

## Introduction and Background

Standing orders and protocols are tools used in many settings and allow health care team members the ability to provide effective and timely access to care. According to the Center for Excellence in Primary Care, standing orders and protocols “enable all members of the care team to function to their fullest capacity.” (CEPC, 2013) Standing orders are widely used, particularly in primary care and correctional settings, to allow registered nurses (RN) and other non-prescribing health care professionals the ability to administer medical treatments, vaccines and other medications without a prescription in certain circumstances. (Centers for Disease Control, 2000) (Jill Wilkinson, 2015). Since they are often specific to setting, population or individual, standardized standing orders and protocols are not universally set, although there are expectations that these tools will follow the law.

In 2012, the Oregon State Board of Nursing (OSBN) issued an interpretive statement “to provide guidance for Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) in a practice setting that uses standing orders to facilitate timely interventions and the removal of barriers to care for various patient populations.” (Oregon State Board of Nursing, Initial approval, 2012: Revised 2017) Even with the interpretive statement, OSBN staff received questions about the appropriate use of standing orders and protocols, particularly when their usage appeared to circumvent laws around diagnosing illness and prescribing medication.

Staff reported to the Board of Nursing at the September 2018 meeting a situation where a county health department nurse stated they had prescribed medication to a patient under a prescriber’s name in an electronic health records system for the treatment of tuberculosis. This occurred without a licensed independent provider (LIP) evaluating the patient and diagnosing the disease. The licensee stated this action was taken due to language in the interpretive statement which indicated that standing orders “provide guidance and direction for licensed nurses when carrying out orders in the absence of a Licensed Independent Practitioner (LIP).” (OSBN, 2017) OSBN staff contacted the Board of Pharmacy to discuss the legality of a person generating medication orders under a prescriber’s name. The Board of Pharmacy responded that for a prescription to be written, there must be the establishment of a patient-provider relationship and that prescriptive authority belongs to the individual who is licensed to prescribe and cannot be delegated. (OSBN, 2018) The Board of Nursing directed Board staff to revise the interpretive statement.

During the Executive Director’s report at the November 2018 board meeting, the Board learned that staff continued to receive concerns from nurses regarding organization protocols which might be out of the scope of practice of a nurse to implement. Staff requested permission from the Board to convene a stakeholder workgroup to discuss the issues and, based upon that work, staff could develop a new interpretive statement or draft new administrative rules related to standing orders and protocols. In March 2019, in conjunction with the release of an updated website, the existing interpretive statement was removed from the OSBN website.

OSBN began conducting its stakeholder meetings in December 2018. In April 2019, OSBN staff reported they had received direction from the Governor’s office to continue stakeholder meetings through the spring.

OSBN contacted the Oregon Center for Nursing (OCN) in February 2019 to evaluate data collected during its stakeholder meetings. Specifically, OCN was asked to accomplish three tasks:

1. Analyze rules related to nurses and standing orders/protocols in Oregon’s Administrative Rule;
2. Evaluate feedback provided via OSBN listening sessions and identify key themes/questions/concerns; and
3. Provide a list of next steps/recommendations for the Board’s consideration.

For this project, OCN evaluated data collected at the six stakeholder sessions, interviewed OSBN staff, and reviewed relevant literature.

## Standing Orders and Protocols in Oregon Administrative Rule

The Oregon Nurse Practice Act does not define the term standing orders or the term protocols. According to OSBN staff, usage of both terms vary depending on the type of practice setting, the laws and rules governing the setting, or the services provided in the setting.

The term standing orders is used once in the Nurse Practice Act.

- 851-056-0004(2) APRN Authority to Prescribe and Dispense. *Standing orders, protocols, or written prescriptions may also be given for over-the-counter medications as clinically necessary.*

The term **standing orders** is not used in the practice act in relation to registered nurses, while the term **protocols** is used four times in Chapter 851 Division 45.

- 851-045-0050(8) Standards related to the LPN’s responsibility for leadership and quality of care. The term is used twice in the codification of the LPN’s responsibility to implement *policies, protocols, and guidelines that are pertinent to nursing service delivery*; and to *contribute to development and implementation of policies, protocols, and guidelines that are pertinent to the practice of nursing and to health services delivery.*
- 851-045-0060(8) Standards related to the RN’s responsibility for leadership and quality of care. The term is used twice in the codification of the RN’s responsibility to *interpret and evaluate policies, protocols, and guidelines that are pertinent to nursing practice and to health services delivery*; and to *develop and implement policies, protocols, and guidelines that are pertinent to the practice of nursing and to health services delivery.*

The term **order** is used in the ORS 678.010 definitions such as **practice of nursing**. In this definition, the *execution of medical orders* is deemed to be inclusive of the practice of nursing.

Chapter 851 Division 45 rule number 0040 (5)(a) through (f) contains standards that detail from which Oregon-licensed practitioners a licensed nurse may accept an implement an order. “The nurse is responsible to adhere to these 851-045-0040(5) standards regardless of whether an order is written, embedded within a treatment plan, verbal, incorporated into a care directive, standing, faxed, electronic, embedded in a protocol, or otherwise. The individual licensed nurse is solely responsible to adhere to these standards and is solely accountable for their own decisions and actions.” (Gretchen Koch, 2019)

Other regulatory agencies have administrative rules which reference *standing orders* and registered nurses. For example:

- The Board of Pharmacy gives detailed information on what information should be included in a pharmacist's *standing order* for a designated registered nurse supervisor to follow in ambulatory and residential drug outlets when normal community or hospital pharmacy services are not available (OAR 855-041-6800(3)).
- The Board of Pharmacy also has rules for how nurses dispense medication in designated community health clinics (OAR 855-043-0700). The rules specify dispensing by an RN may only occur pursuant to the order or prescription of a person authorized by their Board to prescribe a drug; or pursuant to the order or prescription established by the Medical Director or clinic practitioner with prescriptive and dispensing authority; and the RN may only dispense a legend or non-prescription drug to a client for the purpose of birth control, caries prevention, the treatment of amenorrhea, the treatment of a communicable disease, hormone deficiencies, urinary tract infections or sexually transmitted diseases.
- Oregon Health Authority (OHA) rules related to behavioral health specify that personal restraint and seclusion cannot be written into a standing order (OAR 309-022-0175).
- OHA provides model standing orders for local public health providers to utilize related to immunization services. The OHA website expressly communicates that the model standing orders published on their website are not in effect unless they have been reviewed and authorized by a medical doctor. (Oregon Health Authority, n.d.)

## OSBN Stakeholder Session Feedback Evaluation

OSBN staff sought feedback from nurses to assist with the Standing Order and Protocol Interpretive Statement revision through six stakeholder sessions around the state. These sessions were as follows:

- Meeting 1: Tualatin – December 20, 2018
- Meeting 2: Springfield – February 20, 2019
- Meeting 3: Tualatin – April 18, 2019
- Meeting 4: Medford – April 26, 2019
- Meeting 5: Bend – May 9, 2019
- Meeting 6: Pendleton – May 14, 2019

More than 100 people attended these stakeholder sessions, and the audience consisted of stakeholders from Federally Qualified Health Clinics (FQHCs), county organizations, public health agencies, health systems, private practitioners, and more. Each session was conducted in a similar format where OSBN staff presented an introduction to the issues surrounding standing orders and protocols, and then asked the audience to share their feedback. Audience members were asked to share how standing orders are being used and what questions or concerns the audience wanted to share with the Board. Staff explained to the audience the purpose of this data collection was to provide information to the Board so the Board could “make a decision regarding the situation, so that we can move forward either by maybe generating a rule ..., beefing up the interpretive statement, or whatever [the Board] decision might be.” (Oregon State Board of Nursing, 2019)

The sessions lasted between 90 – 120 minutes. Meetings 1 and 2 followed a different format than subsequent meetings. For Meetings 1 and 2, after the presentation, session participants were given 4x3 cards with the

instructions to write their questions and concerns for later evaluation. For Meetings 3 – 6, participants received two forms when arriving at the presentation. These forms asked participants to share their practice setting and level of licensure, and provide feedback on the following questions:

- “Identify or describe how you utilize standing orders or protocols in your practice settings;” and*  
*“Record questions or concerns you may have about the use of standing orders and protocols within your nursing practice.”*

OSBN staff made audio recordings of Meetings 2 – 6. Meeting 1 was not recorded. Transcripts of Meetings 2 – 6 can be found in the appendices.

## Main Findings

### How Standing Orders and Protocols Are Utilized

Most of the stakeholder session participants represented community health or corrections settings, with some representation from acute care settings. Participants reported a variety of ways standing orders are used including:

- Reproductive health care (birth control, emergency contraception, STD/STI treatment, pregnancy tests, PAP screening and pelvic exams),
- Providing immunizations and vaccinations,
- Prevention of illness (colonoscopy treatment, DEXA screening (osteoporosis), cancer navigation, case management),
- Treatment of illness (urinary tract infections, strep testing and treatment, tuberculosis testing/treatment/management, headache, ear pain); and
- Management of illness (diabetes medication, administration of anticoagulation/warfarin, OTC medications).

Participants described a variety of sources of standing orders. Some said they received standing orders from the OHA, particularly in the case of immunizations, signed by the local health officer. In the case of correctional settings, medical directors write protocols for common health problems for an inmate population, and standing orders are used for vaccinations. Public health settings reported standing orders are written to require the RN to “check in with every prescription.” (Oregon Center for Nursing, 2019)

### Lack of Clarity

There is a high degree of misunderstanding and lack of clarity about standing orders and protocols among those who participated in the stakeholder sessions. During the sessions, the audience often focused on specific situations where standing orders were being used. In almost all cases, the answers to these case questions were nuanced and complex, and either needed to incorporate specific details or did not have a clear answer. For example, in Meeting 6, OSBN staff began the meeting with an anecdote about a fictional patient in the correctional system presenting with ear pain. In the example, the patient was treated with an antibiotic as described in a standing order and the LIP was notified after the fact. Staff stated this situation would not be appropriate as the LIP would need to be notified of the antibiotic prescription first. However, later in the meeting, when an audience member asked about a fictional patient who presented with symptoms of a sexually transmitted infection (STI), tested for an STI, and was treated

based on protocols and criteria, staff stated they did not know the appropriateness of that action. (Meeting 6 - Standing Order and Protocols Public Stakeholder Session , 2019)

Some participants commented they did not understand the definitions of standing orders and protocols, and other questioned if the words “standing orders” and “protocols” were being used interchangeably as part of the conversation.

Many comments expressed the need for more guidance about how standing orders and protocols can be used. One participant wrote, “If protocols and standing orders are written according to evidence based practice, reviewed/ authored by a committee, signed by a medical director or chief medical officer, followed by staff nurses then the patient followed up by a LIP, where is this violating the use of protocols or standing orders?” Another said, “I am scared to do my job as an RN because when I ask no one has answers about boundaries/standing orders.” Another participant commented “If there was a template or clear criteria of what a standing order or protocol was to include, and time parameters of when or if follow up by a licensed independent practitioner is required would be helpful by the OSBN.” (Oregon Center for Nursing, 2019)

Participants had many questions about the differences between assessing vs. diagnosing, dispensing vs. prescribing, individual vs. population health standing orders, as well as standing orders for a patient who has been seen LIP for a certain condition vs. a new patient who has not been previously seen by an LIP. Session participants, it seems, used standing orders and protocols to help guide them on answering these questions if they felt uncertain about how best to pursue action.

Some participants expressed concern about being liable for discipline or losing their license. An APRN in attendance said they were concerned about the “use of my license/DEA to prescribe/administer medications on my behalf without my knowledge.” Another said, “Is it not irresponsible to have medical officers that are absent from the clinics and simply signature providers?” (Oregon Center for Nursing, 2019)

Probably the greatest concern for the participants is inability to provide timely patient care. One participant noted, “When patient meets specific criteria and has no confusing deviations from the protocol, why is it necessary to make the patient wait while the RN presents patient to provider?” (Oregon Center for Nursing, 2019) Participants also feared major rule changes or restrictions to using standing orders would adversely impact their ability to treat patients. One participant commented, “With the lack of licensed independent practitioners directly available 24/7 in a correctional setting, there are dramatically increased concerns about nurses not having protocols to use.” (Oregon Center for Nursing, 2019)

# Oregon Center for Nursing Recommendations

Based on reviewing the available evidence, the following recommendations are presented to OSBN:

## **1. Release a Revised Interpretive Statement**

This type of statement is not, and should not, bind the public to rules outside the Nurse Practice Act, and could provide the clarity RNs need to move forward with their practice. The revised statement should include clear definitions of standing orders and protocols, including what elements should be contained within an order, and examples of correct application.

According to the Administrative Conference of the United States, a best practice of creating policy statements is providing for public participation. (Administrative Conference of the United States, 2017) If the Board chooses to create a new interpretive statement, in addition to including public stakeholders, such as representatives from primary care, public health and community health, other regulatory agencies such as the Board of Pharmacy, OHA and Oregon Department of Human Services (DHS) should be included as well.

Because of the fears expressed by stakeholder session participants and other RNs, providing a statement clarifying the use of standing orders and protocols should be implemented as soon as possible. A collaborative approach will increase the amount of time needed to implement a new statement, in which case constituents need clear communication of the process the Board is pursuing in issuing a revised statement with regular updates of progress.

## **2. Collaborate with Other Licensing/Regulatory Boards**

This evaluation encompassed analysis of where standing orders in the Oregon Administrative Rules which address OSBN licensee interactions with standing orders and protocols. Since interpretation of ORS/OARs are highly nuanced, a cross-examination with collaboration from other regulatory boards, such as the Board of Pharmacy, OHA, and DHS would better clarify nurses' overall responsibility in executing standing orders.

## **3. Convene a Special Session for Community Health**

RNs who practice in community health settings are impacted by administrative rules implemented by multiple Boards and regulatory agencies. Convened by the Board of Nursing, this meeting could include perspectives from the Board of Pharmacy and OHA to share the various requirements in rules related to standing orders. The targeted audience could be public health officers, managers, LIPs, corrections RNs, and school nurses.

## **4. Provide Educational Opportunities**

Educational offerings for nurses who regularly work under standing orders and protocols would help diffuse the confusion Oregon RNs are currently facing. These educational opportunities should be provided on an ongoing basis, with attention paid when agencies change rules regarding standing orders and protocols that RNs need to implement.

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## 2.20 OSBN Community Meeting

**Gretchen:** (Begins mid-sentence)... kind of a policy analyst at the Board of Nursing, and Board staff. Also here is Ruby Jason, our Executive Director, Board staff. Peggy Lightfoot, she is Administrative Assistant to Ruby. And Nancy [inaudible 00:00:15], our Education Policy Analyst Coordinator. We also have a Board member with us today. That's Annette Cole. There she is, toward the back. She is the Chief Nursing Officer with Sky Lakes in Klamath Falls. She is a Nurse Administrator [inaudible 00:00:28] the Board, as a Board member.

With that, the purpose of today's meeting is to collect input on the topic of standing orders and protocols. Ruby is going to be providing a presentation, to give construct to this discussion, and to address the concerns that have come up [inaudible 00:00:45] these stakeholder meetings.

When you came in, you noticed there are some 4x3 cards on the table. We encourage you to record and memorialize your thoughts, your concerns, your questions, any issues that you face or things you want resolved, regarding standing orders and protocols. This is how we can actually capture and take the information back, because we can hear and we can make notes.

Actually, Peggy Lightfoot is going to recording today's session, so that we can make sure we get everything verbatim. But the more we memorialize and have hard copy, that's great. So, please take advantage. At our last meeting, we had people fill out anywhere from one to seven. The more the merrier; we've got lots of card.

With that, we're going to be providing a PowerPoint. There will be plenty of time at the end, for discussion. If issues or questions come up, Ruby or myself will vet if it's a good time to discuss it, or we can parking lot it, to make sure we address it at the end. At that point in time, we'll have all of the information of the presentation at hand.

I do believe we're good to go. So, I'm going to [inaudible 00:01:53] that off to Ruby.

**Ruby:** Thank you, Gretchen. Good morning, everybody. Thank you for making the drive up here, down here, wherever you came from.

The Board, the way this all started was the Board received several concerns from nurses who said "My organization has put together this protocol. I'm not sure if that's in my scope of [inaudible 00:02:12]." Gretchen and I and Nancy are some of the team that answers all of the practice questions, and we thought "This doesn't really sound right."

So, we sent out the answer, saying that first of all, physicians can't delegate the practice of medicine to nursing. You can't leave a blank script laying around with a physician's signature, for somebody else to fill out; all of that stuff. Then, we received quite a bit of concern about "But wait a minute. Our public health department, our corrections, our schools, all of these departments have already developed these protocols," and that there was no plan B for the patient. So, if the Board said "Look, this is an issue for us," then what's going to happen to the patient?

I want to talk a little bit about outlining for you what the concerns are. All of you have the opportunity – I think we have enough to take home the slides at the end of this. The reason I don't hand out slides is because people have a tendency to read the slides first, and then not listen to the context where it needs to be put. But you will get copies of all of the slides.



In addition, for those individuals who have not been able to come, what we're going to do is all of the slides are going to be on our website a few days after this meeting ends.

Now, while I have not yet discussed this with the Board, I did discuss this with our Board representative, Annette back there. There was input from the Governor's office that made the request, and again, I have not yet discussed this with the Board, simply because we cancelled the February Board meeting, because of the weather.

It was like, it was going to snow. We had everything from snow-mageddon and rain, and we ended up cancelling the February Board meeting. The request from the Governor's office was that we not follow the Board's original timeline, which meant that we were going to report out to the Board in April, what we found in these stakeholder meetings, and that then, the Board would determine what the next steps were going to be.

There was a request from the Governor's office to continue these throughout the spring, including going to Pendleton and southern Oregon, and getting a really good picture of what all of this is. Then, we would then report off to the Board, probably sometime in June. I apologize to those of you who came from southern Oregon and made the trip. This was supposed to be the one remaining stakeholder group meeting, and we did not know that we would continue.

But you know, there are people that were here at our last one. You too, could do this twice. [inaudible 00:04:38]

Alright, so let's take a look here at what we've got. Let's do a situation outline about what this issue is all about.

First of all, we want to make sure that the Board, that it's clearly understood that the Board has no jurisdiction over an organization implementing any protocol or standing order. No jurisdiction at all. We cannot say "Your protocol is not legal." That's out of our range.

Organizations can do whatever they want to do. We have no jurisdiction over that. However, the Board not only is committed to making sure that public safety is met, but that our nurses that we license are also protected, that they are not found out at the last minute one day, they implement these protocols and procedures, or anything else [inaudible 00:05:35] nursing in good faith, because their employer asked them to. And then, they find themselves on the other end of a disciplinary hearing by the Board, because you practiced out of scope.

So, this is what we're here to do. [inaudible 00:05:47].

Like I said, the Board wants to make sure that we aren't [inaudible 00:05:52] nurses, and making them choose between their employer and the Practice Ace. There has been some discussion about whether or not the Board actually has the jurisdictional authority to tell nurses what they can and cannot do. I need to tell you, yes they can. They have been given that legislative authority. I think that's pretty obvious.

There was also some discussion about how other states let nurses do this, why not Oregon? Well, there may be some organizations in other states that have [inaudible 00:06:17] protocols. But I'm here to tell you they have done that without the knowledge of their Board of Nursing. Because I did put out a query to the 59 licensing Boards in this country, including Northern Area Islands, Samoa, the United States

Virgin Islands – which is a great place to work, by the way, except the only Executive Director of a Board of Nursing [inaudible 00:06:44] Virgin Islands. How fun is that? Certainly better weather than here!

They all said that either they hadn't thought about it, they hadn't realized it's out there, or the answer is no. I specifically asked my counterpart in Washington, and she said "Absolutely not. The provider must see the patient first, and say this person is ready for a protocol."

We're getting a little ahead of ourselves. I just wanted – there are some people here from the last meeting, who said "Other states allow us to do it." The answer is "Well, if they are, those organizations did not discuss it with their Board of Nursing."

But the Oregon Board of Nursing, a lot of those Boards said to me "Please let us know what you are thinking, and what happens eventually with this, because we would like to emulate [inaudible 00:07:29]" So, Oregon right now, I think, is leading the way in making sure that our nurses aren't having to choose between their employer and the Practice Act.

With that, the thing is, though, that we do – and we're not directing any organization to change any process or determining that the protocol or standing order is not legal. We can't do that. We can't do that. The organization can say "Listen. I don't care what that Board of yours says. We're going to keep doing it." No jurisdiction at all over that.

But we do have jurisdiction over nurses who either develop or implement protocols which may be outside of their scope of practice, as per the license type held by them. I'm an RN. I am an RN. I am not an advanced practice nurse. Dr. [inaudible 00:08:18] over there is an advanced practice nurse. I am not. Her practice is much different than mine.

My practice does not allow me to make independent diagnoses and independent prescriptions. However, let's just say your organization says "Listen. We don't have a provider here. Let's just go ahead and implement a protocol where the protocol, basically, the patient comes in with X, Y and Z. Nurse, you're going to diagnose it as this. And then, from this list over here of options, you're going to decide what medications this patient is going to go on."

That is where the darkness happens. That's where the gray happens. In fact, it's not within the fact that the provider is not around when you're doing that. That diagnosis and that particular medication treatment is in lieu of input by a provider, for that particular patient.

Now, if it's something the patient has come in with for a long time, that's just continuing plan of care. But if it's a brand new diagnosis, brand new symptoms that the provider has never seen; so, let's just say you decide to do that. Okay? Because you know, [inaudible 00:09:26].

Let's say a patient comes to us and says "You know, I went to ABC Clinic, and Nurse Haley said that I have this, and that I needed this prescription. But I had this really horrible breakout. I had never really been on that medication before, so it wasn't on my allergy list, but it was a huge breakout, and I ended up in the ER and getting epinephrine." So, they're saying Nurse Haley doesn't know what she's doing.

So, we decide to investigate Nurse Haley over here. The investigator says "Well, Nurse Haley was following this protocol." Well, Nurse Haley was following a protocol that allowed her to practice outside of the scope of an RN [inaudible 00:10:16]. Then, is she or is she not in violation of the Practice Act?. A lot of nurses say no, because the physician told her to.

The answer is yeah, no. Physicians do not have authority over the licensing of nurses, nor to expand the scope.

But Haley's organization did this with good intent. There isn't a provider there all of the time. How is that patient going to get care, if there's not a provider there all of that time? So, the intent and the law sometimes are clashing. That's what we're doing here today, trying to find information so that we have a nice happy medium to protect you, if you're a nurse, and to also make sure the patient gets care, and everybody is staying within the lines of the law.

Right now, if Haley went in front of our Board, our Board would probably say "You're going down!" Especially if there was patient harm associated with what she did. Okay? That's kind of where we are.

Now, this is the big important piece here. Physicians, by law, do not have the authority to expand the scope of practice of any nurse, because the nurse is beholden to the Board of Nursing, for their license. They cannot delegate to a nurse any practice authorized only to independent licensed practitioners.

So, the physician can't say to you "I'm going to write a protocol that's going to allow you to diagnose off of this picklist. You assess the patient. You diagnose this brand new diagnosis, off of this picklist. You decide what medications they're going to go on. And maybe in a day or two or three or four, or five weeks or whatever, I'll look at that chart and sign off on that chart."

They do not have the authority to sign off on your decision. Only the nurse, because your license stands by itself. Only the RN has the legal responsibility to make their own decisions and intervene with a patient on their own critical decision-making process, not something that was written on a piece of paper by someone who is not authorized to do that.

The other thing, too, is we have consulted with the Board of Medicine and the Board of Pharmacy. While this is a nursing issue – it's not a Board of Pharmacy issue, it's not a Board of [\[Medicine – speaker mis-spoke here 00:12:44\]](#) issue. But I wanted to know what they were thinking. This statement actually came from the Board of Medicine.

The Board of Pharmacy, it's against the rules of the Board of Pharmacy to leave prescription pads laying around, with the signature from the provider, so that somebody can come in and fill it in later. It's illegal. They can't pre-sign blank prescription pads.

Well, answering a prescribing order for a physician that never even saw the patient, same thing. It's the electronic version of that.

So, some of the protocols reviewed appear to be an electronic version of this [\[inaudible 00:13:20\]](#). It's like when you can call in a prescription, where the patient has never even seen a provider for that, that's the same thing as leaving around a blank prescription pad, with the physician's signature, or the provider's signature on it.

What is the purpose of what we're doing here today? What we're doing here today is first of all, the Board is seeking information regarding the types of protocols being used in the community. I've been a nurse for 30-some odd years. I was an ER nurse. I was a neonatal intensive care nurse. I worked under protocols and standing orders my entire career.

But the difference between the protocols that I did and the protocols that we are concerned about, all of the protocols that I did in those environments, there was a physician partner right next to me, who was saying “Yes. We’re going to do this.”

I mean, I started – an ER person came in with something, I collected a rainbow, I sent them off for a chest x-ray, because I had the protocol to do that. Then, that would be reviewed by a provider within [inaudible 00:14:19]. All of that was done way ahead of time.

And standing orders, standing orders, same way, same thing.

What the Board is concerned about is the different type of protocols being used. The Board can get a really good picture of what’s actually happening out there. How intensive are these protocols actually, and where are they used? Is community health really the major place where they’re being used? Is our schools?

Our school nurses, I mean, there’s not even a school nurse in every school. Right? School nurses? Anybody a school nurse out there?

**Audience Member:** Yeah.

**Ruby:** Bless you. I don’t have any clue [inaudible 00:14:55]. But you are now giving epinephrine and all kinds of other things to people who are unlicensed, under your delegation protocol.

[inaudible 00:15:07]

**Ruby:** Teachers, sorry. Thank you, Gretchen. Gretchen is our author of our delegation chapter of the Practice Act. But still, bless you. [inaudible 00:15:21]

The point is that there’s nobody around. There’s not even a nurse around. They are teaching an individual to do something to children who are having this, but that’s just how it works, because school districts, right or wrong, can’t afford a nurse in every single campus. In my day, she wore the white cap and had a cape, in my day, my elementary school, long ago.

The point is that these things are out there. They were done because of good faith. They were also done because there was a need. But very rarely, and this is not just for this issue, very rarely do we find anyone first consulting the Practice Act, before they do.

Part of that is because of the way the Practice Act is written. How many of you have tried to read the Practice Act? It’s kind of – does it make any sense? I just want to let you know – this is an aside – we are embarking on a project where, in fact, the entire Practice Act is going to be eventually re-written, at least the rules part, that the Board has control over. It’s going to be in English.

There will not be the this and the that and the thou and all of that, and contextual, and whatever. All of that language that none of us really can understand and appreciate. Because this is kind of how we got here. The Board had a big part in how we got here today. The Board actually contributed to this issue by putting up on our website a very vague interpretive statement that talked about protocols and standing orders.

It talked about the fact that these can be done in the absence of a physician. So, that phrase right there, “in the absence of a physician,” because it was so vague, and not written in English, individuals who read that, in good faith, said “Oh! A physician doesn’t have to be there.”

In reviewing some of the Board information from that time – that had been up there since 2012, way before my time – the intent there was that it wasn’t in lieu of a physician. It was where the physician was not right there, like ER protocols and those types of things.

So, the Board actually contributed to this problem by writing a very vague statement. It allowed individual interpretation, to fit the desired scenario. No one in this room went out and said “[inaudible 00:17:56]. Since that’s what the Board thinks, I’m going to do what I want to do.” [inaudible 00:18:00] that interpretive statement. They said “This is what we think it means.”

Because it was written very vaguely, yeah, so now here we are. We have an issue that the Board is very concerned about. The Board has asked us, staff, when I brought this up to the Board, because Gretchen and I had answered so many of those questions, and we had gotten such feedback from individuals, Gretchen and I took this to the Board. The Board said “You need to go out, get more information on this topic. We also think this might be an issue, but we don’t know yet.”

And we certainly are not in a position to say to Public Health “Oh, no. You can’t do that. Guess what? Your patients are left in the lurch.” We can’t [inaudible 00:18:44] that the organization can or cannot use this protocol or standing order, because we have no authority. We’re trying to protect our nurses. You, in good faith, have implemented something, and now you’re going to find yourself on the other end of a Board investigation, which is not fair. It’s not right. It’s not right for you, and it’s certainly not right for the public.

Alright, so that’s our purpose. Does anybody have any questions, so far?

**Audience Member:** In its purpose, the major piece of feedback that it seems like you’re trying to receive is the types of protocols. If you were going to expand on this purpose for this stakeholder meeting, what additional information, besides just the types of protocols, would be helpful?

**Ruby:** What would happen if the Board said to you “Your protocol is not within what the Board feels is the scope of practice of nursing.”? What would happen to your patient population? What would happen to your organization?

Now any of you, I sent the invitation at the last meeting, and several people did take advantage of that. We said “Send us your protocols, and we’ll review them.” Because not all of these protocols fit into that particular. And you’ll see an example of a protocol that the Board felt was appropriate for the scope of practice of an RN, and a protocol that was not. They maybe answered a little bit of your question.

But our purpose here is not to collect your protocols. Our purpose here is to give you the context of the thinking you need to do, and say “Okay, if we have one of these protocols, what would happen to our patient population if we didn’t have this?” Are there any plan Bs out there? Because in the end, like I said, and I can’t stress this enough – at the end of the day, there are two purposes.

First and foremost, to get the patient the care they need, the child the care they need, all of that. Right? Secondly, it’s to protect you, to make sure that the Board gives guidance to organizations that are

developing protocols and standing orders, about how you can balance patient care and the scope of practice of RNs. That's really what we are here to do.

So, just think about that. Gretchen is going to give some more information, in a little bit. When the slide shows up, Gretchen will get up here, and maybe that will give you some context about thinking about "Hey, we developed these protocols. Maybe if I send the Board the protocol, they can give me more feedback."

We are absolutely willing to do that. Again, DOC sent us some protocols. Anybody here from DOC? You sent some protocols to me, and they're fine. They're fine. And there's no provider there. What it just says is it guides the nurse. It says if you get called for this, this is what you're going to be doing. There's no diagnosing in that. It's just reacting to the individual's symptoms.

**Audience Member:** It's our emergency ones that were okay. It's our assessment ones that we have to go back and work on.

**Ruby:** That's what this is about, is about asking the questions, and seeing what kind. Because again, the Board does not want to impact your ability, and the Board recognizes the reality. Come on, sometimes there just aren't any providers. There isn't enough money for them. There isn't enough people in the pot, that want to do this thing that [inaudible 00:22:13] doing. So now, what are we going to do? How do we keep the nurse within the confines of their education and their license type?

I've been a nurse for a very long time. Some of you in this room [inaudible 00:22:26]. We get it. We know what to do. I could see an ectopic pregnancy coming in through the door. I knew that. But I also knew that I did not go back to school and get the education or the national certification, or the licensure that allowed me to do that independently.

I'm an RN, and these were the boundaries on my license. I wanted to go ahead and say "Oh, yeah. That's an ectopic pregnancy. Let's get her over to the OR, call the OB, do all that." I'd have gone back to school, and done something different. Regardless of how smart we are, we are still bound by the license type that we have.

That's really the quandary the Board is looking at. Taking individuals who are absolutely smart enough to do this stuff, but legally, legally, can you do this? And it is the Board, and only the Board of Nursing, who has been given the legislative authority to supervise the practice of nursing in this state, and to also decide what the scope of practice is of nurses in the state, how they define it.

So, that's kind of where there's some conflict. Not conflict; areas of grayness.

Okay, so the Board needs this information. First of all, we need this information to review if certain standing orders and protocols expand the scope of a nurse, by allowing diagnosing and the calling in of new prescriptions. Really, these two things are the major issue; independent diagnosing for a diagnosis that the patient did not previously have during their encounter with the LIP, and prescribing a brand new medication that the patient has never been on, as prescribed by an LIP. That's really where we are.

So, are these protocols out there? Where do they live? And these protocols, we're going to divide them into buckets. This is hospital-based clinic, this would be independent clinic, this would be public health, this would be schools. This would be whatever buckets we find. We're going to put the concerns in there, and make sure that the Board gets that information.

To discuss over-the-counter meds. Here's the thing about over-the-counter meds.

[Background conversation, unrelated 00:24:44.]

**Ruby:** To discuss OTCs. So, here's the thing about OTCs. Let's just say the patient comes in and says – you're working in a public health clinic or someplace where OTCs are pretty common. You work on a nurse advice line, you work at whatever, and an OTC medication such as acetaminophen or over-the-counter Benadryl, or whatever over-the-counter. Can the nurse say "Okay, it sounds like you've got a headache. Here's some acetaminophen for you."

Alright? Headache diagnosis. Giving acetaminophen for a headache is a prescribing treatment. But really, OTCs? This becomes a little bit of a gray area, too. Because there is nothing in pharmacy discussion or in the Practice Act, that actually discusses OTCs. I will tell you – how many questions do we get on OTCs?

**Gretchen:** Hundreds.

**Ruby:** Hundreds of questions about OTCs. And right now, we're basing our answers on what has been previously done. But Gretchen and I both agree that that is such a waste of our time, in terms of what do we do about OTCs? And is it all OTCs? What about summer camp nurses? What about that? What about school nurses? What about that?

How many OTCs do you teach people how to give? OTC medications, administration for symptoms or diagnosis, this is one of the submissions that people gave us, from the last group, was that perhaps we should stay away from diagnoses, and say dysuria, instead of UTI. Dysuria is a symptom, not a diagnosis, and we do have protocols regarding symptoms, not diagnoses.

So, that's part of the information that came from the last group, and it's like "Oh, that sounds pretty good. Let's throw that in and see." So, the question for you all is, if you change a diagnosis- now, some protocols talk about tuberculosis. You know, there might or not be any symptoms of TB. If you had a positive acid-fast bacilli culture, and that assumed you had [inaudible 00:27:16] clinic, when I was in the Army during Vietnam – that long ago.

We used to have guys who had TB in the elbow. And it's like "Alright, they're coughing there. What is the symptom there?" "My elbow hurts." "Okay, I think you have TB."

But this is the kind of stuff that we want generated from these groups. How can we all, as nurses, work together to do this? Not just keep fighting the Board, saying "No, you're wrong, and we're right. What authority do you have?" We even had one comment last time about "What authority does the Board have, to get in the middle of a relationship between doctors and nurses?"

Well, the doctors can tell the nurses what to do. What authority does the Board have over them? Well, the answer is, the doctors can't tell you what to do. You have your license. You always stand on your own. They can't tell you. They can ask you to assist in their treatment plan for the patient, that they developed based on their authority as an LIP. But they can't tell you "You have to do this." "No, I don't. Not if I don't think it's in the best interest of the patient."

That's part of the Practice Act, by the way. Did I say that very clearly? If you get an order from an LIP to institute some kind of care, and it's not within the existing treatment plan of the patient, or you don't

think it's in the best interest of the patient, the answer is no. Physicians do not dictate the practice of nursing. Nursing dictates the practice of nursing.

The last thing is to determine if rule-making or interpretive statement is the best way to clarify. Let me tell you the difference between an interpretive statement and rule-making. First of all, an interpretive statement is not, not part of the Practice Act. It is not considered law. It is how the Board thinks – and remember, the Board changes every two, three years. It has turnover.

The Board in 2012, none of those people are still on the Board of today. So, these interpretive statements can be – the current Board might say “I don't think that's right. We, the members of the Board, don't interpret it that way.” Because interpretive statements only serve one purpose. It's to clarify how the Board would say “This is how we're going to interpret the Practice Act, if your case ever comes in front of us.”

We have things like can an RN do a medical screening exam for [inaudible 00:29:45]? Can a nurse be a sexual assault nurse examiner, which is a lot of independence there. What's the issue with transport teams going to other states and taking care, taking patients to other states or bringing them back?

That's what interpretive statements are. But your license can never be held accountable for violating an interpretive statement. It's just a fact. “This is what the Board thinks.”

But a rule is different. A rule cannot be changed by just the interpretation of a sitting Board. A rule is the law. So, your Practice Act is made up of two things. One is statute, which is legislatively authorized by those people up in Salem. They say “We give the Board this authority. We give the Board the authority to charge you for your license. We give the Board the authority to determine scope of practice.” And they are the final.

No matter what you think is right or wrong, the legislators are the final decision-makers about the Practice Act, simply because you are not a nurse – this rankles a lot of people when I say this, but unfortunately, this is the law – you are not a nurse, you cannot call yourself a nurse, until the state licenses you to be one.

So, if I were to decide to cash in my license, and I'm done, I could say “I used to be a nurse.” But I cannot say “I am a nurse.” A lot of retired nurses find this a bit difficult to understand, because they say “I'm a nurse. I've been a nurse for 40 years.” No. You have been a nurse because the state authorized you to be a nurse. Nurse is a legal title. It is a protected title.

MAs can't call themselves nurses. So, if you know any MAs in your clinic that call themselves “Oh, I'm Dr. so-and-so's nurse,” that is illegal, and it is subject to civil penalty by the Board. We protect our titles. We are nurses. MAs are not nurses.

There's a new wave coming in the country about veterinary nurses. There's legislative requests in many states, that say “I am a veterinary nurse.” That has not come up in Oregon yet. Hopefully it won't, but whatever.

So, rule-making. The Board has decisions to make. Clearly, the Board has to have some kind of an action. They can say “You know, Ruby. Just write a better interpretive statement about this,” versus “No. We know now what happened, because the Board that approved this interpretive statement is no longer a sitting Board.” But the law is the law. So, is it better to have rule-making regarding this, which will



require more stakeholder input and a public hearing? Then, if the Board approves all of that, it becomes the law. It becomes part of the Practice Act.

Gretchen over here is the author of our Delegation Division, in the Practice Act. We have a whole Division in the Practice Act, just to the act of community delegation. Remember, you don't delegate to CNAs. I'll tell you why in a bit. You don't delegate to CNAs. You assign and you supervise them, but you don't delegate, unless you're in a community care setting.

**Audience Member:** And they're under the title of assistive personnel?

**Ruby:** Under the title of assistive personnel, right. So, a whole Division, because it was such a confusing thing, not that the Division solved that problem, because it's still continuing today, but the Board said "We're going to write this rule. It cannot be changed by any other Board, unless we go through the whole rule-making process."

And quite frankly, the Board does not like the whole rule-making process, because that's actually changing the Practice Act. They'd really rather have it handled different. But is this important enough to have this issue?

Gretchen, statutory language?

**Gretchen:** Oh, okay. I'll start with my piece, and then you can finish up with -.

**Ruby:** Yeah. Start with your piece, and then [inaudible 00:33:37].

**Gretchen:** Just a little basis. As you're looking at the protocols and standing orders that you have [inaudible 00:33:42]. What I'm going to speak to is the statutory authority provided to the RN-LPN level licensure, for the authority to accept and implement orders. And that is what the authority is, for a licensure-level RN-LPN.

It starts in the definition of the practice of nursing, in the 678 statute. It says that the practice of nursing includes accepting and implementing orders or executing medical orders. Now, that's further interpreted in Division 45 of our Practice Act, the rule piece of the Practice Act, and it applies to the RN and LPN.

Ruby had alluded to it a little earlier. For any order that you are presented with, you have legal responsibilities or standards, actions and behaviors that you must demonstrate, to promote patient safety. That is to make sure that the person authorizing or prescribing is authorized by the state of Oregon to independently diagnosis and treat.

45 has a long list of practitioners who meet that definition. You have to know that what is prescribed is within that practitioner's scope of practice to prescribe, because you could have some rogue practitioner that's prescribing something that's not within their legal authority, per their licensing Board. As an RN, you have a responsibility to know that, because you have to keep your patient safe.

You have to make sure that what is prescribed is consistent with that LIP, licensed independent practitioner, that provider's plan of care for the patient. Is it consistent? Does it make sense? Then, you have to know that that order, whatever it is; pharmaco-kinetically, therapeutically, is safe and appropriate for your client; the right dosage, the right route. "Is it consistent and safe to give my client or patient?"

Then, at that point, if you determine that it is safe, you can accept that order. Then, you go to implementation.

But all of these things, from Tylenol to propofol, come into play, when you are presented with a licensed independent prescriber's order for a patient to whom you have a duty of care to keep safe. So, that is what buttresses the discussion around standing orders and protocols. It is an order, no matter what size, shape, flavor it comes in; electronic, verbal, written. It could be on a cocktail napkin.

When you are faced with that, as a licensee, you have a duty of care to keep your patient safe, and that your actions and behaviors on patient safety.

**Ruby:** Gretchen is my practice practice guru-ette. I am more the legal person. So, when you have -the question here for us is, is an order or a protocol given by an LIP, valid, if the LIP has never seen the patient for that particular issue? They've never seen the patient for those particular symptoms. The symptoms are not in their plan of care that was developed the first time the provider ever even saw that patient. Is that legal?

Now, let me tell you what the regulatory, what the statute says about what is the scope of practice of a registered nurse. The scope of practice of a registered nurse is, quite frankly, take all of the information, all of the information that you gather from your comprehensive assessment. And the comprehensive assessment, of course, as you know, is not just [inaudible 00:36:49]. It's all of that holistic stuff.

And then developing a plan of care, and making sure the care is being implemented. And that, ladies and gentlemen, is where the practice of nursing has its specialization. It's the nursing plan of care for that patient. Not the physician's plan of care. That's just a little bit of it. We help our physician partners and our LIP partners establish their plan of care.

But the nurse must develop the nursing plan of care. So, where does that jive with what we're doing today? What we're doing today is we're saying "Alright, if that's the plan, if that's the legal practice of nursing, and if the nurse is authorized to incorporate provider orders into their plan of care, making sure of all that Gretchen said, do standing orders and protocols actually allow a nurse to do something, based on a provider's order, when that provider has never seen that patient?"

I'm going to keep harping on that particular issue, because that's what the Board was concerned about. The other thing is the definition of a protocol is this; that a provider has seen the patient and has deemed the patient to be appropriate for implementation of that protocol. Somewhere down the line, a provider says "Yes, this was the right patient to put in the protocol."

Now, if that provider has never seen that patient, how can they then determine that that patient will meet the protocol? Can they do that on a preprinted order set? Can they delegate that determination, whether the patient fits the protocol, based upon a picklist to a nurse? Can they do that? That's really the question.

**Audience Member:** Could I just clarify what you just said? Is the word protocol then defined in the Nurse's Practice Act?

**Ruby:** No, it is not. No, it is not. The word protocol is not defined in the Practice Act, which is one thing that the Board needs information on. What is it that you consider a protocol? Because it's not. However, when you look at literature, when you look at the evidence-based literature, the definition of protocol in

peer review journals, is this; that the LIP, the nurse practitioner or whoever, the LIP authorized by the state in which they practice, to diagnose and treat, that they determine that the patient fits the protocol, and then orders that patient onto, that specific patient onto a protocol.

The concern the Board has is that some of these protocols talk about a whole patient population, a whole bunch of patients, saying that any patient who presents with this, follow this pathway, based on your judgement as a nurse and the picklist. And then, call in the prescription. That's really where the gray area happens. That's really what we're trying to find out.

Because you're right. The word protocol is not defined in the Practice Act. But maybe it needs to be. It needs to be, so that it satisfies what it is you are trying to do for your patients, and that the Board can protect you from practicing outside of your scope.

Regardless of what anybody may think, oh yeah, it's the Board that determines the practice scope. If the Board says "This is not in your scope," then ladies and gentlemen, it's not, no matter what you might think. This is very clear.

I was just down in Salem, and I actually asked one of the Senators who is very involved with nursing, is does the Board have final say-so about what's in the scope? Basically, he said to me "Well, Ruby, it's in statute." I said "Yes, I know that. But I just need the answer to the question." And he said "Yes. The Board has been given legislative authority to determine what the scope of practice is for a nurse."

So, if the Board says it's not okay, then it's not. Not in Oregon, anyway.

Alright, so here we go.

An RN's diagnosing authority is limited to the human response. That's really the difference between us and LIPs. We have the ability to talk about human responses to the illness. I'll give you an example that I usually use, a real patient that I was unfamiliar with, the mother of several kids, in their 30s, with a terminal diagnosis.

Now, when the nurse does the assessment, the comprehensive assessment, and interviews the patient, the patient says "Listen. I don't care what happens to me. I want to know my kids are [inaudible 00:41:19] once I'm gone, because I know I'm terminal."

So, the nurse's plan of care should address the patient's priorities that say "This patient's response to this is not about them. Its about how she is going to deal with her children. So, we're going to call in these resources and this resource, have a family conference with a social worker, etc., etc." That's the plan of care that the nurse has, and it's based on the patient's response.

The nurse does not have legal authority to treat independently, the condition or the injury that the patient has presented with. The independent scope of practice of nursing is authorized in the Practice Act, and further delineated in Division 45. A lot of you will say "[inaudible 00:42:00] scope of practice. We don't have one." Oh, yes you do.

You do not need an order to teach a patient or the family. You do not need an order to counsel a patient about what's happening with them. You don't need an order for any of that. That is the purview of nursing. And for those people who say "Well, I can't do that, because the doctor hasn't told me that the

patient is okay to be taught,” we get those, a lot of those. Because people do not understand what the real practice of nursing is.

The independent scope of nursing, nothing in the Practice Act, nothing in the Practice Act, do you need that provider’s order for.

Then furthermore, this particular statute, ORS, which is legislatively, allows the Board to write rule regarding advanced practice nursing and diagnosing authority. This is what it says; only advanced practice nursing has the ability to do diagnosing. And this is how they define it.

“Diagnostic authority is contained within the definition of the practice of medicine, and the administrative law of the Board of [inaudible 00:42:59].”

So, the provider has diagnostic authority, and there is nothing in there that says that diagnostic authority [inaudible 00:43:07] the Board of Medicine has said to me “No, Ruby. They can’t do that.” Since it’s not their issue, not their licensees, it’s not their issue. It’s a nursing issue.

Let’s talk a little bit about delegation. There is a definition in the Practice Act about delegation. There is one. What it says is that the process by which a licensee authorizes an unlicensed caregiver to perform activities of practice, while maintaining accountability for the outcome. Which means that the licensee says to the individual “Go into room B, and do blah blah blah.” The person is not licensed by any other Board, or certified by any other Board. Therefore, they do that under their license.

So now, you’re going to go back. The thing is, nurses that delegate are licensed under ORS [inaudible 00:44:10]. Therefore, the legal definition of delegation does not fit any one licensed or certified by the Board of Nursing. So, physicians cannot delegate to you, because they don’t have the legal authority to do that. You have a Board. You have a Board.

