prescription)
H	Hour	SL	Under the tongue (Latin: *sub lingual*, under the tongue)
H2O	Water	SOB	Shortness of Breath
HR	Heart rate	STAT	Immediately (Latin: *statim*, immediately)
HS	Bedtime (Latin: *hora somni*, hour of sleep)	SubQ or SQ	Injection under skin (Latin: *sub cutaneous*, under the skin)
HTN	Hypertension or High blood pressure	Sx	Symptoms
Hx	History	Tab	Tablet
L	Left or Liter	TID	3 times per day (Latin: *ter in die*, three times per day)
mcg	Microgram	Tx	Treatment
mg	Milligram	UTI	Urinary tract infection
ml	Millilter (use this rather than cc)		

Storage of medications

In a home where staff are handling medications, all medications must be secured in a locked room with a locking medication cabinet and locking medication refrigerator. Most medication tasks including opening packaging and controlled medication should be completed in the medication room unless the service plan states otherwise. Clients may decide where they would like to self-administer their medication.

The medication cabinet is used for storing all non-refrigerated medications. It may be locked if needed to provide a second level of security. However it must be locked if there are any controlled substances present. Inside the cabinet, each home resident should have their own compartment, bin, or area for their medications separate from the medication of others. Topical medications should be stored separately, however, in case of leakage. Medications must be kept in their original containers or med packs with the original labeling.

In a multi-person home, the room should have a medication refrigerator which may be locked to provide a second level of security. As with the cabinet, the refrigerator must be locked if controlled substances are present. All new medications should be checked to see if they require refrigeration but the most common refrigerated medications are Insulin, Probiotics and liquid antibiotics. Medications in the refrigerator will be kept in the original container (or med pack) with the original labeling and any spills should be cleaned immediately and reported if necessary. This refrigerator should not be used to store food unless that food is meant to accompany medications.

Reading medication labels on medication bottles

In Crossroads homes, your clients' medications will most often be stored in an OTC bottle, a med pack or a pharmacy bottle. OTC bottles will usually have an eye-catching label and can contain either liquid or non-liquid medications. Unlike containers prepared by a pharmacy, OTC bottles will not have a pharmacy label but will usually have printed instructions for dosing. The medication documentation for your client will provide the correct dosing guidelines as they may be different from the OTC label.

Pharmacy bottles will be familiar to most people. They are bottles of a single medication prepared by a pharmacy and usually hold enough doses for 1-3 months. Pharmacy bottles may contain either liquid or non-liquid medications and will have a pharmacy label with clear instructions printed on it. Med packs (also known as bubble packs) are special containers prepared by the pharmacy to contain a month's worth of non-liquid doses of medications in individual compartments or bubbles. These bubbles make it easy for staff to visualize the medications to count or to assure all doses have been taken. Med packs can contain a single medication or a combination of medications meant to be given at the same time. They will have a separate medication label for each medication contained in them.

Different pharmacies may have different layouts for their labels but most will include the following information:

- Pharmacy information
- Prescription number
- Prescribing Physician's Name
- Client's name and address
- Generic Name and Strength/Concentration of Medication
- Dose/Amount of Medications to take
- Route of Medication administration
- Time or Frequency
- Fill Quantity (QTY)
- Refill information
- Expiration Date
- Physical Description of Medication
- Special instructions or Precautions

Take a look at the fictional medication label below and try to find each piece of information. Remember that each pharmacy may have a different format for labeling but that all labels should contain most of these pieces of information.

Good Drugs Pharmacy **Ph: 907-123-1234** 10 NE 10th St Fairbanks Alaska 99709 Dr. Marcus Welby RX# 98514635 12/28/2023	IMPORTANT INFORMATION Call your doctor for advice about side effects
Minnie Mouse 123 Alaskaland Way, AK **Take One tab by mouth daily** **Darnitall 25mg** QTY: 30 (Generic for Bigproblemo) *White, Oval "DARN"* Refills left: 6 until 6/28/2024 **Expires: 12/28/25**	IMPORTANT: USE AS DIRECTED DO NOT SKIP DOSES OR DISCONTINUE UNLESS DIRECTED BY YOUR DOCTOR **TAKE WITH FOOD** **DO NOT DRIVE AFTER TAKING THIS MEDICATION** **DO NOT TAKE WITH ALCOHOL**

The medication information in the documentation app staff use to record medications are based on these medication labels. A supervisor should be consulted immediately if a medication label does not match the medication instructions in the app.

Disposal of Medications and Containers

Pharmacy medication labels contain a significant amount of protected health information (PHI) on them and if an unauthorized person were to access them, they could find the person's full name, address, physician's name and even medical diagnoses. For this reason medication containers must be disposed of in a particular way. If for any reason there are medications to be disposed of, there is also a specific procedure to be followed. In general, DSPs may assist a supervisor in disposing of medications and packaging but will usually not be responsible for doing so alone. This is done to protect both the client and the DSP.

DSPs should place any empty or discontinued medication containers inside the medication cabinet in a designated disposal area unless they have been given specific instructions to do otherwise. If staff are ever instructed to dispose of empty containers, they should follow these guidelines:

- Ensure that all containers are completely empty before disposing of them
    - If there are any medications still in the containers, contact your supervisor
    - Empty medications containers should not be refilled or re-used
- Peel the label off any empty medication bottles
    - Place the labels into a secure bin for shredding.
    - Bottles can be thrown in the garbage if there is no remaining PHI on them
- Remove all labels from empty med packs
    - Place the labels into a secure bin for shredding.
    - Med packs can be thrown in the garbage if there is no remaining PHI on them

It is possible that there are some situations where unused medications can no longer be given and must be disposed of. DSPs should not dispose of or destroy medications unless they are assisting their supervisor. The most common instances where a medication needs to be destroyed are:

- Medication has been discontinued
    - DSPs should place the containers in the disposal area of the medication cabinet
- Medication has fallen on the ground
    - Report this to your supervisor. Place the pill into a clear plastic bag labeled with the Date, Time, Supervisor's name and DSPs name.
    - Complete a GER if needed
- Medication was found outside of the container (loose meds)
    - Report this to your supervisor. Place the pill into a clear plastic bag labeled with the Date, Time, Supervisor's name and DSPs name.
    - Complete a GER if needed
- Medication was removed from a bubble pack but not taken
    - Report this to your supervisor. Place the pill into a clear plastic bag labeled with the Date, Time, Supervisor's name and DSPs name.
    - Complete a GER if needed

Controlled Substance Counts

Under our licensure Crossroads is required to track any controlled substances that are handled by staff. Timely medication counts can ensure that if any controlled substances go missing, Crossroads can respond quickly to protect the safety of clients and of staff. Crossroads is required to investigate any discrepancies and in some cases may need to report them to the state or to law enforcement. In these cases, Crossroads will likely require drug screenings for all staff working in the home. This is not meant to punish staff, in fact, it is a measure to protect staff in situations involving law enforcement as a clear drug screen is strong evidence during an investigation.

Each home where staff supervise or assist with controlled substances will have a controlled substance count sheet for each controlled substance. If there are multiple med packs for a single medication, they will all be counted together. Here is an example of what the controlled count sheet will look like

Client Name:			Minnie Mouse				3
Medication Name and Dosage:			Darnitall 25 mg				
Client Home			123 Alaskaland Way, AK				
Supervisor Contact information:			Marcus Wellby (907) 456-5656				Number of Packs
Date	Time	Prev Count	# Given	End Count	Signature 1	Signature 2	Notes
2/14/24	8:00am	44	3	41	*Joan Crawford*	*Bette Davis*	

A full procedure will be provided in the Appendix at the end of this manual but here are the most important things to remember about controlled substance counts:

- Counts should be completed at least once per day
- A count should be completed any time a supervisor brings in or removes controlled substances from the home
- A controlled substance count should always be done with two people when possible
    - This can be two DSPs or a DSP and a supervisor
    - Clients and their guardians may request to be involved in a controlled substance count
        - Clients and Guardians should not count anyone else's medications
- Each staff involved in the count should do their own count
    - Never let someone else count for you

- Be sure you are using the correct count sheet for the medication you are counting
    - Verify the Client and Medication on both the sheet and the label
- Always count the number of whole tablets, even if some medications have been split
    - If all tablets in a med pack have been split in half by the pharmacy, count all bubbles then multiply by 0.5.
        - If you have 34 bubbles containing half tablets then you would document 17 tabs (34 x 0.5 = 17)
    - If the med pack has one and a half tablet doses, you may count all bubbles and multiply by 1.5.
        - If you have 9 bubbles containing one and a half tablets each then you would document 13.5 tabs (9 x 1.5 = 13.5)
    - If the med pack has 2 tablet doses in each bubble, you may count all of them and multiply by 2.
        - If you have 9 bubbles containing one and a half tablets each then you would document 13.5 tabs (9 x 1.5 = 13.5)
- Document your count on the count sheet
    - Write down the previous count, number of medications given since last count, number of medications counted, your signature and the signature of the other counter.
    - Make any notes about changes in the notes section
- If you find any discrepancies, perform at least one recount.
    - Human error is always a possibility, especially when there are a large number of pills
- Report any discrepancies to your supervisor immediately

Managing Medications

The 6 Rights of medication

The six “Rights” of medication administration are a systematic approach to providing support for your client when they take their medications. These six considerations reduce risk to the client while also protecting the assisting DSP by ensuring that all possibilities for error are managed. Any failure to follow the 6 rights is an error and must be reported. Medication errors will be discussed further in the next section. The 6 Rights are:

- Right Person
- Right Medication
- Right Amount
- Right Route
- Right Time
- Right Documentation

Right Person means that medications are going to the person they are prescribed to. DSPs should always look at the medication label & medication administration record (MAR) to make sure the name matches the person they are giving the medication to. In some homes you may have multiple people taking the same medication but you should only give a medication to the person whose name is on the label! For example:

> Bob and Steve both take Darnitall 25 mg but Bob doesn’t have any more Darnitall in his medication bottle. The DSP on duty is not allowed to give Bob one of Steve’s Darnitall pills even though they are the dame medication. This would be a “wrong person” error and would need to be reported immediately to a supervisor.

Right Medication means that you have verified the person is supposed to recieve the medication. At Crossroads, all medications have to have been reviewed and signed off by the client’s physician, even OTC medications. If a doctor hasn’t okayed a medication and it isn’t a part of the client’s record then it could be a wrong medication error if they take it.

Another possibility for error comes from the fact that many medication names sound alike but can be VERY different. Additionally, all medications have more than one name, a generic name and at least one brand name which can be very confusing if staff arent careful. Generic names are generally derived from the chemical structure of the medication whereas brand (or trade) names are chosen by the drug manufacturer & picked to be simple or memorable. Staff should always verify that they are giving the right medication by comparing the label and the medication record.

Right Amount means that the medication is taken at the right dosage with the right number of pills or amount of liquid. Many medications come in a variety of different doses depending on

the needs of the client. A client might take the same medication multiple times per day but at different amounts or dosages at different times. It is essential to verify not only the dosage or strength of the medication the client is taking but also how many doses. Here is an example of something staff might encounter:

> Darnitall 25mg Give one tablet by mouth at 9am and two tablets by mouth at 9pm.

In this situation, the client would receive 25mg at 9am and 50mg at 9pm. If staff are assisting with this medication, they should make sure that the number of tablets matches the label and the medication record to avoid a wrong amount error.

Right Route means that a medication is taken in the correct method. The most common examples are:

- Oral (swallowed), most often pills, capsules and liquids
- Ophthalmic (eye), most often liquid drops or ointments
- Otic (ear), most often liquid drops, creams or ointments
- Nasal (nose), most often liquid sprays, creams or ointments
- Inhaled, most often liquid sprays but can also be inhaled powders
- Rectal, most often suppositories, creams or enema
- Vaginal, most often creams or suppositories
- Topical (on the skin), most often patches, creams and ointments.

There are some situations where a medication that is normally given by one route might be ordered by a doctor to be given by a different route. Never assume you know the route of a medication, always review the medication label and medication record to avoid a wrong route error.

Right Time means that the medication is given at the correct time which is within 1 hour of the time listed in the medication record. This means that a medication scheduled for 9am can be given any time after 8am and before 10am as still be considered correct. Some medications may be ordered to be given at multiple times during the day or on different days of the week so it is important to always check the label and medication record to avoid a wrong time error.

Some medications are ordered to be given “PRN” or as needed. These medications will give a clear guideline for when and how they may be given. An example of this would be “as needed at bedtime for difficulty sleeping.” In this situation the client has the option to take the medication at bedtime if they want to but it is not a wrong time error if they do not. It would be a wrong time error if they took the medication in the afternoon to help them nap as that is not the time ordered.

Right Documentation means that all medications taken by the client are documented appropriately and in a timely manner. The medication record is not only the way to verify that

medications are taken correctly but also to document when they have been taken. Different agencies use different medication records but they are all maintained in the same manner. Because DSPs are not trained to update medication records, they should not make modifications. If a DSP notices a difference between a medication label and the medication record, they should report this to their supervisor immediately and the supervisor can make any changes or give further guidance as needed.

Staff should record the medications have been taken immediately after the client has taken them, not when they are removed from the containers. If a medication is not documented in an accurate and timely manner, this is a wrong documentation error. In the event of a scheduled medication being missed or refused (see Right to refuse below), report the situation to your supervisor for guidance and complete a GER.

Right to refuse

While the right to refuse is not one of the 6 rights of medication, it is an essential client right that must be handled according to policy. Every individual has the right to make informed choices about their own health care and this includes choosing not to take a prescribed medication. In managed care settings like Crossroads, however, some medications may be essential for the safety of the client or may help them to manage unsafe conditions or behaviors. Part of the duty of DSPs is to help clients balance their right to make choices with the possible health consequences of refusing medications. In addition staff should look for opportunities to help our clients advocate for themselves.

When a client refuses to take a medication, there are a few things staff can do. It can be helpful to ask why they don't want to take the medication. Some reasons might be easy to fix. If a medication tastes bad, maybe they would prefer to take it with pudding, apple sauce or some other favored food to cover the flavor. Other reasons might need to be communicated to a physician to see what changes could be made such as "it's too big," "it makes me feel weird," or "it makes me sleepy before work." These concerns should be discussed with your supervisor to help communicate them to the physician. Some reasons might not have obvious solutions. If a client says "I don't need that med anymore," or "I think someone put poison in my pills," it may be difficult to redirect them and a supervisor should be contacted to assist in the situation.

If staff can find a way to help the client to be more comfortable with taking their medications that can be very beneficial for them. Sometimes, however, even with the assistance of a supervisor, a client may still choose to refuse the medication. In that case, the supervisor can provide guidance with how to proceed and may direct the DSP to complete a GER for the refused medication. If the client refused to take a medication, do not document that it was given.

Medication errors

In the last section examples of possible medication errors provided for each of the 6 rights. It is important to remember that in any situation where one or more of the 6 rights are not met, a medication error has occurred. So, a medication error is:

- Incorrect person
- Incorrect medication
- Incorrect amount
- Incorrect route
- Incorrect time
- Incorrect or missing documentation

Even with all the medication and training in the world, mistakes may still happen. That is just a fact of life. The most important thing to do when an error occurs is to make sure it is addressed in a safe and timely manner. Every error, even something that feels minor, should be reported to better protect our clients from negative health effects. People tend to be ashamed of making mistakes or may be afraid of getting in trouble so they may try to hide errors but hiding an error is far more dangerous than making an error. In addition to allowing the care team to address any immediate risks to the client in a timely manner, Supervisors and staff can work together to avoid that same error happening in the future.

Any time staff recognize an error, it should be reported to the supervisor or nurse as soon as possible. The supervisor will work with staff to monitor the safety of the client. If any dangerous or life threatening health problems occur 911 must be called. The supervisor will contact the healthcare provider who prescribed the medication for any further follow up instructions if needed. Finally, document the error and steps that were taken to protect the client in a GER after the situation is under control.

All licensed agencies are legally required to document, track and review all medication errors that occur in their homes. Failure to do so could lead to loss of licensure and other legal repercussions leading to the closing of care homes. While doing our best to avoid medication errors is important, ensuring that they are responded to in a safe manner, documented appropriately and reviewed to improve care for all clients is essential to allow the agency to continue to provide support to its clients.

How to find more information

This manual is provided to all staff members as a resource for any questions that might come up during the course of medications management in any Crossroads home. Staff may also reach out to their supervisors or the registered nurse to seek more information. In the homes, staff will have access to the medication records and information sheets for all medications taken by client's in that home. Staff may also utilize the client's pharmacist and physician to help answer any questions that may occur regarding medications.

Review of responsibilities

With the completion of this training and post test with a score of 90% or more, staff will be qualified to supervise the self-administration in Crossroads assisted living homes and assist with the self-administration of medications in all other homes managed by Crossroads. Staff will not be allowed to administer medications in any Crossroads home unless they have received additional training and a legal delegation from the registered nurse that is specific to the clients they work with. If you are ever unsure if you are allowed to administer medications to a client, do not administer medications.

No matter what role staff play in the home, these are essential responsibilities:

- Call 911 in the event of any emergency
- Contact a supervisor with any questions, to report an emergency or to report an error
- Maintain the the privacy of clients and their personal information
- Follow all infection control protocols at al times in the home
- Ensure all medications are stored appropriately and in a safe manner
- Always follow the 6 rights when managing medications
- Complete all documentation for medications and medication errors in timely manner

Staff who provide **supervision of self-administration** in an assisted living may:

- remind a resident to take medication
- open a medication container or prepackaged medication for a resident
- read a medication label to a resident
- observe a resident while they take their medication
- check a resident's self-administered dosage against the label on the container
- reassure a resident that they are taking the dosage as prescribed
- direct or guide a resident’s hand, at their request, to administer their own medications

Staff who provide **assistance with self-administration** in other Crossroads homes may:

- remind a resident to take medication
- open a medication container or prepackaged medication for a resident
- read a medication label to a resident
- provide food or liquids if the medication label instructs the resident to take the medication with food or liquids
- observe a resident while they take their medication
- check a resident's self-administered dosage against the label on the container
- reassure a resident that they are taking the dosage as prescribed
- direct or guide a resident’s hand, at their request, to administer their own medications

Appendix I: Procedure for designating primary and support staff in the home

1. Each house will have ONE staff member designated as the Primary Staff at a time.
2. All other staff in the home will be designated as Support staff
3. The Primary staff member will be responsible for:
    a. Assisting all clients in the home to self-administer their medications and documentation
    b. Reporting any refusals, problems and medication errors to your supervisor as soon as possible
    c. Keeping the medication room and Medication cabinet locked and secure
    d. Completing a hand-off when transferring responsibility to/from another primary
        i. Hand-off from one Primary to the next will involve the following tasks:
            1. Report about any health or medication changes for all clients
            2. Hand-off keys to the medication room and medication cabinet
            3. Complete a controlled substance count for all clients in the home with the off-going primary
        ii. Completing a controlled substance count for all clients in the home with a support staff member on any days they do not do a hand off
4. The Support staff will assist the Primary in the following ways:
    a. Assist clients and reduce distractions as needed while the Primary is in the medication room
    b. Completing a Controlled substance count with the Primary on days when they are not handing off to another primary or when requested.
    c. Be aware of medication times and support the Primary and Clients to ensure they have their medications on time.
    d. Limit entry into the medication room when the Primary is not in the room
5. If the Primary staff member must be out of the house temporarily (appointments, outings, etc.), a supervisor or qualified support staff member may take temporary responsibility for medications without doing a full hand-off.
    a. The following are considered qualified support staff:
        i. Any on-duty supervisor.
        ii. Any on-duty staff member who has previously served as a Primary in this home.
        iii. Any on duty staff member who has completed their 6-month probationary period.
    b. The temporarily responsible staff may administer medications only when the Primary is not present.
6. Each Primary and anyone taking temporary responsibility must be documented on the Primary Designation form in the front of the medication book.
    a. Documentation includes the following information:

i. Primary Y/N: Mark “Y” for the person designated as Primary, mark “N” for anyone taking temporary responsibility.
ii. Start Date and Time.
iii. Printed Name and Initials.
iv. End Date and Time.

b. A primary who is working multiple days in a row only needs to make one entry for that time, even if they temporarily hand off responsibility.
c. Someone taking temporary responsibility must make an entry every time they do so.

Appendix II: Procedure for completing a controlled substance count

1. The primary staff in the home will complete a controlled substance count of all medications with a second person (if possible) at least once per day
    a. The primary staff may complete additional Controlled substance counts in a day if they choose.
    b. The supervisor may complete or instruct the primary to complete additional controlled substance counts in a day if they choose.
        i. A new count should be done any time a supervisor removes or brings in new controlled substances
    c. A client or their guardian may request that they be involved with a controlled substance count of ONLY their medications
        i. The client should not be involved in counting any medications other than their own.
2. The primary staff MUST complete a controlled substance count of all medications during Hand-off with another primary
3. The second person completing a Controlled Substance count of all medications can be:
    a. The other Primary during hand-off
    b. A Crossroads Supervisor or Nurse
    c. A support staff member
4. The second person completing a Controlled Substance count of all medications cannot be:
    a. A client or client guardian
        i. Though they can participate in counting their own medications
    b. An outside caregiver (day hab, job coach, etc)
    c. Any house staff that are not “on the clock.”
    d. Anyone else not listed above.
5. Complete a controlled substance count using the following procedure:
    a. Open the Medication book to the Controlled Substance Count sheet for the medication to be counted
        i. Fill in the date and time that you are completing the count.
        ii. Fill in the “Prev Count” column with the number of medications counted during the last count.
            1. You can find this number in the “End Count” column on the line above
        iii. Review the MAR to determine how many tablets have been administered since the last count then fill in the “# Given” Column
            1. Always review the MAR as there could have been refused or skipped doses.
        iv. Subtract “# Given” from “Prev Count” and note it.
            1. Example: If “Prev Count” was 10 and “# Given” was 3 then staff can expect there will be 7 (10 - 3 = **7**)
    b. Grab the medication bin for the client whose medication is to be counted.

c. Pull out all bottles or Med Packs that contain the medication to be counted, including any discontinued med packs
d. Both people involved in the count should count the total number of tablets of that medications in all med packs
    i. If both people agree on the number of medications, record the count in the “End Count” column
    ii. If each person counted a different number of pills, BOTH must recount until their counts agree.
    iii. If medications are packaged with more or less than 1 tab (0.5, 1.5, 2, etc), count all bubbles then multiply that number by the amount in each bubble for the total tablet count.
        1. For Example:
            a. 5 bubbles with half (0.5) tabs should be multiplied by 0.5 for a total 2.5 tablets
            b. 5 bubbles with one and a half (1.5) tabs should be multiplied by 1.5 for a total of 7.5 tablets.
            c. 5 bubbles with two (2) tabs should be multiplied by 2 for a total of 10 tablets
e. Compare the expected number and the number in the “End Count” Column.
    i. If the expected number and numbering the “End Count” column match, proceed to the next step (f)
    ii. If the numbers do not match, recheck the “Prev Count” and review the MAR to verify the “# Given” then recount all tablets.
        1. If the number is off by five or more, it is possible you are missing a med pack or may have grabbed the wrong one. Double Check the med packs and medication bin.
    iii. If, after repeating all the steps, the “End Count” is different from the expected number, **Notify the supervisor immediately.**
f. Both people involved in the count should sign under the “Signature 1” and “Signature 2” columns before putting away medication bins and moving on to the next task.

Appendix III: Procedure for assistance with self-administration of medications

1. Refer to the client's care plan to determine if medications will be prepared for self-administration by the primary or by the client with the primary's assistance
2. Open Med Binder to the correct Med Assist form for Right Person and Right Time
3. Use a sanitizing wipe on the surface of the page protector.
    a. Allow it to air dry before proceeding
4. Retrieve Client's Medication bin from Cabinet
5. Wash hands with soap and water or hand sanitizer per procedure
6. Don Gloves before handling medications
7. Confirm you have the correct pill packs for the Right Person and Right Time
8. Starting from the Upper left medication on the Assist form, find the matching med pack and confirm the Right Medication, Right Dosage and Right Route
9. The client or staff will place medication on the correct square of the Med assist form
    a. Med Pack: Remove pills from the bubble that corresponds to the current date and place them on the matching square of the med assist form
        i. The person who removes the medication will mark the date and their initials on the back of the pack where they have removed medications
    b. Prescription Bottles: Remove the number of medications indicated on the med assist form and place them on the matching square of the med assist form
    c. Tubes, Creams, Patches, Liquids: Place sealed containers on or near the Assist form
10. Confirm all medications have been pulled from med packs and matched on the med assist form.
    a. If there are any spaces on the Med Assist form that don't have medications matching the entries:
        i. Double check all Med packs for that client and time
        ii. Check the client's medication bin to see if any packs were misplaced in a different section
        iii. Call your supervisor or the nurse if you are still missing medications
    b. If there are any med packs that don't have a corresponding space on the Med Assist form:
        i. Double check that the med pack is for the correct Person and Time
        ii. Call your supervisor or the nurse if you still have medications for the client that don't have a space on the Med Assist form
11. Move all pill/capsule medications from the medication assist form to a clean cup or dish marked with the client's name or initials
12. Remove and dispose of gloves and wash or sanitize hands per policy.
13. Give the Correct Medications to the Correct Client to self-administer. The primary may assist in the following ways:
    a. Remind the client to take medication
    b. Open a medication container for the client
    c. Read a medication label to the client

d. Observe the client while they take medication
e. Check the client's self-administered dosage against the label of the medication container
    i. This has already been completed but you may do so again if requested
f. Reassure the client that they are taking the dosage as prescribed
g. Direct or guide the hand of the client, at their request, while they self-administer their medication

14. If the client chooses not to take some or all of their medications, complete the following steps:
    a. Determine why they are choosing to refuse their medications
    b. Attempt to address the reason if possible:
        i. Offer a preferred food to cover a bad taste
        ii. Offer additional fluids if it is difficult to swallow
        iii. Make a plan to re-approach in 10-15 minutes if they don't want the medication at the time you are offering.
    c. Be aware of the Right Time for administration and complete a GER for the medication error if it is taken outside of the allotted time
    d. If the client continues to refuse medication, contact your supervisor or nurse for assistance or further instructions. They may:
        i. Provide additional strategies to try
        ii. Provide additional information to the client about the purpose of the medications
        iii. Be successful in assisting the client to take their medications
        iv. Communicate the client's concerns to their physician and advocate for adjustments if possible
        v. Instruct you to take back the refused medication and document the refusal
15. Once the client has self-administered their medications the primary will document the time for all medications they have taken in the Therap app.
    a. Use the Med Assist form to confirm each medication as you mark the administration.
    b. Set the "Administered Time" to the time when the client took their medications.
    c. Tap the "Confirm Administered Time" button so it appears green
    d. Confirm all information is correct then tap the "Submit" button
16. If there are any medications still listed as "Due" after you have confirmed the times for all of the medications on the Medication Assist form, complete the following:
    a. Double check that you haven't missed any medications on the Medication Assist form.
    b. Notify the supervisor or nurse for further instructions.
17. After all other steps are complete, put away all medications and materials for the client
    a. If there are no other clients who need assistance at the time, close and lock medication cabinets and medication room,
    b. If there are other clients who meed assistance at the time, repeat this procedure as needed.

Appendix IV: Procedure for managing medication errors

1. Report any medication errors to your supervisor or the nurse AS SOON AS YOU NOTICE IT.
2. Follow any instructions given by the supervisor or nurse.
3. Monitor the client for any signs of an adverse event and call 911 in the event of an emergency.
4. Complete GER per policy for any of the following Medication Errors:
    a. Giving medications to the Wrong Person
    b. Giving a person the Wrong Medication
    c. Giving the Wrong Dosage of medication
    d. Giving medication by the Wrong Route
    e. Giving a medication at the Wrong Time, Defined as more than 1 hour before or after the scheduled time.
    f. Documenting incorrectly or failing to document
5. The supervisor and/or nurse will follow up about any errors to determine ways to avoid them in the future. This may include:
    a. Seeking solutions with the prescribing physician
    b. Providing additional education to client's
    c. Providing additional education to staff
    d. Changing Care Plans to better fit client needs
    e. Adjusting Staffing to better fit client needs
    f. Adjusting housing arrangements to better fit client needs

Appendix V: Medication Management Documents

Medication Management Pre-Test

Name:_____ Date: _____

Instructor:_____

1. What are the 6 Rights of Medication administration:
   Right_____
   Right_____
   Right_____
   Right_____
   Right_____
   Right_____

2. What is the most effective task for infection control?
   _____

3. Name 5 medications that you are familiar with:
   _____
   _____
   _____
   _____
   _____

4. Name 3 routes a medication can be given:
   _____
   _____
   _____

5. Have you ever taken a medication without knowing why you were taking it?
   _____

Medication Management Post-Test

Name:_____ Date: _____

Instructor:_____

Must be passed with a score of at least 36 (out of 40). You may use your medication manual.

1. Give an example of 6 different kinds of medication errors (think of the 6 rights):
   Wrong_____
   Wrong_____
   Wrong_____
   Wrong_____
   Wrong_____
   Wrong_____ (__/6)

2. Once you pass this test you will be allowed to complete the following tasks in your client's home (True or False):
   _____ Supervise Medication Self-Administration
   _____ Assist with Medication Self-Administration
   _____ Administer Medications to your client
   _____ Crush pills when assisting with medication self-administration
   _____ Assist with self-administration of a controlled substance
   _____ Delegate medication administration to a co-worker
   _____ Steady your clients hand while they are self-administering their medications
   _____ Administer injections to your client
   _____ Complete a controlled substance count with a co-worker
   _____ Assist with over-the-counter medications without documenting
   _____ Apply topical medications to your client's skin with gloves on
   _____ Document any time you assist with medications (__/12)

3. What should you do if your client requests a PRN medication that is not on the MAR?
   a. Give it then contact your supervisor to add it to the MAR
   b. Hold it and ask your supervisor about it the next time they are around
   c. Only give it if it is OTC, otherwise hold it and contact your supervisor
   d. Hold it and contact your supervisor immediately (__/1)

4. When can a PRN medication be given?

   _____ (__/1)

5. What should you do if your client starts to develop an itchy rash on their arms shortly after taking a new medication?
   a. This is not an ADVERSE EFFECT and is a normal response to new medications
   b. This may be an ADVERSE EFFECT, you should offer a medicated cream
   c. This may be an ADVERSE EFFECT, contact your supervisor immediately
   d. This may be an ADVERSE EFFECT, you should call 911 immediately (__/1)

6. You are concerned that one of the client's medications may be having an interaction with one of their other medications, where can you get more information?
   a. The Nurse supervisor
   b. The Pharmacist where you get the meds filled
   c. The drug information sheets in your client's med book
   d. The Client's doctor
   e. All of the above (__/1)

7. Circle the <u>six</u> factors that are LEAST likely to affect how the body processes medications:

   Certain foods Medication Color Psychological factors

   Body Composition Number of followers on social media

   Political Party Genetic factors Education level

   Biological Sex Favorite TV show Other Medications

   Age Illnesses/Injuries Bank account Size

   (__/6)

Use this medication label for your client, Funky Brewster, to answer the following questions

Good Drugs Pharmacy **Ph: 907-123-1234** 10 NE 10th St Fairbanks Alaska 99709 Dr. Marcus Welby RX# 98514635 12/28/2023	IMPORTANT INFORMATION Call your doctor for advice about side effects
Funky Brewster 123 Alaskaland Way, AK **Take One tab by mouth daily at Noon** **Darnitall 25mg** QTY: 30 (Generic for Bigproblemo) *White, Oval "DARN"* Refills left: 6 until 6/28/2024 **Expires: 12/28/25**	IMPORTANT: USE AS DIRECTED DO NOT SKIP DOSES OR DISCONTINUE UNLESS DIRECTED BY YOUR DOCTOR **TAKE WITH FOOD** **DO NOT DRIVE AFTER TAKING THIS MEDICATION** **DO NOT TAKE WITH ALCOHOL**

8. What is the EARLIEST and LATEST time the client can take that medication?
   Earliest time:_____ Latest time:_____ (__/2)

9. Funky's brother takes this same medication with the same dosage at the same time but his bottle is empty. Can you give him one of Funky's medications? Why or Why not?
   _____ (__/1)

10. Your client comes home from a Champagne brunch with his friend at 11:30am. He reports that he had a few alcoholic drinks at 11:30 am and requests his Bigproblemo. Mark "Yes" if you should do the following, mark "no" if you should not:
    _____ Give him the Bigproblemo as requested but hold the Darnitall
    _____ Give him the Darnitall but hold the requested Bigproblemo
    _____ Give him a dose of the Bigproblemo as requested and the Darnitall because it is Scheduled for noon and can't be missed
    _____ Hold this medication until the client sobers up, then give it to them
    _____ Tell his friends about his medications so they don't take him out drinking again
    _____ Mark the medication as refused in the MAR
    _____ Mark the medication as "On Hold" in the MAR
    _____ Break the pill, give half now and half when he is sober
    _____ Ask the neighbor who you think is a doctor for advice on what to do
    _____ Call 911 to have his stomach bumped to avoid alcohol poisoning (__/9)

Requirements	Manual Pages	Power Point Slides
Course objectives	1	3
Content of Course	3-4	4
Pretest and Post-test	66-69	169
1. Responsibilities of Caregivers	2	6-8
2. Types of Medications/Classifications	32-36	41-67
2a. Prescription vs. OTC	34	54-56
2b. Controlled Substances	35	57-58
2c. Time Sensitive	35-36	59-62
2d. Medications for chronic conditions	34	52
2e. Psychotopic	34	53
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3. Effects of medications	37-44	69-104
3a. Expected or desired effects	37	69-71
3b. Known Side effects	37	72-75
3c. Anaphylaxis	40	82-83
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3e. Drug to Drug Interaction	40	76-77
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4. Response to adverse effects	40	91-95
4a. What should the person do	40	91-92
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5. Six Rights of Medication	53-57	146-152
5a. Right Person	53	147
5b. Right Medication	53	148
5c. Right Dose	53-54	149
5d. Right Route	54	150
5e. Right Documentation	54-55	152
5f. Right time	54	151
5g. What you need to know and how to find it	56	135-136
6. Measurements and metrics	46	126-128
7. Medical abbreviations	47	129-130
8. Storage of medications	48	131-134
9. Patient Bill of rights	16	17-18
10. Confidentiality	18	19
11. Universal Precautions	19-31	21-39
12. Second Review of responsibilities	57	163-167
13. Medication Errors	56	157-161
13a. When you are unsure of one of the 6 rights	56	157
13b. What to do when an error is made	56	158-159
13c. Incident reports	67	160-161
14. Limitations		See Below

14a. Crushed medications cant be delegated	45	109 and 112
14b. Each delegation is patient specific	15	9
14c. Delegation requires patient specific guidelines	15	11
14d. PRN medication management for unstable medic	14	10
15. Review of 12 AAC 44.950 and 965	14-15	10-15
16 Resources for additional info	56	162
Post test- must be passed with a score of 90%	66-69	169
Additional Content	**Manual Pages**	**Power Point Slides**
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Medication Names	33	50
Forms of medications	45	106-125
Drug-Food interactions	40	78-80
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Addiction, Tolerance and Dependence	42-44	96-104
Right to Refuse	55	153-156
Reading Medication Labels	48	135-136
Medication Disposal	50	137-139
Controlled Substance Counts	51	140-144
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CROSSROADS
COUNSELING & TRAINING SERVICES

Medication Training for Direct Support Professionals

January 2024

Expectations

- Be Respectful and Cooperative
  - To others and to yourself
- Be Timely
  - Show up on time
  - Return from breaks on time
  - Stay until the end
- Be Attentive
  - Listen and watch the trainer
  - Utilize fidgets or stand and stretch quietly if you need to
  - Put away phones and laptop
- Be Communicative
  - Ask questions (there are no silly questions, only silly pets!)
  - Let me know if you need a break

Course Objectives

- Provide DSPs an understanding of how to protect the safety and privacy of the people they are caring for
- Provide DSPs a basic understanding about medications including classifications, names, storage and proper handling of medications
- Define the differences between Administering Medications and Assisting or SUpervising Self Administration
- Provide caregivers without a nursing or medical license, the knowledge to be able to safely and competently assist a person they are caring for to self - administer medications or, if delegated by a nurse, administer medications.
- Help caregivers understand when and how to ask for help, respond to dangerous situations and report problems

Course Content

- Responsibilities, rules and policies
- Infection control and safety
- Understanding medication basics
- How medications affect the body
- Handling Medications
- Managing Medications

Responsibilities, Rules and Policies

- Responsibilities
- Supervising self-administration
- Assisting with self-administration
- Delegation and Medication Administration
- Client's Rights
- Confidentiality and Privacy

Responsibilities

As a Direct Service Professional helping clients with self - administered medications, you will be responsible for multiple key tasks which include:

- **Safety**: Ensuring the safe handling and storage of all medications your client may use
- **Consistency** : Follow the 6 rights of medications and review instructions EVERY time you help with medications
- **Attentiveness** : Pay attention to the medications and clients you work with to avoid mistakes and recognize health risks
- **Communication** : Listen to your clients and report changes in their condition as needed
- **Documenting** : Clear and timely documentation is essential to care. "If you didn't document, it didn't happen"

Supervising Self-Administration

Done in assisted living homes (usually CCATS group homes). It is defined under AS 47.33.020 as:

- Remind the client to take a scheduled medication.
- Open a medication container or prepackaged medication
- Read a medication label to the client.
- Observe the client while they take their scheduled medication.
- Check the client's self-administered dosage against the label of the medication container.
- Reassure the client that they are taking the scheduled dosage as prescribed.
- Direct or guide the client's hand who is administering their own medications if requested.

Assisting with Self - Administration

Done in homes where residential habilitation is provided (usually 1 - to - 1 care homes) it is defined under 7 AAC 130.227 as:

- Remind the client to take a scheduled medication
- Open a medication container or prepackaged medication
- Read a medication label to the client
- Provide food or liquids if the medication label instructs the client to take the medication with food or liquids
- Observe the client while they take their scheduled medication
- Check the client's self-administered dosage against the label of the medication container
- Reassure the client that they are taking the scheduled dosage as prescribed
- Direct or guide the client's hand who is administering their own medications if requested

Delegation and Medication Administration

Medication Administration may only be completed by a DSP who has been delegated by a CCATS Registered Nurse as described in 12 AAC 44.965.

- Delegation is a legal process that is specific to the DSP, the client they work with and the task that client requires delegation for
- If a DSP has not been delegated to administer medications to a specific client, they may not administer to that client.

Medication administration is defined in 7 AAC 130.227 as:

- the direct delivery or application of an oral, nasal, ophthalmic, otic, topical, vaginal, or rectal medication by a provider to or into the body of a recipient that is unable to administer medication independently, and the use of an epinephrine auto-injector for a severe allergic reaction

*Delegation and Medication Administration

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

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

(1) the nursing duty to be delegated must be within the scope of practice of the delegating nurse;

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

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

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

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

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

*Delegation and Medication Administration

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

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

[...]

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

(A) a clear description of the procedure to follow to perform each task in the delegated duty;

(B) the predicted outcomes of the delegated nursing task;

(C) how the person is to observe and report side effects, complications, or unexpected outcomes in the patient, and the actions appropriate to respond to any of these; and

(D) the procedure to document the performance of the nursing duty in the patient's record.

