

**LEGISLATIVE COMMITTEE
MEETING**

**PierSouth Hotel
Boca Rio Ballroom
800 Seacoast Drive
Imperial Beach, CA 91932
(619) 621-5900**

March 12, 2020

AGENDA

**THIS MEETING WILL IMMEDIATELY FOLLOW THE CONCLUSION OF
THE EDUCATION/LICENSING COMMITTEE MEETING**

Thursday, March 12, 2020

8.0 Call to Order/Roll Call/Establishment of a Quorum/Approval of Minutes

8.0.1 Review and Vote on Whether to Approve Previous Meeting Minutes:

- January 09, 2020

8.1 Discussion of Bills of Interest to the Board of Registered Nursing (Board) and Possible Vote to Recommend that the Board Adopt or Modify Positions on Bills Introduced during the 2019-2020 Legislative Session, Including But Not Limited To The Following Bills:

- [AB 329](#) (Rodriguez) Hospitals: assaults and batteries
- [AB 362](#) (Eggman) Controlled substances: overdose prevention program
- [AB 613](#) (Low) Professions and vocations: regulatory fees
- [AB 732](#) (Bonta) County jails: pregnant inmates
- [AB 890](#) (Wood) Nurse practitioners
- [AB 1145](#) (Cristina Garcia) Child abuse: reportable conduct
- [AB 1544](#) (Gipson/Gloria) Community Paramedicine or Triage to Alternate Destination Act
- [AB 1616](#) (Low) Department of Consumer Affairs: boards: expunged convictions
- [AB 1759](#) (Salas) Health care workers: rural and underserved areas
- [AB 1909](#) (Gonzalez) Healing arts licensees: virginity examinations or tests
- [AB 1917](#) (Ting) Budget Act of 2020
- [AB 1928](#) (Kiley/Melendez) Employment standards: independent contractors and employees
- [AB 1998](#) (Low) Dental Practice Act: unprofessional conduct: patient of record
- [AB 2028](#) (Aguiar-Curry) State agencies: meetings
- [AB 2185](#) (Patterson/Gallagher) Professions and vocations: applicants licensed in other states: reciprocity
- [AB 2549](#) (Salas) Department of Consumer Affairs: temporary licenses

- [AB 2704](#) (Ting) Healing Arts: licenses: data collection
- [AB 3016](#) (Dahle) Board of Registered Nursing: online license verification
- [AB 3244](#) (Flora) Nursing, vocational nursing, and psychiatric technicians: schools: examination fraud
- [SB 3](#) (Allen/Glazer) Office of Higher Education Coordination, Accountability, and performance
- [SB 808](#) (Mitchell) Budget Act of 2020
- [SB 878](#) (Jones) Department of Consumer Affairs Licensing: applications: wait times
- [SB 1053](#) (Moorlach) Licensed registered nurses and licensed vocational nurses: Nurse Licensure Compact
- [SB 1237](#) (Dodd) Nurse-Midwives: scope of practice

8.2 Public Comment for Items Not on the Agenda; Items for Future Agendas

Note: The Committee may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting. (Government Code, Sections 11125 and 11125.7(a)).

8.3 Adjournment

NOTICE:

All times are approximate and subject to change. Items may be taken out of order to maintain a quorum, accommodate a speaker, or for convenience. The meeting may be canceled without notice. For verification of the meeting, call (916) 574-7600 or access the Board's Web Site at <http://www.rn.ca.gov>. Action may be taken on any item listed on this agenda, including information only items. Board members who are not members of this committee may attend meetings as observers only, and may not participate or vote.

Public comments will be taken on agenda items at the time the item is heard. Total time allocated for public comment may be limited. The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting the Administration Unit at (916) 574-7600 or email webmasterbrn@dca.ca.gov or send a written request to the Board of Registered Nursing Office at 1747 North Market Blvd., Suite 150, Sacramento, CA 95834. (Hearing impaired: California Relay Service: TDD phone # (800) 326-2297.) Providing your request at least five (5) business days before the meeting will help to ensure the availability of the requested accommodation.

**BOARD OF REGISTERED NURSING
LEGISLATIVE COMMITTEE
MEETING MINUTES**

DRAFT

DATE: January 09, 2019

START TIME: 10:08 a.m.

MAIN LOCATION: Holiday Inn San Jose-Silicon Valley
1350 North 1st Street-Salon H
San Jose, CA 95112
(408) 453-6200

MEMBERS PRESENT: Donna Gerber, Chair
Michael D. Jackson
Imelda Ceja-Butkiewicz

STAFF MEMBERS PRESENT: Ann Salisbury-DCA Legal Attorney
Thelma Harris-Chief of Legislation

8.0 Call to Order/Roll Call/Establishment of a Quorum

Michael D. Jackson called the meeting to order at 10:08 a.m. Following the conclusion of the Education/Licensing Committee. Quorum Established.

NOT PRESENT: ➤ Trande Phillips, RN

8.0.1 Minutes

Review and Vote on Whether to Approve Previous Meeting's Minutes:

➤ October 17, 2019

MOTION: Imelda Ceja-Butkiewicz to Approve the Minutes of October 17, 2019

SECOND: Donna Gerber

VOTE:	DG:	MJ:	TP:	ICB:
	Y	Y	NOT PRESENT	Y

PUBLIC COMMENT: None

8.1 Discussion of Bills of Interest to the Board of Registered Nursing (Board) and Possible Vote to Recommend that the Board Adopt or Modify Positions on Bills Introduced during the 2019-2020 Legislative Session:

- [AB 8](#) (Chu) Pupil health: mental health professionals
- [AB 62](#) (Fong) State government: Fi\$Cal: transparency
- [AB 63](#) (Fong) State government

- [AB 193](#) (Patterson) Professions and vocations
- [AB 251](#) (Patterson) Personal income taxes: credit: family caregiver
- [AB 312](#) (Cooley) State government: administrative regulations: review
- [AB 329](#) (Rodriguez) Hospitals: assaults and batteries
- [AB 358](#) (Low) Sexual assault: medical examination
- [AB 362](#) (Eggman) Controlled substances: overdose prevention program
- [AB 389](#) (Arambula) Substance use disorder treatment: peer navigators
- [AB 535](#) (Brough) Personal income taxes: credit: professional license fees
- [AB 544](#) (Kiley) Professions and vocations: inactive license fees and accrued and unpaid renewal fees
- [AB 613](#) (Low) Professions and vocations: regulatory fees
- [AB 732](#) (Bonta) County jails: pregnant inmates
- [AB 768](#) (Brough) Professions and vocations
- [AB 822](#) (Irwin) Phlebotomy
- [AB 862](#) Professions and vocations: license revocation and suspension: student loan default.
- [AB 890](#) (Wood) Nurse practitioners
- [AB 1145](#) (Cristina Garcia) Child abuse: reportable conduct
- [AB 1271](#) (Diep) Licensing examinations: report
- [AB 1364](#) (Blanca Rubio) Nursing: schools and programs: analysis
- [AB 1444](#) (Flora) Physicians and surgeons and registered nurses: loan repayment grants
- [AB 1490](#) (Carrillo) Medical assistants
- [AB 1544](#) (Gipson) Community Paramedicine or Triage to Alternate Destination Act
- [AB 1592](#) (Bonta) Athletic trainer
- [AB 1676](#) (Maienschein) Health care: mental health
- [SB 207](#) (Hurtado) Medi-Cal: asthma preventive services
- [SB 567](#) (Caballero) Workers compensation: hospital workers
- [SB 700](#) (Roth) Business and professions: noncompliance with support orders and tax delinquencies

BACKGROUND:

Bills of interest for the 2019-2020 legislative session are listed on the attached tables.

Bold denotes a new bill for Committee or Board consideration, is one that has been amended since the last Committee or Board meeting, or is one about which the Board has taken a position and may wish to discuss further and restate or modify its position.

An analysis of and the bill text for these bills are included for further review.

MOTION: Imelda Ceja-Butkiewicz- Adopt an Oppose unless Amended position
SECOND: Donna Gerber
VOTE: **DG:** **MJ:** **TP:** **ICB:**
Y Y NOT PRESENT Y
PUBLIC COMMENT: None

AB 890 (Wood) Nurse practitioners: scope of practice: unsupervised practice
MOTION: Donna Gerber- To recommend o change to the current language
SECOND: Imelda Ceja-Butkiewicz
VOTE: **DG:** **MJ:** **TP:** **ICB:**
Y Y NOT PRESENT Y
PUBLIC COMMENT: **BJ Bartleson-California Hospital Association**

SB 700 (Roth) Business and professions: noncompliance with support orders and tax delinquencies
MOTION: Donna Gerber- Adopt a Watch Position
SECOND: Imelda Ceja-Butkiewicz
VOTE: **DG:** **MJ:** **TP:** **ICB:**
Y Y NOT PRESENT Y
PUBLIC COMMENT: **BJ Bartleson-California Hospital Association**

8.2 **Public Comment for Items Not on the Agenda; Items for Future Agendas**
NOTE: The Committee may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting. (Government Code, Sections 11125 and 11125.7(a)).

PUBLIC COMMENT: **Saskia Kim-SEIU** -See Attached letters

8.3 **Adjournment**
➤ Adjournment at 10:20 a.m.

Submitted by:

Signature:

Date:

Approved by:

Signature:

Date:



**California
Nurses
Association**



**National
Nurses
United**

A Voice for Nurses. A Vision for Health Care.

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January 9, 2020

Michael Deangelo Jackson, MSN, RN, CEN, MICN, President
California Board of Registered Nursing
P.O. Box 944210
Sacramento, CA 94244

**RE: Board of Vocational Nursing and Psychiatric Technicians' Planned Efforts to Expand:
(1) Scope of Practice of Psychiatric Technicians Regarding Invasive Mechanical Ventilation
Care and (2) Scope of Practice of Licensed Vocational Nurses to Include Intravenous
Medication Administration**

Dear Mr. Jackson and Board Members;

The California Nurses Association/National Nurses United (CNA), representing more than 100,000 California registered nurses, respectfully submits the following comments regarding efforts by the Board of Vocational Nursing and Psychiatric Technicians (BVNPT) to sponsor legislation to expand the scope of practice of Licensed Psychiatric Technicians (PTs) and Licensed Vocational Nurses (LVNs). As explained in more detail below, CNA believes the proposal would impact registered nurses and threaten the health and safety of health care consumers and the practice of LVNs. As a result, CNA respectfully requests the Board of Registered Nursing (BRN) oppose any statutory change as described below.