And the Board is the one, again, who determines whether or not. So, the delegation of “I am delegating to the nurse my ability to do A, B and C,” the answer is “No, you cannot.” Because if you look at the definition, it talks about someone licensed by a Board, and someone who is not, like a medical assistant.

So, if you’re working with a medical assistant, nurse, and you are sending the medical assistant to go into a room and do something, and that medical assistant royally messes that up, messes that up, and the medical assistant says “Well, Nurse Jane told me to do this,” or “Nurse John told me to do this, but you know, I’ve never really done it before. But Nurse John or Jane were busy, and I went ahead and did it.” It’s under your license, because the MA isn’t regulated by anybody.

MAs are not regulated by the Board of Medicine. That might be a misconception. They are not. They are free agents. They can do whatever they – if there’s a bad outcome in your clinic or in your agency or whatever, basically, there’s no one to go to. The public has no recourse. They can hope that the organization terminates them, but yeah, so what?

They go down to the next clinic or next hospital, and no one knows that you’ve been terminated for that, because most HR people say “Yes, they’re either eligible or not eligible for rehire,” that sort of thing.

So, that's the difference between someone who is licensed and regulated by a Board, and not. The whole idea of physicians delegating things they can do, to a nurse, is not even within the purview of anyone. And the Board can't even delegate it.

This is where we talk about CNAs. CNAs are certified by the Board of Nursing. They have authorized duties. So, when you work with a CNA and they can only do their authorized duties, that's not delegating. That's assigning a supervisor, because by law, they were already authorized to do that.

Now, if you say to a CNA "Listen. Go ahead and start that IV in room 10, because I'm busy, and you've been a CNA with me for years, and I know you know what you're doing," first of all, the CNA is on the hook with the Board, because they did something that was outside of their authorized duties. And you're on the hook with the Board for knowing, and you authorized something.

If that CNA makes a mistake, and someone [inaudible 00:46:43] or whatever, it's on you. You are going down, as you said. Those are her words, not mine!

Furthermore, Division 45 says the RN shall be accountable for their own actions. You're accountable for your own actions, not "Well, I was following the doctor's orders." That's not even allowed. There's a big sign in our office. It's a big figurative sign that says "Do not come in here and say 'The doctor told me to,'" because basically, this is not okay.

You have to decide whether you want to go down that road with the doctor, and if so, you own that action in that situation.

Then, an RN can only accept assignments that are within the RN's scope of practice. Again, the same thing. And physicians have no authority to expand scope, compel or direct a nurse to work out of scope, or take responsibility or accountability for the actions and decision-making. A nurse's license stands alone.

Here is where we get that juxtaposition of the protocols that are being developed in good faith – no one went out there and said "Screw the Board. We're going to do whatever we want." In good faith, they developed it. But this is how we got here today.

**Audience Member:** Did I hear you just say that if an MA is doing something, and the nurse is supervising, the [inaudible 00:48:03] is on the nurse's license?

**Ruby:** Absolutely, if you are not aware that the MA has the knowledge, skills, ability and competencies to do that particular thing. That's one of the reasons why, I don't know how many of you are reviewed by joint commission or [inaudible 00:48:20]. The issue is that the nurse must always know what the knowledge, skills, abilities and competencies are part of their job description, and are part of their competency validation.

However, if you assign me, as your MA, to go do something. "This patient is kind of [inaudible 00:48:38]. Not very good." And you sent me in there to do that, and I, as an MA, did not recognize that that patient was as ill, and something happened, it could be on your license, because you sent an individual into a situation of patient care that they were not competent to take care of that particular patient.

They may be competent to do the thing, but not for that particular patient. So, MAs, if the patient assessment you've done is appropriate, saying "Yes, the MA can certainly safely do this. Yes, my MA has

competencies. Yes, my MA has the knowledge, skills and abilities, etc.," then you can let them do that particular assignment.

And if it goes bad, you said "No, this was my assessment. This was my decision-making." The Board is going to go "Good girl. Yay you!" The organization might not, but that's not in our [inaudible 00:49:30].

**Audience Member:** The other half of that, and I come from years of community health, if someone is taught how to do something that's delegated to them, they're instructed, they go through the whole competency thing, and then as the nurse, I'm off to lunch, and somebody independently says "I know how to do this." Of course, in the community, it's one patient and one unlicensed person.

If the MA is doing their job, but then they step outside, because they're encouraged by a physician or someone else to do something that is outside their scope, and is outside what the nurse considers their scope and their education, who is responsible for that?

**Ruby:** The physician that gave them that assignment. The physician that – now, delegation, that's why it's a separate definition. Delegation, if you go out in the community health care setting and delegate a task of nursing to an individual, and you leave written instructions, if that individual goes outside of those written instructions, you're not accountable, either. That's actually [inaudible 00:50:28].

**Audience Member:** That, I know. That's why I was – when you said that about the MA, I wanted to hear a little bit more.

**Ruby:** No, no. The MA or the unregulated care provider, the home health aide or whoever you've delegated to, if that's not part of the delegation you did, and a physician comes along and says "Oh, it's okay. I'll cover you," yeah. You're right. They are going to cover them, because they are responsible for the outcome. That's what delegation to an unlicensed person is.

Let's talk about prescription filling. This is not the Board of Nursing. This is about the Board of Pharmacy. I did review this with the Board of Pharmacy, and they said "Yes, that's okay."

So, another thing is "Well, can an RN or an MA or whoever refill a prescription?" The answer is "It depends." It depends on the person.

**Audience Member:** I have a question. [inaudible 00:51:24] I just need to ask. I'm an educator, and sometimes – I've worked with very [inaudible] area. Sometimes [inaudible], there's not enough meds. We're asked to take different kinds of patients that the staff are not used to. I'm trying to put in my head, "I can't teach them everything." I'm like all of a sudden feeling incredibly liable for things.

**Ruby:** You're not.

**Audience Member:** How do I make a nurse competent? I don't think I can [inaudible 00:51:54].

**Ruby:** No. It's their job. Actually, the Practice Act says that a nurse is always responsible for their own continuing education and their own competency. Most nurses, most, not all, most nurses work for organizations who do that for them, because you're ruled by joint commission or [inaudible 00:52:09], or whoever you have, and they require that, and so does OHA.

The Board says that the nurse is responsible. So, here's the thing. A nurse gets "It's busy," you know, and a weird patient comes in that you've never seen before. But you're going to go ahead and take care of

him, because that's the kind of nurse you are. And something happens. The family calls us and says "Something bad happened."

We're going to say "Alright, nurse. Where did you determine that you had the knowledge, skills, competencies and abilities to take care of that patient?" "Well, that patient needed me." No, that patient needed a nurse who could safely care for them. We are not going to come back on you, who is another nurse, and say "Why didn't you teach them?"

A nurse is always accountable for what they do under their own license, and what assignment they take under their own license. So yeah, you are correct. You are given the authority by the organization to say "Listen, in this [inaudible 00:53:03] area, these are the basic competencies we have to make sure our nurses have. These are the routine patients, and this is what we are going to educate them to."

And if it's something outside of that, the nurse and the nurse alone makes the decision whether or not they're going to take that patient, under their license.

Because here's another thing, which may be a little bit off topic for us. But I'm going to finish up here pretty soon, and we're going to have about an hour for you guys to lecture to us [inaudible 00:53:33].

The fact is that there is no such thing as an unsafe assignment. Nurses like to say "That assignment, I was made to take that assignment, but it wasn't safe." No. Once you take it under your license, you have said "I have the knowledge, skills, abilities and competencies to safely take care of this patient." Not "I was forced to," because nobody forces you to take an assignment.

"I was told I had to." No. Nobody can tell you that. You have a license that stands on its own. Now, I do a lot of the lectures for CNOs and Directors and managers. And my question to them is always "What are you doing to support a nurse being able to safely provide care? Are you more answerable to your organization, or are you answerable to your license?"

"And the fact is that you, CNO, Director, manager, are asking your nurses to choose between their job and the Practice Act." Okay? So, even if you take the Practice Act and your organization says "Now you're fired, because you didn't do what we wanted you to do," well, the Practice Act isn't going to put food on your table, pay your rent, or send your kids to school. No.

90-some odd percent of the nurses are always going to pick their job, because that's concrete. That's here. That's now, versus the Board, they're far, far away. You're actually playing Russian Roulette by saying that patient is not going to say anything to anybody.

Once we get a complaint or a concern, and you'd be surprised how many peers call in their other peers, saying "Nurse Haley over here, she keeps taking assignments that I know she can't do. She just likes to fly by the seat of her pants and be everybody's hero." Don't you?

**Audience Member:** Yes!

**Ruby:** You are not accountable. Your organization that you work for has given you authority to educate nurses, and to make sure that these things are in place. Right? These things are in place. But if a patient comes in that's very different than what you usually do, the nurse has the accountability to say "Whoa! I have no idea how to take care of this patient. I need help. Come help me."

And if a manager says “Too bad. You’re a nurse. Figure it out,” then that manager is accountable for that, because they now have given the individual an assignment to do, that they know the individual does not have the competency validation to do.

**Audience Member:** Can you repeat that last part? About the manager being accountable.

**Ruby:** What happens is if you are a manager, if you’re a manager, and you say to the nurse “Listen. I got that. You don’t know how to take care of this patient. But you know, there’s really not anybody else, so you go do it.” You have given someone that nursing assignment, in the scope of your authority, to take an assignment under their license, that they do not have the knowledge, skills, and competencies to do.

That’s in Division 45. You cannot assign someone to do that. So, that’s what you did. Your license, now. They might have some issues with their license, because you decided to do that, and not stand up for their license, because they’re afraid of you, they need their job, they need to pay their rent. I get that.

But eventually, what will happen – in past precedence, past precedence – I’m not saying it’s going to happen every time, because the Board gets to decide this, not me. In past precedence, the Board has just said “We’re going to give you a letter of concern to the nurse. Don’t do that.”

But the manager is the one who is going to face possible increasing action with their license, because you in your position, should have known better.

**Audience Member:** Okay.

**Audience Member:** I’m sorry to stop you on this, but I just want to ask a little gray question about new graduates.

**Ruby:** Sure.

**Audience Member:** If you have a new graduate who has been assigned to a patient, and the charge nurse thinks that this nurse could take care of this particular patient, and they make a mistake. Does that charge nurse -? In other states, so I’m asking in Oregon, in other states, if this nurse makes a mistake, that nurse is held accountable, but so is the charge nurse, because the charge nurse didn’t have oversight.

How is that lived in Oregon?

**Ruby:** The fact is, no nurse has oversight over your license. A charge nurse is basically an air traffic controller. But the charge nurse must know that since this is a new grad, what competencies have they done? And if the charge nurse says to the new grad “Listen. Go take that patient in room 10. I know you’re never had that. If you have questions, just ask me.”

Well, how do you know you’re going to ask a question if [inaudible 00:58:25]. That charge nurse is held accountable, when they assign something to someone that is not qualified to take that patient. This is why it’s so important. Again, we’re getting a little off topic here, but it always happens when you lecture.

That’s why the organization must say “A new grad is expected to have these competencies.” So, if you’re a preceptor, and you do the thing that preceptors do; you know, they put your initial, and then they just



go down the line. You're accountable. You're accountable. You signed your name to it. So, if that grad says "Yeah. Nurse Haley." I'm sorry, Haley.

**Audience Member:** That's okay.

**Ruby:** Your name is right there! All these other people were wise!

[inaudible 00:59:02]

**Ruby:** Here's the deal. If you, Haley, as the charge nurse, you need to make sure that there is a list of "These are the things a new graduate is supposed to come out with." Then, if you know this person is a new graduate, and you say "Listen. This is what you're supposed to know. Are you okay doing that?" And they say yes – and if they say "No, never did that. The preceptor just signed me off," then that's reportable. Because anything you sign your RN to, you're signing to under your license.

Kind of like drug [inaudible 00:59:40], which is a whole other topic.

Does that answer your question? I can always discuss this more.

So, prescriptions. Here's what the Board of Pharmacy said. "If it is a continuous chronic medication, based upon the LIP's established parameters and the LIP's plan of care for a client," absolutely, someone can call in a refill.

For example, this is a patient who is asthmatic, who is going to be out of their inhaler. So, things change in their symptomatology. The physician says "Keep refilling that prescription," because prescriptions are only good for a limited amount of time. They expire. The patient says "Listen, I've got no inhaler, and there are no refills left. What do I do?"

If the individual looks at the plan of care and says "Oh, the provider said yeah, just go ahead and keep refilling it," then they are authorized to refill it, because it's part of the plan. "Routine refills of valid prescriptions, based on an established plan of care developed by the LIP."

Let's just say the LIP ordered the person to get this particular medication, and refillable three times. It's only been refilled twice. They need another refill. For some reason, the pharmacy called us. Absolutely, you can do that. But most of the pharmacists will tell you it's refillable until such-and-such a time.

Remember, it is about the fact that an LIP, who is authorized legally to do so, has said "Based on my assessment of this patient, keep doing this." And then, it's fine. Most LIPs, what they do is they say "Refill that, unless the person says the symptoms have come back," or whatever. Then, it's the person's responsibility to say "Have your symptoms come back? Is this still helping you the way it was?"

If they say yes, then the nurse or the whoever can put in the inhaler refill. So, what about emergency refills? Well, emergency refills, the LIP established plan of care to provide for emergency refills, for example "Need to be seen in clinic prior to the next prescription renewal, but may extend time 60 days, pending appointment availability."

If that's what the provider wrote, that's what the nurse can do. Now, just to let you know, pharmacists, but not nurses – pharmacists can refill a prescription for 72 hours, if the prescription runs out, just to tide them over.

So, “as an agent of the provider, the nurse may communicate the established order for emergency refill of non-controlled drugs. The nurse must always record their level of licensure for any intervention utilizing their license.” This is the Board of Pharmacy.

The provider can say “You are my agent, and I’m authorizing you to go ahead and put in emergency refills for any non-controlled drugs of any of our patients in this clinic, where we have an established relationship, and an established diagnosis.” The nurse can say “Yes, I’m an agent of the provider. The provider is authorizing me to do this.” They don’t say that, but they just have to know that.

That’s why it’s so important for, especially if you work with established patients and you’re in a clinic, for you to know what everybody’s plan of care is. Hopefully, there’s an inter-disciplinary plan of care. But if there’s not, what does the LIP say about those medications, when somebody calls in for a refill?

What you cannot do is to say, the LIP just prescribed something to the patient, and you say “Oh, it looks like you should really be on this medication for a while, so just go ahead. I’ll call in the refill.” You can’t do that. That’s not within our scope.

While not part of the Practice Act, nurses are expected to abide by all state – none of this is in the Practice Act, but you are required to abide by all state rules and regulations, since it’s the state that allows the person to call themselves a nurse [inaudible 01:03:19], etc., etc. The state does say you cannot [inaudible].

And you cannot, the Board of Nursing does not have the authority to say “Look, Board of Pharmacy. Yeah, you’re not as smart as we are.” They are. “And we’re going to just do this anyway.” No, we can’t.

A recent issue about fluoroscopy and advanced practice nurses – advanced practice nurses cannot utilize fluoroscopy in a procedure independently, and they cannot direct the technologist with “Turn the machine on, give me a better view, turn the machine off,” you know, whatever. They can’t do that, because the Board of Medical Imaging says they can’t do that. Not the Practice Act. The Board of Medical Imaging says they can’t do that.

That is currently under – trying to go under legislative change, to provide nurse practitioners and CNS’s and CNAs to use fluoroscopy as part of a diagnostic tool, to guide their procedure. But they have to be certified to do so, not by the Board of Nursing, but by the Board of Medical Imaging.

That’s how all of these Boards interplay. So, if you ever have a question for us about “What does the Board of Pharmacy say about this?”, because their Practice Act is written like ours. It’s hard to read. But we work with them all of the time. It’s important enough, if you have a question, let us know.

That’s prescribing, so you can prescribe refills. Even though our statement, that caused all of this problem in the first place, said “No, you can’t ever refill.” Well, that’s not true, either. This is what’s true.

So again, if you’re going to lay the blame on anybody for why we’re here, it’s this interpretive statement. That’s why we’re here. It’s not on our website anymore.

**Audience Member:** Does it have to say in the plan of care that they can refill?

**Ruby:** If it is not a planned refill, like the provider says “Refill times four, until two years from now,” or whenever. Now, for a controlled substance, you cannot refill a controlled substance. It has to be ordered

every single time. We also do not have the authority to say “Go ahead and keep taking your Oxycodone.” We don’t have that.

**Audience Member:** But it should say in the provider’s plan of care?

**Ruby:** And it can be written in the script. “Refill times three.” Or the provider’s plan of care can say “Refill until further notice.” Then, you can say, when the prescription expires, you can say “Yeah, go ahead. As an agent of the provider, I’m authorizing you to do that, to go ahead and do that.”

Here we have an example of a protocol that actually does combine all of the components which, at present, the Board feels is part of the scope of practice of any nurse. So, here’s an anticoagulation protocol. This was actually submitted to us by an organization that asked for our input.

Here is what the protocol says; “Patient enrolled with LIP, development of patient’s plan of care. Patient referral by the LIP, electronic communication.” So first of all, the provider decided that since this patient is on warfarin or coumadin or whatever they’re on, they need to be referred to an anticoagulation clinic. And it is the provider who said “Yes. You fit the protocol. Go over there and have your INR managed.”

“All patients must be determined to care for themselves, or have appropriate caregivers,” blah blah blah. “Exception for external lab will be done on a case by case basis.” So, here’s the thing. The PCP will document in the patient’s record, the person who is referring the individual, “To include indications for anticoagulation therapy.”

The person is on warfarin or coumadin. “Expected duration of therapy,” it’s going to last the rest of their lives, or whatever. “Target INR range.” Remember, this is what the protocol says. All of this has to be documented. “Target INR range, TRN/LPN/MA,” which you know, the fact that these are specifically interchangeable is a problem for me, but not here nor there, with what we’re talking about. “Places standing orders for point of care INR.”

So, this authorizes the MA to place those standing orders that talk about INR. “RN/LPN/MA places order for warfarin, per recommendation of PCP, using sig, that sig. Dispense amount to reflect 30-day supply, including possible dosage adjustments.” Then, the rest of this protocol says the patient comes in, you draw the INR, you look at it, and you say “Oh, it’s within range or not within range.”

Then, the protocol says if it’s this, then you do this to the medication. If we do this, then we do this to the medication. All of that is based on the initial assessment of an individual authorized by law to independently diagnose or prescribe, that says “This person is qualified for this particular protocol.” And then, off you go, for years, if you need to.

Here is an example of another one that was a little bit problematic for the Board. It’s that gray line that we talk about. The rest of this protocol is actually very nicely done. It’s very appropriate.

But here is where we saw some of these concerns that might indicate that there’s a problem. This is for a person who is known to the clinic, but all of a sudden, now has a symptom of a UTI. We all know what a UTI feels like. So, they come with those symptoms.

Now, most of us are smart enough to figure out, “Yeah, yeah, yeah. Probably a UTI.” Right? “We got that.” But again, legally, we’re not allowed to do that. So, this one says – this is about a mother, breastfeeding. If the mother is not breastfeeding, it says, the other part of the protocol says that if they

have these and these and these and these symptoms, put in the patient's chart that they have a UTI. This was delegated to them, by their providers.

Because quite frankly, in this particular clinic, these providers are incredibly busy. And they're also not always there, because they have other responsibilities. So, a patient comes in with those symptoms, you're not going to say to them "I'm sorry. The doctor's not going to be here for two days. You're going to have to wait." That's not okay, either.

Again, all of these were developed in good faith. So, the other part of the protocol says "Put in the diagnosis of UTI, based on these symptoms." So, the nurse enters a diagnosis into the patient's chart, that was not there previously. Then, it says "Prescribe medications listed below, in order of preference." Whose preference? My preference? The patient's preference? "Except if contraindicated by allergies in history," of course.

So, the nurse can pick Macrobid, Bactrim, Monurol. And you may add Pyridium, if you think it's necessary. This particular protocol leaves the picking of a prescribed drug to the nurse, based upon what the nurse thinks of the signs and symptoms. Now, the intent here was the physicians, and these were physicians who developed this, physicians said "I am delegating this thinking to you," or "This decision-making to you."

That could be a problem, because I, as a nurse, do not have that legal authority to make those decisions. Again, all in good faith, all to answer a need, but this is where [inaudible 01:11:10] problem could [inaudible].

**Audience Member:** The way you just described that, the rest of the protocol is pretty nice. We've got this crazy [inaudible 01:11:20] picklist. So, the hypothetical here is what if it's just Macrobid? What if it's not saying this vague order of preference thing? What if it's not saying "Enter correct X diagnosis into the chart."

**Ruby:** That was what came up in the last meeting we had. You were over there. The issue was that what if it doesn't say "Enter UTI?" Just say dysuria, which is a symptom, not a diagnosis. That has been taken into account, into our feedback to the Board. And the Board, then, is the one who needs to determine what the outline is going to be, to direct Board staff to the next step.

Because you're actually right. What if it doesn't say UTI? UTI is a diagnosis, but dysuria is not. So, does that allow us to stay within? The thing about the Board, the Board is willing to stretch the law on their interpretation, in order to meet the needs. But they are not willing to break it. They are not willing to break it.

So, if the word is UTI, or tuberculosis, or anything that's a diagnosis, that's where that -

**Audience Member:** What is the feeling about supporting labs? If your standing order calls for labs to be done, and you have a positive [inaudible 01:12:36], and then it says "If it's positive, give this."?

**Ruby:** Well, that depends. That's part of our issue, too. If it's positive, again, this is where that gray area is. This is what we're here for, because clearly, Gretchen and I are pretty smart, but not smart enough to figure this out. So, the [inaudible 01:12:57] say "If you have a positive POC test for whatever," I don't know. Give me an example.

**Audience Member:** Strep.

**Ruby:** Strep, alright. You have strep. Strep is a diagnosis. It's not a symptom, it's a diagnosis. So, it's a rapid strep test. If it's strep positive, and we're going to assume that this is a good positive, because there might be some falses – we all know that, but we're willing to take the chance. Then, if the strep is positive, it's a diagnosis of strep, and you can give this drug.

That's a gray area. That's something we have to work through, because again, it's not about if the person has a sore throat and there's pus on the back of their throat, give this. It's a positive strep test that gives you a diagnosis of strep. That's where the gray area is. I'm telling you it's a gray area, because that's what we're trying to figure out here.

Really, if it's positive for strep test, are you going to go hunting down a provider to say "Hello? Can I?"

**Audience Member:** We were.

**Ruby:** The answer is that, again, I want you to take this away. The Board cannot tell you "Don't do that." What the Board can say is if there is a patient safety issue, if there is a concern, the nurse who said "It's a positive strep test, and I'm going to put you on these antibiotics," and the strep test was not positive – it was a false positive, and they put you on antibiotics, and the kid or whoever has a bad response to that, because they've never been on antibiotics before, were you or were you not practicing out of scope?

Maybe. Maybe not. The Board doesn't like that. The Board does not like nurses practicing in a fuzzi. We want to make sure that nurses really do understand what their responsibilities are to the public, within the context of what the law authorizes you to do, under your license.

But again, the Board sent us out here. The Board could very easily have said "Oh, no," because there was a couple of Board members who said "Oh, no. That's not right. Pull all of those protocols. Tell them they can't use them." And the individuals on the Board who – the Board talks through a lot of stuff – says "Wait a minute. There's no plan B for these patients. Let's not do that. Let's -."

When the Board was pointed out that that interpretive statement was a problem, the Board went "Okay, wait a minute. Let's just go out and find some information." Because we don't have the authority. We have authority over you, but not the protocol that your health department or somebody else wants to use. So, that's what we're here for.

Because you can go – your health department can say "We're going to keep building this." Then you, nurse, make the decision of whether or not you're going to stay there and risk. Or whether you're going to say "You know what? I don't think this is in my scope. I'm not going to work here anymore, because I can't get this changed."

The Board does not want nurses to be in that position.

**Audience Member:** I think there's an organization, I think for pharm workers, that looks at use of [\[inaudible 01:15:59\]](#), as well. And these organizations, we want to also protect our nurses. We don't want to put them in a position of having to determine whether or not they are making appropriate decisions, within their own scope.

**Ruby:** Correct.

**Audience Member:** It's our responsibility, as our clinical quality groups, to ensure that we aren't putting them in that position.

**Ruby:** And that's where we're going here, with this. We need – our job, Nancy and Peggy and Gretchen and I, our job is to feed the Board. We feed Annette. Our job is to, when the Board tells us "Go find out some information," our job is to feed that information. That's part of the reason we're doing this, is because no one in this room wants to do that. No one.

You don't want to put your nurses in a position, at least I hope not, and if you do, please get out of my profession. No one wants to do that. But was it inadvertently done, based on interpretation that probably wasn't as clear as that Board back in 2012 had intended it. That's why this Board wants to know what in the world is going on out there.

Are there instances where there's that gray area, they could/they could not be out of scope?

**Audience Member:** Is there a timeline for resolving some of these gray areas?

**Ruby:** I don't know if you were here when I said that, but the Governor's office has contacted me. I have not had a chance to talk to the Board, because at the end of February, the Board meeting was cancelled due to some weather, which my friend from Klamath Falls down there said "What weather? I can get over the pass, with snow! What are you talking about?" The Board was actually concerned about a quorum issue.

So, in March, I will give the Board, not the information we're gathering here, but the information that the Governor's office would like us to continue to do these stakeholder meetings in Pendleton; they specifically said Pendleton. And then also down maybe in Medford, so that we can do some other data gathering.

The estimation is that once we gather the data, we will publish that data, and then it will go to the Board for consideration, June. That's our target line. I did tell the Governor "Look. We can't have these people hanging out here. We can't do this ad nauseum."

At some point, we have to say "This is the information." People who felt like they wanted to attend, attended. And those who didn't attend, well then, your opinion didn't get heard, and that's your choice.

Then, we give that information to the Board, and then the Board reviews that information, and then directs Board staff as to what to do next. So, whenever the Board decides.

**Audience Member:** You said that the interpretive statement is gone?

**Ruby:** Yes, it's gone.

**Audience Member:** When did it go away?

**Ruby:** It went away, actually, when the new website came up.

**Audience Member:** [inaudible 01:18:46]

**Ruby:** Yeah. The new website, it's not on there anymore. It shouldn't be on there anymore. Actually, in all transparency, I had asked for it to be taken down a while ago. However, Board staff didn't quite get

to it. I said “Whoops! We need to do this now.” [inaudible 01:19:03] and went “Now,” and then had it removed. Board staff are human too, believe it or not.

So, yeah. It got taken down. But again, the Board is not going to say – because this is a situation of the Board has said we need to determine what’s going on here. The Board is not going to come down on you and say “You’re practicing out of scope, because you did this and this and this, and we got a complaint.”

The Board isn’t going to quite go there. We’ll have to tell the Board that we’ve gotten some complaints, and the Board is going to just say to us “Yes, investigate,” “Don’t investigate.” But because the Board knows this is such a black and white thing, I think the Board is very cognizant that nurses are doing, that these protocols were implemented in good faith, to take care of patient needs, and our nurses, in good faith, implemented these protocols.

Because they do count on [inaudible 01:19:56]. And the nurses within the hierarchy of that employment know more about the Practice Act in [inaudible 01:20:02], which sometimes is [inaudible].

Anyway, this is what we have here. There’s this choice, because again, diagnosis the patient didn’t have before, medication prescribed for a patient that they didn’t have before, where in that interaction where that happens, there is no LIP involved at all. That’s the gray area, right there.

That first one, absolutely appropriate, because somebody said “This is [inaudible 01:20:29].” And if you’re doing this, please don’t tell me.

**Audience Member:** A chronic UTI patient who had had, then we’re not in this conversation, right?

**Ruby:** If this is a chronic UTI patient.

**Audience Member:** And they’ve had this script.

**Ruby:** And the provider, in their plan of care, says “If this patient comes to you with these symptoms, go ahead and prescribe this,” because the provider who is legally authorized to do so, has seen this. This particular one did not say “This person has had a history of at least three UTIs.” It just said “The person is in the urology clinic, and has these particular things. Go ahead and put in the diagnosis of a UTI, and decide what it is you’re going to do.”

**Audience Member:** I want to say I just normally agree that as a manager in whatever setting you’re in, you want to provide trained competencies, that the policies that surround, like whatever your standing orders or [inaudible 01:21:29] practice orders are. Certainly, you want to be able to provide that access.

I think what the gray area is, for me, being in public health [inaudible 01:21:40], is sometimes we see patients who aren’t established patients. And maybe they’re not coming in with symptoms. Maybe they’re coming in because they want an STI screen or birth control.

**Ruby:** Those are different. Those are held under OHA, and their public health rules. Because what happens is an RN can’t say “Oh, you have an STD. Now, we’re going to prescribe this for you.” Under pharmacy rules, this has nothing – this does not have any language in the Practice Act about this. What the Pharmacy Board and OHA have agreed to, for public health, is the diagnosis has to be established by a provider, and the nurse can stay.

STD, dental caries, birth control, those kinds of things. There are some carveouts that are not part of the Practice Act. So, we are not here discussing the STD, dental caries [inaudible 01:22:34] dispensing of medication. So, the provider can say “Listen, so-and-so has [inaudible 01:22:43] or whatever. Go ahead and give them this medication.” And then, [inaudible 01:22:47].

But what the nurse cannot do is diagnose, “Okay, you have. There’s been no word. No one has seen you, that’s authorized to diagnose what you have [inaudible 01:22:59].” That is not on the table of what public health is allowed to do. That is authored jointly by the Board of Pharmacy and OHA, and that’s exactly what it says. The prescription has to be authorized by a duly authorized prescriber, and then the nurse can take the drug and dispense it. It’s dispensing, not prescribing.

**Audience Member:** I don’t mean to backtrack.

**Ruby:** It’s fine. Backtrack all you want.

**Audience Member:** [inaudible 01:23:35] I guess my question is, just to clarify, there doesn’t have to be a communication order between organizations [inaudible 01:23:45] the nursing staff and the Board of Nursing at all?

**Ruby:** No, it’s not required. But we certainly have a consulting service that we actually – in fact, who’s from Kaiser? Are you one?

**Audience Member:** Yes, I am.

[inaudible 01:23:58]

**Ruby:** Later on this week, to go over his protocols, and to determine what is good and what is not good. Now again, Kaiser, bless them, when this first came out, they said “We’re changing everything.” That’s when we knew we were in trouble, because there was no plan B. They scrambled. The whole thing about LPNs doing triage and all of that, they scrambled to change everything, which caused a lot of distress [inaudible 01:24:33], and a lot of concern among the providers.

And kind of left them in the lurch. “Okay, now what do we do?” That’s why I want to make sure that people know we had no authority to say that. But what we did say was “If you are this LPN triage, you can go [inaudible 01:24:46] triage.” That is a violation of their scope of practice, because they cannot do it. [inaudible 01:24:52]

And your LPNs are going to be in trouble. Not only that, but if you’re a nurse, I now know that I told you that.

[inaudible 01:25:02]

**Ruby:** And this is what it is. So, the fact is that there is, in fact, this [inaudible 01:25:13]. I’ve been with the Board now for five years, five year anniversary this year. Sometimes I wonder what in the world I’ve done. I was happily being the Director of Nursing at Doernbecher.

Actually, no. That’s why I moved over.

[inaudible 01:25:30]

After ten years, I thought I had done a good run, and I was out of there.



**Audience Member:** We also might need some new ideas.

**Ruby:** So, what I have invested in the Board's budget, and with the Board's approval, of course, is in these consultation services, in these education services. We are willing to come out to anybody, even if it's an audience of four. Even a one on one.

We'll be happy to do that, because it's much better to do that up front, and allow us to give you what the Board's view of this is, rather than us saying years later, "Everything was done in good faith, and we're not sure where this goes."

So, yeah. There is not a requirement, but I would definitely recommend it, because what we always say is, and I never ask for a show of hands, because I don't want to embarrass anybody in public – how many of you, when you decide to write a policy, whatever, to direct the practice of nursing, the first place you turn to is take out the Nurse Practice Act, the scope of practice treatment? Well, you do now.

[inaudible 01:26:39]

**Ruby:** And put it in the scope of practice tree that we have, that defines what's in the scope? I know you do, Stacy. I know you do!

And then, use that as a backbone? The fact is we have a scope of practice tree out there that says, if you're ever wondering whether this is in your scope of not, use the tree. It will tell you whether or not it's in your scope.

Anyway, yes, Kaiser has reached out to us numerous times, for consultation. I know Asante -.

**Gretchen:** Marion County Sheriff's.

**Ruby:** Yeah, Marion County Sheriff's Department has reached out to us. So, please do not feel like we're the people in the dark castle up on the hill, who is just waiting to swoop down on you and put you down. We're not here to do that! None of us are. We're nurses. You know what? We lived in fear of the Board calling us, too. Then, when we got to the Board, we said "Wait a minute. Something's got to change here."

We need to be partners in providing safe care. Remember, we're not an advocacy organization. We're not the ONA, we're not the – whatever professional organization you belong to. We are here for public safety, and for goodness sakes, there's no such thing as entrapment. We don't want you to be trapped. We want to work with you, to make sure that you're safe and the public is safe, and that we don't see you.

So now, we have stakeholder feedback. Miss Peggy has the recorder on. If you have something written you want us to have, feel free to deal with Peggy. Peggy is our archivist for this whole thing. If you have cards that you think maybe it's too involved for an answer right now, then we will look at that and include that in our report.

Or if you have something that you want to ask right now, the next half hour is yours. You use it any way you want.

**Audience Member:** Are you taking into account feedback from professional nursing organizations such as ENA, who very much promotes the use of standing orders and protocols, into this?

**Ruby:** Right. The statement that you made is no, we don't, because legally we cannot. They are professional advocacy organizations, and while certainly they establish the standard for other organizations, for other nurses, they do not own the license [inaudible 01:29:00].

I did reach out to all 59 Boards in this country, and asked them "Listen. We've got this situation." Actually, not naming names or drugs, I said "Here's the deal. Diagnosis the patient never had, medications the patient never had, and physician [inaudible 01:29:19]." The ones that answered, they were about 30-some odd people that answered, they all said "No."

And "Oh! Interesting question. Solve it for us, and let us know!" Which is not uncommon. So, our Board is very forward-thinking, and the Board said let's go solve this together, rather than saying "Because we're the Board, we said so, and that's how it needs to be." That's not how you handle nursing practice.

**Audience Member:** I work for the Coalition of Local Health Officials, so I work with all of the county public health departments. The work that's done under standing orders is pretty narrow; communicable disease control, immunizations, reproductive health, and the control of sexually transmitted infections, primarily.

And what I thought I heard you say is that kind of community health is separate. But at the last – I will probably go to all of these stakeholder meetings. But at the last meeting, it seemed like some of this actually is in a gray area, because depending on the provider network in that area, you know, there's not an LIP in. It might be once a week in some health departments, or it might be less than that.

So, this narrow scope is things that are timely and important, and if not caught quickly, can spread.

**Ruby:** We absolutely agree with you. The layer that you guys have, too, is another different layer than perhaps a hospital-based clinic or a private practice, or whatever else has. You have that specter of what exactly is public health.

So, let's just say immunizations. You have a state health officer who says "Hm. Flu season is coming. This is what we're going to be, the flu shot is going to be this." Again, they get from CDC and all of them, this is what it's going to be. Then, they say "Okay. Here are the vaccines for the childhood diseases, and these are the vaccines that every child this age and this age, unless the parent opts out, are going to get."

The question is also for the Board, "Alright. Let's talk about that. Is that population management – it's population management – is that different, when it talks about that?" So, let's talk about immunizations and that.

**Audience Member:** Today is school exclusion immunization day. [inaudible 01:31:44]

**Ruby:** I was at the state legislature Monday. They were all there. It was very interesting to see all of these little -. Actually, I've been in pediatrics most of my career, and yeah, they all came in to talk about the bills being forward, about immunizations. That was on Monday. That was a hearing on Monday.

**Audience Member:** The Informed Consent Bill.

**Ruby:** Yeah, and all of that. So anyway, yes it is. That's one other reason why. We got your message about this being exclusion day, and that's another reason we said we need to do these other times.

The fact is that what's population management, and what umbrella does that fit under? Where everybody gets the same dose of Tdap, unless they screen out. Everybody gets the same flu vaccine, unless they screen out.

What is the difference between that and someone saying "Hey, listen. I think I have the clap."? When I was in the Army, that was very common of the guys. They would line up outside my office, down the road. There were that many of them. This was during Vietnam.

So, is that an individual person with an individual diagnosis and individual prescription? Now, dispensing, we've already got that covered. What's the difference between that, because there's no provider present, and population management? What is that? That's one of the questions that the Board is going to have to grapple with.

Population management is one thing, because everybody in the population gets the same thing for the same thing. Everybody gets that. There's not a diagnosis involved, and there's not a specific prescription for that patient involved. But what happens in that case, where there is some gonorrhea or whatever?

[inaudible 01:33:36]

**Ruby:** So, is gonorrhea management all the same? Is it weight-based? In pediatrics, everything is weight-based. Is the dosage the same for anybody who has got these symptoms? Is that public health?

There's really where I also need to speak with OHA and their Public Health Division, to say "How are you guys managing this?" Because when I read what Public Health has to say, it's about as bad as the Nurse Practice Act. It kind of says some things, and it kind of says not some things, and it implies certain things.

**Audience Member:** I think I said this at the last meeting. It might be helpful to have one of these community meetings specific to community health, because the feedback – of course, you have to look through the lens of the Nurse Practice Act and the laws, and that makes sense. But also, it's very hard to pull out and tease out where some of these really important community-based services that stop the spread.

**Ruby:** Peggy, can you make a note of that?

**Audience Member:** And I would encourage you to make sure it's not just a conversation with OHA. We do have health officers, managers, that are -.

**Ruby:** We will do it as a public posting. I don't have a conversation with OHA, "can we, can we?" It's "Clarify your rules for me." Because again, nurses need to appreciate the fact that there is so much in statute that has nothing to do with the Practice Act, yet guides your practice.

School nurses are the prime example of that. School nurses have all of these rules, all these rules that have nothing to do with the Practice Act. We just license you. We just license you, and then the school whatever certifies them as school nurses. They certify them as school nurses.

They may have some national certifications, but they authorize them to be school nurses. Then, they can say "Okay, you can do this, you can do this. Adrenal insufficiency and diabetes and epinephrine," and all of those things which fall under the school district, not the Board of Nursing.

So, we have to make sure that we understand, we understand what OHA has to say, because their rules are as applicable to you as our rules.

**Audience Member:** Well, the OHA is not writing standing orders for local.

**Ruby:** But they're Public Health Department does have, there are some rules at the Public Health Department about how these diseases get managed. It's not about the standing orders. It's about the disease management, and what is the difference between population management for immunizations and for flu shots and for all that, versus gonorrhea, which is a real health issue? Nobody denies that.

It's a real health issue. How do we treat that, when there's not a provider there, because there just isn't. It's a month away. Every 90 days, somebody comes and looks at your protocols. How do we balance that with the scope of practice that is defined by law, for an RN? That's really what we're about.

**Audience Member:** I think that the don't change anything needs to be said very loudly, because I have asked folks, and folks are looking at their practices, are looking at other states. And without more information getting out, other than just at the stakeholder meetings about don't change anything while we look at this, I think that piece of information will be really helpful.

**Ruby:** The thing is, we have our website and we have the Sentinel. Not everybody reads our website, and not everybody reads the Sentinel, even though it's sent to all licensees by email. It may in your junk filter or whatever. Those are the two documents that we require, because if nobody is reading our information, nobody is reading our literature, how do we get that out to them?

We send letters to everybody? Well, to who?

**Audience Member:** I would like to bring up that we actually looked on your website, and there was a link to meeting minutes that was a bad link. It doesn't work.

**Ruby:** Oh, no. It's the new website. They're correcting all of those links as they come up. Yes, it was on the old website, but it's not on the new one yet. What we can do is we can put something on our website that says if you're going to be there to look at our meeting minutes, we should say "Don't change anything now, because quite frankly, there's no plan B."

If there was a plan B, we would say "Look. Plan B works just as good as plan A. Let's go to plan B." But there isn't one. We're not talking about plan B drugs.

[inaudible 01:37:59]

**Ruby:** Does anybody have anything they wish -?

**Audience Member:** First, I just want to echo what Morgan said, that if we're saying public health is – we are treated differently, then there needs to be a separate meeting.

**Ruby:** Not treated differently. You have different issues.

**Audience Member:** Yes, we do.

**Ruby:** We can't treat you differently than a nurse working ICU and Acute Care. A license is a license.

**Audience Member:** You also just mentioned a table. Is that on the website?

**Ruby:** It's not ours. It's on OHA and Board of Pharmacy. [inaudible 01:38:38] authored it. I just accessed it, but it's not ours to put on our website, because it's not dealing with nursing. Remember, prescriptions of medications, medication ordering, patients taking medications is not under the purview of the Board of Nursing. It's all the Board of Pharmacy.

We have no authority to say this is what you should do with a prescription. If you find anything on our Practice Act about prescriptions, it's only being put there as a courtesy to you, so that you don't have to go hunting in the Board of Pharmacy.

But that particular thing has been online since – remember it used to be public health clinics were designated by the Public Health Department, and now people can contract [inaudible 01:39:14]? Certified? That's when that was developed, to allow these new entities coming into the public health game to know exactly what the rules are about medication management in public health. It's OHA, Board of Pharmacy.

Now, I can see if we can try to find it.

**Gretchen:** We've got a copy here. It just talks about the type of clinic, county clinic license and then community health clinic licensure. It talks about the type of medications included you can dispense.

**Audience Member:** It sounds like the Board of Pharmacy licensure.

**Ruby:** Actually, we found that on the Board of Health website, because it was developed in conjunction with the Board of Health.

**Gretchen:** With the Board of Pharmacy.

**Ruby:** I'm sorry. OHA and the Board of Pharmacy. They did it together.

**Gretchen:** This was published in October 2016. This is Ruby's copy, that I made a copy of. I couldn't find it on either website, so I don't know where it is now.

**Ruby:** You have to dig pretty deep into Public Health. You have to dig pretty deep. It's hidden, but I kept looking for it, because I know that that was a concern of you all. But again, that was published in 2016. It's been there for a while.

It specifically says that for a new community health care clinic license, a CHC, "For public health RNs to dispense medications for prevention and treatment of dental caries, hormone deficiencies, urinary tract infections, sexually transmitted diseases, communicable diseases, amenorrhea and contraception." It does say that that has to be prescribed by someone authorized to prescribe it.

You can dispense it, but you can't prescribe it. So again, if you are saying "Well, wait a minute. If a person comes in with amenorrhea or dental caries, we say 'Okay, you've got that. We're going to give you some medication, and off you go,' and there's not a prescriber involved in that," is that a violation of this? Which is even in our [inaudible 01:41:18] nursing, pharmacy, OHA.

I've talked to OHA, you know, and Gretchen actually is our liaison between a lot of that. We said "Look. If the word 'nurse' happens in any of your rules, can you call us first? Because this is an example of where this runs counter to not only what you've developed, but it is hidden so far that my expert here in perusing the internet can't find it."

I only found it when I called the head of OHA and said “Where is it?” I said “I know it’s out there. I’ve seen it.”

**Audience Member:** When you say prescriber, do you mean they are having face to face contact with a client, or are they reviewing the lab that says they have gonorrhea?

**Ruby:** It doesn’t matter how the contact was made. Let’s just say you have a positive whatever, and you call the provider, and you say “This is what I’ve got.” The provider decides, under their license, to make the diagnosis, and to say “Yeah. Go ahead and follow the protocol.”

That’s enough, because they are taking that responsibility, under their license. They’re taking that responsibility under their license, and they can do whatever they want. They can say “Never mind. Don’t even tell me. This person’s okay for the protocol.” If the person is not okay for the protocol, it’s their license.

**Audience Member:** Can you help me kind of think through how the scenario you just described is different from following a protocol that avoids – the example you gave, with the UTI and the preference issue – but that really is an algorithm of steps, including say a positive lab for gonorrhea. “If positive, then do this.” How is that categorically different from an order over the phone? [inaudible 01:43:18] provider has seen the positive lab themselves?

**Ruby:** The provider had no knowledge of that particular patient. We’re talking about a particular patient with a particular diagnosis and a particular treatment. This is a gray area. Please do not take what I say as “Oh, the Board said this.”

This is a question that has come up. The question is that is it out of scope of a nurse to take a protocol where the diagnosis of a particular thing, and the calling in a prescription was delegated by a protocol, to a nurse, by a provider? It could be an NP. When I’m talking about providers, I’m not just talking about physicians. I’m talking about NPs or anybody who has independent practice.

Does that particular process you’re describing delegate that decision-making and that authority to call in a prescription under that provider’s name, which is tantamount to a blank prescription, according to the Board of Pharmacy? Is that in violation of pharmacy regs, Board of Nursing regs, etc.? Because in that case, where there’s not a provider that says “Yeah, under my license, for this particular patient, go ahead and do this,” and it doesn’t matter.

For us nurses, it’s you decide when your comprehensive assessment is enough for you to make a decision. Right? Same thing with them. A provider can make a decision under their license, that this is enough information, go ahead and do it.

But it is the actual involvement of that provider with that specific patient in that specific scenario, that makes the difference between a protocol that was delegated to nursing – and we proved already here that you can’t delegate nursing, because nurses have a license, and only the Board can determine what their scope of practice is – and the scenario about a provider being involved?

**Audience Member:** It almost seems like that would be more of an issue for the independent licensed provider, as opposed to the registered nurse, who is then taking an order.

**Ruby:** Here's the thing. Again, all of these protocols were developed for the right reasoning. The issue is it doesn't really matter what the provider ordered or directed or delegated or by protocol or whatever, gave the nurse to do. The issue is, is it legal under the Practice Act, for a nurse to do this?

Because a physician or a provider cannot delegate that. They cannot delegate something that could possibly expand the scope of practice to a nurse, by saying "I decided, based on this picklist, that this is what's right. I decided, based on this picklist, that this patient needs this prescription. And I'm going to call it in for the provider, and the provider isn't even involved in this. They may sign off my order in a day, two days, three weeks."

Some nurses even share with me "Really? They never sign those off." So, you know, whatever that is. Yes, you're right. The fact is the providers feel they have the legal authority to do that, and the issue is no, they don't have that legal authority. They don't.

So, the question for us is, how do we balance that legal authorization, where a physician cannot ever direct the practice of nursing? Ever. Only the nurse determines what their practice is going to be. They can implement orders, but those orders come with an assumption that a provider has actually seen that patient and established those orders, or declared that patient appropriate for that protocol.