*Delegation and Medication Administration

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

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

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

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

*Delegation and Medication Administration

12 AAC 44.965. DELEGATION OF THE ADMINISTRATION OF MEDICATION.

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

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

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

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

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

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

*Delegation and Medication Administration

12 AAC 44.965. DELEGATION OF THE ADMINISTRATION OF MEDICATION.

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

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

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

(2) possible interactions of medications;

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

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

*Delegation and Medication Administration

12 AAC 44.965. DELEGATION OF THE ADMINISTRATION OF MEDICATION.

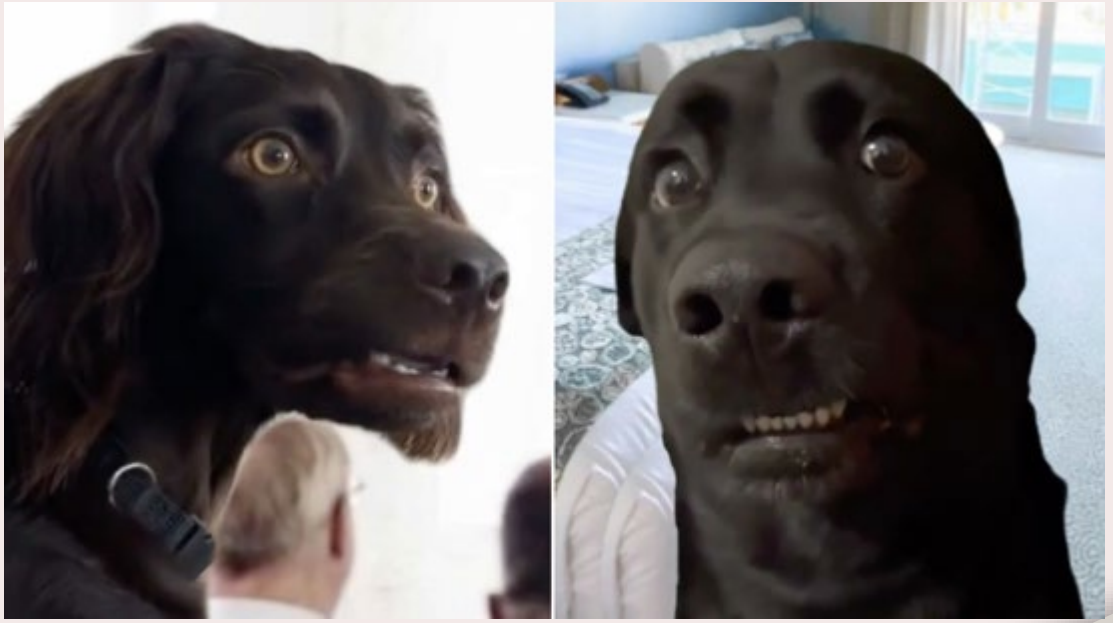
(e) The administration of PRN medication, other than controlled substances, may be delegated under this section if a nurse is not available on - site. Before the administration of PRN medications may be delegated, the nurse shall first assess the patient to determine whether on- site patient assessment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

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

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

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

So easy, Right?



Client's Rights

Every client the DSP works with has access to the same rights as the DSP. Additionally, the state of Alaska has defined specific rights for residents of Assisted living homes in AS 47.33.300. You may find the entire list in your manual but the following rights are important for DSPs to remember:

- live in a safe and sanitary environment free from abuse and discrimination;
- be treated with consideration and respect for personal dignity, individuality, and the need for privacy,
- exercise civil and religious liberties
- self-administer the resident's own medications, unless specifically provided otherwise in the resident's assisted living plan;

Client's Rights: Informed Consent

AS 47.33.300 also includes rights that are fundamental to a client's right to informed consent, meaning they have a right to be active participants in understanding and developing their plan of care and any treatments. These include the right to:

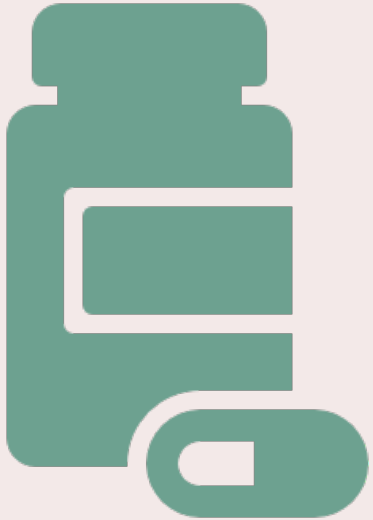
- participate in the development of the resident's assisted living plan
- present to the home grievances and recommendations for change in the policies, procedures, or services of the home without fear of reprisal or retaliation;
- reasonable access to home files relating to the resident, subject to the constitutional right of privacy of other residents of the home;
- receive information in a language the resident understands;
- receive care in accordance with the resident's assisted living plan, plan of care, personal preferences, and health care providers' recommendations.

Informed consent also means that each client has the right to refuse care (this will be discussed further later).

Confidentiality and Privacy

You have already completed training in HIPAA and confidentiality so this is just a review:

- Never discuss your client's medications or health conditions with anyone that isn't involved in their care
- Be aware of who may overhear you when discussing medications over the phone
- Make sure that any medication labels or other documents with personal health information (PHI) are disposed of in a secure way- usually shredded or placed a locked bin



Infection Control and Safety

- Universal and Standard Precautions
- Hand Hygiene
- Personal Protective Equipment (PPE)
- Cleaning, Sanitizing and Disinfecting Surfaces
- Sharps Safety and Management

Universal and Standard Precautions

- Universal precautions (UP) are an older approach to infection control to protect workers from HIV, Hepatitis B and C, and other bloodborne pathogens in human blood and certain body fluids with visible blood in them.

- Standard precautions (SP), were developed later and added additional infection prevention elements to UP in order to protect healthcare workers not only from pathogens in human blood, but also pathogens present in body fluids, non - intact skin and mucous membranes.

Universal and Standard Precautions

- Combined, UP and SP includes hand hygiene, the use of certain types of PPE, safe sharps handling practices and safe management of contaminated equipment and other items in the patient environment.

- We apply these precautions to all clients, even when they are not known or suspected to be infectious.

Hand Hygiene

- The CDC recommends using an alcohol - based (60% or more) hand rub in all situations, except for when your hands are visibly dirty or contaminated.
  - It is more effective for killing germs
  - Quicker to use,
  - Less damaging to the skin after multiple uses
  - Usually easier to access.
- Use hand washing with soap and water for at least 15 seconds when hands are visibly dirty or contaminated.

Hand Hygiene

- **Nail care:** It is safest to clip nails to about ¼ inch. Longer artificial nails should not be used because they may risk scratching a client's skin, may be more difficult to clean, and may damage or reduce the effectiveness of protective gloves. ALSO: Acrylic surfaces allow bacteria to grow more than natural nails
- **Hand jewelry (rings, bracelets, etc.):** Jewelry can reduce the effectiveness of hand hygiene because bacteria may survive between jewelry and skin during hand hygiene. Jewelry with stones or other protrusions can cause scratches or skin tears and may damage protective gloves

Hand Hygiene

Hand Hygiene

- **Skin care:** Repeated hand washing can cause skin dryness, irritation and breakdown, especially in Alaska's already dry climate. Lotions are important to prevent skin dryness and irritation but it is important to only use non-greasy, non-residue lotions and look for products that are recommended for use in a healthcare setting

- **Modeling positive behaviors:** Colleagues and clients watch what others do and research has shown that the actions of care staff influence the behavior of others. Your consistent use of hand hygiene can improve others' hand hygiene

Personal Protective Equipment (PPE)

- The most commonly used PPE in the community setting are masks, gloves and gowns. Other items may be needed for special circumstances and Crossroads will provide additional training for that PPE as needed

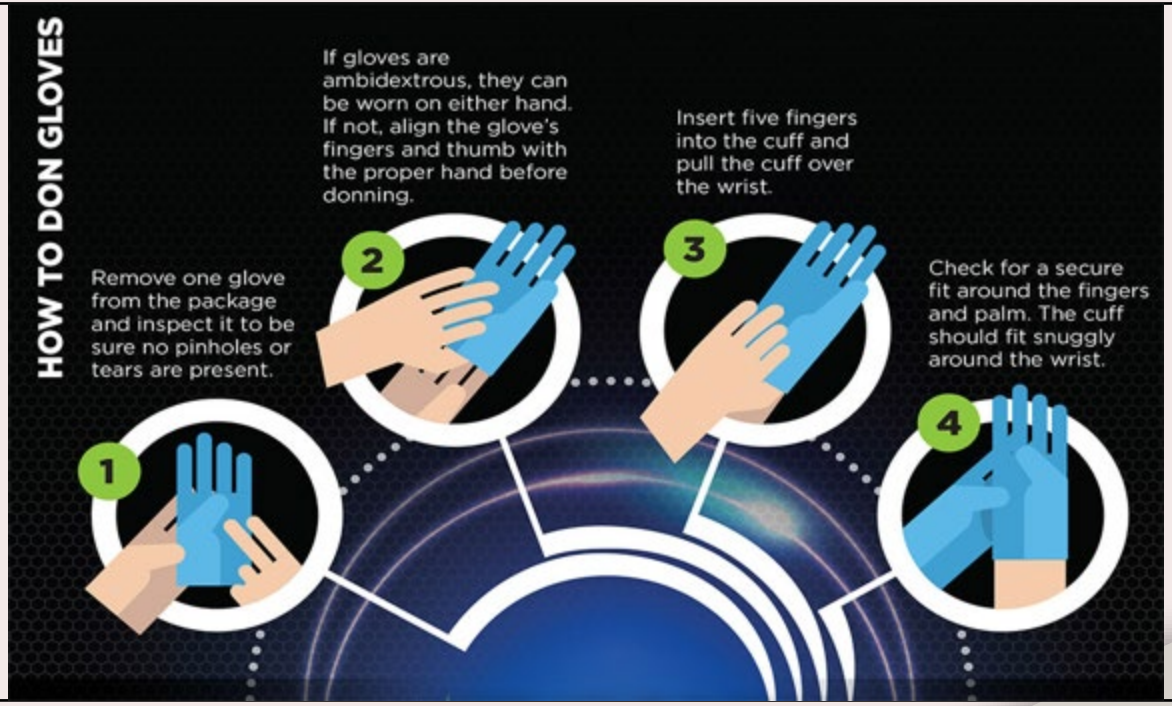
Personal Protective Equipment (PPE)

Donning a Mask

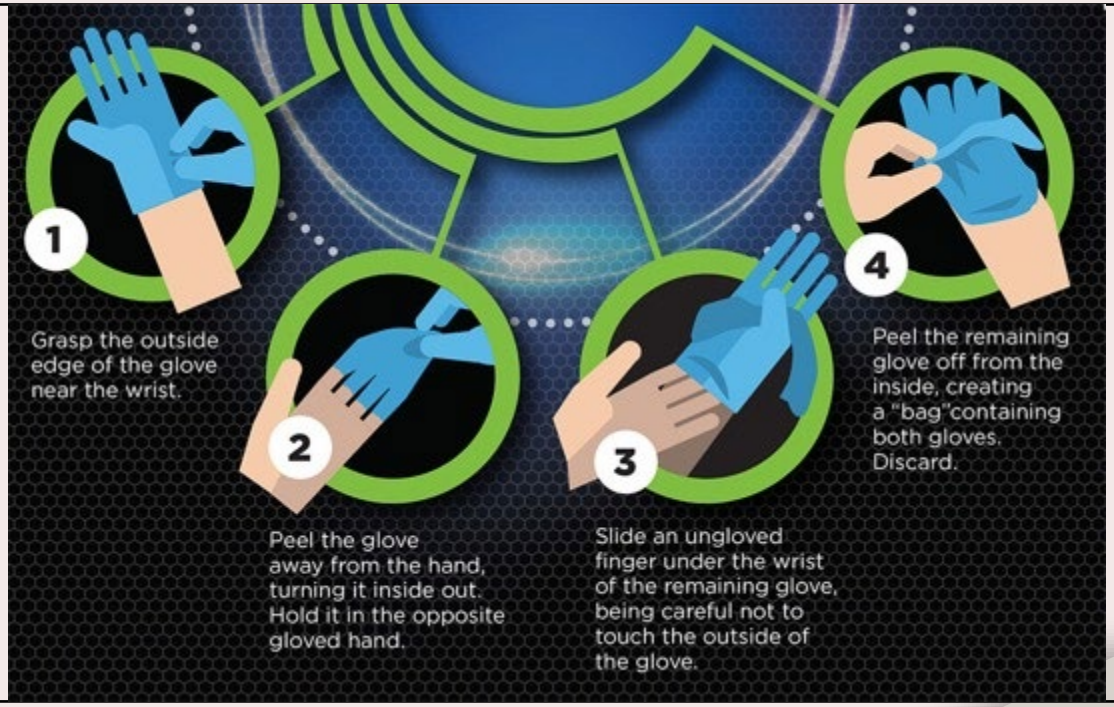
Personal Protective Equipment (PPE)

Doffing a Mask

Personal Protective Equipment (PPE)



Personal Protective Equipment (PPE)

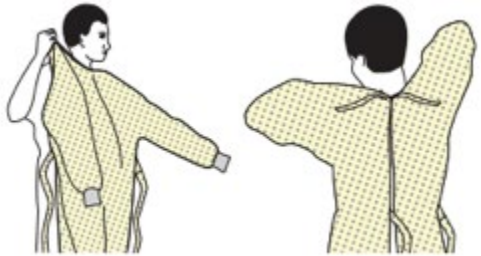


Personal Protective Equipment (PPE)

Donning a Gown

1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist

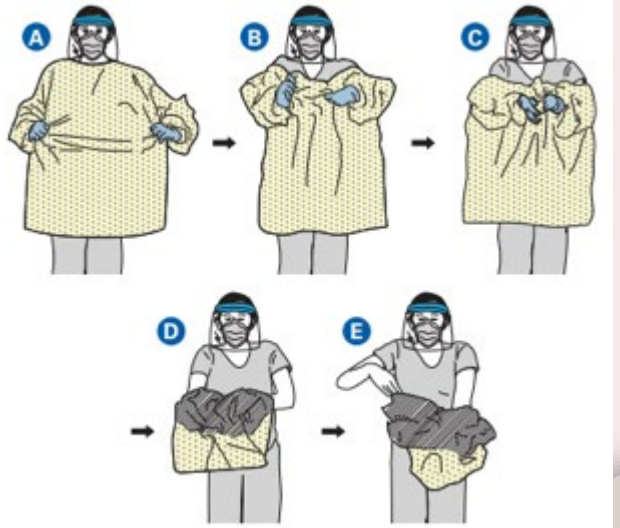


Personal Protective Equipment (PPE)

Doffing a Gown with gloves

1. GOWN AND GLOVES

- Gown front and sleeves and the outside of gloves are contaminated!
- If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands
- While removing the gown, fold or roll the gown inside-out into a bundle
- As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container



Cleaning, Sanitizing and Disinfecting Surfaces

Some bacteria and viruses can survive up to a month or more on tables, counters, durable medical equipment (walkers, wheel chairs, hospital beds, etc) and other surfaces.

It is important to try t nt throughout the day. Common areas such as the kitchen, dining room, medication room and living room should be a main focus for staff.

Cleaning, Sanitizing and Disinfecting Surfaces

- **Cleaning** products remove dirt, dust and other soils from surfaces.
  - Not reliably effective against bacteria or viruses
  - Less likely to irritate skin than stronger products
- **Sanitizing** products may kill bacteria or remove them from surfaces
  - Not reliably effective against viruses
  - Often requires friction to properly remove bacteria
  - May be more harsh than cleaners
- **Disinfecting** products kill harmful bacteria and viruses from surfaces
  - Effective against bacteria and viruses if used as directed
  - Must be left on a surface for a specific amount of time
  - Often harsh on skin and mucus membranes, may cause dangerous fumes

Cleaning, Sanitizing and Disinfecting Surfaces

Never mix any chemicals without clear instructions from the manufacturer and direction from your supervisor. Some of these substances can have serious reactions which can lead to hospitalization or death.

In addition, state regulations prohibit the storage of disinfectants, bleach, household cleaning supplies, etc. with food products or medications.

Sharps Safety and Management

Sharps include any device with sharp points or edges that can puncture or cut skin. They may be used at home, at work, and while traveling to manage the medical conditions of people or their pets. Examples include insulin syringes and blood sugar lancets for diabetic individuals.

Sharps Safety and Management

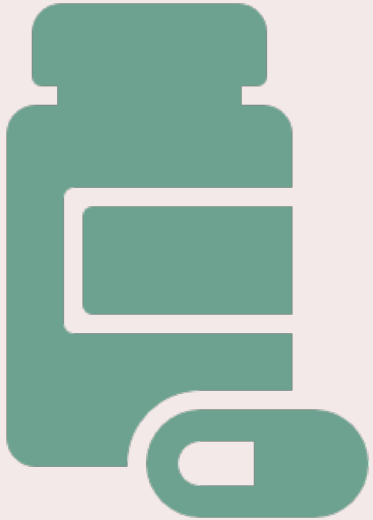
All sharps should be disposed of in a designated Sharps container immediately after use.

If you ever notice improperly disposed of sharps (they are left on a table, using any container other than a designated sharps container, etc.) notify your supervisor immediately.

Sharps Safety and Management

Remember these important points anytime you are in a setting where sharps may be present:

- Treat any sharp as potential infectious.
- Wear gloves before picking up any sharps.
- Move the sharps container to the sharp rather than bringing the sharp to the container.
- Make sure the area is calm and clear of people, don't handle sharps in high traffic areas
- Pick up any sharps on the end furthest from the sharp end
- Do not attempt to recap or cover a sharp, just place it into the sharps container
- If the sharps container is ⅔ or more full, report to your supervisor for disposal
- Report any improperly disposed of sharps to your supervisor



Understanding Medication Basics

- Benefits and Limitations of Medications
- Types and Classifications of Medications
- Examples of Medications for Chronic Conditions
- Examples of Psychotropic medications
- Prescription and Over the Counter (OTC) Medications
- Controlled Substances
- Time Sensitive (Scheduled) vs. PRN (As Needed) medications

Understanding Medication Basics

Medications, also called drugs, are substances utilized to:

- Prevent illnesses (like vaccines)
- Eliminate infections (like antibiotics)
- Reduce symptoms (like a cold medicine or pain killer)
- Replace something that the body is lacking (like vitamins or insulin)

Some drugs are commonly available and used without medical supervision, other medications are strictly controlled due to the risk of injury related to misuse or the high risk of addiction or dependence.

It is important to understand that medications affect different people in different ways.

Benefits and Limitations of Medications

Medications are an important part of quality care but they are not the solution to every problem.

- Medications have limitations and may not work for everyone in the same way.
- Medications may cause adverse reactions and side effects.
- Some medications may interact with other medications or foods in an unexpected way.

Benefits and Limitations of Medications

Age

As a person grows older, their body changes so that interventions for an infant might be different from a child, a teen, an adult, and into old age. Body composition, organ function and other age - related factors can significantly change the impact medications have on a person.

Benefits and Limitations of Medications

Body weight/size/composition

The presence of more or less fat or muscle can affect the absorption and metabolization of medications.

Benefits and Limitations of Medications

Sex

Body composition and water distribution can vary significantly by sex, most often related to the hormones released by the ovaries or testes. People with a menstrual cycle may find that medications may affect them differently at different points in their cycle. Additionally a person who is pregnant may require different medications or may have to choose to stop taking some medications that might have negative effects on their fetus.

Benefits and Limitations of Medications

Genetic factors

Certain genetic conditions can affect the way a person's body responds to medications. They can cause cells or organs to respond differently to medications.

Benefits and Limitations of Medications

Psychological factors

Stress, confusion and other psychological factors can change the way the body absorbs and distributes nutrients. A person who is stressed may be more likely to forget medications and some people who experience paranoia or delusions may avoid certain medications because they don't believe they are safe.

Benefits and Limitations of Medications

Illnesses and Injury

Certain diseases and illnesses can affect the organs that process and distribute medications.

Symptoms of stroke or strep throat may affect a person's ability to swallow medications. A person with significant nausea may have difficulty keeping medications down long enough for them to be absorbed.

Benefits and Limitations of Medications

Allergies

Many people experience some kind of food or drug allergy which can limit which medications they may safely use in some situations.Medications have limitations and may not work for everyone in the same way.

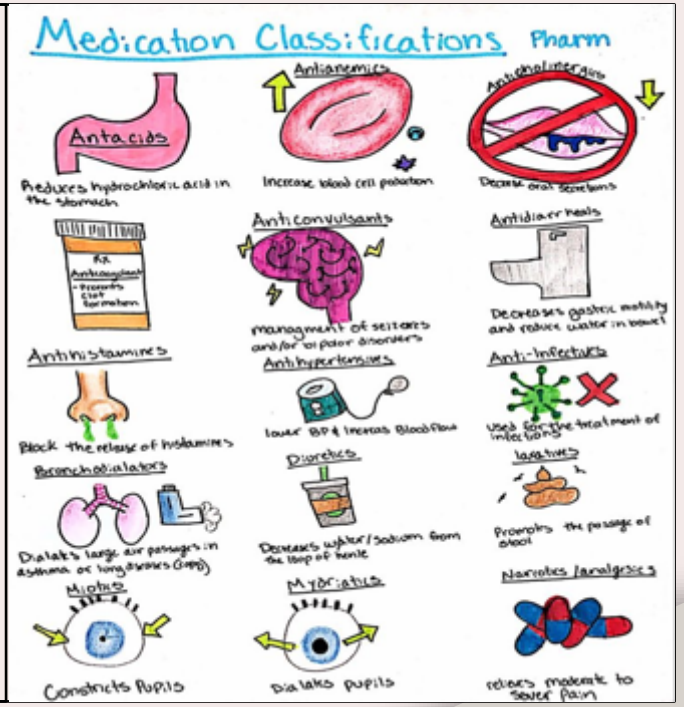
Names of Medications

All medications have two names, a brand name and a generic name

- Brand or trade name: chosen by the drug manufacturer & picked to be simple or memorable. Brand names are usually capitalized
  - There can be more than one brand name of a given medication (Advil and Motrin are both brand names for ibuprofen)
- Generic name: generally derived from the chemical structure of the drug. The generic name is usually written lower case (Tylenol's generic name is acetaminophen)
- Two VERY different medications can have very similar generic names (fluoxetine & fluvoxamine is one example)
- Read all medication labels carefully!

Types and Classifications of Medications

Medications can be grouped based on what conditions they help to treat or manage OR how they affect the body. Some groupings of medications for a specific condition may contain other groupings that affect that condition in different ways.



Examples of Medications for Chronic Conditions

Chronic conditions are long lasting conditions (as opposed to Acute or short term conditions) that a person will likely be managing for a significant portion of time. They tend to become more numerous as a person gets older.

- Analgesics - help relieve pain such as from injury or arthritis (Acute or Chronic)
- Antibiotics - inhibit or kill bacterial infections (Usually Acute)
- Antifungal - inhibit or kill yeast/fungus (Usually Acute)
- Antidiabetics - help manage blood sugar for diabetes (Chronic)
- Anticoagulants - prevent blood from clotting reducing risk of stroke or deep vein blood clots (Chronic)
- Antihypertensives - lower blood pressure (Usually Chronic)
- Anti-Asthmatics - reduce the number of attacks (chronic) and severity (acute)
- Antihyperlipidemics - help to reduce the buildup of cholesterol in blood vessels (chronic)

Examples of Psychotropic medications

Psychotropics are a special set of medications used to manage or treat both acute and chronic mental health disorders.

- Antidepressants - treat or manage depression
- Anti-anxiety - treat or manage anxiety disorders (panic attacks, phobias, anxiety and anxiety related symptoms
- Stimulants - help manage unorganized behavior (ADD/ADHD) by improving concentration and having a calming effect
- Antipsychotics - help manage psychosis where people become separated from their reality and may experience delusions or hallucinations.
- Mood Stabilizers - help regulate extreme emotions related to Bipolar disorder or extreme mood swings

Prescription and Over the Counter (OTC) Medications

Prescription medications require an order from a healthcare provider

- Physician (MD, DO)
- Physician assistant
- Nurse practitioner/Advanced Practice Registered Nurse
- Optometrist/Ophthalmologist
- Podiatrist
- Dentist

These medications must be obtained from a pharmacy

Prescription and Over the Counter (OTC) Medications

Over the counter medications can be obtained without a prescription but they should not be started without consulting with a physician first.

- Some OTC medications can be dangerous if used incorrectly. Examples include:
  - Iron, aspirin, and Tylenol (acetaminophen) can be toxic in large doses
  - Cold medicines can change the way blood pressure medications work
  - Benadryl (diphenhydramine) can cause confusion and falls in elders

Prescription and Over the Counter (OTC) Medications

Additional types of Over the Counter products include:

- Nutritional supplements (FDA approved)
- Herbal remedies (not regulated)

"Natural," "Nutritional" and "Herbal" don't automatically mean "healthy."

- Nutritional and Herbal Remedies might interact with other medications.
- You should consult with a physician before starting any Nutritional or Herbal medications.

Controlled Substances

Controlled substances are a special category of prescription medications

- Monitored by the DEA (Drug Enforcement Agency at the federal level)
- Carry a higher risk for harm and abuse, for example:
  - Opioid pain medications like oxycodone
  - Benzodiazepines like lorazepam or clonazepam
  - ADHD Medications including amphetamines
- Have special policies for handling (counting, disposing, etc.)

Controlled Substances

A registered nurse may not delegate the administration of controlled substances for PRN use in the state of Alaska

- DSPs may not administer controlled substances
- DSPs may supervise or assist a client to self-administer their own controlled substance medications
- Staff may complete Controlled Substance counts to ensure client safety and security

Time Sensitive (Scheduled) vs. PRN (As Needed) medications

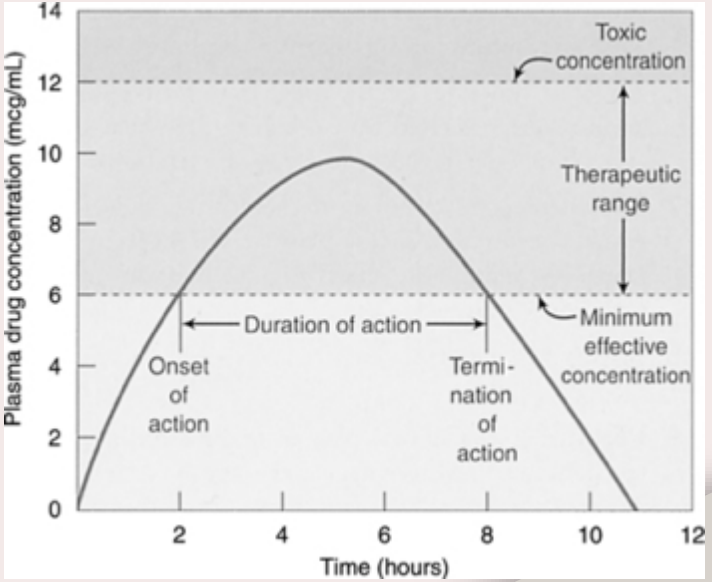
The physician determines whether a medication is time sensitive and scheduled or if it can be given just when needed (PRN) based on the medication and the client's need.

Time Sensitive (Scheduled) vs. PRN (As Needed) medications

Time Sensitive medications are scheduled at a specific time to obtain/maintain a therapeutic level in the body.

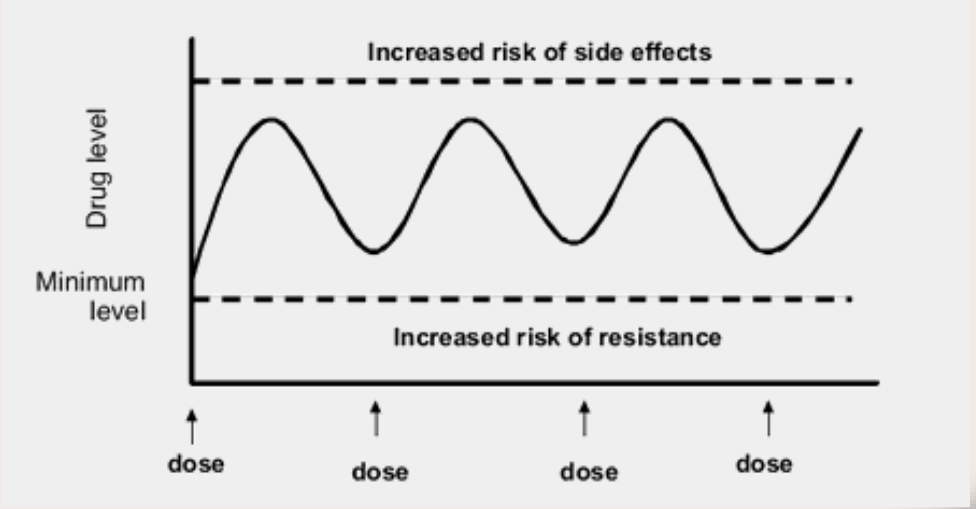
Every drug has a duration of action that lasts from:

- when it is first taken
- to when it starts to have an effect
- to when it reaches its highest level of effect (the peak)
- to when it is no longer acting on the body
- to when it is fully processed out of the body.



Time Sensitive (Scheduled) vs. PRN (As Needed) medications

If medication is not given on time, the effect may not occur when needed or the level in a person's system may be too low or too high (which could be dangerous).



Time Sensitive (Scheduled) vs. PRN (As Needed) medications

Here are a few examples of potential problems that can occur if time sensitive medications are given at the wrong time:

- A stimulant medication (Many ADHD meds) given in the evening could disrupt a healthy sleep schedule
- A person with seizure disorders may have increased seizure frequency if their medications are not given on time
- A person with diabetes can have blood sugar levels too high or too low if insulin is given at the wrong time

Time Sensitive (Scheduled) vs. PRN (As Needed) medications

PRN medications are used to manage an acute or short term condition and are taken whenever the need arises.

- PRNs can either be prescribed or OTC
- They are not scheduled for a specific time but rather “as needed” for a specific situation or symptom
- When a practitioner orders or prescribes a PRN medication, they will list an indication rather than a time.
- For example:
  - As needed for headache or muscle aches
  - As needed for heartburn
  - As needed for seizure lasting more than 3 minutes

Time Sensitive (Scheduled) vs. PRN (As Needed) medications

- DSPs who are supervising or assisting with clients' medications may remind them of available PRN medications but the client must decide if they want to take them
- DSPs who have been delegated to administer medications may administer PRNs as long as they document the reason
  - EXCEPTION: DSPs may not administer PRN Controlled Substances

Time Sensitive (Scheduled) vs. PRN (As Needed) medications

If a client requests a specific PRN, DSPs may not deny them access to that PRN unless clear instructions for doing so are listed in the service plan or it would cause a medication error such as:

- Wrong Person: Medication isn't theirs
  - Client requests a medication that someone else takes because it seems to help them with a similar problem
- Wrong Medication: Medication is not indicated for the concern
  - Med is indicated for Headaches but client is requesting it because of knee pain
- Wrong Amount: Medication is a larger or smaller dose than ordered
  - Client requests a double dose of a pain med because they are in a lot of pain

Time Sensitive (Scheduled) vs. PRN (As Needed) medications

- Wrong Route: Medication is not going to be applied in the right area
  - Client with a sore throat wants to use numbing eye drops to numb their throat
- Wrong Time: Medication is requested at the wrong time or too soon after a previous dose
  - A bed time sleep aid is requested in the afternoon
  - A med that can be given every 8 hours is requested 4 hours after the last dose.

Contact your supervisor in this situation to help explain the reasoning to your client.

Time Sensitive (Scheduled) vs. PRN (As Needed) medications

DSPs should not just tell a client they are not allowed to have medication they request

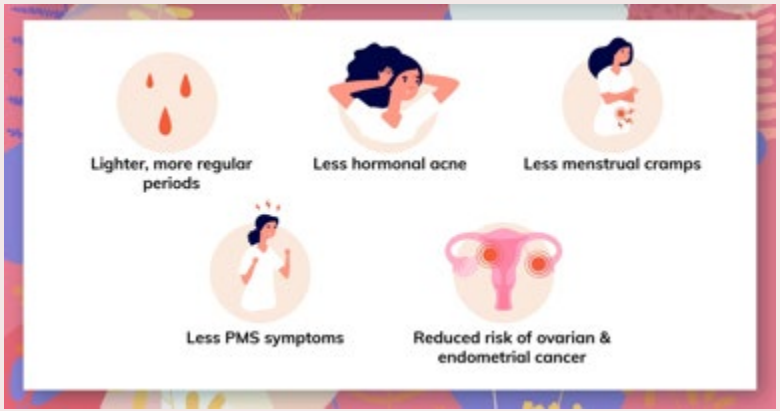
- Help them to understand why you can't assist them with that medication
- Help find other solutions
- Contact the supervisor if help is needed to explain to the client or to find other ways to address the problem

How Medications Affect the Body

- Expected or Desired Effects
- Side effects
- Drug-Drug interactions
- Drug-Food interactions
- Adverse effects
  - Anaphylaxis
  - Extrapyramidal symptoms
  - Over Sedation, Confusion and Falls
  - Toxicity
- Managing adverse effects
- Addiction, Tolerance, Dependence

Expected or Desired Effects

Medications can affect the body in many different ways so it is common for some medications to be used to treat several different kinds of conditions. Consider hormonal birth control medications:



The US Food and Drug Administration approves each medication and designates what conditions each medication is indicated to treat.

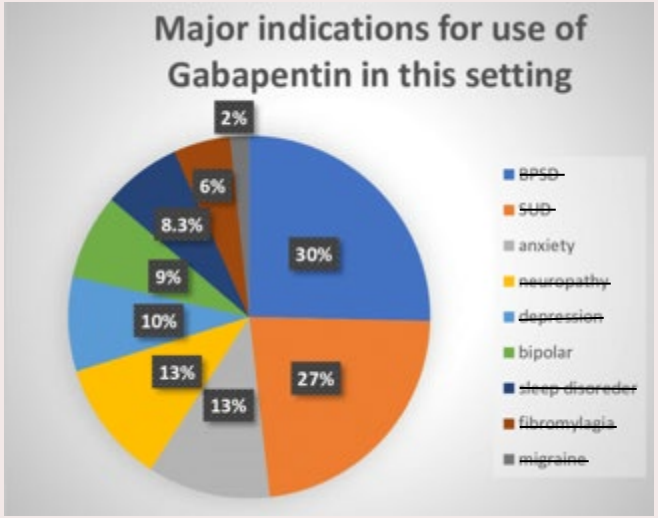
Expected or Desired Effects

There are times when a medication's side effect becomes the desired effect so a doctor may prescribe an "off label" use. Sometimes these "off label" uses become the most desired treatment.

- Viagra is most commonly used to manage erectile dysfunction but was developed as a medication for hypertension and chest pain
- Ozempic/Wegovy, a popular medication used for weight loss was originally approved to help manage type-2 diabetes
- Iproniazid was originally designed to treat tuberculosis but then became one of the world's first antidepressants
    - It was later discovered that this medication caused liver damage and was removed from the market

Expected or Desired Effects

It is important for a DSP providing any level of medication services to understand the specific reason why their client is taking a medication.



Side Effects

Side effects are known and expected reactions to a medication which are not the originally intended therapeutic effect.

Not all side effects affect a person the same way so some people may experience less or more effects from the same dose as others.

Side Effects

Some examples of side effects include:

- Headache (Some Heart Medications- Vasodilators)
- Nausea (Opioids, Antibiotics)
- Dangerously low blood sugar (insulin)
- Diarrhea (Antibiotics)
- Constipation (Opioids)
- Weight loss or gain (Antipsychotics)
- Sleepiness (Opioids, Benadryl)
- Dizziness (Opioids, Anti-hypertensives)
- Increased sensitivity to the sun (some antibiotics)

Side Effects

Staff can help their clients to plan their days to avoid disruptions or problems related to side effects

A medication that causes drowsiness probably shouldn't be given before the client goes out for a meal with friends or family.

Don't ruin a client's scheduled hike by giving a fast acting laxative just before they leave!

Side Effects

A client and their PCP may decide that some side effects are manageable to achieve the desired effect or they may decide to discontinue or change medications.

- Watch for problematic side effects when starting a new medication or an increased dose, especially in the first few days
- Report any physical or behavioral changes to your supervisor
- Some medications might take days or weeks before side effects occur

Drug-Drug Interactions

- Medication Interactions are an often undesired effect due to combination of medications.
- The chances of drug interactions increases as the number of medications a person is taking increases
- Primary care providers (PCPs) should always be aware of all medications someone takes including OTC's such as vitamins, cold meds, laxatives, or pain relievers
  - Notify the PCP before starting a new OTC medication or Health/Nutrition supplement

Drug-Drug Interactions

Interactions may increase or decrease the effects of one or more medications. This could have a positive or negative effect. For example:

- Antacids taken with an antibiotic may prevent the antibiotic from being absorbed in the stomach, reducing its effectiveness
- Alternating between acetaminophen and ibuprofen can have a better analgesic (pain relieving) effect and anti-inflammatory effect than just using one by itself.

Drug-Food Interactions

Medications are often given near meal times but:

- Drug-Food interactions can occur between medications and food or drinks the person might consume
- Absorption of medications can be affected by food
- Some medicines should be given with food (ibuprofen)
- Some medicines should NOT be given with food (levothyroxine)
- Some medications are not significantly affected by food either way

Drug-Food Interactions

Food-Drug interactions may increase or decrease the effects of one or more meds. For example:

- Alcohol increases the sedative effect of Opioids and antipsychotics
- Grapefruit juice reduces the efficacy of Cholesterol Medications
- Dark leafy greens can increase the effect of anticoagulants, potentially increasing the risk of uncontrollable bleeding
- High Calcium foods like Milk and Yogurt can reduce the absorption of some antibiotics

Drug Interactions

Read ALL labels and handouts for each medication to be aware about how medications may interact

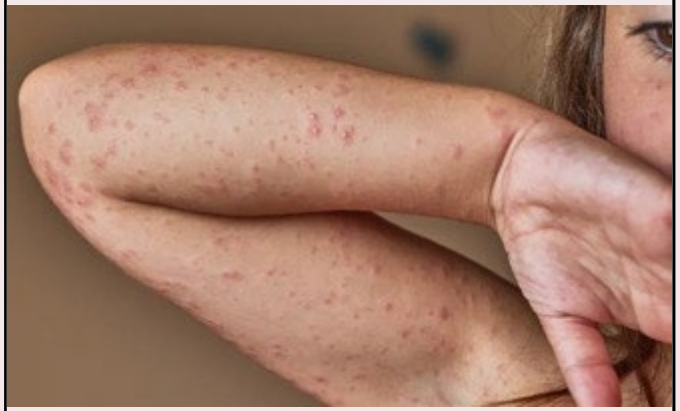
- Information sheets in the Med Book
- Printout from the pharmacy
- Other sources on each medication should be available to reference

Adverse Effects

Adverse effects are an an undesired harmful effect resulting from a medication or other intervention. Examples include:

- Anaphylaxis, a dangerous allergic reaction
- Extrapyramidal Symptoms, a neurological disorder affecting facial movement and balance
- Over Sedation, a condition leading to confusion, falls and respiratory depression
- Toxicity, a condition where a medication becomes too concentrated in the body, causing dangerous effects

Anaphylaxis



- Anaphylaxis is a dangerous form of allergic reaction
- Occurs when the immune system mistakenly recognizes a substance as if it were a bacteria or other harmful organism and enacts an immune response.
- An immune response can inflame the skin, sinuses, airways or digestive system
- Check for medication allergies before giving medications
- Individuals can develop allergies to medications at any time

Symptoms of anaphylaxis

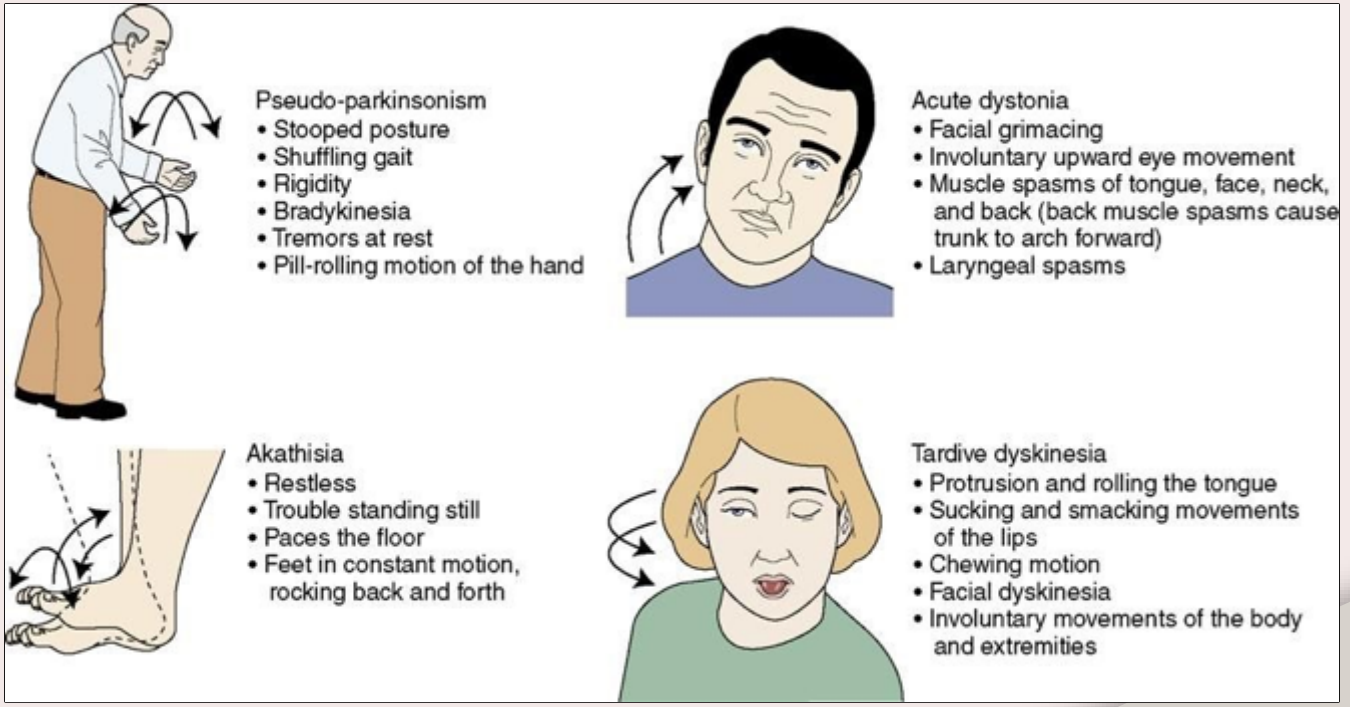
- **Skin**
  - itching
  - Hives
  - Redness
  - Sweaty
  - pale
- **Neurologic**
  - Confusion
  - Anxiety
  - feeling impending doom
- **Digestive**
  - Nausea
  - Vomiting
  - Diarrhea
  - abdominal pain
- **Cardiovascular**
  - swelling of lips, tongue, or throat
  - feeling dizzy or lightheaded
  - passing out
  - fast heart rate
- **Respiratory**
  - runny or itchy nose
  - Coughing
  - sneezing
  - Wheezing
  - shallow or fast breathing
  - swelling of throat
  - hoarse voice

Call 911 if the client has difficulty breathing!