BVNPT Proposal. The BVNPT has indicated that it plans to sponsor legislation during the 2020 session and has put forward draft proposals for public comment. These proposals would impact registered nurses by expanding the scope of practice of PTs to include care of the patient on invasive mechanical ventilation in all healthcare settings. This proposal would allow PTs to practice outside of their existing settings. Additionally, the BVNPT may, once again, be attempting to expand the scope of practice of LVNs to include the administration of intravenous medications.

CNA testified in opposition to these proposals at the BVNPT's November 22, 2019 board meeting and submitted written comments on December 20, 2019. These written comments are included here as Attachment 1, and BVNPT's draft proposals are included as Attachment 1 to our December 20th letter.

Respiratory Care Board Opposes the BVNPT Proposal. The encroachment of PTs on the scope of LVN practice and the administration of intravenous medication by LVNs pose a threat to

patient safety that warrants, at the very least, the immediate involvement of the BRN through a letter of opposition to the BVNPT. It is important to note that the BRN would not be alone in such an action. The Respiratory Care Board (RCB) voted unanimously at its November 1, 2019 board meeting, to oppose the *draft legislative language* that would permit the expanded use of PTs in the care of patients requiring invasive mechanical ventilation and has instructed their executive officer to keep them apprised of legislative language developments.

BRN Has Acted in this Area in the Past. The BRN has previously engaged in the process of defining the relationship between psychiatric technicians and registered nurses in state mental hospitals and publicly opposed the adoption of regulations by the BVNPT that would have had registered nurses delegate the administration of intravenous medication to LVNs.¹ As such, it is within the purview and past practices of the BRN to engage on issues related to patient safety including safe RN supervision, delegation, and assignment of nursing activities. As noted above, the BVNPT *has made the draft proposals public for the purpose of receiving comments*, and we have found that *early engagement* in the pre-rulemaking process as well as the legislative planning process reaps significant benefits. In both processes, positions can be stated that allow the agency, sponsor, or authors of legislation to assess support or opposition as they decide whether and how to move forward.

BVNPT's Proposal Expanding PTs' Scope of Practice. The BVNPT has, historically, viewed the scopes of practice and training of LVNs and PTs differently:

. . . the U.S. Department of Health, Education and Welfare (HEW) [asked] the Board of Vocational Nurse and Psychiatric Technician Examiners in 1977 whether the board, which licenses both licensed vocational nurses and psychiatric technicians, considers them equivalent in their training. The board replied that they were not equivalent because licensed vocational nurses take considerably more nursing courses than do psychiatric technicians.²

CNA's attached comments to the BVNPT contain more extensive arguments regarding the BVNPT's proposal regarding PTs.³ We plan to vigorously oppose the unsafe encroachment of PTs on the practice of LVNs. PTs are dependent practitioners who practice under their own license and are responsible to the director of the service where their duties are performed.⁴ Directors may be physicians, psychiatrist, psychologist, rehabilitation therapist, social workers, RNs or other professional personnel.⁵ However, in health facilities that provide primarily

¹ See Attachment 2.

² Robert D. Anderson, Attorney at Law, *Legal Boundaries of California Nursing Practice*, 1st Edition, 1978 at 21.

³ See Attachment 1 at 6-12.

⁴ Business and Professions Code §4502.

⁵ Business and Professions Code §4502.

nursing care for patients with mental illness or developmental disabilities, nursing care is supervised by a registered nurse.⁶

As noted above, the BRN has been concerned in the past that in state mental hospitals PTs had been placed into supervisory roles that constituted the unlicensed practice of registered nursing.⁷ Although the Attorney General Opinion concluded that PTs, under appropriate circumstances, may supervise RNs who are performing activities of daily living (ADLs) and habilitative nursing activities which a PT may also legally perform, it is important to note that the AG stated definitively that PTs could not supervise a medical-unit within the state mental hospitals:

In so concluding, we of course are in no way holding that a psychiatric technician may act as a supervisor of a medical-unit, where intensive nursing service is required. And it is our understanding that psychiatric technicians have never been so utilized, but that registered nurses are properly assigned such supervisory roles.⁸

The author of an earlier legal opinion, shared with the BRN indicating that PTs supervising RNs in state mental hospitals constituted the unlicensed practice of nursing, later opined that the “poorly reasoned [AG] opinion was written...solely to legitimize the State of California’s mental hospital staffing problem.”⁹ Nonetheless, a distinction was made in the AG opinion between the limited legal authority of PTs to supervise RNs providing *ADLs and habilitative care* to emotionally and developmentally disabled residents on *non-medical units* as distinct from medical units where intensive nursing service were provided to patients under supervision exclusively by registered nurses.¹⁰

CNA has noted that the BVNPT has, in the past, sought parity between LVNs and PTs with respect to discipline, reporting, and denial/suspension/revocation of license for discipline by other healing arts board or by other states.¹¹ However, scope of practice authority has been legislated separately for the two professions.¹² PTs are not licensed nurses and, as noted above

⁶ E.g., acute care, skilled nursing, and intermediate care; 22 CCR §70211(b), 22 CCR §72327, 22 CCR §73319 (b)(c). Note: LVNs can supervise nursing care in Intermediate Care Facilities with RN consultation.

⁷ See Attachment 3 at 2.

⁸ See Attachment 3: CV 78/63, April 18, 1979 at 21.

⁹ Robert D. Anderson, Attorney at Law, *Legal Boundaries of California Nursing Practice*, 2nd Edition, 1981 at 28.

¹⁰ A distinction was made between the routine/habilitative care of the emotionally or developmentally disabled in state mental hospitals and the care in medical units of state mental hospitals where patients were there primarily for intensive nursing services.

¹¹ For example, Stats. 2003, Ch. 640, Sec. 11 and Sec. 18.5 (Suspension or revocation of license), Stats. 2011, Ch. 338, Sec.9 and Sec. 20 (Reporting requirements), Stats. 1992, Ch. 1289 Sec.23 and Sec. 38 (Denial or suspension of license for discipline by other healing arts boards or other states).

¹² E.g., authority for tuberculin skin (TB) testing by LVNs was added by Stats. 1974 Ch. 837 but authority for PT TB skin testing was added much later, by Stats. 1997, Ch. 720, Sec. 3. Although the certification of PTs was passed in

by the BVNPT itself, the training of LVNs differs from that of PTs. In 1998, the Legislature passed and the Governor signed legislation prohibiting the use of the title “nurse” by any individuals except RNs or LVNs.¹³ The exclusive use of the title “nurse” by RNs and LVNs was supported by the BVNPT.¹⁴

PTs may be interchangeable with LVNs, but only in very specific circumstances. For example, when care is provided in supplemental service psychiatric units of a general acute care hospital:

The licensed nurse-to-patient ratio in a psychiatric unit shall be 1:6 or fewer at all times. For purposes of **psychiatric units only**, “licensed nurses” also includes psychiatric technicians in addition to licensed vocational nurses and registered nurses. Licensed vocational nurses, psychiatric technicians, or a combination of both, shall not exceed 50 percent of the licensed nurses on the unit.¹⁵

Also, the California Department of Public Health (CDPH) has a policy concerning the interchangeability of LVNs and PTs in some programs in skilled nursing facilities:

Facilities shall not be cited under F-354, 42 CFR Section 483.30(a) when utilizing licensed psychiatric technicians (LPTs) for licensed nursing staff **when providing 24-hour services to the developmentally disabled or mentally disordered** in skilled nursing facilities **with special treatment programs or distinct parts of state hospitals**. LPTs who have graduated from an accredited school shall be considered to LVNs.¹⁶

The common thread in these exceptions is that LVNs and PTs can be utilized interchangeably in specific settings *for care of developmentally disabled or mentally disordered patients*. In effect, only when considering the care of patients in hospital psychiatric units or care of patients in skilled nursing facilities with developmental or mental disabilities programs can PTs be used in the place of LVNs. The scope of practice of PTs is to “[implement] procedures and techniques that involve understanding of cause and effect and that are used in the care, treatment, and

1959 and the licensing in 1968, the authority for TB skin testing was not added to PT scope of practice in 1974 when LVNs were authorized to perform the testing.

¹³ Stats. 1998 Ch. 1013 §1. (Business and Professions Code §680(a)).

¹⁴ See AB 1439 (Granlund) 1998, Analysis for Senate Committee on Business and Professions, Date of Hearing 6/11/98.

¹⁵ 22 CCR §70217(a)(13). Emphasis added.

¹⁶ Robert D. Anderson, *Legal Boundaries of California Nursing Practice*, 9th Edition, 2016, at 113 (emphasis added); 42 CFR § 483.30 Nursing services. The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. (a) Sufficient staff. (1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (c) of this section, licensed nurses; and (ii) Other nursing personnel.

rehabilitation of mentally ill or emotional disturbed persons, or persons with intellectual disabilities...”¹⁷ However, we are unaware of any circumstances in which current statutes or regulations allow for the substitution of PTs for LVNs where the care that is being provided is not specifically related to the nursing care needs of developmentally or mentally disabled patients.

Nursing care may be performed by other licensed and unlicensed providers including PTs, physician assistants, medical assistants, emergency medical technician, nurse aides, certified nurse assistants and Home Health aides.¹⁸ However, only RNs and LVNs are recognized as nurses. The BVNPT is attempting to blur the differences between LVNs and PTs with respect to the application of manual technical skills in the provision of nursing care of patients on invasive mechanical ventilation. LVNs are already authorized to apply manual and technical skills in the care of patients on mechanical ventilation and they have been doing so for decades.¹⁹ As such, our opposition to this proposed legislation does not impact the current scope of practice of LVNs.