And again, that's why public health gets a little bit of a nuance, which we will take that advice and work with that. We'll have some more in Portland, because quite frankly, that's where most people live. But in some of the rural areas, we will do that.

**Audience Member:** I don't mean to take up too much of your time. I want to say one more thing.

**Ruby:** Oh, no. This is important.

**Audience Member:** What you just said is exactly why I feel so confident that a registered nurse is the right person to implement the standing order or protocol, because no matter how an order gets to a registered nurse, it is always incumbent upon that, to understand the pharmacokinetics of the drug, to check their [inaudible 01:47:30], to have done all of their due diligence.

And regardless of how that order comes to them, that onus remains upon them and only them, as opposed to, say a medical assistant, which in reality, is the other sort of member of the team we're looking at implementing those orders.

**Ruby:** [inaudible 01:47:59]. The issue is will you, as a nurse practitioner, [inaudible 01:48:09]. You as a nurse practitioner, do you have the authority to say, "If a patient comes in, any patient comes in with this symptomatology, this is what the diagnosis is, and this is what the medication should be," and to call those in under this protocol?

The Board of Pharmacy says [inaudible 01:48:58], because the nurse is making the decision. Of course, the nurse is capable. We're not talking about capability here. We're talking about legal. Is this legal? Absolutely, nurses [inaudible 01:48:38]. They can. The question is may they, under the law? And that's what the Board, yeah. So, may they, under the law?

Again, the reason we are here is because we need to figure out that balance of what may happen under the law, what is allowed to happen under the law, versus being able to take care of patients, and not putting nurses in that position.

Absolutely, like I said, when I was an ER triage nurse, and I saw an ectopic pregnancy coming through the hallway, I said “There you go. That’s an ectopic pregnancy. Let’s go ahead and [inaudible 01:49:11]. Let’s go ahead and do this. Let’s go do that,” because her symptomatology fit the protocol.

All of those lab results went to a provider back there who said “Yeah. Ectopic pregnancy. Let’s go call the surgeon or the relief. Let’s go do that.” That’s what the difference is. There is no LIP involved in any of this, for that particular patient in that particular interaction, for that particular diagnosis and that particular [inaudible 01:49:37].

It’s all if this, then that. And if this is in that protocol, are they allowed? Are they not allowed, under the Practice Act? And that’s what we are here, again, and I appreciate your questions. Don’t think I don’t. I do, because that’s the kind of challenge we have to have, so that we can make a report to the Board, and say “Okay, it’s all yours now, Annette!”

**Audience Member:** I also agree that the provider – but I guess my question would be, is consideration being given to ensuring that registered nurses can work to the top of their licensure, as you work through these [inaudible 01:50:13]?

Because I almost feel like we’re going in the opposite direction of working at the top of our licensure. So, when I look at our 398 nurses that work for our organization, who some of were at the last meeting, which is why I drove here this morning from Yakima. They left with the impression that they were really going backwards, almost being given -.

**Ruby:** Let me define for you – let me ask you to define what is top of your licensure? What does top of your license really mean?

**Audience Member:** I think for us, we have a great deal of protocols and standing orders, some of which we did send in. I think there was only some discretion on one that we were asked to make some changes to.

But I think that for us, it’s important that our nurses feel like they are actually working at a level of their education and their licensure, not just rooming patients, taking vital signs, and reporting back to a provider.

I guess I want to have an understanding of the considerations for that, as well.

**Ruby:** You are absolutely right. I don’t want to be dumbed down. [inaudible 01:51:22]. But unfortunately, the definition of what is at the top of your license, and what you can do, is up to the Board to decide, not nurses. And yes, [inaudible 01:51:36]. I can tell you I absolutely feel the same way, [inaudible].

She knows what it feels like to be dumbed down. The question is about the legality, and how do we take the law and say “You don’t have the authority?” The provider, the NP, the physician, does not have the authority to delegate prescriptive authority nor diagnostic authority to a nurse.

It doesn’t matter how smart I am. These are the boundaries that are put under my license. I have a BSN and a B.S. in Nursing Administration. This is [inaudible 01:52:12]. Is that legal for that?

Now, what you want to do and what you are capable of doing, again, that juxtaposition of what you know you can do, because you’re smart, [inaudible 01:52:23].



The question is, what are the boundaries?

**Audience Member:** Right. I guess that's what I'm asking about, too. Because we also have a lot of, a patient comes in for a pregnancy test. Their pregnancy test is positive. We do set them up with a provider, but they are given a prescription for prenatal vitamins. So, under the conversation that's occurred here today, our nurses [inaudible 01:52:56] do that, unless we first talk to the provider.

**Ruby:** Here's the [inaudible 01:53:01]. We need to come to some agreement there. Again, you're not [inaudible 01:53:06 – 01:53:21].

How can the Board structure the rules? Because the Board can't just decide on its own. The Board has legislative parameters. The Board can say "[inaudible 01:53:31], until the legislature changes it."

But we are going to do, we are going to give the Board the information of this is a concern. Let's not dumb down our nurses. How do we take care of patients, within a context of what's -? Because here's the fact of the matter. There aren't enough providers to call.

**Audience Member:** Right. That's an issue we face every day.

**Ruby:** There aren't enough providers to go around. There aren't enough providers. So, has the Practice Act been outstripped? Because the one thing you don't want to do is ask forgiveness, after you've already done it. There's a group of nurses who do that regularly.

**Audience Member:** Is this conversation [inaudible 01:54:11]?

**Ruby:** No. It is not, simply because flight nursing, they always have ground control. They always have ground control, and I used to manage the pediatric [inaudible 01:54:23] transport team, and everything that they did was "This is the patient." The provider would say "Go ahead and do the protocol."

Now, if it's an emergent situation, a lifesaving situation, [inaudible 01:54:34], in order to save a patient's life, you can work within what you have to do. If the transport nurse wasn't able to put in an arterial line, they're not going to [inaudible 01:54:48].

**Audience Member:** Returning to what's your competency.

**Ruby:** Right. And they are always [inaudible 01:54:54].

Again, there are not enough. Here's the reality of the situation. There are not enough providers. Protocols have been developed, to answer the patient need. The nurses are the ones best capable of carrying out these protocols and standing orders.

The question is, where does it bump up against what the law allows in Oregon? And what does the Board of Pharmacy allow? And what does the Board of Medicine allow?

There was a suggestion that I bring the Board of Pharmacy and Board of Medicine in here, and I said "You know what? I don't think that's a good idea," simply because this is not their rules. These are our rules. These are our rules.

Again, I told you the Board of Nursing has no authority over what a blank prescription pad is. The Board of Pharmacy [inaudible 01:55:39]. So, when you call in a prescription for Dr. so-and-so or nurse

practitioner so-and-so, and they don't know anything about it, because it's under a protocol, that's a blank prescription form.

That's the exact question I asked the Board of Pharmacy, their Compliance Officer, and she said "Yeah. That's about right. They can't do that. They can't do it on paper. Why can they do it electronically?"

So, there's a lot that we have to deal with. The only way we can do this is to get information about what's the reality. We know the reality now. I mean, we always knew it, but you corroborated it. There aren't enough providers to do this.

**Audience Member:** If they can take verbal orders, why can't they take written orders? Isn't that a sort of [inaudible 01:56:19]?

**Ruby:** Because the verbal order that a provider gives you is a conversation where the nurse says to the provider "Listen. I've got a patient here that fits all of the parameters that we usually work with, that's got, I don't know, pregnancy." The provider says "Okay. Put them on a protocol." They are judging their verbal order. It's their judgement to say to you "Yes. This person is okay for the protocol. Go ahead and do that."

That's the difference between a verbal order – the verbal order, again, is a spoken order. It is a conversation you have. And those are not what we're here to talk about. We're here to talk about when the provider is not even in the vicinity, and has never been discussed with. Because that's how this does business.

If there was a physician or a provider in every single health care clinic, we wouldn't have this conversation. We wouldn't have this conversation. But there isn't, and that's the reality. Does the Practice Act – one of the things that we are concerned about, that my Board is concerned about is, is the Practice Act putting up too many barriers to safe patient care? Because that's what the rules used to look like.

Is it time to keep up with? I will tell you that from my staff, who have been doing this for a while, this is the first Board that has ever said "Go out and go find some information. Go out and go find some information, and have a discussion with the people who this affects."

We're almost out of time. I don't want to hold you up, especially if you have to drive all the way back to Yakima!

**Audience Member:** No, I'm staying.

**Ruby:** Okay. What we're going to do is number one, we're going to have a special stakeholder meeting for community, and what we might do is we might – and this is just me thinking – is that we might have a session where maybe the first hour and a half is for everybody else, and if people want to stay for the second part, it can be community health, but that's all we're going to focus on.

**Audience Member:** If that happens, and that would be great, more than two weeks' notice would be really helpful.

**Ruby:** Oh, yes. This time, we did how much notice, Peggy? It was a while. The first meeting was two weeks.

**Audience Member:** I only got notice a little more than two weeks.

**Ruby:** Here's the thing, is that there is a listserv that you can sign up for.

**Audience Member:** It did, after the last meeting, and it did not come out for that.

**Unknown:** Which listserv did you sign up for?

**Audience Member:** I was instructed to sign up for the RN/LPN list.

**Ruby:** Yeah. That's the problem. We determined that that is the right listserv, because this is about RN/LPN practice, right? The thing is that in our agency, everyone is assigned to a listserv, to make sure that their stuff gets on that listserv, like CNAs and the APRNs and those things.

Apparently, the RN/LPN listserv is really not as active as I had assumed it was. So, we will remedy that. But we will also put it on the public announcement for that. I apologize. That is absolutely our fault. Yeah, two weeks' notice, not enough. We try to give you at least a month, so that you can arrange your business. You all have jobs, and that's not okay.

We put something together in two weeks, because the Board asked us to have a report to them in February, and because of the holidays, that whole issue about the holidays, because this was in December, right? So, yeah.

The thing about it is this, is that when we do something like this, it's never perfect. But we learn from each one. Therefore, those of you who went to the last meeting and those of you who are at this meeting, we incorporated what we learned from the last meeting into this meeting. Because I think you all know this is a little bit different than the meeting last time.

So, we know now what the issues really are, and where the heartburn is, so we want to make sure that we capture that, versus what we, as Board staff and the Board, thought the issue was. The only sin about all of that is if we get feedback, and we don't change the way we [inaudible 02:00:17].

Now, the next one, we'll have different. The next one will be about public health, because that came out in this one. So, we will do that, but because we have to go to Pendleton and probably down to Medford, and then back to Portland, we want to make sure that those people who are not in public health in those areas get the opportunity.

**Audience Member:** If you know when, it would be really great if there were like "Here are the stakeholder meetings" in advance. Because we've got somebody from Lincoln City. Maybe they would have gone to the southern Oregon one, if they knew. So, when you kind of look ahead and plan ahead, that would be awesome.

**Ruby:** Again, like I said, we were under the impression that this was going to be our last one. Then, we got a request from the Governor's office to continue to expand it. Again, I have not talked to the Board, but quite frankly, the Governor's office says, that's what [inaudible 02:01:08].

**Audience Member:** Are you looking at FQHCs under public health, because that's a little – it's close.

[inaudible 02:01:13]

**Audience Member:** We're not public health. They overlap, but [inaudible 02:01:23].

**Unknown:** But sometimes, for Multnomah County, for Lane County, for Lincoln County, that are all here, where some of the clinical services are part of the FQHCs, it might be a first half/second half with the FQHCs, that might be helpful.

**Audience Member:** Can you talk about that being up here in Portland, so that we offer the other ones, too?

**Ruby:** Again, the logistics of this, we have to figure it out. We have to figure out the logistics. I'm not saying this is what it's going to look like, but it could look like overall general concepts, public health.

[inaudible 02:02:00]

**Audience Member:** [inaudible 02:02:04] presentation from the Board of Pharmacy and the Board of Medicine?

**Ruby:** No, they're not coming, because this is a nursing issue.

**Audience Member:** We talk about a lot of how that impacts us, and [inaudible 02:02:14].

**Ruby:** The thing is that those two statements I put up there about a provider can't delegate their practice to an RN, and the Board of Pharmacy, about not filling out blank prescriptions, that's about all that's pertinent to this. Because it's ours.

[inaudible 02:02:34]

**Audience Member:** When people say "I go out and look at other states," you can't. You have to stay in your own state.

[inaudible background conversation 02:02:42 to end]

#### 4.18 OSBN Community Meeting

**Gretchen:** Good morning and welcome! Thank you for coming today, and spending your time with us. Today is our third meeting that we've had, to collect stakeholder input regarding the use of standing orders and protocols by nurses across various practice settings.

First, I'm going to do a little housekeeping. If you have not signed in, please do so on the way out, so we have a head count of people who have participated.

There is a copy of the PowerPoint slides, there's only two, just for some review information. If you want those, you're welcome to them. There's also two separately-colored documents out there. They are different.

One is to collect any recorded input that you might have on how you or your organization utilizes standing orders in your practice setting. The second one is for you to articulate, to discuss, to describe any concerns or questions that you might have, that you are faced with, for the input collection, about standing orders and protocol usage.

We put them on two different colors, so you can document accordingly. If you get transposed, I'm not responsible. But we want to make sure that we get information.

To let you know, this session is being tape recorded, so that we can capture all of the feedback. We don't want to have to paraphrase what you are saying. We want it directly recorded, or on the information we're collecting.

One thing that has changed since our last meeting, Oregon Center for Nursing is going to be collecting and collating all of the data from these presentations. For those of you that have checked out or picked up a copy of the public notice, you'll notice there's going to be a total of six. We have four remaining, today being the first of the last four.

They will be collecting all of that data, and then they will be reporting out that data to the Board. Now, due to the request of our Board President and approval of all of the Board members, that report out of the data by the Oregon Center for Nursing is going to occur on our September 2019 Board meeting. We initially thought it was going to be in June, but at the request of our Board President, that date has been pushed back to September 2019.

Before we get started with the discussion and data collection, those of you that have attended previous meetings, we had a great amount of feedback about the format and structure, whereby with the exception of two slides, to provide some background and framework, we are not presenting. We are not going to be discussing or presenting what a standing order is, in what setting it could be used.

It was very clear that the stakeholders did not want that, and felt and very strongly verbally communicated that it impinged on their time for feedback. So, we're not doing that. Once we get through these two slides, we want to hear from you, period.

Let's go over some parameters here. We're going to outline the situation. As a framework for starting, just so that everyone's on the same page, please understand that the Board has no jurisdiction over any organization who is implementing a standing order. Our jurisdiction as a health licensing body is over each individual licensed nurse.

Secondly, the Board is not directing any organization to change their process, nor declaring protocols or standing orders illegal. We don't have that jurisdiction.

I received multiple emails and questions and phone calls over the last two months, about everyone angry that the Board of Nursing has prohibited the use of protocols. It's not true. **The RN and LPN still have the total scope of practice authority to accept and implement orders from those authorized by the state of Oregon to independently diagnose, treat and prescribe. That has not changed.**

**We do have jurisdiction over the individual RN who either authors or contributes to the development and implementation of standing orders, and that is where the Board's jurisdiction comes in, to make sure that when that occurs, it occurs within the parameters of the Practice Act and through the standards that dictate how that is to be occurring, according to safe and essential standards for nursing practice.**

**Physicians do not hold the authority to delegate prescriptive authority to the RN or to the LPN. It's not a practice that they are authorized by the Board of Medicine. No one but the Board of Nursing can alter or change the scope of practice for the RN or LPN. The physician does not have the authority to do that.**

**Lastly, the Board of Pharmacy prohibits the pre-signing of prescription pads. Blank medication orders, that's illegal. That falls under Board of Pharmacy rules. And some protocols that have been presented to us to review, it appears that that same process exists, but it's in electronic format. But it's the same type of situation. It's a blank field, a blank prescription. There's no authority for the RN to fill that out, as a prescription, because an RN does not hold prescriptive authority in the state of Oregon.**

That's the situation outline that we are.

So, let's talk about the purpose of today's meeting. We are seeking information regarding the types of protocols that are being used in the community and other settings, which could be in violation of the Practice Act, based on the level of licensure the individual nurse who is implementing that protocol or standing order has.

We need to collect that information, so that we can present it to the Board, so they know what the state of the state is, and then they can make a decision as to how to proceed.

It is very clear that the Board recognizes that many protocols were put in place to facilitate and expedite the care of patients. So, they're put in place for a good reason, and it's mostly in situations where a licensed independent practitioner who does have the authority by the state of Oregon, to diagnose and treat, is not available. We're seeing this in community health settings, in schools, and in other non-structured settings where the intent of the practice is someone comes, [inaudible 00:06:40] incidental to the setting.

Now, the Board did contribute to this process. We formerly had a standing orders interpretive statement posted. As with all of our interpretive statements, they are not law. It is the Board's interpretation of law. And we have contributed to this problem, the Board, because of some vague language that was in that standing order interpretive statement, allowing people to interpret it to fit their need.

Only the Board gets to interpret statute and write rule for standing orders. That interpretive statement has been pulled. If you click on it now, you'll see a little statement saying it's not there. It's under discussion.

Here today, the Board has directed staff, and for me, it's myself, Gretchen Koch, Policy Analyst; Ruby Jason, our Executive Director; and Linda [inaudible 00:07:27], one of our nurse investigators – I'm not sure if we have a Board member here today – to go around and collect information from those persons who are faced with implementation of standing orders, to make sure we know how they're being used, what are the parameters of those questions and concerns that we can bring to the Board, to have them make a decision regarding the situation, so that we can move forward either by maybe generating a rule on it, beefing up the interpretive statement, or whatever their decision might be, to address the issue.

So, that is where we are today. With that, it's your show. You can either record your comments and concerns, questions, on those sheets or let us hear how you're using them, concerns or questions that you are faced with, or maybe licensees within your organization are faced with when you have a standing and now you have a nurse, and now what do I do?

**Audience Member:** I have an issue that came up yesterday at 4:00. This is very timely. I work for Providence, and we are in the process of adding Narcan to all of the physician orders, so that they can order it at the time they order opioids. Unfortunately, we have hundreds of orders, and it's taking some time. So, what was done is they added a pdf that's available to every nurse, that says "In an emergency, give Narcan."

There's no order, so what I'm coming up against is they're saying it's an emergency drug, and that covers them, because it's a pdf attached to a physician order.

**Ruby:** Clearly, there has been lots of legislation around fighting the opioid crisis, and making sure that Narcan is available, even to individuals who are not licensed. The fact remains that if your organization declares it an emergency drug, because there is no other alternative, eventually though, what will happen is it is hopeful that if that Narcan is given, that somewhere along that line, during that particular incident, there is going to be someone seeing that patient, who can say "Yes, this was an appropriate intervention."

There doesn't need to be another order written for it. But the whole issue is, does someone who has the legal authority to diagnose and prescribe, eventually see that patient to say "Yes, we did right by this patient."?

So again, this is part of the fact that health care is changing. It's one of the reasons we're here. Health care is changing. There is more and more procedures and interventions that are being done outside of what has been the typical norm of nursing.

And the Board is accountable for all of the activities and the interventions that nurses do. So, one of the directions that the Board gave us was, does the Practice Act really even address these things? It's not addressed in statute. So then, it is up to the Board to write rule, because the statute does allow the Board to write rule to supervise the practice of nursing, and to develop the scope of practice for nursing.

That's one of the reasons why we're here, because you've got Narcan, that ordinary people are giving. You've got, again, people out in the middle of nowhere, where there is no provider. I mean, we just saw

data that in about ten years, there's going to be 46,000 less primary care providers than the nation is going to need. So, clearly nursing is changing, and the Board recognizes that, and the Board has to wrestle with what they have been legislatively mandated to do and not.

So, in your particular case, if your organization declares it an emergency medication, and the nurse has the appropriate assessment and documentation – it doesn't have to happen, "I'm going to document this, and then I'm going to give you the Narcan." No, you give the Narcan. You save the patient first. Then, you say, as a nurse, "This patient was obtunded when they came in, and we gave Narcan because that's what we do here, to make sure."

Because Narcan, unless there's an opioid on board, is pretty benign. It just does the whole receptor thing. But after the nurse documents. The nurse can't just give it and walk away. It's documentation, "This is how this patient fit this particular protocol, and that's why I implemented it."

**Gretchen:** And from a regulatory, also, standpoint, you always think "Well, why would that be an issue?" When the Board comes in, it's because someone has filed a complaint against the nurse. So, if someone were to take the initiative to say "Oh, I take issue for some reason, why that nurse rescued that person with the Narcan," the facts of the case would be collected, whereby we would look at the pdf, we would look at organizational policy, we would look at the declaration of emergency, by the organization, to make sure that all lined up.

**Audience Member:** So, I think what I need to do is we need to develop an organizational policy that is in conjunction to give Narcan in an emergency.

**Ruby:** Right. And of course, that should be an inter-disciplinary policy, aligned with physicians and nursing leadership.

**Audience Member:** Thank you.

**Audience Member:** I'm just curious as to how this fits in. We're not allowed – the Board is only legislating the particular nurse.

**Gretchen:** Correct.

**Audience Member:** If the Board is directing this nurse, and goes "Okay, in this circumstance, there is policy," then it is driven a little bit by policy of the organization. Or no?

**Ruby:** Nurses are driven somewhat by the organizational policy. However, it always comes back to does that organizational policy fit in with the Board's interpretation of the Practice Act? We have a patient who could possibly expire, because we don't know what's wrong with him. Then, you give Narcan.

I used to be an ED Director. Narcan was always our first. They were obtunded, they were found under a bridge, give them Narcan.

There are those cases where they are declaring that an emergency drug.

**Audience Member:** For all people, all the time. And I think that's probably the difference.

**Ruby:** Right. For all people, all the time, if they come in with this symptomatology, where they are not rousable, you're going to give Narcan as an emergency med. That then covers the fact that not only will the organization stand by the nurse -. Because there's two things.



When nurses are employees, there's two things you have to stand by. First of all, you have to follow your organizational policies, because if you don't, your organization, if there's litigation, your organization is going to say "You didn't follow our policy and you're on your own. I hope you have malpractice insurance."

Unfortunately, as a former nursing director, I've seen many a nurse do that, and end up on their own.

The second piece is the nurse is answerable to the Board. The Board, of course, is about the license, not the work environment. The nurse is accountable to say "Is this within my -?" Well, saving a patient's life absolutely is in your scope, and using emergency drugs to do so, because you have, in the Practice Act, it says that the nurse will provide interventions to assure that the patient stays safe.

So, that's really where that covers it. An emergency situation is a little bit – it's a lot different than what we're talking about, what these sessions have been about.

**Audience Member:** My name is [inaudible 00:15:22]. I'm with Oregon Youth Authority, which is a correctional facility for adolescents. My question relates to the Narcan issue, and basically you've answered part of the question that I had. However, because we are a correctional facility, there's also staff that we don't necessarily attend to, the nurses there. Maybe the first aid situation.

It sounds like the layperson is less restricted to use Narcan, because Narcan -.

**Gretchen:** We don't regulate laypeople, but by statute, when Narcan first came out, it was designed for an MP, a physician to be able to train someone, to train laypeople how to administer it.

**Audience Member:** Oh, okay.

**Gretchen:** But your organization is going to decide if it's going to be more restrictive than that.

**Ruby:** Yes, laypeople have a lot more leeway, because they're not regulated by anyone. So, a lot of people are saying "Well then, heck, why should I hire nurses? Why don't I just get some people, and they do whatever they want?"

However, what happens there is the Board vouches for the fact that the nurse has met the minimum education and minimum qualifications, in order to practice nursing. If there is something that happens, the Board is the public recourse, saying "I know that was okay over in Providence, but I don't like the fact that you were cruel by resuscitating my son who," whatever. Because believe us, and Wendy can vouch for that, there are all kinds of complaints that come to the Board that are a little bit "Really? You're going to complain about that?" But we are bound by law to investigate all of those.

So, the public has recourse with the Board, that says "Hey, you said this person was qualified. Now, this person isn't qualified, and you need to do something about that." Whereas if a public member does that, there is no recourse. They can't go to jail, really.

The concern is that since these individuals, and this is Gretchen's really, Gretchen's strength here, is if you are in a community based setting, where nursing care is not what people are there for, there are those things about how are you educating your staff, to assure that they can safely do this, to protect your clients, and also to protect the staff, that they know exactly.

So, there's the whole thing about teaching plan, and all of that. So, I would say that the idea of licensure is all about public recourse, and assuring that there are certain people who say "I practice." Now, that person who is the layperson can never say "I am a nurse." That is a legal title in this state. With that legal title comes an inordinate amount of public trust.

So, that individual can do that procedure. They will not be reported to a Board, but the point is, Boards exist for public protection. So, where is that person going to go?

**Audience Member:** Right. This issue came up recently, because it was the security department that sometimes have an individual, and they're doing a body search. We tell them "Always use protection when you're doing this," but it happens. So, they may come in, they're concerned that they may come into contact with medication, or not medication. A drug that [inaudible 00:19:09] have on them, and absorbed.

So, they're asking us what is the process to take, concerning Narcan.

**Gretchen:** Again, it would be how your organization terms to declare it, and then puts the policy in place to support that, so the employees are safe.

**Audience Member:** That makes sense.

**Audience Member:** Can you touch on vaccine routine standing orders around CDC recommended vaccinations?

**Gretchen:** The question was to touch on vaccine standing orders. In what respect?

**Audience Member:** In the nurse's authority to order it, based on the standing order, if the patient meets the criteria.

**Gretchen:** Linguistically, if an order exists, there is no need to reorder. A nurse might communicate that – a nurse would go in and assess the patient, the client, to determine they meet the criteria of the standing order that has already been authored by a person authorized by the state of Oregon to independently diagnose and treat.

The RN determines or the LPN determines the patient meets that criteria. So, they're doing an assessment of the client, i.e. engaging in nursing practice. The client meets that criteria. That order exists, and then they may implement that order.

I don't know if there was something beyond that.

**Ruby:** The key difference for immunizations is it's population management. So, the nurse isn't going to say "Okay, we're going to give you a vaccine for" whatever, Tdap or whatever you're going to give, "And we're going to give you .1 cc. But we're going to give you .5." It's the same dose, and all the nurse is doing is, based upon the CDC guidelines and all of that, saying "You don't meet the criteria."

It's an exclusion activity, rather than an inclusion activity. So, vaccines are something that is more of a public health, and there is someone, a public health officer who said "This is what we're going to do for the community," and your organization has adapted that. That then authorizes the nurse to go ahead and implement that.

Because someone who has made that decision, authorized to make that decision, says “Everyone in this room is going to get the same dose, except you, because you’re allergic to eggs.” So, it’s exclusion rather than inclusion.

**Gretchen:** And the RN or LPN faced with that order would look at those Division 45 standards that any nurse looks at with any order, from propofol to Tylenol – people have heard me say that – to make sure that my actions are consistent with acceptable standards of safe care, before I accept, and then implement it, the order that exists.

**Audience Member:** I have a question to immunizations, also. So, I understood that part completely, about immunizations, and it is just that situation where you’re not really making a diagnosis. You’re making an assessment, which we can do.

However, with those immunizations, there’s an attachment that talks about allergic reaction, and what to do in the event of an allergic reaction. And it will tell you anything from producing an EpiPen to Benadryl. So, is that part of that?

**Gretchen:** Whatever document it is that you would be referring to would demonstrate that. If there is a clear nexus, and those instructions are included as a part of the emergency response, that’s signed by the prescriber for that population, versus someone who just comes and staples it on after the fact.

**Audience Member:** We have a variety of standing orders that we’re trying to clean up. Is there a list or guideline as to what is needed for a standing order to be [inaudible 00:23:24]?

**Gretchen:** From an RN, if I’m authoring it, I’m going to look at my Division 45 standards, on what needs to be in place for any order. And then, whatever the demographic population is, and any organizational policies around the RN and LPN’s role in accepting and implementing orders, integrating all of those.

**Ruby:** I think the question from us to you is, what scenarios are you using your standing orders in? How are you using them, in your organization?

**Audience Member:** We have quite a few for pre-op, in terms of lab work, medications for anxiety or sleep. We have some in the emergency department. A patient comes in and needs to go home with something, and there’s a standing order to provide whatever that is.

Those are the two main areas.

**Ruby:** So, let’s run down the list. Has someone who is legally authorized by law to diagnose and prescribe, seen that patient prior to or after the implementation of those standing orders? For example, pre-op; have they been seen by the surgeon previously, and the surgeon has said “You’re clear. We’re going to go do the pre-op orders, and implement my pre-op orders.”?

**Audience Member:** At some point, yes.

**Ruby:** At some point, yes, at some point. So, one of the things that the Board is trying to figure out is at what point does there need to be an intervention by someone authorized to diagnose and prescribe? Protocols and standing orders have been used for years and years and years, alright? And again, because practice is changing, as we all know, is our former concept of what a standing order is, answering the needs of the patient, and keeping the nurse safe, within their parameters of education and licensure?

Because this is all about education and licensure, not how smart you are or how experienced you are. So, a standing order traditionally has been someone has seen the patient or is going to see the patient, like ER. ER; you come in, you draw a rainbow, you may be doing an EKG, you're doing all of these things, and you might even be sending the labs off, rather than just drawing the rainbow and holding.

So, you go ahead and do all of that. And at the end of the visit, or some time during the visit, somebody comes and says "Yes, this is the data I needed, to take care of this patient, and I am going to diagnose this patient based on the data that you've collected up front, that this patient is okay to go home," or whatever it is they need.

There is someone signing off on all of that, at the end of the visit, that is authorized by law to diagnose and prescribe. And that's the traditional viewpoint of that.

The Board, again, has no authority over whether you use standing orders or not. The question is, is the nurse backed up by someone who has legal authority? And that's really the issue.

I would probably tell you that the majority of standing orders, when that order has been authorized by someone, or is going to be validated by someone at some point, is okay. I mean, it's what standing orders have always been.

I think what this discussion was predicated upon the fact that in some cases, standing orders and protocols have been developed that there is no one, either at the beginning, saying "Yes, you fit the protocol," or someone at the end, saying "Yes, I authorize this to be done," that is doing that. So, the nurse is doing that kind of in a vacuum, based upon written orders that are not specific to that patient.

**Audience Member:** Like immunizations.

**Ruby:** Immunizations are not single patients. They are population.

**Audience Member:** [inaudible 00:27:51]

**Ruby:** Right. What we're concerned about -. And again, we need to absolutely stress that this is a new area for the Board. That's why the Board asked us to do this. Get information. And it is very clear that the vernacular of what standing orders and protocols are has morphed over time, because of the need. There just aren't enough LIPs out there.

So, what does the Board now need to do to keep up, but not allow nurses to say "Okay, you know what? You don't need a provider to do any of this. You can just use your own judgement."? Which we, as RNs, do not have the education, preparation or licensure to do.

So, standing orders, if there's a bookend somewhere, where there is someone who is licensed saying "Yes, this is the right thing to do," then I'm just going to use Ms. [inaudible 00:28:48] over here, as an example. Wendy used to be part of PANDA transport team, and they did nothing but work under protocols. Nothing.

They came in, went to every hospital around here, went to the ER, went to the ICUs, took care of their patients. They went back, they reported off to the provider, and the provider signed off on the chart, all under standing orders and protocols. But they did not – that order was validated by that particular provider as correct for that particular patient, based upon the previously designed protocols that I signed off on, you signed off on, we all signed off on it.

**Wendy:** And had to make a phone call to the provider.

**Ruby:** And had to make a phone call.

**Wendy:** There had to be a phone call to the provider, at some point during that process.

**Ruby:** And that's the traditional model.

**Gretchen:** Did you still have a question?

**Audience Member:** I have a question. I work with outdoor school. I'm the program nurse. We had standing orders that enabled us to have staff meds. Without having standard orders, now the parents have to provide all of the over-the-counter meds. So, we can have up to 150 kids, which potentially we would have up to 150 ibuprofen, Tylenol, Benadryl, which trying to oversee, manage that with a new group of kids each week is a huge problem, where we can't have like just one vial, because the law says they need to come from – the parents need to provide it.

**Gretchen:** Is that Department of Ed law?

**Audience Member:** Department of Ed law. So, that ties our hands that way. If a parent doesn't send it, and we have a kid who has a fever of 105, which we recently had, the parent had to come get them. But it can take an hour or more to come get them, and we have nothing to give them. Dealing with that is [inaudible 00:30:47] frustrating.

**Ruby:** There are so many practices out there that have developed, that have outstripped what the Practice Act says. The Practice Act is absolutely silent on over-the-counter medications, based on a nurse's assessment whether or not they need to give it.

It's gotten to the point where, if it's a fever, that would be a diagnosis. But if the kid feels warm, that's a symptom. Right? So, that's how convoluted all of this gets. And clearly, the Board of Nursing has never addressed this, and it is time that they do, and the time that we give information to the Board, for those nine people to make those decisions about "Yes, we have to keep up."

Because clearly, the Practice Act, which is kind of like the Titanic trying to avoid the iceberg [inaudible 00:31:36]. The fact is that the law is very difficult to move. But clearly, we do not, none of us want to see a nurse hanging out there, flapping by themselves, because they implemented something they thought was right for the patient, but by law, may be out of their scope.

So, we're trying to get the information so that we can give that to the Board, so that rules can be developed that protects the patient from individuals who are not as conscientious as others, but allows nurses to be able to take care of their patients, without worrying about "Is that in my scope? Is that not in my scope?"

Because one of the things we are doing with the Board is trying to write all of our rules in clear English, because this is one of those examples when it was not in clear English, and here we are. Everybody had a need and they went "Oh, I think this is what this means," and they moved forward.

When we brought this to the Board, the Board went "Oh, no. That's not what we mean." That's how we got here today, when we said to the Board "Well, we're going to need more information, because it's out there."

So, over-the-counter meds is part of this. Your situation, as camp nurse, I mean, most camp nurses do nothing but, you know.

**Audience Member:** Do you have a provider to contact?

**Audience Member:** We did, but now they [inaudible 00:33:06].

[inaudible 00:33:07]

**Audience Member:** I'm surprised that fever would be considered a diagnosis, when that's a data point. That is a temperature of X, as a symptom of whatever the underlying diagnosis is.

**Ruby:** I think we'll find fever of unknown origin in the diagnosis code, and that's really where we're going here. What is so – I'm going to use this word, that's not an official word – what is so ridiculous is that a nurse cannot use their judgement to say "This kid is going to -."

I was a pediatric nurse for a long time. I'm not going to let this kid have a febrile seizure. But what does that do? Because right now, the law is silent on that. And again, those nine people that are on the Board, they are the ones who determine whether somebody is practicing out of scope or not. Not any of us here.

What we want to make sure is that they have, and our investigators have, the ability to say "Yes, this is. No, this is not a violation of the Practice Act." And these issues have not been addressed by the Practice Act. So, we need to start doing that.

But again, fever is a diagnostic code.

**Audience Member:** Is elevated temperature a diagnostic code?

**Ruby:** Elevated temperature, no.

**Audience Member:** [inaudible 00:34:20] what could help her?

**Ruby:** We're trying to help her, too! But the fact is that fever is a diagnostic code, where elevated temperature is not. So, do we say -?

**Audience Member:** Right. So, is it our own documentation that is hurting us?

**Ruby:** No. There's nothing right now that we have, that says it's hurting you or it's not hurting you. We don't know. That's why we need this, this -.

**Gretchen:** This information.

**Audience Member:** Fever may be diagnostic, but 105, 104.3, whatever, is data.

**Ruby:** Data.

[inaudible 00:34:53]

**Ruby:** It's symptomatology. But if there is no provider, she says there is no provider because of the laws that govern those types of programs. Because one of the things that the Board of Nursing – and Gretchen is really our community liaison – one of the things the Board of Nursing struggles with is so many people writing rules and laws for nurses, that is not in the Practice Act.

There are many times when somebody calls us and says “Hey, this law passed,” and we’re going “What? What?” There’s a law right now, saying all of you need suicide prevention education, three to six hours.

**Gretchen:** Every two years.

**Ruby:** Every two years. Not us. And we have to implement that, because we are executive branch of the state government, and we have to implement this.

These are the kind of questions we need. So, one of your situations is I’ve got these kids, this is the laws I have to follow. I’ve got no provider, but this patient has an elevated temperature of 101. What am I supposed to do about this?

Now again, we can’t change those laws, because that’s not in our jurisdiction. But we can give guidance to the nurse, so that they can stay out of investigation by the Board, and that they have clear language that says “This is good for you to do to your patient. It’s the right thing to do.”

**Audience Member:** Ruby, you’ve obviously heard me say this before, but the way that other states have worked through this, the way that it seemingly, based on advice published by OSBN previously, is to have it be symptom-based, data-based, algorithmic approaches to providing care. Right?

So, like if the diagnosis piece sort of becomes moot, or becomes a red herring, when we start talking about condition-specific standing orders that allow the nurse to provide treatment, based on presence or absence of inclusion and exclusion criteria.

And that’s well established in the literature. It’s well established in what other states are practicing. And it’s one of the things that’s concerning to us, as we go through this process, is why are we only circling around patient specifically? What is the obstacle to opening up our concept to include condition-specific standing orders?

**Ruby:** That’s why we’re collecting this information, because the answer right now really isn’t out there. The answer right now is that the traditional model is; there’s the provider, there’s the nurse. The provider determines the diagnosis for that individual patient. They provide the treatment. And if that requires prescribing, then those prescriptions are given by someone.

The models you all have developed, out of your need – no one is stating that this wasn’t necessary – have outstripped that traditional model, and it’s the Board that’s going to have to look at information like that, to say that “Alright. What does the literature support?”

Because one of the things that’s facing Boards, too, is our Boards being more – and this is national. The Supreme Court decision in 2015 has pretty much changed a lot of the landscape of regulatory.

I can’t go into it today, because it’s too lengthy, but if you want to Google it, it’s FTC versus the Board of Dentistry of North Carolina. What they determined was that, is the Board more concerned about the sanctity of the profession versus the safety of the public? And that rules need to be written according to what literature says is safe for the public, but that stays within the educational and licensure parameters of whatever license type we hold.

So, that’s what the Board is struggling with. How do we accommodate this literature? And you are absolutely correct in stating that the literature about symptom-based treatments and all of that is out there. But the Board of Nursing in Oregon has not answered that question.

We have been researching all of the other Boards, and there is a variety of ways, across the country, that Boards handle this. We've also obtained literature from the U.K. and from Canada about nurses prescribing. And we have actually talked about that in this group.

So, all of that, and that feedback you're giving, is going to the Board, for the Board to assimilate and do their nursing assessment on that, and then give guidance to the Board staff about what the next steps are. Because we can't decide that. It has to be the Board.

**Audience Member:** We have two kinds of protocols that we use frequently for our nurses. One is based on a referral from a provider, and we -

**Gretchen:** In what type of setting are you practicing?

**Audience Member:** We're a primary care FQHC. So for example, under the referral category, we adjust warfarin and diabetes medications, based on inclusionary criteria and exclusionary criteria, and then set a data point, and then they recommended those adjustments to our patients. And then, those charts are forwarded, like after the recommendation to the patient is made, they're forwarded to the provider.

Then, another kind of protocol that we have are for nurses, that are based on symptoms, specifically for example, pharyngitis or sore throat. And they're scheduled for those appointments based on some basic inclusionary and exclusionary criteria, when they call our call center. Then, the nurse kind of rules them in or rules them out.

In the case of the pharyngitis protocol, they're either looking at either or both of Centor score and a rapid strep test. If they indicate [inaudible 00:41:17] for strep, we have a [inaudible 00:41:20] approach for what the prescription antibiotic would be; if they're allergic to penicillin or if they're not allergic to penicillin, or they're this or that or whatever.

Then, the nurse, as it's written, pens the prescription, reviews with the provider, the provider signs the prescription. But one of the issues that we have is if the patient meets the inclusionary criteria, doesn't meet the exclusionary criteria, has this objective positive strep test, or meets the Centor score, which is diagnostic criteria, is not allergic to penicillin; is it necessary that the patient be held back in the clinic for 15 to 30 minutes, so that the nurse can present to the provider this very yes/no, yes/no, yes/no, does not deviate kind of thing? And then, have the provider click that last button.

This is something that we struggle with, about it is very prescriptive and it is not like -. All of the decisions are made by the provider, and the nurse is including or excluding the patient. So, that's something, like both types of those protocols, that we've struggled with, and actually have submitted some requests to you guys, and have kind of gotten vague responses that left us uncertain about how to proceed.

**Gretchen:** Do you want to speak to the coumadin?

**Ruby:** The first protocol that you're talking about, where someone has said "You have diabetes, or you need some anticoagulation. Go get your care over there, and they're going to implement a protocol on you." Someone has assigned that protocol to that particular patient. Right?

Again, coumadin is a maintenance, is absolutely the poster child for all of this, because that is exactly what the traditional model looks like. Someone says "Yes, you're on that protocol. Go to this clinic



where you're going to see nothing but nurses, and the nurses are going to manage you under this protocol."

And the protocol says "If the INR is this or that, you need to call somebody."

**Gretchen:** By someone, she means a licensed independent practitioner.

**Ruby:** A licensed independent practitioner.

[inaudible 00:43:38]

**Ruby:** The second part of your question is exactly what we're here to answer, because if you've got very, very clear criteria, and it's an inclusion/exclusion criteria, and it's very clear and it doesn't deviate at all, and there's not this choice in paths about "Well, you can give this many of this and this many of that," that is what we're here to talk about.

That's what the Board wants to know, about how you are using those right now. Because again, the traditional model is that yes, you do have to wait. Because that's the traditional model. Does the traditional model work in this day and age? That's what the Board wants to know.

So, this is one of those inputs that we need, that says "This is how we're using this protocol." This patient shouldn't have to wait half an hour or however, so the nurse can go "Hey, fits protocol [inaudible 00:44:41]," and the person on the other end says "Yeah, go ahead." That doesn't quite work out.

**Audience Member:** That's exactly what happens a lot.

**Ruby:** Yes, exactly. I know that. I've worked in those scenarios. Yes, that's exactly what happens.

So, that's what the Board is here to answer, and that's the kind of information the Board needs. What is it that we're really seeing out there, that currently, the traditional view of the Practice Act no longer fits? And how are we going to work together, and what decisions and directions are the Board going to give us?

**Audience Member:** Under that, what you said about addressing the diabetes and the warfarin and stuff, is it that, in your interpretation of that scenario, unnecessary for the nurse to pend the prescription, and then go have the provider sign it, since they're working under that established protocol that they have a referral for?

**Gretchen:** Well, I would say that the provider has evaluated that individual. They have a treatment plan that includes that protocol, and they have signed that, so it is existing. It is a living, breathing order. And then per your assessment, then you would say how they would meet the criteria, and the pieces that are implemented.

**Audience Member:** Right. The provider has to take responsibility for that, on the back side. It's not having signed prescriptions that [inaudible 00:45:58].

**Gretchen:** Exactly. It's not the blank pad.

**Audience Member:** I guess what I'm saying is right now, even under that protocol, we require that the nurse pend the prescription, and send it to the provider, and the provider [inaudible 00:46:11], even

though they're working under an assigned referral protocol. And that creates a delay for the prescription to get transmitted to the pharmacy, for the patient to be able to get it, even though the nurse is working under this protocol.

So, I guess I'm just saying in that instance, for a point of clarity, what I'm hearing you guys say is that extra step is unnecessary, and that the requirements of practicing within the scope of protocol and this existing rules is met by the initial referral.

**Ruby:** We don't know.

**Gretchen:** Yeah. We don't know. That's why we're here.

**Ruby:** That's why we're here. We don't know.

**Audience Member:** Can I add a piece to that? In some of these protocols – I'm from [inaudible 00:46:50]. Do some of these protocols suggest that there is [inaudible 00:46:56] diagnosis, a medical diagnosis?

**Gretchen:** We've seen those, too.

**Ruby:** Yes. We've seen those, too. That's really where a lot of that issue is, is you've made a medical diagnosis that's a diagnosis, a legal diagnosis, and you, the nurse, have determined that the treatment plan is appropriate, and have the ability to taper or – I'm sorry, to determine a variety of solutions that require prescriptions.

You know, "If the person is breastfeeding, you do this, and consider this medication, and consider that. And if they have this symptomatology, consider that." That's really where we have some, where the Board has said "We have some concerns about that."

I wish I could sit here and tell you "Yes, this is the interpretation." But clearly, the way the Board had previously interpreted this led to this Board making some concerns about this. Because quite frankly, when we brought this to the Board, about questions we were getting, the Board went "Oh, no no no no no! Can't do that!"

Well, okay. The problem is that there's no plan B for these patients. So, the Board said "Let's let everybody just do what they're doing. Don't change anything," which again, don't change anything. Because again, if your organization is signed off on that protocol, fine.

What we're talking about, don't change anything, is we get a complaint about a patient who got a medication from your clinic, that was implemented by an RN, and that RN implemented the protocol and there was a complaint. Right now, the Board doesn't have a lot of guidelines that says that is or is not within the Practice Act.

So, we want nurses to be able to care for their patients, without that threat of the Board's going to come get you. We want that gone, and have very clear language. And right now, we don't.

**Audience Member:** We would like that gone, too.

**Ruby:** Yes. So would I. My goal, when I got to the Board of Nursing, was to clarify the Practice Act, and make it speak English.

[inaudible 00:49:12]

**Ruby:** Because there are people who don't want it to speak English, because of the fact that it needs to have enough leeway to fit every single clinical scenario. That's why in the Practice Act, you will not find any laundry lists of stuff. In fact, for those that yes, you do all get, if you're licensed by this Board, you do get the Sentinel. It may go to your junk mail, but it is emailed to everyone. And there's an article -.

**Gretchen:** Last time.

**Ruby:** Last time, about why there are no easy answers in the Practice Act. But if it's up to a Board to determine whether a nurse, a single nurse, has violated the Practice Act or not, then the Board needs some very clear language that nurses also read it, and they understand it the same way.

So, we do not have an answer for that part, but what the Board has said is "Don't change anything. Don't do anything. Just do what you're doing, and no nurse is going to be held accountable to the Board." Whether or not your patients agree with you or not, that's not – they may still complain to us. But it will be brought forward, and be under that caveat of protocol. And the Board knows it still needs to make some decisions.

**Gretchen:** Did you have a question?

**Audience Member:** I did, and you may have answered it. I was sitting here thinking if there is an algorithm right now that people are using, built on symptoms, and I'm going back to the over-the-counter stuff, and I think about telephone advice specifically. And I think that [inaudible 00:50:41] OTCs some time ago, so it's really saying that's not appropriate for the nurse to do. That is considered prescribing.