Extrapyramidal Symptoms (EPS)

- EPS are involuntary or uncontrolled movements, tremors, or muscle contractions of the face, mouth, neck, or limbs
- A known potential side effect of long - term use of antipsychotic and certain other medications
- If you notice any of these movements, contact your supervisor who will communicate with the healthcare provider who prescribes the medications for that person
- Some newer antipsychotics have a reduced risk of causing EPS but a client and their physician may have to weigh the desired effects of their current medication against the symptoms of EPS

Extrapyramidal Symptoms (EPS)



Pseudo-parkinsonism
- Stooped posture
- Shuffling gait
- Rigidity
- Bradykinesia
- Tremors at rest
- Pill-rolling motion of the hand

Acute dystonia
- Facial grimacing
- Involuntary upward eye movement
- Muscle spasms of tongue, face, neck, and back (back muscle spasms cause trunk to arch forward)
- Laryngeal spasms

Akathisia
- Restless
- Trouble standing still
- Paces the floor
- Feet in constant motion, rocking back and forth

Tardive dyskinesia
- Protrusion and rolling the tongue
- Sucking and smacking movements of the lips
- Chewing motion
- Facial dyskinesia
- Involuntary movements of the body and extremities

Over Sedation, Confusion and Falls

- Many medications can have a mild to strong sedating effect, leading to a client feeling tired, drowsy or sleepy.
- Medications, like sleep aids, are intended to induce this effect.
- Drowsiness is considered a side effect for some other medications like Benadryl and Opioids.
- Taking a medications with a strong sedating effect (or multiple milder sedating medications) can lead to risk for oversedation, confusion and increased risk for falls.

Over Sedation, Confusion and Falls

- Oversedation is a condition where a person may:
  - Have reduced orientation (confusion)
  - Have reduced consciousness to the point of deep sleep
  - Be difficult to rouse - not responding to talking, touch or even gentle shaking to wake them.
  - Slower and shallower breathing (respiratory depression).

Over Sedation, Confusion and Falls

- A oversedated person who remains awake could appear confused, “out of it,” or “zombie - like”
- Confusion or delirium can significantly increase the risk for injury through lack of judgment and falls
- Falls can lead to significant injuries including broken bones, internal injuries and even death

Report signs of confusion, delirium, and falls to a supervisor right away!

Over Sedation, Confusion and Falls

Over sedation can include **Respiratory depression** which can lead to suffocation and death.

- Breathing may become more shallow
- Breathing slows from the average number of breaths per minute (around 12-20) down to 7 breaths per minute or less.
- The reduced breathing could lead to lips and nail beds turning blue from lack of oxygen.

Call 911 immediately if you notice signs of respiratory depression.

Toxicity

Some medications can cause injury, illness or death if they reach a high concentration in the system, this is called toxicity.

- Accidentally or intentionally taking more of a medication than instructed is called overdose and is the most common cause of toxicity
- Medication or food interactions may also cause toxicity
- Organ disease or injury can reduce the body's ability to filter or break down (metabolize) substances which can lead to a toxicity.

Managing adverse effects

As with any potentially dangerous situation it is important for DSPs to remember these important steps when dealing with adverse effects of medications

- Recognize there is a problem
- Respond appropriately based on the care plan and training
- Report the situation to your supervisor
- Record or document the incident in a GER

Managing adverse effects

Recognize there is a problem

- Be aware of signs of distress, injury or concern
- Understand the possible side effects of medications your client takes
- Understand the possible interactions your clients medications may have with other drugs or foods they consume
- Be able to recognize signs of an adverse effect or toxicity

Managing adverse effects

Respond appropriately based on the care plan and training

- Call 911 immediately if a client has difficulty breathing or loses consciousness.
- Follow any protocols established in the care plan
- Administer or assist a client to use a rescue medication if indicated and if you have been trained or instructed to do so:
  - Epinephrine injector (Epi-Pen) for anaphylaxis
  - Naloxone (Narcan) nasal spray for opioid related respiratory depression or overdose
  - There are some nasal sprays meant to manage emergency seizures which DSPs **MAY NOT** administer because they are controlled substances
  - Call 911 any time a rescue medication is used because they are only temporary solutions

Managing adverse effects

Report the situation to your supervisor

- In an emergency situation call 911 before calling your supervisor to ensure a timely response
- Notify your supervisor as soon as it is safe to do so
  - Your supervisor can provide you support in a stressful situation
  - Provide any information the supervisor requests in a timely manner
  - Follow any instructions your supervisor gives you

Managing adverse effects

Record or document the incident in a GER (general event report)

- CCATS staff have already been trained to complete a GER on Therap every time an incident occurs
- This must be done within 24 hours of the incident
- Clearly document as much information about the event as possible
  - The agency will review the report and work with the client, physician and care team to reduce the risk of the incident occurring again

Addiction, Tolerance and Dependence

In our society, many people worry that taking any controlled substances, even controlled medications prescribed by a physician, can lead to developing a “drug abuse problem.”

This worry may cause people to avoid, reduce or discourage others from using controlled medications even when a physician determines they are medically necessary.

Taking a controlled medication as ordered by a physician is not drug abuse. However, the use of prescribed controlled medications can lead to addiction, tolerance and dependence so it is important to understand these concepts.

Addiction

- The national institute of health defines addiction as the “chronic, relapsing disorder characterized by compulsive drug seeking and use despite adverse consequences.”
- CCATS clients may experience difficulties with impulse control related to their diagnoses and may exhibit signs and symptoms of addiction to medications or substances
- Staff can still provide safe and supportive boundaries for those clients to assist them to take their medications as ordered
- It is not okay to ignore doctors orders because of personal worries about a client’s medications

Tolerance

- Drug tolerance is the change in how one's body processes medications over time, and often requires an increasing dosage to maintain the same effect
- Drug tolerance is not the same as addiction
- A person can become tolerant of many different kinds of medications but this does not mean their use is becoming "problematic"
- A person who has been taking the medication for a long time (drug tolerant) might end up taking more than 10 times the dosage that a person new to the medication (drug naive) might take
- People with a history of drug abuse may be at a greater risk for toxicity or overdose after stopping a drug because they might try to take the amount they were used to when they had a higher tolerance

Dependence

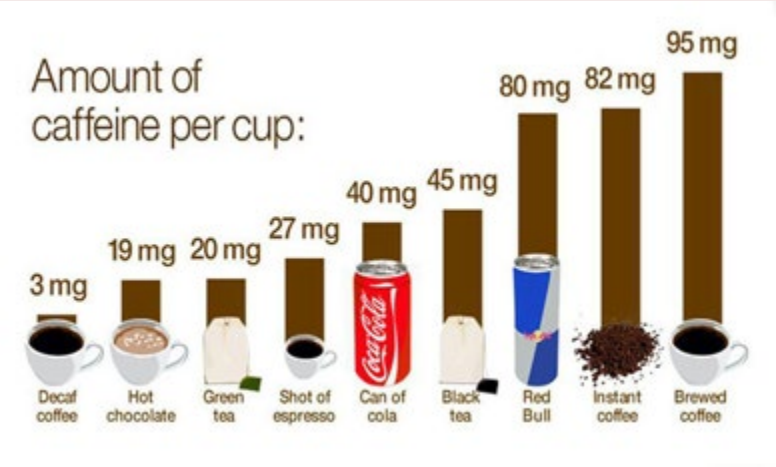
- **Physical dependence** involves the body changing over time to adjust to the medication's presence.
  - a medication that replaces a substance that the body might normally make itself may lead to the body adjusting to make less of the chemical naturally
- **Psychological dependence** involves the emotional or mental processes that are associated with the medications.
  - A person may find they miss a drug because it gave them positive effects, made them feel good or even helped fight boredom.
  - Psychological dependence can last far longer than physical dependence and may require assistance from a counselor to help build healthy behaviors.
  - Example: ex- smokers can be hit with a cigarette craving decades after they quit smoking

Dependence

- The physician and client may decide to stop or reduce a medication to reduce the person's tolerance to it, this is called a "drug holiday" or "medication vacation"
  - This should only be done with guidance from a physician and there may be risks to reducing or stopping medications
- People dealing with an addiction may try to quit "cold turkey" which has the potential to cause serious and even potentially fatal consequences.
- It may be necessary to work with a physician to reduce the risks of stopping an addictive substance such as alcohol or opioids.

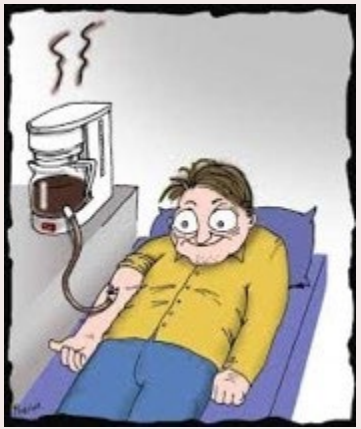
Example of Addiction, Tolerance and Dependence

- Around the world people use caffeine in the form of coffee, tea, energy drinks and chocolate covered coffee beans to help them stay awake and more focused throughout the day



Example of Addiction, Tolerance and Dependence

- Because it is readily available and minimally disruptive to a person's life, it may or not be described as an addiction based on our previous definition (it also avoids the same stigma because it is so socially acceptable)

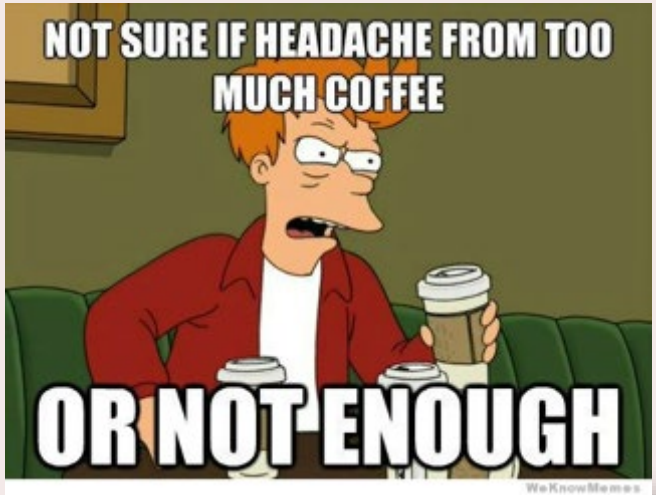


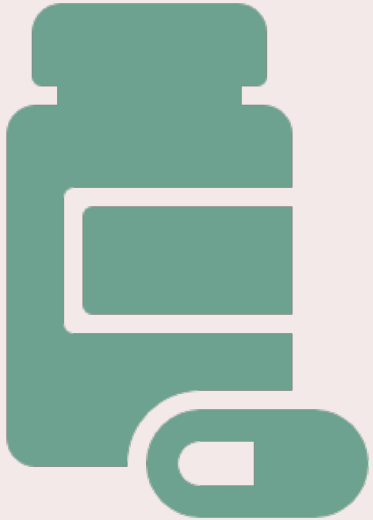
Example of Addiction, Tolerance and Dependence

- Many seasoned caffeine consumers no longer settle for a single 6 oz cup of coffee to get them through the day. They have to consume more caffeine to achieve the desired effect. This is tolerance.

Example of Addiction, Tolerance and Dependence

- Psychological dependence - the desire to feel caffeine's effects like wakefulness or improved focus; "I could really use a coffee to get me through this morning!"
- Physical dependency - such as headache, irritability, drowsiness, brain fog, decreased energy and depressed mood
- These symptoms can make it very difficult to stop caffeine completely but may be reduced by gradually reducing the amount of caffeine consumed to allow the body to adjust





Handling Medications

- Forms of medications
- Measurements and metrics
- Medical abbreviations
- Storage of medications
- Reading medication labels
- Disposal of Medications and containers
- Controlled Substance

Forms of Medications

Medications are manufactured in many different forms based on:

- Type of medications
- Intended Use
- Route of administrations
- Other factors

Forms of Medications

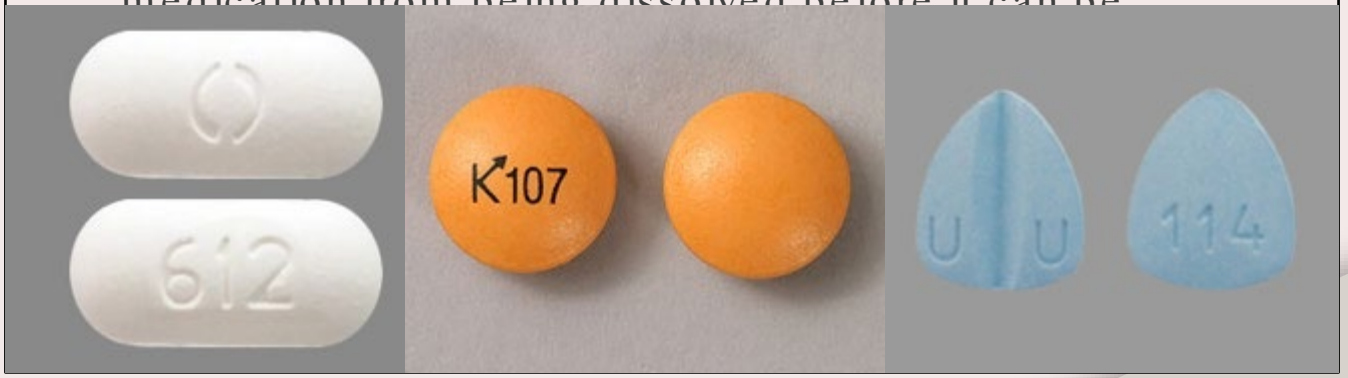
The form of medication may impact how it is stored, handled and administered, for example:

- Insulin must be stored in a refrigerator
- A transdermal patch could transfer medication to the DSP if handled incorrectly
- A Bisacodyl tablet shouldn't be taken rectally and a Bisacodyl suppository shouldn't be taken orally.

Forms: Tablets

A medication, usually mixed with a binder powder, molded into a circular, oblong or other shape.

- May have an imprint stamped onto it to help with identification
- May have a coating called Enteric Coating which protects medication from being dissolved before it can be



Forms: Tablets

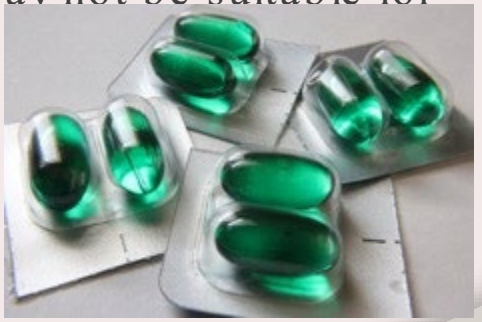
DO NOT CRUSH!

- Only a Pharmacy can prepare crushed medications

Forms: Capsules

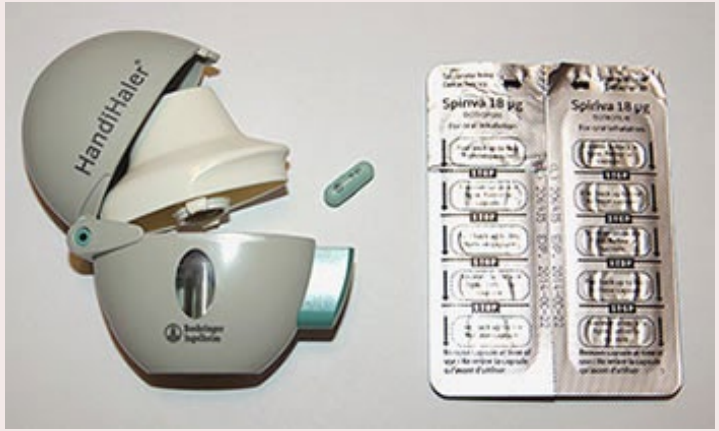
A hard or soft dissolvable container enclosing a dose of medicine

- Capsules usually contain powder or enteric coated capsules
- Gel Capsules usually contain liquids
- Some are made of Gelatin (may not be suitable for V nts)



Forms: Capsules

- Usually taken by mouth but not always - check administration instructions
  - Spiriva, an inhaled respiratory medication, is packaged in a capsule but has no effect if swallowed



Forms: Capsules

DO NOT OPEN OR CUT!

- You may not open/cut capsules when assisting with self administration

Forms: Liquids

- An Elixir is a solution that doesn't require mixing
- A Suspension is a solution that needs to be mixed before taking

Forms: Liquids

Liquid medications can be administered via different routes. Check instructions to ensure they are take correctly

- Oral- Given by mouth
- Ocular- Give in the eye (eye drops)
- Otic- Given in the ear (ear drops)
- Nasal- Given in the nose (nasal spray)

Forms: Liquids

DO NOT POUR!

- DSPs may not pour medications when assisting with self administration

Forms: Topicals

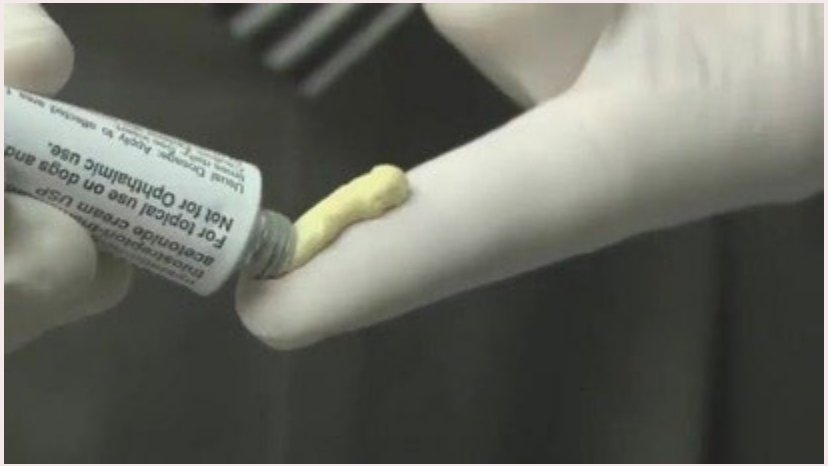
Topical medications are absorbed through the skin and usually take the form of a cream or ointment

- Creams are water-soluble preparations which tend to be fully absorbed into the skin (non-greasy).
- Ointments are oil-based preparations which tend to
onger than creams.

Forms: Topicals

WEAR GLOVES!

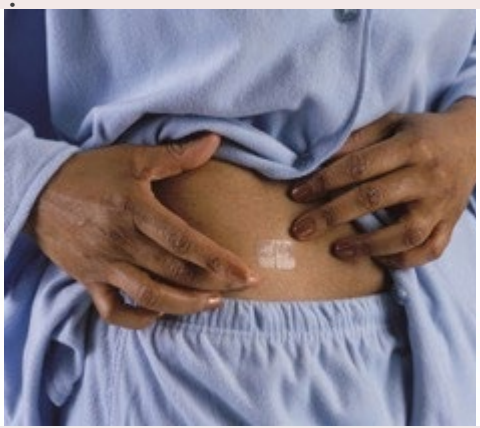
- Because they are absorbed by the skin, DSPs should wear gloves while handling them.



Forms: Transdermal Patch

A small or large adhesive patch applied to the skin to deliver a measured amount of medication over a set period of time.

- May leave a residue that should be cleaned when removed
- May cause skin irritation if the same spot is used for



Forms: Transdermal Patch

WEAR GLOVES!

- Because they are absorbed by the skin, DSPs should wear gloves while handling them.

Forms: Inhaler

A device used to provide aerosolized liquid or powder medication by inhalation.

- May use an aerosolizer chamber to improve absorption of liquids
- Rinse mouth after use as some m in in

Forms: Inhaler

REVIEW INSTRUCTIONS!

- Some inhalers require multiple steps to use so always review instructions before assisting.

Forms: Suppository

Used for rectal or vaginal administration of medications

- Is a measured amount of medication mixed with a substance like glycerin or cocoa butter that melts at body temperature.
- Needs to be in place at least 5-10 minutes for full
- el lik tl oura

Forms: Suppository

DO NOT INSERT!

- DSPs may not insert suppositories when assisting with medication self-administration

Forms: Enema

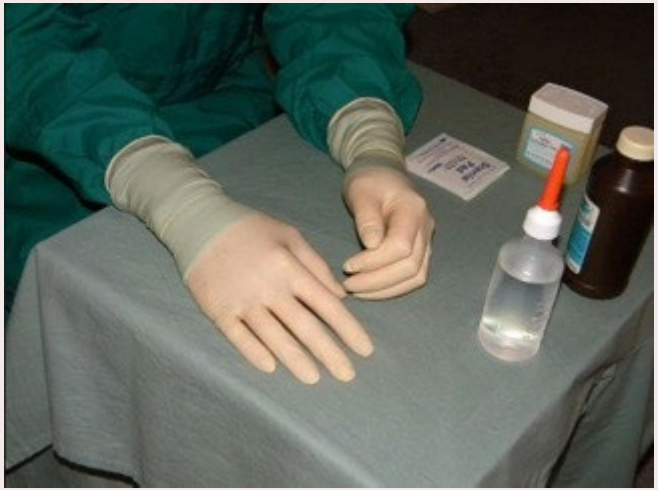
Enemas are injections of fluids into the rectum. They are most often used to cleanse or stimulate the emptying of your bowel.

- Needs to be in place at least 5 minutes for full effect
- Client may feel like they need to use the toilet shortly after insert ourage them to wait.

Forms: Enema

DO NOT INSERT!

- You may not insert an enema when assisting with self-administration



Measurements and Metrics

DSPs are not allowed to pour liquid medications when assisting with self - administration, the client must do so for themselves

DSPs may need to physically assist a client to pour a liquid medication accurately

Always check that a dose of medication matches the prescription label when assisting

Measurements and Metrics

Only use labeled measuring devices specifically dedicated to that medication, usually a measuring cup with marked dosages

It is important to be aware of certain measurements that may be used commonly:

- Teaspoon (tsp) = 5ml
- Tablespoon (tbsp) = 15ml
- 1ounce = 30ml

Measurements and Metrics

- Measuring containers should be rested on a clean flat surface when pouring and reading them
- If the cup is being held up, it may not be level and could be misread
- DSPs should get down to surface level to verify the amount of medication

Medical Abbreviations

It Commonly seen abbreviations for DOSAGE:

- act = Actuation or Puff from an inhaler
- cap = Capsule
- gt or gtt = Drop
- mcg = microgram (1/1000th of a milligram)
- mg = milligram (1/1000th of a gram)
- ml = milliliter (1/1000th of a liter)
- oz = Ounce (240ml or ⅛ of a cup)
- sup or supp = suppository
- tab = tablet
- Tbsp = tablespoonful (15ml)
- tsp = teaspoon (5ml)

Commonly used abbreviations for TIME:

- AM = morning
- ASAP or STAT = As soon as possible
- BID = two times a day
- H or HR = hour
- HS = Hour of Sleep (bedtime)
- NOC = During the Night
- PM = afternoon; evening
- PRN = as needed
- QXH = Every X Hours (Q8H is every 8 hrs, Q4H is every 4 hrs)
- TID = three times a day

Medical Abbreviations

Some abbreviations are easy to mistake and, to avoid confusion, should not be used according to the Joint commission and the Institute for safe medical practice.

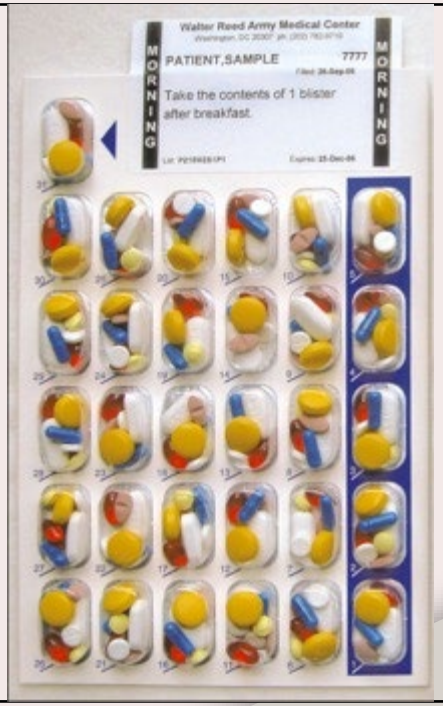
If you encounter one of these abbreviations, check with your supervisor before giving the medication

- U, u or IU for Unit or International Unit
- Q.D., DQ, q.d. or qd for Daily or Every day
- Q.O.D., QOD, q.o.d. or qod for Every other day
- CC, cc for cubic centimeters (another term for milliliters)

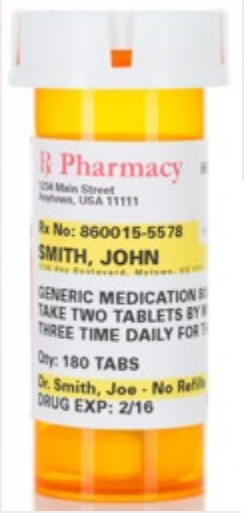
Medication Storage

Medications are to be stored in their original containers which can be Med packs, Pharmacy bottles or OTC bottles

- Med packs or sets
  - Have 1or more pharmacy labels with specific instructions
  - May come in blister/bubble packs, rolls, or sachets
  - Contain medications for an entire week or month
  - Clear plastic on the front of the package to allow for inspection of the medications by the caregiver without opening first



Medication Storage



- Pharmacy bottles
  - Have a pharmacy label with specific instructions
  - Contains one type of medication
  - Enough for 1 to 3 months
  - May be liquid, tablet, capsule
- OTC Bottles
  - Have a general label with suggested instructions
  - Contains one type of medication
  - Contain a number of doses listed on the label
  - May be liquid, tablet, capsule

Medication Storage

All medications are stored and secured in a locked medication room with a medication cabinet and medication refrigerator.

- Medication Cabinet
  - May be locked if needed to provide a second level of security (must be locked if controlled substances are present)
  - Each client will have their own compartment, bin, or area for their own medications in the cabinet
  - Topical medications will be stored separately in case of leakage

Medication Storage

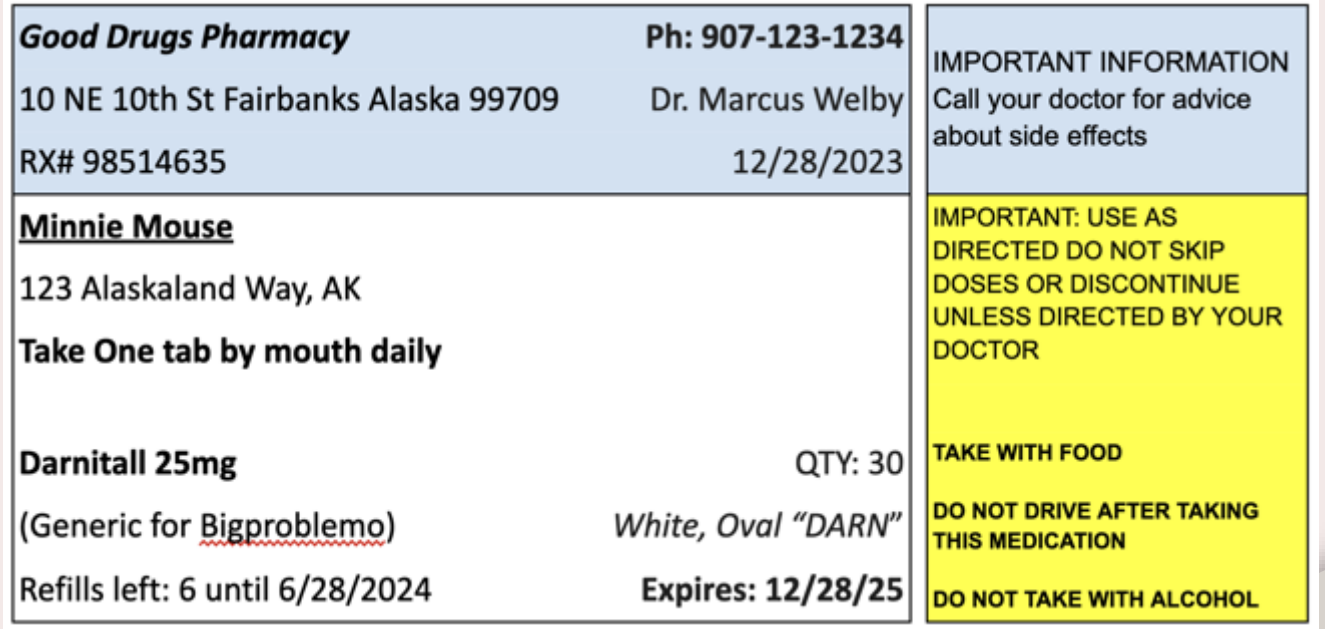
- Medication Refrigerator (All new medications should be checked to see if they require refrigeration)
  - May be locked if needed to provide a second level of security (must be locked if controlled substances are present)
  - Most common are Insulin, Probiotics and liquid antibiotics.
  - Refrigerator should not be used to store food unless that food is meant to accompany medications

Reading medication labels

Different pharmacies may have different label layouts but most will include the following information:

- Individual's name
- Name and Strength/Concentration of Medication
- Dose/Amount of Medications to take
- Route of Medication administrations
- Time or Frequency
- Physical Description of Medication
- Special instructions or Precautions
- Expiration Date
- Prescription number
- Prescriber information

Reading medication labels



Good Drugs Pharmacy	**Ph: 907-123-1234**
10 NE 10th St Fairbanks Alaska 99709	Dr. Marcus Welby
RX# 98514635	12/28/2023
Minnie Mouse	
123 Alaskaland Way, AK	
Take One tab by mouth daily	
Darnitall 25mg	QTY: 30
(Generic for Bigproblemo)	*White, Oval "DARN"*
Refills left: 6 until 6/28/2024	**Expires: 12/28/25**

IMPORTANT INFORMATION
Call your doctor for advice about side effects

IMPORTANT: USE AS DIRECTED DO NOT SKIP DOSES OR DISCONTINUE UNLESS DIRECTED BY YOUR DOCTOR

TAKE WITH FOOD

DO NOT DRIVE AFTER TAKING THIS MEDICATION

DO NOT TAKE WITH ALCOHOL

Disposal of medications and containers

Medications and their containers must be disposed of in a particular way to protect a client's privacy

- If a medication is discontinued or there are no more medications in the container, DSPs should place the containers inside the medication cabinet in a designated disposal area to be managed later
- If a pill is dropped or found outside of a container, DSPs should place them in a ziplock bag and mark it with the time and date the medication was found and the initials of the person who found them and place them in the designated disposal area
  - Report the situation to your supervisor and complete a GER

Disposal of medications and containers

For empty medication containers and med packs:

- Ensure that all containers are completely empty before disposing of them
  - If there are any medications still in the containers, contact the supervisor
  - Empty medications containers should not be refilled or re-used
- Peel the label off any empty medication bottles
  - Place the labels into a secure bin for shredding.
  - Bottles can be thrown in the garbage if there is no remaining PHI on them
- Remove all labels from empty med packs
  - Place the labels into a secure bin for shredding.
  - Med packs can be thrown in the garbage if there is no remaining PHI on them

Disposal of medications and containers

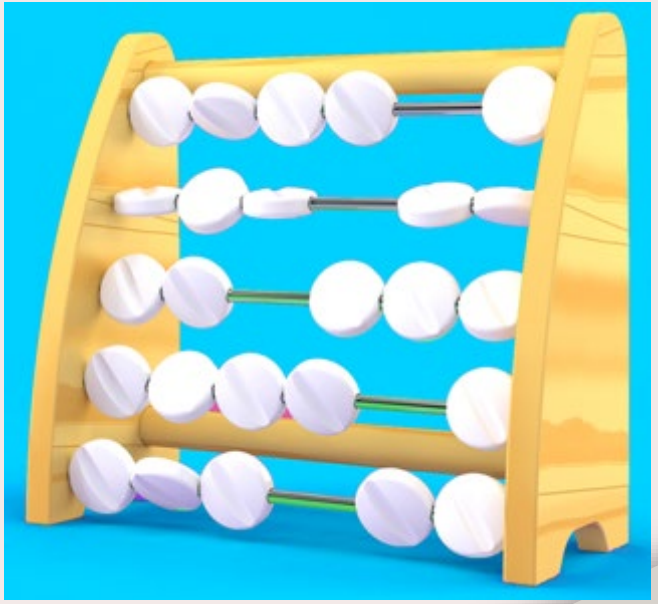
DSPs should not dispose of or destroy medications unless they are assisting their supervisor

Controlled substance counts

- Agencies are required to track any controlled substances that are handled by staff
  - Timely medication counts ensure that agencies can respond quickly to protect clients and staff
  - The agency must investigate any discrepancies and in some cases may report state or to law enforcement
- There will be a controlled substance count sheet for each controlled substance in the home
  - If there are multiple med packs for a single medication, they will all be counted together.

Controlled substance counts

- Controlled Substance Counts should be completed at least once per day
  - Daily in the morning
  - Any time a supervisor brings in or removes controlled substances from the home



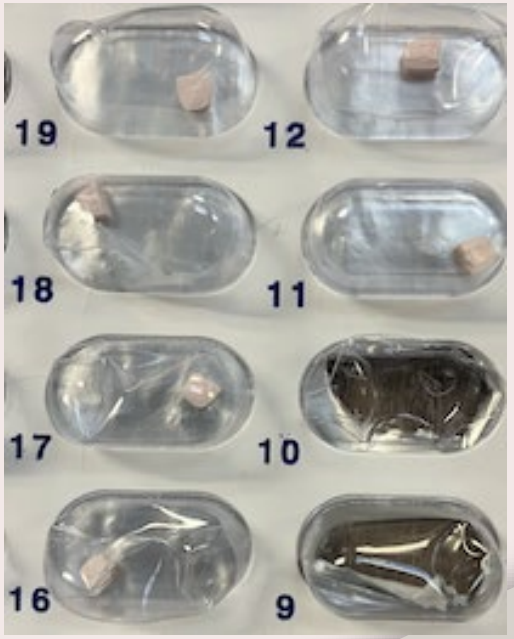
Controlled substance counts

- A controlled substance count should always be done with two people when possible
  - This can be two DSPs or a DSP and a supervisor
- Each person involved should do their own count
  - Never let someone else count for you

Controlled substance counts

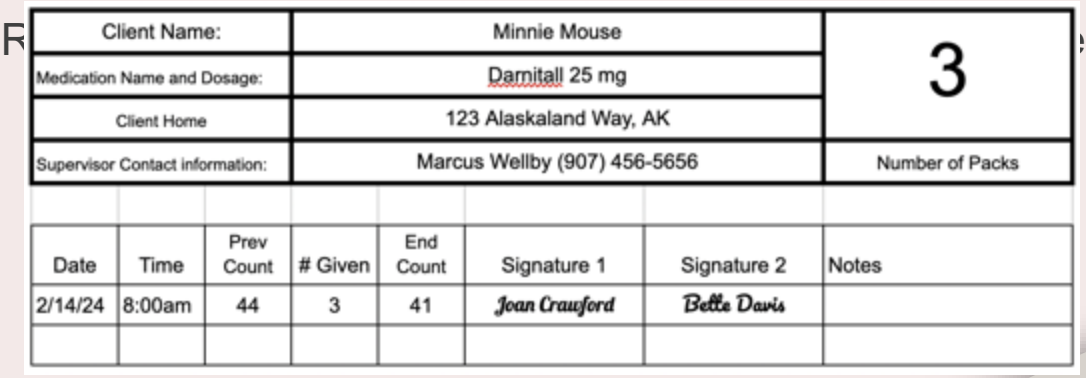
Always count the number of whole tablets, even if some medications have been split

- If all tablets in a med pack have been split in half by the pharmacy, count all bubbles then multiply by 0.5
  - 6 half tablet bubbles X 0.5 = 3 whole tablets
- If the med pack has one and a half tablet doses, you may count all bubbles and multiply by 1.5.
  - 6 one-and-a-half tablet bubbles X 1.5 = 9 whole tablets



Controlled substance counts

- Write down the previous count, number of medications given since last count, number of medications counted, your signature and the signature of the other counter
- Make any notes about changes in the notes section
- If you find any discrepancies, perform at least one recount
- R…ely



Client Name:	Minnie Mouse	3
Medication Name and Dosage:	Darnitall 25 mg	
Client Home	123 Alaskaland Way, AK	
Supervisor Contact information:	Marcus Wellby (907) 456-5656	Number of Packs

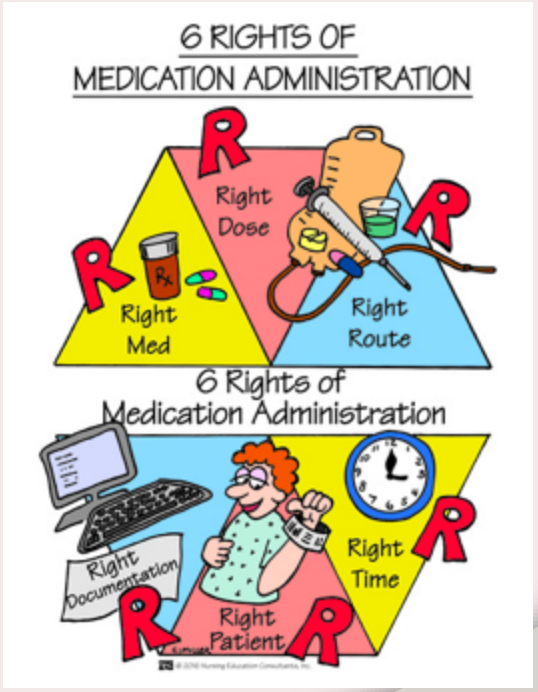
Date	Time	Prev Count	# Given	End Count	Signature 1	Signature 2	Notes
2/14/24	8:00am	44	3	41	Joan Crawford	Bette Davis	

Managing Medications

- 6 rights of medications
- Right to refuse
- Medication Errors
- How to find more information
- Review of responsibilities

6 rights of medication

- The Right Person
- The Right Medication
- The Right Dose
- The Right Route
- The Right Time
- The Right Documentation



6 rights of medication

The Right Person

- Always look on the medication label & Medication Administration Record (MAR) to make sure the name matches the person
- Medications are to be used ONLY for the person whose name is on the label, even if it is the same medication and dosage as another person's medication!