BVNPT’s Draft Proposal Allowing LVNs to Administer Intravenous Medication. With respect to our opposition to expanding the scope of LVN practice to include the administration of intravenous medication, it is important to note that California is the only state that supports equivalency licensure for LVNs based only on work experience and a 54-hour course in pharmacology.²⁰ The BVNPT notifies such applicants that their license will not be recognized in other states.²¹ This means that a significant number of California LVNs have been able to gain licensure without ever having attended a BVNPT approved nursing program.²² CNA recognizes the important public policy benefits of this method of qualifying for licensure, and we have supported and will continue to support equivalency licensure. However, in order to protect the public, it is also important to note that this unique California LVN workforce must have a scope of practice appropriate to the minimum level of educational attainment required for licensure. Furthermore, according to the BVNPT, California’s NCLEX-PN pass rate ranked between 47th to 50th out of the 50 states over the last decade.²³

In summary, and after you have had the opportunity to review the comments that CNA has submitted to the BVNPT, we respectfully request that the BRN submit a letter to the BVNPT opposing statutory change that would: (1) allow PTs to practice outside of their existing settings

¹⁷ Business and Professions Code §4502.

¹⁸ Robert D. Anderson, *Legal Boundaries of California Nursing Practice*, 9th Edition, 2016, Chapter 7, at 93-132.

¹⁹ See Attachment 3 at 2-4.

²⁰ https://www.bvnpt.ca.gov/applicants/method_3.shtml

²¹ https://www.bvnpt.ca.gov/applicants/method_3.shtml

²² See Attachment 4 at 5. More than 1,700 applications received by BVNPT by equivalency applicants in 2017 and 2018.

²³ See Attachment 5.

by permitting the care of patients on invasive mechanical ventilation by PTs in any setting and (2) allow the administration of intravenous medication by LVNs. Thank you very much for your consideration of this request, and please let me know if you have any questions.

Sincerely,

CALIFORNIA NURSES ASSOCIATION/
NATIONAL NURSES UNITED



Saskia Kim
Regulatory Policy Specialist

Cc: Dr. Joseph Morris, PhD, MSN, RN

Attachment 1



**California
Nurses
Association**



**National
Nurses
United**

A Voice for Nurses. A Vision for Health Care.

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December 20, 2019

Ms. Tammy Endozo, LVN, President
Board of Vocational Nursing and Psychiatric Technicians
2535 Capitol Oaks Drive, Suite 205
Sacramento, CA 95833

Dear Ms. Endozo and Board Members;

The California Nurses Association/National Nurses United (CNA), representing over 100,000 registered nurses, appreciates the opportunity to give input to the Board of Vocational Nursing and Psychiatric Technicians (BVNPT) on its proposal related to changes in the scope of practice of Licensed Vocational Nurses (LVNs) and/or Psychiatric Technicians (PTs) with respect to:

- (1) Care of the patient on invasive mechanical ventilation (PTs);
- (2) Medication administration (LVNs and PTs); and
- (3) Starting and superimposing intravenous fluids (LVNs)

The comments below are based on proposed language which was given to CNA at the December 13, 2019 (12/13/19 draft) BVNPT Executive Committee meeting (See Attachment 1). CNA appreciates the opportunity to express our concerns where—we believe—the proposed language threatens the health and safety of health care consumers and the practice of LVNs.

As you know, the Respiratory Care Board and Board of Vocational Nursing and Psychiatric Technicians Joint Statement (Joint Statement), as updated in July 2019, was amended to remove “home care locations” in response to numerous comments received from stakeholders (See Attachment 2). The two boards then agreed to use the regulatory and/or legislative process to address the needs of patients in the home setting at a later date. Yet, here, the BVNPT is using the legislative process to go well beyond the home setting. Instead, the draft language would expand the LVN scope of practice and would authorize PTs to encroach on the practice of LVNs. In addition, the proposed language would make scope of practice changes that go well beyond care of the patient on mechanical ventilation (e.g., parenteral medication administration and “Intravenous Therapy”). For all the reasons stated below, CNA opposes the draft language.



- **Draft Language Would Usurp the Legislature’s Role in Authorizing Scope of Practice Changes for LVNs and PTs**

The draft language would allow for unlimited scope of practice expansion and enhancement through specialized Board-approved continuing education courses. Specifically, the language would provide that an LVN and PT could have their license modified by successfully completing specialized CE courses *including but not limited to* intravenous therapy, blood withdrawal, intravenous therapy with blood withdrawal, or mechanical ventilator care.¹ In effect, this language would allow the Board to add additional “enhancements” to this list in the future, thus allowing the Board, and not the Legislature, to determine the scope of practice for LVNs and PTs.

It is well settled that the authority for determining licensed scope of practice remains with the Legislature. On this point, the California Health Care Foundation has noted, “In California, as in most states, the state legislature makes SOP [scope of practice] laws, and major modifications to those statutes. SOP laws, once enacted come under the administrative authority of one of the following: the Department of Public Health (CDPH); the Emergency Medical Services Authority (EMSA); or the boards, bureaus, and committees housed in the Department of Consumer Affairs.”²

The draft language threatens the health and safety of health care consumers by usurping the Legislature’s prerogative to determine the appropriate scope of practice for healing arts licensees. The unidentified and unlimited future “enhancements” to scope of practice for LVNs and PTs—based solely on approval of the licensing board—is the rightful authority of the Legislature, not the BVNPT.

LICENSED VOCATIONAL NURSES

- **The Joint Statements Contradict BVNPT’s Prior Scope of Practice Decisions for LVNs**

While the Joint Statements limit what LVNs can do with respect to adjustment of mechanical ventilators for stable patients, the BVNPT’s prior scope of practice decisions and representations to the Legislature were not as limiting. In fact, those decisions and representations stated that LVNs could make ventilator adjustments. For example, the BVNPT’s Sunset Review Report, presented to the Joint Legislative Sunset Review Committee in October 1996, contained a

¹ See Attachment 1, Sections 2859.1, 4502.4.

² California HealthCare Foundation, *Scope of Practice Laws in Health Care: Exploring New Approaches for California*.

summary of decision made by the Board about the scope of practice of LVNs that permits LVNs to make ventilator adjustments for stable patients.³ The summary stated, in relevant part:

“LVN Adjustment of Ventilator Settings: Effective Date: March 22, 1996

In rendering this decision, the Board acted to permit LVNs to manipulate mechanical ventilator settings, including positive pressure ventilators, pressure-cycled ventilators, and volume-cycled ventilators, for clients who are ventilator dependent and whose medical condition is stable or chronic only under specific conditions. In pediatric and fragile populations, the Board concluded that the stability of the client’s condition must be determined by the supervising physician. Within the basic preparation of LVNs, theory instruction and clinical practice relative to the anatomy and physiology of the respiratory system, respiratory disease processes, treatments, and mechanical ventilation are required curricular content. Therefore, the Board concluded that, under specific conditions, LVNs possess the knowledge, skills, and abilities necessary to safely and competently adjust ventilator setting for the client.”⁴

As an integral part of invasive mechanical ventilation patient care, the BVNPT also stated in the 1996 summary to the Joint Legislative Sunset Review Committee that LVNs could perform endotracheal suctioning and reinsertion of tracheostomy tubes:

“LVN Performance of Deep Endotracheal Suctioning: Effective Date: September 16, 1994

The Board determined that LVNs can perform deep endotracheal suctioning under specific conditions.”⁵

“LVN Reinsertion of One-Piece Tracheostomy Tubes: Effective Date: September 16, 1994

The Board determined that LVNs can insert one-piece or outer cannulas of two-piece tracheostomy tubes only under specific conditions.”⁶

Moreover, stakeholders have relied on the BVNPT’s decisions. Licensed Home Health Agencies employ LVNs to provide home care to patients under the direction of a home health RN. Even

³ Robert D. Anderson, *Legal Boundaries of California Nursing Practice*, 5th Edition, 1997, at 63. Although all subsequent editions through to the 9th Edition (2016) contain the same summary language, we have referenced the contemporaneous edition since it includes the fact that this information was presented by the BVNPT to the Legislature during Joint Legislative Sunset Review.

⁴ Anderson, *supra* note 3, at 63. (Emphasis in the original)

⁵ *Id.*, at 65. (Emphasis in the original)

⁶ *Id.* (Emphasis in the original)

without statutory change, LVNs can provide skilled nursing care applying their manual and technical skills for patients on home invasive mechanical ventilation when under the direction of a registered nurse.⁷ A 2004 response by the California Association for Health Services at Home (CAHSAH) to a member inquiring about LVN Scope of Practice in the home setting stated that LVNs cannot *regulate* respirators and “only under specific condition can they *adjust* respirators.”⁸ This suggests that LVNs, as employees of licensed home health agencies, have had some responsibility for mechanical ventilator (respirators) adjustment *in the home setting*, authorized by the BVNPT, for at least fourteen years.

- **LVNs Should be Able, With Competency Validation, to Apply Manual and Technical Skills to Make Adjustments to Home Mechanical Ventilators in Order to Provide Skilled Nursing Care to Stable Patients**

RNs and LVNs must have at least one year of prior professional nursing experience before working for a licensed home health agency and before providing skilled nursing services in the home setting.⁹ The regulations for licensed home health agencies state that the only licensed health care providers who can provide skilled nursing services are RNs and LVNs.¹⁰ Neither respiratory care practitioners nor psychiatric technicians are included in the definitions of licensed professionals who provide skilled nursing care in the home health setting.¹¹

Since respiratory care practitioners are not authorized to provide skilled nursing care services ordered by a physician to patients under the care of licensed home care agencies, we suspect that some level of mechanical ventilator care must already be provided by LVNs under the direction of RNs in that setting. For all the above reasons, we believe that LVNs should be able, with competency validation, to apply manual and technical skills and make the adjustments to home mechanical ventilators, necessary to provide skilled nursing care to stable patients on home invasive mechanical ventilation. Additionally, home mechanical ventilator care (operation and maintenance) could be at least equivalent to that of the unlicensed personnel approved by the RCB, but provided *under the direction of a qualified home health RN*.¹²

⁷ California Health Care Foundation, California Health Care Almanac, *California Nurses: Taking the Pulse*, March 2014 at 27.

⁸ See Attachment 3, California Association for Health Services at Home, Subject: LVN and Intravenous Therapy and Scope of Practice, 9/13/2004 at 2. Note: The stated source for LVN adjusting respirators under specific conditions is the BVNPT. (Emphasis added)

⁹ 22 CCR § 74707 (c)(d).