But I see two things – just an observation. I see nurses see a fever, see a data point, and they see a UA, and they say "UTI." They don't say the symptomatology. So, that is a very fine line. And I think that as these protocols are written on symptoms, nurses are quick, and they are moving through what they are doing. And they often do the diagnosis, and they will say that to people on the phone, or they will do that when they're working with patients.

And I think that is a danger point, where we are right now. But it seems to be ongoing. They still have to do it based on symptomatology.

But my question, then, was going to be, if somebody is practicing with an algorithm like that for telephone advice or something else, and they are getting symptoms, and they document symptoms, and they have some sort of protocol around symptomatology; if the Board is silent, is that acceptable? Or is that another "I don't know. If you're doing it, don't stop it. If you're not doing it, don't start it."

[inaudible 00:51:57]

**Ruby:** That's the message today. One of the things that is absolutely in our feedback from everyone, is that we have to address the symptomatology piece. If the technical piece is – because I can tell you our physician partners don't want us to diagnose, diagnosing, because they may want to do that.

They may want to give you a protocol, but if you're diagnosing without a protocol, there would be a problem. So, there are patients that have a need, nurses that know how to deal with symptoms,

because that's what we do. Right? Sometimes the gray line comes when there's medication involved, because that is a prescribing thing.

But the Board absolutely has to have this information about what about symptomatology? Does that cross that line? And again, yes, you're absolutely right. If you're doing something, don't stop. If you're not doing [inaudible 00:52:59], until all of this is done.

**Audience Member:** It sounds almost like there's three pieces that are – like we're using protocols and standing order kind of as the same thing. But it almost sounds like you need a facility or policy to support your protocol, that's your algorithm, to decide you have a standing order that's appropriate, and a provider to back up that standing order.

**Ruby:** When you look at the literature about what is a standing order and what is a protocol, those two things are differently defined.

**Audience Member:** Right. And that's kind of where I think we're getting a little, using them interchangeably may make it more confusing.

**Ruby:** And that's the word that's out in the community. The Board doesn't want us to use standing orders. Well, no. The Board never said that. The Board is looking at the legality of an RN, and how they are written, whether or not the RN can implement that, and stay within the scope of practice, as defined by the Board.

That's what this issue is all about. It's not about whether organizations can use it or not. We're not like the Pharmacy Board. The Pharmacy Board can shut down a pharmacy or shut down a hospital pharmacy, if they're not compliant. We can't do that. We only have jurisdiction over individuals.

So again, yes. But the Board, it would benefit if direction came from an official discussion and definition. Because you know, you get one piece of literature, and you can't get another piece of literature that says something different. So, the Board has to have all of that information, to say "In Oregon, this is our definition of what is a standing order and what is a protocol."

There was a lot of discussion about refills of medications, too.

**Audience Member:** Even thinking of your example of the sore throat, you're following a protocol that determines that you need a signature. But that's not a standing order. The order is when the physician signs it.

**Audience Member:** Well, at the end of the protocol, if you're like yes, yes, yes, this patient meets the criteria to treat them for strep throat, the treatment is the next step. So, it's kind of like what you were saying. You used a protocol to arrive at, should you use the standing order? Then, the standing order is the next page.

**Audience Member:** But it's not a standing order if you have to then get a signature. A standing order is predetermined by the provider that yes, this is appropriate, and I will verify later.

**Audience Member:** That's one of our questions. Why do we have to get a [inaudible 00:55:16], if we can work our way all the way through this?

**Audience Member:** Right. Because you don't have a standing order. You have a protocol for the patient.

**Audience Member:** And is that requirement based on the work that you're doing, or is it based on the policy of your institution? Of your business?

**Audience Member:** I don't understand the question.

**Audience Member:** You're saying that you're going through all of this, and then you're still having to have the patient wait for the doctor. So, is that something that is directed to you to do by your entity, the business you work with?

[inaudible 00:55:56]

**Audience Member:** That's them not wanting to take liability, so they're wanting to "Yeah, you can do this. You can do this. You can do all of this that you can do, but we still need the doctor to follow up."

[inaudible 00:56:10]

**Audience Member:** I am a physician. I'm a public health officer and a primary care provider [inaudible 00:56:26]. I oversee nursing activity in both settings, and I'm curious about how much the Board of Nursing can verify what physician oversight needs to be, versus how much I need to take to the Medical Board, to clarify what physician oversight would be, when we talk about standing orders in particular.

Because if we have a [inaudible 00:56:56] waiver, somebody who immigrates, who has something that looks like it needs to be evaluated [inaudible 00:57:03]. There's some very, very clear symptoms and labs, yes or no, that don't need much interpretation. If I write a standing order that says all of these things are met, then you can start this medication under my name, versus if all of these things are met, call me, tell me those things, and I say yes; that doesn't seem like a huge difference in my [inaudible 00:57:31].

So, I'm happy to get those phone calls throughout the day and say "Oh, yes. The patient meets the criteria. Go ahead and do it." But it's weird. Is there a clarification of what sort of oversight the doctor needs to have, that can be written here, to clarify things? Or does that totally have to come from the Medical Board?

**Ruby:** In answer to your question, I can't answer those questions specifically, because again, the Board hasn't made a decision. But let's talk about the physician/nurse legal type, alright? The physician, when you say you have oversight of the practice of nursing, you have oversight in how nurses help you, as a physician, care for that patient population you're responsible for.

**Audience Member:** [inaudible 00:58:19]

**Ruby:** Right. You don't have oversight over what is in their scope and not in their scope. So, if a nurse works outside of the scope, as defined by the Practice Act of Nursing, the Board has jurisdiction over that, and they are the deciders. Not anyone else in this room. They are the deciders, because that's what the legislature has given them the authority to do.

So, the relationship between physicians and nurses, as you all know, gets blurry after a while. But the legal – and we're not here to talk about in practice. We're here to talk about what the law says. The law says that the individual who is licensed by a Board has no authority over the practice of another individual who is licensed by another Board.

So, while you're talking about nurses helping you implement your treatment plan for a specific patient, via a pre-written document that guides the decision-making, the nurse is still bound by the Practice Act, to determine whether or not that is appropriate for the patient, even if there is guidelines. So, if the nurse says "Yeah, I got this, but this is not what this patient feels like, looks like. I don't agree with this protocol on this patient," the nurse has the obligation to call you and say "Hey, listen. We've got an outlier here. What are you going to do about it?"

That's really where the nurse – if the nurse, at the end of the day, says "Yes, this patient fits the protocol, and I have the ability to call someone," could that be within the scope of practice of a nurse? That is what the Board is trying to wrestle with.

Really, the relationship between a physician and a nurse is the fact that the nurse is assisting you to implement your medical plan of care. But the nurse has their very own independent scope of practice that they are always accountable to, to say "No, this is not okay for this patient," or "No, I don't agree with this protocol."

Because the nurse is ultimately responsible for their own decision-making, regardless of what protocol has driven their decision-making, what algorithm has driven it.

**Audience Member:** So, the Nursing Board can't make any decision as to what extent of involvement the physician has in a particular order?

**Ruby:** No. And we don't have any -.

**Audience Member:** You can't say it has to be emailed or it has to be phoned or it has to be in person.

**Ruby:** No. We don't have any authority to tell you how to practice. We only have authority to say that nurses are not practicing within what the Board defines as the scope of practice of a nurse.

**Audience Member:** Is there anything from the Oregon Medical Board that could be adjusted, that can help clarify some of these questions?

**Gretchen:** Like a definition for oversight.

**Audience Member:** Right.

**Ruby:** The only thing that the Board of Medicine has, and I have corresponded with them extensively about this, and they're very hesitant to do much of anything about this – they're going to leave it to us. Because they say "Ruby, that's a nursing issue. You're talking about nursing. It's a nursing issue."

But the only thing that the Board has done, that philosophical statement about spa ownership, about working with unregulated individuals -.

**Gretchen:** Medical spas.

**Ruby:** The Board of Medicine doesn't really want to discuss talking about it, because it is up to the Board. And they're amazing people. I love [inaudible 01:01:35] them. But they don't want to talk about when is there that – and I'm going to – it's not the right word, but it's the only word I can't think of right now – is the intrusion of medical practice, to dictate what the practice of what nursing is going to be.

They don't want to get into that, because that's the Board of Nursing's purview. Because we have had requests. "Get the Board of Medicine up here. Get the Board of Pharmacy up here." The point is, this is about the practice of nursing.

The only thing the Board of Pharmacy will commit to is that bottom statement. That is all. The physicians not having authority to expand, that's not even the Medical Board's determination. That is in statute, that only the Nursing Board has it.

So, where does a nurse assist a provider, an LIP, into implementing their plan of care, in addition to the nursing plan of care, because the nurse cannot just practice off of the provider's plan of care. We have our own domain we have to [inaudible 01:02:32].

Where does it traverse into the – well, now you delegate the practice of medicine, which is independent diagnosis and prescribing on a specific patient, for a specific symptomatology attributed to that patient, versus population management versus immunizations versus coumadin protocols. That whole morass of how this has all developed, that's what the Board is trying to deal with.

The fact is that nurses will assist. But where is that line drawn? We have seen protocols that are amazing, amazing. And actually, we've seen very few protocols that could possibly traverse into that gray area. And that's really what we're talking about now, because we don't want it to be gray for you, and we certainly don't want it to be gray for our licensees.

We want, at the end of the day, the patient to be cared for safely. Because at the end of the day, this is all about the patient. It's not about the Board. It's not about you and me. It's about what is right for the patient, and how health care has had to change, to accommodate the changing structure.

More and more individuals are going out in their community. Well, there aren't enough nurses, there aren't enough providers in their community. So, now you have unregulated individuals providing all of this health care. They may or may not be qualified. Where do we go with that?

So, there's that changing environment. Basically, it's you, as a physician, have no authority to dictate the practice of nursing, and nursing has no authority to dictate the practice of medicine. Now, where does that juncture go?

Because the traditional model of you write the order, [inaudible 01:04:07] the order, we're all nice and clean, that doesn't work anymore. Not in these environments.

That's what we're trying to address here, and we do not have an answer for you, because the Board has to answer for you.

**Audience Member:** So, in the situation that the provider described here, where you have A, B and C, and do this at the end of the A, B and C. And you have A, B and C, and it's A, B and C, such as in the case of a standing order. The nurse still has that understanding of "I have to do A, B and C, but along A, B and C, I have to assess."

[inaudible 01:04:56]

**Audience Member:** Right. And as soon as you do not have that A, B and C, and this has always been my understanding of a standing order, is you stop. You get on the phone, and you call the provider.

**Ruby:** Absolutely.

**Audience Member:** Because it doesn't fit this mold anymore, that I am authorized to use and to practice, or to follow this guidelines, and to yes, initiate treatment to an individual. That's always been my understanding of a standing order, is follow that. And I think that that's part of the problem right there, is when the nurses don't stop and assess, do their own assessment, when they're missing one of those points, and don't get on the phone and call the physician.

**Gretchen:** That's when they go to the Board. You diagnosed. You did not follow protocol. You did not assess. You went outside of your facility's policy and protocol to follow a standing order.

**Ruby:** You're absolutely right. And the other part of the Practice Act says that you will not implement any provider order if you do not believe this is in the best interest of the patient, or follows the treatment plan for the patient.

There's so many facets to this, and one of them is how nurses themselves view their relationship with licensed independent providers, to say "Well, I have to do it, because the doctor ordered it." No, no, no, no, no. If that was the case, the Medical Board would be deciding the practice of nursing, and that's just not how it's set up.

But again, that's way outside the parameters of this. We could talk about that one forever. What we're here to do is, how are these protocols being used? What do they contain? What is the current landscape of practice? That we really need to make sure that, first of all, public safety is being met.

Secondly, that nurses understand what their parameters are, and that physicians and PAs and nurse practitioners and DOs and MDs and all of the other individuals who are authorized by law to prescribe and diagnose, that they also understand what the parameters are.

And right now, the Board of Nursing has not clarified that very well.

**Gretchen:** We had a question in the back.

**Audience Member:** [inaudible 01:07:14] about in terms of the standing orders or nursing protocols, if you will, if a Chief Medical Officer is signing off on all of these orders. We have over a hundred providers, from specialists to primary care physicians and nurse practitioners working, who are either signing off or co-signing all of these [inaudible 01:07:39] patients. But that Chief Medical Officer has in theory never seen the patient, [inaudible 01:07:45] pre- or post-treatment medication.

Is that an area of concern? Or would we have to get [inaudible 0:07:54] signatures, because [inaudible] applies to all of our providers.

**Gretchen:** That's a good situation to describe on your sheet, or hopefully it was picked up on the recorder, because that's the kind of practice situation the Board needs to know about.

And then, you had a question?

**Audience Member:** That was actually almost exactly my question.

**Gretchen:** That's great!



**Audience Member:** I was considering, I was struck by you said kind of the bookend approach, pre-care or post-care, having an LIP involved in the individual, linking that individual plan of care protocol to the unique patient situation [inaudible 01:08:29] described.

If you are bookending on the pre- end, and you have a protocol that then could be implemented for a specific patient, but there is not that loop-around for validation, like you used that validation word, how would that then work? Because you wouldn't have documentation, where you wouldn't have a way to prove that that unique plan of care was validated by the provider, if it was bookending it on the front end.

I'm thinking, for example, any type of protocol that could be implemented based on symptomatology and assessment findings by the RN.

**Ruby:** At the end of the day, it is – I heard the question say it's on the front end, and the nurse implements the protocol, because this person fits the protocol. And someone has said "Yes, this person fits the protocol. We're going to go do surgery on this person on Tuesday. They're all good to go. My pre-op assessment has said that they're fine. You go ahead and implement my pre-op orders, and you go down the line."

That's where the nurse's independent judgement comes in. The nurse has to document, throughout the encounter with the patient, their assessment information, and has said that "Yes, this person is okay to implement."

It can't just be "Okay, I got this standing order from Dr. Z over here, and this patient's showing up, so I'm just going to go down my checklist. And now that I'm done with my checklist, I've implemented everything I was ordered, and now I'm done."

The nursing independent scope of practice is that you assess the patient, to say "Yes. This patient looks like they fit the protocol," and that that is documented. Then, you go ahead and implement the protocol. Then, you sign off on your documentation and your plan of care that says "This patient fits the profile, and we're going to go ahead and do this."

And then, at the end of somewhere, later on, a day, two days, three days later, there's a provider that signs off on it, because they have to, because that's about billing. You can't bill for that stuff, and the facility fee, you can't bill for that stuff if it's not signed off by a provider.

But the question is that, I mean I'm hearing that what you're concerned about is that what if that bookend doesn't come until days later? Well, that's fine, if the nurse has said "Yes, they fit the profile," and has stopped in mid-stream, saying "Hey, surgeon, friend of mine. This is not okay. This person is wheezing. This person has elevated temperature. This person has all of these things."

And then, if the person fits the protocol and does it perfectly, there's no need to have this "Yeah, you did okay, nurse," because that was all done up at the front end.

**Audience Member:** Which should be also, in establishing these standing orders or nurse-initiated orders, is that they have that oversight to begin with, to establish that protocol. And that still covers the oversight. I think the confusion is, what is physician oversight?

**Ruby:** Physician oversight is the medical plan of care. That's it.

**Audience Member:** Plain and simple.

**Ruby:** Plain and simple, and assuring that the nurse has the information they need, in order to appropriately care for the patient. That's what medical oversight is.

**Gretchen:** We'll take one more question, and then I think we'll transition. It's kind of been a combination of acute care, community and public health. We'll transition to public health, but we'll address your question.

**Audience Member:** I just want to go back to the FQHC question back there, in which you had [inaudible 01:12:18], if you have the standing order, the protocol you're following, the document is signed off on the front end of this protocol, they fit "Please implement the coumadin order," so the RN does implement the coumadin order, based on what the INR says.

Why does, then, the nurse need to have a doctor's signature at the end, if the doctor has signed in the beginning?

**Gretchen:** The order exists at the beginning? It's part of the incorporated plan of care for that person? It would be facility policy.

**Audience Member:** I think what she was saying was like the strep throat thing, that you don't have that signed prescription order. They don't have that order signed.

**Audience Member:** The strep throat thing is different, because the provider hasn't seen them at the beginning. I just wanted to clarify those two things.

**Gretchen:** So, public health specific; concerns, observations, descriptions of utilization of standing orders or protocols, so that the Board can make informed decisions.

**Audience Member:** I'm also with Providence, in the ambulatory setting. So, our EMR has done extensive work to program in, based on physician-determined criteria, some best practice – they call them best practice advisories. So, as long as we have an accurate health history in the patient's chart, the EMR will say "This patient is due for a colonoscopy."

So, if the nurse can assess the patient and show that an accurate health history is in the chart, when it comes up with that suggestion, "This patient is due for a coloscopy," one of the things that we're talking about is can the nurse have that discussion with the patient, and place the order for that colonoscopy?

We have a group of system physicians who are programming that into the chart for all patients, so it's a public health or a population health based algorithm. We don't have an individual physician signature on that. Our physicians do have to sign them on the back end, because that's how most EMRs are set up.

**Gretchen:** Okay. Thank you for sharing that system, because we've got a lot of chefs in the kitchen. And you're an organization that wants preventative health care, and per standard, "This is how frequently we have this test, to identify more data," and ultimately diagnose, and the nurse's role in flipping the switch in that.

**Audience Member:** The system does also suggest things like prescription of statin medication. We're not crossing over that line yet, because we haven't started, so we're holding out for now, pending these conversations. But it's in a similar vein. The system has inputted those criteria, so that the system

screens all of those patients. So, as long as we have an accurate history in the chart, the system suggests that, based on inputted criteria.

**Gretchen:** I just had a discussion with the Board on Amazon Comprehend Medical. [inaudible 01:15:28] all that data, and get an electronic diagnosis. What's the loop in there, for health care?

**Ruby:** Add that to the robot nurses they're using in Japan, and who needs any of us?

**Audience Member:** Just an interesting question regarding the last statement there, about we can't pre-sign something [inaudible 01:15:49]. Oregon has a law around expedited partner therapy for chlamydia.

**Gretchen:** Yes.

**Audience Member:** Which is basically a blank prescription, without a name on it, without blanks to fill in. So, can I ask one of my nurses to give nameless prescriptions, with my signature, to people that I diagnose with chlamydia, to give to their partners, without me signing that individual [inaudible 01:16:18]?

**Gretchen:** I think so. Yeah, it's based on statute. Not Board of Nursing statute, but yeah, they have a statute in Oregon. I think it's one of the dispensing criteria.

**Ruby:** It is one of the dispensing criteria. And again, what nurses do is predicated by an awful lot of people. When you're talking about medication and prescriptions, and what can and cannot be dispensed, that's Board of Pharmacy. But expedited partner – if something is written in statute, it supersedes anything these Boards do.

So, if you know your expedited partner statute, then you follow that.

**Audience Member:** I'd like to talk a little bit about reproductive health medications, and how to kind of dig into the application of this population-based health methodology approach to nurses utilizing standing orders to apply a protocol to a patient who is interested in birth control.

We currently use our nurses to provide first line birth control for all patients who come to Clackamas County. The nurses are the people who see these patients. Based on Oregon Health Authority standing orders that we have adapted, a nurse can follow a set of criteria, using medical eligibility criteria, which is the same criteria that I would use or any provider would use, to offer birth control to a patient, to help the patient select a birth control method.

The patient goes home that day with a dispensed pack of birth control pills.

**Gretchen:** On the dispensing formulary from Oregon Health Authority and Board of Pharmacy, or some birth control that's not on that dispensing formulary?

**Audience Member:** I'm sorry. I didn't understand that.

**Gretchen:** There's a specific formulary published by the Board of Pharmacy and public health, on the birth control that may be dispensed by an RN. And then, when something falls off -. I was just curious. You had quite a process to get there, if that was just for the ones that are authorized for dispensing by an RN, or if it would be a method of birth control that is not on the formulary list.

So, we might be talking about two different processes.

**Audience Member:** There is never any dispensing or prescribing that's done outside of anything written down in the protocol, if that's what the question [inaudible 01:18:48].

**Ruby:** Is it OHA's protocol?

**Audience Member:** It's our protocol, adapted from OHA.

**Gretchen:** I don't know that I have enough information.

**Audience Member:** Let me try again. A patient comes and wants a combined oral contraceptive pill. So, we have a clinical protocol, adapted through the Oregon Health Authority, that a nurse applies to this patient, to assure that they meet medical eligibility criteria for the birth control method that they would like to have.

We have a dispensary that carries three options, just looking at combined oral contraceptives. A patient must meet the criteria, in order to be eligible for that combined oral contraceptive. The nurse may dispense it, regulated by the Board of Pharmacy, out of our dispensary. And then, schedule the patient back to meet with the provider in three months.

**Gretchen:** Okay, so it sounds like it's on the formulary dispensing list.

**Audience Member:** It is.

**Ruby:** This is where public law and public health and OHA and the Board of Pharmacy got together and said "Nurses can dispense."

**Gretchen:** They're only saying they can dispense it.

**Ruby:** Yes, in these settings, they can dispense it. They can't dispense that in an acute care setting or anything like that. But there's a chart that talks about public health, and what nurses can and cannot do, in terms of dispensing. And that actually is a Board of Pharmacy thing, not ours.

In fact, I didn't even know it existed, until I started looking at all of this stuff. And it says that nurses absolutely can dispense oral contraceptives, prevention of dental caries. Do you have that list?

**Audience Member:** Yes.

**Ruby:** That's the one you follow. It works the way you're working it. It comes under OHA and it comes under public health, and it comes under Board of Pharmacy.

**Gretchen:** Adhering to their rules about having the prescriber order in place, that says "People come in with this. This is our options to deliver, and the RN chooses."

**Audience Member:** Yes.

**Ruby:** They can dispense.

**Audience Member:** So, this is concerning to us, too, in Multnomah. What we're talking about leaves an issue unresolved, because we're kind of completing the dispensing and the prescribing and the ordering or whatever. A nurse may absolutely dispense these contraceptive meds, but where does the order come from? And can that order be an algorithmic [inaudible 01:21:22] standing order? Right?

**Gretchen:** Well, the order is specific to the medications on the formulary. Oregon Health Authority statute clearly says how that order is generated.

**Ruby:** Right. And the fact is that the nurse is not diagnosing anything. The person comes and says “Listen. I would like to have some birth control.” The nurse is not saying “Well, because you have diagnoses A, B, C, you get this birth control.” This is an overall population – I don’t want to say population management.

[inaudible 01:21:52]

**Gretchen:** The population of the county [inaudible 01:21:56] community is the client that the medical director has put in, so that when people fall under this umbrella, hence the woman that comes in and needs birth control, that is on the formulary, whereby they fit the criteria of the existing orders to dispense a birth control to that individual, so that they can prevent pregnancy.

**Audience Member:** It’s preventative.

**Ruby:** And again, that is something that the Board has to address in whatever language they adopt, about the clarification about the fact that there are other laws that nurses need to be aware of, that have nothing to do with the Board of Nursing. This is one of those.

Because this is about, again, it’s a population issue. You come from Clackamas County, this is a population management issue, and people will come for medications, and they absolutely have no diagnosis. It’s preventative. That’s what they need, and the medical director of that area has said “When these patients come in, based on these pathways, this is the medication.”

This is the box. That box goes to every person who fits that particular algorithmic whatever, and you are backed up by existing laws through OHA, and existing laws through the Pharmacy.

That’s really their purview. Our job is, does the nurse follow state law? And in this case, the answer is yes, they do. That’s state law that is outside of the purview of the Board of Nursing.

I know it gets very confusing. For those of us who study the Practice Act daily, it is confusing also. Because again, we’re trying to give information to nurses that says “This is where you are not going to be -.”

Basically, at the end of the day, this is all about, because we have had no complaints about this. There are no public complaints. The only reason we even knew of all of this going on is because we got concerns from nurses. So, at the end of the day, there has clearly been not any patient harm that we know of. There might have been, but we never got word of it.

Because at the end of the day, what we’re trying to do is to prevent your nurses from coming to see us, by saying “This is in my scope.” When people say “I don’t know if this is in my scope or not,” the thing you’re worried about is “Is the Board going to come after me and take my license?”

So, it’s up the Board to give you enough clarity to say “No, you’re okay, based on these other laws.” And the Board doesn’t have that, at this point. That’s what we’re trying to kind of grasp with, and say “How much do we need to do?”

If we see, from your feedback, that this birth control or whatever is a big question, then the Board has to address that question, and we, Board staff, will probably be directed to provide something to say “These are the clarifications.”

**Audience Member:** I was a public health nurse, and so I’m very familiar with that. So, it took me a while to learn “Okay, I’m allowed to do this, because the Board of Pharmacy, the Oregon Health Department.” But it also may be another area that I also learned about, is after 9/11, where public health nurses are allowed to dispense medication, to break up medication from a bottle, because of an emergency outbreak or something like that [inaudible 01:25:22] not even doctors are allowed to do that. But we’re authorized by the Board of Pharmacy to do that.

**Ruby:** The whole emergency medication stuff, I mean in a disaster, actually there are laws that supersede the Boards, and those come into play when whoever is authorized to declare an emergency, declares an emergency. So then, we just follow whatever they tell us to do, including licensing people who are coming in, and suspending licensure, and all of those things that we are directed, as the Board, that we have to do.

**Audience Member:** The only sort of fuzzy area question for me has to do with sexually transmitted diseases, and how standing orders and protocols come into that.

**Ruby:** I believe that’s covered under that same -.

**Gretchen:** Are you in a Board of Pharmacy registered community health clinic?

[inaudible 01:26:19]

**Gretchen:** So then yeah, that falls under.

**Ruby:** That comes under Board of Pharmacy. That table that I keep referring to, that’s the one that guides you exactly how the Board of Pharmacy and public health have agreed that this is how it’s going to be managed.

Because now we’re talking about medications, and if nurses follow that, they are following the scope of practice, because the scope of practice says you shall follow all state and federal regulations regarding the distribution of medication.

**Audience Member:** I have a question about that. Again, we’re in a health system. We’re not in an FQHC, but a lot of the work that we’re doing is the same, just for patients with a different payer, potentially, right? So, if we were to explore expanding, those regulations that allow nurses to use protocols in that way; to dispense birth control, to assess or treat STDs, into non-FQHC settings, would that be under the purview of the Board of Nursing, or under the purview of [inaudible 01:27:20]?

**Gretchen:** The Board of Pharmacy.

**Ruby:** The Board of Pharmacy and public health, because again, those particular laws are written specifically for those clinics that are designated public health clinics, and come under the authority of OHA and under federal funding and all of that.

So yeah, that would come under the Board of Pharmacy, absolutely.

**Audience Member:** Where is the box that you were referring to? Is it in the Board of Pharmacy?

**Ruby:** It is, and it's also under the OHA website for public health. It's a table that describes under what conditions, for public health clinics, who can prescribe what. It talks about sexually transmitted diseases, dental caries, all of those things that public health deals with.

There are places in there where it says "RN can dispense? No." That's the Board of Pharmacy. But it's under OHA, under public health. It's not easy to find. I looked for it for a very long time.

**Audience Member:** I sort of have a question that goes along those lines, because now that the Board of Pharmacy can prescribe and dispense -.

**Gretchen:** Various things.

**Audience Member:** But they want to then, because, and I'm from Kaiser, and many of our pharmacies don't have a good private place to have a discussion around that. So, they want to prescribe it, but have the nurse give it. And I have said to them that in our rules, they cannot prescribe to nurses. So, I just want to confirm it out loud with you. Is that still true?

**Gretchen:** Okay. I think there's statutes. I don't [inaudible 01:29:05] speak on behalf of the Board of Pharmacy, but it's specific to pharmacists, and that it stays in that pharmacy box. They can't distribute those prescriptions [inaudible 01:29:13].

**Ruby:** The Board of Pharmacy does not have any rules about nurses being able to take direct orders for implementation from pharmacists.

**Audience Member:** They can consult with them. I can't remember the language.

**Ruby:** The rules for that statute are currently being written by the Board of Pharmacy. We have a Board member and also a consultant for the Board, [inaudible 01:29:32], who is pediatric pain management. She and our Board member, who is an advanced practice nurse, are all on that rule-writing committee.

And we are looking forward to that, because again, there's a lot of "I'm going to let the nurse give it." No, you're not authorized by law to -.

[inaudible 01:29:55]

**Gretchen:** Discussion, comments?

**Ruby:** We talked about public health. Does public health need any more? Because there was a specific request that there be a special session for public health, because their questions may be different than other peoples' questions. So, we decided to tack it on, so that we, again, we have four -.

**Gretchen:** We have three left.

**Ruby:** We're going to Pendleton, we're going to Medford, and we're going to Bend, to have these same discussions, and they're all scheduled the same way; up front discussion for other people who are interested in this topic, and then a specific discussion, which anybody can participate in, but we hoped that the last hour would be really where public health can say "Listen, this is a big issue for us." It feels like people have been able to -.

Please give us your feedback on those papers. OCN is going to be tabulating that. They have a statistician that works with them.

**Gretchen:** They'll be getting a copy of the tape, so they can take off those comments, as well.

**Audience Member:** Do you have a timeline and estimation?

**Gretchen:** Yes. The direction from the Board is that all of the information gathered from these sessions will be presented by Oregon Center for Nursing to Board members, during our September Board meeting.

**Ruby:** It will be the Tuesday night of our September Board meeting. We have a Board meeting from 6:30 to 8:00 on Tuesday nights, where the Board really deals with substantive issues, and this is probably the most substantive issue the Board is going to be – well, not really the most, but one of the most.

The Board has asked that we hold off until September, so that we can have the full Board complement, because several of the Board members will not be at the June meeting, which is when -. It was originally supposed to be in April. Then, it got pushed to June, for us to get more information. Now, it's pushed to September, at the request of the President of the Board.

**Audience Member:** Are those open meetings?

**Gretchen:** Yes. Public meetings.

**Ruby:** All Board meetings are open meetings, unless they are called to executive session, and in all transparency, the days – so, Tuesday nights are public meetings, where the Board talks about substantive issues, and could direct Board staff at some time, to do some things.

Wednesdays are what we call "discipline day," which is where the Board reviews all of the investigative cases. While those are also public meetings, the actual discussion of those is in executive session. So, if you attend a Board meeting on a Wednesday, you'll be up and down, up and down, up and down. Half the time, you'll be thrown out of the room, and invited back for the vote.

But Thursdays of the Board meeting are always open to the public the entire day.

**Audience Member:** Do you know which Tuesday in September, or do we just need to call?

**Audience Member:** It's online, I think.

**Gretchen:** It is online.

**Ruby:** It is online.

**Gretchen:** I was going to put the date in, but I wasn't sure if we were Tuesday or Thursday night.

**Ruby:** It's Tuesday night. Now, the Board may not take a vote on Tuesday night, depending on what the OCN is reporting, but we never know, because it's up to the Board to do what the Board is going to do.

Where's my calendar? There it is. It is, I believe, the 10<sup>th</sup> of September. That's the Tuesday night.

**Gretchen:** Double check on our calendar list we have posted.

**Ruby:** I'll use my Board phone. You have to have a Board phone... Yes, Tuesday the 10<sup>th</sup> of September. It starts at 6:30 PM and it goes to 8:00 PM. And the Board actually wanted this Tuesday night meeting to



allow people who work to participate in this. Board members also all have jobs, so it's just easier for them. And they wanted some time to just think about things.

Mostly Thursdays, again, public day. That's when we report out on school surveys, which programs are re-approved by the Board, those types of things. And rule hearing.

But the Board wanted a day to just talk about issues. Please attend! Attend all of them.

[inaudible 01:34:41]

**Audience Member:** You're lying!

**Ruby:** There are people who find them very interesting, as I do, and some people who find them extremely dry, clearly like Ms. Wendy does!

**Wendy:** I don't find them boring. I just don't find them fun!

**Ruby:** They're at the Board office, which is behind Bridgeport Mall. You go to Bridgeport Mall, the street dead-ends, and then you make a left, and you go down to, on the right, it's the very last little office building there. It says Oregon State Board of Nursing.

**Audience Member:** My question is, what that will be is the report from OCN, which will be a summary of what happened. So, whatever they vote on, if they're going to do rule-making, if things need to be changed in statute, we will be able to hear what they say. But we are going to be living under this whatever we're living under now, for a while.

**Gretchen:** Yes.

**Audience Member:** How long does rule-making take?

**Audience Member:** You've got a while.

**Audience Member:** I don't want everybody thinking that September 10<sup>th</sup>, we'll have an answer.

**Gretchen:** No.

**Ruby:** What you'll have on September 10<sup>th</sup> is direction from the Board, hopefully. Because the Board could say "Hm. We don't have enough yet. Go get some more." That's at the purview of the Board.

That's why I want to make it very clear, don't stop anything that you're doing, because there is not going to be an answer.

I think for those of you who have been to all of these meetings, I almost feel like I have groupies, I encourage you to keep coming, because every meeting has different information. You've heard me say that if the Board says "Go write rule," that cannot be [inaudible 01:36:39]. There has to be very specific numbers, and we have to have cross-representation.

What usually happens – I'm not saying it's going to happen this time, because it's at the direction of the Board – what usually happens is we will have a public call for membership. We will ask your credentials, we will ask about why you want to be on this, how you're involved in this. And then, there will be a selection made.

And once the selection is made, the selection is made. And if you feel like you're being left out, the fact is that all of those stakeholder meetings are public meetings. So, you can come to all of those meetings, and there will always be a public comment session about what the task force or group has been discussing, but you don't get to vote on what recommendation goes forward to the Board.

The task force does not write the rule. The task force gives recommendations to the Board about what it should look like. They do format it as rule, so that the Board can read it. We have had one APRN group that's been working for a long time. We presented information about where we are, and the Board said "Yeah, no. We don't like it. Go back. Figure it out again."

And that's their call. That's the Board. So, the task force is not writing rule. The Board is the only one who can approve rule, after there's a public hearing. But all of those meetings are open to the public, and they will all be on our website.

I encourage you to go in and sign up for the RN/LPN listserv, because all of those notices will come on that listserv, and if you're signed up for that listserv, you'll get it. You do not have to be an RN or LPN to sign up for that. Anybody can sign up for any of our listservs, licensed or not, nurse or not, or licensed in other professions.

We can do all of that, so please stay involved. Stay tuned, and if you can find yourself coming to more of these meetings, please do so, so that we can continue the conversation.

**Gretchen:** Thank you for coming, and for your information.

#### 4.26 OSBN Community Meeting

**Gretchen:** (Begins mid-sentence) ... State Board of Nursing. My name is Gretchen Koch. I'm a Policy Analyst, specializing in RN/LPN practice, with the Board of Nursing. I am Board staff. [inaudible 00:00:08] introduce themselves.

**Ruby:** Hi. I'm Ruby Jason. I'm the Executive Director of the Board of Nursing.

**Peggy:** Peggy Lightfoot, Executive Assistant, Board of Nursing.

**Gretchen:** I wanted to make sure that you had all of the handouts.

**Ruby:** One more!

**Gretchen:** One more? Oh, I'm sorry! I apologize, Annette.

**Annette:** Hi. Annette Cole. I'm a Board member.

**Gretchen:** We have to make sure you have a handout. We have just two slides we're going to go over. There's copies back there for you. There are two different colored sheets, for those of you that would like to give written input.

One is so that you can record questions, concerns that you have about the use of standing orders and protocols. The other one is to describe how you and your practice are utilizing standing orders or protocols in the work that you do every day.

Our charge here today is to collect information from you, addressing how you use standing orders and questions that you have about it, so that we can collect the data and present it back to our Board members, the nine-member Governor-appointed Board.

The collection to that – we're having the data all put together by the Oregon Center for Nursing. Then, they will provide the data to the Board on our September Board meeting, which I believe the date is September – it's a Tuesday night.

**Ruby:** It's a Tuesday night.

**Gretchen:** Tuesday night Board meeting.

**Ruby:** I think it's the 10<sup>th</sup>.

**Gretchen:** Yeah. [inaudible 00:01:27]. This is one of the series of data collection meetings we've had. We have two more scheduled for next month; one in Bend and one in the Pendleton area, at the Tamastlikt Cultural Institute.

With that, I'm just going to be providing a brief, about information, at the beginning, just to kind of set the stage as to why we're here, and the purpose, to kind of refresh. Then, I'll bring one of the slides back up, so we can have the reference as we get information from you, as you ask questions. So, it might give you kind of a buttress as to where you base your questions from.

Why we are here, and the situation outline:

First and foremost, I want you to understand that the Board holds no jurisdictional authority over practice settings or employers of Nurses. Our authority rests with each individual licensee.

Also, it's very important, the Board is not directing any organization to change any processes currently in place, or to stop using standing orders or protocols. I get questions every week, and Ruby probably gets some too, about "Now that the Board has prohibited RNs from using standing orders..."

I don't know where that's coming from. You have a full scope of practice authority to accept and implement orders in Division 45. That remains, and it will remain so after this meeting. So, don't change any processes.

Next, the OSBN does have jurisdictional authority over RNs that author protocols, or that develop them or implement protocols, and some of these may be, that's why we're collecting data today, to examine how to position the nurse for safe practice, that might be out of scope of practice at the RN level of licensure, or at the LPN level of licensure.

We'll get into that as we get more clarification, as the morning goes on, and the second slide is going to have some information about that.

Important: Physicians do not have the authority to expand scope of practice of licensees of the Board. The only entity that may expand scope of practice is the Legislative Assembly, who directs the Board members to promulgate rules about scope of practice for each licensee. That is where the authority to expand scope.

A physician, an employer or protocol cannot expand scope of practice, beyond what's allowed by the parameters of the Nurse Practice Act.

Now, important: The Board of Pharmacy – not the Board of Nursing – the Board of Pharmacy holds statutory and rule over prescriptions. The Board of Pharmacy prohibits the pre-signing of prescriptions, for someone else to fill in the blanks, after the form is signed. Some of the protocols that the Board has reviewed to date appear to be the electronic version of this process, which per Board of Pharmacy, is not okay. But that rests with the Board of Pharmacy.

For today, we're seeking information from licensees, from people that interact with protocols and standing orders, and seeing how they're used in the community, to find out if there are certain protocols that might put the RN, the LPN in a position of being in violation of the rules governing their license, when they accept, implement or act on the directions found within a standing order or protocol.

Now, the Board does recognize that there are a lot of protocols out there that were put in place, in good faith, and people are following them [inaudible 00:04:58] faith, and they're there to expedite the care of patients. They're there to – if there is a practitioner within a clinic, and there's an established plan of care, and someone is coming into the clinic for help, there's an existing treatment plan, protocol, standing orders related to that treatment plan. Those mechanisms have been used, so that people can get the care that they need, and they don't have to be put off.

Protocols, they're used everywhere. We personally, as a Board, do not define the term "protocol." We do not define the term "standing orders." But documents that contain directives to a nurse must assess on, to make a decision if they're going to accept an implemented order, they're found in hospitals, in community settings and schools, correctional lockup, private in-home health, all sorts of areas of

practice that are, as we know, as health care is moving out of the hospital in various areas. So, they're used everywhere.

The Board contributed to some of the confusion that's out there. They had previously posted a standing orders protocol, the use of standing orders by RNs and LPNs, I do believe, which per the language in there, allowed individuals to interpret how to apply that, to fit the need of an organization. That protocol has since been removed – not protocol. That interpretive statement has since been removed, pending direction from the Board, from the data that's collected on September 11<sup>th</sup>, and how we're going to proceed from there, forward.

And here we are, today. The Board has directed staff to convene stakeholder meetings, to collect input from people that are interfacing with those standing orders, interfacing with the protocols; what they're for, how are you using them, what kind of mechanism and practice situations they're used in. Whereby they can understand the scope of how they are being used in today's health care delivery system, and where the RN, the LPN stands, as they are faced day in and day out with "Here is a protocol and standing order. What do I do with it? Is it okay? Can I integrate with this, because it's written by a licensed independent practitioner? I'm making sure it meets the standards of the Practice Act," and those type of things.

So, we are here to listen to you, and to record your questions. This session is being tape recorded. We also encourage you, instead of trying to paraphrase or remembering, we're going to have the tape recorder transcribed. But it's also important, if you can use these sheets to actually first-hand record how you are using those protocols, and specific questions or concerns that you would like to bring to the Board, so that the Board can look at the data and make some decisions, and then give Board staff a direction to take and address to the protocol and standing order issue.

We're going to have general data collection until 11:00. At 11:00, we are going to switch to collecting data specific to public health clinics, county public health departments and those type of things.

So, I'll be watching the clock. But until then, we are opening it up to you. So, please share with us your experiences, questions. Sometimes it does create an awkward moment, because the questions [inaudible 00:08:10], and you may or may not get an answer, because that's not why we're here.

We're here to help you clarify the questions, so we can take that information back to the Board, which not so much for Ruby, but for me. I'm faced with a question, and I feel like I've got to dialogue and hammer that out and try to figure it out.

It's not a teaching session, today. We're not going to be doing presentations on what is and what isn't. We want the nine-member Governor-appointed Board to make those decisions, and give us direction on how to proceed. But we need your input.

I'm going to put it back up to our situation outline, that references some of the laws. So, opening it up to you. Yes?

**Audience Member:** I'm not shy. I'll start. My name is [inaudible 00:08:51]. I am a Nurse Case Manager at Rogue Community Health, a federally funded qualified health center. I spoke to you on the phone a couple of weeks ago, I think. What has come up in our practice is that they're working on quote/unquote standing orders for the nurses, to manage hypertension.

The standing order is being written by a licensed clinical pharmacist and a physician assistant. They are wanting the nurses to basically have the authority to see a patient and over a course of however long, they want the nurses to have the authority to increase medication and add medications. And the nurses in our clinic are saying “No, we cannot do that, because we don’t have prescribing authority.”

But they’re saying “Well, if we put it in a standing order, then of course you can do it.” And we’re pushing back, and saying “No, we cannot.” So, that is just one situation that has come up, and that is why I’m here.

**Gretchen:** So very glad you came, and thank you for sharing that with everyone else.

**Ruby:** What are the nurses saying? Why do they not think it’s in their scope?

**Audience Member:** Because they’re having us add medications, and that is the same as prescribing.

**Ruby:** So, you’re telling us a pharmacist and a physician assistant, who is not an LIP, by the way, -

**Audience Member:** Yes.

**Ruby:** Is providing this. Where is nursing in this?

**Audience Member:** Until I came onto the committee, there was no nursing reference.

**Ruby:** Okay. Because a physician assistant is not an LIP.

**Audience Member:** And according to the protocol and standing orders, we can take recommendations from a pharmacist, but we can’t take orders. Also, for a physician assistant, according to the standing orders and protocol, there has to be a prescribing physician present at the time that the standing order is to be implemented, in case there is any question.

And that is not always the case in our clinic. We do not always have a physician available. So, that negates the whole protocol right there.

**Ruby:** Right. Like Gretchen said, this is not the time for answering questions specifically, if people are seeking guidance from the Board as to how, but I think it’s important for us to ask questions, probing questions. So, how does this patient get on this protocol, or this standing order? How do they get there?

**Audience Member:** Right. Well, they’re basing it on the recommendations of hypertension, and that’s another thing. No one can decide if we’re going to follow the 140/90, or I think it’s the 120/80 now. You know, there’s different beliefs. The American Association of Physicians or whatever, they say 140/90. The cardiologists say 120/80. So, nobody can decide about that.

Then, apparently the standing order that they have, that they’re trying to get us to agree to, it states that the patient is going to be started on HCTZ, hydrochlorothiazide. And then, if they fail the hydrochlorothiazide, it’s like they would have four different appointments with the nurse. And each time, the nurse would increase the medication.

When they fail that, then it says “Add Lisinopril.” And after four times, then add another medication. But my other thought is that we can’t treat patients as if they’re all the same, and not every patient is started on HCTZ. So, how in the world are we going to even get all of the doctors and the practitioners

on board, to say “Oh, yeah. They’re going to start everybody who has hypertension on hydrochlorothiazide.” It’s just not realistic.

**Audience Member:** My name is [inaudible 00:13:50]. I’m from La Clinica, Director of Nursing there. We have a fairly robust, I feel like, standing order for hypertension/protocol. My question is, and what I’d like to see addressed, is the difference between titrating and prescribing.

So, within this protocol, [inaudible 00:14:07] someone’s going to [inaudible 00:14:09] HCTZ, can we titrate that? Because that’s how we’re using it, that they see a provider, they’re placed on the protocol, and then they come in for nurse visits. And we may go up to a certain amount, two steps, basically. But it’s the same medication, so basically, we’re titrating, like you would. So, that would be clarification I would want.

**Ruby:** Please write that down. The basic issue here is where is the LIP that says, and again, not a PA, not a pharmacist. But an LIP that says “I have assessed this patient, and this patient is good to go on this protocol.”? And then, the LIPs who manage those patients or who see those patients, or who have the authority to refer those patients to the protocol, are they part of that development?

Have they all agreed to it, that this is how we’re going to manage our patients? “Patients who come to this clinic are going to get managed this way.” And that nursing is also a part of that conversation, not just a recipient of the outcome, but part of that conversation.

Because there is a big difference between protocols that say “I, as an LIP,” and it could be an NP, physician, whatever; says “I have assessed this patient, and this patient is good to go, and fits this particular protocol. Because they have this diagnosis, they fit this particular protocol. And this person is to follow the protocol, unless,” you know, blah, blah, blah, blah, blah. “Something bad happens, and then the nurse can go ahead and call me.”

What Gretchen referred to was the plan of care. That is that patient’s plan of care, and the nurse, in their independent decision-making, is able to say “This person is good to go on this protocol.” Because one thing nurses cannot do is just “Oh, you’re here? Okay, you’re on the protocol. Okay, let’s do this for you.”

The nurse has to have an independent assessment on their own, to say “You still fit the protocol. Let’s go. Let’s titrate. Let’s do this. You’re good to go. Your blood pressure is great, fine.” Or the “Hmm, no. This is not okay. You’re not responding well. The protocol says if they’re not responding, that I need to at least notify my LIP.”

But that LIP is dependent on the independent scope of practice of an RN or an LPN, RN or LPN, to make that assessment and keep that person on the protocol, or determine when they’re no longer fitting that protocol.

But it all starts with someone saying “In my LIP authority, I am saying this is the diagnosis, and this is the protocol this person needs to be on.” And then you go, until the patient falls off.