6 rights of medication

The Right Medication

- The medication must be prescribed or authorized by a healthcare provider
- Many medication names sound alike but are VERY different
- There can be several names for the same medication; double check the generic or trade names

6 rights of medication

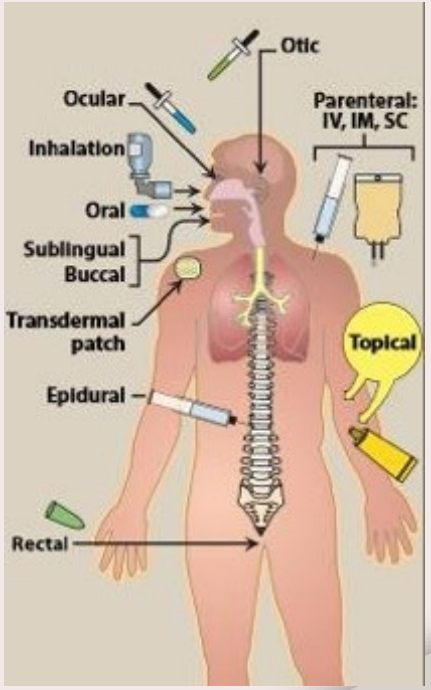
The Right Dose

- The correct dose will be documented on the prescription label
- Abbreviations & measurements might be used
- Multiple tablets or measuring liquids may need to be given to get the correct dose

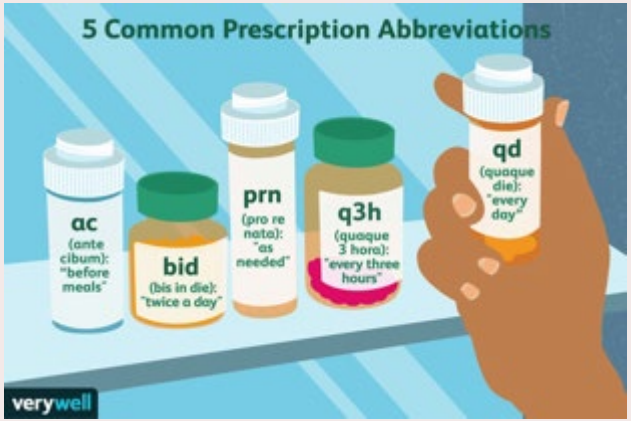
6 rights of medication

The Right Route

- A medication must be applied to the correct location to be effective
- The main routes include:
  - Oral (by mouth),
  - Ophthalmic (eye)
  - Otic (ear)
  - Inhaled
  - Rectal
  - Vaginal
  - Topical (patches, cream, ointment)



6 rights of medication



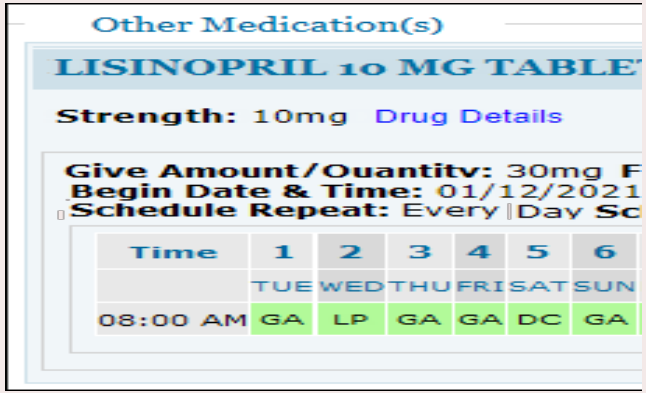
The Right Time

- Medications & Treatments must be given within a period 1 hour before, or 1 hour after the scheduled time
- Some may be given multiple times per day
- Might be Scheduled or PRN (As Needed)

6 rights of medication

The Right Documentation

- The purpose of documentation is to accurately and completely record care
  - Medication records are legal Documents
  - “If it wasn’t documented, it wasn’t done.”
- Document AFTER the medication has been taken by the client
- If a scheduled medication is MISSED or REFUSED:
  - Report to the supervisor and complete a GER

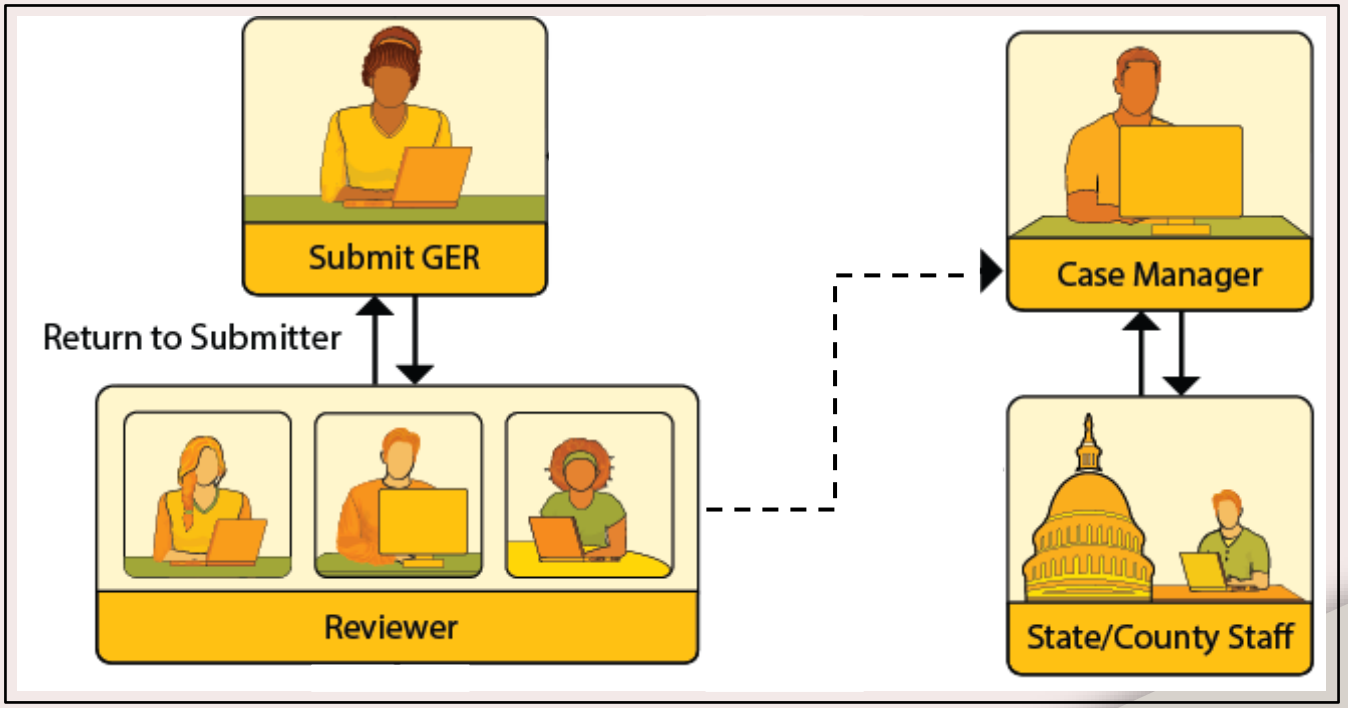


6 rights of medication

GER (General Event Report)

- Used by Crossroads to document incidents and can include:
  - injury
  - medication error
  - emergency room visits
  - behavioral events

6 rights of medication



Right to refuse

- Each individual has the right to make informed choices about their own health care and this includes choosing not to take a prescribed medication
- BUT! Some medications may be essential for the safety of the client or may help them to manage unsafe conditions or behaviors
- Help clients balance their right to make choices with the possible health consequences of refusing medications
- Look for opportunities to help our clients advocate for themselves.

Right to refuse

- When a client refuses to a medication:
- Ask why they don't want to take the medication
  - Some reasons might be easy to fix: If it tastes bad, maybe they would prefer to take it with pudding, apple sauce or ice cream to cover the flavor
  - Some reasons might need to be communicated to a physician to see what changes could be made: Too big, Makes me feel weird, Makes me sleepy before work
  - Some reasons might not have obvious solutions: Client says "I don't need that med anymore." or "I think someone put poison in my pills.

Right to refuse

If staff can't find a way to help the client to be more comfortable with taking their meds or they still refuse the medication:

- Report the situation to the supervisor
  - They may be successful with helping the client to take the medication
  - They can communicate with the PCP or Nurse for other solutions
  - They can authorize staff to document the refusal in the MAR

Right to refuse

After communicating with your supervisor, if the client still refuses the medication:

- Document the refusal
- Note that the medication was refused and the supervisor contacted
- Complete a GER with as much information about the situation as possible

Medication Errors

- A medication error occurs anytime one of the 6 Rights is WRONG!
  - WRONG person
  - WRONG medication
  - WRONG amount
  - WRONG route
  - WRONG Time
  - WRONG (or inaccurate) documentation

Medication Errors

No matter how careful we are, errors do occur

- Never try to cover up an error, this can make a bad situation worse
- Reporting errors allows us to better protect our clients from negative health effects
- If we know how an error occurred, we can work to avoid that same error happening in the future

Medication Errors

Steps to take if a medication error occurs:

- Report to the supervisor or nurse as soon as it is noticed
- Work with the Supervisor to monitor the safety of the client
- If any dangerous or life threatening health problems occur Call 9-1-1
- If needed, the supervisor will contact the healthcare provider who prescribed the medication for any further follow up instructions
- Document the error and steps you took in a GER after the situation is under control

How to find more information

- Review the Crossroads Medication Manual
- Review the information in each home's Medication Book
- Review the Medication Information Sheets from where the prescriptions were filled
- Speak to your Supervisor
- Speak to the Crossroads Registered Nurse
- Review information on www.drugs.com
- Review information in the Davis Drug Guide
- Speak to the client's primary care provider

Review of Responsibilities

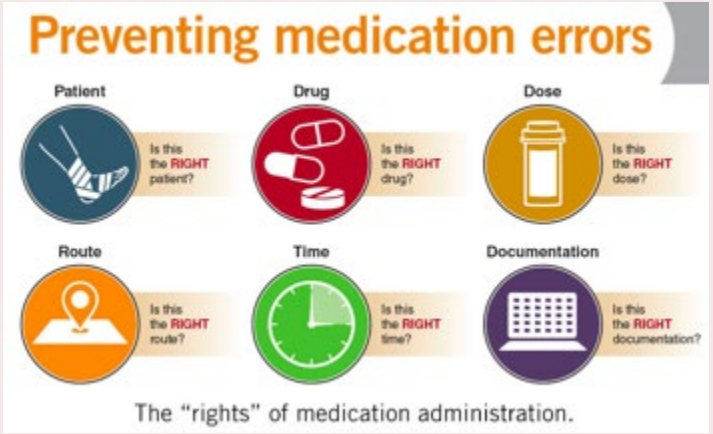
As a Direct Service Provider assisting clients with self - administered medications, you will be responsible for:

- Safety: Ensuring the safe handling and storage of all medications your client may use

Review of Responsibilities

As a Direct Service Provider assisting clients with self - administered medications, you will be responsible for:

- Consistency: Follow the 6 rights of medications and review instructions EVERY time you help with medications



The "rights" of medication administration.

Review of Responsibilities

As a Direct Service Provider assisting clients with self - administered medications, you will be responsible for:

- Attentiveness: Pay attention to the medications and clients you work with to avoid mistakes and recognize health risks

Review of Responsibilities

As a Direct Service Provider assisting clients with self - administered medications, you will be responsible for:

- Communication: Listen to your clients and report their concerns and changes in their condition to the supervisor or nurse as needed

Review of Responsibilities

As a Direct Service Provider assisting clients with self - administered medications, you will be responsible for:

- Documenting: Clear and timely documentation is essential to care. “If you didn’t document, it didn’t happen”

Any Questions?

Quiz Time!

*Quiz time

This PowerPoint was created to meet the needs of Crossroads Counseling and Training Services, a Non-profit Organization, by Jason Sanders, RN BSN in January, 2024.

It was built using elements and some content from the powerpoint created by Ivan Wang, MS, PA-C, Alaska Pioneer Homes (Jan 2022) and includes content from UAA ASAM training created by Liz Gerken-Miller.

As the State of Alaska moves towards joining the Nursing Licensure Compact (NLC), now is the best time to review and reflect on the content of the Nurse Practice Act (NPA) and how it affects the practice of nursing. It is extremely important to reflect upon regulations as they stand and consider how they support or limit the people of Alaska in receiving meaningful care and support, not only in our cities, but also in our rural communities.

It is my intention to focus on regulations related to the process of nursing delegation and to present evidence-based information about the role of the nurse in Alaska. I will examine specific provisions in the Alaska NPA, Advisory Opinions and Board guidance documents and provide examples of how they may affect care for people in our state. Finally, I will address the board regarding these topics and request clarification for some, immediate action on others and a meaningful reflection on the rest. It is my hope that this presentation will provide the Board of nursing with useful information to assist in shaping the unique future of nursing practice in our state.

Through my research for this presentation I've discovered portions of our state's nurse practice act have been out of date for over a decade. In one case, 12 AAC 44.965(b)(1) and (2), the rule refers to 7 AAC 43.1110 which was repealed in 2010. If nothing else, I hope the board will consider a comprehensive review of the Nurse Practice Act for currency and clarity.

Specific concerns regarding provisions in the Alaska NPA, Advisory Opinions and other Board guidance documents

The scope of this presentation is limited to delegation-specific tasks therefore I will only focus on sections 12 AAC 44.950-975 of the Alaska Nurse Practice act, Advisory Opinions related to medication and guidance for med admin training. Many of the below items are listed with the intent of prompting discussion among the board, however a few items are relevant to care practices in settings where nurses may not be immediately available, impacting Alaskan's ability to choose a care provider or a setting to receive care. The items I will address are:

1. Ambiguity related to the term "complex nursing skills"
2. Contradiction, lack of currency and limiting access to care related to who may be delegated to administer medications
3. Case Study: Profound seizure disorder in Assisted living setting
4. Limiting access to care and poorly regulated workarounds related to PRN controlled substances
5. Case Study: Injectable medications with cognitive disabilities
6. Limiting access to care and poorly regulated workarounds related to injectable medications
7. Contradiction and limiting access to care in advisory opinion and training requirements related to crushing, measuring and calculating medications
8. Proposed changes to Alaska Board of nursing medication administration course requirements

1. **Ambiguity related to the term "complex nursing skills"**

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

   and

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

   and

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

   CONCERN: Ambiguous Terminology. "Complex nursing skills" is not defined in the NPA and the term cannot be found in any guidance documents from state or national sources. Alternatively, the NPA does define "basic nursing skills" in 12 AAC 44.845(2), and outlines "Specialized nursing duties/tasks" in 12 AAC 44.960. While the ambiguous lack of definition for "Complex Nursing skills" doesn't limit practice specifically, the board has set a precedent for citing the term to limit delegable activities. A 2007 advisory opinion active until November of 2023 (now archived) prohibited the delegation of administration of controlled substances based on 12 AAC 44.955(a)(3).

   The advisory opinion implies that ALL instances of administering controlled substances constitute a complex nursing skill and so can not be delegated. This position is contradicted, however, by the Board's approval of Medication Administration A Guide for Training Unlicensed School Staff in 2013, its update in 2018 and a newer version in 2021. These documents state clearly "Only routine doses of controlled substances (e.g. Ritalin) are delegable by the school nurse to an unlicensed school staff." (Pg. 15, 2018) and "Only routine doses of controlled substances (e.g., Ritalin, or other ADHD medications) are delegable by the school nurse to a trained unlicensed school staff after receipt of a provider order and parent/guardian consent." (Pg. 13, 2021).

   PROPOSED SOLUTION: Remove instances of "complex nursing skills" from the NPA rather than attempting to define it.

   REASONING: I would argue that a "complex nursing skill" is made complex because of the nursing knowledge and judgment required to perform it rather than the technical difficulty of a task (analogously, one could teach the functional skill of driving a car to a teenager in one afternoon, but knowledge and judgment to safely drive without the instructor present would take a specialized driver's education course). The rules already specifically prohibit delegating tasks requiring "professional nursing judgment or knowledge," so "Complex nursing skills" becomes redundant. Evidence related to the school setting and advisory opinion shows that this term's ambiguity has clearly caused contradictory practice and application in the state since at least 2013.

2. **Contradiction, lack of currency and limiting access to care related to who may be delegated to administer medications**

12 AAC 44.965(b) Administration of medication may be delegated only to a
(1) "home and community-based services provider" as defined in 7 AAC 43.1110(8);
(2) "residential supported living services provider" as defined in 7 AAC 43.1110(15);
(3) school setting provider; in this paragraph, "school setting provider" means a person who is employed at a school that provides educational services to students age 21 or younger; or
(4) certified nurse aide employed by a long-term care facility licensed and certified by the Health Facilities Licensing and Certification section of the Department of Health.

and

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

CONCERN: Redundant/Contradictory, Limits access to care, No longer current.

Redundant/Contradictory: 12 AAC 44.950, which is cited in 965(a), describes highly detailed criteria for individuals a nurse may delegate which includes defining "unlicensed assistive personnel." 12 AAC 44.965(b), contradicts this by limiting delegation of medication administration by setting rather than by personnel. Most settings with nursing staff that are regulated by the state have additional limitations/requirements on delegation of medication administration. While most of these regulations reference the Nurse Practice Act, section (b) does not refer to all of these settings. The new advisory opinion regarding CMAs is the only potential rule that does not limit setting (even state licensed CNAs are limited by specific locations), which brings it in line with 950, but in conflict with 965(a).

Limits access to care: The statement "Administration of medication may be delegated *only* to a [...]" provides an exclusionary rule which removes flexibility for changes or new circumstances (such as the need to add CMA's to the rules). It also means that any omission from the NPA (Alaskan Correctional facilities, some services defined in AS 47.32.900 and other settings with nurses delegating staff) are limited from safe, legal practice. Finally, it removes the flexibility to handle changes to other state rules, as described below.

No Longer Current: Items (1) and (2) of 12 AAC 44.965(b) refer to 7 AAC 43.1110 but the entirety of that rule was repealed on February 1st, 2010. Though the board reserves the right to interpret rules by intent, the prudent delegating nurse would be wise to follow the rules as written until guided otherwise. To that standard, it could be read that any setting previously listed under (8) and (15) of 7 AAC 43.1110 has not been allowed by the NPA to have nurses delegate for 14 years.

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

REASONING: 12 AAC 44.950(a) states:

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

Sec. AS 08.68.850(12) of the NPA defines unlicensed assistive personnel (UAP) as:

"persons, such as orderlies, assistants, attendants, technicians, members of a nursing client's immediate family, or the guardian of a nursing client, who are not licensed to practice practical nursing, registered nursing, medicine, or any other health occupation that requires a license in this state."

Because 7 AAC 44.950(a) already lays out specific guidelines regarding who can receive a nursing delegation and what criteria the nurse must follow to do so, the additional limitations provided in 965(b) are unnecessarily limiting. Keeping the rule in place means the board will have the potentially onerous burden of maintaining and updating it on a regular basis with delays impacting safe nursing care in multiple settings.

To illustrate this, the correction of 965(b)(1) and 965(b)(2) by themselves will likely take extensive discussion and delay because the rules are no longer as neatly encapsulated as they were prior to 2010. Additionally, a deeper review of section (b) will likely lead to nurses in other settings that are excluded by the limitations of the rule bringing further exceptions, potentially causing numerous additions and revisions when a simple deletion could remove unnecessary barriers.

Regarding scope of practice, if the CMA advisory opinion were placed into rule as it is currently written, the omission of specific locational limitations would mean giving a non-state regulated UAP a greater degree of flexibility of practice than a state regulated UAP (CNAs). This could be seen as devaluing the state certification and diminishing the authority of the board to regulate nursing activity.

3. **Case Study: Profound seizure disorder in Assisted living setting**

   “James” is a 58 year old man who loves pizza almost as much as he loves Rocky 5. He is his own guardian, and has been married in the past but prefers his own space and his privacy. James experiences cognitive impairments, a life-long seizure disorder, speech and language impairment, and deficiencies in the area of both fine and gross motor skills. He uses a hospital bed, hoyer lift and wheelchair for mobility.

   James lives in a licensed assisted-living group home where he requires 24 hour non-nursing support to provide him with physical assistance in completing activities of daily living. Though his seizure disorder is well managed with medications and environmental controls, it has led to multiple significant injuries including broken bones and teeth over his lifetime. His seizures can last anywhere from 30 seconds to 15 minutes (or longer) and he sometimes experiences seizure clusters where multiple seizures occur over a short period of time. James is always confused and tired after a seizure occurs and may not fully reorient before having additional seizures. His home staff have a specific protocol from his physician to follow whenever he has a seizure. This involves monitoring him for safety, placing pillows and cushions as needed, timing the seizures and calling 911 for cluster seizures or seizures lasting a certain amount of time.

   He is currently able to self administer his medications, which include time-sensitive benzodiazepines (schedule IIIA), with supervision but may require medication administrations in the future. In December, James'doctor prescribed Nayzilam (Midazolam) or Valtoco (Diazepam) nasal spray for emergency intervention for a seizure lasting 5 minutes or more. These sprays, approved by the FDA in the last few years, come in a pre-filled, single-use nasal spray applicator similar in form to the Narcan (Naloxone) nasal spray applicator. They are not refillable and are only intended for emergency intervention as part of a more robust plan for seizure management.

   At this time, James is not able to utilize this emergency medication due to the Nurse Practice Act. There is not a nurse in his home to administer this PRN controlled substance in a timely manner and Alaska assisted-living rules do not allow a workaround for the guardian to delegate as is established in other settings (explained in item 4). The situation has been communicated to his neurologist who provided the following letter regarding the situation:

[redacted], [redacted] (id # [redacted], dob: [redacted])

TROY MEDICAL
2555 PHILLIPS FIELD ROAD FAIRBANKS AK 99709-3833
TEL# (907) 415-1257, FAX# (833) 941-2429

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

To Whom it May Concern,

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

Please reach out with any questions.

Sincerely,

Aka Mohamed Tom Bakhit

Electronically Signed by: MOHAMED B. TOM, MD

4. **Limiting access to care and poorly regulated workarounds related to PRN controlled substances**

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

(1) when to administer the PRN medication to the patient;
(2) the procedure to follow for the administration of the PRN medication, including dosage amount, frequency, and duration; and
(3) the circumstances under which the person should contact the delegating nurse

CONCERN: Limits access to care, Poorly regulated workarounds

Limits access to care: By removing the the ability for a licensed RN or APRN to delegate the administration of PRN controlled substances to anyone, in any setting and under any circumstance, the NPA currently limits Alaskans from accessing meaningful care interventions in situations where a nurse or other appropriately licensed individual is not able to directly administer that medication. Individuals requiring medication administration including some school children, adults with developmental disabilities, state prisoners, disabled elderly and individuals receiving home hospice care are denied access to medications such as Benzodiazepines for emergency seizure intervention or anxiety, Codeine suspensions for cough suppression, and Morphine Suspension for end of life pain management.

Poorly regulated workarounds: Despite the prohibition, there is still a need for individuals to be administered PRN controlled substances in some circumstances. Because of this, multiple care settings have written workarounds into their rules to avoid the limitation. The Alaska Board of nursing approved one workaround in 2012 with the Alaska Schools Medication Delegation Decision Tree (pg. 26 of Medication Administration A Guide for Training Unlicensed School Staff) where the parent/guardian delegates the task when a nurse is not allowed to (most often the administration of a controlled PRN or insulin injection). The approved framework requires the nurse to provide all oversight and education to the delegee and family, including regular monitoring and evaluation. They are the delegator in all but name and legal accountability. Other settings have delegation workarounds written into their rules which have likely not been reviewed by the board and often do not require any significant oversight by a licensed professional. Two examples include:

7 AAC 130.227, defines rules for medication administration in adult day services, day habilitation services, residential habilitation services, employment services, intensive active treatment services and respite care services. According to section (i)(3), these rules don't apply if "the recipient or the recipient's representative gives the provider written notice designating an individual that will be responsible for administration of medication or assistance with self-administration of medication for the recipient, and the provider arranges with that individual to administer the medication or assist with self-administration at the time medication is required by the recipient." Unlike the school rules, there is no further requirement or guidance for oversight.

22 AAC 05.120 describes health services in a correctional facility. Paragraph (d) states "Facility health care personnel shall supervise the prescription and administration of medication. The superintendent may designate appropriate staff members to assist facility health care personnel. The superintendent of each facility shall devise procedures to prevent access by prisoners to pharmaceuticals and medical records. Only correctional officers who have graduated from a training program for the identification and administration of medication may administer prescription medication when health care staff are not on duty." It is unclear if the training listed in this rule needs to be approved by the Alaska BON per 12 AAC 44.965(c).

PROPOSED SOLUTION: Remove the words "other than controlled substances" from 12 AAC 44.965(e). Add the following items to the medication training course requirements required by the BON per 12 AAC 44.965(c):

Section 3:
-Oversedation and Falls
-Food to Drug Interactions (Specifically Alcohol)
-Addiction vs. Tolerance vs. Dependence

Section 4:
-Narcan

REASONING: The types, uses and administration methods of PRN controlled substances have changed significantly since 2004 when this rule was originally established. Additionally, the role and education of nurses has evolved to meet the ever expanding needs and technology shifts in our field. The safeguards put in place under 12 AAC 44.950-965 combined with the delegation framework laid out in National Guidelines for Nurse Delegation provide an RN or APRN the tools necessary to make a reasonable determination in each situation to decide if a medication administration can be safely delegated.

Provision (e) of 12 AAC 44.965 clearly states:

> [...] before the administration of PRN medications may be delegated, the nurse shall first assess the patient to determine whether on-site patient assessment will be required before administration of each dose of PRN medication. The written instructions provided to the person under 12 AAC 44.950(a)(7) must meet the requirements of (d) of this section, and must also include
>
> (1) when to administer the PRN medication to the patient;
> (2) the procedure to follow for the administration of the PRN medication, including dosage amount, frequency, and duration; and
> (3) the circumstances under which the person should contact the delegating nurse

This provision alone should be sufficient to ensure a safe delegation of controlled PRNs while allowing patients to receive essential rescue medications when an RN isn't physically present. Combined with 12 AAC 44.950(b) which requires "either the original delegating nurse or the substitute nurse [to] remain readily available for consultation by the person, either in person or by telecommunication," there should be no situation where a nurse would not be able to direct intervention if needed for a patients safety.

12 AAC 44.950(a)(3), which requires that a "patient's medical condition must be stable and predictable" for the nurse to delegate, provides further layers of protection. Stable and Predictable is defined in 12 AAC 44.990(29): "the patient's medical condition is known, through the nurse's assessment, to be consistent and non fluctuating; 'stable and predictable' includes a terminally ill patient with a predictable deteriorating condition." While there is still room for each nurse's interpretation, 950(a)(3) will ensure that unstable or unpredictable patients, those at the greatest risk for toxicity (overdose), addiction or abuse, will not have administration of their controlled PRNs delegated to a UAP.

Alternatively, if the prohibition of delegating PRN controlled substances is removed, nurses working with hospice patients may be able to delegate pain medications or anxiolytics to avoid delays in these essential treatments. School nurses may delegate emergency response medications without having to workaround the Nurse Practice Act and nurses like myself in other community settings will be able to delegate the administration of controlled emergency medications in the case of life threatening events.

To support the additional training needs to address the proposed change, I have suggested the addition of training sections covering Oversedation, Falls, Food to Drug Interactions (Specifically Alcohol), Addiction vs. Tolerance vs. Dependence and Narcan. I believe the inclusion of these items will address most of the more significant concerns and demystify the risks related to the administration of controlled substances.

5. **Case Study: Injectable medications with cognitive disabilities**

"DJ Smooth*" is a 34 year old man who enjoys participating in team special olympics events, especially bowling and track and field. He experiences cognitive impairments and is on the autism spectrum. He also experiences schizophrenia, ulcerative colitis and type 2 diabetes. He sometimes has difficulty with remembering details or communicating his needs but has been successful in group home activities and day habilitation.

DJ Smooth lives in a licensed assisted-living group home where he receives 24 hour non-nursing behavioral support to develop skills of independent living. He has worked with the same assisted living provider for 15 years and is very much an active part of his community with a girlfriend and a bowling team. He is friendly and humorous and loves to be a part of a group.

A month ago, DJ Smooth was prescribed weekly Semeglutide (Ozempic) injections by his physician to help manage his diabetes. Ozempic comes in a preloaded subcutaneous injection pen with a dial for easy dose selection. The pen comes with a supply of disposable needles and has been designed with straightforward instructions for easy home use.

Despite DJ Smooth receiving training in how to self administer the medication at the doctor's office, he and his caregiving staff required an additional 3 hours of training with a nurse employed by the assisted living provider before he felt comfortable with self administration of the injection. "DJ Speed" benefits from having his staff present to remind him of all the safety steps and would be unable to self administer without this assistance.

Though DJ Smooth has been able to safely self-administer with assistance, there may be situations in the future where he would not be able to self administer due to physical or cognitive limitations. The nurse practice act currently prohibits the delegation of subcutaneous injections in most settings, including assisted living. Also, just like the case of "James," there is no workaround in assisted living regulations to allow administration. This means that DJ Smooth would not be able to utilize his prescribed medication without a nurse present if his limitations rendered him unable to self administer. While one weekly injection in DJ Smooth's case is not so onerous, this would also limit an individual with a similar condition or physical limitations who receives one or more insulin injections daily. It is essential that the board considers the repercussions of limiting care as the NPA stands currently.

*** When I asked this individual if I could use their story, they asked me to use their preferred alias, DJ Smooth**

6. **Limiting access to care and poorly regulated workarounds related to injectable medications**

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

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

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

(c) Repealed 5/16/2018.

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

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

(f) Repealed 3/19/2014.

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

(h) In this section,

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

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

(3) repealed 5/16/2018.

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

and

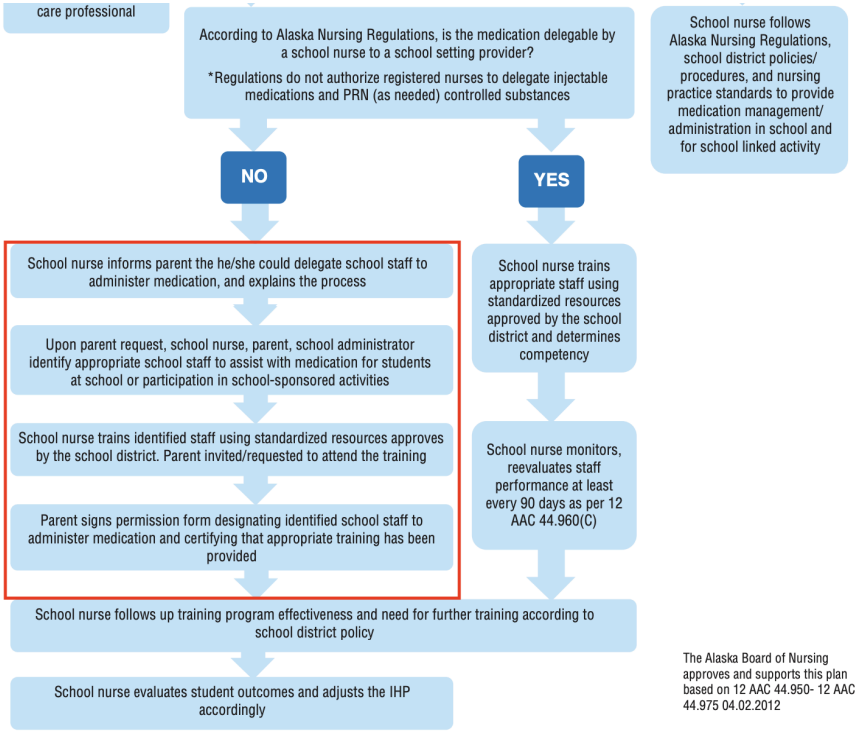
12 AAC 44.970. NURSING DUTIES THAT MAY NOT BE DELEGATED

(13) except as provided in 12 AAC 44.966, the administration of injectable medications; and

CONCERN: Limits access to care, Poorly regulated workarounds

Limits access to care: Though 966(a) designates the delegation of injectable medications as a specialized nursing task delegable by an RN according to 960(a), 966(b) limits the task to APRNs delegating to Medical Assistants and only in very specific settings and situations. This limits patient's access to injectable medications (such as insulin for diabetes or Wegovy for diabetes or heart disease) in all other settings including schools and assisted living homes. While schools have a workaround (mentioned in item 4), assisted living homes do not. Individuals needing medication administration of insulin (inability to self administer could be related to cognitive impairment, amputation, arthritis, cerebral palsy, paralysis, etc.) may not legally live in an assisted living home because of this rule in the Nurse Practice Act.

Poorly regulated workarounds: The workarounds described in item 4 also apply to this topic. The Board of nursing itself has been forced to approve workarounds to allow access to medications prohibited by this rule. Not only is there an advisory opinion on epipens which, without nursing delegation, states: "Use of epi-pen by UAP is permitted in an emergency situation if staff is trained to use this as first aid." There is also the decision making framework for the school setting (pg. 26) which a school RN may use when they are unable to legally delegate a task that can't be refused :



The guide then offers this specific direction:

> “Injectable medications may not be delegated by a registered nurse to unlicensed school staff. Unlicensed school staff may be trained in administering injectable emergency and diabetic medications, such as epinephrine and glucagon, when authorized by the parent and trained by a registered nurse. (Pg. 25)”

School registered nurses are still responsible for providing medication administration training per 965(c). The delegating parents are encouraged, but not required, to attend the training for administering medications the nurse can’t delegate. After the parent has signed the delegation, the nurse is required to follow up on the effectiveness of the training program but is not required to monitor and re-evaluate the trainee as they would be for someone they had delegated. Even an APRN employed by the school would be required to utilize this workaround due to the strictures set by the NPA..

PROPOSED SOLUTION: Change the rules to distinguish between subcutaneous and non-subcutaneous injections. Allow Registered Nurses and APRNs to delegate subcutaneous injections in non-clinical settings as long as all other requirements for delegation in 950 and 965 are met. Add the following items to Medication Administration course requirements:

Section 2:
-Subcutaneous injections

Section 3:
-Hypo- and Hyperglycemia

Section 4:
-Epipen
-Glucagon

REASONING: There is a clear need for the administration of some injectable medications in non-clinical settings where a nurse may not be present. The CDC has identified that about 1 in 6 people with Intellectual and Developmental Disabilities (IDD), experience diabetes in the US. For school aged children, 89% of students with diabetes are type 1 (sometimes called insulin dependent) diabetics (NIDDK NIH). These two groups are the most likely to be helped by a change in the NPA, but other populations including the elderly, non-IDD disabled and incarcerated individuals will also benefit.

Diabetes is not the only condition that can be managed through subcutaneous injections, however. New technology has allowed safe access to other subcutaneous injectable medications such as other hormone therapies and GLP-1 agonists such as Wegovy and Ozempic which are currently approved for diabetes, weight management and most recently, cardiovascular risk reduction for patients with heart disease.

In the school setting, some UAPs are already being trained and allowed to administer injectable medications to school aged children without a nursing delegation and without the same nursing oversight required for nursing delegations. Alternately, in settings without legal workarounds like assisted living homes for adults with IDDs, people with otherwise very low care needs are being denied access. Thus forcing them to seek higher acuity care settings or institutions simply because a nurse cannot legally delegate the administration of the injectable medications they need to survive.

7. **Contradiction and limiting access to care in advisory opinion and training requirements related to crushing, measuring and calculating medications**

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

and

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

and

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

CONCERN: Contradictory/Ambiguous, Limits access to care

Contradictory/Ambiguous: The first half of this advisory opinion contradicts the second but it is unclear if the second half means that a nurse may delegate the task of crushing medications if they have verified with the pharmacist or if this task can be completed by the nurse. 14a of the MACR would seem to indicate that neither the nurse nor a delegated UAP would be allowed to crush medications. The inclusion of "Measurement and metrics" in the MACR would seem to contradict the Advisory Opinion's prohibition on delegating the measuring of medications.

Limits access to care: Based on the most conservative interpretation of this guidance, a UAP delegated to administer medication may not crush a medication and is not allowed to measure medications even though they have been trained to understand measurements and metrics. This means that a patient in a non-clinical setting would require a nurse to be present to pour a liquid into a measuring cup (or crush a pill if needed) or they would have to go without the medication.

PROPOSED SOLUTION: Retire the current advisory opinion and remove 14(a) from the MACR. Consider new advisory opinions stating:

"The crushing, splitting or opening of capsule medications may only be delegated after an RN verifies with a pharmacist or the prescribing physician that the medication may be crushed, split or opened."

“Measuring of non-injectable medications is a component of the task of Medication Administration and the procedure for measuring that medication must be included in the written instructions required by 12 AAC 44.965(d)(1) by the delegating nurse.”

“The calculating of medications cannot be delegated to a UAP by a registered nurse as it requires the utilization of professional nursing judgment and knowledge as required in 12 AAC 44.950(a)(6).”

REASONING: An alternate interpretation of the advisory opinion is that the board had intended to allow for the crushing of medications but that changes were not made clear and updates were not made to (14)(a) of the MACR to reflect it. If it was not the board’s intention to allow the crushing of medication then I would argue that once a medication has been identified as crushable by a pharmacist and that information has been documented as part of the medication plan, there is no further nursing judgment required to crush that medication. Though it was not included, in the original opinion, it is reasonable to add the splitting of medications and the opening of capsules as long as it has been reviewed by a physician or pharmacist.

I would argue that the measurement of non-injectable substances is not a task of nursing and is a common task utilized daily in many homes and workplaces. Only because the task involves the measurement of medications does it become a task of nursing but I would argue that this task is a standard component of the medication administration task and 12 AAC 44.965(d)(1) would seem to agree when it requires written instructions which include “the dosage amount and proper measurement” of medications. According to the above rule, a delegated UAP would not be allowed to measure a capful of Miralax (polyethylene glycol), a scoop of metamucil or a dose of cough syrup during the cold and flu season.

I am in agreement with the prohibition against the calculation of medication doses as it requires the exercise of nursing judgment and knowledge.

8. **Proposed changes to Alaska Board of nursing medication administration course requirements**

The following items are from the Alaska Board of Nursing's MEDICATION ADMINISTRATION COURSE REQUIREMENTS (MACR). Rather than following the format of the previous items, I will provide basic commentary for discussion or modification for review by the board:

Pretest & Post-test

It is unclear why the training program requires a pretest. According to Apperson, a standardized testing provider, the benefit of a pretest is that it gives the "ability to quickly see what a student knows at the beginning," "provide the ability to independently measure a student's growth," and determine "what areas allow for the most improvement and where to direct instruction." However, because the medication administration training is a pass/fail course with clearly regimented content, these benefits are irrelevant. The nurse instructor is not allowed to modify the content of the course, and the student's growth will only be measured in the end by whether they pass or fail the post-test. If there is to be a benefit from a pretest, it would likely need to be designed by an education specialist. As it is, I recommend the removal of the pretest requirement.

9. Patient Bill of Rights

There are numerous "Patient Bill of Rights" in existence and most of them are only relevant to a hospital setting and have very little to do with medication administration. These include the AHA Patient Bill of Rights (1973, revised 1992), Patient Bill of Rights (2010), and several more from a variety of medical facilities. While some Alaska statutes provide lists of rights that are specific to particular care settings or recipients, content can vary from rule to rule. As far as I have found, the state of Alaska does not have a general Patient Bill of Rights. I recommend either removing this item from the MACR or having the board specifically identify which rights are most relevant to the safe administration of medication. It would be beneficial to include a discussion of the "Right to refuse."