¹⁰ 22 CCR § 74707.

¹¹ 22 CCR Div.5, Ch. 6, Article I Definitions, §§ 74600-74657.

¹² See, 16 CCR § 1399.360, Unlicensed Personnel Services; Home Care.

- **The Licensed Practice of Respiratory Care Does Not Limit the Practice of Other Licensed Healthcare Providers**

The licensed practice of respiratory care is not an exclusive scope of practice. The Legislature specified it intended for there to be overlapping functions between respiratory care practitioners and other licensed health care personnel including, *but not limited to*, registered nurses:

(b) It is the intent of the Legislature in this chapter to provide clear legal authority for functions and procedures which have common acceptance and usage. It is the intent also to recognize the existence of *overlapping functions between physicians and surgeons, registered nurse s, physical therapists, respiratory care practitioners, and other licensed health care personnel, and to permit additional sharing of functions within organized health care systems*. The organized health care systems include, but are not limited to, health facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, clinics, home health agencies, physicians' offices, and public or community health services.¹³

In effect, the door of overlapping practice swings both ways requiring, for example, only RN licensure, training and competency to provide safe respiratory care to patients on invasive mechanical ventilation and mechanical ventilator operation. RN standardized procedures in organized health systems allow for RN practice overlapping that of physicians and surgeons. For example, under standardized procedures, RNs with training and competency validation, intubate neonates in the delivery room. This is a skill requiring substantial knowledge and technical ability and is a skill shared with licensed physicians and surgeons as well as with licensed respiratory care practitioners. It is noteworthy that LVNs, as "other licensed health care personnel" above, are not excluded from functions that overlap those of respiratory care practitioners, despite the concession made by the BVNPT in the Joint Statements.

The distinction between the practice of LVNs and that of RNs is that the practice of the RN requires a *substantial amount of scientific knowledge or technical skill* whereas the practice of LVNs is defined as those services requiring *technical, manual skills* acquired by means of a course in an approved school of vocational nursing, *or its equivalent*, practiced under the direction of a licensed physician, or an RN.¹⁴ As we noted previously, LVNs can and do apply manual and technical skills in the care of patients on invasive mechanical ventilation under the direction of an RN in numerous licensed healthcare settings and, according to the BVNPT in 1996, it represented to the Legislature that care of the patient on mechanical ventilation and adjustment of ventilators for stable patients was covered in the LVN curriculum.¹⁵

¹³ Business and Professions Code Section 3701. (Emphasis added).

¹⁴ Business and Professions Code Section 2725(b), 2859. (Emphasis added).

¹⁵ Anderson, *supra* note 3, at 63.

PSYCHIATRIC TECHNICIANS

- **BVNPT Proposes the Expansion of the Practice of the Psychiatric Technician to Any Setting for Any Patient**

The draft language would delete all current language in §4502.2 on blood withdrawal from a patient with a mental illness or developmental disability.¹⁶ The proposal would amend in a new definition of the practice of PTs that would supplement the current scope of practice of PT, stating:

Practicing as a psychiatric technician within the meaning of this chapter is the performance of services requiring those technical, manual skills acquired by means of a course in an approved school for preparation of psychiatric technicians, or its equivalent, and is responsible to the director of the service in which their duties are performed. The director may be a licensed physician, psychiatrist, psychologist, rehabilitation therapist, social worker, registered nurse, or other professional personnel.¹⁷

This expansive language would **supplement** existing Business and Professions Code section 450.2 which limits PTs to the care and treatment of mentally ill or emotionally disturbed persons, or persons with intellectual disabilities.

The proposed supplementary new scope of practice, the deletion of language in §4502.1 that limits the administration of medication by hypodermic injection to mental health or developmental disability facilities, and the deletion of the language in §4502.2 that limits the withdrawal of blood from a patient with a mental illness or disability, represent a massive expansion of both the setting and the patient population that could be provided care by a PT. In effect, the PT would be authorized to practice in a manner equivalent to that of the LVN whose basic training and scope of practice is in care of any patients in any setting under direction of a physician or registered nurse.¹⁸

CNA does not believe that the basic training of PTs in schools of psychiatric technology provides an adequate foundation upon which *to expand the services provided by PTs* to settings other than those that provide care, treatment, and rehabilitation of mentally ill, emotionally

¹⁶ See Attachment 1, Section 4502.2.

¹⁷ See Attachment 1, Section 4502.2.

¹⁸ Business and Professions Code Section 2859. "The practice of vocational nursing within the meaning of this chapter is the performance of services requiring those technical, manual skills acquired by means of a course in an approved school of vocational nursing, or its equivalent, practiced under the direction of a licensed physician, or registered professional nurse, as defined in Section 2725. "

disturbed or persons with intellectual abilities much less adding the care of patients receiving invasive mechanical ventilation *in any setting with only additional continuing education.*

Furthermore, the draft language would allow the PT's expanded authority to provide care for patients under mechanical ventilation to be under the direction of a *psychologist, rehabilitation therapist or a social worker.*¹⁹ But, none of these practitioners engage in the medical/surgical practices proposed for the PT by the draft language. None of these practitioners are authorized or qualified to provide, direct or supervise the medical or medical/surgical nursing care of patients on invasive mechanical ventilation. In contrast, the LVN provides manual technical care under the direction of a physician or a registered nurse who has both the training and competency to provide, direct and supervise the nursing care activities of the LVN or the PT.

- **LVNs and PTs Have Different Scopes of Practice Because Their Different Educational Focus Prepares Them for Different Jobs**

Despite the fact that both LVNs and PTs are licensed by the same board, are not independent practitioners, and apply manual and technical skills in the provision of patient care, the scope of practice focus of each profession differs in significant ways relevant to the issues being addressed in the draft language.²⁰ The differences can be seen, first, in the distribution of hours of theory and clinical practice.

As seen in Table 1, below the curriculum for PT prelicensure programs has a specific plan for theory and clinical practice in mental disorders and developmental disabilities. Only 24 percent of theory hours and 28 percent of clinical hours are dedicated to “nursing” science.²¹ LVN theory and clinical hours are fully dedicated to nursing science that includes medical/surgical nursing, gerontological nursing, pediatric nursing, and obstetrical nursing.²² Forty-one percent of the curriculum hours and fifty-seven percent of the clinical hours in psychiatric technology is focused on mental disorders and developmental disabilities.²³

¹⁹ See Attachment 1, Sections 4502.2, and 4502.4, referring to the supplemental scope of practice being proposed at section 4502.2.

²⁰ https://www.bvnpt.ca.gov/licensees/psychiatric_technician.shtml,
https://www.bvnpt.ca.gov/licensees/licensed_vocational_nurses.shtml

²¹ $126/(576-54)= 24\%$, $270/954 =28\%$.

²² 16 CCR §§ 2532, 2533.

²³ $216/(576-54)= 41\%$, $540/954 = 57\%$

Table 1.

Curriculum	LVN²⁴	Psychiatric Technician²⁵
Hours	1530 (50 Semester Units)	1530 (50 Semester Units)
Theory	576	576
Nursing Science	576	126
Mental Disorders	Not specified	108
Developmental Disabilities	Not specified	108
Pharmacology	54 units of 576	54
Clinical	954	954
Nursing Science	954	270
Mental Disorders	Not specified	270
Developmental Disabilities	Not specified	270
Related Content	Not specified	144

Next, this focus is consistent with the BVNPT *Occupational Analysis of Psychiatric Technician Practice*, the “unbiased investigation of the Psychiatric Technician profession.” The content areas for the new Psychiatric Technician Test Plan included the following:

- Activities of Daily Living
- Basic Nursing Care
- Medication
- Treatment Plan Development and Implementation
- Individual & Group Therapy
- Behavioral Management²⁶

Additionally, the focus on emotional or mental conditions and on developmental disabilities is consistent with the program descriptions, employment opportunities, and clinical training for PTs in all 14 approved PT programs in the 13 approved schools that are listed on the BVNPT website (see Attachment 4).²⁷ Finally, the job description of the Health Workforce Initiative of the California Community Colleges, the American Association of Psychiatric Technicians the Bureau of Labor Statistics, and the BVNPT specifically state that PTs work with people who have emotional or mental conditions or disabilities in state hospitals, psychiatric units in general hospitals, private psychiatric hospitals, community mental health centers, day treatment centers, developmental centers, and correctional facilities (see Attachment 5).

²⁴16 CCR § 2532.

²⁵ 16 CCR § 2586.

²⁶ https://www.bvnpt.ca.gov/about_us/occupational_analysis_pt.shtml.

²⁷ https://www.bvnpt.ca.gov/applicants/program/psychiatric_technician_programs.shtml.

Further evidence that the education of PTs prepares them for different care settings than those of LVNs can be seen in CMS standards for home health agencies. In 2007, CAHSAH issued a statement, *Psych Tech vs. Licensed Vocational Nurse (LVN)* (see Attachment 6), stating definitively that a PT could not be used in place of an LVN in a home health agency since neither Title 22 nor the Medicare conditions of participation allow for it. They also noted in the document that “though the scope of practice for a Psych Tech and an LVN is very similar, the educational and experiential requirements for eligibility of licensure are different.”²⁸

- **Including PTs in the Draft Language is Not Justified Because They Do Not Provide Skilled Nursing Care**

It is our understanding that PTs are included in the draft language because they provide care in facilities for the developmentally disabled. According to the Department of Health Care Services, an “Intermediate Care Facility for the Developmentally Disabled” means a health facility which provides care and support services to developmentally disabled clients *whose primary need is for developmental services* and have a recurring but intermittent need for skilled nursing services (22 CCR §76079 (emphasis added)).²⁹ The primary emphasis on the need for developmental service is evident by the extensive licensing requirements of the Developmental Program Services in §§76305-76339.

CNA asserts that stable ventilator-dependent developmentally disabled patients require continuous access to skilled nursing care and not intermittent and recurring skilled nursing care as provided in the Intermediate Care Developmentally Disabled setting. As a result, including PTs in the draft language is not justified because they are not providing skilled nursing care and they cannot be substituted for LVNs in skilled nursing, as noted above.