**Audience Member:** Just along those lines, we have, our standing order has very specific parameters for what the assessment has to be, basically depending on what the results of that is, [inaudible 00:17:15].

My question [inaudible 00:17:20] how many, does it have to be more than one LIP, in order to be an approved protocol, or can it just be one [inaudible 00:17:30]?

**Ruby:** There's no rules about that. The question is, is each provider going to have their own protocol, based on whether they're a GP or a cardiologist or a nephrologist, or an -ologist whatever? So, it's not about so much who authors it. It's who is all agreeing that this is how we are going to manage these patients?

You know, I've been in situations where we did have every single physician who went to that clinic had their own protocol, and it was a mess. And it was really hard for the staff to keep up.

So, it's about how you manage your protocols. The Board doesn't have any authority over how you develop those. The only thing we're here to do is – we've had calls from nurses, just like yours, who are saying "Listen, we've got this protocol in my county or in my hospital or in my clinic, and we're concerned that this is not within our scope of practice."

So, Gretchen and I answer an awful lot of those practice questions, and Gretchen and I answer them by saying "Well, the way your protocol is written, no. That's not okay. You're doing more of an independent scope of practice than you are authorized by your license."

It's not about how smart you are or how great you are or whatever. It's about we chose to stop our education at a certain point, and our license type is a certain thing, and these are the legal parameters that the Board has authority to say "These are the legal parameters of nursing practice."

Now again, that vague statement that the Board put up in 2012 was so vague that, in good faith, people read that and said "Oh! Okay, we're fine." And now, it's "Well, maybe we're not so fine." That's what we're here to do.

We're here to make sure that you, the individual nurse over who we have authority over, and we do not have authority over your organization or your development of whatever it is, is that if something goes wrong, and a patient calls us and says "I was at this blood pressure clinic, and this nurse didn't recognize that I was whatever, and now I have this sequela, and now I want the Board to take that nurse out of practice, because they didn't do this right."

We would come and talk to you, and say "What protocol are you using?" If the Board, at that point, decided that that protocol was not in keeping with the Practice Act, then you and you alone would be accountable for the decision-making of your practice. Not the person who developed the protocol, not the organization, not the physician, not anybody else. It's your decision-making.

That's why we want to make sure that the Board gives individual organizations enough direction to say "Listen. This is the intent of how standing orders and protocols -." They've been around since I was a baby nurse. You know? Standing orders and protocols, I mean, I worked ERs, and that's what we did.

Now, health care is changing. There aren't as many providers as there used to be. They aren't around, as they used to be. They are not engaged in that daily management. And more and more and more is being asked of nursing, in order to bridge that gap between needing to take care of patients, and the lack of providers, or providers who need to do things that get reimbursed at a little bit of a higher rate. Because that's really where they are. They need to do their cutting and surgerizing, and doing all that.



So, we are here today, not to tell you protocols are a wrong thing. It's how does a nurse implement the protocols, and be assured that it is in their scope of practice? Because the only entity that can say it's in someone's scope of practice, yes or no, is those nine members of the Board, which Annette back there is one of those. It's not us. It's the Board.

**Audience Member:** So, Becky wrote a question, and I want to make sure that we ask the right question about the prescribing versus titrating. But to me, it doesn't even feel like per our protocol, it doesn't even feel like prescribing. It feels like initiating a medication, due to a certain outcome of a protocol. So, would we write in the question "Initiate?"

Do you know what I'm saying? Like there's a protocol written. We're not going to just prescribe a medication out of randomness, so it's not exactly prescribing. It's initiating medication, due to a certain result.

**Ruby:** Right. What happens is, is that clinics who titrate, again, there's a protocol that the provider said "Yes. This patient fits this protocol. This is what the protocol says. I have diagnosed, and I have placed this patient on the protocol. Go forth and manage, until you, as the nurse, decide that it's not."

So, you can initiate a medication, based on that protocol that someone put that patient on.

**Audience Member:** [inaudible 00:22:25]

**Ruby:** Right. And the protocol says -

**Unknown:** The patient was seen by the exact provider.

**Audience Member:** So, it's not prescribing.

**Ruby:** It's not prescribing, because you did not make the independent decision and diagnosis that this is what this patient needs. That's where we need the information from you, because that's one of those gray areas. What you're describing is one of those gray areas that we really do need the Board to get that information, and look at that and say "Well, where is that prescribing?"

That's why I've talked to my friends at the Board of Pharmacy. Basically, the Board of Pharmacy says that to take a brand new prescription on a patient, to write a prescription on a patient before that patient has ever been seen by someone, by an LIP who is authorized to diagnose and prescribe, is tantamount to pre-signing a blank prescription pad. That you just left it laying around, and the provider has signed it and said "Here."

That's really where the gray area is, and why the Board needs this information about how are they using it? Is it really a gray area or is it not?

But what you're saying is the nurse has the option to switch all the medications, to say "Okay. Hydrochlorothiazide didn't work. Now, we're going to go to Lisinopril, and this is how much Lisinopril I think you need." Right? Because it's not one size fits all. It's not like vaccines.

**Audience Member:** But yet they're treating patients like one size fits all. Because they're saying "Okay then, you're going to start them at this dose. Then, you're going to titrate them to this dose and then this dose and this dose." It's like, where is the practitioner in all of this? You know, the LIP?

Can I add another wrench in the works? This is all metric driven.

**Ruby:** Of course it is.

**Audience Member:** Right.

**Ruby:** It's either metric or reimbursement driven.

**Audience Member:** Yes, exactly. So there's, I think, a sense of frantic – they're frantic a little bit, to try to fit everybody into this "Oh, well, we've met our metric. We've successfully lowered everyone's blood pressure." But what about the one person who comes in and they're stressed out, and they have a one-time blood pressure? They're saying "Oh, they're hypertensive," even though it's a one-time occurrence.

Or you have the patient, like I have one, for example, who has extreme social anxiety. And the moment he walks through the door, he is shaking. And no matter what I do, I will never get his blood pressure down, no matter what medications, I don't care. He is a special circumstance.

So, I just don't like thinking that they're going to put everybody who has a diagnosis of hypertension, whether it was a one-time occurrence or a chronic condition, they're going to say everybody has to follow this exact same protocol.

**Ruby:** I will tell you that currently, in the Practice Act, it says in Division 45, it says "The nurse shall not implement any order or treatment plan that they do not feel is in the best interest of the patient." So, if you did do a treatment plan – and this is current. This is not what the Board needs to think about. This is current.

If you do institute a treatment plan, a one size fits all treatment plan, and something happens to that patient, for example your social anxiety patient, and his blood pressure bottoms out while he's shopping at Freddie's, and hits his head, that's on you. That is not the protocol, because you made the assessment that one size fits all, and you, under your license, chose to implement that protocol.

I will tell you that it's hard for nursing, because nursing then comes between "Well, here's my Board, my scope of practice. And here's my job that pays my bills and does all of that. And what kind of pressures do I have?" Nursing does get put in an untenable position frequently, of "My employer says this."

Well, legally, your employer does not have authority over your license. The Board has authority. So, anything you decide under your license, is really under the jurisdiction of the Board. And because of the way the Board is structured, the Governor has said to those nine people "You are responsible for assuring that the legislative intent is being met."

So currently, they have approved law that says you shall not implement anything you do not think is appropriate for your patient. And if you don't think that patient is appropriate for that, then the answer is no, regardless of what metric. But that does put you in a very difficult position with your employer. And that can be an issue.

But again, either your employer or a patient, something bad happens to the patient, you're going to come visit the Board.

**Audience Member:** I think that's one of the things that we've had to do a lot of work on with our providers, is helping them understand that when we work with them to create protocols, the way that we have transitioned to – and I think it was probably around 2012. That was a little bit before my time, so maybe when that interpretive statement first came out.

I remember we used to have a ton of standing orders. Then, we got rid of all of our standing orders, and we transitioned to protocols. And how we develop our protocols is, typically our advanced practice team is the one that's developing them, and then we work with a variety of providers, our pharmacy and therapeutics committee, and we make sure that both providers, nursing and pharmacy have all signed off on it.

I think one of our challenges has always been that typically, protocols will fit. When we build it, we want it to meet more than 80% of the population it's going to be used for. So, a lot of times, when we're getting feedback from our providers, they come up with the patient, the social anxiety patient or the patient with heart failure, that doesn't meet the parameters of the protocol.

Then, we have to work with them to say "Well then, that's not the patient that you order the protocol on. If it doesn't fit your patient, you as the provider shouldn't order it." So, the way that we've moved forward is we develop our protocols.

One of the things I appreciate about the previous interpretive guideline was that it did outline all of the elements that should be included in it, so I definitely like that piece.

**Ruby:** Put that in your comments.

**Audience Member:** Yeah, I will. I like that piece, because that was helpful to make sure it had all of the right – when the nurse would initiate it. The way that we worked with the providers is that we develop the protocol with the aforementioned groups, and then we'll put it on their provider order sets. Sometimes they are pre-checked orders, if they've been signed off in that way. Sometimes they are unchecked orders, where the provider can then choose to order them.

So again, the determination that we say is, like on a general admission order set, "If we think this will meet more than 80% of the patients that come in," like an electrolyte replacement protocol, we'll pre-check it. The provider can always uncheck it. Or if it won't meet 80% and we leave it unchecked, then they can choose to check it.

But the way that the nurse uses a protocol, therefore, is then standardized. So, for potassium [inaudible 00:29:50], do this. Then, we usually give like oral and IV options. That's just one example. But we've had to do work with our provider teams, to say "When do you check it or not check it?"

One of the challenges that we've seen is they don't always – we run it through the certain groups, but not all of them go to those meetings. So, how do we make it accessible, so they can see what that nursing protocol says? Those are just some of the challenges that we've run into.

We have a couple of different protocols. I think one point for clarification that I would be interested in moving forward is what is the difference between a standing order versus a protocol? Like even in this conversation, we've kind of used them interchangeably, and I just think it adds confusion.

**Ruby:** Right.

**Audience Member:** So historically, to me, the standing order was like you didn't have to have the written – electronic, now – go-ahead to use that document. Right? So, like the flu immunization, to me, would be more of a standing order. It's just kind of across the board. We don't have it written anywhere, other than maybe in a policy that says "All patients get X."

So, that's kind of how we've interpreted that. Some of the other things that might fall into that bucket are ACLS medications. We don't really have protocols around that. We just call it ACLS. Emergency anaphylaxis treatment. Those are kind of some of the gray area ones that we run into.

**Ruby:** When Gretchen and I started preparing for this, we did quite a bit of review of the literature, because that's what we do. We read the literature, right? And there are multiple definitions for standing orders and protocols. We do know that, with some of the feedback, is that you are going to – all of you desire that definition.

And it's not a matter of what Merriam Webster says, or whatever. It's what the Board says is a standing order or a protocol.

Generally, from the literature, a standing order is correct. This person comes in, we've got to take some action. But at the end of the day, a provider is going to come by and say "Yes, this is appropriate." You know, OR standing orders and anaphylactic, and all of that stuff.

Or if you're working in an ER, these symptoms, draw a rainbow and don't send it or send it, or whatever it is. You know, call Ultrasound and get us an ultrasound, if you think it's an ectopic pregnancy or whatever. But eventually, a provider is going to see that person, at the end of the line or somewhere in between.

That's what the literature says. Now, whether the Board is going to agree with that or not is up to the Board. That's what the literature say.

The literature then says a protocol is something where the provider is ahead of the game, where the provider is out here, saying "Because of what I'm diagnosing, you fit this protocol, and you're going to be managed by nurses, until you no longer fit the protocol. Then, they're going to call me back in."

So, literature-wise, that's what the literature has said. It's pretty common throughout, but again, we will give that literature review to the Board, and the Board can decide what it is they need to be doing. But technically, that's most of the agreement.

Standing orders are boom! "Right now, gotta help you." A provider is going to come. A protocol is, "A provider is going to put you on that protocol, and off you go."

**Audience Member:** I know that this isn't an answering questions sort of thing, but I work in a school-based health center, where the providers aren't onsite most of the time. We have a few days a week, in most of our sites.

So then, if we're looking at the difference between protocol versus standing order, is there a possibility – and you don't have to answer this today – but is there a possibility that we could start something, and then have a follow-up within a certain amount of time, such as if they were in the hospital, without a provider being present on scene, at that time that it was initiated?

**Ruby:** We can't answer that question today, but I will tell you that has come up quite a bit, particularly in protocols where there is no provider. For example, if you're out in a rural community, and there is no provider there, and someone comes in with suspected TB or whatever. The gray area that Gretchen and I have found is the part where there is no provider in this mix at all.

And the protocols that call for the nurse to make a diagnosis, based upon some lab values and a picklist, “If these symptoms, get these labs. If these are the results, then this is the diagnosis for the patient.” And then, “If this is the diagnosis for the patient, here are the medications that you can pick from, depending on your assessment of allergies and whether they’re breastfeeding or not breastfeeding,” or whatever. And then, off they go.

Then, at some point, a provider may or may not, in a short amount of time, review that chart and go “Yeah. This is okay.” Those are the real gray ones that really have us concerned. But again, since this is our third – fourth? – fourth one, and we have a few more to go, sharing with you what other people – there are some people in the audience who have been to all of them, so thank you. We’re starting to get to know you.

But some of the issues that they brought up was “Well, what if the nurse stays away from a diagnosis? What if the nurse treats symptom?” Like, is increased temperature a symptom, or is fever a symptom? Is fever a diagnosis? Is it not?

Because there’s multiple camps and schools and stuff. A kid’s got a headache. And again, the other thing that has come up for the Board is over-the-counter meds. Over-the-counter meds. When can you give an over-the-counter med, as an RN or as a nurse, without -? Are you diagnosing a headache? Is that a diagnosis? Is it not? Is headache a symptom? Is it not?

So, there’s a lot of questions that have come up. But the Board is very eager to say “Okay, we’re going to have to solve this problem once and for all, and talk about it.” Because nothing in the Practice Act talks about over-the-counter meds. We get this question all the time, particularly in the summer, when they’re ramping up the summer camps, and schools.

Now, you’ve got FERPA and all of that other stuff that you guys have to deal with, and parents.

**Audience Member:** The Department of Education.

**Ruby:** And the Department of Education. The fact is, your rules that you deal with are so far outside of the Board’s. The Department of Ed really rules how school nurses have to implement. And our job is to make sure that you know that when the Board of Education does that, that you are within your scope, and you’re okay.

But the big thing is, now that health care is changing, and there aren’t enough providers around, what happens when there’s no provider in a rural area? And it’s the nurse, and there’s a patient who presents, who needs care? How is that nurse going to be sure that “What I’m doing, I’m doing within the scope of my education and my license type,” and keep the patient safe?

**Audience Member:** I would also like to clarify that, so I’m a school-based health center, instead of a school nurse. Even within the way that we give OTCs are different. So, an OTC in the school, the parents are bringing it in. And the parents are saying “Yes, you have permission to give this,” and that sort of thing.

We also get consent from the parent, saying “Yes, you can give OTCs,” but they don’t physically bring it in. So, it’s our medication that we’re giving them. It feels a little bit different.

**Ruby:** Yeah, it is different.

**Audience Member:** It's not the parent who's saying "This is my ibuprofen. This is what I want you to give them." It's me saying "Oh, do I give them Tylenol? Do I give them ibuprofen, or any other of the OTCs?"

**Ruby:** So, the parents give you permission, but they are not the health care provider.

**Audience Member:** Right.

**Ruby:** Which still depends on your judgement and your knowledge of what is going on with that child, and your knowledge, skills, abilities and competencies. Because that's really – yeah. Gretchen is our school liaison. She works with the school nurses and school-based clinics and all of that.

As nurses have spread out, and have filled the niche that this health care system requires of nurses, these questions come up quite a bit. And there is no one size fits all type.

But the Board is legislatively required to supervise the practice of nursing, because that's what the legislative is, that's the mandate, supervise the practice of nursing. Not your employer, doesn't supervise your practice. They may give you the protocols, but your practice and your decision-making is under the supervision of the Board.

How can those guidelines and those parameters be defined, so that it's not in this box that was present when the Board made this decision? Because that's what happened in 2012. This is the box. Alright? Now, how is the Board going to define rule, to keep up with those changes?

Right now, not related to this discussion, but we're being asked "When are schools going to teach more about community, rather than acute care?" And what is the Board's authority to say to nursing programs, "You need to stop focusing on acute care, and really go out into the community a lot more, because that's where health care is going."

Well, health care was going there in the 1980s, and here we are again! I remember when I was a nurse. "They're going to have only ICUs. You're not going to have Med-surg. Everything is going to be outpatient." You know. It depends on where the funding goes.

**Audience Member:** I guess that is – I would like to see, as you're going back to the Board and having these conversations, is we seem to be kind of in nursing, and Oregon is stuck a little bit in health care 2.0, and Oregon as a state has moved to health care 3.0.

**Ruby:** Exactly.

**Audience Member:** And how are the tripling or the quadrupling, especially the quadrupling, when we think about supporting physicians and independent licensed practitioners, are those conversations happening? I'm really curious about that. And who are we talking to? Are we talking to CCOs who are asking us to meet metrics, and that's how we're getting paid?

I just wondered if those conversations are happening.

**Ruby:** Well, Annette is from the Board, and she's a Board rep. So, I do believe that the Board is trying to become more proactive than reactive. The Practice Act is the law. And changing a law is not an easy process. That's why we're here. That's why we need your feedback. This is how we're using them.

Because the Board absolutely does not want to catch nurses short, and say “Gotcha! Come see us!” That’s not what the Board does. The Board is here to say “How can we keep the public safe, through safe nursing practice?” And this particular Board is extremely proactive.

They have had discussions about “How do we incorporate our rules, to make sure that they continue to meet the needs of the health care system, and how nurses play the most significant role?” Don’t tell our physician partners that, but how nurses play the most significant role in the future of health care. “And yet, let the rules grow with that, without making the rules so wishy-washy that we cannot get bad actors out of the practice.”

Because that’s really what it’s for. The rules are made to say “These are the parameters. You have some room in those parameters to, because of your independent scope of practice and your individual judgements.” But what is the box?

Because we all live in a box, you know. Our driver’s license tells us we live in a box. Even if we think we should drive 50, if it says 30, you’ve got to drive 30. So, where is the extent of how the rules have to be written, to make sure that individuals who do not practice with the same cognizance and intent and understanding of the needs of the patient, as others do, can be moved along out of the practice?

We get, what? About 1,700 cases a year of nurses who are reported to the Board. And probably only about 10% of those ever face any disciplinary, and most of those are reprimands. Revocations, very rare. The Board does not like to do that at all. But they do. They say “You’re violating every scrap of what nursing is supposed to be.”

So, how do you write rule to keep the box firm for those who need it, and yet flexible enough for those who really do understand what nursing is really supposed to be doing? Over-the-counter meds, schools, rural areas where there’s not a provider in 50 miles, hospital-based clinics where there are a lot of providers, but they’re off doing something else that reimburses better.

Patients who don’t have four weeks to wait for an appointment, but can go have their coumadin or their high blood pressure medicine titrated in a nursing clinic, within two or three days of needing it. How does that all happen?

And that’s not how it was in the past. We all know that. That’s not how. So, the Practice Act has to be more far-reaching and less restrictive, but still do its primary function. The Practice Act is not written for you. It’s written for public safety. So, how do we do that? Because I’m not an LIP, I’m not an advanced practice nurse. My education was this.

How do we accommodate the increasing scope that nurses are being asked to perform, without going past that public safety barrier?

**Gretchen:** And it’s difficult, too, for those of you that have read the Practice Act, and specifically Division 45, it is broad statements of actions and behaviors that set acceptable levels of standards. It doesn’t contain interventions. It doesn’t contain medications. It doesn’t contain tasks. It’s about putting that client in the best position for health to act upon.

As you had indicated, patients aren’t one size fits all entities. It’s that behavioral health model and the interviewing, and taking all of that nursing science to “How do I make this person so that all of these things that are coming at them are putting them in a healthy place, and a place where they want to be?”

Then, you codify these different things about “Well, we have this order and that order.” It’s a hard thing to weave together.

**Audience Member:** So, are you leaning toward – I realize that changing the Practice Act would be pretty colossal.

**Ruby:** It’s what we’re doing. It is pretty colossal, isn’t it?

**Audience Member:** That first meeting was kind of like “We don’t want to do that. We don’t want to do that.” So now, am I hearing that that’s kind of the direction that they’re thinking of going? Or are you thinking of re-writing an interpretive statement that’s more defined?

**Ruby:** If that’s the impression you got, then I apologize for that. Because that’s why we were there. The Board said “We need to do something about this. Go forth and find out in the community what there is.”

Currently, currently, it’s a real gray area. That’s why the Board has said – somebody said at the last meeting, what did she say?

**Gretchen:** They had the best quote. I wrote it down, but I didn’t bring it. Do you have it?

**Ruby:** You’ve got it.

**Unknown:** It’s “If you’re doing it, don’t stop. If you’re not doing it, don’t start.”

**Ruby:** Don’t start, right. Exactly. So, the answer to your question is, it’s up to the Board. Whether the Board directs Board staff to write another interpretive statement, whether the Board directs staff to write rule, that’s why this information is so important.

**Audience Member:** So, maybe it’s a question for you. I mean, it’s a general question. What would be changed in the Nurse Practice Act [inaudible 00:47:00]? Because I have it here in front of me, [inaudible 00:47:03]. The only place that I see that maybe is going to be qualified is there’s a statement about, we are supposed to do orders.

**Ruby:** Well, it already says you’re supposed to do orders. The question is, how far does the protocol ask? There’s a difference between implementing a provider order in an acute care setting, implementing a provider order in a community setting, where there’s not a provider in 50 miles and it’s just all telephonic, or you know, electronic.

**Audience Member:** So, you would be adding an interpretive statement that says -.

**Ruby:** That’s up to the Board. That’s up to the Board. But the thing about an interpretive statement is it’s not the Practice Act. An interpretive statement is a statement that – . So, statute, which is what’s written by the people in Salem, are very broad. And then, in statute, it says “The Board shall provide supervision for the practice of nursing in Oregon.”

Then, it says “The Board shall write rule about how that’s done.” So, the Practice Act applies to you, it applies to the nurse in the ICU, it applies to the nurse who’s an informatics nurse, it applies to me, who’s an administrator. The statements are very general.



So, the decision the Board has to do is, are we going to put it in the Practice Act, which makes it law, or are we going to make an interpretive statement that says "Given the Board's authority, this is how the Board would interpret the Practice Act."

Now, I will tell you that the only division we have currently, that really talks about a setting, is Division 47, which is delegation in the community-based setting. Delegation to an individual who is not regulated by another Board.

The Board can decide a variety of things; another interpretive statement, a new Division in the Practice Act. Like right now, we're working on a new Division in the Practice Act, where all of the definitions of the Practice Act are going to be put in one Division. The Board is looking at that, and it's going for public hearing in June, where we explain what a focused assessment is, and what a focused plan of care is, and what a plan of care is.

So, that's how the Board has chosen. The Board has the authority to change the rules. Not the statute, but the rules that they have purview over. So, the Board could say "Write another Division about standing orders and protocols. Write an interpretive statement." And it all is going to be dependent on the feedback they get from you about how is this being used, and what are the questions out there, and all of that.

Because again, like I said, standing orders and protocols have been around since I was a baby nurse.

**Audience Member:** Who oversees medical assistants?

**Unknown:** Nobody, in Oregon.

**Ruby:** In Oregon, nobody.

**Audience Member:** That's why all of your standing orders should be written for medical assistants.

**Ruby:** Yep! But let's talk about that. Let's just say that all of the protocols are written for a medical assistant.

**Audience Member:** I was joking!

**Ruby:** No, no! I'm here to tell you that has been suggested several times. The issue with a non-regulated individual is that - a CNA is a regulated individual, so they are considered licensed, for lack of a better term. So, if there is an error there, they have authorized duties and standards, that the Board has said "You must adhere to. And if you don't, you don't get to be this anymore."

Now, an unregulated individual is a little different. Let's just say you work with an unregulated individual, an MA, and you decide that your MA is going to do whatever. Because they have no scope or authorized duties promulgated by a Board, the individual who gives them that task, they do so under their license.

So, for example, if you give a CNA a task that's within their authorized duties, and they mess it up, there may be a, you know, "Did you know this person -?" That's not under your license, though. It might be under your job role, but it's not under your license. CNAs do not work under the license of an RN. They have their own Board-regulated standards and authorized duties.

An MA, because there is no Board, works under the license of an individual or the auspices of an organization. The Board of Medicine has a really nice statement about how physicians should work with unregulated staff. But if you take the word “physician” out of there and put in “RN” or “nurse practitioner,” it’s the exact same concept.

If you ask them to do something that you want them to do, but you’re not sure that they can do it under the employer’s protocols or that they don’t have the knowledge, skills or abilities to do it, then it’s under your license. And if there’s a problem, the public has no recourse.

That’s what licensure is about, that the public has recourse.

**Audience Member:** MA is a certification, not a license.

**Ruby:** No, it’s not even a certification. They just take a voluntary national test. But it’s not like a Certified Nursing Assistant. That’s – the Board has given them that certification. But an MA can be certified if they want to be, or not, if they want to be. It’s more about employment. But the public has no recourse.

So nurses, we can touch people in a way that the general public can’t; put things in body cavities and take things out of body cavities, and make decisions about whether you should be on this protocol or not – or should stay on this protocol or not.

Therefore, the law says because of that, you have to make sure that, because you are with people in their vulnerable state, that you do so safely, and that if it’s not safe, the public has recourse to go somewhere and say “Listen, this person needs to not be doing this.”

For an MA, the public has no recourse. The person can be fired from their job, and go to Asante down the street, and say “Hire me please!” And Asante probably would, because there’s nobody that says “This person shouldn’t be that.”

**Audience Member:** That’s actually one thing we’ve been discussing. Again, this is a pretty specific population, but the use of techs in certain procedural scenarios. The example that we’ve most recently been considering is in an endoscopy procedure. I don’t want to [inaudible 00:54:06], but whatever medications they put down during the endoscopy, the tech is the one doing those things.

Who should draw it up? Who should prepare it? Who should administer? Whose license does that fall under? Is it the provider who’s ordering it? Is it the nurse that’s in the room? In looking at all of the guidelines and the standards, that’s definitely something of late that we’ve been looking at, making sure that we have the right organizational policies, procedures, processes, staffing, all of those different elements to cover that particular scenario.

While I can’t answer that, but that’s definitely something that we’ve been looking at, is if we are in an area or a situation where that’s just part of the role as its built, outlined in the job description, they have documented knowledge and competencies. Where and does the nurse have any responsibility over that at all?

If there’s a provider in the room, as well.

**Ruby:** It doesn’t matter if there’s a provider in the room.

**Audience Member:** Right, because it’s the nurse who’s responsible for the patient.

**Ruby:** The fact is that if the organization has written a job description for that tech, has put parameters around that tech's job, and that tech has been competency-validated and all of that. And when it comes to medication, you really need to talk to the Board of Pharmacy about that, because that's not ours. There's no medications in the Practice Act.

The question is always "Well, because I'm the nurse in the room, is this under my license?" And nurses take that on, when it's really not. It's the individual who is telling the tech to do it. That's the individual.

If the organization has given them the knowledge, skills, competencies and abilities, and the provider knows that, then it's the organization that takes the accountability for that, because the organization has told the provider "This person can assist you in this way."

Nursing is not responsible for everything that happens in the room. Now, if the nurse is the supervisor of that individual, because that's the role – the nurse is in charge of the room; not the procedure, but the room, and the way that goes – then the relationship between the tech and the nurse is more of a supervisor/employee, of this person is not doing their job right.

But if it's an intervention, and the provider orders it, then it's that relationship. And that's current. That's not under anything new.

We do have a lot of presentations that we can provide you, and one of those is how to work with unregulated staff.

[inaudible 00:56:40]

**Gretchen:** If there's no more comments, it's almost 11:00 AM, so we can transition to any public health-related questions and concerns and issues and processes.

**Ruby:** If you'd like.

**Audience Member:** We are community health, not public health. It's sort of one of those [inaudible 00:57:07], because we are rural. But I guess I wanted to sort of present a scenario of how most of our standing orders and protocols happen. If they present with certain symptoms – we don't deal with meds a lot. It's school-based. OTCs, at most.

But labs, and that's sort of one of those gray areas, as well. They present with certain symptoms. Can we then initiate a lab? And then, if we can initiate a lab, most of the time, based on the outcome, we are probably calling a provider to review their chart. Now, the provider is reviewing their chart, but not physically assessing the patient. How does that weigh in with standing orders and protocols?

Because the provider is not there. And possibly, we can have them follow up. I mean, a lot of the times we do. If the provider has to be called, they're probably going to be following up, eventually. But at that point in time, is just reviewing an electronic chart for everything that you've done – you know, you've made your assessment, you've possibly done some labs, and they were positive.

Now I'm calling the provider and saying "We need some medication," and I'm taking a [inaudible 00:58:34] order over the phone. They're looking at their electronic chart, but they're offsite.

**Ruby:** It's up to them. They are the ones, under their license and their legal authority as an independent decision-maker, to say "You have given me all of the information I need, and I am making this decision. And the decision is go ahead and" whatever it is you're going to do.

Now, we get this question a lot. Can nurses collect labs? Of course they can. Just, who's going to pay for it? Are you set up with your payer, that the individual can have a lab before they're ever even seen by a provider? Because at the end of the day, it's about who is going to foot the bill for this.

So, of course nurses can collect labs. If there's a standing order that says "If the person presents with blah blah blah blah blah, collect these labs, get the results, call me." Then, that LIP, whether it be an NP or a physician, can say "Based on that, this is my decision, to go ahead and order" whatever it is they're going to order.

Then, you take the verbal order. Make sure you do a read-back. Take a verbal order, and there you go.

**Audience Member:** Okay. So, because they are the ones who are then taking on the responsibility?

**Ruby:** They are the ones who made an independent decision under their authority, to say "This is what's wrong with this patient, and this is going to be the treatment plan."

**Audience Member:** If they're onsite or offsite?

**Gretchen:** Correct. It doesn't speak to geographic proximity.

**Ruby:** It does not talk about that at all. They have enough. Now, there are some states where tele-health is not allowed, unless there's a face-to-face, but that's not Oregon.

**Audience Member:** I just had one more question. So, this change will address things like the OHA? The OHA, I'm assuming that their model of standing orders for vaccines, and how would you partner expedited therapy?

**Ruby:** We would ask the Board to make sure that whatever is published by the Board answers those questions, because we get that quite a bit. One of the big questions we get is "What's the difference between this individual patient and population management?"

So, vaccines are population management. Partner expedited therapy, those are rules that go – because it's not just the Board of Nursing that writes interventions that nurses will implement. If you have the knowledge, skills and abilities, and there's partner expedited therapies, which are part of what the Board of Pharmacy and OHA have agreed to what that is.

**Audience Member:** So, that falls under Board of Pharmacy? That was one of those things I had put back in the feedback, is that it would be really clear.

**Ruby:** Yes. We would be really clear on that.

**Audience Member:** The Board of Pharmacy and the Board of Nursing, like you're using the same language.

**Ruby:** Yeah. That would be good, wouldn't it?

**Audience Member:** Because when I go in there, and sometimes I look and try to get clarification, I'm a little bit [inaudible 01:01:55].

**Ruby:** Right. Because again, a lot of people think that the Board of Nursing is the only entity that speaks for nursing. But there are so many entities that write rules for nursing. But again, I think at the last meeting, we talked about that chart that's available through OHA and Public Health, that talks about what nurses are allowed to do at public health clinics.

**Gretchen:** In the RN Dispensing Authority.

**Ruby:** Dispensing Authority and Expedited Partner.

**Audience Member:** Oh, right. Like, we are allowed to treat infectious disease caries.

**Ruby:** Dental caries and all of that. Right, right.

**Audience Member:** But we're a federally qualified health center, so I'm not sure if we follow under that, because we're [inaudible 01:02:36].

**Ruby:** Right. So, are you federal property? Yes or no? Is the property that you're working on federal? You're talking about federal funding.

**Audience Member:** Federally funded, correct.

**Ruby:** So, if your property is in Oregon, and you're on Oregon property – because like the VA is not in Oregon. It's its own island. It's federal. So, the Nurse Practice Act has no jurisdiction in the VA. You do not need an Oregon license, to work in the VA. You can go anywhere you want to go.

[inaudible 01:03:11]

**Ruby:** Anywhere you want to go. But as long as your workplace, whatever, is in Oregon, it's Oregon rules that are – even if you're federally funded, still, you have to follow Oregon rules. So, usually what happens is OHA is the one who really does talk about public health. That's under their purview.

And we do talk to OHA quite a bit, but they're such a huge OHA, that sometimes we talk to people we think we're supposed to be talking to, and then it's not that person.

But we've heard that loud and clear through these sessions, that the rules have to be – the jurisdictions, not rules – but the jurisdictions of each entity that interface with a nurse, need to be a little clearer spelled out. I'm not sure you can put that in a rule, which is the law. Maybe that's more along the lines of a guideline, or "Hey, this is how this is. OHA does this. The Department of Ed does this. Nursing does this."

But for nursing, if the Department of Ed tells a school nurse "Look. You guys are going to go ahead and do an evaluation for adrenal insufficiency," yes, adrenal insufficiency, that becomes now OHA's mandate from the legislature. What we would say to you, "Do you have the knowledge, skills and abilities and competencies to have that evaluation process in your independent scope of practice?"

The nice thing about scope of practice is it grows as you grow. When you get that knowledge, skills and abilities and competencies to recognize adrenal insufficiency, now that becomes part of your scope. If

you say “I have no clue how to do this, but I think that’s what it looks like,” then you’re practicing out of scope.

Or if you’re saying “I’m going to do this for my patient, because it’s the right thing,” it might not be in your scope. And if it’s not an emergency, it might not be in your scope. So, the main question is “Do you have the knowledge, skills, abilities, competencies?” And the very first question in our scope tree is “Is it legal?”

That’s what we’re here to ask you input, to make sure that we get it right. Without you, the Board isn’t going to get it right. And then, maybe in about four years after I’m done, we’ll be back here. So, the Board wants to get it right, and we need your help to do that.

Anything else? Burning questions?

**Audience Member:** The last thing is, it sounds like you guys, you keep saying you’re seeking information. So, have you guys received any protocols or standing orders that you can review, that you [inaudible 01:05:59]?

**Ruby:** Yes. And quite frankly, the majority of them are just fine, as far as now. Again, as we’ve noted, the gray area is when there is an individual patient with a brand new diagnosis specific to that patient, and the nurse is the one making that diagnosis, and the nurse is on a picklist, based on deciding which medication and at what dosage the patient needs to go on.

Now again, there are some states that might allow that. But right now, that’s the question in Oregon. Is that something? And then, it’s the Boards that decide that. Now, we have the National Council and State Boards of Nursing, and I’ve put that query out, and there are more Boards than not, that are asking those same questions, because this is not an Oregon thing. This is an all-over health care thing.

Actually, a lot of them are looking to us. “When you figure that out, let us know what you’re going to do.”

So yes, we have looked at protocols. But if you’d like to send them, we can certainly put them in information to the Board about the different kinds of protocols and standing orders that you do have out there.

The one question that hasn’t come up this time, that usually does come up, is about refills, and the clarification. Because that particular standing order, protocol, interpretive statement said that a nurse could not do refills.

**Audience Member:** Could you talk about that? Because I know you said something different, and I didn’t get it.

**Ruby:** Yeah. So, let’s just say the provider says to the patient “You’re going to be on hydrochlorothiazide forever, until -,” you know. And that’s part of the treatment plan. Now, prescriptions are good in Oregon, for a year. I think it’s a year. And then, they’re going to need to be renewed.

If it’s part of the treatment plan, that the provider has said “This individual is going to be on hydrochlorothiazide. Just keep refilling it,” absolutely. The designee of that individual provider, whether it be an office person or a nurse or whatever, in a protocol-driven clinic, says “Hey, go ahead and call in a refill for that.” Alright?

If you have a policy in your organization and the providers have signed off on it, that says “If the person runs out of their meds that they have to have, but they can’t get in, go ahead and authorize another 30 days,” or whatever it is.

**Audience Member:** Like coumadin.

**Ruby:** Yeah. “Another 30 days,” then that’s okay, because that’s part of the patient’s treatment plan. What nurses cannot do is to say, let’s just imagine the provider wants to put the person on a two-week course of antibiotics. The person calls and says “Hey, this isn’t working right. Maybe I should take it for another week or so.”

And the nurse says “Sure. I’ll call in that prescription, and have them refill that antibiotic prescription for another week, because that’s what you say you need.” That’s an extreme case, but that is clearly not okay. Is the refill part of the patient’s treatment plan?

I worked at Doernbecher. I was the Director of Nursing at Doernbecher, before I got this job. Those kids were on enzymes for the rest of their lives, and the clinic nurses constantly called in those refills, because the prescriptions expire. But the patient’s need doesn’t. If it’s part of the treatment plan that a CF patient is going to be on these enzymes forever, why do they need the provider to do that, when a nurse can see the treatment plan and move forward?

Now, if the patient says “Listen. These enzymes aren’t working anymore,” then the nurse, again, in their assessment, makes a different decision. But that’s what refills are about.

**Audience Member:** Where is that? You put something on the screen last time, when we were in Eugene.

**Ruby:** That’s the Board of Pharmacy. The Board of Pharmacy, but because we got feedback that you didn’t want all of that, you didn’t want education on what was okay, that you didn’t want education on what kind of protocols were okay.

[inaudible 01:10:15]

**Ruby:** Oh, well. Believe me! That was not what they wanted. We put up there example protocols that were good, and examples of protocols that were iffy. It’s not that the protocols weren’t good, but were they good in scope? Were they out of scope?

And we pretty much got the barrage of “You didn’t give us an opportunity to give you feedback, and that’s what this is supposed to be,” so basically, it was “We don’t want to hear from you. You need to hear from us.” So, here we are. That’s why we’ve removed all of those slides.

[inaudible 01:10:47]

**Audience Member:** I didn’t get a copy of the slides last time, and I really wish that I did, and I was sad that they were gone.

**Ruby:** Yeah, because we were asked not to give you all of this information. Because we felt that because – the reason it got to that point was because we felt that the average nurse, again, putting things in good faith, is not as well-versed in the Practice Act as those of us who make a study of it. So, we wanted to bring you information of “This looks great! This is good! This is iffy, and this is what we’re here for. And this is what refills are,” and we gave examples of refills.

And we were told “That’s not what we wanted.” This is what you’ve got, now.

**Audience Member:** I have a question, in regards to refills. Would that include like the PRN medications? You know, for routine meds, this is a patient’s treatment plan, that they’re going to be on this medication for [inaudible 01:11:44]. But if the patient comes in for an acute situation, and they’re prescribed this certain medication for “as needed,” but would the refill -?

**Ruby:** What’s the treatment plan? Is it as needed forever? Or is it as needed, until the next time they come see me?

**Audience Member:** Okay. So, a patient, chronic back pain, and they’re prescribed this medication to take as needed, for this chronic issue. Would that be [inaudible 01:12:15]?

**Ruby:** It depends on what the treatment plan says. “This patient will be on these PRN,” and this is paraphrasing. I’m sure they write it different. But the intent is “This person is going to be on this PRN medication until I stop it.”

Then, absolutely. It’s that same thing. What is the treatment plan of the patient? If it’s a PRN med, and they’re going to be on it. Now, if it’s an opioid, it expires. No refills on opioids!

**Audience Member:** Inhalers.

**Ruby:** An inhaler, right.

**Audience Member:** Yeah, inhalers for asthma, or allergies medicine.

**Ruby:** Inhalers are perfect. Yes. This person, “Inhaler will be used until I, as the LIP, stop it.” So, if it’s not stopped for ten years, then -. Of course, the nurse is going to do the assessment, to make sure that that patient is still appropriate, not just blindly call it in.

**Audience Member:** In a perfect world, a physician would actually say that in the chart note.

**Ruby:** Yes, they would.

**Audience Member:** The physician would actually say how many times a day a patient is supposed to test their blood sugar.

**Ruby:** But that’s -.

**Audience Member:** It would make life so much easier.

**Ruby:** Because there’s not a perfect world, this is how protocols come up. Because they don’t do this. So, protocols are developed by those individuals who manage these patients, and say “Look. You’re not going to give me this? This is what we’re going to have to write.”

And again, at what point does that cross over into medical practice? And the Medical Board, who I have consulted with quite a bit on this thing, the only thing they will tell me is “You cannot delegate the practice of medicine to nursing.” So, what is the practice of medicine? Where does that nursing and practice of medicine line cross?

**Audience Member:** Where does that take into account a nurse practitioner?



**Ruby:** A practitioner is an LIP. They can make their own decisions. Now, a lot of organizations say that the nurse practitioners work with physicians, but that's not the law. The law says "You are an LIP, just like a physician is an LIP. You can diagnose and you can prescribe independently, without anything. But then, you're also responsible for it."

A PA is not an LIP.

**Audience Member:** Because they are under the authority of a physician.

**Ruby:** Their license actually has a physician supervisor attached to it. A nurse practitioner, no. A nurse practitioner has a license that is freestanding on their own. They can write protocols, they can sign them, they can do whatever they need, based upon the organization, and how the organization is set up.

Because again, at OHSU, we had nurse practitioners who managed their own patients. And we had nurse practitioners who [inaudible 01:15:08] for the physicians, and the physicians signed off. That's again, a reimbursement thing. Because for facility fee, it's 80% reimbursement for an NP and 100% for a physician. But an NP gets paid – the individual NP gets paid at par, in Oregon, with the provider. Just the facility does not.

Anything else? Please give us your feedback.

**Audience Member:** Just put these on the back table?

**Ruby:** Yes, and we will collect them, and they will go immediately to the OCN, and the OCN will write a synopsis. Again, the Board is going to hear that report on September 10<sup>th</sup>, a Tuesday night. It's up to the Board to decide what happens after that.

(Background conversation 01:16:07 to end.)

## 5.9 OSBN Community Meeting

**Ruby:** ...input into the process now the same word protocol. Needless to say, this particular topic that the Board has asked us to review and to provide information to them, has caused much confusion and much angst to say the least among [inaudible]. There seems to be this rumor that the Board has changed rules, no, there's no change at all. There are no changes.

What the Board is trying to do is to really ascertain for itself where these have morphed to. The fact is, is that standing orders and protocols used to have a very clean definition. But because healthcare has changed, because nursing has moved out into the community because of a lack of providers in some scenarios, but the fact that providers can't make ends meet because they have to do certain things and not other things. These topics have changed dramatically, and that's what the Board is trying to do, because the one thing the Board does not want is for our nurses to have, in good faith, implement protocols that they thought were okay because their employer said it was okay. Then something happens, we get a complaint, and then the nurse is called in front of the Board and the Board goes, "Well, no, I think you were practicing out of scope," so that's not what we want. We don't want nurses to get a "gotcha". We want nurses to be able to have a Practice Act that describes what their practice is all about.

So with me today, Gretchen Cook is usually at these meetings, but Gretchen currently is attending a meeting in Portland or Salem, about school nursing. So I thought she'd better be there because school nursing is something that is being hit from all directions, and we thought she needed be there.

So with me today is Barbara Holtry, raise your hand Barb. Barbara is our communications officer and our PR officer. She's going to be assisting us in making sure that we get down the pertinent points in the recordings. With me today also is Wendy Bigelow. Wendy is one of our nurse investigators, and she is going to actually present most of the context.

The way this is going to work today is we're going to give you two slides, you have copies of the exact slides there, and Wendy is going to talk to you about those slides and go through them. We all know you can read, but we want to make sure we all get the same information. Then you have two pieces of paper, one yellow, one blue or beige or blue, whatever. They have questions on it: one is, how do you use protocols and standing orders in the context where you work? and two, what are your major concerns about protocols and standing orders? So the idea of this is to collect information. So those of you on the phone, if you would go ahead and send your questions to the Ask a Practice Question, which is on our website, we can segregate those questions and just say, "This is from the Bend meeting, here are my questions, here are my concerns," because I know you want to have papers. So at the end of this, I'd like you to collect or we're going to collect those papers. That feedback as well as this is recorded, it's being recorded. Everything will go to the Oregon Center for Nursing, where their data people will review it and write a report for the Board, which the Board will hear in their September board meeting. At that point, the Board can do a number of things. They can ask us to do all this again, because they don't have it quite clear. They can say, "Let's write rule." They can say, "Let's do another interpretative statement." They can do a lot of things, but that would be totally up to the Board, not to any of us in this room. So, Ms. Wendy, I'll drive.

**Wendy:** Good morning.

**Audience:** Good morning.

**Wendy:** So, I want to call myself us. Everybody is always worried about the Board of Nursing. You show up at the Board of Nursing you're like, "Oh my God, that's so scary, it's horrible, it's scary, it's just like us." You put up the curtain, guess what. It's just us. We're board staff, okay, we're not board members. So, we work at the guidance of the Board and at the direction of the Board. So, some things we want you to know first today as far as asking here and really kind of address the generals of that, we do not have any jurisdiction at OSBN as far as your workplaces and your work organizations. No jurisdiction, okay? We can't change things at that work level. Where we do have jurisdiction is at the nursing level, and like where we talked about, we don't want you to be in that position where you have to come to see us because now, all of a sudden, maybe I'm out of scope. We want to get you before that. So that's why we're doing this information gathering, to try to get that so you never have to visit us at the Board of Nursing.

We've talked about, we also have jurisdiction over nursing school implement, policies, procedures, protocols. We hope, it doesn't always happen, but we hope that people in those positions are actually using your Nurse Practice Act side by side when you're writing notes, to make sure that you're keeping nurses safe and within the guidelines in the Nurse Practice Act. Physicians do not have the authority to expand your scope of practice. They also cannot delegate things to you. You have your own license, you have the ownership of that license. If you do something out of your scope from a doctor's order or at their discretion and you choose to do it, you choose to put your license at risk. You are not working under their license. Does that make sense?

The Board of Pharmacy, absolutely does not allow any licensed independent practitioner to sign a blank, and I know we don't use a lot of blank prescription pads anymore, and a lot of it is electronic, but for those prescription pads, they cannot sign a blank pad and hand it over and leave it in a place where people can fill it out as necessary, and turn that in like it's theirs when they didn't write the order or the information of that medication on that prescription pad. They just already pre-signed it and allowed it to just go. It's illegal.