11. Universal precautions

Alaska's laws cite the use of universal precautions in many locations for a variety of purposes, however, I would strongly recommend updating the MACR requirements to include standard precautions- especially since the pandemic. OSHA provides a valuable refresher on the difference between Universal and standard precautions with standard precautions including "hand hygiene; the use of certain types of PPE based on anticipated exposure; safe injection practices; and safe management of contaminated equipment and other items in the patient environment. SP is applied to all patients even when they are not known or suspected to be infectious." OSHA further states that "although the [Bloodborne Pathogen] standard incorporates [universal precautions], the infection control community no longer uses [universal precautions] on its own.

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

By the current rules regarding who can be delegated, every individual being delegated for medication administration will be an employee of a business that falls under the criteria of 12 AAC 44.965(b)(1-4). That employer is responsible for determining if that individual is able to complete the tasks related to their job before they ever receive medication training. Regardless, the completion of medication administration training is a separate act from delegation and may be completed by two separate nurses. I would argue that it is the responsibility of the delegating nurse, not the training nurse, to determine if “the person to whom a nursing duty is to be delegated is competent to perform the delegated duty correctly and safely and accepts the delegation of the duty and the accountability for carrying out the duty correctly;” per 12 AAC 44.950(a)(5). For these reasons I recommend removing the prohibition from using computer based testing for the medication administration post test.

In this presentation I have provided an extensive list of questions and concerns facing Nurse Delegators in Alaska. While it is not my intention to overwhelm the board with so many items at once, decisions on these topics will have a significant impact on Alaskan nursing practice in the future. When Alaska eventually joins the Nursing Licensure Compact, clear and current guidance on these matters will be essential to ensure safe practice not only by local nurses but also by traveling nurses who will need to quickly acquaint themselves with Alaska's Nursing Practice act.

To review, I am asking the board to consider the following propositions:

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

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

3. The nurse practice act currently limits James' access to life saving treatment in his preferred home setting. Because there is no workaround in the assisted living regulations, he would need to move to a less private, more expensive setting to ensure he could be administered the controlled PRN medication his doctor has prescribed.

4. The prohibition against delegating the administration of PRN controlled substances in 7 AAC 44.965(e) limits access to care and requires specific settings (and the Board) to create poorly regulated workarounds. This situation requires review to remove the prohibition or maintain it. If it is maintained, I will request the board's assistance with advocating for adding a workaround into the rules for assisted living providers.

5. DJ Smooth is one of many examples of individuals living with intellectual and developmental disabilities who benefit from the assisted living care setting but may be unable to access prescribed treatments if their abilities limit them from self-administering subcutaneous injectable medications.

6. The current rules for delegating the administration of injectable medications in 12 AAC 44.966 do not fully address the varying technology and complexity of different forms of injections. The prohibition against RNs delegating subcutaneous injections under any circumstances limits access to care and requires specific settings (and the Board) to create poorly regulated workarounds. This situation requires review to either add an allowance for subcutaneous injections or maintain the rules as written. As above, if the

rules are maintained, I will request the board's assistance with advocating for adding a workaround into the rules for assisted living providers.

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

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

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

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

State	eNLC	Sched. Non-CS	PRN Non-CS	Sched. CS	PRN CS	Insulin Injection
Alabama	Y	Yes	Not Prohibited	Not Prohibited	Not Prohibited	*Only in schools
Alaska	P*	Yes	Yes	Not Prohibited	No	No
Colorado	Y	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited
Florida	Y	Yes	Yes	No	No	Yes
Georgia	Y	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited
Hawaii	P*	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited
Idaho	Y	Yes	Yes	Yes	Yes	Yes
Illinois	P*	Yes	Yes	Not Prohibited	Not Prohibited	Not Prohibited
Indiana	Y	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited
Iowa	Y	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited
Kansas	Y	Yes	Yes	Not Prohibited	Not Prohibited	Not Prohibited
Kentucky	Y	Yes	Yes	Not Prohibited	Not Prohibited	Yes
Louisiana	Y	Yes	Yes	Not Prohibited	Not Prohibited	No
Maine	Y	Yes	Yes	Yes	Yes	Yes
Maryland	Y	Yes	Yes	Not Prohibited	Not Prohibited	Yes
Michigan	P*	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited
Minnesota	P*	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited
Missouri	Y	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited
Montana	Y	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited
Nebraska	Y	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited
Nevada	N	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited
New Hampshire	Y	Yes	Yes	Not Prohibited	Not Prohibited	Yes
New Jersey	Y	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited
New Mexico	Y	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited
North Carolina	Y	Yes	Yes	Yes	Yes	Yes
North Dakota	Y	Yes	Yes	Yes	Yes	Yes
Oregon	N	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited
Rhode Island	Y*	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited
South Dakota	Y	Yes	Yes	Yes	Yes	assistants only
Texas	Y	Yes	Not Prohibited	Not Prohibited	Not Prohibited	Yes
Utah	Y	Yes	Yes	Yes	Yes	Yes
Vermont	Y	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited
Washington	Y*	Yes	Not Prohibited	Not Prohibited	Not Prohibited	Yes
West Virginia	Y*	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited
Wisconsin	Y	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited
Wyoming	Y	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited	Not Prohibited

Medication	UAP Certification required		Nurse Practice act Link
Yes	N/A	depending on Setting.	https://www.abn.alabama.go
Yes	N/A	specifically prohibited,	https://www.commerce.alask
Not Prohibited	N/A	delegable tasks but gives	https://casetext.com/statute/
Yes	N/A	controlled substances may	http://www.leg.state.fl.us/stat
Not Prohibited	N/A	delegable tasks but gives	https://sos.ga.gov/sites/defau
Not Prohibited	N/A	delegation of medication	https://www.capitol.hawaii.gc
Yes	N/A	medication assistance	https://casetext.com/regulati
Yes	N/A	delegation of medication	https://ilga.gov/legislation/ilcs
Not Prohibited	N/A	mention delegation	https://law.justia.com/codes/i
Not Prohibited	N/A	delegation of medication	https://www.legis.iowa.gov/d
Not Prohibited	N/A	of medication	https://ksbn.kansas.gov/wp-c
Not Prohibited	N/A	guidance for delegating	https://apps.legislature.ky.go
Yes	N/A	med delegation in out	https://www.doa.la.gov/media
Yes	CNA; CNA-M	delegation of med admin to	https://legislature.maine.gov/
Yes	Medication Technicians	administration delegation to	https://govt.westlaw.com/md
Not Prohibited	N/A	delegable tasks but gives	https://www.legislature.mi.go
Not Prohibited	N/A	delegation. Supplemental	https://mn.gov/boards/nursin
Not Prohibited	N/A	delegable tasks only	https://pr.mo.gov/boards/nurs
Not Prohibited	N/A	delegable tasks only	https://rules.mt.gov/gateway/
Not Prohibited	N/A	delegable tasks but lays out	https://dhhs.ne.gov/licensure
Not Prohibited	N/A	delegable tasks but gives	https://casetext.com/regulati
Not Prohibited	N/A	that can be delegated. First	https://www.gencourt.state.n
Not Prohibited	N/A	of med admin but places no	https://www.njconsumeraffai
Not Prohibited	N/A	delegable tasks but lays out	https://law.justia.com/codes/
Yes	N/A	delegation to UAPs of	https://www.ncleg.net/enacte
Yes	N/A	administrarion via the	https://ndlegis.gov/cencode/t
Not Prohibited	N/A	prohibited in the NPA or	https://www.oregon.gov/osbr
Not Prohibited	Medication Aides, CNA	delegation of medication	http://webserver.rilin.state.ri.
Yes	Assistants	specific guidance for all	https://sdlegislature.gov/Rule
Yes	N/A	for delegation of med	https://www.bon.texas.gov/p
Yes	N/A	administer non-controlled	https://adminrules.utah.gov/p
Not Prohibited	N/A	delegation to the NCSBN	https://legislature.vermont.gc
Yes	CNA or Home Care Aide	prohibited in the NPA or AO	https://app.leg.wa.gov/RCW/
Not Prohibited	Assistive Personnel	delegation but other	https://apps.sos.wv.gov/adla
Not Prohibited	N/A	but guidance ofr del of	https://dsps.wi.gov/Pages/Ru
Not Prohibited	N/A	delegable tasks but gives	https://wsbn.wyo.gov/home

Othe Relevant links

https://admincode.leg https://adminco https://admincode.legislature.state.al.us/api/chapter/610-X-7
https://www.commerce.alaska.gov/web/portals/5/pub/NUR_AdOp_Archive.pdf
colorado-revised-statutes/title-12-professions-and-occupations/health-care-professions-and-occupati
http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=04
https://sos.ga.gov/sites/default/files/forms/38%20Reference%20-%20Position%20Statement%20-%2
https://www.capitol.h https://cca.hawaii.gov/pvl/files/2013/08/HAR-89-C.pdf
https://healthandwelf https://www.idhca.org/nurse-delegation-toolkit/
https://www.ilga.gov/ https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=313&ChapterID=5
https://casetext.com/ https://casetext.com/regulation/indiana-administrative-code/title-511-indiana-sta
ocs/iac/chapter/655.6.pdf
content/uploads/NPA/npa.pdf
https://apps.legislatu https://kbn.ky.gov/KBN%20Documents/aos15-delegation.pdf
https://casetext.com/ https://higherlogicdownload.s3.amazonaws.com/NASN/9489f5de-2886-4e48-b
https://www.maine.g https://www.ma https://www.maine.gov/boardofnursing/laws-rules/rules-chapter
https://dsd.maryland. https://dhs.maryland.gov/documents/Licensing-and-Monitoring/Maryland%20La
https://www.michigan.gov/-/media/Project/Websites/mde/2021/12/09/ADA_Delegation_final_6-29-21
https://mn.gov/boards/nursing/practice/nursing-practice-topics/
sing/npa.pdf
https://boards.bsd.dli.mt.gov/_docs/nur/sp_guide.pdf
https://casetext.com/regulation/nebraska-administrative-code/health-and-human-services-system/titl
https://nevadanursingboard.org/practice-information/
https://casetext.com/ https://www.oplc.nh.gov/sites/g/files/ehbemt441/files/inline-documents/sonh/rn-
rs.gov/regulations/Chapter-37-New-Jersey-Board-of-Nursing.pdf
https://casetext.com/regulation/new-mexico-administrative-code/title-16-occupational-and-professior
http://reports.oah.sta https://www.ncb https://www.ncb https://www.ncbon.com/myfiles/downloads/boa
https://www.ndbon.org/FAQ/SchoolNsgMedAdmin.asp
https://www.oregon.gov/osbn/Pages/interpretive-statements.aspx
https://rules.sos.ri.go https://health.ri. https://rules.sos.ri.gov/regulations/part/216-40-05-22
https://sdlegislature.gov/Rules/Administrative/20:48:04.01:18
https://www.bon.texas.gov/pdfs/law_rules_pdfs/rules_regulations_pdfs/September%202022%20Rul
https://dopl.utah.gov/wp-content/uploads/2022/10/tasks-unlicensed-individual-may-perform-without-
https://sos.vermont.g https://www.hea https://healthve https://sedation https://www.healthvermont.gov/
https://nursing.wa.gov/support-practicing-nurses/practice-guidance
https://code.wvlegisla https://wvrnboa https://apps.sos https://casetext.com/regulation/west-virginia-ad
https://docs.legis.wis https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Print.aspx?ia=1&p=
https://drive.google.c https://drive.goo https://drive.goo https://drive.google.com/file/d/1vOheoAZbh2Jc

ions/article-255-nurses/part-1-nurses-and-nurse-aides
00-0499/0464/Sections/0464.0156.html
20Assignment%20to%20Unlicensed%20Assistive%20Personnel.pdf

ate-board-of-education/article-7-special-education/rule-511-iac-7-36-general-administration-of-programs/sectior

5b0-605e44051f41/UploadedImages/Oct%202000-%20RN%20Delegation%20Insulin.pdf
rs/Adopted%20Chapter%205%20Rule%20-%20Effective%201-1-2023/Chapter%205%20Adopted%20Rule_.pc
aw%20Articles/RCC/COMAR%2010.27.11%20Delegation%20of%20Nursing%20Functions.pdf
1pdf.pdf?rev=bee6045c5e01406892f93f55833d0030

le-172-professional-and-occupational-licensure/chapter-99-provision-of-nursing-care/section-172-99-004-standa

-scope.pdf

nal-licensing/chapter-12-nursing-and-health-care-related-providers/part-2-nurse-licensure
rd%20information/laws-rules/position-statements/ps-delegation-of-medication-administration-to-uap.pdf

es%20and%20Regulations.pdf
delegation.pdf
/sites/default/files/documents/pdf/cyf_22%20N%20MedicationTrainingGuide-3-18-2019.pdf

lministrative-code/agency-64-health/title-64-legislative-rule-bureau-for-public-health/series-64-60-medication-ad
=1&sa=47&s=2&c=61&nt=Delegation+of+Medically+Oriented+Tasks
b7vNng9xAKV9TlU414QZ/view

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ards-for-delegation

dministration-and-performance-of-health-maintenance-tasks-by-unlicensed-personnel

Presentation to the Alaska State Board of nursing: Delegations

Jason Sanders, RN BSN
May, 2024

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

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

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

Are the rules up to date with current information?

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

Are they clear, are there contradictions?

The Scope of this Presentation

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

1. “Complex Nursing Skills”

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

and

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

and

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

1. What is the definition “Complex Nursing Skills”

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

Reasoning:

- Are not defined like “basic nursing skills” or “Specialized nursing tasks/duties”
- Are only complex because of “nursing knowledge and judgment” which are already required
    - Example: You can teach someone the physical *skill* of driving in one afternoon but teaching the specialized *knowledge and judgment* for driving requires additional training and experience like driver’s education

2. Specific Settings for delegation of Medication Administration

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

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

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

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

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

and

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

2. Specific Settings for delegation of Medication Administration

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

Reasoning:

- **965(b)(1)** and **965(b)(2)** have been out of date since 2010 and may be difficult to re-define
- **7 AAC 44.950(a)** already allows nursing delegation to UAPs
    - persons, such as orderlies, assistants, attendants, technicians, members of a nursing client's immediate family, or the guardian of a nursing client, who are not licensed to practice practical nursing, registered nursing, medicine, or any other health occupation that requires a license in this state.
- **7 AAC 44.950(a)(1-7)** already provides strong guidance regarding who can be delegated and in which situations
- Fails to anticipate the evolution of nursing practice and settings where care is provided

3. Case Study: “James”

3. Case Study: “James”

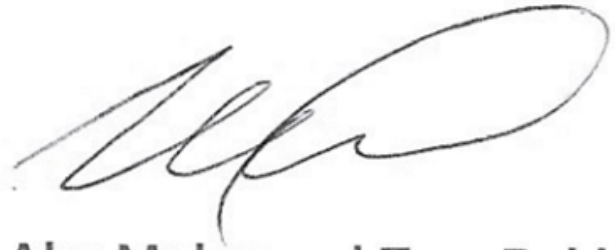
Date: 03/15/2024
RE: [redacted] DOB: [redacted] PT ID [redacted]

To Whom it May Concern,

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

Please reach out with any questions.

Sincerely,



Aka Mohamed Tom Bakhit

Electronically Signed by: MOHAMED B. TOM, MD

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

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

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

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

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

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

Title 22: Department of corrections

Chapter 05: Adult Facilities

22 AAC 05.120(d)

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

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

Proposed solution: Remove the words “other than controlled substances” from 12 AAC 44.965(e). Add the following items to the medication training course requirements required by the BON per 12 AAC 44.965(c): Oversedation and Falls; Food to Drug Interactions (Specifically Alcohol), Addiction vs. Tolerance vs. Dependence; Narcan

Reasoning:

- Not current with new medical technology
  - Medication delivery devices such as nasal sprays
  - Improved communication technology for consulting with a nurse under 965(e)(3)
- Has forced workarounds in some settings (Schools, Prisons)
- Limits access to care in settings without workarounds (Assisted Living)

5. Case Study: “DJ Smooth”

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

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

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

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

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

(h) In this section,

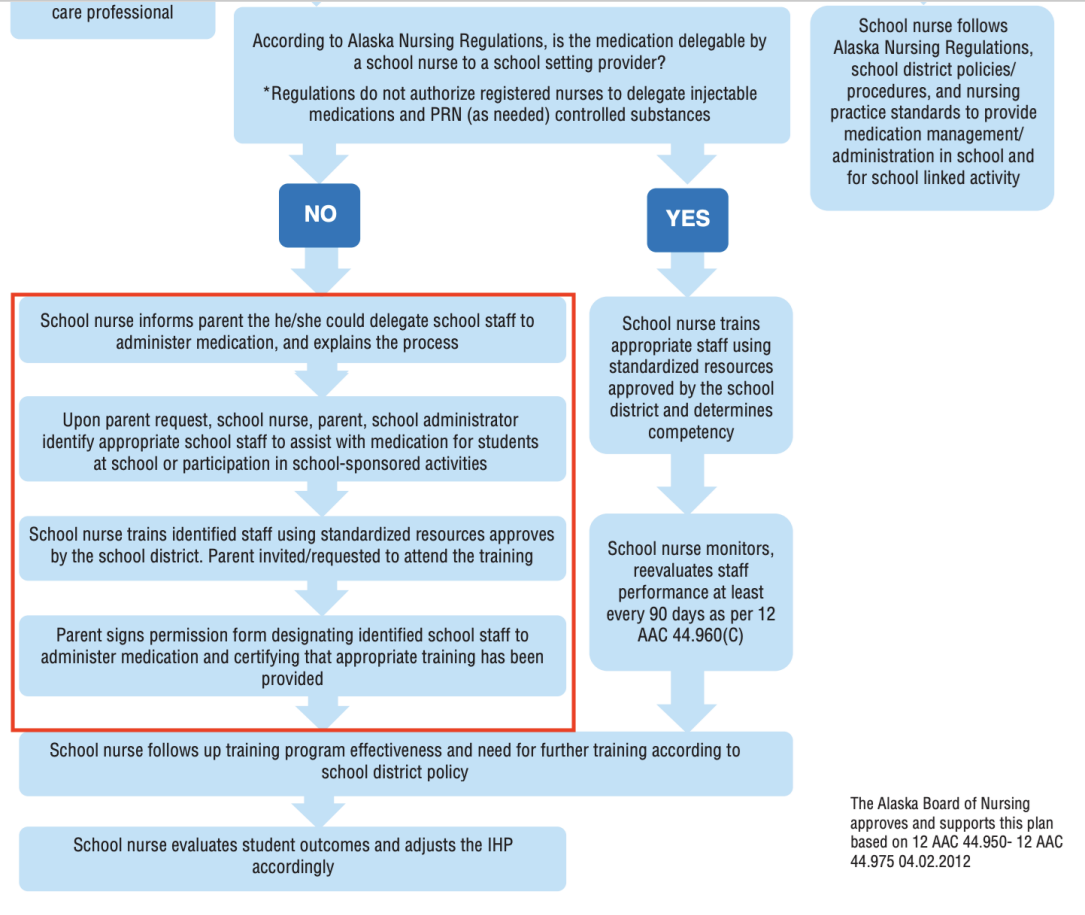
(1) "certified medical assistant" means a person who is currently nationally certified as a medical assistant by a national body accredited by the National Commission for Certifying Agencies (NCCA) and meets the requirements of this section;

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

(3) repealed 5/16/2018.

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

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



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

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

Reasoning:

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

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

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

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

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

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

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

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

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

Reasoning:

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

8. Discussion: AK BON Medication Administration Course requirements

Alaska Board of Nursing
MEDICATION ADMINISTRATION COURSE REQUIREMENTS

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

OUTLINE OF REQUIREMENTS

Course objective

Content of course

Pretest & Post-test

Content to include:

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

8. Discussion: AK BON Medication Administration Course requirements

Alaska Board of Nursing
MEDICATION ADMINISTRATION COURSE REQUIREMENTS

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

OUTLINE OF REQUIREMENTS

Course objective

Content of course

Pretest & Post-test

Content to include:

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

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

8. Discussion: AK BON Medication Administration Course requirements

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

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

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

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

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

8. Discussion: AK BON Medication Administration Course requirements

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

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

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

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

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

-osha.gov

8. Discussion: AK BON Medication Administration Course requirements

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13. Medication errors
    a. When you are unsure of one of the six (6) rights
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    c. Incident reports
14. Limitations
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Post test - not computer based because you need to assess the reading and writing ability of the person being delegated to.

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

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

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

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

-osha.gov

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

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

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

Medication administration training is a separate act from Delegating Medications administration

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

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

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

To review, please consider the following propositions:

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

1. **12 AAC 44.965(b)** which describes settings where medication administration may be delegated is out of date and, if enforced, would excessively limits access to care. It requires review to remove or edit it to make it current to allow safe delegation of medication administration in all settings where delegation may be required.

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

To review, please consider the following propositions:

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

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

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

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

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

Alaska Board of Nursing

Agenda Item #7

APU Nursing Program Update

Alaska Board of Nursing

Agenda Item #8

Span Tran: Evaluation of Foreign Educated Nurses

SpanTran the Evaluation Company

- Established in 1982, SpanTran: The Evaluation Company has been among the most trusted names for foreign academic credential evaluations and translations for over to 40 years. We have been a proud member of the National Association of Credential Evaluation Services (NACES®) since 1996. NACES® evaluations are by far the most requested by academic institutions, employers and professional licensing boards in the United States.

Contents

- Introduction
- Evaluator qualifications
- What states approve SpanTran
- Nurse Submission process
- Sample Evaluation
- SpanTran Policies
- Customer Service
- Questions

Introduction

Evaluator qualifications

- As a member of NACES since 1996, SpanTran: TEC (The Evaluation Company) is recognized as an expert in the field of foreign credential evaluation. Our staff regularly presents at regional, national, and international conferences such as NAFSA, AACRAO, TAICEP, IACAC, and others.

What states approve SpanTran

- Texas
- Kentucky
- Illinois
- Florida
- Louisiana
- North Dakota
- Utah
- Virginia
- Colorado
- Wyoming
- South Carolina

Nurse Submission process

- Exhibit A – SpanTran Licensure Verification Form
- Exhibit B - SpanTran Nursing Transcript Request - **(Classroom & Clinical Hours)**

Sample Evaluation

- Exhibit C – Sample Nursing Course Analysis with academic documents

SpanTran Policies

- Exhibit D - SpanTran Policies/Procedures for Evaluating Foreign Academic Coursework and Nursing Licensure

Dedicated customer service team

- Alaska BoN applicant can contact SpanTran at a dedicated email address status@spantran.com or by phone.

General questions?

SPANTRAN
THE EVALUATION COMPANY

NURSE LICENSURE/NURSING DIPLOMA VERIFICATION

Verification of your nursing licensure in the country where you completed your nursing education is required. Complete Section 1 of this form and then send it to the authority that licenses nurses in the country where you completed your nursing education. **The licensure authority must complete Section 2 and then send the completed form directly to SpanTran by email or by postal mail or courier. SpanTran will not accept completed forms sent by you to SpanTran.**

IF THE COUNTRY WHERE YOU COMPLETED YOUR NURSING EDUCATION DOES NOT LICENSE NURSES OR IF YOUR NURSING DIPLOMA ALLOWS YOU TO PRACTICE AS A NURSE IN THAT COUNTRY, complete Section 1 of this form and then send it to the school where you completed your nursing education. **Your school must complete Section 2 and then send the completed form directly to SpanTran by email or by postal mail or courier. SpanTran will not accept completed forms sent by you to SpanTran.**

IF THE COUNTRY WHERE YOU COMPLETED YOUR NURSING EDUCATION REQUIRES NURSES TO BE LICENSED BY A GOVERNMENTAL ORGANIZATION, THIS FORM MUST BE COMPLETED BY THAT ORGANIZATION. WE WILL NOT ACCEPT FORMS COMPLETED BY YOUR NURSING SCHOOL.

SECTION 1: APPLICANT COMPLETE THIS SECTION

1. YOUR CURRENT NAME

_____

Family name(s) First name Other names

2. YOUR NAME AS IT APPEARS ON YOUR NURSE LICENSE OR DIPLOMA

_____

Family name(s) First name Other names

3. DATE OF BIRTH _____ 4. **SPANTRAN NUMBER** (if known) _____

month / day / year

5. APPLICANT SIGNATURE

_____

SECTION 2: NURSE LICENSURE AUTHORITY OR NURSING SCHOOL COMPLETE THIS SECTION

1. NAME OF NURSE LICENSURE AUTHORITY OR NURSING SCHOOL

_____

2. ADDRESS OF NURSE LICENSURE AUTHORITY OR NURSING SCHOOL

_____
School name

_____
Street City Province/State Country Postal Code

3. UNDER WHICH AUTHORITY CAN NURSES IN YOUR COUNTRY PRACTICE THEIR PROFESSION?

☐ ational Examination ☐ Registration with this licensure authority ☐ iploma from a recognized/accredited nursing program

☐ ther (please explain) _____

4. WHEN WAS THE APPLICANT LISTED IN SECTION 1 ABOVE FIRST LICENSED AS A NURSE IN YOUR COUNTRY?

_____
month / day / year

5. APPLICANT'S CURRENT NURSE LICENSURE STATUS

☐ Active/current ☐ Expired ☐ Inactive

6. HAS THE APPLICANT'S NURSE LICENSURE OR ABILITY TO WORK AS A NURSE IN YOUR COUNTRY EVER BEEN REVOKED OR SUSPENDED?

☐ No ☐ Yes (list the nurse licensure revocation or suspension dates) _____

7. SIGNATURE OF PERSON WHO COMPLETED THIS FORM

_____ _____
month / day / year

8. NAME OF PERSON WHO COMPLETED THIS FORM

_____
Name Title email address

RETURN THIS FORM BY EMAIL TO VERIFICATION@SPANTRAN.COM USING AN OFFICIAL INSTITUTIONAL EMAIL ACCOUNT. EMAILS SENT USING AN OPEN SERVER EMAIL ADDRESS, SUCH AS YAHOO MAIL OR GMAIL, WILL NOT BE ACCEPTED.

Completed forms can also be sent directly to SpanTran in a sealed envelope with your institutional stamp or seal on both this form and the envelope. Send the sealed envelope to:

SpanTran: The Evaluation Company 2400 Augusta Drive, Suite 451 Houston, TX 77057 US

SPANTRAN
THE EVALUATION COMPANY

REQUEST FOR ACADEMIC TRANSCRIPTS

Complete Section 1 of this form and then send the form to the school where you completed your nursing education. If you studied at more than one school, send a completed form to each school. **Your school must complete Section 2 and then send the completed form directly to SpanTran by email or courier. SpanTran will not accept completed forms sent by you to SpanTran.**

SECTION 1: APPLICANT COMPLETE THIS SECTION

1. YOUR CURRENT NAME

_____

Family name(s) First name Other names

2. YOUR NAME WHEN YOU WERE A STUDENT

_____

Family name(s) First name Other names

3. DATE OF BIRTH _____ 4. **SPANTRAN NUMBER** (if known) _____

month / day / year

4. NAME OF NURSING SCHOOL _____

5. DATES OF ATTENDANCE from _____ to _____

month / day / year month / day / year

6. DATE OF GRADUATION OR COMPLETION OF STUDIES _____

month / day / year

7. YOUR SIGNATURE _____ **8. DATE** _____

month / day / year

SECTION 2: NURSING SCHOOL COMPLETE THIS SECTION

1. NAME OF SCHOOL _____

2. SCHOOL WEBSITE ADDRESS _____

3. STUDENT'S DATES OF ATTENDANCE from _____ to _____
month / day / year month / day / year

4. STUDENT'S DATE OF GRADUATION OR COMPLETION OF STUDIES _____
month / day / year

5. NAME OF DIPLOMA AWARDED (in original language) _____

6. DATE DIPLOMA WAS AWARDED _____
month / day / year

7. LANGUAGE(S) OF INSTRUCTION _____ **TEXTBOOK LANGUAGE(S)** _____

8. LENGTH OF NURSING PROGRAM _____

9. IS YOUR SCHOOL ACCREDITED OR RECOGNIZED BY THE GOVERNMENT? ☐ Yes ☐ No

10. NAME OF GOVERNMENT BODY THAT ACCREDITATED OR RECOGNIZED YOUR SCHOOL

_____

11. DATE YOUR SCHOOL WAS FIRST ACCREDITED OR RECOGNIZED _____
month / day / year

12. In the chart below, list the theoretical instruction hours and clinical practice hours this student completed. If your program does not have separate courses for any of the subjects in the chart, please estimate the hours.

SUBJECT	**TOTAL THEORETICAL INSTRUCTION HOURS***	**TOTAL CLINICAL PRACTICE HOURS**
Adult medical nursing		
Adult surgical nursing		
Maternal-infant nursing (excluding gynecology)		
Pediatric nursing		
Psychiatric-mental health nursing (excluding neurology)		
Neurology		
Community health/public health nursing		
Gerontology/geriatric nursing		
Long term care nursing		
Acute care nursing		
Physical assessment		

*classroom instruction, laboratory hours, ward/clinical teaching hours

I confirm that the information listed above is complete and accurate.

NAME OF PERSON COMPLETING THIS FORM _____

TITLE _____ **DATE** _____

month / day / year

SIGNATURE _____

RETURN THE FOLLOWING AS EMAIL ATTACHMENTS TO VERIFICATION@SPANTRAN.COM USING AN OFFICIAL INSTITUTIONAL EMAIL ACCOUNT:

- This completed and signed form (incomplete forms and forms without a signature will not be accepted)
- Original language academic transcript or statement of marks that lists the student's courses, grades, and credits/hours
- Certified English translations (if available)

EMAILS SENT USING AN OPEN SERVER EMAIL ADDRESS, SUCH AS YAHOO MAIL OR GMAIL, WILL NOT BE ACCEPTED.

Completed forms can also be sent directly to SpanTran in a sealed envelope with your organization's stamp or seal on both the form and the envelope. Send the sealed envelope to:

SpanTran: The Evaluation Company
2400 Augusta Drive, Suite 451
Houston, TX 77057 USA

Notes: Course materials and textbooks for this program were issued in Spanish

COURSE ANALYSIS

Grade Conversion:

Original Grade	9.0 - 10	8.0 - 8.9	7.0 - 7.9	6.0 - 6.9	0.0 - 5.9
U.S. Grade	4.00/A	3.33/B+	2.67/B-	2.00/C	0.00/F

L = Lower Division U = Upper Division G = Graduate

SUBJECT	U.S. CREDITS	U.S. GRADES
FEBRUARY-JUNE 2014		
Biochemistry	3.50 L	4.00/A
General Anatomy	3.50 L	3.33/B+
Microbiology	2.00 L	2.67/B-
Reading and Writing	2.50 L	3.33/B+
Nursing Models and Theories	2.50 L	3.33/B+
Healthy Individual Fundamental Nursing	2.50 L	3.33/B+
AUGUST-DECEMBER 2014		
Parasitology	2.00 L	3.33/B+
Physiology	3.50 L	4.00/A
Pharmacology I	2.50 L	3.33/B+
Bioethics and Nursing Legislation	2.50 L	3.33/B+
Nursing Process	2.50 L	3.33/B+
Maternal and Child Fundamental Nursing	2.50 L	3.33/B+
FEBRUARY-JUNE 2015		
Pharmacology II	2.50 L	4.00/A
Teaching Skills Development	2.00 L	4.00/A
Primary Nursing Care	4.00 L	4.00/A
Hospitalized Individual Fundamental Nursing	3.50 L	3.33/B+
Epidemiology and Biostatistics	2.50 L	2.67/B-
Gynecology	3.50 L	4.00/A
Selected Topics on Nursing	2.00 L	4.00/A
Introduction to Epistemology	2.00 L	4.00/A
JUNE-JULY 2015		
Surgical Pathology	2.50 L	3.33/B+
AUGUST-DECEMBER 2015		
Nutrition and Diet Therapy	2.50 L	3.33/B+
Technical English	2.00 L	3.33/B+
Nursing Propaedeutics I	6.50 L	3.33/B+
Healthy and Sick Child Care	3.50 L	3.33/B+
Gynecological Nursing	2.50 L	3.33/B+
Human Development	2.00 L	4.00/A
FEBRUARYY-JUNE 2016		
Mental Health	2.50 U	4.00/A
Industrial Nursing	2.00 U	4.00/A
Surgical Nursing	3.50 U	3.33/B+
Nursing Propaedeutics II	6.50 U	4.00/A

JUNE-JULY 2016		
Research Methodology	2.50 U	4.00/A
Internal Medicine	3.50 U	3.33/B+
AUGUST-DECEMBER 2016		
Nursing Management and Leadership I	2.00 U	3.33/B+
Nursing Propaedeutics III	6.50 U	2.67/B-
Nursing Research I	2.50 U	4.00/A
Geriatric Nursing	2.50 U	4.00/A
Mental Health Nursing	2.50 U	4.00/A
FEBRUARY-JUNE 2017		
Nursing Propaedeutics Iv	6.50 U	4.00/A
Nursing Research II	2.50 U	2.67/B-
Critical Patient Care Provider	3.50 U	3.33/B+
JUNE-JULY 2017		
Nursing Propaedeutics V	6.50 U	4.00/A
AUGUST-DECEMBER 2017		
Nursing Management and Leadership II	2.00 U	4.00/A
Thesis	2.50 U	4.00/A
Pediatrics	2.50 U	2.67/B-
Public Health Nursing	2.50 U	3.33/B+
FEBRUARY-JUNE 2018		
Nursing Internship	6.50 U	4.00/A
CLINICAL EXPERIENCE	HOURS	
Adult Medical Nursing	320	
Adult Surginal Nursing	320	
Maternal-Infant Nursing (Excluding Gynecology)	320	
Pediatric Nursing	320	
Psychiatric-Mental Health Nursing (Exlcuding Neurology)	192	
Community Health/Public Health Nursing	320	
Long Term Care Nursing	320	
Acute Care Nursing	320	
TOTAL HOURS	2432	
U.S. Credits and Cumulative Grade Point Average	***147.00***	***3.58***

Comments:

SpanTran: The Evaluation Company is a member of the National Association of Credential Evaluation Services (NACES). This evaluation is advisory only.

References:

Freeman, K. (2021). AACRAO EDGE: Mexico. Retrieved from https://www.aacrao.org/edge/country/Mexico.

NUFFIC. (2021). Education System Mexico: Higher Education. Retrieved from https://www.nuffic.nl/en/education-systems/mexico/higher-education.

International Nursing Foundation of Japan. (2008). Nursing in the world: The facts, needs and prospects (5th ed.). Tokyo, Chiyoda-Ku, Japan.

Records pertaining to this file will be retained until July 13, 2028

Prepared by:

SPANTRAN
THE EVALUATION COMPANY

Marianne T. Lee

Marianne T. Lee / SL
Senior Credentials Evaluator
Issuing Office - Houston, TX

General Information and Policy Statements for Services

Located in Houston, Texas, New York, New York, Miami, Florida (intake office), and Los Angeles, California (intake office). SpanTran: The Evaluation Company referred to herein as *SpanTran,* provides academic credential evaluations, verification, and translations. Spantran was incorporated in Texas in 1989, and joined the National Association of Credential Evaluation Services (NACES®) as a regular member in 1996.

SpanTran does not discriminate on the basis of race, disability, religion, gender, national origin, or age. However, as a private company not supported by any governmental or public funds, SpanTran retains the right to decline to provide services according to internal business practices and policies.

SpanTran retains evaluations and translations for five years from the date of file initiation. Questions regarding completed services must be submitted in writing within 30 calendar days of the date the evaluation was issued. Questions submitted after 30 calendar days must be submitted in writing, and accompanied by a non-refundable revision fee of $50.00. This fee covers administrative costs and does not guarantee that any modifications will be made to the evaluation.

Credential Evaluation Policies

The U.S. government does not set standards for the evaluation of foreign educational credentials. SpanTran bases its evaluations on extensive in-house research, information gained through participation in professional development opportunities, and on-line and print resources. SpanTran is a member of NACES® but evaluation methodologies and outcomes vary among NACES member organizations. The recipient retains the right to accept, modify, or reject the recommendation(s) listed on the evaluation.

SpanTran does not knowingly evaluate falsified or altered documents. In cases of confirmed forgeries, SpanTran shares this information with NACES member organizations and notifies other entities as deemed appropriate.

General Analysis evaluations state recommended U.S. equivalency/ies and establish recognition/accreditation. Course Analysis evaluations additionally list coursework with a converted U.S. grade and credit value for each course, and a cumulative grade point average. Divisional Course Analysis evaluations provide the same information and also indicate the course level as follows: L = lower level (required prerequisites and entry-level undergraduate coursework), U = upper level (advanced-level undergraduate coursework), and G = graduate level (beyond undergraduate level coursework). Engineering and Teacher Course Analysis evaluations group courses by category. Nursing Course Analysis evaluations provide the same information as Divisional Course Analysis evaluations, and also include clinical and/or practical training if listed on the submitted documentation.

Course Analysis evaluations include recommended U.S. semester credit hours. In the U.S., one semester credit hour requires a minimum of 15 contact hours of theoretical instruction or 30 to 45 contact hours of laboratory and/or practical instruction per semester. A typical student enrolled in full-time studies in U.S. higher education earns approximately 30 semester credit hours per academic year.

SpanTran converts foreign academic credits, units, hours, etc. into U.S. semester credit hours regardless of the number of foreign credits, units, hours earned or completed. Courses may be assigned a lower number of U.S. semester credit hours than the applicant expects to receive; some courses may receive only one or two credits while others may receive no credit at all. Evaluations state the total recommended credit hours and may list courses for which no U.S. credit is recommended.

Foreign grades are converted to U.S. letter grades based on the 4.00 system. Letter grade values are generally: A = 4.00, A- = 3.67, B+ = 3.33, B = 3.00, B- = 2.67, C+ = 2.33, C = 2.00, C- = 1.67, D+ = 1.33, D = 1.00, D- = 0.67/D-, F = 0.00. A grade point average/GPA is a weighted average by which recommended credits per course are multiplied by the 4.00-based grade per course arriving at quality points. The total number of quality points are then divided by the total number of attempted credits. SpanTran lists the equivalent grade per course, including failures, incomplete, withdrawn, and pass grades. Failures are included in grade point average calculation. In cases of pass/fail grades, pass grades are awarded credit but not factored into the grade point average. If a specific course is attempted multiple times, the evaluation only includes the first and final attempts. The cumulative grade point average/CGPA will reflect both grades.

UNIVERSIDAD AUTÓNOMA DE CIUDAD JUÁREZ

CD. JUÁREZ, CHIH., MÉXICO • **CERTIFICADO DE ESTUDIOS**

La Dirección General de Servicios Académicos de la Universidad Autónoma de Ciudad Juárez, certifica que el alumno cuyo nombre y fotografía aparecen en este documento, aprobó en los períodos escolares indicados las materias que abajo se enumeran.

Este certificado es válido únicamente con el holograma de la Universidad y las firmas del Rector, el Director General de Servicios Académicos y el Director del Instituto correspondiente.

Los estudios amparados por este certificado tienen validez oficial de acuerdo con el decreto estatal No. 346-73 del 10 de octubre de 1973.