Even if stable ventilator-dependent developmentally disabled patients were to be admitted to these settings, the Code of Federal Regulations, Subpart I- Conditions of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), §483.460(d)(2) states that the facility must employ or arrange for *licensed nursing services* sufficient to care for clients’ health *needs including those clients with medical care plans*. The term “licensed nurse” is defined as a registered nurse, a licensed practical nurse, or a licensed vocational nurse currently licensed by the State in which the facility is located.³⁰

²⁸ Attachment 6.

²⁹ See, <https://www.dhcs.ca.gov/services/medi-cal/Pages/LTCRU.aspx>.

³⁰ State Operations Manual, Appendix J- Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities, Appendix J., Guidance § 483.460(c)(3)(ii). (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_j_intermcare.pdf).

- **Draft Language Contradicts Stated Concerns of BVNPT and Respiratory Care Board Regarding Competency Certification**

Notwithstanding our position that PTs lack sufficient theory and clinical practice to provide safe care for patients on invasive mechanical ventilation, the draft language proposes that competency certification for PTs could be provided by the PT employer.³¹ Yet, 16 CCR § 2576.7 Private Duty Patient Care states that private duty care is *contracted directly between the PT and the patient with mental disorders or developmental disabilities*.³² Under those circumstances, the employer is the patient. CNA does not believe that a patient should be documenting competencies for licensed services by a licensed healthcare provider.

- **Differences in LVN and PT Equivalency Licensing Provides Further Evidence of Distinctions in Educational Focus**

There are differences in the acceptable training courses for military training and practice when applying for the licensure examination as a PT or as an LVN, thus demonstrating a significant difference in the training standards of PTs in comparison to those of LVNs. The BVNPT website summarizes the requirements for licensure based on nursing service in the military:

Summary of Requirements for Licensure as a Psychiatric Technician:

Nursing Service in the Medical Corps of any Branch of the Armed Forces of the United States. This method requires you to:

1. Completion of an armed forces course involving *Neuropsychiatric Nursing* and an armed forces or civilian course from an approved school in the *care of the developmentally disabled client*.
2. Completion of at least one year of verified full time paid work experience, including at least six months in a military clinical facility rendering bedside care to clients with mental disorders and at least six months in a military or civilian clinical facility rendering bedside care to clients with developmental disabilities.³³

Neuropsychiatric disorder is a blanket medical term that encompasses a broad range of medical conditions that involve both *neurology and psychiatry*.³⁴ The requirement that military personnel applying for licensure through military training and service, must have completed a course involving neuropsychiatric nursing and a course in the case of the developmentally

³¹ See Attachment 1, Section 4502.5.

³² Business and Professions Code Section 2576.7. (Emphasis added)

³³ https://www.bvnpt.ca.gov/applicants/summary_pt.shtml, Section B (3) Nursing Service in the Medical Corps of any Branch of the Armed Forces of the United States. (Emphasis added).

³⁴ <https://www.nicklauschildrens.org/conditions/neuropsychiatric-disorders>; <https://www.merriam-webster.com/dictionary/neuropsychiatry>.

disabled client, mirrors the *scope of practice of PTs*. LVN licensure by examination, on the other hand, has different requirements:

Application for Vocational Nurse Licensure by Examination:

Method #4 - Military Applicants: This method requires no less than 12 months of active duty bedside patient care on a hospital ward, completion of the *basic course of instruction in nursing* while in the armed forces and proof that service has been honorable.³⁵

By contrast, the requirements for military personnel applying for licensure as an LVN through military training and service, requires completion of a *basic course of instruction in nursing*, mirroring the scope of practice of LVNs who provide nursing care *to all patients in all settings* under specified conditions. This difference in the acceptable training courses for military training and practice when applying for the licensure examination as a PT or as an LVN, demonstrates a significant difference in the training standards of PTs in comparison to those of LVNs.

- **LVNs Have Educational Preparation in Diverse Settings and With Diverse Patient Populations**

LVNs perform services applying those technical, manual skills acquired in approved schools of vocational nursing practiced under the direction of a physician or registered nurse.³⁶ When directed by a physician and surgeon, an LVN is authorized to administer medication including by hypodermic injection and, with appropriate instruction and documented competency to the satisfaction of the board, withdraw blood from a patient and start and superimpose intravenous fluids.³⁷ 16 CCR §2533 Curriculum Content for LVNs and 16 CCR §2587 for PTs share many common elements. However, as noted above, the focus of LVNs on nursing practice theory and clinical practice provides much more time in nursing science than those of approved PT schools. PT clinical practice requirements is heavily weighted toward care for persons with mental or emotional illness or intellectual disabilities.

PTs work in general acute care hospitals (GACH) *in psychiatric units* under the direction of a registered nurse who is responsible for all of the nursing care provided in that setting.³⁸ PTs may also provide private duty patient care *to patients with mental disorders or developmental disabilities* under the direction of an RN who directs nursing care, the patient's physician who

³⁵ https://www.bvnpt.ca.gov/applicants/application_for_vocational_nurse_licensure_by_examination.shtml, #4 Military Applicants. (Emphasis added)

³⁶ Business and Professions Code Section 2859.

³⁷ Subcutaneous or intramuscular only.

³⁸ 22 CCR §§ 70217(a), 70217(a)(13), 70579(c).

directs medical care, or be responsible to the director of the service in which the duties are performed.³⁹

By comparison, LVNs are allowed to work in every patient care unit of a GACH, except for the Intensive Care Newborn Nursery, providing nursing care to patients, within their scope of practice.⁴⁰ Private duty LVN patient care may be performed in any setting, under the direction of an RN who directs nursing care and/or the patient's physician who directs medical care.⁴¹

PARENTERAL MEDICATION ADMINISTRATION & "INTRAVENOUS THERAPY"

- **Hypodermic Injection of Medication is an Archaic Term Referring to The Subcutaneous Administration of Medication**

According to Essentials of Nursing Practice, there are three routes for administering medication: oral routes, topical routes, and parenteral routes. Parenteral routes are defined as follows:

Parenteral Routes. Injection of medication into body tissues and not by the gastro-intestinal tract.

- Intradermal: Injection into the dermis just under the epidermis.
- Subcutaneous: Injection into tissues just below the dermis of the skin.
- Intramuscular: Injection into a muscle.
- Intravenous: Injection into a vein⁴²

Under existing law, an LVN is permitted to administer medications by oral routes, topical routes and parenterally by "hypodermic injection" (i.e., subcutaneously), intradermal injection (e.g. TB skin tests), and intramuscular injection (e.g., immunizations) when directed by a physician and surgeon.⁴³ LVNs are not permitted to administer intravenous medication and, pursuant to a 2005 superior court decision, the BVNPT is prohibited from adopting a regulation authorizing LVNs to administer intravenous medications by §2860.5 of the B&P Code.⁴⁴

The draft language changes the scope of practice of LVNs and PTs through rulemaking *by seeking broad statutory authority to enhance scope of practice through continuing education*

³⁹ 16 CCR § 2576.7. The director may be a licensed physician & surgeon, psychiatrist, psychologist, rehabilitation therapist, social worker, registered nurse, or other professional personnel. The registered nurse, physician or director of the service must be responsible for direct to the private duty PT regarding the respective nursing and medical procedures. The direction provided must be available at least by telephone.

⁴⁰ 22 CCR §§ 70215(a)(2), 70217(a).

⁴¹ 16 CCR § 2518.7.

⁴² Potter and Perry, *Essentials of Nursing Practice*, Ninth Edition, Elsevier, 2019, at 387-389.

⁴³ Business and Professions Code Sections 2860.5(a), 2860.7; 16 CCR § 2518.5(b)(2).

⁴⁴ See Attachment 7, California Nurses Association vs. BVNPT (2005) Sacramento Superior Court Case No. 00AS00900, at 15.

*courses and with the exclusive approval of the BVNPT.*⁴⁵ The BVNPT's regulations were set aside by the court in its previous attempt at expanding the scope of practice of LVNs to administer intravenous medications.⁴⁶ However, with this new and expanded statutory authority, the rulemaking process could be utilized to make the changes in LVN scope of practice the Board sought in 2002 but that were rejected by the superior court in 2005.⁴⁷

The California superior court decision illustrates the fact that "hypodermic injection," as it currently applies to LVNs and, therefore to PTs, does not mean intravenous and must therefore only refer to the subcutaneous administration of medication. The intradermal, and intramuscular routes of administration of medication are authorized for TB application and immunizations, respectively.⁴⁸ LVNs are also permitted to start and superimpose intravenous fluid solutions of electrolytes, nutrients, vitamins, blood and blood products under specified conditions and when directed by a physician and surgeon.⁴⁹ PTs do not have the authority to start or superimpose intravenous fluid solutions.⁵⁰

The PT has the authority to administer medications by oral or topical routes used in the care and treatment of mentally ill or emotionally disturbed persons or persons with intellectual disabilities when ordered by a licensed physician or psychiatrist.⁵¹ A PT, when working in a mental health facility or developmental disability facility, may administer medication by "hypodermic injection" when prescribed by a physician and surgeon. Like LVNs, PTs may administer intradermal skin tests (e.g. TB skin test) and intramuscular injections (e.g. immunizations) but only on a patient with a mental illness or developmental disability.⁵² As noted above, PTs do not have the authority to administer intravenous medication in any setting or to any patient and, unlike LVNs, are also not able to start and superimpose intravenous fluids.⁵³

⁴⁵ See Attachment 1, Sections 2859.1, 4502.4.

⁴⁶ See Attachment 7, at 1.

⁴⁷ *Id.*, at 8-9.

⁴⁸ *Id.*, at 8.

⁴⁹ Business and Professions Code Section 2860.5(c); 16 CCR § 2547(a).

⁵⁰ Business and Profession Code Sections 2860.5 and 2860.7.

⁵¹ Business and Professions Code Sections 4502(a), 4502.1, 4502.3.

⁵² Business and Professions Code Section 4502.3.

⁵³ Business and Professions Code Section 2860.5(c).