So, let's talk about why we're here today? So, we are seeking information, like Ruby said, about how people are using protocols, how you're using standing orders and what that looks like, so that the Board can figure out where we're at. Some of this did come up from investigations where we started to learn that some places are using this in ways in which we're like, "This isn't in your scope of practice." Our hope is, and the Board's hope is, we can gather all this information and we can make sure that what was in place works for you where you're working.

We recognize that these were put in place in good faith and we just talked about that. We know that there is a lack of providers specially in our world communities. We understand that nurses are capable of doing a lot of this work, and being able to provide this care, we just want to make sure you're staying within your scope. We recognize as a Board and for its staff, that this interpretative statement that was placed on our website was vague, and it did leave some openings for interpretation that may or may not have been the intents of the interpretive statement in the first place. It has been pulled back.

This part of this is to try to make things clear, so we don't need that interpretive statement. So, they've asked us to hold stakeholder meetings which is what we're doing, kind of around the state. We're gathering information, we allow you to have the opportunity to discussions, questions, whatever it is, so that we can help OCN gather all this data, put it together, OCN will then present it to the Board, and then the Board can make this work for you and keep you safe so you don't have to visit us at the Board.

So, with that, we're going to leave at as pretty much an open forum. So, questions, how you're using situations, all of that were open to. Now that said, again we're information gathering, you may have a question for us and we may say, "We can't answer that question for you today. We can give you guidance and we can tell you not to change things right now and leave them like they are until there's been a decision, but we're happy to do what we can." We just are trying to gather how they're used in your environments, what you're using, how they are viewed, those types of things to gather that information. So, with that, I'm going to leave that to you, guys. Yes?

**Audience:** I'll be the first.

**Wendy:** Great.

**Audience:** I am Dr. Mackay, nurse practitioner. I'm working for County Public Health Department as a clinical supervisor and a nurse practitioner, and I'm also helping cover Jefferson County because, for what, six months, without a provider.

**Wendy:** Oh, wow.

**Audience:** So, my biggest concern is protecting my nurses without limiting access to care. The average wait for primary care in my community is easily over six weeks, easily. That's if they have any insurance, and you can attribute it to all different kinds of things, but the bottom line is my rural community doesn't have the \$50 from [inaudible] and publicly purchased emergency contraception. They don't have the money to drive to them and see the provider who are willing to prescribe one birth control at a time. Yes, it's great. The families when we share our building a week, which works out beautifully, when we have a week family, the mother wants contraception and the kids are out of date on their MEs, then we can do all of that in one stop, and the family doesn't have to go somewhere else. I don't want that access to stop. I do not see the kids with MEs. My nurses work a very strict protocol and standing orders that were written by the state and they are very responsible with it. If they have a question, they call.

**Wendy:** Okay. So, the question is really about community health where individuals either don't have the funds or the money to go see their primary care and then at six weeks, they may not even have a primary care. So, what you're talking about is community health and population management. Now the Board has no authority over population management, that is OHA Public Health Department. So, let's talk the difference between population management and what we are talking about. In your community, especially when it comes to things like birth control, nurses under OHA rule and Pharmacy rule are allowed to dispense because the Board of Nursing has no authority over medications. That's the Board of Pharmacy. Nurses are, more often than not, the agent where the last person to hand that drug to the patient or put that drug in the patient's body. So, there's a lot of discussion about, "Well, what does the Board of Nursing think about meds?" Well, we don't think anything about meds because, the fact is, we don't have any jurisdiction over that. We would expect nurses to understand the mechanism and you know the "five rights", you know of things we learned in nursing school, in making sure their patient is safe, that you gave them a safe medication. So, population management has usually a medical director of some type that says, "Oh, it's flu season. Here's the vaccination we're going to use," and they do CDC and they do a lot of other research, but the entire population is going to get this. Same with birth control. Birth control, you do a little bit of exclusionary discussion and then from that exclusionary discussion, you decide what birth control to dispense. That is also under public health, and it's also a rule in this state that nurses can dispense, they can't prescribe, but they can dispense it.

So, we really, in that context, anything that has to do with population management, so that everybody in that population is going to get a Tdap. Anybody in that population is going to get whatever vaccination they're due. It is exclusionary criteria rather than inclusionary criteria. What we're here to talk about today is the single patient who comes in with a single issue, where the nurse has been delegated by the physicians the authority to, "Here are some tests based on symptoms, pick a test. Now the test comes back, based on the test results, pick a diagnosis." The nurse actually gives the patient the diagnosis that the patient didn't have when they walked in before. You're not diagnosed in the protocols you just mentioned. You're not diagnosing anything, it's a need, right? It's a population need. Then once the nurse gives them an ICD-10 diagnosis, then the nurse says, questions them more based on the protocol and the nurse says, "Okay, because you have an allergy to this I'm going to do this. Because you're a breastfeeding mother, I'm going to give you this med." Then the nurse calls in the med to the pharmacist under the name of the provider, that no provider has ever seen that patient during that encounter. Then maybe, maybe three days later, two weeks later we've heard from input from other nurses that have said, "My provider never signs off on this. It just glitched." Which also, which is not under the jurisdiction of the board, who's billing for that? How is that ICD9 code? How is that okay? But we're not sure. We don't have an answer today about that. That's what the Board is looking at and you're absolutely right. Nursing has absolutely gone into new frontiers that the Practice Act has not kept up with, because the Practice Act is really-- the purpose of the Practice Act is to define your practice so that you can keep patient safe.

All of us who have licenses have a social contract, and the social contract says, "I, nurse, will keep you, patient, safe. That would include not implementing provider orders if I don't think that provider order is safe for you or in your plan of care, in your treatment plan." So, this is why we're here because there are those areas, there are no providers. So how does a nurse, how is a nurse able, persons coming in with signs of TB or a UTI, there's no provider, how do we manage that? Because currently, is that or is that not out of the scope of practice of the nurse, the Board has not addressed that question, and the Practice Act, while we always must keep patient safe and it's not just, you know, don't ask permission just seek forgiveness later on. That's not how the law works, and the Practice Act is the law. So that's not how laws work. You can't just say, "Listen, officer, it's silly for me to drive 30 in this mile, you know, and I think 50 is the better one." The officer doesn't care that you think it's the best thing to do because you can get there faster. There's someone that will give you a ticket. Yes.

**Audience:** I'm also from a rural county. You will think that be on the coast of Lincoln County is very rural. We have [inaudible] public health center but we have so many sites that are primary care. We either [inaudible]. Our concern is about the immunizations, the family planning, the emergency response and a clinic for the provider is not there. After your conversation, I was thinking about adding on to that. We do have a lot of tests associated with family planning visits like your pregnancy testing, your STI screening, and then what's the next steps after that. So, I can see where maybe, I guess, into a gray area. I guess my question is, you said that public health, Oregon Health Authority umbrella, our protocols are based on that, is the Board looking at that as being like a hard wine? It's just not black and white, it's a little bright. But we really are concerned about access, and I don't know about the rest of the state, but we have a tsunami of STIs, you know, how we get our nurses to screen for them, test for them and probably treat it by protocol. I think that will be a public health issue. I don't know, that's my thought on that.

**Wendy:** Okay, so the question is about--

[laughter]

**Audience:** I've got too many questions.

**Wendy:** The question is about STIs and running tests for STIs, and the nurse being that one person that does that. So, part of the Nurse Practice Act says, "You shall follow all the rules and regulations of the state and Federal rules also, rules and regulations." So OHA is charged with public health. OHA, in its desire to have people give access, have developed these rules along with our friends at the Board of Pharmacy that says that, "Nurses can dispense medications for dental caries, STIs, birth control, that sort of thing." Where the gray area comes, and I've talked to our partners at the Board of Pharmacy quite a bit about this, is that, okay, so you're telling me that the law, their law, their rules currently say that the nurse cannot write the prescription for that but can dispense based upon a prescription of a bona fide practitioner who has independent diagnosing and prescribing authority. So that, the dispensing part, got that one down because that's, again, the Board of Nursing does not talk about specific diagnosis. The Board of Nursing does not talk about specific medications or treatments for specific things. The Board of Nursing says, "As an RN, and I am an RN, I am not an advanced practice nurse, your rule does not include the independent diagnosing and prescribing. That's not your role simply because, it's not that you're not smart enough, because I work ER trauma for many years and I pretty much can tell you what's coming through the door, but I'm not legally allowed because I chose my nursing career to stop. Had a Master's in Nursing Administration, I never went on to be an advanced practice nurse that has independent prescribing and independent diagnostic authority under the state law.

Because if you look at state law, a Board cannot give someone prescriptive authority and no licensee can say, "Oh, I'm going to give you my prescriptive authority, you can do that." No, that's not legal. You cannot give away prescriptive authority. Prescriptive authority is given to an individual because a legislature, and only the legislature, can give prescriptive authority to a licensed type. For example, MTs have full prescriptive authority for years and years and years and years. CRNAs, no, they did not have prescriptive authority at all because the statute that directs the practice of nursing did not give them that authority. Pharmacists cannot prescribe many things, right, many things. But they couldn't do that until a legislature said, "Pharmacists can do that." For the registered nurse, not the APRN but the registered nurse, there is no legislative authority to independently diagnose and treat because our education did not include that. Our experience may have included it and we can figure it out, but our education and the education that allowed us to have a license within a certain framework did not include independent diagnosing, did not include independent prescribing. So that's really kind of where the cross is. We do have to talk to our friends in OHA, however, the Board has not asked us to go into those discussions with them. They basically said, "Let's get some information, how they're used and then go from there." But right now, the law very clearly states that nurses can dispense based off a prescription from an authorized prescriber, and that's been in law for a long time, it's not Practice Act but clearly, there had been protocols because there is a need developed that it actually lets the nurse go from beginning to end. Is that a violation of public health rules? Is that a violation of pharmacy rules? We're not sure yet because we don't know how prevalent this is. We have to have data before we can say this is going to be the plan. But right now, I will share with you, that's what the law says. Yes.

**Audience:** So can I get you different scenarios to make sure that I have this correct? So, patient comes in, I only have a nurse on staff, I'm not there, I'm at the beach, which is where I should be.

[laughter]

**Wendy:** A hole or just at the beach?

[laughter]

**Audience:** They can always call, but just at the beach. So, patient comes in and they're complaining of vaginal discharge odor. No known contact with chlamydia. So, nurse says, "Sure, let's screen you." Then the nurse says, "Oh, let's do pelvic exam too." Looks in the pelvic exam and says, "Oh, this looks like chlamydia." Then dispenses azithromycin without having a positive-screening test. So that's one scenario. The other scenario is nurse says, "That's a bummer. Let's screen you. Either abstain or use condoms until we know what's going on," and then when they get the positive chlamydia, then they call them back and say, "You need to come in for treatment."

[crosstalk]

**Audience:** [inaudible]

**Wendy:** That was my next question. Any point are you called--

[crosstalk]

**Audience:** Now, I'm the physician.

**Audience:** Just we understand what-- to do that.

**Audience:** So, at what point in that gray area does the diagnosis versus the confirmatory test happen? Does that make sense? Like you're diagnosing somebody with many fairly common and well known...

**Wendy:** Signs and symptoms.

**Audience:** ...signs and symptoms, is that different than having a positive chlamydia test?

**Wendy:** So, they can't diagnose?

**Audience:** Correct.

**Wendy:** So, clearly, you do the exam, you say that looks like can't diagnose. The positive result, did they call you with that positive result? Is there a set of antibiotics that they choose or like how does that work?

**Audience:** There's a specific written set for first choice, second choice for allergy that the OHA published just based off the CDC.

**Wendy:** A public population management-

**Audience:** Right.

**Wendy:** Okay.

**Audience:** So is there a difference between just going on the signs and symptoms?

**Wendy:** Yes, there is a difference.

**Audience:** Okay, right. So like if you have a positive chlamydia and you said, "Hey, you're positive. Come in and get treatment." That's one thing. But if you say, "Hmm, you got some weird discharge in, you know.

[crosstalk]

**Wendy:** I believe that I'm going to diagnose you with this. Right.

**Audience:** Even with that second scenario, the patient can potentially never see anyone but the RN, so I think that that's part of the question, right?

**Wendy:** That is part of the discussion. Because one of the things we have talked about, and again this is going to go into the report to the Board, but several groups that we've been in front of, have said, "Well, okay, if we can't diagnose an ICD-9 code or 10 code we can't do that because you have to have that to bill, yes?

**Audience:** Yes, oh, yes.

**Wendy:** You have to have that to bill. The nurse cannot diagnose the individual with an ICD-9 code, cannot do that. So, one of the things that has been suggested and whether the Board is going to do this or not, it's going to be totally up to the Board is, can a nurse do treatment based on signs and symptoms because Wendy here had a case with the Department of Corrections. You have talked to them about a scenario kind of like that is...

**Ruby:** Department of Corrections is very similar.

**Wendy:** Right, it's very similar. So, in the Department of Corrections scenario in this particular agency, which was obviously here in Oregon, they don't have a physician on site, pretty much all we get long and pretty much most nights. It may come to them with a new issue. Same ear infection, my ear hurts it's red, it's bothering me. They come, the nurse looks in their ear, says this looks like kind of like the whole, doing the exam, "Look, I think you have an ear infection. These symptoms are on my protocol, the signs are on the protocol." I then move to say, "Well, okay, because you have an ear infection, I'm going to move to the ear infection protocol, which is a diagnostic protocol. I'm going to pick this antibiotic from a list of antibiotics you're not allergic." There's nursing assessment that goes on in there, hopefully. Then I call in that script to the pharmacy and say, "Doctor whoever is calling in the script for this antibiotic for this is ear infection, for this inmate who never had this problem prior, this is a new problem." It gets filled on the back provider's name, and the provider may or may not ever see that inmate. That's not within their scope but they diagnosed that person, they treated that person, and not only did they treat that person, but they called into the pharmacy under another provider's name and said that provider basically said, "I can do this." Now that said, those protocols are reviewed by a medical director every single year, signs off on them annually, "Yes, I agree that this all match up still, and I agree that these are the things I want the nurses to do." He can't delegate that to them, he or she. Oregon has a very specific definition for the word delegate. Now all of us who started out in hospitals, you have a CNA, you delegate to the CNA, right? That's the language, that's the nomenclature, and that nomenclature in



Oregon is not correct. In Oregon, the definition of delegation is someone who has a license given to them by a healthcare board, some kind, medicine, dentistry, whoever, takes a part of what is known as their practice and allows someone who is unregulated to perform that activity. That activity then, the individual licensee who gives that person that activity unregulated-- now, CNAs are not unregulated. CNAs are regulated by the Board, therefore they have their authorized duty as in their divisions in the Practice Act. We're talking about people like ED techs. We're talking about people like OR techs, labor and delivery techs.

**Ruby:** MAs.

**Wendy:** MAs. MAs are holding, and, no, we are not going to regulate MA's, not us, okay? So, what happens is when you delegate to someone, that person does that activity under your license. That's delegation, all right? Now, a nurse has a license, they're answerable to the Board. A physician has a license, they're answerable to Board of Medicine. So how can one licensee delegate something to another licensee because we never, ever, ever, work under the license of a physician, ever. You have your own license, your own responsibility. What nursing does is nursing assists our physician partners in the implementation of their medical plan, period. But you have your own independent scope of practice, and quite frankly, a lot of nurses have kind of given that away but that's their choice. But they're always accountable for either implementing or not implementing the provider's plan of care because all you're doing is assisting them. So, one of the things that has come out is, well, can we take diagnosing off the table? Can we take diagnosing off the table? For example, school nurses, camp nurses, they do this all the time. Kid comes in and says, "My head hurts, " and the camp nurse says, "All right, I have this protocol, I'm going to go ahead and give you two acetaminophens," or whatever it is you're going to give, right? Is that diagnosing and is that treatment? If you take it to the very nitpickiness of the Practice Act, probably, yes, because that kid could have a brain tumor but you're calling it a headache and you're giving treatment for it. Is that or is that not? But that happens everywhere. So where is that camp nurse in there because I can tell you, before every summer we get these phone calls, "Hey, I am in a camp and there's so many kids. What can I do or what can't I do? I've got kids with rashes, I've got kids with sprains, how do I know they're not broken arms?" So that's something else the Board has to look at, is over-the-counters scenarios where a nurse is-- there's no reason for that patient, that kid probably to see a provider, but at what point does the nurse have the information to say, "Whoa, I don't think I need to be doing this." Is it just a matter of judgement? If it is a matter of, you know, I think it's broken. I don't think it's sprained or I think it's something else. Your eyes, you know, there's nystagmus in your eyes, whatever you've got, maybe it's not just a headache.

So, a lot of that is a gray area, and that's what we're here to find out. How do you use protocols in your environment, and what would happen if those protocols would not be in place because the Board has to know that too? What are the consequences to the public? The public is not going to be safe if they don't have access to care, right? They're not going to be safe. So where do we balance what our education and our license allow us to do and the needs of a very shifting healthcare environment? Where do we go with that? The Practice Act has not kept up with that and it needs to. It needs to not say, "Ooh, caught you," and that's not what the Board is here for. We don't want to do that. That's not fair, that's not right. So, a lot of the things you're talking about are gray areas and if you would write that down, also what would happen? An STDs, dental caries, STIs, I'm sorry. STIs, dental caries, birth control, fall under public health management. That is even more of a gray area but OHA has rules about that. But what we are finding in these groups that we talked to is that a lot of people who put these protocols together don't know which of these rules either because OHA constantly changes their rules based upon what like-- there's a bunch of legislation going on right now that OHA is going to have to implement.

Who knows? Unless you keep up with OHA and all of their changes and all of their public rule making, you're not going to know that this isn't okay because like most clinicians, we see a need and we want to fill it, and not very frequently do we say, "Let me call the Board and see if this works. Let me call OHA and see if this works." You have a need, you have a way to fix it, you're going to write a protocol to fix it. Somewhere along the line, all of those gray area started to come up, and that's why the Board has asked us, "What is the state of this."

One thing too is what is the difference between a protocol and a standing order? What is the difference between a protocol and a standing order? What are the definitions? Yes, that's pretty much the response we get because people don't know. People don't know what the difference is a standing order. Now, I have done research on this and I had looked at various sources, lots of resources. They mostly say this, "A standing order is something that is done by someone," mostly nursing of course because everything goes to nursing eventually. No, nobody wants to do it, nursing steps in, which is okay because we're the right ones to do it. For example, I work level one trauma. I was a level 1 trauma director for a number of years. So, the patient would come in and they would show various signs and symptoms, and the triage nurse says, "Okay, you fit our standing order. I'm going to draw a rainbow. I may send, may not send. I'm going to send you over to ultrasound. I'm going to send you over to X-ray. We're going to make you NPO. We're going to do this, we're going to do that." Then all of that data is gathered to give to a provider who says, "Oh, based on this data, I think you have whatever," and then they do the treatment plan and then the nurse helps discharge the patient based upon the treatment plan. So, the literature says, now this is not the Practice Act, the literature says in the standing order, the provider is on the backend, okay? The literature also says, and again this is not the Practice Act, and this information will go to the Board because the Board, first of all, has to define what this up. A protocol is one that a group of providers, hopefully including nurses, has sat down and said, "Listen, this is a coumadin clinic. We need to do a coumadin or a blood thinner clinic or whatever thing that deals with blood thinners."

Patients will fit a certain diagnosis type, and the provider will decide that this patient fits this protocol, orders the patient to be on the protocol, and off they go managed by nursing in the coumadin clinic for years and years until something changes. So, in a protocol, the literature says, "The provider is at the frontend making an independent diagnosis and an independent treatment plan saying, "This person fits the protocol. They write an independent order that they are authorized to do by law that says, "Herby Jason fits the coumadin protocol, go to the protocol, go to the coumadin clinic, and Herby Jason, unless there's a problem, will not see that provider for a very long time, and the nurses are the ones who draw the labs. The nurses are the ones who manage. The nurses are the ones who titrate and do all of that. The nurses are the ones who counsel. The nurses are the one who do all of that. That is the literature-based definition of a protocol. Now what we're seeing is that there's no provider who has independent diagnosis and independent prescriptive authority at either end of this book end, either end. Now that's what the literature says. But what is happening out in the rural areas in the community areas, that's what we need to know because there is no provider to be available to be a book end. There isn't one. There is not any PRN, there's no physician, there is not a naturopath, there's not anyone to book end this. So, when there's no book end, where the patient first sees the provider, provider says, "Go on this protocol. There's no provider at the back end saying, "Yes, I'm looking at all the data that someone else has collected for me," which would be usually the nurse, and I am making an independent diagnosis and independent treatment. So that's really kind of what the literature says, the protocols and standing orders. Oregon has not defined that and it is up to the Board to define what that means in Oregon because literature is not law. You have a question?

**Audience:** I don't have a question. I have a comment. So, I work in public health for many, many years, and I thought it was interesting when you were talking in the beginning about how practice has morphed into something maybe that it shouldn't be, and that has not been my experience over the years. In fact, I had felt for many years this tightening and more definition within standing orders and protocols, and limiting what the nurses are doing, which I think is a good thing in many ways. So, when I started 27 years ago, it was really hard for somebody to get screened for an STD. In fact, in our area we had one nurse practitioner who came in and tried to see 30 clients in one day with the help of several ends and the other services were done by friends, and they were called expand services. Over the years, we have gotten rid of that practice in our area. But we happen to be a county that has more funding, and we have the ability to hire amazing NPs to run the clinic mostly. Currently, our RNs never see a symptomatic person, but we still do some screening services and we work under protocol to do that, and I think that's the definition of a protocol as well. That is a decision-making tree, a person comes in asking for screening or STD services, they can get these tests based on this request that they have to be screened. We have a certain population of people that don't have insurance that wouldn't be able to go anywhere else to get those screening, and we're never going to get ahead of the STD issues that we're having now if we don't provide those screening for people within public health. It's that the other systems were just not set-up to provide that, and so I think that's incredibly important. Also, we work very closely with our health officer. We have an STD program that does all of our disease investigation and does some screening, and we treat people who are positive, we also treat contacts based on our investigative guidelines and our protocols. We work very closely with OHA, which I think has tightened their processes over the years as well and has standardized some of the protocols which has been amazing. So, there's more standardization across public health in the state of Oregon, and so I think that's really good. So, I see that very differently than what I think came out as in the very beginning. I think in public health, we've definitely tightened what we're doing, we're more careful about the role that we put our hands into, and I would love to see you having more of a conversation with OHA.

**Ruby:** We will.

**Audience:** Okay.

**Ruby:** At the direction of the Board, we will. If you put that in your comments, then that will go into the report also. We recognize that community health is not the same from community to community, based on funding, based on it. What we are seeing at the Board is because in some communities, there are very few providers that nursing is the one that is being looked at to fill that void, and often it's not advanced practice nurses, it's RNs, and really that's what we're talking. That collaboration and collegial relationship you have with your providers should probably be like a role model for what everybody has, but not everybody's got that kind of funding, and there are so many places where nurses are going into now that they didn't before outside of public health. We see a lot of nurses do delegations in the home which is to unregulated individuals, and unfortunately, we're seeing new graduates do that. New grads going into the homes and declaring patient stability for a minimum or a maximum of six months and then educating unregulated individuals who have no medical training at all in these community health care settings to give insulin, to do CBGs, to do wound care, to do all of these things. So, nursing is expanding in that area also, that is allowed by the Practice Act. There's a part of our statute that says you can do that in these certain settings. So, what we're trying to do is gather the information so that the Board has a really clear picture of your county versus your county versus your hospital system. Because hospital systems also work off protocols where the nurses are the ones who see the patient from beginning to end and the patient leaves with a brand-new diagnosis and a brand-new medication, because either the providers need to be in surgery, and they can't do any other stuff, or the providers in

some areas. If it's an academic medical center, they got to go teach or they got to go do their research and they don't really have the time to see patients that are not acutely ill.

So that's what we're trying to do here, is we're trying to get how would yours be different than yours, because clearly, you have a really well-rounded system. You are correct, it used to be the wild west out there and it has corralled in, and it is corralled in, why? Not because somebody decided to coral because it's safe. Remember, the Practice Act is not written for your high-performing normal RNs that understand what nursing is. The Practice Act is written for the people who like to be in the wild west and do what they want to do simply because they want to do it. It keeps, my phrase, and my staff always gets very upset to me whenever I use it, particularly my PR person, is the Practice Act is written for the volunteers. It's written for the volunteers and it really is. It's written for those individuals who don't get it. That you have a license and your responsibility is to keep the public safe, not to do whatever it is you want to do because you want to and you think you can. So that's what we're trying to do, balance what you all, who are probably top tier or were 90% of the nurses list, from being able to do and make the judgements you know you are making safely, and balance that with those people who would take those rules if they are lessened and make it a wild west, which is why OHAs has had to do this, because they have gotten into trouble with the Federal government about their lack of oversight for vulnerable populations. DHS, it's a news, they're doing it too and you can be sure we work with DHS quite a bit and they are ratcheting in. Ratcheting it in to make sure that they have oversight over whatever population they have the authority over. So, yes, what we want is that balance. We have to have that balance, not to stifle you but to say, "Okay, where is the nice middle ground?" Those nine people on the Board, those nine people are nurses like you and me and advanced practice over there. Yes.

**Wendy:** I wanted to say one other thing too before, and then I'll totally get to your question. The other piece of this that you have to remember is the reason why this comes to our attention, why topics come to the Board's attention, is as we do investigations, we start to see trends and things. We see trends and things that aren't happening correctly or trends and things that aren't within the Practice Act. So those are the things the Board then goes, "Hey, wait a minute, why are we seeing six of these same cases? We don't see the good stuff which is the other reason why we're kind of out there trying to gather data. We don't see what else is going on that might be really good, we're seeing what's going wrong." When we start to see trends in what's going wrong, then we want to do that outreach and that education to say, "Wait a minute, where are we, and are we okay? Are we not okay? What do we need to change to make sure everybody is keeping the public safe?" So you have a question.

**Audience:** Well, yes, I have I guess a couple of comments. One is I'm concerned that we often think that the lack of providers is only a rural area concern, certainly in Lane County. We do not have a full-time health officer in our public health department nor did we have any nurse practitioners employed in our local public health department. So, nurses are often providing population-based services. I guess that's my second concern is, what are we using for, what are we including in that "community health population-based services" because certainly we do tuberculosis screening, we do med starts with tuberculosis cases, we do STIs immunizations and a number of things

**Wendy:** OHA actually defines that. So, they have a definition for population health and it tells you exactly which things are covered [inaudible].

**Ruby:** Well one of the reasons we're here is we need you to write that down as a comment because it is not just rural, it is where there is, where nurses are being the ones who are doing that and what are we

going to do, and how does the board, in concert with OHA, define all of this so that our nurses know this is okay to do, no one's going to tell me I'm practicing out of scope.

**Audience:** But Oregon Health Authority provides documents that the local health officers are the ones who sign the actual standing orders that are provided from Oregon Health Authority. So, the immunization standing orders for instance that go across the state to every county health department is actually a signed document by the local health department, by your local health officer. So, I think your comment and you want to have a discussion with the Oregon Health Authority makes sense, but you also need to make-- I would like to ask that local health officers, maybe the local health officer caucus, also have some input into that discussion.

Ruby: Sure, absolutely.

**Wendy:** That's what we need to know because we don't know all the groups that are out there. We want stakeholder input but it's up to you all to tell us who the stakeholders are. Because you're right, OHA makes the law and rules because that's what we are, we're state agency. But again, if the Board needs to craft rules to fit what the public needs and what nurses can do to keep their patients safe and within the scope of their education and experience and all of that and their license type, how we're going to do that and who do we need to talk to, that's really what we also need to know because we don't. Yes.

**Audience:** I have to [inaudible] that's why I have this comment on as far as stakeholders in an acute-care setting too, that's not only rural. I think in our '80s we use so much initiated orders. My previous facility, our nurse-initiated orders were a lot more broad, but in my experience I find that those protocols definitely help drive patient care and even meet, say, you're required when you start to set excellence to meet certain numbers. Often that's really challenging if you're waiting for a physician order or you get that patient decide to do this. So, I think, in a lot of ways, protocols help keep our patients very safe, and especially when we are in surge, how do we pull out those chest pains that are more critical than the other? A lot of times that's for different components and EKGs, so that's how we're using our own system.

**Wendy:** Within that in-patient, you're gathering all that information based on that protocol and then at end, a provider is going to see that. That's the difference is there will be a provider involved. Yes.

**Audience:** I think we're limiting patient safety and access to care with the requirement, and I know it's a Federal level, but the requirement that a health officer be an MD. I just put that out there. I'm in a clinic every week.

**Wendy:** Yes, and like I said, we have no authority about that at all.

**Audience:** But if anybody wants to work with us, we'll be happy to take that back.

**Ruby:** Remember, licensing is state based, there are rules, of course, because the Federal government always likes to tie payment. At the end of the day, we all want to get paid, and you can't get paid if you don't have a position as a health officer. That I would say is something that the National Nurse Practitioners groups need to let individuals in the Federal government know. We can't change that. The Board doesn't have the authority, and that's more than advocacy thing, and the Board does not advocate. However, I believe that as the provider shortage, the physician shortage, because there is one coming, increases particularly in your areas of practice, there is not going to be much of a choice pretty

soon and CMS is going to have to start listening to the fact. But remember, there's only 20-some states where nurse practitioners have full-scope practice, and those states are going to say no.

**Audience:** I just think we have people and I know that we have individual signing, yes, I review this for cost, they don't know how to do it.

**Wendy:** Oh, sure, absolutely. We are well aware of that, but when I said they review them annually, I mean they sign them annually.

**Audience:** Exactly. We're paying them for a signature.

**Wendy:** But remember, anytime you sign your name to any document and put your license at the end, MD, RN, NP, you are attesting that you will take accountability for what was being written. So, if those protocols, if you go back and you say, "Whoa, whoa, this protocol is a lot of work," then your obligation is to say, "Back it goes, no." As a nurse, as a provider or as one who works with registered nurses, we're not going to do this because this isn't right, and that is in the Practice Act. You do have that. But anytime you write your name RN, that's on your license, you're saying, "By my license, I am attesting that this is true." That's why when we ask people on their application, did you work 960 hours in five years and they just check the box, and they get haunted and they don't have it, guess what, because in Oregon, there's no CEUs for RNs and LPNs. Competency is based on the hours you practiced. Anybody else? Yes.

**Audience:** We're here with a category of questions that sounds a lot simpler if you put this specially behind us, but it affects a great number of people, and that serves camp nursing. We're school nursing which is school nursing in a camp site. Until last fall, most of us were operating on what we called protocols, standing orders that were reviewed and signed off by physicians each season, and then we would prescribe only over-the-counter medications-- we will dispense only over-the-counter medications based on symptoms that they suggested. The doctor did not see the patient, we did and if he would need a referral, we refer. Then we were told, you can't do it, but the parent consent the OTC med and we can give it if the parent says so.

**Wendy:** So, you are in the FERPA which is a whole different ball game too. You now have these rules in a school setting where they are saying the parents dictate what medications these kids can get and have to provide them, or you have to call the parents and say, "You didn't send any Tylenol for your kind. They have a headache and now you have to come out and give it to them."

**Audience:** Yeah, that's where we are.

**Wendy:** Yeah and that's FERPA.

**Ruby:** That's not Board of Nursing.

**Wendy:** That's FERPA, not us.

**Audience:** FERPA?

**Wendy:** Yes. FERPA pretty much--

**Audience:** So how is this going to affect the same type of things like summer camps? Only two or three in the state have providers at those. So what are we supposed to do?

**Ruby:** Are they under the auspices of school district?

**Wendy:** Right, for the summer camp.

**Audience:** No, not summer camp.

**Wendy:** Not summer camp, okay.

**Audience:** Church, scouts, other places.

**Ruby:** FERPA doesn't suit.

**Wendy:** Yes, then it doesn't apply.

**Audience:** It doesn't apply?

**Wendy:** FERPA does not apply. It does for outdoor school if you're taking your school children, then those rules of the education.

**Ruby:** If determined it's in auspices of the school district, then FERPA applies. Now, if you're going to ask me what does FERPA stand for? I don't remember, but the offshoot of FERPA it is a Federal law that says that the parents have control over the child's medical record. The parents also have control over what happens to their child when they are in school with their medical treatment. So for example, and this is not what we're here to talk about today, but since you asked the question, field education every once in a while is good for everyone. So what happens is in FERPA, let's just say your child has a medical condition, diabetes, whatever it is, asthma, whatever, and there is an order from a provider that says, "When Little Johnny has this, you need to do this for Little Johnny." Well now the nurse is looking at Little Johnny and Little Johnny is looking really weird and maybe she should give another dose of the med, maybe she shouldn't, whatever, and instead of calling the provider he or she has to call the parents, because it's the parents that have more authority over the treatment of that child than the provider. We've been working with the school nurses quite a bit about FERPA because they're saying, "Wait a minute, wait a minute. I think this patient needs different medical intervention, I have to call the parent, but what happens in the meantime if Little Johnny gets really ill and something happens to Little Johnny but I didn't notify someone who is legally authorized to do something about that, where is my license? Basically, Federal law always supersedes state law. So FERPA is what they have to deal with and it's very confusing for the school nurses. But the reason you have to change is with calling the family first and asking the parents to do all the stuff, is if you're associated with the school district, that's what they have to go by but that is not us, nor the State Board of Pharmacy or anybody else. Now there's a camp that is not affiliated with the school district at all. It's not sponsored, the people don't work for the school district during that time, then you fall under what we're talking about today, and as I said previously, we are going to be discussing camp scenarios where the kid has a headache, the kid has a boom, the kid has whatever they've got. Pharmacy Board only regulates drugs that are used for OTCs but the Pharmacy Board does not regulate how OTCs are used, they don't. So it's a gray area for everybody. So we as the Board of Nursing, our Board, would like to ungray that a little bit, make it a little

clearer as much as we legally can because we are also bound by other rules too, but you're talking about FERPA because we haven't changed a thing.

**Audience:** I'm talking about two things because there are two hats.

**Wendy:** Yes, you are, FERPA and summer camp.

[crosstalk]

**Audience:** But the parents at our school has signed off with this permission that they want to give Tylenol, if needed, according to the labels, quantity and so on. We do the same thing at the camps, which the parents have signed off that the information for a certain medication be given based on the standing orders that we have, and now we're told that we can no longer stock medications. Is that correct?

**Ruby:** That's not us.

**Wendy:** We don't have any authority.

**Ruby:** That's not us.

**Audience:** Does the Board of Nursing do that?

**Wendy:** No, Board of Nursing has no authority.

**Audience:** This is one doctor who didn't like to sign off standing orders?

**Wendy:** I don't know. I don't know what your situation is, but the Board of Nursing has no authority over medications.

**Audience:** So for a camp health form, can a parent authorize the nurse there to give over-the-counter medications when their child needs them?

**Wendy:** Gray area.

**Ruby:** That's part of what we're trying to figure out.

**Wendy:** Gray area. We are not sure. We probably think yes, but the question is, again, the question is again, there's never been a clarification of it. What point is a nurse diagnosing and then what point is a nurse prescribing a treatment? Because even if you give an OTC, you're still saying because you have this, I'm going to give you this.

**Audience:** Based on what the doctor--

**Wendy:** So is that in there or is the Board, after the Board collects information, for example, they could decide to exclude all of that, say, "Yeah, that's fine," but we don't know.

**Ruby:** We don't know.



**Wendy:** That's why we need that information from you so that the Board has all of those scenarios to say, "Okay, we know camp nursing has been around since day one and this is what camp nurses have always done and is that okay?" Because we're in this discussion right now that makes some clarifications. Clarifications that actually were about a very small number of, "That's where we're starting," very small number of protocols. Then we started talking about this, and the more information we got, it got bigger and bigger and bigger and bigger, and people started to panic. But the Board, as our side says, "We don't have the authority to change anything your organizations do. We only have authority about what you do."

**Audience:** As stated in my scope of practice, if I see a child or a girl that comes in and has dysmenorrhea and has cramps and lots ibuprofen?

**Wendy:** I don't know.

**Ruby:** We don't know.

**Wendy:** Gray area.

**Ruby:** Even though we're investigating that.

**Wendy:** All right, so here's the deal. Someone said this at one of our meetings, "If you're doing it, don't stop. If you're not doing it, don't start." Don't stop what you're doing because we have no plan B. This little girl with dysmenorrhea comes in and you're going to give her some Tylenol or Midol or whatever, if we say, "Oh, no, out of your scope," what's that little girl going to do? We don't know and we're not going to do that. The truth, I mean, we're not looking. We are not out there and looking. We are complaint based as far as investigations and your scope of practice. Unless there is a complaint that says you gave Tylenol and I don't want my kid to have Tylenol. I wanted my kid to have ibuprofen, and they sent a complaint to the Board of Nursing and we will look at it. What we're trying to do is be proactive so that you do not have to be in front of me should some parent or a situation occur, or you decide they have a headache and they have a brain tumor and they crushed and burn a camp and they wanted to go to the hospital, it's now your responsibility because you didn't notice this kid had this symptoms and you thought it was this, then they're going to say you exceeded your scope. Yeah, because parents will say that camp nurse should have known that my child, based on their assessment, should have known that my child didn't have much than a simple headache. Well, sometimes you know, sometimes you don't know. But they will complain to us and then we are involved and then there you are, and we don't want you to be there.

**Ruby:** Then we have to dig.

**Wendy:** Then we have to dig. Then we have to because this is how all of these started. It also started because we got calls from nurses saying, "Hey, we have a protocol that talks about TB." There are new nurses in these areas, "We don't think this is in our scope, tell me." Basically, when people call the Board of Nursing, they want yes or no answers, and, yes, we said we don't have an answer for that because it hasn't been thoroughly explored yet.

**Male Speaker:** Two things, so this is called the Family Educational Rights and Privacy Act?

**Wendy:** Yes.

**Audience:** Then finally got a recommendation for that setting. There should be an amendment on [inaudible] an average parent to do for their child in a situation.

**Wendy:** Can the Board decide the OTCs because their OTCs are acceptable? Yeah, they could.

**Ruby:** We just don't know.

**Wendy:** No, what we could say is, dispensing OTCs is within the scope of practice of a nurse, that's all we have, the abilities to do, because that's what we're here about. That's what you're all afraid of. You're all afraid of the Board coming and saying, "Oh, you exceeded your scope of practice. You exceeded your scope of practice. So, we want to be able to say to you, this as close as we can get, in this context, in public health, in camps, in clinics where there are providers or there are no providers or whatever, this is what you can comfortably say is my scope of practice. But one thing we cannot ever do is to say, the physician delegated the practice of medicine to me and told me to do this, therefore I'm going to. Because there have been unfortunately, one we can tell you, lots of nurses who have been called in front of us who said just that.

**Ruby:** I had a doctor's order, so I did it. Nope. That outcome occurred.

**Audience:** Can we use provider [crosstalk]. Thank you.

**Ruby:** Provider, yes, we can. Provider, yes, sorry. We've been interchanging it a little bit but yes.

**Wendy:** Well I will tell you though, when most--

**Ruby:** They never say I had a nurse practitioner [crosstalk]. Never.

**Wendy:** I was just going to say that, it's never been nurse practitioner.

**Audience:** [crosstalk] More than seeing the patient.

**Wendy:** Right. It is I think very rare that we actually have a nurse who said the nurse practitioner. It is a physician because of that power dynamic that was there for years and years and years, and they don't understand. To be honest, your physician colleagues don't understand that nurses, nurse practitioners as well, have their own scope of practice and their own licensure and their own Board that they're accountable to, and you don't work underneath their license. You don't work for them and that's why I use physician in that example because usually, they don't even understand what our nurse practitioners do. They don't understand our nurse practitioners have independent prescribing. We get complaints, "So and so prescribe blah, blah, blah." Yes. Yes, they did, because they're allowed to. So when we group that, it really is under that old adage that the nurse works under the physicians, their license. Well, that's not true at all. You say, "I take a license, I really keep the public safe, and I'm going to follow my Board rules and my Practice Act. They follow theirs." I can tell you that they will not back you up even if you've given that med a hundred times, and I had this many investigations. You have given that med a hundred times. That's a med they choose every single time, and you choose it one time and something goes wrong and they go, "I didn't tell them they could do that." So those are the types of situations you end up in when you think you're safe, and that one time something goes wrong and all of a sudden,

there is no back up and then you are out of your scope, because not only do you not have a provider order, you chose to give a medication which you basically don't have the authority to and gave it to that patient without an order.

**Ruby:** It's not about ability, it's about what's legally and what is authorized by law for you to do. Then sometimes our investigators kind of have to counsel the nurse about the nurse is hurt that the provider that they work with for years to do that, and a lot of counseling goes on.

**Wendy:** Right. A lot of education and counseling.

**Ruby:** A lot of education.

**Wendy:** This is no different than the outreach and the education that we're trying to do. We're trying to completely pull the Practice Act out of the dark. We want people to understand it. We want you to be practicing so that you have a working knowledge so you use it. We know that most people don't take it out and they don't read it and they don't know what's what like I do, I get that. When I was practicing nursing outside of the Board of Nursing, I never had a Practice Act, I'll admit it. Now I know it inside and out. I was not that person that you had to worry about falling outside of that practice. But at the same time, and I will share the standing orders, the protocols things, I worked in an environment, I was a transport nurse. I worked in an environment straight up on protocols. I get it. It's just we're trying to figure out how people are using them so that we can be sure it works for you, it works in your environment, but that you're also staying in within the scope of your licensure. You have a question?

**Audience:** I was going to say, coming from another state, and looking at the nuances and differences in the scope of practice, I was just wondering, is this something that's been highlighted across the country or in other states or this is kind of a specific question that came up with working [inaudible]?

**Wendy:** This came up specific as a pattern of behaviors and things we were investigating for the Board of Nursing. I don't know, if it's an issue.

**Ruby:** It is. So all of the--

**Wendy:** [inaudible]

**Ruby:** Yes. Wendy is right. This here is because of what happened in Oregon, but your question is about is this a national issue and the answer is, yes it is. We belong to the National Council of State Boards of Nursing, all the boards in the country, including territories. There are 59 different nursing boards because some states have an LPN Board and some states have a separate APRN Board from the RN Board and all of that. So, there are 59 different boards in the state. The organization also has membership of all of Canada, Australia, Wales and New Zealand and now Singapore, and pretty soon Kazakhstan, I think it is, it's how you pronounce it. Anyway, this is a worldwide phenomenon and my statement about nursing is changing. It's not just nursing here, it's nursing everywhere. Nursing is taking a very, very clear role in providing care that 20 years ago we didn't do or only the people that work the wild west did. But that's not the kind of nurses we want taking care of patients. So, yes, it is. They are reviewing this. This is a national conversation people are having and international conversation people are having actually. At our last conference, we have someone from Africa come and talk about how they had to change their Practice Act because, yes, Africa has a Nurse Practice Act. So, you can't just go to Africa and go practice nursing and think you're good on your US license because, guess what, you're not.

Now, most missionary type people have contracts with the local governments and say it's okay, but if you decide to go on your own because you're an Oregon-licensed nurse and you can practice in Zimbabwe, the answer is, no, you can't. They have their own rule. They have their own license.

So anyway, we had someone come from Africa and they talked about how nursing was this. Everybody knew what nursing was and then population changed, needs changed, and nurses are now this. That's happening everywhere, and the fact is that we want you to practice at the top of whatever is your scope allows you to do in your context of care. My scope is within your scope. This is, doing this, this is what is on top of our license: being able to manage a patient, screening for TB, being able to do those STIs. When I was in the army there was no STD. They went from VD to STDs, now they're STIs. So I treated people in the military. I was not a nurse. I was 18 years old and I treated VD because it's a Federal problem. Z, yes. Anyway, nursing has changed, but we want you to practice what's best for your patient and what's safe for you within the education that you have and the experience that you have because scope of practice is a beautiful thing. CNAs have what's called authorized duties. Authorized duties never change. I don't care how long the CNAs has been there, it doesn't matter how wonderful they are, how great they are or that they're a nursing student on another day, no. This is their box. They live in this box their entire career, nurses don't. Nurses, as your experience grows, your scope grows. Your scope is different than her scope. Scope is individualized. There's no rule. So when a nurse says, "Well, it's not in my scope," and we say to them, "What is in your scope?" There are a few nurses who know what that means. "That's the Board thing, it's in my scope. I don't know, you tell me."

**Audience:** Sticking to being a transport nurse, obviously your scope of practice, your protocols are supported by your education, your competencies...

**Ruby:** Absolutely, they were.

**Audience:** ...and that's what you're speaking to [inaudible].

**Ruby:** Yes, it was my knowledge, my skills and ability, it was documented in my facility that those were, and that I continue to stay competent in those things, that a certain amount of hours and certain things, continue education, though not required in Oregon. You know what was that from my job, it was defined and broadly by the Practice Act and then honed down by OHSU to say, "Within our world, you can do these things and we have competency validated you and agreed that you are ready to go out and do this under our umbrella." So, yes.

**Audience:** You always had to contact.

**Ruby:** And I always call the physician even in my transport days, at any point.

**Audience:** I'm sorry, what's a physician.

**Ruby:** Sorry, it was a physician, it was ICU doctor. I try to be really good about my language in wild west.

**Audience:** I truly appreciate your rationale for choosing [inaudible]

**Ruby:** Yes, because it was different reason at that point, but it was an ICU physician and I might implement a protocol, I might do everything I need to do, that might be intubate the patient, that might be putting lines, that might be get the X-ray, make sure all the labs are drawn and then I provided, in a

phone call before I ever left that facility, this is the information I have gathered. These are the things I have done. Are we good or are there other things I need to do? So, there was a physician at the end of even that. You don't want to make the Practice Act define, you don't want a list, people want lists, you don't want a list. We want nursing practice to grow as nursing practice grows. We sometimes had to play catch up because in the regulatory world, certainly what's happening in nursing is going way out in front of us and then as we start to get issues and complaints raised, we're like, "Whoa, wait, nursing went where?" But we want you to have that ability. We want it to be flexible but we want you to stay in your knowledge, skills and abilities, and we don't want you to come visit. I don't want you on my caseload, to be honest. I want you to practice to your full scope, enjoy your nursing career and do what you can to take care of the patients and provide access to care. We just want to educate you and we want to gather these information so the Board can do that for you.