No.- C0000032614

NOM

CUR

NAC

LOS ESTUDIOS AMPARADOS POR ESTE CERTIFICADO CORRESPONDEN AL PROGRAMA DE LICENCIATURA EN ENFERMERÍA

CLAVE DE LA MATERIA	NOMBRE DE LA MATERIA	CRÉDITOS	CALIFICACIÓN	OBS
	Febrero Junio 2014			
BAS120903	BIOQUIMICA	10	9.0	
BAS130103	ANATOMIA GENERAL	10	8.5	
BAS140903	MICROBIOLOGIA	6	7.0	
HUM131903	LECTURA Y REDACCION	8	8.1	
MED160703	MODELOS Y TEORIAS DE ENFERMERIA	8	8.5	
MED161303	ENFERMERIA FUNDAMENTAL INDIVIDUO SANO	8	8.0	
	Agosto Diciembre 2014			
BAS131003	PARASITOLOGIA	6	8.1	
BAS140503	FISIOLOGIA	10	9.0	
BAS140703	FARMACOLOGIA I	8	8.7	
HUM123903	BIOETICA Y LEGISLACION EN ENFERMERIA	8	8.0	
MED160503	PROCESO ENFERMERO	8	8.7	
MED160903	ENFERMERIA FUNDAMENTAL MATERNO INFANTIL	8	8.4	
	Febrero Junio 2015			
BAS141003	FARMACOLOGIA II	8	9.0	
HUM313103	DESARROLLO DE HABILIDADES DOCENTES	6	9.0	
MED161103	CUIDADOS PRIMARIOS EN ENFERMERIA	12	9.2	
MED161203	ENFERMERIA FUNDAMENTAL INDIVIDUO HOSPITAL	10	8.3	
MED240503	EPIDEMIOLOGIA Y BIOESTADISTICA	8	7.8	
MED261303	GINECOLOGIA	10	9.0	
MED362303	TOPICOS SELECTOS ENFERMERIA	6	9.0	
MED362503	INTRODUCCION A LA EPISTEMOLOGIA	6	9.0	
	Junio Julio 2015			
MED261103	PATOLOGIA QUIRURGICA	8	8.5	
	Agosto Diciembre 2015			
BAS240103	NUTRICION Y DIETOTERAPIA	8	8.0	
HUM160803	INGLES TECNICO	6	8.1	
MED161503	PROPEDEUTICA ENFERMERIA I	20	8.0	
MED262103	CUIDADOS DEL NIÑO SANO Y ENFERMO	10	8.0	
MED262303	ENFERMERIA GINECOLOGICA	8	8.9	
MED362703	DESARROLLO HUMANO	6	9.2	
	Febrero Junio 2016			
CIS241303	SALUD MENTAL	8	9.3	
MED261703	ENFERMERIA INDUSTRIAL	6	10.0	
MED261903	ENFERMERIA QUIRURGICA	10	8.8	
MED262603	PROPEDEUTICA EN ENFERMERIA II	20	9.2	
	Junio Julio 2016			
BAS200103	METODOLOGIA DE LA INVESTIGACION	8	9.6	
MED250303	MEDICINA INTERNA	10	8.2	
	Agosto Diciembre 2016			
ADM314103	GESTION Y LIDERAZGO ENFERMERIA I	6	8.3	
MED262803	PROPEDEUTICA EN ENFERMERIA III	20	7.6	
MED363003	INVESTIGACION EN ENFERMERIA I	8	9.2	
MED363503	ENFERMERIA GERIATRICA	8	9.6	
MED363803	ENFERMERIA SALUD MENTAL	8	9.0	
	Febrero Junio 2017			
MED361603	PROPEDEUTICA EN ENFERMERIA IV	20	9.6	
MED363203	INVESTIGACION EN ENFERMERIA II	8	7.2	
MED363903	PROVEEDOR CUIDADOS PACIENTE CRITICO	10	8.7	
	Junio Julio 2017			
MED361803	PROPEDEUTICA EN ENFERMERIA V	20	10.0	
	Agosto Diciembre 2017			
ADM314203	GESTION Y LIDERAZGO ENFERMERIA II	6	9.4	
BAS300303	TESIS	8	9.4	
MED261503	PEDIATRIA	8	7.8	
MED363303	ENFERMERIA SALUD PUBLICA	8	8.6	
	Febrero Junio 2018			
MED300403	RESIDENCIA DE ENFERMERIA	20	9.4	

Rector

Mtro. Juan Ignacio Camargo Nassar

Director General de Servicios Académicos

Dr. Antonio de la Mora Covarrubias

Director de Instituto

C.D. Salvador David Nava Martinez

LA UNIVERSIDAD AUTÓNOMA DE CIUDAD JUÁREZ

Le otorga a

[redacted]

Firma del alumno

el Título de:

Licenciatura en Enfermería

Al haber acreditado los conocimientos, integrado las habilidades, criterios y valores propios del perfil profesional seleccionado, según Matrícula 135100 se certifica que cumplió con la totalidad de los créditos del programa, además de los requisitos académicos y administrativos exigibles por la reglamentación interna de esta institución

"POR UNA VIDA CIENTÍFICA, POR UNA CIENCIA VITAL"

Dado en el Municipio de Juárez, Estado de Chihuahua México, a los 14 días del mes de Abril del 2021

El Secretario General

C.D. Daniel Alberto Constandse Cortez

El Director General de Servicios Académicos

Dr. Antonio de la Mora Covarrubias

El Rector

Mtro. Juan Ignacio Camargo Nassar

[redacted]

directly. Students ask the registrar's office at their foreign university to submit their official academic and clinical transcripts, along with SpanTran's 'Transcript Request' form. SpanTran accepts mailed copies or emailed copies of these documents.

Emailed copies must come directly through an official institutional email account, complete with the sender's name, job title, and department. Email submissions from public domains (e.g. @gmail.com, @yahoo.com, @mail.ru) are not accepted. This includes the use of software to catch spoofing and ensure that the information received can be verified on the issuing institutions/nursing authority's website."

As an alternative, the nurse can mail the form and transcript in an official, sealed institutional envelope directly to: SpanTran: The Evaluation Company, 2400 Augusta Drive, Suite 451, Houston, TX 77057. Documents cannot be mailed by the nurse, a relative, or any other party. The "Sender" field on the shipping label or envelope must clearly show the name of the foreign academic institution's address.

SpanTran has a database of thousands of foreign institutions, documents, and contacts from abroad to help us ensure that the documents we're getting are authentic and from the correct department in charge of student records.

License Verification: SpanTran can verify licenses using two main methods: national databases and closed loop communications.

-National and Regional Databases
-Select countries have a national or regional registry of professional licenses. SpanTran evaluators confirm the authenticity of these licenses on these registries.
-México: Registro Nacional de Profesionistas
-Philippines: Professional Regulation Commission

Closed Loop Communication

SpanTran provides a "Licensure Verification Form" to applicants (Exhibit A). This form requires applicants to contact the foreign Nursing Board or authority that issues nursing licenses with information confirming information about the license. This includes the authority that grants nurses ability to practice nursing and the applicant's licensure status. Forms are signed by a representative at the Nursing Board or authority and sent via mail or email to SpanTran's verification department. The verification department checks that the nurse has completed a nursing education program, passed exams, has an active and unblemished license, and confirms the date of issuance.

3. Experience and expertise in evaluating nursing educational programs

SpanTran: The Evaluation Company was founded in 1982 and has been continuously operational to present. We have been evaluating foreign nursing education for more than 40 years. SpanTran joined the National Association of Credential Evaluation Services (NACES®) as a regular member in 1996.

SpanTran staffs both junior and senior evaluators as outlined by NACES. SpanTran's seven senior evaluators are full-time, U.S. based employees who have been primarily evaluating academic coursework from abroad consistently for a period of at least five years. In the course of their time at SpanTran, each

has evaluated and reviewed hundreds of foreign nursing credentials.

In the course of our evaluations, SpanTran utilizes various databases and publications not available to the general public. We reference years of extensive in-house research, multiple on- site international education libraries, external print and web sources, international education databases such as EDGE, ECCTIS, and Nuffic databases, foreign ministerial, governmental and institutional publications and websites, and more. These sources are cited on every report. (Refer to Exhibit B - Kentucky and Texas Samples).

For Example:
References (MEXICO):
Freeman, K. (2021). AACRAO EDGE: Mexico. Retrieved from
https://www.aacrao.org/edge/country/Mexico.

NUFFIC. (2021). Education System Mexico: Higher Education. Retrieved from
https://www.nuffic.nl/en/educationsystems/
mexico/higher-education.

International Nursing Foundation of Japan. (2008). Nursing in the world: The facts, needs and prospects (5th ed.). Tokyo,
Chiyoda-Ku, Japan.

4. Quality control and standards for evaluation:

SpanTran maintains strict quality controls ensuring each evaluation is precise and maintains the integrity required by the nursing profession. Our evaluations of nursing credentials are based solely on original documents received directly from the foreign issuing institution. Our evaluators and verification team reviews all documents to ensure only authentic documents are used for evaluation. All evaluation, translations, and verification records, along with copies of original source documents such as academic transcripts, diplomas, clinical experience data, etc., are protected using a combination of private company servers and secure cloud technology powered by Microsoft and Salesforce. SpanTran staff work exclusively on company-issued computers and other electronic devices, which are monitored by our technology partner, Big Idea Technology. We have never experienced a data breach in over 40 years of operation.

SpanTran: The Evaluation Company provides a standard turnaround time of 10 business days (two weeks) after receipt of official documents or verification of studies. Should inconsistencies be found, SpanTran will immediately notify the relevant nursing board, all NACES-member agencies, and other stakeholders.

Alaska Board of Nursing

Agenda Item #9

AK NLC Survey Results

2023 Alaska Nurse Licensure Compact Survey
(Update, 1-12-24)

ABSTRACT

Purpose: The goal of the current survey is to gather Alaska nurses' views on the Nurse Licensure Compact (NLC) and to address any possible concerns regarding the adoption of the NLC. **Methods:** This online survey was conducted by the National Council of State Boards of Nursing (NCSBN), in partnership with the Alaska Board of Nursing (AK BON). The survey instrument was designed by NCSBN with input from the AK BON. The subjects of the current survey are all nurses holding an active registered nurse (RN) or licensed practical nurse (LPN) license in Alaska. **Procedures:** The Division of Corporations, Business, and Professional Licensing pulled a list of all actively licensed RNs and LPNs as of October 17, 2023, which was a total of 20,870 licensees. The survey was sent via email or mail, depending on the nurse's communication preference with the Alaska Board of Nursing, to each of those nurses on October 30, 2023. The survey closed on November 30, 2023. **Results:** In total, 4,593 nurses completed the current survey, with an approximate response rate of 22%.

Most respondents (92%) supported Alaska joining the NLC, and only 5% opposed. The high support rates were consistent regardless of respondents' union membership, practice experience, primary state of residency, etc. The current survey mirrors the findings reported in the 2019 Alaska Compact survey. The main reasons for supporting Alaska in adopting the NLC included increased mobility, access to care, and cost-effectiveness of the licensure process. The main concerns raised by respondents who opposed the NLC included unsafe practices from nurses out of state, potential loss of

union bargaining power, and weakening of the job market for Alaska nurses.

Conclusion: The vast majority of responding nurses support Alaska joining the NLC.

Background of the Study

The National Council of State Boards of Nursing (NCSBN) developed the Nurse Licensure Compact (NLC) to allow for mutual recognition of state licenses among participating states in 2000. The NLC streamlines nurse mobility and promotes the standardization of nursing practice regulations (Evans, 2015; Litchfield, 2010; Poe, 2008; Thomas & Thomas, 2018). To further increase access to care and enhance public protection, NCSBN promoted an enhanced NLC in 2015 (Alexander, 2016; Fotsch, 2018). The enhanced NLC was implemented in January 2018. Currently, 41 jurisdictions have enacted the NLC (NCSBN, n.d.).

In 2019, one year after the implementation of the enhanced NLC, the AK BON, in partnership with NCSBN conducted the 2019 Alaska Compact Survey of all nurses licensed in Alaska to gather their views on the adoption of the NLC. A total of 3,573 nurses participated in the 2019 survey. The survey indicated 92% (3,259 of 3,527) of respondents supported Alaska joining the NLC at the time.

The 2022 National Workforce Survey Study projects a significant nursing shortage in the wake of the COVID-19 pandemic, absent some form of policy intervention to support nurses who are burned out and overworked (Martin et al., 2023; Smiley, et al, 2023). In response, policymakers and researchers are exploring licensure compacts as a long-term policy option to mitigate healthcare workforce crises and improve access to care. To gather current opinions from Alaska nurses on the NLC for decision-making, the AK BON, in collaboration with NCSBN, conducted the 2023 Alaska Compact survey.

METHODOLOGY

This was a descriptive online survey of all nurses who hold an active RN or LPN license in Alaska. The survey instrument was developed by NCSBN in collaboration with the AK BON. It comprised ten questions regarding nurses' opinions about Alaska joining the compact, as well as basic details regarding their license and practice (Appendix). It was estimated to take fewer than five minutes to complete the survey. NCSBN designed and maintained the online survey via the Qualtrics platform. On October 30, 2023, the AK BON distributed the study announcement with an anonymous survey link developed by NCSBN to about 20,000 study subjects. The online survey was closed on November 30, 2023.

Data Analysis and Confidentiality

Data were exported from Qualtrics into an Excel file (Microsoft, Redmond, WA). Standard descriptive analysis was performed on fixed-response items using SAS version 9.4 (Cary, NC). The current survey did not collect identifiable personal information, such as the name of the participants. The survey was distributed using a general survey link. Only aggregate data were analyzed and reported.

RESULTS

Characteristics of Study Subjects

A total of 4,593 respondents participated in the survey and 60% of them (n = 2,735) considered Alaska their primary residence (**Table 1**). The 2019 survey revealed that 57% of the respondents considered Alaska their primary residence.

Table 1. Primary Residency in Alaska

	2023 Survey (4,593)		*2019 Survey (N = 3,573)*	
	Percent	***n***	Percent	n
Yes	59.6	2,735	56.5	2,018
No	40.5	1,858	43.5	1,555

When asked whether Alaska was the first state where they ever held a nursing license, one-quarter of respondents answered yes (**Table 2**). This is a new question asked in the 2023 survey.

Table 2. Alaska is the First State to Receive a Nurse License

	2023 Survey N = 4,565	
	Percent	***n***
Yes	25.1	1,144
No	74.9	3,421

Most responding nurses (95%) hold an RN license, while 4% hold an LPN license. Table 3 showed that 473 respondents (10%) also hold an advanced practice registered nurse (APRN) license.

Table3. Type of License Held

	2023 Survey (N = 4,559)		*2019 Survey (N = 3,495)*	
	Percent	***N****	Percent	N*
RN	94.7	4,319	93.5	3,268
LPN	4.3	196	5.7	199
APRN	10.4	473	8.4	295

*Note. Respondents could hold more than one license, such as RN and LPN.

Over fifty percent of respondents (53%) were direct care nurses, while 20% specified some other roles, which included certified registered nurse anesthetist; nurse practitioner; certified nurse midwife, travel nurse, etc. (**Table 4**). The 2019 report shows

that 58% of the respondents were direct care nurses, slightly higher than the current report (53%).

Table 4. Primary Role in Nursing?

	2023 Survey (N = 4,559)		***2019 Survey (N = 3,504)***	
	Percent	***n***	Percent	n
Telephone triage nurse	5.8	262	4.4	153
Transport nurse	1.2	54	0.9	33
Case manager nurse	9.7	443	7.1	249
Nurse administration/manager	7.4	338	7.5	263
Direct care nurse	53.4	2,436	57.9	2,029
Nurse educator	3.0	136	4.3	149
Other	19.5	890	17.9	628

Most respondents (98%, *n* = 4,479) were employed in a position that required a nursing license in the past 24 months. The current survey further shows that 62% of respondents had provided nursing services and/or communicated with a patient or client who was located in a state other than Alaska (**Table 5**).

Table 5. Practiced in the Past 24 Months with Patients/Clients Outside of Alaska

2023 Survey (N= 4,559)		***2019 Survey (N = 3,504)***	
Percent	***n***	Percent	n
61.6	2,810	63.9	2,240
38.4	1,749	36.1	1,264

Sixty-four percent of respondents (*n* = 2,911) also held an active nursing license in another state (**Table 6**).

Table 6. Hold a License Outside of Alaska

	2023 Survey (N = 4,572)		***2019 Survey (N = 3,527)***	
	Percent	***n***	Percent	n
Yes	63.7	2,911	60.9	2,148
No	36.3	1,661	39.1	1,379

Additionally, 23% of respondents reported that they were members of a union during employment (**Table 7**).

Table 7. Union Membership during Employment

	2023 Survey (N = 4,593)		***2019 Survey (N =3,466)***	
Union Membership	***Percent***	***n***	Percent	n
Yes	23.4	1,074	21.6	749
No	76.6	3,519	78.4	2,717

Table 8 shows most respondents (92%, *n* = 4,199) support Alaska joining the compact (**Figure 1**).

Figure 1. Nurses' Opinions about Alaska Joining the NLC

(*N* = 4,572)

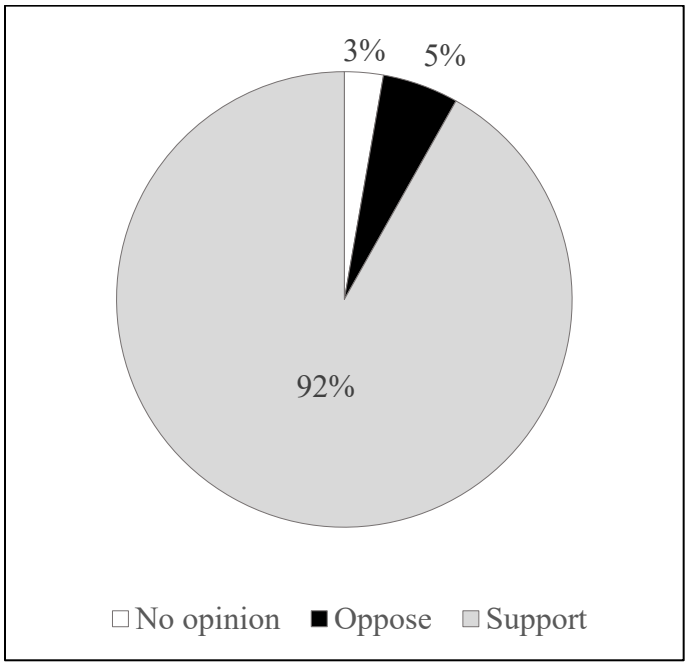

Table 8. In Favor of Alaska Joining the Compact

	2023 Survey (N = 4,572)		*2019 Survey (N =3,527)*	
	Percent	***n***	***Percent***	***n***
Yes (in favor)	91.8	4,199	92.4	3,259
No (opposed)	5.4	247	3.4	119
No Opinion	2.8	126	4.2	149

High levels of support for Alaska adopting the NLC were identified among various respondent sub-groups (**Table 9**). The highest support (90% and above) was indicated in the following group of nurses, consistent from the 2019 survey report:

- Considered Alaska their primary residency (96% in 2023; 97% in 2019)
- Practiced outside of Alaska (96% in both 2023 and 2019)
- Held a license outside of Alaska (95% in 2023; 96% in 2019)

- Did not belong to a union (94% in both 2023 and 2019)
- Practice nursing in the past two years (92% in 2023; 93% in 2019)
- Held the first nurse license outside of Alaska (94% in 2023).

Table 9. Opinions about Alaska Joining the Compact

Sub-group		In Favor of Joining the Compact		
		Yes	No	No Opinion
Primary residency in Alaska	Yes	89.2 (2,430)	7.5 (205)	3.3 (89)
	No	95.7 (1,769)	2.3 (42)	2.0 (37)
Practiced nursing within the past 24 months	Yes	92.1 (4,110)	5.3 (236)	2.6 (118)
	No	82.4 (89)	10.2 (11)	7.4 (8)
Practiced out of Alaska in the past 24 months	Yes	95.5 (2,683)	2.9 (80)	1.7 (47)
	No	86.0 (1,504)	9.6 (167)	4.5 (78)
Member of a union during employment	Yes	84.8 (909)	12.2 (131)	3.0 (32)
	No	94.0 (3,290)	3.3 (116)	2.7 (94)
Hold a license outside of Alaska	Yes	95.0 (2,766)	3.2 (94)	1.8 (51)
	No	86.3 (1,433)	9.2 (153)	4.5 (75)
Hold the first nurse license in Alaska	Yes	86.4 (988)	9.8 (112)	3.9 (44)
	No	93.7 (3,204)	4.0 (135)	2.4 (82)

The current survey also asked respondents to specify why they are for or against Alaska joining the compact. Two text boxes were provided for respondents' free-text comments. A total of 204 respondents shared their reasons.

Benefits of Alaska Joining the Compact (*N* = 172)

- Increases care for patients.
- Reduces nursing shortage by mobilizing nursing workforce among 41 jurisdictions.
- Eliminates costs and burdens of applying for and maintaining multiple state licenses.
- Facilitates across-state practice, particularly benefits military spouses who need to relocate.
- Eases the work for travel nurses.

Stated Concerns of Alaska Joining the Compact (*N* = 32)

- Patient safety. Unsafe nurses may practice in Alaska from other states, leading to potential deficiencies in quality control.
- Revenue loss for Boards of Nursing and potential license fee increase for nurses due to the implementation of the NLC.
- Different scope of practice across states. Do not want to be subject to the restrictions put in place in other Compact states such as restricting access to abortion services.
- Destroys the nurse bargaining power with unions.
- Weakens the job market and lowers the wages for Alaska nurses. More travel nurses lead to negative outcomes in hospitals.

Finally, 87% of the respondents (*n* = 3,966) showed their interest in applying for a Compact license if the opportunity becomes available. This proportion has remained unchanged since the 2019 report (87%, *n* = 3,058).

LIMITATIONS

This study relied upon voluntary self-reported data. The current survey was distributed to all Alaska licensed nurses via an anonymous web link. We were unable to track the exact response rate and target subsequent communications directly to non-respondents following the survey launch.

DISCUSSION

Over four thousand nurses participated in the current survey. On an assumption that non-response is random, at the 95% confidence level, the maximum margin of error

for the findings from the current survey is less than ±1.48%. In line with the 2019 survey findings, most respondents (92%) are in favor of Alaska joining the compact. Patient safety is the major concern raised by less than 1% of opponents. Studies consistently show that the uniform NLC licensure requirements provide additional safety layers for public protection through a mandatory criminal background check, and require no active discipline on a license, and no current enrollment in an alternative-to-discipline program. According to Nursys, the national nursing licensure and discipline database, the annual discipline rate for nurses holding a multistate license is lower than the nurses holding a single state license in the same jurisdiction, suggesting nurses holding a Compact license are safe practitioners (Zhong et al., 2022; Zhong et al., 2024).

CONCLUSION

The vast majority (92%) of responding nurses support Alaska joining the NLC, and only a small fraction (5%) oppose. Many respondents believe their work would be made easier and more effective through the implementation of the NLC in Alaska.

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Evans, S. (2015). The Nurse Licensure Compact: A historical perspective. *Journal of Nursing Regulation, 6*(3), 11-16.

Fotsch, R. (2018). The enhanced Nurse Licensure Compact goes live. *Journal of Nursing Regulation, 8*(4), 61-62.

Litchfield, S. M. (2010). Update on the nurse licensure compact. *AAOHN J, 58*(7), 277-279. doi:10.3928/08910162-20100625-03

Martin, B., Kaminski-Ozturk, N., O'Hara, C., & Smiley, R. (2023). Examining the impact of the COVID-19 pandemic on burnout and stress among U.S. nurses. *Journal of Nursing Regulation, 14*(1), 4–12.

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Poe, L. (2008). Nursing regulation, the nurse licensure compact, and nurse administrators: working together for patient safety. *Nurs Adm Q, 32*(4), 267-272. doi:10.1097/01.NAQ.0000336722.10689.d3

Smiley, R. A., Allgeyer, R. L., Shobo, Y., Lyons, K. C., Letourneau, R., Zhong, E. H., Kaminski-Ozturk, N., & Alexander, M. (2023). The 2022 National Nursing Workforce Survey. *Journal of Nursing Regulation, 14* (Supple 2), S1-S90. https://doi.org/10.1016/S2155-8256(23)00047-9

Thomas, K. A., & Thomas, M. B. (2018). The Texas Board of Nursing responds to disaster. *Journal of Nursing Regulation, 9*(2), 41-46.

Zhong, E. H., Martin, B., & Alexander, M. (2022). A comparison of discipline between nurses holding a multi- or single-state license. *Journal of Nursing Regulation, 13*(1), 22–26. https://doi.org/10.1016/S2155-8256(22)00030-8

Zhong, E. H., Martin, B., O'Hara, C., Kaminski-Ozturk, N., Buck, M., Livanos, N., & Alexander, M. (2024). Advanced practice registered nurses' views of the APRN Compact: Survey findings from five U.S. states. Journal of *Nursing Regulation, 14*(4), 5–12.

Appendix: 2023 Alaska Compact Survey Instrument

The Alaska Board of Nursing (AK BON) is seeking your input on the Nurse Licensure Compact (NLC).

The NLC allows a nurse who holds one multi-state license issued by a Compact state to practice in any other Compact state without obtaining additional licenses. Currently, 41 jurisdictions have enacted the NLC legislation in the United States. The NLC facilitates cross-border practice and allows a nurse to move freely among Compact states without obtaining a license from each.

To better understand your opinions of joining the NLC, please answer the following questions:

Q1. In the past 24 months, have you been employed in a position that required a nursing license?

□ Yes
□ No

Q2. During that employment, were you a member of a nursing union?

□ Yes
□ No

Q3. Is Alaska your state of primary residence?

□ Yes
□ No

Q4. Is Alaska the first state where you ever held a nursing license?

□ Yes
□ No

Q5. Other than Alaska, do you hold an active nursing license in any other state?

□ Yes
□ No

Q6. Would you be in favor of Alaska joining the Nurse Licensure Compact?

□ Yes (please provide reason)_____
□ No (please provide reason) _____
□ No opinion

Q7. If Alaska were to join the Nurse Licensure Compact, would you be interested in applying for a Compact license?

□ Yes
□ No

Q8. What type of license do you currently hold? (Select all that apply)

- □ LPN/VN
- □ RN
- □ APRN

Q9. In the past 24 months, have you provided nursing services and/or communicated with a patient, client, or student who was in a state other than Alaska?

- □ Yes
- □ No

Q10. What is your primary role in nursing? (Select one only)

- □ Telephone Triage Nurse
- □ Transport Nurse
- □ Case manager nurse
- □ Nurse Administrator/Manager
- □ Direct Care Nurse
- □ Nurse Educator
- □ Other_____ (please specify)

If you have questions or concerns, please contact Dr. Elizabeth Zhong, Research, NCSBN at ezhong@ncsbn.org. Thank you for your participation. Thank you very much for your time and participation!

2023 Alaska Nurse Licensure Compact (NLC) Survey Snapshot

In fall 2023, the National Council of State Boards of Nursing, in partnership with the Alaska Board of Nursing, completed a mail- and email-based survey of registered nurses (RNs) and licensed practical nurses (LPNs) who hold licensure in Alaska.

Survey distributed: October 30, 2023

Survey closed: November 30, 2023

4,593 nurses completed the survey

Response rate of 22%

Licensure and Union Membership

- 95% of respondents hold an RN license
- 98% of respondents reported practicing nursing in the past 24 months
- 23% of respondents were members of a union

Practice Across State Lines

- 62% of respondents reported providing nursing services and/or communicating with a patient or client who was located outside of Alaska in the last 24 months
- 64% of respondents hold an active nursing license in at least one additional state

Nurse Licensure Compact

- 92% (*n = 4,199*) of respondents are in favor of Alaska joining the compact
    - Cited reasons for supporting: access to care, nursing shortage, cost savings, mobility
- 5% (*n =* 247) of respondents oppose Alaska joining the compact
    - Cited reasons for opposing: patient safety, licensure fees, scope of practice, bargaining power
- 3% (*n = 126*) of respondents expressed “no opinion” on Alaska joining the compact

By Sub-Group

- 89% (*n= 2,430*) of respondents with a primary state of residence in Alaska support Alaska joining the compact
- 85% (*n= 909*) of respondents who are members of a union support Alaska joining the compact
- 95% (*n= 2,766*) of respondents who hold a nursing license in at least one additional state support Alaska joining the compact

Alaska Board of Nursing

Agenda Item #10

PDMP Update

Alaska Board of Nursing

Adjourned for Lunch

Alaska Board of Nursing

Agenda Item #11

2024 Annual Report

Department of Commerce, Community
and Economic Development

Division of Corporations, Business
and Professional Licensing

Board of Nursing
Annual Report

Fiscal Year 2024

Department of Commerce, Community and Economic Development
Division of Corporations, Business and Professional Licensing

P.O. Box 110806
Juneau, Alaska 99811-0806
Email: *License@Alaska.Gov*

This report is required under Alaska Statute 08.01.070(10).

Program Name
FY 2024 Annual Report

Table of Contents

Board Membership (as of the Date This Report was Approved)

Date of Final Board Approval: Click or tap to enter a date.

Danette Schloeder, Chair Registered Nurse (RN)
Lena M. Lafferty, Registered Nurse (RN)
April Erickson, Advanced Nurse Practitionel (APRN)
Vianne Smith, RN/Baccalaureate Education
Michael Collins, Public Member

Vacant, LPN Seat
Vacant, Public Member Seat

Accomplishments

Regulation Projects/Changes:
Alternative to Probation program included within regulation

- Standard Operating Procedure developed and put into practice

Telehealth Regulation updated

Regulation Project in Process:

LPN Scope of Practice
CNA Education Alignment
English Language profficency

Supported Legislation:
Continued support of Nurse Licesnure Compact – HB 149
Support of HB 314 and SB 225- Occupational Licesnign Fees
Supporting APRN's with a letter of concern for SB 91
Supporting CNM's with a letter of concern for HB 175

Program Name
FY 2024 Annual Report

Activities

Click or tap here to enter text. ("Activities" include but are not limited to board meetings, subcommittee or workgroup meetings, attendance at conferences, public speaking events, involvement in legislative hearings, in process statute or regulation changes, etc.)

The Annual Report reflects the Alaska Board of Nursing's ("Board") support for acceptable standards in nursing practice and nursing education in Alaska. The members of the Board take their responsibility to protect the public very seriously. The number of nursing applications received each year continues to rise. This increase coupled with continual board staffing shortages and turnover presented many challenges this past year. However, the Board looks forward to another year of service to the Alaskan consumers of nursing care.
The Board of Nursing has over 20,000 total active licensees in six distinct categories: Advanced Practice Registered Nurses (APRNs), Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Certified Nurse Aides (CNAs), Retired Registered Nurses, and preceptorship approval for Advanced Practice Nursing students. The Board grants various types of annual approval to three schools of nursing in Alaska and ensures that nursing education standards are maintained to ensure safe healthcare for the citizens of Alaska. The Board's notable accomplishments during Fiscal Year (FY) 2024 include:

Board Meetings:
August 2023
September 2023, Strategic Planning Summit
November 2023
January 31 & February 1st, 2024
May 14 & 15, 2024

Developing a Strategic Plan document
Supported 2023 NLC Survey of Licensed Nurses in Alaska
Danette Schloeder appointed as Area 1 Board of Directors member, NCSBN
Board Chair and EA attended NCSBN Annual meeting August 2023
Vianne Smith, Spoke at the CNA Conference , December 2023
Patty Wolf attended the Scientific Symposium, January 2024
Danette Schloeder, Vianne Smith, and Patty Wolf attended the NCSBN Mid Year Meeting, March 2024.
IT representative will attend the NCSBN IT conference.
Investigations representative will attend the NCSBN Discipline Conference in May 2024.

Needs

Needs:

Vacant Public Seat to be filled to assist with the boards business.

Reconsider the board structure to include either 2 more seats (an APRN and a CNA) or to convert the public seat to a CNA seat.

The Board has requested and desires to hold board meetings in different places such as Juneau or Fairbanks.

Annual Report Instructions and Checklist

This document serves as both the instructions and checklist for the 2024 annual reports. Save a copy to be completed for your program(s) in the specific program folder (within the (I:) drive for Juneau or the (J:) drive for Anchorage).

Purpose: The annual performance report is presented by each board in accordance with AS 08.01.070(10). The purpose is to report the accomplishments, activities, and the past and present needs of the licensing program from the board's perspective.

Timeframe: Annual reports must be reviewed and approved by each board and submitted to the division's publication specialist no later than June 30 each year. Boards and staff should plan to ensure an adequate amount of time to discuss, edit, and approve.

Upcoming Board Meeting Dates: _____

_____

_____

☐ Discussed with Board Date: _____

☐ Draft Completed by Board Date: _____

☐ Ready for Board Review Date: _____

Approval and Finalizing Process: *Do NOT send annual reports to the publication team without obtaining board approval first.* Official board approval should be recorded below in the "Board Approval" section. Once the board has approved the annual report content, the document should be emailed to the publications specialist for finalizing. After the document is finalized, it is posted online. The content is not altered during the finalizing process – a 2nd review and approval from the board is not required.

Personnel: It can be difficult to write a report by committee, so boards may wish to appoint a drafter and set forth a process and timeline for completion. Often, this is the board chair or a long-serving member. Boards may also assign sections to members to help allocate the responsibility.

Guidance: Only the content (i.e., informational board-specific text) should be modified by staff. **Do not add, remove or format the annual report yourself.**

- If additional pages, sections, etc. are needed, **contact the publications specialist** and ask for assistance.
- It is imperative that the changes to formatting (i.e., additional pages, etc.) are completed ONLY by the publications team - there are specific formatting aspects that must remain in place.
- If changes to formatting are made by staff, you will be asked to re-do the entire template after the publications team has made the formatting changes for you.

Remember this is a public document. Do not include information that may be confidential or create a liability for the board or its members.

Professional licensing staff may not write the report on behalf of the board. Staff may work with the division's administrative team to fill in staff/board information, statistics and other objective data.

Annual Report Instructions and Checklist (continued)

Board Review and Approval: A mentioned above, *do NOT send annual reports to the publication team prior to obtaining board approval.* Official board approval means a motion to approve the document as-is, with a quorum reached. No changes should be made to the document (outside of final formatting) after receiving board approval. Final formatting is to be completed by the publications specialist only.

☐ Approved Date of Final Board Approval: _____

Comments: _____

_____

_____

Program Staff (Name): _____

This instruction/checklist page, with official board approval, must be submitted to the publications team with the approved annual report document. Annual reports submitted to the publications team without this sign-off will not be accepted.

Alaska Board of Nursing

Agenda Item #12

Discussion: Notification for records subpoena requirements

Initial discussion: Notification for records subpoena requirements in statute.

The following statute lives in the Centralized regulations.

AS 08.01.087 Investigative and enforcement powers

"(b) If it appears to the Commissioner that a person has engaged in or is about to engage in an act or practice in violation of a provision of this chapter or a regulation adopted under it, or a provision of AS 43.70., or a provision of this title or regulation adopted under this title dealing with an occupation or board listed in AS 08.01.010, the commissioner may, if the commissioner considers it in the public interest, and after notification of a proposed order or action by ***telephone or facsimile*** *to all board members, if a board regulates the act or practice involved, unless a majority of the members of the board object within 10 days;*

(4) issue subpoenas for the attendance of witnesses, and the production of books, records, and other documents…"

There is division support for a clean up bill to adjust the verbiage to add email as an option.

In order to change this statute, we would need support for a bill. We need to find the support for the bill, and it would be introduced with the next legislative session in January 2025.

Alaska Board of Nursing

Agenda Item #13

Regulation Projects

Chapter 44. Board of Nursing.

(Words in **boldface and underlined** indicate language being added; words [CAPITALIZED AND BRACKETED] indicate language being deleted. Complete new sections are not in boldface or underlined.)

12 AAC 44 is amended by adding a new section to Article 1 –

12 AAC 44.136. Licensed practical nurses' scope of practice. (a) A licensed practical nurse shall be licensed to provide health care services within the nature and extent of the licensed practical nurse's training and experience under the supervision of an individual who must hold an active license, in good standing, to practice in the state as a registered nurse, an advanced practice registered nurse, a physician or other authorized licensed health care provider. A licensed practical nurse may only provide health care services which are within the scope of practice established by the board and set out under this section and advisory opinions adopted by the board under 12 AAC 44.290(a)(3)(E)(iii). To the extent that the action is within the scope of the licensee's education, training and experience, a licensed practical nurse may

(1) collect data and conduct focused nursing assessments of the health status of patients;

(2) participate with other health care providers and contribute to the development, modification and implementation of the patient centered health care plan;

(3) implement nursing interventions within a patient centered health care plan;

(4) assist in the evaluation of responses to interventions;

(5) administer medications not excluded in (b) of this section;

(6) provide for the maintenance of safe and effective nursing care rendered directly or indirectly;

(7) advocate for the best interest of patients;

(8) communicate and collaborate with patients and members of the health care team;

(9) provide health care information to patients;

(10) delegate nursing interventions to implement the plan of care and maintain accountability of the outcome;

(11) assign nursing interventions to implement the plan of care; and

(12) other acts that require education and training consistent with professional standards as prescribed by the board and commensurate with the licensee's education, demonstrated competencies, and experience.

(b) A licensed practical nurse may not function outside the scope of practice as established by (a)(1)-(12) of this section and in accordance with the scope of practice advisory opinions adopted by the board under 12 AAC 44.290(a)(3)(E)(iii). The board can specify limitations on the scope of practice as necessary to protect the safety of the public. A licensee under this section is prohibited from

(1) providing comprehensive assessments of a client who has been admitted to an institution or unit;

(2) the practice of assimilation and analysis of objective and subjective data to formulate the plan of care;

(3) performing arterial punctures;

(4) the management of arterial lines;

(5) starting an IV or administering IV medication unless the proper IV education has taken place. The licensee must successfully pass such an education course, practice the

skills, demonstrate competency, and provide evidence of continued competence on a yearly basis;

(6) administering IV push medications other than saline to flush an intermittent infusion device;

(7) practicing phlebotomy unless additional training and demonstration of competency has been documented;

(8) administering IV fluids and medications to neonates;

(9) mixing IV solutions;

(10) administering blood products;

(11) changing the rate and dose of response in PCA pumps;

(12) the administration of chemotherapy drugs;

(13) dispensing medications;

(14) flushing central lines or PICC lines;

(15) performing central line or PICC line dressing changes;

(16) identifying unlabeled medications;

(17) providing a complete physical to a patient;

(18) working independently;

(19) triaging patients; and

(20) taking X-Rays.

(c) A licensed practical nurse must wear identification which clearly identifies the nurse as a licensed practical nurse when providing direct patient care, unless wearing identification creates a safety or health risk for either the nurse or the patient. (Eff. ____/____/_____, Register _____)

Authority: AS 08.68.100

12 AAC 44.290(a)(3) repealed and readopted to read:

(3) provide the board with, if the applicant

(A) is a graduate of a foreign prelicensure education program not taught in English or if English is not the individual's native language, evidence satisfactory to the board that the applicant has successfully passed an English proficiency examination that includes the components of reading, speaking, writing, and listening;

(i) a valid evaluation of the applicant's nursing education by the Commission on Graduates of Foreign Nursing Schools Credentials Evaluation Service, with a full education, course-by-course report that indicates the applicant's nursing education was taught in English; or

(ii) an official International Commission on Healthcare Professions (ICHP) certificate verifying successful completion of the VisaScreen: Visa Credential Assessment Service;

(B) is a practical nurse applicant who has completed the United States Army Practical Nurse Program or Air Force Basic Medical Technician Corpsman Program (BMTCP) 4N051 (5 Skill Level) and who is on active duty or has been discharged for not more than five years from the date of application,

(i) a complete certified transcript of the applicant's military education, mailed directly to the board from the appropriate military program;

(ii) verification of employment, on a form provided by the board, confirming the applicant has, within the last five years, worked in the United States Army or Air Force in the nursing role for which the applicant was trained in either the U.S. Army Practical Nurse Program or the Air Force Base Medical Technician Corpsman Program (BMTCP) 4N051 (5 Skill Level);

(Eff. 10/14/72, Register 43; am 4/27/83, Register 86; am 8/2/86, Register 99; am 7/28/95, Register 135; am 4/27/97, Register 142; am 9/25/98, Register 147; am 6/16/2002, Register 162; am 10/9/2002, Register 164; am 11/23/2003, Register 168; am 10/15/2004, Register 172; am 5/18/2006, Register 178; am 3/4/2007, Register 181; am 5/7/2010, Register 194; am 10/3/2011, Register 200; am 8/10/2016, Register 219; am 5/16/2018, Register 226; am 4/14/2021, Register 238; am 6/12/2022, Register 242; am 8/19/2022, Register 243; am 8/25/2023, Register 247; am ____/____/_____, Register _____)

Authority: AS 08.68.100 AS 08.68.190 AS 08.68.280

AS 08.68.170 AS 08.68.270

tor's Note: [INFORMATION REGARDING THE INTERNATIONAL ENGLISH LANGUAGE TESTING SYSTEM (IELTS) DESCRIBED IN 12 AAC 44.290(a)(3)(D)(i) IS AVAILABLE AT WWW.IELTS.ORG

THE TEST OF ENGLISH AS A FOREIGN LANGUAGE (TOEFL-iBT) EXAMINATION DESCRIBED IN 12 AAC 44.290(a)(3)(D)(ii) IS ADMINISTERED BY EDUCATIONAL TESTING SERVICES, P.O. BOX 6151, PRINCETON, NEW JERSEY 08541; TELEPHONE: (609) 771-7100 OR (877) 863-3546; WEBSITE AT WWW.ETS.ORG/TOEFL.]