- **Subcutaneous, Hypodermic and Intramuscular Routes Could Involve Scope of Practice Expansion to allow for the Administration of Medication Via A Parenteral Route Below the Dermis**

Hypodermic means beneath the dermis (i.e., the subcutaneous tissue).⁵⁴ The proposed language amends Business and Professions Code Section 2860.5 to modify the term “hypodermic injection” by (1) deleting “injection,” so that Section 2860.5 (a) would read:

- (a) Administer medications by routes that include but are not limited to:
oral, subcutaneous, hypodermic, and intramuscular routes...

Unless the redundant use of hypodermic and subcutaneous is a drafting error, it is not clear why it remains in the newly proposed language or, if not a redundant use, what route of parenteral administration it intends to reference. The draft language would grant BVNPT broad authority over the routes of administration of medication since, when read in conjunction with the authority sought in Section 2859.1(a) and Section 4502.4(a), the BVNPT could “enhance” the scope of practice of LVNs and/or PTs beyond manual and technical skills into areas of medication administration requiring *a substantial amount of scientific knowledge and technical skill*, though continuing education approved by the BVNPT.⁵⁵

Administering medications by hypodermic injection, withdrawal of blood from a patient, and starting and superimposing intravenous fluids under specified conditions were all practices determined by the Legislature to be appropriate for the LVN scope of practice.⁵⁶ For example, with respect to starting and superimposing intravenous fluids, the Legislature determined the acceptable conditions (e.g. satisfactory completion of a prescribed course of instruction approved by the BVNPT), the acceptable environment of care (e.g., organized health systems), and the method of professional review outside of the BVNPT (e.g., in accordance with written standardized procedures adopted by the organized health care system as formulated by a committee which includes representatives of the medical, nursing and administrative staffs) for the scope enhancements.⁵⁷ The draft language would rely only upon the BVNPT’s notion of appropriate specialized continuing education certification courses to make potentially significant change in the scope of practice of LVNs and PTs who are not independent practitioners.

⁵⁴ Potter, *supra* note 45, at 813.

⁵⁵ The definition of registered nursing is the application of skills that require *a substantial amount of scientific knowledge and technical skill* (Business and Professions Code Section 2725(b) and is one of the differences between the practice of RNs and that of LVNs (Business and Professions Code Section 2859).

⁵⁶ Business and Professions Code Section 2860.5.

⁵⁷ Business and Professions Code Section 2860.5.

- **“Intravenous Therapy” as a Substitute for Starting and Superimposing Intravenous Fluids**

Intravenous means injection into a vein and therapy refers to a treatment.⁵⁸ As such, the term Intravenous Therapy is a broad term that includes the intravenous administration of medications, therapeutic fluids, chemotherapeutic agents, vasoactive medications and other critical medical therapies that require a substantial amount of scientific knowledge and technical skill.⁵⁹ The starting and superimposing of intravenous fluids containing electrolytes, vitamins, blood and blood products is the subcategory of fluids that an LVN is currently authorized to administer after fulfilling specific requirements. The use of “Intravenous Therapy” in statute significantly expands the potential intravenous therapies that could be authorized by the BVNPT for administration by LVNs especially given the expansive language proposed in new Section 2859.1, as discussed earlier.

CNA’s concern over an overly broad interpretation, now or in the future, by the BVNPT of “intravenous therapy” is wholly consistent with the Board’s expansive interpretation of intravenous therapy in the past. For example, the Board sought a new legal opinion by Department of Consumer Affairs (DCA) legal counsel to submit to the OAL for consideration after the initial disapproval of the regulations submitted to the Office of Administrative Law. This opinion stated the following:

“Intravenous” is defined as “situated within, performed within, occurring within, or administered by entering a vein” Merriam Webster Medical Dictionary. A “fluid” is defined as “a substance (as a liquid or gas) tending to flow or conform to the outline of its container; *specifically*: one in the body of an animal or plant.” [Emphasis in original; references omitted.] The term “intravenous fluids” in section 2860.5 above is a broad term that can and does include any fluid that can be administered intravenously, including fluids of “medications” (as they are referred to in the comments). If the Legislature had intended to prevent what the opponents contend are “medicated” intravenous fluids from being started or superimposed by LVNs pursuant to section 2860(c), it could easily have so stated by simply inserting the adjective “non-medicated” before “intravenous fluids.” It did not.⁶⁰

The arguments made in the DCA opinion were rejected by the court and—after three years of briefs, hearings, court testimony, and legal costs—the court granted the peremptory writ of

⁵⁸ Potter, *supra* note 45, at 389; <https://medical-dictionary.thefreedictionary.com/intravenous+therapy>.

⁵⁹ <https://summitmedicine.net/iv-therapy/>, <http://www.lemmo.com/cancer-care/intravenous-therapy/>, <https://peoplebeatingcancer.org/top-benefits-of-iv-therapy/>, <https://www.nursingtimes.net/clinical-archive/assessment-skills/nt-skills-intravenous-therapy-10-12-2002/>.

⁶⁰ Memorandum from Department of Consumer Affairs Legal Office, *Authority for Intravenous Therapy Regulatory Amendments*, June 4, 2002, at 4.

mandamus, requiring the BVNPT to permanently set aside the amended *intravenous therapy* regulations. The court completely rejected the misconstruing of intravenous fluids and medications used to justify the unauthorized expansion of the scope of practice of LVNs.

Finally, while we understand that the BVNPT and Respiratory Care Board were responding to competency deficiencies in LVN care of patients on invasive mechanical ventilation, it is important to also note that such patient care errors by licensed practitioners resulting in patient harm is not limited to LVNs providing respiratory care (See Attachment 8).

Training and competency validation is only one aspect of providing safe patient care. Any licensed health care provider that fails to follow the standards of practice of their profession poses a risk to vulnerable patients dependent on their care. When these patient care incidents occur, it is the responsibility of the licensing board to determine whether the violations of the scope of practice of the profession, causing patient harm, should result in discipline with practice remediation or license revocation.

Thank you again for the opportunity to comment. If you have any questions, please do not hesitate to contact me at skim@calnurses.org or (916) 491-3204. Thank you.

Sincerely,
CALIFORNIA NURSES ASSOCIATION/
NATIONAL NURSES UNITED, AFL- CIO

A handwritten signature in blue ink, appearing to be 'Saskia Kim', with a long, sweeping underline.

Saskia Kim
Regulatory Policy Specialist

Attachments

Attachment 1

12/13/19

DEPARTMENT OF CONSUMER AFFAIRS
BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS

PROPOSED STATUTORY LANGUAGE
CALIFORNIA BUSINESS AND PROFESSIONS CODE
Chapter 6.5. VOCATIONAL NURSING

New language is *italicized* and in blue.

Deleted language is shown in ~~strikeout~~ and in red.

(1) Add Section 2859.1; Article 2, Chapter 6.5, Division 2 of the California Business and Professions Code to read as follows:

§2859.1

The licensed vocational nurse may enhance basic scope of practice as identified in section 2859 and have their license modified by successfully completing specialized continuing education certification courses approved by the board including but not limited to: intravenous therapy, blood withdrawal, intravenous therapy with blood withdrawal, or care for patients on mechanical ventilation.

(2) Add Section 2859.2; Article 2, Chapter 6.5, Division 2 of the California Business and Professions Code to read as follows:

§2859.2

(a) The board will accept a verification of competency form as prescribed by the board from the licensed vocational nurse's employer verifying the licensed vocational nurse has completed formal training and has demonstrated competency to provide care for patients on mechanical ventilation. The board will add a temporary license modifier recognizing the licensed vocational nurse's additional training in the care for patients on mechanical ventilation.

(b) The employer of a licensed vocational nurse who provides care for patients on mechanical ventilation on or before December 31, 2020, shall submit to the board a verification of competency form as specified in section 2859.2(a), no later than July 1, 2021.

(c) The employer of a licensed vocational nurse who provides care for patients on mechanical ventilation on or after January 1, 2021, shall submit to the board a verification of competency form as specified in section 2859.2(a), no later than July 1, 2021 or 60 days after a licensed vocational nurse begins providing care for patients on mechanical ventilation, whichever date is later.

(d) This section shall remain in effect only until December 31, 2023, and as of that date is repealed, unless a later enacted statute, that is enacted before December 31, 2023, deletes or extends that date.

(3) Add Section 2859.3, Article 2, Chapter 6.5, Division 2 of the California Business and Professions Code to read as follows:

§2859.3

(a) A licensed vocational nurse who obtains a temporary modified license under section 2859.2(a) shall complete a board-approved certification course in the care for patients on mechanical ventilation, as described in regulation, no later than December 31, 2023.

(b) All temporary license modifiers related to care for patients on mechanical ventilation will be cancelled on December 31, 2023.

(c) On or after January 1, 2024, all licensed vocational nurses who provide care for patients on mechanical ventilation must complete a board-approved certification course in the care for patients on mechanical ventilation prior to providing care to patients on mechanical ventilation.

(4) Amend Section 2860.5, Article 2, Chapter 6.5, Division 2 of the California Business and Professions Code to read as follows:

§2860.5

A licensed vocational nurse ~~when directed by a physician and surgeon~~ may do all ~~of~~ the following ~~per a patient-specific order from a licensed physician~~:

(a) Administer medications by routes that include but are not limited to: oral, subcutaneous, hypodermic ~~injection~~, and intramuscular routes except for those specialized medications that require a knowledge base or level of assessment that exceeds the scope of practice of the licensed vocational nurse.

(b) ~~Withdraw blood from a patient, if prior thereto such nurse has been instructed by a physician and surgeon and has demonstrated competence to such physician and surgeon in the proper procedure to be employed when withdrawing blood, or has satisfactorily completed a prescribed course of instruction approved by the board, or has demonstrated competence to the satisfaction of the board.~~

If the licensed vocational nurse has satisfactorily completed a prescribed course of instruction approved by the board or has demonstrated competence to the satisfaction of the board in:

- (1) Blood withdrawal.
- (2) Intravenous therapy.
- (3) Care for patients on mechanical ventilation.