**Wendy:** That's why it's so hard for us to define anything for anyone. The Practice Act is made up of very broad statements because some of you are in public health, some of you are in acute care, some of you are CNOs, some of you are whatever you are and no single document that has a laundry list of staff is going to cover every nurse in every scenario. That's why the statements are so broad, which is why people have so many questions. Statements can be broad but they shouldn't be vague. For example, the nurse is accountable to the patient for the safety of the environment and that's pretty clear. That's pretty clear. Safety of the environment where the patients, all right. Now, that's very clear when you are a staff nurse or you are a nurse and there's a patient in front of you and I'm responsible. But what if you're a CNO? What if you're a CNO? He's like out, I'm out the door. But I'm sure you will tell him the story. You will tell them your story. If you're a CNO, the beautiful thing about nursing is your client changes based upon your context. So, who is her client? Nursing services in this entire facility. She is responsible under her license to make sure that nurses in this environment practice safely, have the tools they need and barriers are removed. That's her accountability, because there have been times when we have had cases where nurses have said, "Well, you know, this is the situation blah, blah, blah. I was told to do this." Now they should have understand on their own practice but then Ms. Wendy over here has a legal authority to say, "Well, let me talk to your manager because your license says, "You will keep them safe." They're going to make this decision on their own, and when I talked to nursing administrators, I always say, "What are you doing in your organization to allow a nurse to practice for the Practice Act to say, "This is not safe. I cannot take this assignment."" Because once you take an assignment, it is no longer unsafe because you said you could do it under your license.

That's why I like to say, there's no such thing as an unsafe assignment because you took it. It is only unsafe before you take it and then you have to say, and this is not unsafe. This assignment, whether that assignment is to manage a clinic, whether this assignment is to manage people with symptoms of TB or whatever you've got, this assignment is under my knowledge, skills, abilities to do it, and if it's not, I am not allowed to take it under my license and that's what the Practice Act says. The Practice Act very clearly says, "A nurse shall only accept an assignment which is within their knowledge, skills and abilities to safely provide care to that patient, whoever your client will be." That's one of the reason we got away from the word patient, because my client is off of the nurses in Oregon and my client is the Practice Act. So each nurse when they change their levels, because a lot of nurses get the idea that, "Well, I don't do direct patient care so it doesn't apply to me." Because nursing is one of those wonderful professions that allows you to grow but you are always accountable to the Practice Act. It just depends on how you define your client. Okay, you can go now.

[laughter]

**Wendy:** Okay, so please, please, please, give us your comments, give us your angry comments, your friendly comments, whatever comments you need. You could be angry as long as you are professional. Professional angry is good. Your questions, everything, please, because the more you ask us, the more the Board is going to get a very clear picture of what is out there so that the Board can then provide direction to the Board staff about what to do next because I don't know.

**Ruby:** Let me just ask, for you that are on the phone, just in case, because we've kind of not directed anything at you, do you have any questions or concerns or things that you wanted to raise with us before we kind of close? Hello?

**Audience:** Hello? No, I don't have any questions at all, but can I clarify anything that we have we should send to you through the website first...

**Ruby:** Yes.

**Audience:** [clears throat] Excuse me, for practice questions, is that?

**Ruby:** Yeah, so on the OSBN website, yes, it will say ask us about practice question and then put in there feedback from the Bend using the word protocols and list your questions, concerns.

## 5.14 OSBN Community Meeting

**Wendy:** We're going to go ahead and get started. If people wander in and out, it's totally okay. Feel free to eat your lunch. Not a big deal. Not going to be a lot of – this isn't really a presentation. It's going to be more on an engaging conversation.

I'm Wendy [inaudible 00:00:15]. I'm one of the nurse investigators with the Board of Nursing. I also do some public outreach, and have tagged along at three of these now, I think; one in Tualatin, one in Bend, and the one today.

With us, with the Board also, is Ruby Jason, who is our Executive Director. And then, Peggy Lightfoot, who is an Administrative Assistant.

We are here mostly to kind of gather information. With that, what we're going to do is we're going to walk through the slides, and you guys actually have the slides. We're going to talk a little bit about why; why we're here, why this topic, why now.

You need to know, for the Board of Nursing, just kind of as an oversight, how this all came to be is we are a complaint-driven organization, as far as investigations and those types of things. What we started to see was a pattern of different ways that protocols and different ways that standing orders were being used.

The Board started to have some questions for us, and then asked that we go out and have some public input into how people are using them. What works? What doesn't work? Because obviously, we want you to be able to provide access to care.

At the same time, we need to keep the public safe. So, in doing that, we have to find this balance, and we're not sure right now, where that balance is. So, the Board has asked us to gather this information. We will actually take it back.

OCN, who is the Center for Nursing, they're actually going to take all of the data. They're going to put it all together, and they're actually going to present it to the Board in September.

So, there aren't any answers. We will certainly try to answer some questions you might have today. But there isn't a lot of answers right now. It's more fact gathering. Okay? Does that make sense?

Kind of what we're going to talk about:

We have no jurisdiction over your facilities, over agencies, over hospitals. OSBN only has jurisdiction over individual licensees. We can't change that for you. That's why we want to talk to you, as our licensees, to make sure you're keeping the public safe, and that we are making sure you're actually operating within the Nurse Practice Act.

We do have jurisdiction over you that are in manager roles, who are implementing and placing these protocols and these standing orders. The reason that is, is because as a manager, it is your job to make sure that your personnel are doing that. We ask that in implementing these types of things, that you've actually side-by-sided the Practice Act with this implementation.

We know a lot of times, that doesn't happen. We've actually found that in several different situations, where different organizations have not laid those side-by-side, and they've asked nurses to do things

that are actually outside of their scope, or outside of what they're allowed to do. Then, that licensee ends up being the one who has to come join us at the Board of Nursing, and have a conversation.

So, we want to kind of prevent that, if we can. I'm not a mean person, totally not scary to come visit me, but I want to keep you from me, if that's possible.

Physicians do not have the authority to expand your practice. They don't understand that. Now, we're talking specifically about physicians – last time, I got kind of asked like “Hey, what about us nurse practitioners?” I'm like “You guys aren't a problem.” In this particular circumstance, it is the physicians who don't understand they cannot delegate power to you. They cannot ask you to do something that is outside of your scope.

It doesn't matter if they taught it to you. It doesn't matter if it was a good intent. They cannot. They have a license and a Licensing Board. You have a license and a Licensing Board. And both of you need to stay in that realm. Does that make sense?

The Board of Pharmacy prohibits pre-signed prescriptions. I know we don't have a lot of prescription pads out there now, but even the electronic. You cannot have a blank script that somebody else fills out, with a provider's signature on it, that you then send basically in their name, whether or not they have seen the patient, without them actually seeing the patient. Prohibited.

We know that there are some circumstances out there where providers have pre-signed prescription pads. Then, the nurse comes in, diagnoses, writes that script out based on a standing order or protocol that says “Pick this, this or this.” Then, they call it in, and the provider never ever sees that patient, ever. Yet, the person who signed on that script is that provider. It's not allowed.

What we're trying to do: We are seeking information. How are you guys using protocols? How are you using standing orders in the community?

We recognize that, though what we thought was kind of here has kind of expanded out here. Now, we want to know what that is, because we understand these got put in place in complete good faith. We understand that this was done to provide access where there might not have been access, where there might not be a provider.

We want to help you provide care. We just want to make sure it's done safely.

We own that our position statement on this is super-vague. We own that it's vague. There have definitely been some interpretations that we weren't expecting, and some questions about how those came to be. It's come down. It's not there any longer. We're trying to make this work for you and work for us.

We have been asked by the Board to actually hold these stakeholder meetings – this is our last one – to gather this information, to understand, so that the Board can make some decisions about how we can do this.

With that, we're actually going to open it up to you guys. We're going to let you ask those questions, let you kind of share with us how you're using. If there are specific things that you aren't sure about, feel free to ask. For you guys who are students, feel free to ask, too. This is a learning opportunity for you, just as much as everybody else in the room. So, feel free.



Your two sheets; the beige/yellow one, this is the one you're going to use, because we are trying to separate the data for OCN. That one is used for your questions and concerns. The blue one is how you're utilizing standing orders and protocols currently, so that we have a good idea of how to put that information together for them, so they can see.

Some places are using them very differently than other places, and we need to know that.

Questions, concerns?

**Audience Member:** Thank you for the overview. I feel a little hung up on the pharmacists, the Board of Pharmacy comment that you put up, that it is not possible to initiate a medication, unless the provider has seen the patient. Can you explain more what you mean by "seen?" Does that mean it's an established patient? Physically see them?

That really suggests that under no circumstances will any medications be part of any care, unless the licensed independent practitioner is the one that directly initiates it.

**Wendy:** Yes and no. There are some that fall under public health, that don't need that. But there are things – so, I'll give an example. Department of Corrections has a process currently in place, where they have an inmate who comes up for sick call. That inmate says "My ear has been bothering me. I'm pulling on it. It really hurts."

The nurse looks in the ear and says "Hey, it looks like you have an ear infection." They go to that ear infection protocol, and they run down that protocol. It says "You can order this antibiotic, this antibiotic or this antibiotic." They go "Okay. You don't have an allergy to this. I'm going to pick this antibiotic."

They actually write out the script for that antibiotic, or electronically place in that antibiotic with the provider who has agreed to these protocols, and signed them ahead of time. Then, in that moment, they send it over to the pharmacy, saying "Please fill this script." And maybe three days later, maybe a month later, the physician glances at it, makes sure everything's okay, and signs it. Not okay.

We're not saying there has to be a physical, necessarily. But that provider needs to be in the loop. They need to be aware that their name is utilized, and Ruby can speak more to this. I see you moving.

**Ruby:** Yes. I couldn't help myself. I knew [inaudible 00:09:00].

Alright, so let's put this into context. The majority of us, who have been in nursing for a short time or a long time, have using standing orders and protocols forever. We are [inaudible 00:09:13]. We couldn't survive without our standing orders and our protocols. So, they are a fact of life.

What's happened lately, though – not lately – but the Board has become aware, through concerns that have been brought to us by our licensees, saying "Hey, I've been asked to put in this protocol my organization [inaudible 00:09:31]. I don't know if I can do this or not. Can you tell me?"

And the answer to us was "Well, we didn't know." That's why the Board wants us to come in.

So, most of the protocols are fine. The protocols that we are very concerned about seem to be the ones that are used in public health, or used in those areas where there is just not a provider available. There just isn't one. It's the Public Health Department, and they have providers 50 miles away.

Well, how is that patient going to access care? And the individual that sees them is an RN, like me. I'm not an APRN. I'm an RN. My license does not allow me to diagnose and prescribe. It does not allow me. I didn't get that advanced education.

And the Board is accountable to the citizens, to make sure that the citizens of Oregon, that they have safe nursing practice. So, your practice may be perfectly safe, because it's you. But legally, - remember, the Board is about the legal framework of nursing. Legally, are you within your boundaries of what your license type is?

Advanced practice nurses, they can diagnose and they can prescribe, because the Legislature has given them that authority. No one in this state can prescribe anything, unless the Legislature has given them the authority.

So, one of the questions we had for our partners at the Board of Pharmacy was, can a physician – it is usually a physician. Sometimes it's a nurse practitioner, because again, there is a huge shortage of physicians out in the areas, and some people are – they're nurse practitioners actually [inaudible 00:11:13]. But let's just talk about an LIP, a licensed independent provider.

Can the LIP delegate their prescriptive authority to anyone? And the answer is no, they cannot. They cannot delegate their prescriptive authority to anyone. Because again, pharmacists have just been given the right to prescribe. That had to go through the Legislature.

CRNAs, certified registered nurse anesthetists, could not prescribe, even though NPs and CNS's could, because they were not given legislative authority until a few years ago, to prescribe. And then, there were boundaries. Then this year, the CRNAs were successful in getting a broadening of their prescriptive authority.

Prescriptive authority is very tightly regulated, because again, it's about the safety of the public. We don't want anybody to say "Oh, we can write a prescription, and we're ready to go."

So, one of our questions was, and one of the concerns that were brought to us was "Alright, I've got this protocol, and it says 'Alright, this patient is going to come in, and they're exhibiting these symptoms. And based on these symptoms, you're going to order these labs. And based on the results of those labs, you're going to give the patient a diagnosis.'" UTI, tuberculosis, those types of things.

"Then, based upon your assessment, RN, you're going to decide from this list, what medication is appropriate. You're going to call that in, and you're going to use my name."

Then, again, the chart goes to wherever it goes. And what we are hearing is that sometimes it's really great; the providers see it the same day, and they go "Yes, this is great!" Or they don't see it at all.

But either way, do those protocols delegate to an RN the ability to develop a diagnosis, and decide on a prescription to give a patient, for something they didn't have before?

Now, your question about prescribing is always no. The answer is no. If you've got a patient who has a treatment plan, let's just say they're cystic fibrosis, and they're going to be on enzymes. Or they're on coumadin, or they're on any kind of inhaler, or anything that's a chronic condition. The provider says "Okay, Mr. Jones. You have chronic COPD, you have chronic whatever. And these are the medications

you're going to have, and you're going to be on these the rest of your life, until something else happens. And we'll decide what happens then."

Now, prescriptions are good for only a specific time in this state. Prescriptions can't go on and on and on and on. They're only good for a specific time. So, the question then is, alright now, when that patient runs out of their prescription, does the provider need to see them again? The answer is, not unless the provider says "Don't refill the prescription, until they see me again."

It's a year, right?

**Wendy:** It's a year.

**Ruby:** It's a year, or "Unless they're having problems, just keep refilling that prescription. Keep calling it in." That is okay, because under pharmacy rules, the physician or the LIP can designate an agent to continue treatment.

What is unclear for all of us is, how about the initiation of a medication that patient's never been on? It's not part of the current treatment plan, and the nurse is the one who actually takes the patient, from the time they enter the building until the time they leave, and they do it under protocols?

Now, these protocols, of course, have been generated for a variety of reasons. Again, no provider. Nurses are plenty smart. We can do this. I know I can do it. But the fact is, legally, I'm an RN. I'm not an APRN.

The other part is, in Oregon, delegation has a very, very specific legal definition. Delegation is the ability of someone who is licensed to take a task of their profession, or an intervention of their profession, and assign it to someone who is not regulated by another Board. Because physicians cannot delegate their practice to a nurse, because the nurse, their practice is supervised by the Board of Nursing. And only the Board of Nursing can determine what's in their scope.

Now, that's what the law says. The issue is that there are patients out there who need care. And there are protocols out there, that may or may not prevent that individual from getting care. And it's the RN, because I know, RNs, we get to do everything, when there's no one else to do it. Right? That's how it works.

If their [inaudible 00:16:16] the hospital, because they have too many pressure sores, nurses have to take care of it. And if there are people that are accessing care in the rural areas, let's put a nurse there. They can do that.

But because of our ability to do so much, have we or have we not overstepped the legal boundaries that are in the Practice Act? Have physicians delegated their medical practice? And again, you can't delegate to someone who is supervised by another Board. You can't. Not in Oregon. You can't do that in Oregon.

So, the question for us is, how are you using those protocols? What concerns would you have? Because once this information goes to the Board, the Board is going to review it all, and turn to Board staff and say "This is what we need you to do."

I have no idea what that's going to be. I know the Board. I can pretty much predict, but I'm not going to in this case, because I don't know. But one thing is very clear. While the Nurse Practice Act is not about

your practice, it's about public safety. The purpose of the Practice Act is to keep the public safe from unsafe and inappropriate nursing care. That's what we're here for.

So, how do we balance that with the needs of the health care system, that are moving more and more into the community, more and more into public health, less and less – because, you know -. I remember in the day when I started, people were in the hospital for a very long time, because they paid. You got paid by the day.

Now, that's gone, so the hospitals are kicking you out as soon as they can. Because they're not going to make any money off of you, and they have bills to pay, too, and they have nurses to pay. Everybody has to be paid. So, they put them out in the community.

Well, who is going to answer the needs of those patients? Again, it's nurses. And there is a huge misunderstanding with our physician colleagues, about what nursing is. Nursing is an independently licensed profession that has its own standards, its own independent scope of practice. Nurses do not have just the scope of their practice of following orders from an LIP.

We have our own science, we have our own scopes. Everybody's scope, by the way, is different, in here, depending on your knowledge, skills, ability and competencies. But that misunderstanding of "Well, the physician will just write a protocol, and the nurses will do it," is not [inaudible 00:18:54] what the law actually says.

But we all know that times are changing, and that perhaps, perhaps the Practice Act is trying to keep things safe, when it really doesn't need to be this box. It could be this box, and the public could be just as safe. But we don't have enough information.

All we have is complaints and concerns, and "Oh, this is terrible!" So, we want to hear from people who actually use these every day, and how it would affect you if, for example, the protocols that allow a nurse to have a patient come in, have a brand new diagnosis that they didn't have when they got there, and have brand new meds that weren't previously prescribed to them, and on their way.

Is that dangerous? Is that not? Well, probably for everyone in this room, nope. But I'm here to tell you, and Miss Wendy can tell you that there are nurses out there who will have this protocol, and they'll end up doing this. And that's what we need, to have that good balance between people who know what nursing is, who understand what nursing is, and those who think "Oh! I have a protocol. I can do A, B and C, and now I'm going to do D and E, because I know how."

So, in answer to your question, no, that it's not always prohibited. And we're not even sure whether it's prohibited now. What I'm saying to you is what the Board of Pharmacy shared with us. This is their law, not ours, because we don't control meds. You know, the Board of Nursing doesn't control medication administration in this state. We just authorize nurses to be able to provide medications, based on their knowledge, skills, abilities and competencies.

But the Board of Pharmacy controls every single medication administration in this entire state. They have said to me "You cannot delegate prescriptive authority." Now, pharmacists are very busy people, like all of us. They don't have time to say "Did Dr. Jones really write this, or did nurse so-and-so actually do this?"

If they were to call your health department and say “Hey! I need to talk to Dr. Jones, because Dr. Jones signed this prescription, and there’s a problem here,” and the nurse goes “Oh, no. Dr. Jones isn’t here. He’s in Salem somewhere, and I did all of that,” legally, that pharmacist has to say “Well then, I’m sorry. I can’t fill it.” Because there was no one with prescriptive authority that actually authorized that prescription with that patient, in front of them. Because that patient has a brand new thing.

If that patient has an established thing, of course nurses can call in refills, based on the treatment plan. Of course they can. Because the Practice Act very clearly says that nursing will make sure that any implementation or intervention that they do for a patient is within the treatment plan.

And I’m hoping that most nurses here don’t just have a treatment plan authored by an LIP, that nursing has its own treatment plan, also. Because the hallmark of nursing is the plan of care. That’s the legal definition of nursing, the plan of care.

So, in answer to your question, yes, of course. If the provider says “Look. This person is going to be on this med for the rest of their life.” Or coumadin clinics. Coumadin clinics are a perfect example of a protocol that historically has been used correctly. It is, the patient comes in and they have an issue, whatever the issue is, and the provider says “I’m going to put you on some blood thinner,” warfarin, coumadin, whatever.

“And once I put you on this protocol, your plan is to attend the nurse-run coumadin clinic, and those nurses are going to draw blood from you, titrate your coumadin, based upon the protocol that everybody has agreed to. And if there is a problem, or if your labs are way out of whack, then and only then is the nurse going to call us, and we’re going to try something different, or whatever we’re going to adjust.”

That patient may be in that coumadin clinic for years, never see their provider again, and are just fine. But someone placed that person on that protocol, who has the authority to diagnose and prescribe a medical treatment plan. So, that’s kind of where we are.

[inaudible 00:23:15], but I’m trying to give you the context of kind of where we are. That’s why it’s important for us to know exactly how you are using those protocols. And it’s not right or wrong. It just happened, because there was a need. People saw a need, and they [inaudible 00:23:30]. But as often happens both in acute care and community care, people don’t pay any attention to the Practice Act, that the relationship between the provider and the nurse is independent of anything, and it’s not.

The provider has a Practice Act that they have to abide by, and it is also not allowed for them to delegate their medical practice to someone who is licensed by another Board. [inaudible 00:23:56] what’s in your scope, what’s not, what’s legal, what’s not? And that’s what we’re here to figure out.

**Wendy:** Any other thoughts, questions, how you’re using it?

**Audience Member:** Another way that it can be used in the public health setting is with immunizations. So, as you were talking right there about how that applies [inaudible 00:24:23] somebody with a new diagnosis, on a new medication. That makes sense in a lot of contexts, but with immunizations, it could be a lifetime thing. It could be just a series.

**Wendy:** There are different laws and rules for population health; immunizations, birth control. And those are actually through Oregon Health Authority. Those are different than the Practice Act. So, that

particular realm of public health and population protection falls under an entirely different law, and does not fall under your Practice Act.

That's already been decided in an entirely different legal realm.

**Ruby:** There's no diagnosis with an immunization, right? It is a CDC-recommended "This is the dose. We're managing this population, a group of people in a defined setting." And everyone, unless they are screened out, is going to get that, unless, of course, they don't want it. But that's a different story.

But the fact is that there is no diagnosis. There is no prescription. It is population management, where there has been a medical director who has said "In our jurisdiction, these are the immunizations we're going to give in our public health clinics. These are the things we're going to be doing in our public health clinics." But there is really no diagnosis that is driven from a protocol and a new prescription.

There's no prescription. It's an immunization. It's CDC. It comes under CDC rules. It comes under public health rules. So, immunizations are population management.

What we're talking about are protocols that manage individual patients with individual diagnoses, new diagnoses, and new medications.

**Audience Member:** What about under the realm of STI? Somebody comes in, and based on the symptoms that they're presenting with; they have discharge, they have odor, they have itching, they've had unprotected sex with an unknown partner, whenever. So, based on those criteria, at this point, we've been treating them empirically, and testing.

Then, the test comes back and it's either positive or not. Or if somebody comes in and, say we tested them and it came back positive, we would call them back into the clinic to treat them, based on the protocols and the criteria set forth. It wasn't so much like we were diagnosing what they had. We had a set of "You have this, ergo you get this."

It wasn't like we were picking from a list of antibiotics. That's just what we're going to -. How does that?

**Wendy:** That's one of the ones we really don't know. We don't have a really good answer right now. There are some means of where those are being treated just simply based on the symptoms, like you said. And then, there are other times where we're waiting for a lab to come back. And once that labwork is confirmed, then the proper medication is being given for that.

And that is one of those we just don't know.

**Audience Member:** Or they've had sex with a known confirmed case, and they have no symptoms yet.

**Wendy:** Right. That's the partner. The partner falls under that.

**Audience Member:** Partner treatment.

**Wendy:** Right. We don't have a good answer for that. We're not asking you to stop anything you're doing, and we're not asking you to do something you're not currently doing. We just don't know right now. That's why we are gathering this information. And that one is a really good one to have on your sheet, as far as are you treating based on symptoms, or are you treating based on a lab? And then, who established that particular set of medications with the lab, for the nurse to determine or [inaudible]

00:28:14] make a call to a nurse practitioner or to a physician and say “Hey, this is what the lab came back. Can I give them a script?”

**Ruby:** To put another wrinkle in that scenario, and this is from our friends at the Board of Pharmacy. They, along with OHA, have developed a grid, which I’m happy to send to people; a grid that talks about when nurses can dispense. Alright? Dispense. It’s STI, dental caries, birth control. There’s a bunch of stuff.

But then, there’s also a column in that same grid that says “Who is to prescribe?” And it says “Advanced practice, physician, etc.” So, one of the questions we have to ask our pharmacy friends is the scenario you have. “Okay, you’ve had sex with an unknown individual. You have these symptoms, blah blah blah. This is what we’re going to give you, and we’re going to give you this pack of whatever, or inject you with whatever, whatever we’re going to do for you.” And there’s not a provider there.

So, our question to the Board of Pharmacy, and this is ruled by the Board of Pharmacy, not nursing, because our job is also to make sure you don’t violate other laws. And there are many, many other laws that rule nursing, besides us. Are you actually prescribing them? Prescribing is really – is it a piece of paper, and then you take it to your local pharmacy? Or can the nurse skip the prescription, and just go ahead and dispense?

Because that’s really what the law says. The nurse can dispense, but the nurse cannot prescribe that medication. So, that’s why we need to also understand exactly. Expedited partner therapy, that’s a whole different Board of Pharmacy rule. Those are Board of Pharmacy rules.

So, we have to get enough information from you about how you’re using it, to see where it overlaps with our other Board partners. Because the Board of Nursing has no authority to tell the Board of Pharmacy what they can and cannot do. The Board of Medicine, same thing.

The Board of Medicine, conversely; the Board of Pharmacy, conversely; cannot tell the Board of Nursing what to do. But we certainly want to keep our licensees aware of what the laws say, and to really explain those laws to you. Because there are so many laws out there, that you would have a hard time trying to corral them all in, with something as simple as “Can I give this med? Can I not?”

So, that’s what we need to know. Right now, we do not have an answer for you, because at the face of it, the Board of Pharmacy says all you can do is dispense, which is not what’s happening. You’re doing the whole thing.

**Wendy:** Are you calling a provider, to say -?

**Ruby:** No. You’re not calling a provider.

**Audience Member:** I’m not writing a prescription, either.

**Ruby:** No, but you’re dispensing. But the grid that I’m referring to says that the nurse can dispense, based upon a prescription written by someone who has the authority to prescribe. And there’s not that person there.

**Wendy:** Because there’s no dispense, without somebody who prescribed.

**Audience Member:** [inaudible 00:31:28]

**Audience Member:** So, how is that different in public health, versus immunizations? Because what they're doing is the same thing as immunizations.

**Ruby:** They're not prescribing it.

**Wendy:** They're protecting an entire population from a disease, which is different.

**Ruby:** You're protecting a population, don't get me wrong. I totally agree. But an immunization is a little bit different, because you're not prescribing anything. It's not for a disease treatment. It's for immunizing an individual, based upon science, for prevention. When you're doing an STI, you actually have to make sure the person has an STI, because you're just not going to give him that drug, whether you do it on symptomatology.

That's one of the things that someone suggested to us. "Well, let's stay away from diagnosis, and just go symptomatology." Okay, that got written down, and I don't know what the Board is going to say about that.

But immunizations are different, because again, you don't prescribe for that individual. That individual screens out. It's screening out. Everybody else is included. Only those that screen out are not. So, it's a little bit different than one patient, one diagnosis, one medication.

**Audience Member:** So, what you're saying, in STI, we're screening out the population to the individual.

**Ruby:** You are treating the individual. STIs are a public health issue, but they are different than immunizations. They are different because that individual presents on their own, "I have these symptoms." And because people want them to get treated right away, the law says that a nurse can dispense. You don't have to wait for a pharmacist.

Because quite frankly, providers order, pharmacies dispense, nurses administer. Except in those areas where nurses have been given the authority by the Board of Pharmacy, to dispense.

So, it's an individual who says "These are my symptoms." You decide, based on your knowledge, skills, abilities, and your protocols. "Okay, they do, they do not." Right? That would be kind of a diagnosis. They do or do not. Then, "I'm going to give them a specific medication," based on whatever it is. There's usually three or four to pick from, based upon what your protocols are saying.

**Audience Member:** So, in STIs, we constantly do screening and surveillance. Like I said, we're screening a population, and we're screening out a population, and then we're coming down to an individual. You're saying immunizations, we're screening out individuals, and coming with a population.

**Ruby:** Correct. And again, we don't have an answer for that right now. That's one of the things we need to know.

**Wendy:** I'm sure that model was brought together, assuming that there would be providers in those communities, without the anticipation that we were going to have a shortage of those providers in these rural communities. I'm sure that was the thought process, at the time.

We know it's not the reality. Now, how do we do it, and how do we do it safely? That's the Board's decision, as far as what's the nursing practice of that.



**Audience Member:** When you're looking at safety, are you looking at statistics, and researching data? What has been a safety concern in family planning clinics, STI clinics, and things like that, that have brought concerns, rather than just "Well, you may be doing this out of your scope of practice?"

**Wendy:** Do you want to answer the question, because you did the research?

**Ruby:** Yeah. The Board doesn't have the authority to look at that kind of data, because it's multi-factorial and inter-disciplinary. The Board only has authority over does the nurse have the education, and within the scope that is provided both by legislation and by rule, the ability to do A, B, C and D? No nurse can implement an intervention for which they do not have established competencies. No nurse can establish an intervention for which is not authorized them by law.

So then, you go back to the whole diagnosis/prescribing thing. Diagnosis of a disease or an injury, and the prescription to treat thereof, even if it's some kind of an intervention such as -. So, you've got a camp nurse. The kid's got a fever or got a headache. "Here, have some. Your parents said I could give you some acetaminophen."

Is that treatment and diagnosing? We don't know. And those camp nurses need an answer to that. Because every year, every year like clockwork, we get this deluge of questions from camp nurses, because it's not clear.

**Wendy:** Because they've kept a stock of over-the-counters, and they've always felt comfortable doing that. Now, with these questions being raised, they're not sure.

**Audience Member:** The same as in schools, yeah.

**Wendy:** Well, same and different, what we learned in Bend. The schools fall also under FERPA, which is the parents can essentially say "These are okay. You don't have to call the provider. I'm saying you can do this." Where school nurses might not be associated with any type of school program. We can say like outdoor school is associated with the schools.

But say they go off to a CYO camp, or they go off to Boy Scout camp. Those nurses aren't affiliated with any type of a school district, so they're falling under something entirely different.

**Ruby:** Nothing.

**Wendy:** Pretty much nothing, yeah. And there's almost never a provider associated with that.

**Audience Member:** I'm going to ask one more question. So, we're talking process here, actually. And when you talk about safety, I really don't know how you can make this decision if you don't look at data and research on safety.

**Ruby:** Correct. There have been no – there have been zero complaints to the Board. That is how the Board generates its work. We can't go and say "Alright, we've had no complaints about this, so it must be okay." No. the Board still has the legislative responsibility to say "Given within the scope of education of an RN, are they allowed to do this?"

And you're absolutely right. Public safety has an amazing record for safety. This is not a – you're not talking about a statistically safe issue. You're talking about what is legally authorized by the legislature, for an RN to do in this state. That's what we're talking about.

The Board has to have rule, which is research-based. Which is why we're trying to get this information. And if the Board says "Well, wait a minute. If public health is doing all of this, and we've really had no concerns about it," what then is the Board going to allow to have happen?

Is it symptom-driven? Is that okay? Because right now, it's diagnosing and prescribing under a provider's name.

We had that very vague statement that said that protocols and standing orders would be used in the absence of a physician. Right? What they meant by that was a physician just isn't there at that moment, physically. What was translated was "You can do it without one. As long as you have a protocol, you can do it without one."

And clearly, you've proven that you can. The question is, may you? May you? You can. Absolutely, you can. But may you, by the law? That's the question the Board has to answer.

The answer may be "Why not? Statistically, we haven't had any complaints. There's nobody screaming at us, going 'Those public health nurses are running amok!' None of that."

**Audience Member:** They've been screaming that for a long time!

**Ruby:** Well, that's a different story. But they're actually – so again, yeah. What is public safety? What is public safety? And how is this new rule for nursing going to be adapted to the laws that were written a while ago?

**Audience Member:** They're going to change the laws.

**Ruby:** Well, the Practice Act is the law, based on legislative authority. But also, what the Board cannot do is overreach, either. Because if we overreach, you can be sure that there will be provider groups, physicians, pharmacy, saying "You don't have the authority to do that."

**Unknown:** That's my territory.

**Audience Member:** And we're seeing the people that they don't.

**Wendy:** And we're seeing, surely the complaints that we've gotten, the ones that we have had an investigation, where even we don't know how to apply that, as far as an investigation goes. Those are the ones the Board has seen. That's probably a very, very, very small population of the entire state, and we understand that.

But we want to make sure that we cover everybody for what everybody's doing, if we can. And if we can't, then we certainly want to provide you the education and the knowledge about where you can keep it, where you do not have to come in and speak to the Board on your practice, because you've kept it within what everybody understands.

Where right now, that isn't the case. It's being used from all the way over there to very tight and completely provider-driven.

And we want you to have your full scope. We want you to practice to the top of your scope. And that isn't about task. That's about what you can do with your nursing knowledge, and how you implement and assess that. We want you to do that. Because if we didn't, then I don't have a job, because I'm a nurse.

I'm a nurse investigator. Okay, I don't do hands-on nursing practice. I don't do tasks. So, what is the top of my scope? The top of my scope is making sure, one, that I treat you with dignity and respect when you come to see me as an investigator, and I give you due process. But also for me, because I like being out and about, it's public education.

It's the staff nurses that I choose usually to focus on, because I want them to know at that level, too. "Here's what you can do, and here's what you can't do. And this is the Nurse Practice Act, and did you know it even existed?"

Because most people actually, they know that there's a Nurse Practice Act. They've never opened it up, they've never read it. They have no clue. So, it's my job to bring that to them. Because as a staff nurse, I was a transport nurse. I lived off of protocols. Everything I did was protocol, every time I flew somewhere, every time I was in the helicopter, every time I was in an ambulance. I operated on a protocol.

What was key to that was, even within that protocol, I never, ever left a facility without picking up that phone and calling my ICU docs. "Hey, this is what I have. This is what I did. I've run these things down the protocol. Do I need to do anything else? Are you good with that, or can we head back?"

There was always a provider. And they also approved them ahead of time, so we had a provider kind of at both ends. They approved those protocols annually. They reviewed them. But I always had a provider on that end, to say "Hey, this is where we're at."

Because my scope at that point was intubations and chest tubes and lines and all kinds of things that a lot of nurses can't do. But it wasn't about the task. It was about my assessment. "What does this kid look like? What am I going to do? How am I going to get him back to OHSU safely?" So, different for everybody, in lots of different realms of practice.

We want you to practice to the top of your scope.

Now, as far as your question about research and data, do we know that standing orders and protocols are a problem outside of Oregon? Yes, we do. This is not an Oregon problem. This is a United States problem. We know that, because we're part of the National Council of State Boards of Nursing.

There are lots of questions around standing orders and protocols right now. Not just Oregon. This isn't an Oregon-based thing. It's just that it came to our attention in a way that we weren't quite anticipating, and we started going "Oh, wait. We need to start asking these questions." That's when the Board directed us to come and start talking to people, and start figuring it out.

And OCN is very research-driven. So, when we hand all of this over to OCN, they're going to have all the data, they're going to have all the input. They're going to have everything they need. They're going to put it all together and then present it to the Board.

**Ruby:** You know, the last thing that we want at the Board, is to chase nurses because "Oh, you violated the Practice Act. But you know what? Nobody got hurt. You did fine." We don't want to chase people, because they didn't understand the Practice Act.

We want to take individuals and investigate them, when they have ignored the Practice Act, and ignored what the practice of nursing should be. So, we want to make sure that where there are these issues,

these controversial issues that seem to put the Board in a different light as compared to the Practice Act, and a different light, as compared to what is going on.

Does that need to change, to fit what the Board has said? Or does the Board's rules need to change, based upon what is out there and what has proven to be safe? That's really what we're here about.

And we don't know the extent of how you're using protocols. We have no idea. So, that's what we're here to ask.

**Audience Member:** I want to actually go back to the research. Yeah, exactly what you just said. You mentioned a couple of times that you are taking this information and going to -.

**Ruby:** OCN.

**Audience Member:** OCN, and give them sort of the summary. Is this the only way? Are these forms the only way they're gathering the data? I'm just thinking that like if it's truly research-driven, and this is obviously such a minute fraction of the amount of nurses in just this area, let alone the different scopes of practice, from acute care to public health, and everything in between.

How are you collecting the data, and is it going to be a true representation of nursing?

**Ruby:** We are not doing research. We're getting public stakeholder, because that's what the Board asked us to do.

**Audience Member:** Is there any opportunity for the public stakeholders to provide this information? Is there any outreach being done in another capacity?

**Ruby:** That's what you're doing now.

**Wendy:** This was what the Board directed us. This is our sixth or seventh. We've gone all over the state. We have publicly announced stakeholder meetings. We have asked people to come and meet with us, to talk to us, to provide us input.

And we've been doing that since December. This is our final stop. We've been to Medford, to Bend, to two different spots in Portland, and Eugene. So, we've been around the state. We've asked people to come to us, to provide this.

When all of this is said and done, the Board is not going to make law or rule, without again, public input. There is going to be that opportunity. If there's going to be change, there's going to be the opportunity for public input.

**Ruby:** If the Board decides to write rule – if – that means rule becomes part of the Practice Act. They will be calling for a stakeholder group. Now, you can't have 100 people in a stakeholder group. You'll never get anything done. So, we are going to have to be extremely judicious, to make sure that every geographic area of our state is represented by at least one person.

And every type of public health or, you know, federally funded clinics, school nursing, all of those people are included. But you cannot have a stakeholder group of 100. It will not work.

It is open to the public, but only nursing will be part of it. This is a nursing thing.

**Audience Member:** When will we hear of that next step, though?

**Wendy:** All we know at this point in the process is that this information will be given to the Board in September, at the September Board meeting. That's what we know right now.

**Ruby:** Now, your question about research. If you feel that this venue does not give you the ability to provide the information you think the Board needs to have, you are perfectly free to send us whatever it is that you want. But the Board does not do IRB-level research or massive [inaudible 00:47:50]-type reviews of literature.

We are only allowed to do what the law allows us to do. And the law, the public meeting law in Oregon, and rule-writing law in Oregon, says the Board may use stakeholders. There are some Boards that don't even have any of these. But the Board of Nursing doesn't want that.

The Board of Nursing is committed to making sure that its licensees understand what the Board is doing. The next steps for the Board? September – what day is that, Peggy? It's a Tuesday. The second Tuesday in September, from 6:30 to 8:00 in the evening, the Board will get the report from the Oregon Center for Nursing.

The Board can either decide "Okay, thank you for that information. Whatever." Or they can say "Hmm. Rewrite that interpretive rule and bring it back to us." Or they can say "Hmm. Let's write rule." Or they can say "Ruby, we need to get more information from other states, other Boards." They can do whatever they direct us to do. So, I can't tell you that.

Oh, in September, we're going to get the answer to this, because it's up to those nine people. And those nine people are all nurses, except for two. They are public members. So, they know the stakes here. They know what is.

And there are people from rural areas on the Board, and urban areas on the Board. So, it depends. But our job right now is to give them this information. OCN has been gracious enough to say "We're a research-based organization. We will bucket all of the comments, and organize all of the comments." Because through all of these stakeholder meetings, there have been hundreds and hundreds of comments.

We want to make sure, because there was a feeling along the way, that there would be bias toward keeping the Practice Act the same. Well, that is absolutely untrue. If it was to be kept the same, we wouldn't have these stakeholder meetings.

But we want to make sure that the public is very comfortable in the fact that Board staff doesn't look at this. We take your information. I don't even read it. It goes straight to OCN, and they are the ones that are going to be developing a report. And they are neutral. You know that \$9 surcharge you guys pay on your license? They get that, because they are the state nursing workforce research arm. They get that money. We don't get it.

**Audience Member:** I have two questions. One of them is to earlier, the same thing that you had mentioned with Wendy. But with OCN, as part of the report, are they making an analysis and integrating outside evidence?

**Wendy:** I don't believe so. I don't believe so. I believe this one is just fact-gathering, and then kind of laying that out in a way that from all of this input, the Board can see it in a very concrete, very organized way.

**Ruby:** Because an analysis, a scientific analysis of the information would be very biased for the Board. Because all the Board wants is these questions: What is being used out there? And what would happen, if those protocols – what would happen to your patient population if those protocols were not going to be allowed anymore? What would happen?

That's the kind of information the Board needs. The Board is not a scientific body. It is not peer reviewed research. It is what is legal for us, and what is not? Now, if the Board decides to stakeholder, that's where you start looking at the data. That's where you start looking at research.

Now, a stakeholder meeting is advisory only. We could do all the research in the world, and bring the Board, and those nine people on the Board go "No, I don't think this is okay." They have the final say. They are appointed by the Governor. They have been given that legislative authority. They have the final say.

So, if they say "No, we're not comfortable with the way nursing is going," which I don't think they will. But they could say "We're not comfortable with the way nursing is going, and we're going to put this box around nursing, and that's going to be the law." I don't think they're going to, because again, they recognize that there are patients that have no plan B.

You know, "We've got to go here for our STI. There's no other place for us to go. What are we going to do? There is no provider." You can't just say "Okay, we'll put a provider in every clinic every day, all the time." That's not going to work.

[inaudible 00:52:35]

**Audience Member:** My second question was in reference to what you said about OHA, and I guess the jurisdiction that OHA has.

**Ruby:** For public health.

**Audience Member:** For public health. Can you define again, because it doesn't seem clear in my mind, exactly where the boundaries are, between OHA's authority over public health nurses, and the Board's authority? Or is that still something that needs to be determined?

**Wendy:** I'm going to let Ruby handle that one.

**Audience Member:** If we're going to talk, can we all introduce ourselves, so we kind of get a flavor of what's in the room?

**Wendy:** I could do the sign-in sheets, but if everybody wants to know who everybody is, absolutely. We'll start over here with you, and kind of go this way, and weave back and forth.

**Audience Member:** I'm [inaudible 00:53:20]. I'm the Deputy Nurse Practitioner and Director for Multnomah County Health Department in Portland.

**Audience Member:** I'm [inaudible]. I am the Clinic Nurse Supervisor and the Reproductive Health Coordinator for Morrow County.

**Audience Member:** I'm [inaudible]. I am the Registered Nurse and the Care Manager for the [inaudible] Services for the Morrow County Schools.

**Audience Member:** [inaudible]. I'm an RN, also, and Morrow County Public Health Director.

**Audience Member:** [inaudible]. Community Health Nurse at [inaudible] Disease Management and [inaudible].

**Audience Member:** [inaudible]. I'm the Community Health Nursing Supervisor and [inaudible].

**Audience Member:** [inaudible] County Public Health.

**Audience Member:** I'm [inaudible]. I'm an OSU nursing student, and I'm also an OHSU nursing student.

**Audience Member:** My name is Elizabeth, and I'm a Public Health Nurse in [inaudible] County.

**Audience Member:** I'm [inaudible], Nursing Supervisor in Union County Public Health.

**Audience Member:** I'm [inaudible], and I'm the Partnership Liaison on the [inaudible], RN in primary care.

**Ruby:** Yay!

**Audience Member:** It sounds real good!

**Audience Member:** My name's [inaudible]. I work with Belinda on the clinical faculty for OHSU.

**Audience Member:** My name is [inaudible]. I'm an OHSU student.

**Audience Member:** I'm [inaudible]. I'm an RN, and I'm Health Services Training Manager for the Department of Corrections.

**Audience Member:** I'm [inaudible]. I am also an RN for the Oregon Department of Corrections. I'm a staff trainer, and serve on the protocol committee.

**Audience Member:** I'm [inaudible]. I'm Nurse Manager for Two Rivers and Department of Corrections.

**Audience Member:** [inaudible], Medical Services Manager to [inaudible].

**Audience Member:** [inaudible]. I'm Board staff [inaudible].

**Audience Member:** My name is [inaudible], and I'm a Registered Nurse at [inaudible].

**Ruby:** Okay. Let's go back to your question. The question was, where does the authority of OHA, regarding nursing practice, and the Board's authority over the practice of nursing, intersect? First of all, OHA has no authority over the practice of nursing. None. Only the Board does. That's what the law says. That's what the Legislature said. The Board can't change it, only legislative.

However, all of us work for someone else. And the question is, you bring your nursing license to the job. You leave that job, you leave with your nursing license, right? And you go peddle your skill elsewhere.

So, the Board has authority over what you are authorized to do, by law. The employer may put in policies and procedures and protocols and standing orders, which may or may not violate what the

Board has said are the requirements of nursing, and what the Legislature has said “This is what nursing is. This is nursing, this is medicine, this is dentistry, this is pharmacy.”

The nurse must always, and is always accountable for knowing what the limitations of their practice are. As I said, every one of us in this room have a different scope of practice, based upon what our knowledge, skills, abilities, and competencies. My scope of practice is not yours.

But you know, if you were to go today, and decide that you’re going to work in an ICU. Decide you’re going to leave what you’re doing, and you’re going to go to ICU, and they ask you to run an aortic balloon pump, what are you going to say?

**Audience Member:** No.

**Ruby:** No. It’s not in my scope. Because what you’re saying is “I do not have the knowledge, skills, abilities and competencies to safely do this for this patient. I am not safe.”

So, OHA, because they have authority over health departments and nursing homes and adult foster homes and all of that, they start to propagate rule. But they are also not allowed to go outside of what the Board says. We have had conversations with OHA and said “You can’t do that.”

For example, the QMPs. These are these people that go out in the community and diagnose people. What they told us was – we follow this quite a bit. We have policy analysts, and they kind of ferret out and see what everybody’s doing.

So, OHA said that the nurse will give the individual a DSM diagnosis. And the requirement is a bachelor’s degree in nursing. And we said “Nope. Independently cannot do a DSM-5 diagnosis for this particular individual, for any individual, because it’s based on an assessment and it’s based on a diagnosis. And from that diagnosis, this patient is going to qualify for whatever treatment they’re going to be getting, and there’s chart review and all of that.”

So, what they did was, because we said we have authority over that, OHA actually changed their rules, and said that if you’re an RN, you have to follow what the Board of Nursing says you have to do. Because OHA recognized that individual licensees are what we have authority over.

It is your accountability, that when you take a license from the Board, that you work within the parameters of what the Practice Act says. Now, that said, the Practice Act can be a little confusing, if you’re ever read it. It’s a little confusing.

So, what we are doing at the Board is we are trying to re-write actually most of the rules, to make sure that they’re in English, not interpretable. They say what they say. And really give more guidance to our nurses about what is safe and what is not safe.

For example, the Practice Act doesn’t talk about interventions. You won’t find an IV or a med or a line or an intra-aortic balloon pump or [inaudible 00:59:48] or transport, anywhere in there. Because the Practice Act is applicable to every single licensee in every single setting, with every single level of scope.

So, the Practice Act says things such as “The nurse shall work with the inter-disciplinary team, to assure that the patient’s treatment plan of all of those disciplines is being implemented, and doesn’t conflict with each other. The nurse shall not implement any order given by a provider, that is not in the best interest of the patient, or that the nurse deems to be safe.”



“The nurse shall assure that the patient’s rights to have information are protected, and the nurse shall advocate for their patient to have the appropriate information.” And you can go on and on.

So, if you say “Alright, appropriate.” What is appropriate information, in your context of care? You would define that. Appropriate information in our context of care is what we’re doing today. And patient – that’s why the Practice Act also has gotten away from the word “patient,” and used the word “client.” Most of us older nurses don’t really like that. We like the patient thing.

But because nursing has expanded to so many different areas, who is your client? For you all, mostly, it’s the patient in front of you, the person in front of you. My client is every single licensee in the state, and the Board is my client. Same with Wendy.