Information regarding the Commission on Graduates of Foreign Nursing Schools Credentials Evaluation Service and the International Commission on Healthcare Professions (ICHP) certificate described in **12 AAC 44.290(a)(3)(A)(i) and (ii)** [12 AAC 44.290(a)(3)(D)(iii) AND (iv)] is available at CGFNS International, 3600 Market Street, Suite 400, Philadelphia, Pennsylvania 19104-2651; Telephone: (215) 222-8454; website at www.cgfns.org.

[THE LICENSED PRACTICAL NURSE SCOPE OF PRACTICE ADVISORY OPINIONS REFERENCED IN 12 AAC 44.290(a)(3)(E)(iii) ARE AVAILABLE AT HTTPS://WWW.COMMERCE.ALASKA.GOV/WEB/PORTALS/5/PUB/NUR_ADOP_SCOPE.PDF.]

12 AAC 44.305(a)(1)(H) is amended to read:

(H) if the applicant **is a graduate of a foreign prelicensure education program not taught in English or if English is not the individual's native language, evidence satisfactory to the board that the applicant has successfully passed an English proficiency examination that includes the components of reading, speaking, writing, and listening** [GRADUATED FROM A PRE-LICENSURE NURSING PROGRAM OUTSIDE OF THE UNITED STATES OR CANADA, EXCEPT QUEBEC, CANADA, VERIFICATION OF PASSING ONE OF THE FOLLOWING ENGLISH PROFICIENCY EXAMINATIONS, WITH AT LEAST THE FOLLOWING MINIMUM SCORES:

(i) INTERNATIONAL ENGLISH LANGUAGE TESTING SYSTEM (IELTS) ACADEMIC EXAMINATION - OVERALL SCORE OF 6.5 WITH A MINIMUM OF 6.0 ON ALL MODULES;

(ii) TEST OF ENGLISH AS A FOREIGN LANGUAGE, INTERNET-BASED TEST (TOEFL – iBT) - OVERALL SCORE OF 84 WITH A SPEAKING SCORE OF 26;

[] **(i)** a valid evaluation of the applicant's nursing education by the Commission on Graduates of Foreign Nursing Schools Credentials Evaluation Service, with a full education, course-by-course report that indicates the applicant's nursing education was taught in English; or

[(iv)] **(ii)** an official International Commission on Healthcare Professions (ICHP) certificate verifying successful completion of the VisaScreen: Visa Credential Assessment Service;

(Eff. 4/27/83, Register 86; am 8/2/86, Register 99; am 4/29/91, Register 118; am 4/27/97, Register 142; am 9/25/98, Register 147; am 11/2/2001, Register 160; am 6/16/2002, Register 162; am 3/4/2007, Register 181; am 12/27/2012, Register 204; am 3/19/2014, Register 209; am 8/10/2016, Register 219; am 5/16/2018, Register 226; am 4/14/2021, Register 238; am 4/21/2022, Register 242; am 6/12/2022, Register 242; am 8/19/2022, Register 243; am 8/25/2023, Register 247; am ____/____/_____, Register _____)

Authority: AS 08.68.100 AS 08.68.200 AS 08.68.270

AS 08.68.170

Editor's note: [INFORMATION REGARDING THE INTERNATIONAL ENGLISH LANGUAGE TESTING SYSTEM (IELTS) DESCRIBED IN 12 AAC 44.305(a)(1)(H)(i) IS AVAILABLE AT WWW.IELTS.ORG.

THE TEST OF ENGLISH AS A FOREIGN LANGUAGE (TOEFL-iBT) EXAMINATION DESCRIBED IN 12 AAC 44.305(a)(1)(H)(ii) IS ADMINISTERED BY EDUCATIONAL TESTING SERVICES, P.O. BOX 6151, PRINCETON, NEW JERSEY 08541; TELEPHONE: (609) 771-7100 OR (877) 863-3546; WEBSITE AT WWW.ETS.ORG/TOEFL.]

Information regarding the Commission on Graduates of Foreign Nursing Schools Credentials Evaluation Service and the International Commission on Healthcare Professions (ICHP) certificate described in **12 AAC 44.305(a)(1)(H) (i) and (ii)** [12 AAC 44.305(a)(1)(H)(iii) AND (iv)] is available at CGFNS International, 3600 Market Street, Suite 400, Philadelphia, Pennsylvania 19104-2651; Telephone: (215) 222-8454; website at www.cgfns.org.

12 AAC 44.317(b)(1)(B) is amended to read:

(B) the applicant's **international** nursing license history;

(Eff. 11/2/2001, Register 160; am 10/15/2004, Register 172; am 3/4/2007, Register 181; am 3/28/2008, Register 185; am 11/19/2008, Register 188; am 12/23/2009, Register 192; am 10/3/2011, Register 200; am 12/27/2012, Register 204; am 8/10/2016, Register 219; am 5/16/2018, Register 226; am 8/25/2023, Register 247; am ____/____/_____, Register _____)

Authority: AS 08.01.100 AS 08.68.251 AS 08.68.276

AS 08.68.100

12 AAC 44.400(a)(6)(E) is amended to read:

(E) if the applicant **is a graduate of a foreign prelicensure education program not taught in English or if English is not the individual's native language, evidence satisfactory to the board that the applicant has successfully passed an English proficiency examination that includes the components of reading, speaking, writing, and listening** [GRADUATED FROM AN ADVANCED PRACTICE REGISTERED NURSE PROGRAM OUTSIDE OF THE UNITED STATES OR CANADA, EXCEPT QUEBEC, CANADA,

(i) VERIFICATION OF HAVING EVER PASSED THE INTERNATIONAL ENGLISH LANGUAGE TESTING SYSTEM (IELTS) ACADEMIC EXAMINATION - OVERALL SCORE OF 6.5 WITH A MINIMUM OF 6.0 ON ALL MODULES;

(ii) VERIFICATION OF HAVING EVER PASSED THE TEST OF ENGLISH AS A FOREIGN LANGUAGE, INTERNET-BASED TEST (TOEFL – iBT) - OVERALL SCORE OF 84 WITH A SPEAKING SCORE OF 26;

(iii)] **(i)** a valid evaluation of the applicant's nursing education by the Commission on Graduates of Foreign Nursing Schools Credentials Evaluation Service, with a full education, course-by-course report that indicates the applicant's nursing education was taught in English; or

[(iv)] **(ii)** an official International Commission on Healthcare Professions (ICHP) certificate verifying successful completion of the VisaScreen: Visa Credential Assessment Service; and

(Eff. 1/13/80, Register 73; am 5/16/81, Register 78; am 12/1/84, Register 91; am 11/7/87, Register 104; am 4/27/97, Register 142; am 11/2/2001, Register 160; am 11/16/2002, Register 164; am 3/28/2008, Register 185; am 11/19/2008, Register 188; am 4/16/2010, Register 194; am 10/3/2011, Register 200; am 12/27/2012, Register 204; am 3/19/2014, Register 209; am 8/10/2016, Register 219; am 5/16/2018, Register 226; am 10/20/2018, Register 228; am 4/14/2021, Register 238; am 1/19/2022, Register 241; am 6/12/2022, Register 242; am 8/25/2023, Register 247; am ____/____/_____, Register _____)

Authority: AS 08.68.100 AS 08.68.850

Editor's note: Information on the Psychiatric Mental Health Clinical Nurse Specialist examination and the Adult or Family Psychiatric Mental Health Nurse Practitioner examination referred to in 12 AAC 44.400 may be obtained from the American Nurses Credentialing Center, 8515 Georgia Avenue, Suite 400, Silver Spring, MD 20910-3492; telephone: (800) 284-2378.

[INFORMATION REGARDING THE INTERNATIONAL ENGLISH LANGUAGE TESTING SYSTEM (IELTS) DESCRIBED IN 12 AAC 44.400(a)(6)(E)(i) IS AVAILABLE AT WWW.IELTS.ORG.

THE TEST OF ENGLISH AS A FOREIGN LANGUAGE (TOEFL-iBT) EXAMINATION DESCRIBED IN 12 AAC 44.400(a)(6)(E)(ii) IS ADMINISTERED BY EDUCATIONAL TESTING SERVICES, P.O. BOX 6151, PRINCETON, NEW JERSEY

08541; TELEPHONE: (609) 771-7100 OR (877) 863-3546; WEBSITE AT WWW.ETS.ORG/TOEFL.]

Information regarding the Commission on Graduates of Foreign Nursing Schools Credentials Evaluation Service and the International Commission on Healthcare Professions (ICHP) certificate described in **12 AAC 44.400(a)(6)(E)(i) and (ii)** [12 AAC 44.400(a)(6)(E)(iii) AND (iv)] is available at CGFNS International, 3600 Market Street, Suite 400, Philadelphia, Pennsylvania 19104-2651; Telephone: (215) 222-8454; website at www.cgfns.org.

12 AAC 44.800(a)(2) is amended to read:

(2) submits, if applying under (1)(A), (B), (C), or (E) of this subsection, and if the applicant **is a graduate of a foreign prelicensure education program not taught in English or if English is not the individual's native language, evidence satisfactory to the board that the applicant has successfully passed an English proficiency examination that includes the components of reading, speaking, writing, and listening** [GRADUATED FROM A CNA CERTIFICATION PROGRAM OUTSIDE OF THE UNITED STATES OR CANADA, EXCEPT QUEBEC, CANADA,

(A) VERIFICATION OF HAVING EVER PASSED THE INTERNATIONAL ENGLISH LANGUAGE TESTING SYSTEM (IELTS) ACADEMIC EXAMINATION - OVERALL SCORE OF 6.5 WITH A MINIMUM OF 6.0 ON ALL MODULES;

(B) VERIFICATION OF HAVING EVER PASSED THE TEST OF ENGLISH AS A FOREIGN LANGUAGE, INTERNET-BASED TEST (TOEFL - iBT) - OVERALL SCORE OF 84 WITH A SPEAKING SCORE OF 26.

(C)] **(A)** a valid evaluation of the applicant's nursing education by the Commission on Graduates of Foreign Nursing Schools Credentials Evaluation Service, with a full education, course-by-course report that indicates the applicant's nursing education was taught in English; or

[(D)] **(B)** an official International Commission on Healthcare Professions (ICHP) certificate verifying successful completion of the VisaScreen: Visa Credential Assessment Service.

(Eff. 2/14/99, Register 149; am 5/29/99, Register 150; am 5/29/2005, Register 174; am 12/27/2012, Register 204; am 3/19/2014, Register 209; am 5/16/2018, Register 226; am 4/14/2021, Register 238; am 6/12/2022, Register 242; am ____/____/_____, Register _____)

Authority: AS 08.68.100 AS 08.68.331 AS 08.68.334

Editor's note: A list of nursing schools that have been approved by a state or territory of the United States may be obtained by contacting the Commission on Collegiate Nursing Education (CCNE), 655 K Street, NW, Suite 750, Washington, DC 20001; telephone (202) 887-6791; website at www.aacnnursing.org/CCNE, Accreditation Commission for Education in Nursing (ACEN), 3343 Peachtree Road NE, Suite 850, Atlanta, GA 30326; telephone (404) 975-5000; website at www.acenursing.org, or the National League of Nursing, 61 Broadway, 33rd Floor, New York, NY 10006.

[INFORMATION REGARDING THE INTERNATIONAL ENGLISH LANGUAGE TESTING SYSTEM (IELTS) DESCRIBED IN 12 AAC 44.800(a)(2)(A) IS AVAILABLE AT WWW.IELTS.ORG.

THE TEST OF ENGLISH AS A FOREIGN LANGUAGE (TOEFL-iBT) EXAMINATION DESCRIBED IN 12 AAC 44.800(a)(2)(B) IS ADMINISTERED BY EDUCATIONAL TESTING SERVICES, P.O. BOX 6151, PRINCETON, NEW JERSEY 08541; TELEPHONE: (609) 771-7100 OR (877) 863-3546; WEBSITE AT WWW.ETS.ORG/TOEFL.]

Information regarding the Commission on Graduates of Foreign Nursing Schools Credentials Evaluation Service and the International Commission on Healthcare Professions (ICHP) certificate described in **12 AAC 44.800(a)(2)(A) and (B)** [12 AAC 44.800(a)(2)(C) AND (D)] is available at CGFNS International, 3600 Market Street, Suite 400, Philadelphia, Pennsylvania 19104-2651; Telephone: (215) 222-8454; website at www.cgfns.org.

12 AAC 44.805(4) is amended to read:

(4) if the applicant **is a graduate of a foreign prelicensure education program not taught in English or if English is not the individual's native language, evidence satisfactory to the board that the applicant has successfully passed an English proficiency examination that includes the components of reading, speaking, writing, and listening** [GRADUATED FROM A CNA CERTIFICATION PROGRAM OUTSIDE OF THE UNITED STATES OR CANADA, EXCEPT QUEBEC, CANADA, SUBMISSION OF

(A) VERIFICATION OF HAVING EVER PASSED THE INTERNATIONAL ENGLISH LANGUAGE TESTING SYSTEM (IELTS) ACADEMIC EXAMINATION - OVERALL SCORE OF 6.5 WITH A MINIMUM OF 6.0 ON ALL MODULES;

(B) VERIFICATION OF HAVING EVER PASSED THE TEST OF ENGLISH AS A FOREIGN LANGUAGE, INTERNET-BASED TEST (TOEFL - iBT) - OVERALL SCORE OF 84 WITH A SPEAKING SCORE OF 26;

(C)] **(A)** a valid evaluation of the applicant's nursing education by the Commission on Graduates of Foreign Nursing Schools Credentials Evaluation Service, with a full education, course-by-course report that indicates the applicant's nursing education was taught in English; or

[(D)] **(B)** an official International Commission on Healthcare Professions (ICHP) certificate verifying successful completion of the VisaScreen: Visa Credential Assessment Service.

(Eff. 2/14/99, Register 149; am 3/28/2008, Register 185; am 12/27/2012, Register 204; am 3/19/2014, Register 209; am 5/16/2018, Register 226; am 4/14/2021, Register 238; am 1/19/2022, Register 241; am 6/12/2022, Register 242; am 8/25/2023, Register 247; am ____/____/_____, Register _____)

Authority: AS 08.68.100 AS 08.68.331

Editor's note: [INFORMATION REGARDING THE INTERNATIONAL ENGLISH LANGUAGE TESTING SYSTEM (IELTS) DESCRIBED IN 12 AAC 44.805(4)(A) IS AVAILABLE AT WWW.IELTS.ORG,

THE TEST OF ENGLISH AS A FOREIGN LANGUAGE (TOEFL-iBT) EXAMINATION DESCRIBED IN 12 AAC 44.805(4)(B) IS ADMINISTERED BY EDUCATIONAL TESTING SERVICES, P.O. BOX 6151, PRINCETON, NEW JERSEY 08541; TELEPHONE: (609) 771-7100 OR (877) 863-3546; WEBSITE AT WWW.ETS.ORG/TOEFL.]

Information regarding the Commission on Graduates of Foreign Nursing Schools Credentials Evaluation Service and the International Commission on Healthcare Professions (ICHP) certificate described in **12 AAC 44.805(4)(A) and (B)** [12 AAC 44.805(4)(C) AND (D)] is available at CGFNS International, 3600 Market Street, Suite 400, Philadelphia, Pennsylvania 19104-2651; Telephone: (215) 222-8454; website at www.cgfns.org.

12 AAC 44.810 is repealed and readopted to read:

12 AAC 44.810. Application for certification. (a) An applicant for certification as a nurse aide must submit

(1) a completed application, on a form provided by the department, verifying that the applicant meets the requirements of 12 AAC 44.800(a) or 12 AAC 44.805; the completed application must include

(A) notarized signature of the applicant, certifying that the information in the application is correct to the best of the applicant's knowledge;

(B) personal identification information;

(C) attestation that the applicant has completed or is eligible to complete a state approved nurse aide training program;

(D) information on the applicant's physical and mental health related to the grounds for license denial, suspension, or revocation in AS 08.68.270; and

(E) information on any criminal convictions related to the grounds for license denial, suspension, or revocation in AS 08.68.270;

(2) the applicable fees established in 12 AAC 02.282;

(3) the applicant's fingerprint information required by 12 AAC 44.812;

(4) if the submitted application has remained dormant for over one year from the original date of application, an additional application fee and fingerprint processing fee;

(5) the nurse aide program verification form, completed by an official of the program attended, and submitted directly to the department from the nurse aide training program; and

(6) at the written request of the board, additional information that is necessary to demonstrate that the applicant has met the licensing requirements of AS 08.68 and this chapter.

(b) If the applicant applies for certification under 12 AAC 44.800, the application for certification is also the application to take the competency evaluation required under 12 AAC 44.800(b);

(c) If applying by endorsement, an applicant must secure certificate verification by an official of the certifying jurisdiction in which the applicant was certified by examination and from the jurisdiction in which the applicant is currently certified, on a form provided by the department. The examination jurisdiction must verify that the certification was obtained by meeting the following qualifications;

(1) successful completion of a state approved nurse aide training program that adheres to 42 CFR 483.152; and

(2) obtained a passing score on a nurse aide competency evaluation that adheres to CFR 42 CFR 483.154. (Eff. 2/14/99, Register 149; am 6/16/2002, Register 162; am 10/9/2002, Register 164; am 8/10/2016, Register 219; am 5/16/2018, Register 226; am ____/____/_____, Register _____)

Authority: AS 08.68.100 AS 08.68.331

12AAC 44.845 is amended by adding a new paragraph to read:

(8) care of the cognitively impaired residents, including

(A) techniques for addressing the unique needs and behaviors of the individual with dementia (Alzheimer's and others);

(B) communicating with cognitively impaired residents;

(C) understanding the behavior of cognitively impaired residents;

(D) appropriate responses to the behavior of cognitively impaired residents; and

(E) methods of reducing the effects of cognitive impairments. (Eff. 2/14/99, Register 149; am ____/____/_____, Register _____)

Authority: AS 08.68.100 AS 08.68.331

12 AAC 44.965(b) is amended by adding a new paragraph to read:

(5) certified medical assistant (CMA).

(Eff. 10/14/2004, Register 172; am 11/4/2004, Register 172; am 12/23/2009, Register 192; am 12/27/2012, Register 204; am 8/10/2016, Register 219; am 2/26/2021, Register 238; am 7/18/2021, Register 239; am ____/____/_____, Register _____)

Authority: AS 08.68.100 AS 08.68.805 AS 08.68.850

12 AAC 44.990 is amended by adding a new paragraph to read:

(34) "triage" means determining the level of treatment order, including determining whether a patient should make an appointment or be seen by a healthcare provider.

(Eff. 1/13/80, Register 73; am 10/8/81, Register 80; am 12/1/84, Register 91; am 4/2/86, Register 97; am 4/29/91, Register 118; am 7/28/95, Register 135; am 11/2/2001, Register 160; am 6/16/2002, Register 162; am 11/10/2002, Register 164; am 10/14/2004, Register 172; am 2/9/2007, Register 181; am 11/19/2008, Register 188; am 12/27/2012, Register 204; am 8/10/2016, Register 219; am 5/16/2018, Register 226; am 5/7/2020, Register 234; am ____/____/_____, Register _____)

Authority: AS 08.68.100 AS 08.68.275 AS 08.68.805

Proposal : The below proposed change aligns the regulation with the federal regulation. Federal regulations require that an RN facilitate and evaluate the skills portion of the CNA exam. Yet, allows the written portion to be facilitated by a proctor trained in the required process of the written exam but does not need to be an RN

12 AAC 44.850. NURSE AIDE COMPETENCY EVALUATION.

(a) To be approved by the board a certified nurse aide competency evaluation must include

(1) an examination covering the subjects specified in 12 AAC 44.845 and 12 AAC 44.847; the competency evaluation must offer the applicant a choice between a written examination and an oral examination;

(2) a practical examination demonstrating the applicant's clinical and practical nurse aide skills; and

(3) notification to the applicant of the applicant's performance on the competency evaluation, identifying those portions, if any, of the competency evaluation that the applicant did not pass.

(b) A competency evaluation must be administered and evaluated as required by 42 CFR 483.154. ~~by a registered nurse approved by the board who has at least one year's experience in providing care for the elderly or the chronically ill of any age.~~

(c) Except as provided in (d) of this section, an applicant who does not successfully complete the competency evaluation required under this section may retake that portion of the competency evaluation that the applicant did not pass, upon payment of the examination fee required under 12 AAC 02.282.

(d) An applicant who does not successfully complete the competency evaluation after three attempts must complete a remedial course of training as required by the board. The applicant must provide proof of having fulfilled the requirements of the remedial course of training before the board will approve the applicant to retake the competency evaluation.

(e) The board may allow the competency evaluation to be conducted at a facility in which the nurse aide is or will be employed, if the facility meets the requirements for the written and skills portions of the evaluation and is approved by the board.

(f) The board may advise individuals who successfully completed the competency evaluation that a record of their successful completion of the evaluation will be included in the nurse aide registry.

Board or Commission Regulation Project Opening Questionnaire

Board: of Nursing

General subject matter/topic: Nurse Aide Competency Evaluation

Regulation(s) to be amended: 12 AAC 44.850

Companion regulations (fees, related regulations proposed by other boards, etc. if applicable)**:** _____

Instructions:

(1) The purpose of this worksheet is to provide the agency's regulation specialist with a detailed an overview of the proposed regulation change(s), including specific information as required by statute or the Department of Law.
(2) Details should be kept brief, succinct, and comprehensive. If a section of the form is not relevant to the project, please mark it as "N/A." Do not leave any sections blank.
(3) The board section of this worksheet must be completed by the board during a meeting or delegated to a board member, then submitted to agency staff.
(4) The regulation specialist may reach out to staff or board members at any stage during the project for additional information needed to compile the FAQ. The FAQ will be posted in the Online Public Notice System and on the board website during the public comment period.
(5) A draft of the proposed changes and excerpt of board minutes reflecting their discussion and vote must be attached to the completed worksheet and submitted to the Regulations Specialist within 10 days of the meeting.
(6) If the proposed regulation changes comprise more than one subject matter, the board must complete a separate worksheet for each subject. For example, if the intent is to (a) update continuing education requirements for license renewals, (b) repeal redundant provisions, and (c) introduce new regulations following statutory changes, the board would submit a total of three worksheets, one for each the subjects (a), (b), and (c).

TO BE COMPLETED BY THE BOARD OR A DESIGNATED BOARD MEMBER:

1. Has the board passed the following motions on the record: X Approve draft language to initiate a regulations project X Approve for public comment, unless substantive changes are made by regulations specialist or Department of Law ☐ Approve an oral hearing on the proposed regulations (if applicable) Date of the meeting: May 2024
2. What will the regulation do? Update the requirements for Nurse Aide Competency evaluation to align with the federal laws.
3. What is the public need or reason for this regulation? To align with federal laws and remove restrictions of title for proctors for the written exam portion.
4. What is the known or estimated annual cost of the new regulation to a private person, another agency, or a municipality? Zero
5. How will this have a <u>positive</u> or <u>negative</u> impact on public or private people, businesses, or organizations?

Provide clarity and alignment with federal law.	
6. If any negative consequences, please address the reasons why the public need for this change outweighs the negative impact.	
List any additional questions or comments that may arise from licensees, stakeholders, or the public during the comment period: What concerns or issues might they raise about the proposal? Will the new regulations affect licensees or the public in dramatic ways? Are there unintended consequences to the proposal? Include the board's response to the questions. This information will be included on the FAQs.	
8. In addition to the 30-day minimum written notice, does the board request a public hearing? If yes, when and where. NO	
9. Does the change add a new license type?	**NO**
If yes:	
Does it affect current licensees?	Yes No
Do current licensees/non-licensees already perform the service for which the new license type is required?	Yes No
Is a date included in the regulation to allow for a transition period?	Yes No
10. Does it affect continuing education/competency requirements?	No
If yes:	
Does it add additional requirements or hours?	Yes No
Does it clarify existing regulations?	Yes No
Is there an effective date in the future to give licensees time to comply?	Yes No
11. Does it require a fee change or a new fee in centralized regulations? If yes, please explain:	No
12. Does it make changes to the qualifications or requirements of licensees?	No
If yes:	
All licensees	Yes No
Only initial licensees	Yes No
Certain licensees (List types)	Yes No
13. Is the new regulation required by a certain date?	No
If yes:	
What is the date the regulation should be effective?	
Explain the reason (statute change, renewal qualifications, etc.):	
Is a date included in the regulation to allow for a transition period?	Yes No
14. In addition to interested parties, who should receive public notice?	
Certain license types (list them): ___CNA_____	

Other stakeholders: ____ CNA's and CNA schools , AHHA_____
15. What is the date of the next meeting when the board plans to address regulations? November 6 & 7, 2024

TO BE COMPLETED BY LICENSING STAFF:

16. Will implementation include changes to official public forms or internal checklists? If so, please provide a list of form numbers to the publications specialist to initiate the forms revision process.	No
17. If a public hearing was requested by motion, please include complete teleconference details:	
18. Have you attached an excerpt of the meeting minutes that reflects: • Board discussion about the proposal • Draft language of the proposal • Motion reflecting intent to propose the draft language, including approval for public notice if no significant changes are made by the regulations specialist or drafting attorney	

Staff submitting this worksheet: Patty Wolf Date submitted to Regulations Specialist: 2024

* Cost information is described simply as an estimate of annual costs within the board's ability to determine due to its familiarity with the regulated community. *Example:* A board is proposing to require three CE credits to their continuing competency standards for biennial license renewal. The proposal requires licensees to take additional courses, so it may cost:

- A private person: $50-$200 per applicant/licensee biannually
- Another state agency: None known
- A municipality: None known

Alaska Board of Nursing

Agenda Item #14

Advisory Opinion Updates

Alaska Board of Nursing

Break

Alaska Board of Nursing

Agenda Item #15

Certification Review

Recognized Advance Practice Registered Nurse Certifications

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

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

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

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

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

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

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

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

    If certified or licensed as of January 1, 2024, may continue to practice as long as that certification is maintained.
    - Emergency Nurse Practitioner
    - Family Nurse Practitioner
    - Gerontological Nurse Practitioner

7. **American Association of Critical-Care Nurses (AACN)**
    - Acute Care Nurse Practitioner
    - Adult-Gero Clinical Nurse Specialist
    - Pediatric Clinical Nurse Specialist
    - Neonatal Clinical Nurse Specialist

ANCC
AMERICAN NURSES CREDENTIALING CENTER
CERTIFICATION

The Commission on Certification grants

[redacted]

the credential of

CHILD/ADOLESCENT PSYCHIATRIC-MENTAL HEALTH
CLINICAL NURSE SPECIALIST
PMHCNS-BC

valid from March 6, 2022 to March 5, 2027

Certification Number: 2012001291

Heidi McNeely, MSN, RN, PCNS-BC
Chair, Commission on Certification

Rhonda Anderson, DNSC(h), MPA, RN, FAAN
President, American Nurses Credentialing Center

ABSNC Accreditation Board for Specialty Nursing Certification
Formerly the AANP Accreditation Council

This ANCC certification is accredited by the Accreditation Board for Specialty Nursing Certification.

ANCC
AMERICAN NURSES CREDENTIALING CENTER

8515 Georgia Ave, Suite 400
Silver Spring, MD 20910

1.800.284.2378
nursingworld.org/ANCC

[redacted]

March 14, 2022

Certification: Clinical Nurse Specialist in Child and Adolescent Psychiatric and Mental Health
Certification Period: March 6, 2022 to March 5, 2027
Certification Number: 2012001291
Customer ID Number (for ANCC internal use): 30153780

Congratulations! Your certification was successfully renewed. The American Nurses Credentialing Center certifications are valid for five years, provided that your RN license is maintained. Your wall certificate package, with wallet card and pin, will arrive in approximately 4 weeks. Please use your certification number in any future communication with ANCC.

It is your professional responsibility to remain aware of your certification period dates and the certification renewal requirements. Current certification renewal requirements are available for review on the ANCC website at www.nursingworld.org.

Please inform ANCC of any name or contact information changes. Name changes must be sent by mail to ANCC at the street address listed below and must contain a copy of a marriage decree, divorce decree, or a court order indicating a legal name change. Note that ANCC certification records are maintained separately from the American Nurses Association records.

You may request one free verification letter of your certification at www.nursingworld.org. Verifications of certification are not automatically sent to State Boards of Nursing or employers. Please place requests for the verifications you need.

If you require any assistance during your next five-year certification, please call ANCC at 1.800.284.2378 or send an e-mail to certification@ana.org. We look forward to hearing from you.

Again, congratulations on your certification renewal.

American Nurses Credentialing Center
Certification
8515 Georgia Avenue, Suite 400
Silver Spring, Maryland 20910
Web: www.nursingworld.org
E-mail: certification@ana.org
Phone: 1.800.284.2378

Alaska Board of Nursing

Agenda Item #16

CNA Abuse Registry Update

Alaska Board of Nursing

Agenda Item #17

Discussion: Standard CEUs for advanced certifications with valid cards

Situation:

Some Nurses will provide documentation of a current card for ACLS, PALS, and NRP but are unable to provide the certificate with the hours recorded. This information was received from our paralegal: Nurses fail to get certificates of completion, and when they reach out to the providers, the providers either say they were to request that within six months or that it didn't count for CE.

If they have no proof of hours, they do not get CEU credit for an audit. One example was a nurse who had taken both an ACLS and PALS class in the licensing renewal timeframe but because they were unable to produce the correct certificate documentation, they were unable to count those CEU's towards their audit and were considered short. They had valid cards showing an issue date within the official timeframe.

Other boards have set a specific hour amount that they will accept for each certification no matter what proof is provided.

PALS initial class is worth 8 CEUs and a recertification is work 4 hours.

ACLS- 8- 16 CEU's depending on the class.

Suggestion to consider a set number of hours for an ACLS course, PALS course, or NRP course with a valid completion card within the timeframe:

Example:

Although it's for CPR, for dentists the board accepts four hours for CPR certification no matter if they have proof of hours or not.

Alaska Board of Nursing

Review/Assign Action Items and Due Dates

Alaska Board of Nursing

Adjourn

Alaska Board of Nursing

Agenda Item #19

Roll Call/Call to Order

Alaska Board of Nursing

Agenda Item #20

Deliberative Session

Closed to the Public

Alaska Board of Nursing

Agenda Item #21

Executive Session

Closed to the Public

Alaska Board of Nursing

Agenda Item #22

Investigative and Probation Reports

THE STATE of ALASKA

Department of Commerce, Community, and Economic Development

DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING

550 West Seventh Avenue, Suite 1500
Anchorage, AK 99501-3567
Main: 907.269.8160
Fax: 907.269.8156

MEMORANDUM

DATE: April 24, 2024

TO: Board of Nursing

THRU: Erika Prieksat, Chief Investigator

FROM: Christina Bond, Investigator

RE: Investigative Report for the May 15, 2024 Meeting

The following information was compiled as an investigative report to the Board for the period of January 24, 2024 thru April 24, 2024; this report includes cases, complaints, and intake matters handled since the last report.

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

OPEN - 102

Case Number	Violation Type	Case Status	Status Date
2024-000310	Unprofessional conduct	Intake	04/03/2024
ADVANCED NURSE PRACTITIONER			
2022-000085	PDMP Violation	Intake	01/25/2022
2023-001053	PDMP Violation	Intake	10/06/2023
2023-001164	Violation of licensing regulation	Intake	11/28/2023
2019-000516	Standard of care	Complaint	07/02/2019
2020-000292	PDMP Violation	Complaint	11/03/2021
2020-000369	Prescriptive practice	Complaint	04/15/2020
2021-000969	Standard of care	Complaint	10/04/2022

2022-000359	Standard of care	Complaint	05/16/2022
2023-000066	Unprofessional conduct	Complaint	05/04/2023
2023-000740	Unprofessional conduct	Complaint	07/26/2023
2023-000741	Unlicensed practice or activity	Complaint	07/26/2023
2023-000849	Substance abuse	Complaint	08/21/2023
2023-000956	PDMP Violation	Complaint	09/14/2023
2023-000971	Unethical conduct	Complaint	10/02/2023
2023-001035	PDMP Violation	Complaint	11/15/2023
2023-001079	PDMP Violation	Complaint	11/15/2023
2023-001118	Unprofessional conduct	Complaint	11/08/2023
2023-001170	PDMP Violation: Failure to Register	Complaint	02/14/2024
2023-001171	PDMP Violation: Failure to Register	Complaint	02/14/2024
2023-001172	PDMP Violation	Complaint	02/14/2024
2023-001211	Standard of care	Complaint	01/10/2024
2023-001214	Unprofessional conduct	Complaint	02/20/2024
2024-000147	Unprofessional conduct	Complaint	03/20/2024
2024-000180	Standard of care	Complaint	02/27/2024
2024-000190	Standard of care	Complaint	03/05/2024
2024-000249	Standard of care	Complaint	04/05/2024
2018-000492	Standard of care	Investigation	07/08/2021
2020-001172	Patient or client abuse	Investigation	07/08/2021
2021-000478	Practice beyond scope	Investigation	04/19/2023
2021-001023	Standard of care	Investigation	06/02/2023
2023-001106	Criminal action - conviction	Investigation	04/04/2024
2023-001143	Unprofessional conduct	Investigation	04/11/2024
2019-000056	Falsified application	Litigation Initiated	11/05/2020
2019-000171	Prescriptive practice	Litigation Initiated	10/06/2020
2020-000302	Criminal action - no conviction	Litigation Initiated	11/05/2020
2021-000311	Unlicensed practice or activity	Litigation Initiated	

CERTIFIED NURSE AIDE

2024-000363	License Application Review/Referral	Intake	04/18/2024
2023-000379	License Application Problem	Complaint	05/24/2023
2024-000219	Falsified application	Complaint	03/12/2024
2024-000231	Substance abuse	Complaint	03/14/2024
2024-000274	Substance abuse	Complaint	03/21/2024
2022-000940	Continuing education	Investigation	05/30/2023
2023-000866	Unprofessional conduct	Investigation	11/01/2023
2023-001003	License Application Problem	Investigation	12/05/2023

LICENSED PRACTICAL NURSE

2023-000567	Unprofessional conduct	Complaint	06/23/2023
2024-000275	Unprofessional conduct	Complaint	04/04/2024
2022-001167	Continuing education	Investigation	01/23/2023

PRACTICAL NURSE

2024-000322	Patient or client abuse	Intake	04/04/2024
2024-000343	Unprofessional conduct	Intake	04/12/2024
2023-001191	Unprofessional conduct	Investigation	03/07/2024

REGISTERED NURSE

2024-000235	Unlicensed practice or activity	Intake	03/15/2024
2024-000311	Unprofessional conduct	Intake	04/03/2024
2024-000332	Unprofessional conduct	Intake	04/10/2024
2024-000336	Substance abuse	Intake	04/11/2024
2024-000345	Unprofessional conduct	Intake	04/15/2024
2021-000250	Unlicensed practice or activity	Complaint	04/06/2021
2021-000570	Unprofessional conduct	Complaint	07/08/2021
2021-000802	Criminal action - no conviction	Complaint	06/24/2022
2021-001199	Unprofessional conduct	Complaint	01/07/2022
2022-000635	Unprofessional conduct	Complaint	07/06/2022
2022-000770	Unprofessional conduct	Complaint	04/17/2023
2023-000615	Continuing education	Complaint	06/16/2023

2023-000648	Continuing education	Complaint	06/16/2023
2023-000996	Unprofessional conduct	Complaint	09/25/2023
2023-001102	Unprofessional conduct	Complaint	12/26/2023
2023-001161	Substance abuse	Complaint	02/22/2024
2023-001173	Substance abuse	Complaint	12/08/2023
2024-000223	Unprofessional conduct	Complaint	03/20/2024
2024-000228	Substance abuse	Complaint	03/19/2024
2024-000269	License Application Review/Referral	Complaint	03/21/2024
2024-000292	Substance abuse	Complaint	03/29/2024
2024-000318	Violation of agreement	Complaint	04/04/2024
2024-000349	License Application Review/Referral	Complaint	04/16/2024
2024-000351	Falsified application	Complaint	04/16/2024
2024-000356	License Application Review/Referral	Complaint	04/19/2024
2023-000242	Unprofessional conduct	Monitor	
2019-000351	Probation violation	Investigation	04/11/2019
2019-001088	Substance abuse	Investigation	11/03/2021
2021-000766	Fraud or misrepresentation	Investigation	06/21/2023
2022-001151	Substance abuse	Investigation	01/03/2023
2022-001170	Unlicensed practice or activity	Investigation	08/21/2023
2022-001181	Unlicensed practice or activity	Investigation	01/12/2023
2023-000522	Continuing education	Investigation	12/20/2023
2023-000524	Continuing education	Investigation	01/22/2024
2023-000579	Continuing education	Investigation	03/20/2024
2023-000588	Continuing education	Investigation	09/21/2023
2023-000611	Continuing education	Investigation	02/21/2024
2023-000624	Continuing education	Investigation	02/21/2024
2023-000634	Continuing education	Investigation	11/07/2023
2023-000653	Continuing education	Investigation	11/20/2023
2023-000656	Continuing education	Investigation	01/30/2024
2023-000661	Continuing education	Investigation	03/29/2024
2023-000662	Continuing education	Investigation	02/21/2024

2023-000708	Continuing education	Investigation	10/12/2023
2023-000719	Continuing education	Investigation	09/21/2023
2023-000820	Continuing education	Investigation	01/19/2024
2023-000965	Unprofessional conduct	Investigation	
2023-001054	Unprofessional conduct	Investigation	01/10/2024
2024-000014	Substance abuse	Investigation	03/11/2024
2024-000167	Unlicensed practice or activity	Investigation	03/18/2024

REGISTERED NURSE ANESTHETIST

2019-001275	Unprofessional conduct	Complaint	02/04/2020

Closed - 43

Case #	Violation Type	Case Status	Closed	Closure
2024-000022	Unlicensed practice or activity	Closed-Intake	02/13/2024	Incomplete Complaint
2024-000027	Violation of licensing regulation	Closed-Intake	02/27/2024	Incomplete Complaint
2024-000088	Violation of licensing regulation	Closed-Investigation	02/13/2024	Incomplete Complaint

ADVANCED NURSE PRACTITIONER

2023-001213	Prescriptive practice	Closed-Intake	02/01/2024	Incomplete Complaint
2021-000770	Prescriptive practice	Closed-Complaint	04/01/2024	No Action - No Violation
2023-001142	Physical or mental disability	Closed-Complaint	04/11/2024	Other (See Abstract)
2024-000028	Negligence	Closed-Complaint	04/02/2024	No Action - No Violation
2023-000945	PDMP Violation	Investigation	04/03/2024	Advisement Letter

CERTIFIED NURSE AIDE

2024-000089	Unprofessional conduct	Closed-Intake	03/19/2024	Incomplete Complaint
2022-000916	Continuing education	Closed-Investigation	03/06/2024	License Action
2023-001077	Continuing education	Closed-Investigation	02/05/2024	License Action

LICENSED PRACTICAL NURSE

2023-001152	License Application Problem	Closed-Complaint	02/15/2024	No Action - No Violation
2022-000417	Unprofessional conduct	Closed-Investigation	02/13/2024	License Action
2023-000091	Unlicensed practice or activity	Closed-Investigation	02/13/2024	License Action
2024-000168	Falsified application	Closed-Investigation	04/01/2024	Advisement Letter

REGISTERED NURSE

2023-001136	Criminal action - no conviction	Closed-Intake	02/27/2024	No Action - Lack of Jurisdiction
2024-000007	Unprofessional conduct	Closed-Intake	02/21/2024	Incomplete Complaint
2024-000095	Substance abuse	Closed-Intake	02/15/2024	No Action - Lack of Jurisdiction
2023-000521	Continuing education	Closed-Complaint	03/20/2024	No Action - No Violation
2023-000523	Continuing education	Closed-Complaint	04/18/2024	No Action - No Violation
2023-000626	Continuing education	Closed-Complaint	02/26/2024	No Action - No Violation
2023-000630	Continuing education	Closed-Complaint	02/26/2024	No Action - No Violation
2023-000657	Continuing education	Closed-Complaint	03/21/2024	No Action - No Violation
2023-000710	Continuing education	Closed-Complaint	03/21/2024	No Action - No Violation
2023-000781	Continuing education	Closed-Complaint	02/12/2024	No Action - No Violation
2023-000822	Continuing education	Closed-Complaint	02/12/2024	No Action - No Violation
2023-000952	Continuing education	Closed-Complaint	02/02/2024	No Action - No Violation
2023-001080	Unprofessional conduct	Closed-Complaint	02/01/2024	No Action - No Violation
2023-001204	Practice beyond scope	Closed-Complaint	04/01/2024	No Action - No Violation
2024-000202	Unlicensed practice or activity	Closed-Complaint	04/02/2024	No Action - No Violation
2016-000744	Practice beyond scope	Closed-Investigation	02/23/2024	License Action
2019-000391	Probation	Closed-Investigation	02/15/2024	License Action
2019-001414	Practice beyond scope	Closed-Investigation	02/23/2024	License Action
2022-000896	Unprofessional conduct	Closed-Investigation	02/01/2024	Advisement Letter
2022-000897	Unprofessional conduct	Closed-Investigation	02/01/2024	Advisement Letter
2023-000507	Continuing education	Closed-Investigation	02/05/2024	License Action
2023-000518	Continuing education	Closed-Investigation	02/05/2024	License Action

2023-000563	Continuing education	Closed-Investigation	02/26/2024	Advisement Letter
2023-000635	Continuing education	Closed-Investigation	02/05/2024	License Action
2023-000640	Continuing education	Closed-Investigation	02/05/2024	License Action
2023-000714	Continuing education	Closed-Investigation	02/02/2024	No Action - No Violation
2023-001220	Falsified application	Closed-Investigation	02/14/2024	Advisement Letter
2024-000103	Fraud or misrepresentation	Closed-Investigation	03/29/2024	Advisement Letter

END OF REPORT

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Commerce, Community, and Economic Development

DIVISION OF CORPORATIONS, BUSINESS, AND PROFESSIONAL LICENSING
Anchorage Office

550 West Seventh Avenue, Suite 1500
Anchorage, AK 99501-3567
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PROBATION REPORT

DATE: April 9, 2024

TO: Alaska Board of Nursing

THROUGH: Sonia Lipker, Senior Investigator

FROM: Karina Medina, Investigator

SUBJECT: Probation Report for the May 2024 Meeting

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

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

Samuel Seale	01/19/2017	01/19/2020
Alixandra Stewart	08/11/2023	08/11/2028
*Quenna Szafran	05/11/2023	05/11/2028 SUSPENDED
Ciri Vail	08/11/2023	08/11/2028
Samantha Weber	08/16/2021	08/16/2026
Wendy Webster	11/09/2023	11/09/2025
*Sheriene Wilson	05/05/2022	05/05/2023 SUSPENDED
Jodi Wolcoff	03/15/2022	03/15/2027
Erika Yeager	11/01/2022	11/01/2024

The following were released after probation completion:

NAME	**START DATE**	**END DATE**
Michelle Scott	02/04/2021	02/14/2024

Board Requests:
Kelly Linebarger- Early Release Request

License Actions:

Melissa Dutkiewicz	03/28/2019	**REVOKED**

END OF REPORT

Alaska Board of Nursing

Break

Alaska Board of Nursing

Agenda Item #23

Reviewing Process Training for Board Members

Reviewing Board Member Process Updates
March 2024

The Division of Corporations, Business and Professional Licensing is updating certain forms and processes used to assist reviewing board members (RBMs) in understanding and navigating their important case review responsibilities. This memo provides a rationale for and overview of these changes, as well as the outcomes desired from these updates.