~~(c) Start and superimpose intravenous fluids if all of the following additional conditions exist:~~

~~(1) The nurse has satisfactorily completed a prescribed course of instruction approved by the board or has demonstrated competence to the satisfaction of the board.~~

~~(2) The procedure is performed in an organized health care system in accordance with the written standardized procedures adopted by the organized health care system as formulated by a committee which includes representatives of the medical, nursing, and administrative staffs. "Organized health care system," as used in this section, includes facilities licensed pursuant to Section 1250 of the~~

~~Health and Safety Code, clinics, home health agencies, physician's offices, and public or community health services. Standardized procedures so adopted will be reproduced in writing and made available to total medical and nursing staffs.~~

(5) Amend Section 2892.7, Article 6, Chapter 6.5, Division 2 of the California Business and Professions Code to read as follows:

§2892.7

The board shall collect an initial approval and a biennial renewal fee in the amount of one hundred fifty dollars (\$150) unless a higher fee, not to exceed two hundred fifty dollars (\$250), is established by the board, from any provider *requesting approval by the board to provide certification courses that include but are not limited to* ~~of a course in~~ intravenous therapy, blood withdrawal, ~~or intravenous therapy with blood withdrawal, or care for patients on mechanical ventilation who requests approval by the board of such a course for purposes of intravenous therapy, blood withdrawal, or intravenous therapy with blood withdrawal requirements under this chapter.~~ That fee, however, shall not exceed the ~~regulatory~~ cost required for the board to administer the approval of intravenous therapy, blood withdrawal, ~~or intravenous therapy with blood withdrawal, or care for patients on mechanical ventilation courses by intravenous therapy, blood withdrawal, or intravenous therapy with blood withdrawal~~ providers.

(6) Amend Section 2895, Article 6, Chapter 6.5, Division 2 of the California Business and Professions Code to read as follows:

§2895

The amount of the fees prescribed by this chapter in connection with the issuance of licenses under its provisions shall be according to the following schedule:

(a) – (k)...

(l) The fee to be paid for postlicensure certification *including but not limited to:* intravenous therapy, blood withdrawal, ~~or intravenous therapy with blood withdrawal, or care for patients on mechanical ventilation~~ shall be twenty dollars (\$20) unless a higher fee, not to exceed fifty dollars (\$50), is established by the board.

**DEPARTMENT OF CONSUMER AFFAIRS
BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS**

**PROPOSED STATUTORY LANGUAGE
CALIFORNIA BUSINESS AND PROFESSIONS CODE
Chapter 10. PSYCHIATRIC TECHNICIANS**

New language is *italicized* and in blue.

Deleted language is shown in ~~strikeout~~ and in red.

(7) Amend Section 4502.1, Article 1, Chapter 10, Division 2 of the California Business and Professions Code to read as follows:

§4502.1

~~A psychiatric technician, working in a mental health facility or developmental disability facility, when prescribed by a physician and surgeon, may administer medications by hypodermic injection.~~

A licensed psychiatric technician may do all the following per a patient-specific order from a licensed physician:

- (a) Administer medications by routes that include but are not limited to: oral, subcutaneous, hypodermic, and intramuscular routes except for those specialized medications that require a knowledge base or level of assessment that exceeds the scope of practice of the psychiatric technician.*
- (b) If the psychiatric technician has satisfactorily completed a prescribed course of instruction approved by the board or has demonstrated competence to the satisfaction of the board in:
 - (1) Blood withdrawal.*
 - (2) Care for patients on mechanical ventilation.**

(8) Amend Section 4502.2, Article 1, Chapter 10, Division 2 of the California Business and Professions Code to read as follows:

§4502.2

~~A psychiatric technician, when prescribed by a physician and surgeon, may withdraw blood from a patient with a mental illness or developmental disability if the psychiatric technician has received certification from the board that the psychiatric technician has completed a prescribed course of instruction approved by the board or has demonstrated competence to the satisfaction of the board.~~

Practicing as a psychiatric technician within the meaning of this chapter is the performance of services requiring those technical, manual skills acquired by means of a course in an approved school for preparation of psychiatric technicians, or its equivalent, and is responsible to the director of the service in which their duties are performed. The director may be a licensed physician, psychiatrist, psychologist, rehabilitation therapist, social worker, registered nurse, or other professional personnel.

(9) Add Section 4502.4, Article 1, Chapter 10, Division 2 of the California Business and Professions Code to read as follows:

§4502.4

The psychiatric technician may enhance basic scope of practice as identified in section 4502.1 and have their license modified by successfully completing specialized continuing education certification courses approved by the board including but not limited to: blood withdrawal or care for patients on mechanical ventilation.

(10) Add Section 4502.5, Article 1, Chapter 10, Division 2 of the California Business and Professions Code to read as follows:

§4502.5

(a) The board will accept a verification of competency form as prescribed by the board from the psychiatric technician's employer verifying the psychiatric technician has completed formal training and has demonstrated competency to provide care for patients on mechanical ventilation. The board will add a temporary license modifier recognizing the psychiatric technician's additional training in the care for patients on mechanical ventilation.

(b) The employer of a psychiatric technician who provides care for patients on mechanical ventilation on or before December 31, 2020, shall submit to the board a verification of competency form as specified in section 4502.5(a), no later than July 1, 2021.

(c) The employer of a psychiatric technician who provides care for patients on mechanical ventilation on or after January 1, 2021, shall submit to the board a verification of competency form as specified in section 4502.5(a), no later than July 1, 2021 or 60 days after a psychiatric technician begins providing care for patients on mechanical ventilation, whichever date is later.

(d) This section shall remain in effect only until December 31, 2023, and as of that date is repealed, unless a later enacted statute, that is enacted before December 31, 2023, deletes or extends that date.

(11) Add Section 4502.6, Article 1, Chapter 10, Division 2 of the California Business and Professions Code to read as follows:

§4502.6

(a) A psychiatric technician who obtains a temporary modified license under section 4502.5(a) shall complete a board-approved certification course in the care for patients on mechanical ventilation, as described in regulation, no later than December 31, 2023.

(b) All temporary license modifiers permitting a psychiatric technician to care for patients on mechanical ventilation will be cancelled on December 31, 2023.

(c) After December 31, 2023, all psychiatric technicians who provide care to for patients on mechanical ventilation will complete a board-approved certification course in the care for patients on mechanical ventilation prior to providing care to patients on mechanical ventilation.

(12) Amend Section 4518, Article 2, Chapter 10, Division 2 of the California Business and Professions Code to read as follows:

§4518

In the event the board adopts a continuing education, ~~or blood withdrawal, or care for patients on mechanical ventilation~~ program, the board shall collect an initial approval and a biennial renewal fee ~~as prescribed under Sections 4548 and 4518.1~~ of one hundred and fifty dollars (\$150) unless a higher fee, not to exceed two hundred fifty dollars (\$250), is established by the board from any provider ~~of a course in requesting approval by the board to provide courses for the purposes of continuing education, or blood withdrawal, or care for patients on mechanical ventilation who requests approval by the board of the course for purposes of continuing education or blood withdrawal requirements adopted by the board.~~ The fee, however, shall in no event exceed the cost required for the board to administer the approval of ~~continuing education or blood withdrawal courses by~~ continuing education, ~~or blood withdrawal, or care for patients on mechanical ventilation~~ course providers.

(13) Abolish Section 4518.1, Article 2, Chapter 10, Division 2 of the California Business and Professions Code to read as follows:

§4518.1

~~The board shall collect an initial approval and a biennial renewal fee in the amount of one hundred fifty dollars (\$150) unless a higher fee, not to exceed two hundred fifty dollars (\$250), is established by the board, from any provider of continuing education or a course to meet the certification requirements for blood withdrawal who requests approval by the board of the course for purposes of continuing education or blood withdrawal requirements under this chapter. That fee, however, shall not exceed the regulatory cost required for the board to administer the approval of continuing education or blood withdrawal by continuing education or blood withdrawal providers.~~

(14) Amend Section 4548, Article 6, Chapter 10, Division 2 of the California Business and Professions Code to read as follows:

§4548

The amount of the fees prescribed by this chapter in connection with the issuance of licenses under its provisions shall be according to the following schedule:

(a) – (k) ...

(l) The fee to be paid for postlicensure certification *including but not limited to:* blood withdrawal or care for patients on mechanical ventilation shall be twenty dollars (\$20) unless a higher fee, not to exceed fifty dollars (\$50), is established by the board.

Attachment 2



**RESPIRATORY
CARE BOARD
OF CALIFORNIA**



**BVNPT
BOARD OF VOCATIONAL NURSING
AND PSYCHIATRIC TECHNICIANS**

**Respiratory Care Board of California and
Board of Vocational Nursing and Psychiatric Technicians
Joint Statement – April 2019 (Revised July 2019)**

The Respiratory Care Board (RCB) and the Board of Vocational Nursing and Psychiatric Technicians (BVNPT) began meeting in 2018 to discuss concerns related to reports of scope of practice issues occurring in sub-acute facilities, long-term care, and skilled nursing facilities in California. Board members, staff, legal counsel and experts weighed in on the issues by considering current laws, education and training. Prioritizing both boards’ highest priority of public protection, the boards have agreed on a joint statement.

Both boards agree that respiratory care practitioners (RCPs), licensed vocational nurses (LVNs) and psychiatric technicians (PTs) are invaluable members of the patient care team in providing optimum care to patients. Each health care professional relies on others to perform their practice well. They establish a therapeutic interface among all health care personnel that benefits patients in their care and safety.

Both boards’ mandates require that “protection of the public shall be the highest priority... in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.” (*Business and Professions Code sections 2841.1, 3710.1 and 4501.1*) Each board’s oversight responsibility is summarized below:

Respiratory Care Board of California (RCB)	Board of Vocational Nursing and Psychiatric Technicians (BVNPT)
Responsible for licensing and regulating the practice of respiratory care pursuant to the Respiratory Care Practice Act (<i>Business and Professions Code section 3700 et seq.</i>). The RCB is statutorily charged with protecting the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care (<i>Business and Professions Code section 3701</i>).	Responsible for licensing and regulating the practice of vocational nurses and psychiatric technicians pursuant to the Vocational Nursing Practice Act and the Psychiatric Technicians Law (<i>Business and Professions Code Section 2840 et seq. and Section 4500 et seq., respectively</i>).

The boards jointly agree that stakeholders should be aware that RCPs, LVNs and PTs must follow their respective scopes of practice for patient safety. Violating the respective scope of practice could lead to patient harm and the license being formally disciplined by the respective boards.