So, a CNO. Their client is all of the nursing practice done in a specific environment. That’s really kind of where we are, and that’s the difference between. OHA talks about “This is the process we use, to take care of individuals. And by the way, we use nurses to do that.”

Nurses fit into there by saying “Because I’m educated as an RN, because these are my knowledge, skills, competencies and abilities, this is what I’m allowed to do, and I’m allowed to do safely.” Let’s just say you implement a protocol that was developed by OHA, and something bad happens to the patient, and we get word of it. And you say “But wait a minute. I’ve got this protocol. I’ve got this protocol.” Irrelevant. You have to decide. You are responsible for every single decision you make, as a nurse.

Now, that’s what we want to avoid. Because if we have these protocols, and they do violate the Practice Act in some way, and remember, the Board determines whether you’ve violated the Practice Act, not you. If they violated the Practice Act in some way, that nurse implemented those things in good faith. The developers developed it in good faith, to meet a need of their community. We don’t want you to get caught in the middle.

So, we need to make sure that we know exactly what’s going on, so that we can craft language that will last for years, rather than language that is already outdated. But we have to have general enough statements in our Practice Act, to meet the context.

Now, there are some exceptions. For example, delegation in a community setting has its own chapter in the Practice Act, because it is so unique. And it is true delegation. You are delegating the practice of nursing to someone who is not regulated, who might have a third grade education and got fired from Burgerville yesterday. But today, they’re going to do CBGs and administer insulin.

So, the nurse takes that person under their license, and teaches, and does all of that stuff.

**Wendy:** And they can say no.

**Ruby:** Yeah. They can say “No, we’re not delegating this at all.” But is this an issue, where we should have a separate chapter? That’s up to the Board to decide, because it is an issue. Is it symptom-driven? Is it this? Is it that?

And what are other states doing? I can tell you, when I asked the other states – I sent a question out to all 59 Boards in this country, plus territories. I even sent some to Canada. And they said “Yeah, it’s a huge issue.” Because quite frankly, the Practice Acts have not addressed it.

And of course, they all said “Ruby, when you figure this out, why don’t you just let us know what you’ve done?”

But in answer to your question, you’ve been to a lot of our – and your questions are very, very valid. Most of them, I don’t have an answer to. That’s why we’re here. But as far as OHA is concerned, OHA implements based upon what they need, to get their work done.

They bring nurses into it. Nurses come with their own license, and say “Alright. I know that this is safe to do.” We get probably 10 to 20 practice questions a day, nurses asking us “Is this safe? Is this not?” And the answer is “Well, let’s talk about that.”

And there is no – I wrote an article for the Sentinel. The Sentinel actually comes to you via email. Check your junk mail, if you don’t get it, because you get it every quarter. There is an article in there that says “Why the Practice Act has no easy answers.” That article, if you want to know why the Practice Act is written the way it is, read that. Because there are no directions in the Practice Act.

There’s no “You can do this, but you can’t do this.” It’s where are you, in your practice? What have you done? So again, OHA uses nurses. Nurses are then responsible for making sure that they know the Practice Act, and what is and is not allowed.

**Audience Member:** I want to make sure I’m understanding correctly. I’ve worked in public health for years, and I [inaudible 01:05:27] a private health program. Years ago, I understand that grid had, like it worked with the Board of Pharmacy. There was a lot of work that had gone into that with the Board of Nursing and the Board of Pharmacy.

So, my understanding, so at this point then, we are [inaudible 01:05:45] start a new client on a new prescription, with a contraceptive. So, is that really – at this point, you’re saying things are worked out for dispensing, and RN can dispense. [inaudible 01:05:56] the Board of Pharmacy, depending on how they want to handle that technical prescriptive piece?

**Wendy:** Yeah, because we have no control over medication.

**Ruby:** We have no jurisdiction over that. Now, there have been questions, is the Board of Pharmacy going to be part of this? I can ask the Board of Pharmacy, but the Board of Pharmacy and the Board of Medicine have pretty much said “This is a nursing thing. The Board of Nursing needs to decide what it is for nursing.” It’s not relevant, what the Board of Pharmacy rules are and what the Board of Medicine rules are. It is relevant what the Board of Nursing says about nursing.

So, I have gotten input from them and clarification, and I’m sharing that clarification with you, but that’s all they’ll give me.

**Audience Member:** Can you speak a little bit more to over-the-counters and care plans? Any clarification yet, on that?

**Wendy:** We don’t have any good clarification on over-the-counters, at all. We just need to know at this point, how they’re being -. We know that they are used in camp settings. We don’t know how else they’re being used, and what that looks like, so we need to know that. But we have no clarification, at this point, on over-the-counters.

Again, don't change what you're doing. Don't start something new. Just let it lie, right now, and hopefully, we'll have some more answers.

**Audience Member:** As a nurse that's been in the schools, I've had an issue with the secretary dispensing. And I've come across issues. She's not licensed. She's not a nurse, or they. And I've had issues, because there has been side effects that they didn't know about, and actually come across them. So, where are you in that?

**Ruby:** We don't have authority.

**Wendy:** They're not regulated. We have no authority over them, just like an MA. We have no authority over a medical assistant.

**Audience Member:** But if they're practicing nursing?

**Ruby:** Dispensing is not practicing nursing.

**Wendy:** No. It's actually pharmacy, isn't it? Yeah, it's pharmacy.

**Ruby:** Dispensing is not the practice of nursing. The administration of medication is a very small piece of the practice of nursing. The legal definition of the practice of nursing is the diagnose and treatment of the human reaction to illness and injury states. That's what's the diagnosis – and the practice of nursing legally is defined; the nurse using an advanced knowledge of the social sciences, the biological sciences, etc., to assess and development, implement, and evaluate the plan of care for that patient.

That's the legal definition. There's nothing in there about the nurse shall dispense, because that's not us. The nurse shall start IVs. IVs have nothing to do with nursing. It's a task that people associate, simply because the nurse is the one that can assess that patient, to make sure that it is appropriate for that intervention.

That nursing plan of care and that assessment is what you do constantly.

Come on. We all know, we go to the grocery store and we see somebody, and go "Oh, yeah." I was a neonatal nurse. "Oh, yeah. [inaudible 01:09:09] baby. That baby was probably 27 weeks, when they were born." Because I'm assessing and I'm determining. When you start an IV, you're determining that this is the right thing to do for this patient, and that it's within the plan of care.

We don't have authority over anybody that isn't one of our licensees. And if they want to do that, their employer takes the legal risk. What happens if the school secretary gave the kid an over-the-counter med that they were allergic to? Who do you think takes the liability for that?

**Audience Member:** Or has a bleeding ulcer.

**Ruby:** Or has a bleeding ulcer. The school just gives this. But that's why FERPA came in, too. FERPA was the one who said the parents have more authority over the child than the practitioners do, basically. It says more than that, but-

**Audience Member:** I guess I'm needing some clarification. If there's nothing in the Nurse Practice Act about dispensing, and as a nurse, we cannot prescribe, but we can dispense?

**Ruby:** Under certain [inaudible 01:10:14] only.

**Wendy:** Right. Under specific conditions designated by law, from Board of Pharmacy.

**Audience Member:** The Board of Pharmacy does not think that this is their problem. But it's not a Nurse Practice Act thing. It's not something we're governed under OCN. It's something that's in that grid that you referenced to, of whether we can or cannot dispense, and that is regulated by the Board of Pharmacy.

So, that right there, to me, calls why they should be part of the conversation, and called to the table.

**Ruby:** No, because we're not talking about dispensing here. What we're talking about are individual – the law is very clear about what nurses can dispense. And that's law way beyond the Practice Act. The law says the Board of Pharmacy and OHA, for these public health entities, will develop a grid for medication distribution, because that's what the Board of Pharmacy has.

The Board of Pharmacy and OHA got together and said "For these particular diseases, nurses can dispense these medications." And when you look at that grid, it says "Who can prescribe?" And it says "An LIP."

So, where are we in that? And if the nurse does not have an LIP in this mix, like you guys seem to not have, is that a violation of the state law? And the Practice Act says you shall follow all state laws regulating whatever it is you're doing.

Like fluoroscopy. The CRNAs used to think they could do fluoroscopy. They can't. It's not legal, in the Board of Medical Imaging. So, they had to stop. Well, we told them to stop. I don't know whether they stopped or not.

**Audience Member:** Again, going back to the immunizations, I know that those fall under the OHA, population here. But again, what I'm doing is I'm dispensing. So, I'm struggling there.

**Ruby:** You're administering.

**Wendy:** You're administering, not dispensing.

**Ruby:** You're not dispensing.

**Wendy:** Because dispensing means you take it out of a place and you physically give it to them. You don't administer to them. You're giving it to the client. An immunization, you're administering that medication. It's different.

**Audience Member:** It's also a prescription. [inaudible 01:12:25]

**Ruby:** Why are you giving them a prescription for a vaccine?

**Audience Member:** Some vaccines are prescriptions, right? We have standing orders for vaccines.

**Ruby:** So, tell me. In the immunization, are you giving them the immunization before they leave?

**Audience Member:** Yes.

**Ruby:** Then, it's not a prescription.

**Audience Member:** We have to order it.

**Ruby:** Right. You have to order it, but you're administering it. It's like in the hospital. Like in the hospital. Let's go back to acute care. The provider has a standing order for their patients to get A, B and C. The nurse is authorized by that organization to go ahead and order that medication from the pharmacy, and administer that medication.

But the nurse cannot give the patient that medication and say "Here. Take this at home." That's dispensing. Dispensing is when you actually give the individual a medication that they are going to take outside of your view, after they finish seeing you.

A prescription is "I am calling something in to a pharmacist, and a pharmacist is going to dispense that medication to you, and you go home and take it."

**Audience Member:** So, if we have our own supplies?

**Ruby:** Big gray area. Does the pharmacy know you have all of those supplies?

**Audience Member:** Yeah.

**Ruby:** Yeah. They inspect you, right?

**Wendy:** The Board of Pharmacy inspects for those [\[inaudible 01:13:46\]](#).

**Ruby:** Right. The Board of Pharmacy inspects. The fact is that they are the ones who determine what is dispensable and what is not. You have to understand the terms administration, dispensing, prescription writing. Those are the three different terms.

When a nurse takes an immunization and administers it to the patient, based upon a standing order that says population-wise, if this person doesn't screen out and they are 18 months old or whatever, this is what they get, unless the parents say no. It's not that they're going to get something unique or individual. They are going to get this, unless these conditions persist.

Then, the nurse takes the vaccination and administers it to the child. That's administration. That's not dispensing. The reason the pharmacy doesn't want you to dispense is because the dispensing laws of this state say that the medication has to be labelled very, very specifically. And there are laws about how they have to be labelled, and that there has to be teaching, and there has to be this, and there has to be that.

Under the Pharmacy Board, it is the pharmacist that's supposed to do that. For certain medications, because of population management, the law allows clinics that are designated to do so, to bypass the pharmacist. Because when you dispense, you're bypassing the pharmacist, is basically what you're doing.

And your clinic has to have the ability to dispense. You have to have dispensing authorization by the pharmacy. You can't just say "I'm going to open up a clinic and I'm going to go ahead and dispense drugs from this clinic. Yay me!" No. In fact, our nurse practitioners who have their own private practice have to have dispensing authority from us, which was delegated to us by the Board of Pharmacy, for a paperwork thing.

We don't have the authority to give anybody dispensing authority, but the Board of Pharmacy said "To make things easier, they only have to apply to one place. These are the rules, Board of Nursing, you have to follow." So, dispensing is a pharmacy thing, and they're the ones who get to control that.

**Audience Member:** On the topic of medication administration, I train and supervise [inaudible 01:16:04]. So, it falls under Oregon Health Authority and Oregon Department of Education. So, it seems like there's [inaudible] their manual. It's still in accordance of Division 47, their manual and their ORS's and their OARs all fall under [inaudible].

**Ruby:** Yes.

**Audience Member:** It has to be provided by the parent. So, I struggled with going to variable school districts for the first time, when I first started, and opening up these giant medication cabinets that were stocked meds, that were not supposed to be there. They have since disappeared in my district, but I had to explain [inaudible 01:16:45].

So, I see what you're saying [inaudible 01:16:53]. If they can't taking something out of their desk, it has to be for Joey Smith, from Joey Smith's mom, and an authorization from Joey Smith's mom.

**Ruby:** In a container for Joey Smith.

**Audience Member:** In a container for Joey Smith, and it's labelled [inaudible 01:17:04], under the discretion and the training of that ODE training manual, under the supervision of my license [inaudible]. It's very difficult, because administrators change, and then the [inaudible] change and the secretaries change. It's a constant ongoing struggle, and I know your pain. Because there's no checks and balances. There's no audits. [inaudible]

**Ruby:** You brought up a very important point. How you delegate, and the requirements under your license, to assure that delegation is done safely, because in statute, it says nurses can delegate to unregulated or unlicensed individuals, certain tasks that are associated with nursing, in the following scenarios; jails, schools, foster homes, long-term care facilities, etc., community settings.

47 tells you the rules on what you have to know, as a nurse, of what is appropriate delegation under your license. The content of that is really what the school district and/or OHA is really telling you you need to do.

The Practice Act gives you the skeleton. These are the things that are safe nursing practice; making sure that the individual has the motor skills in order to do that, making sure the patient is stable for no less than six months, or whatever it is. That's the skeleton.

Your organization's rules, OHA's rules, the rules of the pharmacy, flesh out that skeleton of your practice. But it is the Practice Act that gives you the foundation of how you are supposed to delegate.

So, 47 is being re-written. What we want to make sure is that we don't make it so prescriptive that it's more of a process. The Practice Act should not be process. The Practice Act says "When you do this, this is safe nursing. When you do this, this is safe nursing." But not the "Okay, you shall only have a container for Jonnie, with Jonnie's name on it, and you have to fill out this form." That's not in the jurisdiction of the Practice Act.

But yeah. I feel your pain.

**Audience Member:** [inaudible 01:19:15] manual from ODE and OHA.

**Ruby:** We do have, on our 47 committee, school nursing is on there, also. There's lots of representation. It is very convoluted.

**Audience Member:** I'm not a school nurse. I'm in the schools, but I'm not a school nurse. I just want to make that clear. They do not have any medication now, anymore.

**Audience Member:** Looking at all of our protocols, and we have thrown out the one just [inaudible 01:19:44]. And you're totally right. We have the ability to [inaudible 0:19:49]. So, are they looking at possibilities of, okay, if you have a protocol for an ear infection, and you're only allowed to give this antibiotic if you see these symptoms. Are they looking at that?

**Wendy:** We don't know what they're going to determine, to be honest. All we know is we're trying to determine who everybody does it, so they can look at that and say "Is it going to be this way? Is it going to be this way?"

Ruby had done some research. I think it's also important, besides knowing administration and dispensing and kind of what those are, to understand what protocols and standing orders are.

Standing orders get used most often in hospital acute care type settings. Where for example, you come in the ER. You come in, you're a cancer patient, you have a fever. You have to run down these [inaudible 01:20:37] things. And there's a standing order that says you have to do this, this, this, draw these labs, get an IV in, get fluids running. Then, a provider sees them, to put all of that information together, to then make a follow-through on that.

A protocol means that a provider has looked at this patient, at this plan of care. Like we talked about coumadin clinics. "I've seen this patient. I've determined that they are going to be on this coumadin protocol for years. I am now going to say that this order says that they can have this medication under this scale. As long as everything goes great, they stay over here. If there's a change in condition, or if they're way outside the realm, then they come back to me."

But there's always a provider either on the front end or the back end of those. And that's the piece that we believe is missing.

**Ruby:** Right. So again, literature-driven, research-driven, that's the definition of a protocol in almost every -. The Joint Commission says that's the definition of a protocol and standing orders. The AMA says the same thing. The National Council of State Boards of Nursing says the same thing.

But that said, these things have been developed to help your patients. Now what are we going to do? Now what are we going to do? Because there's no plan B. You can't make a provider, when there isn't one. You can't say "Oh, but this is what you're supposed to do, because that's what the literature says you're supposed to do."

That's why sometimes literature-based will give you good context, but it may not work. Because what are your patients going to do, if we say "No. You can't do this anymore." That's what the Board is struggling with. That's why the Board has to know the breadth and type of protocols that are out there.

If you're saying "No. We absolutely – the patient comes in, we diagnose an ear infection, we give them this antibiotic, we call in this prescription, the provider may or may not see them." Billing is a totally different thing. Let's not get into billing, because who's billing for all of this? If there is any billing.

So, "This is how we're using them. And if we don't use that, this is what's going to happen. These people have nowhere to go." That's the kind of information the Board needs.

**Audience Member:** Does the Board also take [inaudible 01:22:52], like you're saying, 18,000 MDs statewide. We all know we don't have providers to see all of those.

**Ruby:** Exactly. Of course they will.

**Audience Member:** It impacts every state taxpayer, because [inaudible 01:23:05]. Do they want that kind of information?

**Ruby:** Yes. They want whatever it is you want to tell the Board. They want to know. We've had comments such as "Who does the Board think they are that they can decide what nursing does?" The Board.

"Who is the Board to dictate the relationship between a physician and what they want their nurse to do?" Yeah, well, they're the Board.

So, yes. Quite frankly, the Board could have said "No, that's the rule. That's the way it works." But that's not the Board. The Board understands all of this. They are nurses. They get it.

**Audience Member:** And they know it's all legislative ruling. Every inmate gets constitutional care.

**Ruby:** Absolutely. And we love reading the inmate complaints, all 64 pages of them.

[inaudible 01:24:05]

**Ruby:** But they do. They get all of that. The question is, how in these contexts, are we going to assure that there is safe care, access to care, and still keep the nurse comfortable that yes, "This is in my scope. I'm okay doing this, and I can do so confidently," without wondering whether Miss Wendy is going to come down in her black robe and her black horse, and chop your head off, because we're the Board.

People are afraid of the Board.

**Wendy:** Yeah, we're not scary. I didn't introduce myself this way, but I often introduce, when I'm doing a public outreach thing, I say "The Board is Oz." It's that scary voice in the Wizard of Oz, and everybody is like "Oh, my God! It's Oz!" Then, when they actually get in there and they pull back the curtain, it's this teeny little guy with a microphone.

**Ruby:** The Board is not scary. The Board is here to help.

**Wendy:** We want you to do safe nursing care. I have a caseload. I quite honestly don't want you on my caseload. I have more than enough complaints to deal with on a regular basis, that if I can impact – it's my preventative health. If I can impact you at this level, where I keep you safe, I keep the public safe, and you never visit me, that's a win.



I don't want to investigate a nurse. I want them to understand their practice, their scope. I want them to do good for the public and give safe care, because that's what you said, when you took that license. "I agree that I am going to provide the people of Oregon safe quality nursing care." I want you to do that.

**Ruby:** And what is that? That's the question.

**Audience Member:** So, your job is two-fold, and probably more than that. But your job is not just to make sure that the nurses practice within their scope of practice. But you're looking out for public safety. You're advocating for your patient, which is the population. So, you're balancing those two things, so public safety is also access.

**Ruby:** Absolutely. It's access. It's making sure that that nurse who is taking care of you understands that "Yeah. I can do this, and I can do this safely, because I have the knowledge, skills, abilities and competencies, and it does not violate the law."

**Wendy:** "The law says I can do it."

**Ruby:** One of the big issues is, go ahead, read the Practice Act, and then tell me whether or not you know whether you're violating the law or not. I will tell you that most of you aren't going to be able to answer. Because right now, the Practice Act does not really address your specific situation.

Legislation takes years and years to change. Rule-writing is how the Board really affects change. And again, it's up to the Board, but they can't make information, unless they know what the problem is. If it's just one county that's doing it, it's like "No, county. You need to get in line." But if affects the entire health of our population, and the safety of our patients, which includes access, then something has to give here.

The Board has to craft rule that doesn't allow it to say "Oh, yeah. Why do you even need a physician's protocol? You know what you're doing."

Why do you need that? Why do you need a provider's protocol? After following a protocol 14 times, you probably know it by heart. Let's just get away with it. No, that's not okay, either. Because now, you really are working outside of what the legislative authorization is to do. Because again, the practice of nursing is the human response. Not the diagnosis itself, and not the actual prescribing a treatment for that disease or injury. It is the human response. That's what nursing does.

**Wendy:** And it's individualized. It's meant to be. It's not the same for you as it is for you, as it is for you, as it is for me. Everybody's is going to be different. That assessment is going to be different. The care is going to be different.

Except for population management, but that doesn't fall under the Practice Act, other than community health.

**Ruby:** My take on this is going to have to be that there going to have to be some language somewhere, about population management, to stop this confusion. What's the difference between population management, immunizations, and someone getting treatment for an STI or a communicable disease of some type? What is the difference between the prison system and the public health system, and all of that?

There's got to be some clear language in there, because you all and us, we're all confused about what all of this is, because nursing is just -. You know, in the day, nurses worked in the hospitals, and some public health nurses went out. And maybe there was a nice school nurse in every single school, with a nice cap and a cape and all of that.

But that's done. It's over. So, how are we going to write the Practice Act, so that nurses know "When I take this license, this is what I'm expected to do."? And you are answerable for that license, only to the Board. Because the Board crafts the rules by which your license must be implemented.

[inaudible 01:29:14]

**Ruby:** What does that mean? What does the top of your license really mean?

**Audience Member:** Would you please tell us?

**Ruby:** The top of your license, does that mean things like "I can drop an external jugular, I can intubate, I can put in a chest tube."? Or does the top of your license mean "I'm going to assess this patient that is in front of me, and what it is they need. And I'm going to make sure that that patient gets the care that they need, safely, and gets the resources they need, by calling in all of those resources, and dealing with the human response."

It's even the boring stuff; the assessment, the plan of care, and all of that. That's top of your license. It's how you approach your client, your patient, whatever you want to call them, every single day. That's the top of your license, what you're capable of doing.

We have no doubt that all of those protocols you all are on, 95% of you are perfectly capable of doing it. 5% are not. They are the ones we get to see. Because we get – about 5% of the population of nurses get a complaint, on an annual basis. That's why Wendy has 80 cases on her caseload.

**Wendy:** And there are 14 of us. I'm not the only investigator.

**Ruby:** She's not the only one. Each one of them has about that same amount. So, the fact is that the top of your license means that you know exactly what the law allows you to do, that you're not in lieu of a provider. You are an adjunct. Not an extension, either. You are an adjunct to what that provider feels needs to be done for that particular client.

And that is the top of your license. Doing what you can do. Not stuff. Not violating the law, and we have to clarify what the law is, first. And that's what the Board needs to do. The Practice Act is the law. It is not an option. If you think driving 50 miles an hour in a 30 mile zone is the right thing to do for you, that cop doesn't really care. It's still 30 miles an hour, no matter what your assessment is.

It's a complicated question. We've been all over the state. It is huge. The Governor's office has been involved. It's huge, because it does affect the safety of the public, and the inmates in the DOC. It does affect everyone. And it affects future generations of nurses, too, to understand exactly what it is that nursing really does.

**Wendy:** And we want your input, and how you're using it, because you're using it. And the other thing we don't want is for somebody else to make that decision for you, because you did not provide that input. Because often, as we listen to bills and things, often things in nursing get changed, not by nurses. But by other people, who don't know nursing. And we don't want that to happen.

That's why we're being proactive. We want your input. We want to know how you're using it. We want to make sure it's nursing. We don't want somebody else to come in and take that practice over, or affect change to that practice, that doesn't work for nursing.

**Ruby:** It would be really great if you were able to articulate in writing, on your paper, what you are confused about. Because the confusion out there means that we have to write language in anything that we do, to un-confuse you. If we don't answer your question, then what's the point?

So, if you are confused about what is public health, if you're confused about how does Department of Corrections deal with their clients, when there's no one around, and these people come day after day after day after day. What about your environment? What confuses you? How are you going to use these protocols?

What would happen to your patient population if you couldn't use your protocols?

[inaudible 01:33:25]

**Ruby:** That's the last thing we want to do. You know, to have our Board read a 900-page discipline document or a Board document, is a lot. Discipline usually runs, what? 300 or 400 pages? 500 pages? Something like that?

**Wendy:** 300 or 400, on a slow month.

**Ruby:** On a slow month. And the Board meets every month, to talk about discipline cases. That's how many of them there are out there. This is not something – because there's no public safety issue here. It's just, are you legally able to do what you're doing?

**Wendy:** Any other questions, comments, concerns?

**Ruby:** If you have anything that you would like to talk about or submit, please. We have our "Ask A Practice Question" email on our website. Please put in there "Comments about standing orders and protocols," so we can pull those off, and you have the ability to say "Okay, I thought about it for a day or so, and I forgot to ask something. Or I think this is –" whatever your personal opinion is, or your professional.

Actually your professional opinion, not your personal, because that's not relevant. Decide what it is you want to write, and just sent it to "As a Practice Question," and we will triage those out, and make sure that that goes to OCN also.

OCN, again, as people trickle in more information, we will give it to them, also. I think they have a deadline that they're going to start doing this around mid-June, when they're going to start looking at everything, to make sure everybody has an opportunity to have any [inaudible 01:35:14].

**Audience Member:** Is TB screening considered population health [inaudible 01:35:22]?

**Ruby:** Screening is not what we are talking about. Screening is screening. It's are you in or are you out? A TB test is not a diagnosis of tuberculosis. But screening, it's just are you in or are you out.

**Wendy:** It's when a positive screening comes up.

**Ruby:** A positive screen, or you have symptoms, and they walk into your clinic, and there's a protocol that says "If they have these symptoms, order this test, an acid-fast bacilli test, sputum." I've worked in a TB clinic during the Vietnam War, and we used to have patients have TB in their synovial fluid. TB of the elbow. No symptoms, no nothing. Just weight loss, night sweats, all of that. So, we drew those labs.

So, if you draw the lab and you're making a diagnosis, that's gray area. I'm not saying it's wrong, but the question is, is that a gray area? Where you're making a diagnosis, and you're going to prescribe rifampin, or whatever it is they do nowadays. It used to be [inaudible 01:36:43] in my day, but I don't know about that anymore.

But you're prescribing that, and no one who has the authority to diagnose or prescribe has seen that patient. The question is, can that be written in a protocol, and not be considered delegation of medical practice? That's really kind of the crux of the whole thing.

So screening, no. It's just are you in, are you out?

**Audience Member:** So, we can screen for TB, screen for STIs.

**Wendy:** You can screen for anything.

**Ruby:** Absolutely.

[inaudible 01:37:16]

**Wendy:** Exactly. It's once you have a confirmation, either by lab work or by a bubble, or whatever it is, or symptoms. What next?

**Audience Member:** Our providers would love us, if we started sending them [inaudible 01:37:33].

**Wendy:** And we recognize that for corrections, too. Are they going to call the provider on call, every single time they have this or that? Their providers aren't going to sleep, ever.

**Ruby:** The interesting thing about the Department of Corrections, we get the same complaints about the same providers over and over and over and over. And we investigate 90% of those.

But again, please give us your feedback. I know there's a lot of gray areas left, but we don't have any answers for you. That's what we're here to find out.

**Audience Member:** So, the bottom line is to keep doing what we're doing?

**Ruby:** Yes.

**Wendy:** Don't change things right now. Hold steady. In September, the Board will make some sort of determination. And what that is, we have no idea. Then, that information will get dispersed, to kind of what the next step is.

**Ruby:** It could even be just keep doing what you're doing, until further notice.

**Audience Member:** In the beginning of your talk today, you talked about putting down Division 47 alongside a document that you're comparing in. Sometimes, I see things that we get in practical nursing, that we're like "We can't do that. This doesn't align with this." Then, we consult with a consultant, and they're like "Well, that's a gray area."

So, there have been times. Say, adrenal insufficiency. A protocol came out from Oregon Health Authority. I had a student that had it, and it was a IM injection.

**Wendy:** You can't delegate that, no.

**Audience Member:** I'm not close to that student. I'm not available, so I did not. Then, somebody was saying "Well, now you're failing to follow the plan of care."

So, I appreciate that Division 47 recognizes that within my scope of practice, what I can basically delegate and supervise is at my discretion, and mine alone.

**Ruby:** Yes, it's your discretion.

**Audience Member:** I take that to heart a lot, because we're in a rural area. Because administrators at schools will say "You have to do this," or "This parent wants you to do this." They can want, but what I can do is at my discretion alone. So, I [inaudible 01:39:36].

It's something that we have to teach other people, though, administrators and educators about. They have a rule that they make through Oregon Health Authority, but it has to coincide with my scope of practice and my license. And it's my responsibility to make sure that [inaudible 01:39:53].

And if it doesn't, it's my discretion to decline to protocol that out. And I have.

**Wendy:** Absolutely.

**Audience Member:** So, that's really hard over there, because those students need it. So, I write a protocol that this is a high risk. If this kid breaks his arm, and he needs a hydrocortisone injection, this is what you've got to do very quickly, and hand that to the ambulance driver.

Those are where we kind of [inaudible 01:40:17].

**Wendy:** Or a parent can come in and administer at certain times of the day, to do that, because you're on the other side of the state.

**Audience Member:** [inaudible 01:40:23] the child is injured, he falls on the playground and breaks his arm. So, we actually reach out to the ambulance crew, "This is where they are. This is where they're kept." No way will I delegate that, but the protocol says to.

**Ruby:** Again, if there's a Chief Nursing Officer or whatever, that approves that protocol, knowing that that's not within what the law says, then they are violating the Practice Act also. Because the front line nurse isn't out there flapping by themselves. If there is a nurse in that up-line that said "Yeah, this is what we're going to do, because the organization says that's what we're going to do," then that nurse is responsible for that particular decision that they are making.

There have many a Nursing Director or CNO who has been investigated, because they authorized a protocol. Because the Practice Act very clearly says aiding and abetting the development and implementation of protocols and practices that are not in the best interest of the patient. That's in the Practice Act, also.

But originally, you couldn't delegate out IM injections, originally. But we had to change it, because that's what's happening out there. Adrenal insufficiency is a prime example of what we call the disease du'

jour, that the Legislature says “We’re going to fix this by having a rule, and we’re going to make the school nurses do it, because there’s so many of them!” That was sarcastic.

**Audience Member:** [inaudible 01:41:56]

**Ruby:** Then, they give it all to the OHA, and most often than not, OHA will call us and say “What’s the story here?” But then, they don’t. That’s why we have a policy analyst who does nothing but review OHA rule-writing. She has changed many a rule that OHA was going to implement, and said “No. That’s not within the scope of nursing.”

**Audience Member:** And changed big-time. [inaudible 01:42:22]

**Ruby:** The Legislature now is talking about suicide prevention education for everyone, regardless of where you work. They’re talking about consult competency education, no matter where you work, no matter what your organization gives you. So, there’s a lot that the Legislature says “Okay, let’s go do this.” And we have to implement it, because that’s the law.

**Wendy:** And we figure out how to implement it.

**Ruby:** We figure it out.

**Audience Member:** You mentioned somebody looking at protocol that OHA puts out. Because they obviously provide immunization standing orders, but they just started a year ago, providing standing orders for reproductive health. So, someone already, on that end, reviewed it, didn’t they?

**Ruby:** Maybe, maybe not. Maybe they did that without letting us know. Because reproductive health, there are laws about reproductive health. Do they or do they not supersede the Practice Act? That’s what a lot of people ask us about. Do they or do they not?

A lot of times, we say “Well, do you have the knowledge, skills, abilities to do this? And is there a law to cover you?” The Board of Nursing is not going to countermand someone else’s law, we hope, because that gets confusing. That gets to be infighting.

What our policy analyst does is she works with OHA and says “You need to reword that a little bit. You need to tweak that a little bit.” Like I said, you can’t have them diagnose out of a DSM-5. You just can’t. That’s how we work that.

So, no clear answer there, either. But hopefully, it will be less unclear when the Board decides what it is it’s going to do. There’s a lot of work ahead. This is just gathering information. This is our assessment phase.

Now, OCN is going to pull out the pertinent data and present it to the Board. Then, the Board has to discuss it and develop a plan. Then, the Board staff implements that plan and evaluates that plan, and gives it back to the Board.

**Wendy:** So, turn your sheets in to us, if you filled them out. If you didn’t fill them out or you want to think on it, and then give us that feedback, then you need to use that “Ask a Scope of Practice” question part on our website. Make sure you designate that it’s specifically for the stakeholder outreach for protocols and standing orders. That way, we can pull that information out, and make sure it goes to OCN.

[inaudible 01:44:58]

**Wendy:** They're different. One is for how are you currently? And then, the other one is for questions and concerns.

**Ruby:** Thank you all. Thank you for your questions, truly.

Meeting ID	Response Type	Comments
122018	Concerns/Questions	There is significant precedent for RN-initiated, symptom-based prescription treatment in other states, in response to the need for safe, expedited, accessible care.
122018	Concerns/Questions	RNs and LPNs have an important role to play in decreasing overall cost of care, increasing access and improving patient care. There is an excellent article addressing this: Registered Nurses in Primary Care: Emerging Roles and Contributions to Team-based Care in High Performing Practices. Margaret Flinter - J. Ambulatory Care Manage Vol. 40, No. 4, pp 287-296. 2017
122018	Concerns/Questions	Interpretive statement seems to say NO refills of expired meds, but Ruby says yes under specific circumstances. Confusing... what about a protocol for a population for refills of specific chronic post-diagnosis meds.
122018	Concerns/Questions	Seems like if licensed independent practitioner agrees and signs off on a nurse assessment within 24 hours, then population-based protocol of prescribing well-written is OK. ----?
122018	Concerns/Questions	What impact will the OSBN decision have on sexual health? Will RNs maintain authority to prescribe for contraceptive/STI care?
122018	Concerns/Questions	RN provides care, documents in chart "per protocol." Does that full protocol need to be in that patient's individual chart? Or can nurse reference a protocol that is on a separate document?
122018	Concerns/Questions	I work with pharmacy on scope of practice issues as a compliance manager. Recent question was when will nurses be able to give meds that pharmacist prescribes? Glad to here you are talking regarding boards working together to address these team care issues!
122018	Concerns/Questions	Can protocols be written for the RN/LPN to initiate a plan of care to where there is a section to que the nurse to call to obtain approval if a provider is only available telephonically?
122018	Concerns/Questions	Is there a difference between an LPN and an RN using nursing protocols? Are there RN ones? Are there LPN ones? Or can there be RN/LPN ones?
122018	Concerns/Questions	Please include medications in protocols that are based on empirical data that nurses are collecting (labs) or refill meds based on chronic meds necessary for condition management.
122018	Concerns/Questions	Need more clarity around boundaries of what is public or population health.



Meeting ID	Response Type	Comments
122018	Concerns/Questions	There is a scarcity of licensed independent practitioners to attend to (directly) patients presenting without appointments to our FQHCs. If the symptoms and (diagnostic) labs meet simple algorithms, and are uncomplicated, the RN should be able to prescribe medications from a specific formulary.
122018	Concerns/Questions	Are the applications of nurse protocols at all dependent on existing plans of care? Or is it/are they more dependent on the presence or application of prescription medications?
122018	Concerns/Questions	Better clarification is needed regarding public and population health interventions. I am the TB nurse consultant for OHA. Very confused about which aspects are public health vs. individual level care.
122018	Concerns/Questions	Look online at OHA reproductive health program protocols for RN dispensing - very broad.
122018	Concerns/Questions	Relative to school nursing, are standing orders written by a licensed independent practitioner, say for Tylenol, Benadryl, topical creams (OTC meds), able to be given by a RN who is supporting a student population who are at outdoor school for a week?
122018	Concerns/Questions	ORS 678.010(8)(6)(A) Can nurse follow physician assistant orders? Not listed on slide #7. Or naturopath? Both have prescriptive authority and are approved to prescribe by OHA standing orders/protocols.
122018	Concerns/Questions	How does epinephrine and naloxone in the school setting fit in to the discussion of standing orders.
122018	Concerns/Questions	True or False. Providers must be included in process to diagnose and prescribe even protocol medications, prior to the conclusion of the interaction, whether via telephonic/verbal report or face-to-face, either before or after the medications were actually administered?
122018	Concerns/Questions	It seems like OSBN is dictating medical practice by not allowing RNs to follow licensed independent practitioners' orders.
122018	Concerns/Questions	Please address parent-directed OTC medications. Can a RN legally administer an OTC that parents have consented to?
122018	Concerns/Questions	Oregon law allows ER meds (epi, naloxone) to be administered to any person experiencing side effects of anaphylaxis/opioid overdose. How does this mesh with the Nurse Practice Act? Would a RN be allowed to administer either of the medications to a person without a prescription?
122018	Concerns/Questions	Does consulting provider by phone or chart message count as "keeping them in the loop?"
122018	Concerns/Questions	Why does OSBN not take into consideration what other states are doing?
122018	Concerns/Questions	Who decides if it is a population health issue?

Meeting ID	Response Type	Comments
122018	Concerns/Questions	It would be great for OSBN to provide clear, articulate, concise interpretation of rules/regulations - there is <u>no</u> clarity.
122018	Concerns/Questions	I was under the impression that this meeting was about gathering stakeholder information, feedback and concern. There is no indication, facilitation or openness to gather such info.
122018	Concerns/Questions	Clearly this is a hot topic with strong opinions - an objective neutral facilitator would be useful.
122018	Concerns/Questions	There are a lot of ways to get feedback - this meeting clearly not facilitated to gather info.
122018	Concerns/Questions	Are you familiar with or interested in knowing what other states are doing? There are many others who clearly sanction the practices you are suggesting are out of scope in Oregon.
122018	Concerns/Questions	Many other states have set precedent for RNs following standing orders resulting in prescriptions (WA, AZ, MN, CO, ND, MO - to name a few). Massachusetts has a particularly good Advisory Ruling (9324) around standing orders resulting in prescription.
122018	Concerns/Questions	"Public health supersedes OSBN." How is it determined what falls into the public health realm? And who falls into that category? Only community health centers?
122018	Concerns/Questions	RNs, utilizing protocols for condition- and symptom-based care, have an opportunity to move care toward current evidence-based practice standards, improving health of patients in our care.
122018	Concerns/Questions	If OSBN continues to hear from stakeholders that it would be prudent to alter the statutes governing nursing scope of practice if doing so would protect the public who might otherwise not receive needed healthcare, why is OSBN not involved in advocacy for altering these laws accordingly?
122018	Concerns/Questions	Since there is only licenses by states for RN/LPNs, in an FQHC, what rules/Nurse Practice Act do individuals not working in FQHC in Oregon go by?
122018	Concerns/Questions	Corrections poses some challenges to the health care delivery system due to lack of the licensed independent practitioners on site and depend on nursing. Putting strict parameters on standing orders/protocols without further input from corrections is a concern. Please allow more time for further gathering of input.
122018	Concerns/Questions	Please consider more time for public health stakeholder input.
122018	Concerns/Questions	More time is requested for stakeholder input.
122018	Concerns/Questions	Who is OHA representative for public health? There are multiple programs.
122018	Concerns/Questions	My comment is to move forward to board meeting on 2/14.

Meeting ID	Response Type	Comments
122018	Concerns/Questions	Please have a separate meeting for public health, again in more than one location across the state of Oregon.
122018	Concerns/Questions	Please provide more opportunity for stakeholder meetings across the state of Oregon.
122018	Concerns/Questions	There should be more meetings about this and a delay on decision. An advisory group or more opportunity to weigh in.
122018	Concerns/Questions	Stakeholders representing community groups require more time to determine impact on preventative care, specifically contraceptive care. Please delay board decision.
122018	Concerns/Questions	More time for stakeholder involvement please
122018	Concerns/Questions	Please consider more time for public health stakeholder input.
122018	Concerns/Questions	The issues specific to local public health authorities acting quickly to address community health issues - communicable diseases, family planning and STDs - need <u>more time</u> to discuss and give feedback.
122018	Concerns/Questions	Are you familiar with the concepts of patient-specific standing orders and condition-specific standing orders? It seems like the framework I've heard so far only incorporates patient-specific, yet condition-specific is a widespread and long-established practice.
122018	Concerns/Questions	If there is an evidence based practice/standardized medication given every time, unless previous allergy (and there's a second option) - can a protocol cover ordering the medication (ex. Antibiotic for UTI or strep or STI/STD)?
122018	Current Use	Types of protocols (similarities and differences) - triage and advice before licensed independent practitioner, care management/care coordination, procedure, nurse visit, emergency, population health vs. individual
122018	Concerns/Questions	In the interpretive statement please add that while the nurse may order something (i.e. a lab) there may be billing implications - they need to know this.
122018	Concerns/Questions	Protocols with standing orders - used in person/face to face or telehealth - any differences?
122018	Current Use	Can we dive into exceptions that exist and could inadvertently be impacted by OAR changes? Specifically will RN authority regarding birth control and STI care change? Can we talk more about this and the negative impact a change could have?
122018	Concerns/Questions	Are protocols meant to be used for a new issue or medical complaint a patient hasn't had before?
122018	Concerns/Questions	If the care happens asynchronously (by phone, for example), how long do we have for the provider to sign off on a standing order the RN followed? Some things are urgent; some are not.

Meeting ID	Response Type	Comments
122018	Concerns/Questions	What about protocols in which RN does assessment and orders labs (per standing order), then must immediately consult provider? Provider is making diagnosis and treatment decisions, but does this count as "delegating" the practice of assessment?
122018	Concerns/Questions	What's the statutory foundation for determining that the act of carrying out an order per protocol is delegation of prescriptive authority?
122018	Concerns/Questions	What if my clinics are not licensed CHCs but we see the same things (STIs, TB, etc.)? Why can't I operate under those guidelines? Do they get additional training?
122018	Concerns/Questions	The pharmacy boards CHC guidelines sets precedent for RNs having limited prescriptive authority via a standing order.
122018	Concerns/Questions	Would strongly encourage consideration of rule change to allow RNs to prescribe in order to prevent spread of any communicable disease.
122018	Concerns/Questions	Time for legislative action to allow RNs to have more broad authority.
122018	Concerns/Questions	Protocols are really designed to benefit PATIENTS, and not to benefit providers or serve times when provides are not available.
122018	Concerns/Questions	We seem to be confusing delegation and following orders. If we have a standing order and follow that, this is not delegation.
122018	Concerns/Questions	If we want stipulation around how much time should pass before a licensed independent practitioner sees a patient after a nurse has provided treatment using a standing order, we need to be specific about that. Stating "it depends" is not appropriate.
122018	Concerns/Questions	In the example of the standing order in an ER setting - you stated that this is acceptable because the licensed independent practitioner is there. Does that mean that a nursing standing order/protocol is acceptable when a licensed independent practitioner is physically present even if they are not consulted?
122018	Concerns/Questions	Please clarify the steps required by the licensed independent practitioner to authorize a visit conducted under standing orders you mentioned. A time period the licensed independent practitioner must authorize agreement of plan - before patient leaves the facility? What if this occurs over the phone?
122018	Concerns/Questions	Are we using the words "standing orders" and "protocols" interchangeably?
122018	Concerns/Questions	Will you make slides available to all?
122018	Concerns/Questions	How are nurses to use protocols in emergency situations when there are no providers physically on site?
122018	Concerns/Questions	What are the best ways to title a nursing protocol? (Ex. Diagnosis vs. nursing diagnosis)
122018	Concerns/Questions	Explain the definition of community health clinics for dispensing.

Meeting ID	Response Type	Comments
122018	Concerns/Questions	Can there be clear parameters on what would be a protocol vs. a standing order? Is there a difference?
122018	Concerns/Questions	Define references for population health model used today.
122018	Concerns/Questions	Can the Board clearly identify exceptions where nursing standing orders and protocols without licensed independent practitioner involvement is acceptable? Emergency contraception? Gonorrhea/chlamydia exposure? Emergency situations?
122018	Concerns/Questions	Health care transformation relies on utilizing the shared scope of the health care team to provide value-based care outside of the office visit. One of the OHA metrics is based on the care of ambulatory care sensitive conditions and reducing ED and hospital utilization. I see a huge role of nursing who have assessment skills and can help care for clients using licensed independent practitioner authorized nursing standing orders.
122018	Concerns/Questions	If the action has already been initiated and is no longer retrievable, why would it matter if the provider validates the order in a particular timeframe or within the same episode of care?
22019	Concerns/Questions	I would like to address the following: standing orders for immunizations (especially if patient has never been seen by provider) (ex. "flu clinics" off-site), role of RN (and ability) to refill non-controlled prescriptions, symptomatic (dysuria) vs. diagnostic (UTI) verbiage permissions for standing orders, titration of meds (coag clinics, insulin), OTC meds for telehealth (ex. RN triage thompson protocols)
22019	Concerns/Questions	Regarding school nurse structure - 11 schools in district with 2.5 FTE RN, BSN. No "charge nurse." If new nurse has not cared for a particular disease, like Type 1 diabetes, does one of the "seasoned" nurses need to care for the student alongside the new school nurse until seeing competency?
22019	Concerns/Questions	Public health. What about emergency protocols? Ours are written to support emergency for client, staff, visitors - many of which are not established with a licensed independent practitioner. We have standing orders for Narcan.
22019	Current Use	Public health. For STI testing, often no symptoms, so could not list symptom instead of diagnosis (gonorrhea). What about treating partners (expedited partner treatment)? In public health, nurses dispense birth control up to 6 month supply until can be seen by NP.
22019	Current Use	"Population health" is used by Kaiser as well for protocols - just want to be sure it is not just looked at for public health.

Meeting ID	Response Type	Comments
22019	Concerns/Questions	This did not feel like a listening session whatsoever. Rather than opening up space to hear who is represented and what our concerns were, we were talked at the entire time. Restating the same points, saying we're looking for answers. I suggest having an expert from the board give a talk, then an experienced facilitator elicit feedback from the audience.
22019	Concerns/Questions	Is it a standing order if the physician has to sign the electronic order that the nurse entered before it goes to pharmacy? Patient cannot get the script until licensed independent practitioner signs it.
22019	Concerns/Questions	Please have a stakeholder meeting addressing critical access/rural hospitals.
22019	Concerns/Questions	Please address not disrupting patient flow in EDs because standing orders are used.
22019	Concerns/Questions	What about national certifications such as sedation that are attained by nurses doing moderate sedation in patients using protocols. This could cause increase in cost of care and disruption of service to patients.
22019	Concerns/Questions	With the federal mandate for inmates to have access to care without having licensed independent practitioners present 24/7 the patient has a complaint of a clinical symptom - nurses have to see them within a time parameter. How can this be met if there is a patient need without a licensed independent practitioner present when there may be a concern/need for prescription?