RATIONALE

Reviewing board members play a crucial role in ensuring best outcomes of matters under investigation. RBMs provide expertise and insight that only a similarly licensed provider could offer. Although division investigators are professionally trained and certified, they are not licensees and do not have the understanding and context to evaluate complex or sophisticated practice situations that comes with licensed practice.

RBMs also serve as proxies for full board review. It would be impossible for the entire board to perform a full review of every case—no board has the amount of time or resources to fully examine every case file. So, the RBM steps into deeply analyze the details and offer a thoughtful recommendation for the board to consider.

The Department of Law has recently offered guidance on multiple situations relating to RBM review and participation in deliberation. A few takeaways regarding RBM responsibilities have urged the department to assist the division in developing additional resources:

RBMs have the responsibility to:

1. Ensure they do not have conflicts of interest with any elements of the case.
2. Ensure they do not share case information with other persons without express authorization by the investigator, including other board members.
3. Review precedent for similar cases and consider any mitigating or aggravating circumstances.
4. Provide a full written review to assist the board in their deliberation, including explanation of any noteworthy relevant facts, especially if the reviewer recommends a departure from precedent in similar matters.
5. Ensure their written review and recommendation are free of bias and are based on the relevant facts, statutes, and regulations.
6. Request recusal from deliberation and voting on any case they reviewed.

Following these guidelines will help achieve best outcomes for the case:

1. They help preserve due process of the respondent. This is an important provision of state law and is a fundamental value of American society.
2. They help assure appropriate decisionmaking standards are being followed.
3. They help ensure the correct administrative processes have been followed: Failure to follow the Administrative Procedure Act can open opportunities to overturn the board's decision upon appeal.
4. They help support the Department of Law's ability to defend the board's decision.
5. They help defend public safety: Delaying or overturning a board's disciplinary decision can place an unsafe or unfit licensee back into public practice.
6. They protect board members from individual legal or financial liability.

OVERVIEW

The changes being made to the board member review process are not dramatic; however, they will provide additional education and understanding to members, help boards more fully understand the basis for the reviewing

board member's recommendation, and assist the investigator in assessing any risk associated with board member review of the matter.

1. The new *RBM Case Review Agreement* spells out the mutually agreed-upon standards for board member evaluation of a matter. It will help set expectations up front and prompt any questions an RBM may have prior to investing time and energy into case review.
2. The *Board Member Review Form* is being updated to clarify certain terms and offer a space for the RBM to thoroughly explain their recommendation and rationale. The goal of this update is to provide boards more information to aid in their decisionmaking without placing the process or final outcome at risk.
3. A new *RBM Risk Assessment Worksheet* has been created to assist investigators in identifying the level of legal or process risk associated with a particular board case. This internal tool is for informational and educational use so investigators can best identify next steps in obtaining guidance for a board when preparing to enter the deliberative process.

DESIRED OUTCOMES

- Reviewing board members will feel more empowered in understanding the expectations and parameters of case review.
- RBMs will provide a written analysis of their recommendations and the reasons why they support that pathway.
- Board members will receive the RBM's written analysis within the investigative memo.
- Board members will feel confident in the additional information provided by the RBM, aiding in decisionmaking and resulting in consistent adherence to the decisionmaking processes advised by department staff and board attorneys.

Board members are urged to provide feedback on these improvements so they can continually be refined and remain useful and relevant tools to support members in fulfilling their boards' missions.

Reviewing Board Member Case Review Agreement

Board _____ Board Member _____
Investigator _____ Case Number _____

Thank you for reviewing this confidential case. Please sign this agreement indicating that you understand the following standards of case review and return to the assigned investigator as part of the complaint packet. If you have any questions or concerns, or if you do not believe you can meet these standards, please contact the investigator immediately to discuss further.

I do not have any significant business interests, personal or legal complications, or other potential conflicts of interest with the parties to the case. If unsure, I will discuss with the investigator immediately. *AS 39.52*

I understand the role of the Reviewing Board Member. I will fairly and impartially review the facts of the case alongside statute and regulation and make a thorough, dispassionate, educated recommendation on the review form.

I will review all precedents regarding similar cases and strive to either (1) make a recommendation that is aligned with matters containing similar facts, or (2) fully explain why my recommendation is inconsistent with matters that are similarly situated. *AS 08.01.075(f)*

I will not discuss this case or any of its components with other board members, licensees, or members of the public. If I have questions regarding the case, I will contact the assigned investigator or his/her supervisor. *AS 40.25*

For scope of practice matters: My professional experience in this field of practice qualifies me to make an educated evaluation and recommendation regarding this case.

For scope of practice matters: The facts of this case fall within the scope of practice of my license or a subordinate license type.

I understand that I will likely be required to recuse myself on the record from deliberation and voting on this matter. If I have concerns about this, I will immediately alert the investigator.

I will fully complete all aspects of this review, including citing all relevant statutes and regulations and providing a clear and logical written explanation of my recommendation.

I will complete this review within 30 days of receipt of full documentation. If I am unable to keep this commitment, I will inform the investigator immediately and make arrangements for an agreeable substitute deadline.

_____ _____
Signature of Reviewing Board Member Date

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Commerce, Community, and Economic Development

DIVISION OF CORPORATIONS, BUSINESS PROFESSIONAL LICENSING

550 West Seventh Avenue, Suite 1500
Anchorage, AK 99501-3567
Main: 907.269.8124
Fax: 907.269.8195

CASE REVIEW FORM

CONFIDENTIAL

Deliberative Process Privilege

DATE: Click or tap to enter a date.

TO: Reviewing Choose an item.
Alaska State Choose an item.

FROM: INVESTIGATOR NAME, Investigator

RE: Complaint Review for RESPONDENT

CASE#: CASE NUMBER

As the reviewing Choose an item. on behalf of the Choose an item., please review the attached material, including a review memo from the Investigator and all material from the case file, in order to provide an opinion whether the Respondent has violated any statutes or regulations governing their license. Your review is necessary to assist the Division in determining appropriate action, if any, including whether board action is necessary.

Please provide written answers to all questions and attach additional pages if needed.

1. In your professional opinion, do the records reviewed demonstrate the Respondent violated:

COPY & PASTE APPLICABLE LANGUAGE

☐ Yes ☐ No (If YES, explain why and how you arrived at that conclusion.)

Click or tap here to enter text.

2. (Repeat section #1 for each individual violation)

3. If violations are present, do you recommend disciplinary action to resolve this case? (If YES, identify the action you believe appropriate. If disciplinary action is not recommended, check NO)

☐ Yes ☐ No

☐ **Alternative to Probation for Substance Use Disorders (NUR)**

☐ **Consent Agreement** with the following terms (see page 4 to select consent agreement terms)
Click or tap here to enter text.

☐ **Imposition of Civil Fine**: $Click or tap here to enter text.

☐ **Other Action** (to be outlined for the Division to proceed).

Click or tap here to enter text.

4. Provide a brief statement of explanation that can be provided to the board to help inform the rationale for your recommendation. If recommending discipline outside the historical case precedent for similarly situated matters/disciplinary matrix, state those reasons per AS 08.1.075(f):
Click or tap here to enter text.

5. If Respondent possesses multiple licenses, and disciplinary action is warranted, please specify which license(s) are to be affected and why.
Click or tap here to enter text.

6. If violations are present, but in your opinion, do not rise to the level of formal disciplinary action, do you recommend a non-disciplinary letter of advisement (NDLOA) to resolve this case? (If YES, write the specific advisement language you believe to be appropriate and explain why this path is recommended. If a NDLOA is not recommended, check NO)

☐ Yes ☐ No

Click or tap here to enter text.

7. If no violations were discovered upon your review, do you recommend this case be closed with no further action taken? The Respondent and Complainant will be sent letters indicating no violations were found and the matter is closed with no further investigation.

☐ Yes ☐ No

Click or tap here to enter text.

8. As a result of your review, do you recommend this matter be reviewed by an expert, specialist, or another board member?

☐Yes ☐ No (If YES, explain in detail why and identify the appropriate type of expert or specialist.)

Click or tap here to enter text.

9. Are there any other concerns about this case that you believe require further action or attention?

☐ Yes ☐ No (If YES, please describe the matters you feel require further action or attention.)

Click or tap here to enter text.

AFFIDAVIT: I affirm the following: I have fully reviewed all information relating to this case, including all case documentation from all parties, as well as all board statutes and regulations. I have analyzed the existing precedents regarding similarly situated matters and explained any deviation as required under AS 08.01.075(f). I have not discussed this matter with another board member, party, or member of the public without the express knowledge and consent of the investigator. I have no new conflicts of interest regarding this case since signing the Case Review Contract.

FULL NAME & POSITION

_____ Click or tap to enter a date.

(Print) Date

This memo is not releasable to the public - IAW Alaska Statute 40.25.120(a)(6)(C)

X _____

Signature

ADDITIONAL COMMENTS OR REMARKS:
Click or tap here to enter text.

Consent Agreement terms (specify below):

Conditions/Restrictions/Advisement

☐ Suspension for _____ months

☐ Suspension stayed: ☐ all time or ☐ portion of time _____

☐ Probation for _____ months

☐ Practice monitor (monitor receives a copy, understands their role, and agrees to the plan)

☐ Employer Reports (quarterly report to the Board)

☐ Employment must be supervised (constant, direct supervision)

☐ Hospital Privileges (advise Chief of Staff or administrator of all hospitals of terms of probation)

Counseling/Therapy/Assessment

☐ Psychotherapy Counseling (psychiatric and/or psychological therapy)

☐ with quarterly reports from counselor/therapist

☐ without quarterly reports from counselor/therapist

☐ Inpatient Chemical Dependency/Alcohol treatment

☐ Rehabilitative Counseling (chemical dependency/alcohol outpatient treatment)

☐ AA/NA meetings (3 per week unless noted)

☐ Health Care Provider Support Group

☐ Ability to Practice Evaluation

☐ Restriction on remote employment (may only work in communities which have access to requirements set forth i.e. drug testing/psychotherapy)

Substance Restrictions/Testing

☐ Consume no controlled drugs, alcohol, or marijuana.

☐ No consumption of drug of choice _____ (specify) unless medically necessary.

☐ Drug/Alcohol Tests

☐ Limitation of Access to Controlled Drugs (cannot practice where Schedule I, II, III, IV or V controlled drugs are accessible OR must have adequate safeguards in place)

☐ Restricted Prescription Authority (must surrender DEA registration for Schedule II and III drugs as well as triplicate system for schedule IV and V drugs)

☐ Restriction on remote employment (may only work in communities which have access to requirements set forth i.e., drug testing/psychotherapy)

Other

☐ Fine: $_____ with $_____suspended

☐ Self-Evaluation Report (submit quarterly reports on mental health, management of stress, physical health, professional responsibilities/activities and personal activities)

☐ Personal Health Care Provider (receive medical care who receives a copy of the consent agreement and use a pharmacy approved by the board)

☐ Additional Education (CMEs) for _____ (topic)

- ☐ Complete _____ hours

☐ Public Reprimand (for healthcare-related professions, this will display with their licensure information on NPDB)

☐ _____

***Cautionary Note**: Please review your historical case precedents and/or matrix to ensure consistency is applied to your recommendation. Any recommendation that falls outside of historical case precedents or matrix will require additional explanation to justify the deviation.*

Alaska Board of Nursing

Agenda Item #24

Strategic Planning

ALASKA BOARD OF NURSING
STRATEGIC PLAN 2024-27

1 LICENSING

To license qualified persons for the practice of nursing and to certify qualified nurse aides

- 1A Actively work to to enact passage of the Nurse Licensure Compact (NLC)
- 1B Identify licensure barriers in regulations
- 1C Reduce license turnaround time
- 1D Complete the CNA Certifications Regulations Project
- 1E Review types of licenses offered
- 1F Review requirements for renewal and continuing education to identify efficiencies.

2 PRACTICE

To determine, communicate, and enforce nursing practice as established in statute and regulations.

- 2A Update LPN scope of practice
- 2B Review processes to address scope of practice questions
- 2C Review delegation regulations and develop guidelines for delegation
- 2D Review IV hydration clinics and related prescribing practices

3 EDUCATION

To approve, communicate, and enforce standards for the education of nurses and nurse aides for practice at all levels.

- 3A Update RN and LPN program site visit process
- 3B Review education regulations
- 3C Review the possibility of LPN and/or RN apprenticeship programs

4 GOVERNANCE

To assure the governance framework and culture supports the board's Values and Guiding Principles and accomplishment of its Mission, Vision, and Goals.

- 4A Create and implement a formal strategic plan
- 4B Formalize a system for board member education and onboarding

5 COMMUNICATION

To facilitate information exchange between the board and its colleagues, stakeholder groups, the public, and other agencies.

- 5A Engage with stakeholders (APRNA, AaNA, AHHA, etc.)
- 5B Increase communications with licensees

6 ORGANIZATION

To ensure the organizational infrastructure supports the board's Mission, Vision, and Goals.

- 6A Support legislation to ensure APRN and CNA representation on the board

Alaska Board of Nursing

Adjourned for Lunch

Alaska Board of Nursing

Agenda Item #25

Licensing and Program Reports

LICENSING SUMMARY

Fiscal 3rd Quarter 2024 (Jan 1-March 31, 2024)

LICENSE TYPE/METHOD		3rd Quarter Total	Running Total YTD	Total Active
RN	Exam	122	242	
	Endorsement	754	2346	
	Total:	**876**	**2588**	**21,204**
LPN	Exam	6	8	
	Endorsement	17	69	
	Total:	**23**	**77**	**765**
APRN		74	317	**2284**
	Total:	**74**	**317**	
PERMITS	RN	256	989	
	LPN	5	33	
	APRN	2	15	
	TOTAL:	**263**	**1037**	
REINSTATE	RN	34	149	
	LPN	5	9	
	APRN	3	15	
	TOTAL:	**42**	**173**	
RETIRED		**2**	**5**	**195**
ANP PRECEPTORSHIP		**18**	**42**	**67**
GRAND TOTAL:		**1298**	**4239**	**24,515**

Note:
***Exam permits become void when an applicant is unsuccessful on their exam.**

Licensing Statistics	July 1, 2021-June 30, 2022 fiscal year	July 1 2022-June 30, fiscal year	July 1 2023-March 31 2024 fiscal YTD
RN			
RN Exam	328	327	242
RN Endorsement	3008	3310	2346
ECL/Courtesy license	977	0	0
Total licenses issued	4313	3637	2588
Total ACTIVE RN licensees	19275	18413	21204
LPN			
LPN Exam	1	6	8
LPN Endorsement	82	116	69
ECL License	103	0	0
Total licenses issued	186	122	77
Total ACTIVE LPN licensees	765	671	765
APRN			
Total licenses issued	336	381	317
ECL/courtesy license	45	0	0
Total ACTIVE APRN licensees	1806	1937	2284

N.C.S.B.N. EDUCATION PROGRAM SUMMARY

Educated in Alaska

TESTED DURING 1st Quarter 2024 (January 1-March 31, 2024)

NURSING PROGRAM	FIRST TIME TESTERS	PASS	PASS%	FAIL	FAIL%		REPEAT TESTERS	PASS	PASS%	FAIL	FAIL%
UAA A.A.S	28	27	**96%**	1	**4%**		2	1	**50%**	1	**50%**
UAA B.S.N.	34	31	**91%**	3	**9%**		3	2	**67%**	1	**43%**
CHARTER A.D.N	16	15	**94.0%**	1	**6.0%**		5	2	**40%**	3	**60%**
APU ADN	22	22	**100%**	0	**0%**		0	0	**0.0%**	0	**0.0%**
APU LPN	7	7	**100%**	0	**0%**		0	0	**0%**	0	**0%**

*NOTE: NCSBN does not provide data on “repeat testers” taken in other states. “First time tester” data shown here reflects testing information from all states, whereas “repeat tester” data reflects only our state. This means there may be a repeat testing candidate in another state not included in these totals.

NCLEX Pass Rate Year to Date Summary

Nursing Program	2022	2023	2024 1ST QUARTER
UAA AAS	90% (73/80)	83% (67/81)	96% (27/28)
UAA BSN	89% (59/66)	87% (102/117)	91% (31/34)
Charter ADN	91% (49/54)	80% (61/76)	94% (15/16)
APU ADN	73% (11/15)	60% (12/20)	100% (22/22)
APU LPN	--	78% (7/9)	100% (7/7)

CERTIFIED NURSE AIDE BOARD STATISTICS & UPDATES

Presented by Michelle Griffin, Licensing Examiner
(907) 269-8402
michelle.griffin@alaska.gov

CNA Q3 2024 CERTIFICATION REPORT

CNA Certifications by Recent Fiscal Quarter (oldest first):

	New Permanent certificates issued	*Reinstatements*	*Temporary certificates issued*	*Emergency Courtesy Certificates issued*	*Total permanent certificates*
FY 24 Quarter 1 7/1/23 – 9/30/23	144	3	13	0	2,983
FY 24 Quarter 2 10/1/23 – 12/31/23	48	2	12	0	3,027
FY 24 Quarter 3 1/1/24 – 3/31/24	133	0	15	0	2,046
FY 24 Quarter 4 4/1/24 – 6/30/24					

2024 – 2026 CNA RENEWAL STATUS

All CNA renewal date was 3/31/2024. As of 4/1/2024- 1,860 certifications had been renewed. CNAs can still renew until 3/31/2025:

- CNAs that lapsed on 3/31/2024 and have not renewed are still eligible for renewal if they have completed 24 CEUs and worked at least 160 hours performing CNA duties for monetary compensation between 4/1/2022 and 3/31/2024.

- CNAs are eligible for reinstatement if they worked at least 160 hours performing CNA duties for monetary compensation between 4/1/2022 and 3/31/2024 but did not complete 24 CEUs during that timeframe by completing their CEUs.

- CNAs are eligible for reinstatement if they did not work as a CNA during 4/1/2022 and 3/31/2024 by retaking the CNA competency evaluation.

TEMPORARY FEE WAIVER
(4/8/2024 THRU 6/6/2024)

- For applications filed with the Alaska Division of Corporations, Business, and Professional Licensing between April 8, 2024 and June 6, 2024, the Alaska Certified Nurse Aide (CNA) initial application fees and certificate fees will be covered by the Alaska Division of Public Health, Section of Epidemiology via the CDC Strike Team Grant. CFDA number 93.923. Funding was approved to support efforts to address CNA staffing shortages at healthcare facilities statewide – a collaborative effort to address infection prevention and control gaps by removing a cost barrier limiting entry into the CNA profession. The $75 fingerprint processing fees are still required.

THE STATE of ALASKA
GOVERNOR MICHAEL J. DUNLEAVY

Department of Commerce, Community, and Economic Development
BOARD OF NURSING

550 West Seventh Avenue, Suite 1500
Anchorage, AK 99501-3567
Main: 907.269.8161
Toll free fax: 907.269.8156

DATE: April 12, 2024

TO: Alaska Board of Nursing

FROM: Michelle Griffin – Licensing Examiner

SUBJECT: Nurse Aide Quarterly Report

Quarterly Nurse Aide Statistics **Fiscal 2024 - Quarter 3: January 1 – March 31, 2024**

Permanent certificates issued: 133

Reinstatements issued: 0

Temporary certificates issued: 15

Total permanent nurse aide certificates as of March 31, 2024: **2,046**

CNA Certifications by Recent Fiscal Quarter (oldest first):

	New Permanent certificates issued	*Reinstatements*	*Temporary certificates issued*	*Emergency Courtesy Certificates issued*	*Total permanent certificates*
FY 24 Quarter 1 7/1/23 – 9/30/23	144	3	13	0	2,983
FY 24 Quarter 2 10/1/23 – 12/31/23	48	2	12	0	3,027
FY 24 Quarter 3 1/1/24 – 3/31/24	133	0	15	0	2,046
FY 24 Quarter 4 4/1/24 – 6/30/24					

CNA Renewals

All CNA renewal date was 3/31/2024. As of 4/1/2024- 1,860 certifications had been renewed. CNAs can still renew until 3/31/2025:

- CNAs that lapsed on 3/31/2024 and have not renewed are still eligible for renewal if they have completed 24 CEUs and worked at least 160 hours performing CNA duties for monetary compensation between 4/1/2022 and 3/31/2024.
- CNAs are eligible for reinstatement if they worked at least 160 hours performing CNA duties for monetary compensation between 4/1/2022 and 3/31/2024 but did not complete 24 CEUs during that timeframe by completing their CEUs.
- CNAs are eligible for reinstatement if they did not work as a CNA during 4/1/2022 and 3/31/2024 by retaking the CNA competency evaluation.

CNA Application & Certification Fees Temporarily Waived

For applications filed with the Alaska Division of Corporations, Business, and Professional Licensing between April 8, 2024 and June 6, 2024, the Alaska Certified Nurse Aide (CNA) initial application fees and certificate fees will be covered by the Alaska Division of Public Health, Section of Epidemiology via the CDC Strike Team Grant. CFDA number 93.923. Funding was approved to support efforts to address CNA staffing shortages at healthcare facilities statewide – a collaborative effort to address infection prevention and control gaps by removing a cost barrier limiting entry into the CNA profession. The $75 fingerprint processing fees are still required.

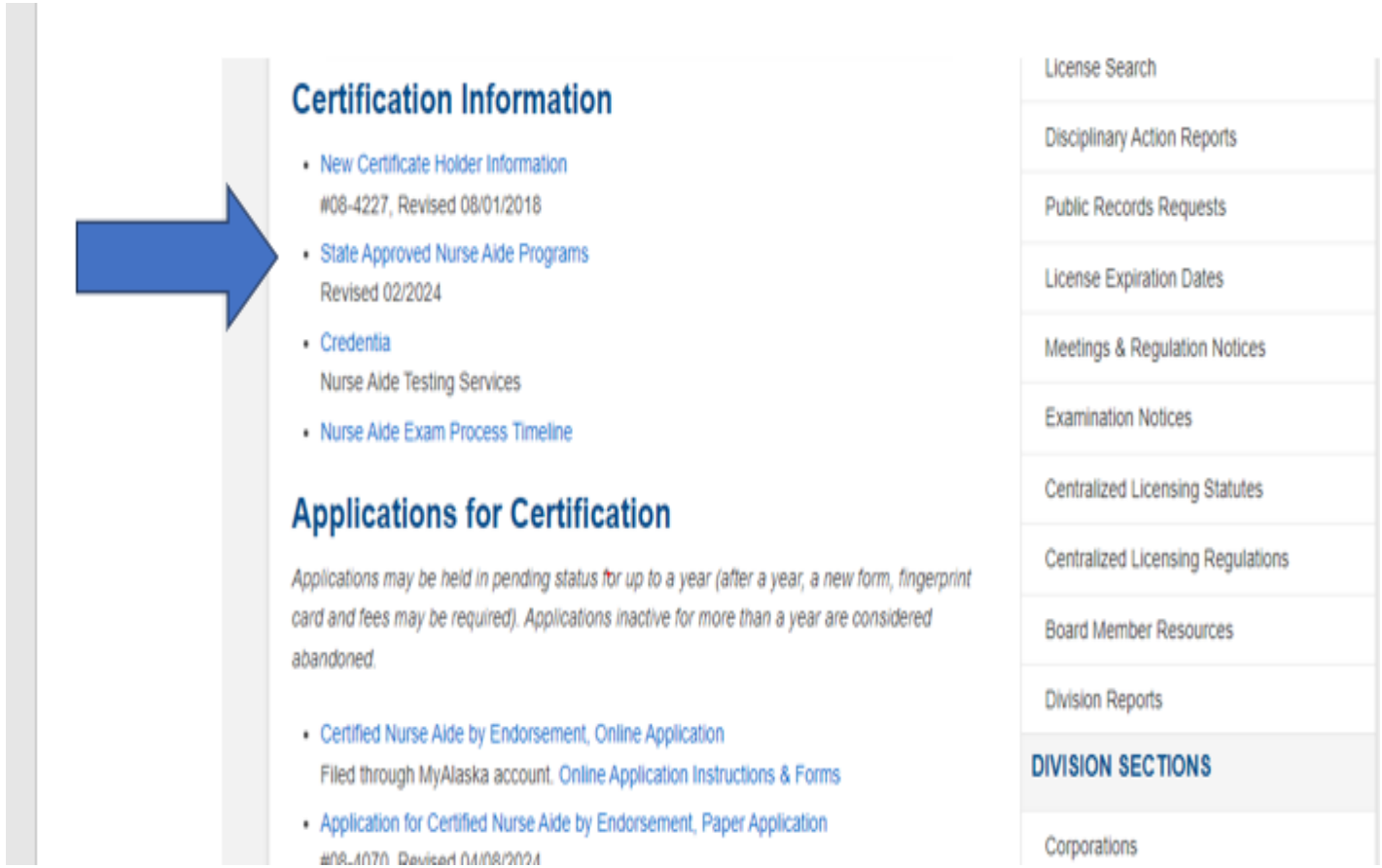
CNA Program Report FY24 Q3

May 2024 Board Meeting

Alaska Board of Nursing

- 33 State Approved Nurse Aide Training Programs

- Complete list is available on the AKBON Website- “Nurse Aide Registry” page under Certification Information.



NEWLY APPROVED INSTRUCTORS
12 AAC 44.840

Newly approved instructors

FY24 Q3

Providence Seward Mountain Haven-

1 New Instructor- March 2024

TRAINING PROGRAM PASS RATES
12 AAC 44.858

*Overall program pass rate FY24 Q3:

85.2%

(FY24 Q2: 74.5%)

FY24 Q3 (Jan-March 2024)

- 81 exams administered.
- 20 Programs had test takers.
- 14 Programs → Above 80%
- 11 Programs → 100% pass rate
- 6 Programs → Less than 80%

NEW PROGRAM REQUESTS
12 AAC 44.830

Providence Alaska Medical Center
3200 Providence Drive
Anchorage, Alaska 99508
907-212-5256
Pam Vrenna, Sr. Director of Education

Projected date of 1st class offering:

July 2024

Clinical Site: ***Providence Alaska Medical Center- Acute Care***

(Program outline and curriculum meet requirements set forth in regulations)- Motion attached

TRAINING PROGRAM REVIEWS
12 AAC 44.857

FY24 Q3 On-Site Reviews Completed:

- Alaska CNA
- Denali Center
- Prestige Care & Rehabilitation
- UAF CTC Fairbanks

All program documentation reviewed, a tour of the classroom, skills and clinical site were completed. These programs have met the requirements set forth in regulations. Recommend these training programs be granted re approval for the next two years.

**Motions attached*

TRAINING PROGRAM REVIEWS
12 AAC 44.857

Upcoming FY24 Q4 On-Site Visits Scheduled

- *Alaska Job Corp*
- *Alaska Technical Center-Kotzebue*
- *Heritage Place*
- *Kenai Peninsula College/KPBSD*
- *Kenai Peninsula College/KBB*
- *Mat-Su CNA*
- *Providence Seward Mountain Haven*
- *Providence Valdez*
- *SEARHC Sitka*

Follow up February 2024 Board Meeting

New Training Programs granted Provisional Approval:

Charter College (August 2023)- No tentative first course offering date set at this time. Training program working on further development of the program.

Alaska Native Medical Center (November 2023)- Tentative first course offering: July 2024

Thank you

Kelly Olson, RN
Nurse Consultant-Alaska Board of Nursing
kelly.olson@alaska.gov
(907)269-8098

Alaska Board of Nursing

Agenda Item #26

Division Updates

Board of Nursing	FY 18	FY 19	Biennium	FY 20	FY 21	Biennium	FY 22	FY 23	Biennium	FY 24 1st - 3rd QTR
Revenue										
Revenue from License Fees	$ 1,230,358	$ 4,018,325	$ 5,248,683	$ 1,822,883	$ 4,677,555	$ 6,500,438	$ 2,628,125	$ 5,564,976	$ 8,193,101	$ 895,536
General Fund Received					$ -	-	$ 630,266	$ 23,618	653,884	$ -
Allowable Third Party Reimbursements	1,666	731	2,397	$ 964	$ -	964	$ 833	$ 1,487	2,320	$ 954
TOTAL REVENUE	$ 1,232,024	$ 4,019,056	$ 5,251,080	$ 1,823,847	$ 4,677,555	$ 6,501,402	$ 3,259,224	$ 5,590,081	$ 8,849,305	$ 896,490
Expenditures										
Non Investigation Expenditures										
1000 - Personal Services	705,104	755,692	1,460,796	803,659	722,490	1,526,149	913,703	942,425	1,856,128	686,111
2000 - Travel	24,362	16,024	40,386	9,220	353	9,573	6,531	6,808	13,339	3,010
3000 - Services	295,510	311,479	606,989	278,101	304,961	583,062	367,557	383,215	750,772	189,325
4000 - Commodities	3,001	3,034	6,035	641	759	1,400	1,240	2,615	3,855	2,197
5000 - Capital Outlay	-		-	50	-	50	-	-	-	-
Total Non-Investigation Expenditures	1,027,977	1,086,229	2,114,206	1,091,671	1,028,563	2,120,234	1,289,031	1,335,062	2,624,094	880,643
Investigation Expenditures										
1000-Personal Services	362,849	408,727	771,576	467,051	478,976	946,027	519,387	484,948	1,004,335	347,445
2000 - Travel		912	912	-	-	-	-	628	628	339
3023 - Expert Witness	11,765	8,958	20,723	300	6,550	6,850	6,825	5,088	11,913	4,650
3088 - Inter-Agency Legal	80,559	57,504	138,063	96,615	116,487	213,102	146,895	118,553	265,448	34,771
3094 - Inter-Agency Hearing/Mediation	21,250	12,876	34,126	25,107	43,140	68,247	79,682	39,354	119,036	33,197
3000 - Services other		4,488	4,488	3,278	1,280	4,558	3,412	1,967	5,379	2,377
4000 - Commodities		-	-	-	-	-	10	734	744	-
Total Investigation Expenditures	476,423	493,465	969,888	592,351	646,433	1,238,784	756,211	651,272	1,407,483	422,780
Total Direct Expenditures	1,504,400	1,579,694	3,084,094	1,684,022	1,674,996	3,359,018	2,045,242	1,986,334	4,031,577	1,303,423
Indirect Expenditures										
Internal Administrative Costs	585,920	631,655	1,217,575	631,028	635,747	1,266,775	769,027	853,182	1,622,209	639,887
Departmental Costs	314,440	340,968	655,408	256,415	257,726	514,141	298,812	292,596	591,408	219,447
Statewide Costs	119,352	120,554	239,906	167,408	164,903	332,311	180,129	155,228	335,357	116,421
Total Indirect Expenditures	1,019,712	1,093,177	2,112,889	1,054,851	1,058,376	2,113,227	1,247,968	1,301,006	2,548,974	975,755
			-			-				
TOTAL EXPENDITURES	**$ 2,524,112**	**$ 2,672,871**	**$ 5,196,983**	**$ 2,738,873**	**$ 2,733,372**	**$ 5,472,245**	**$ 3,293,210**	**$ 3,287,340**	**$ 6,580,551**	**$ 2,279,178**
Cumulative Surplus (Deficit)										
Beginning Cumulative Surplus (Deficit)	$ 544,515	$ (747,573)		$ 598,612	$ (316,414)		$ 1,627,769	$ 1,593,783		$ 3,896,524
Annual Increase/(Decrease)	(1,292,088)	1,346,185		(915,026)	1,944,183		(33,986)	2,302,741		(1,382,688)
Ending Cumulative Surplus (Deficit)	$ (747,573)	598,612		$ (316,414)	$ 1,627,769		$ 1,593,783	$ 3,896,524		$ 2,513,836
Statistical Information										
Number of Licenses for Indirect calculation	23,970	24,126		23,705	27,695		28,173	32,169		

Additional information:

- *General fund dollars were received in FY21-FY23 to offset increases in personal services and help prevent programs from going into deficit or increase fees.*
- *Most recent fee change: NUA fee increase FY19; NUR fee reduction FY22*
- *Annual license fee analysis will include consideration of other factors such as board and licensee input, potential investigation load, court cases, multiple license and fee types under one program, and program changes per AS 08.01.065.*

Appropriation Name (Ex)	(Multiple Items)
Sub Unit	(Multiple Items)
PL Task Code	(Multiple Items)

Sum of Budgetary Expenditures	**Object Type Name (Ex)**				
Object Name (Ex)	**1000 - Personal Services**	**2000 - Travel**	**3000 - Services**	**4000 - Commodities**	**Grand Total**
1011 - Regular Compensation	536,998.30				536,998.30
1014 - Overtime	6,086.08				6,086.08
1016 - Other Premium Pay	39.65				39.65
1021 - Allowances to Employees	72.00				72.00
1023 - Leave Taken	91,479.49				91,479.49
1028 - Alaska Supplemental Benefit	38,902.13				38,902.13
1029 - Public Employee's Retirement System Defined Benefits	34,838.60				34,838.60
1030 - Public Employee's Retirement System Defined Contribution	25,868.16				25,868.16
1034 - Public Employee's Retirement System Defined Cont Health Reim	17,409.42				17,409.42
1035 - Public Employee's Retiremnt Sys Defined Cont Retiree Medical	4,924.51				4,924.51
1037 - Public Employee's Retiremnt Sys Defined Benefit Unfnd Liab	73,970.15				73,970.15
1040 - Group Health Insurance	166,621.31				166,621.31
1041 - Basic Life and Travel	86.39				86.39
1042 - Worker's Compensation Insurance	4,318.67				4,318.67
1047 - Leave Cash In Employer Charge	14,496.16				14,496.16
1048 - Terminal Leave Employer Charge	10,040.86				10,040.86
1053 - Medicare Tax	8,864.41				8,864.41
1077 - ASEA Legal Trust	714.15				714.15
1079 - ASEA Injury Leave Usage	94.54				94.54
1080 - SU Legal Trst	152.39				152.39
1970 - Personal Services Transfer	(2,420.31)				(2,420.31)
2000 - In-State Employee Airfare		512.80			512.80
2001 - In-State Employee Surface Transportation		64.94			64.94
2002 - In-State Employee Lodging		1,135.68			1,135.68
2003 - In-State Employee Meals and Incidentals		390.00			390.00
2008 - In-State Non-Employee Meals and Incidentals		402.21			402.21
2013 - Out-State Employee Surface Transportation		333.61			333.61
2015 - Out-State Employee Meals and Incidentals		1,157.00			1,157.00
2016 - Out-State Employee Reimbursable Travel Costs		30.00			30.00
2020 - Out-State Non-Employee Meals and Incidentals		1,400.50			1,400.50
2022 - Out-State Non-Employee Non-Taxable Reimbursement		393.25			393.25
2970 - Travel Cost Transfer		(2,470.80)			(2,470.80)
3001 - Test Monitor/Proctor			20,955.00		20,955.00
3023 - Expert Witness			4,650.00		4,650.00
3035 - Long Distance			44.13		44.13
3036 - Local/Equipment Charges			3.43		3.43
3043 - Freight			6.95		6.95
3044 - Courier			356.56		356.56
3045 - Postage			3,239.38		3,239.38
3046 - Advertising			639.78		639.78
3057 - Structure, Infrastructure and Land - Rentals/Leases			1,538.00		1,538.00
3085 - Inter-Agency Mail			3,764.19		3,764.19
3088 - Inter-Agency Legal			74,820.80		74,820.80
3094 - Inter-Agency Hearing/Mediation			33,196.80		33,196.80
3100 - Inter-Agency Safety			117,295.75		117,295.75
3970 - Contractual Transfer			3,810.00		3,810.00
4002 - Business Supplies				853.88	853.88
4005 - Subscriptions				1,342.50	1,342.50
Grand Total	**1,033,557.06**	**3,349.19**	**264,320.77**	**2,196.38**	**1,303,423.40**

Alaska Board of Nursing

Public Comment Period

Alaska Board of Nursing

For the Good of the Order

For the Good of the Order:

- Assign/Review action items.
- Any further topics to cover?
- Agenda ideas for future meetings
- Review and confirm the dates of the next meetings: August 7 & 8 and November 6 & 7.

Alaska Board of Nursing

Chair Final Comments/Adjourn