A concern to both boards is unlicensed and/or unqualified vendors instructing health care professionals to provide ventilator care. Both boards agree this is an unsafe practice. Further, section 3702.7 of the Business and Professions Code provides that the education of health care professionals about respiratory care, including clinical instruction and the operation or

application of respiratory care equipment and appliances is within the respiratory care scope of practice and would require licensure as an RCP.

Given that numerous patients admitted to sub-acute facilities, long-term care, and skilled nursing facilities require respiratory care, with some dependent upon ventilators to sustain life, and given concerns for care that is being provided at some facilities in California, the RCB and the BVNPT issues this joint statement to inform administrators and staff at sub-acute facilities, long-term care, and skilled nursing facilities on the following issues:

PATIENT CARE PRACTICES

Invasive Mechanical Ventilation

Invasive mechanical ventilation is a lifesaving intervention for patients with respiratory failure and is at the core of respiratory care practitioners' education, training, and competency testing. Given the clinical knowledge of the hazards, indications, contraindications of mechanical ventilation, and complexity associated with invasive mechanical ventilation, and that extensive and formal education and training is required to provide such care.

Respiratory Care Practitioners are authorized to provide the following types of care (LVNs and PTs are not authorized to provide this care):	Licensed Vocational Nurses and Psychiatric Technicians role in patient care:
<ul style="list-style-type: none"> • Changing any setting on a ventilator, with or without a physician's order. • Routine and/or emergent changing inner and/or outer cannulas. • Reconfiguring or changing aerosol or ventilator circuits. • Manipulating ventilator breathing circuits including disconnecting or reconnecting the circuit, for any purpose, including, but not limited to administering bronchodilator or nebulizer treatments. • Troubleshooting artificial airway problems and ventilator-related controls and alarms. • Assessment of a patient's response to ventilator adjustments or current settings. • Assessment for the placement and/or placement of a speaking valve or trach plugging. • Transporting patients intra or inter facility to daily activities and/or scheduled shower days. 	<p>The LVN and PT are authorized to provide care to the patient receiving invasive mechanical ventilation when the care is not specifically related to the mechanical ventilation but is within the LVN or PT's scope of practice. That care includes but is not limited to:</p> <ul style="list-style-type: none"> • Basic Assessment (data gathering) of <u>total</u> patient. • Administration of ordered medications that do not require manipulation of the mechanical ventilator. • Provision of ordered treatments. • Hygiene care. • Comfort care. • Patient and family education. • LVNs and PTs are <u>not</u> responsible for ensuring the security of the artificial airway and related functionality of the ventilator before, during and after transport. However, LVNs and PTs can go as part of the team, but they are not responsible for the ventilator or related care.

CARE/TREATMENT PLANS

Respiratory Care Practitioner	Licensed Vocational Nurses and Psychiatric Technicians
Recommend appropriate respiratory care intervention/s, and manage, or modify, respiratory care interventions based on the patient's response to therapy and written protocols approved by the medical staff.	Contribute data to the registered nurse needed for the evaluation process. However, LVNs and PTs cannot make clinical diagnosis of the patient's respiratory condition, and/or make respiratory care recommendations based on their clinical findings.

Both boards recognize that working titles using any derivative or synonymous meaning of the word "respiratory" for LVNs and PTs is prohibited. This includes but is not limited to: Respiratory Aide, Respiratory Nurse, Inhalation Nurse, etc.

Scope of Practice Questions and Information

Both Boards prefer written inquiries to ensure accurate and complete responses. Phone calls are accepted, and you will be requested to submit the inquiry in writing. Responses to written inquiries may take up to five business days depending on the complexity of the question.

Respiratory Care Board	Board of Vocational Nursing and Psychiatric Technicians
E-mail: rcbinfo@dca.ca.gov Telephone: 916.999.2190 Toll-free: 866-375-0386 Website: www.rcb.ca.gov	Email: bvnpt.sop@dca.ca.gov Telephone: 916.263.7843 Website: www.bvnpt.ca.gov

July 2019 Revision

Both boards agreed to remove "home care locations" from the Joint Statement in response to numerous comments received at the RCB's teleconference board meeting held June 7, 2019 and a stakeholder meeting held June 27, 2019. At the RCB meeting, the board passed a motion "to move forward with excluding home care and continuing working with the BVNPT to modify the Joint Statement."

It was noted at all meetings that services provided in home care, as well as Adult Day Health Care Facilities, Congregate Living Health Facilities, and Pediatric Day Health & Respite Care Facilities [including transport to/from and care during daily outside activities (e.g. school)] serve a population who may need greater access to care and may hold different expectations for care given consideration to patients' quality of life and health care reimbursement allowed. For this reason, both the BVNPT and the RCB will continue conducting research in this area to determine how greater consumer protection safeguards may be put in place such as possible standardization of training in some areas. Any such actions are expected to be addressed through regulations and/or legislation where public comment is encouraged.

Attachment 3

Date: 9/13/2004

Subject: LVN and Intravenous Therapy and Scope of Practice

The information included in this paper is provided as general information only. This information should not be considered complete or dispositive guidance for legal or regulatory compliance. The specific application of laws and regulations to an organization requires a careful consideration of all the relevant facts and circumstances and may require assistance of competent legal counsel.

Question:

I have not been able to find in either the CoP's, Title XXII, or the LVN practice act that LVN's are **not permitted** to provide IV therapy services in the home (with proper credentialing of course) I have always understood that they are not permitted to but I can't find any documentation to back that up. Can someone tell me for a fact that they know one way or the other?

Answer:

The LVN Code of Regulations is vague on this issue. For example, Section 2518.5 on the Scope of Vocational Nursing Practice in Regulation only states that the LVN performs services requiring **technical and manual skills** which include the following:

(a) Uses and practices basic assessment (data collection), **participates** in planning, executes interventions in accordance with the care plan or treatment plan, and contributes to evaluation of individualized interventions related to the care plan or treatment plan.

(b) Provides direct patient/client care by which the licensee:

- (1) Performs basic nursing services as defined in subdivision (a);
- (2) Administers medications;
- (3) Applies communication skills for the purpose of patient/client care and education;
- (4) Contributes to the development and implementation of a teaching plan related to self-care for the patient/client.

However, per the Board of Licensed Vocational Nurses and Psychiatric Technicians, LVNs **may not** administer any IV medications or administer IV therapies through a central line. An LVN **may** administer IV therapies/fluids (Category I ONLY) through a peripheral line if IV certified. Category I fluids are defined in the California Code of Regulations on Vocational Nurses, Division 25, Chapter 1, Section 2542 on page 25 as "blood, blood products, vitamins, nutrients and electrolytes." (There are Category II fluids, but they only apply in hemodialysis, pheresis or blood bank settings, which would not apply to a home health setting.)

Specifically, Section 2860.5 of the Nurses Practice Act indicates:

"A licensed vocational nurse when directed by a physician and surgeon may do all of the following:

(a) Administer medications by hypodermic injection.

(b) Withdraw blood from a patient, if prior thereto such nurse has been instructed by a physician and surgeon and has demonstrated competence to such physician and surgeon in the proper procedure to be employed when withdrawing blood, or has satisfactorily completed a prescribed course of instruction approved by the board, or has demonstrated competence to the satisfaction of the board.

(c) Start and superimpose intravenous fluids if all of the following additional conditions exist:

(1) The nurse has satisfactorily completed a prescribed course of instruction approved by the board or has demonstrated competence to the satisfaction of the board.

(2) The procedure is performed in an organized health care system in accordance with the written standardized procedures adopted by the organized health care system as formulated by a committee which includes representatives of the medical, nursing, and administrative staffs. "Organized health care system," as used in this section, includes facilities licensed pursuant to Section 1250 of the Health and Safety Code, clinics, home health agencies, physician's offices,

and public or community health services. Standardized procedures so adopted will be reproduced in writing and made available to total medical and nursing staffs.

See the LVN Regulations, Article 8 (Intravenous Therapy), Section 2542-2542.5 for the details of these requirements at: <http://www.bvnpt.ca.gov/pdf/vnregs.pdf>

Further, home health regulations further limit the scope of an LVN in home health in Title 22, Section 74707 (b), which essentially indicates that an LVN can not do the following in home health:

- 1) Provide the initial nursing assessment prior to the provision of care, provide the ongoing periodic assessment of the patient and initiate preventative and rehabilitative nursing procedures (Section 74707 (a) (2))
- 2) Assist in coordinating all services provided (Section 74707 (a) (4))

Therefore: the difference between an LVN and RN are as follows, per our CAHSAH Health Care: A Health Care Cost Management Tool:

An LVN can not:

1. Perform initial assessments and reassessments (Home Health Specific Prohibition; allowed in LVN scope per Bd of LVN and PT)
2. Develop and implement the plan of care (Source: Not allowed in Home Health or in Scope per Bd of LVN and PT)
3. Can't Administer IV medications or IV therapies through a central line. (Source: Bd of LVN and PT per scope of practice)
[They can administer Category I IV fluids through a peripheral line if IV certified under very specific circumstances.]
1. Regulate Respirators – only under specific conditions can they adjust respirators. (Source: Bd of LVN and PT per scope of practice)

To get the details of the regulations and the LVN practice Act, you should print out the resources below and you can call the Bd of LVN and PT at (916) 263-7800.

Resources:

1. California Code of Regulations, Licensed Vocational Nurses, Division 25, Chapter 1, Vocational Nurses, Article 8, Section 2542-2542.5 (Intravenous Therapy), Article 9, Section 2544-2544.4 (Blood Withdrawal), and Article 10, Section 2547-2556 (Intravenous Therapy/Blood Withdrawal, and Section 2518.5 (Scope of Vocational Nursing Practices) located here: <http://www.bvnpt.ca.gov/pdf/vnregs.pdf>
2. Vocational Nursing Practice Act located here: <http://www.bvnpt.ca.gov/bnppv.htm>, most recent issue – updated as of January 1, 2002
3. CAHSAH Publication – Home Care: A Health Care Cost Management Tool (November 6, 1992) – CAHSAH Office
4. Home Health Regulations specifically specifying LVN services in a home health setting, Title 22, Division 5, Chapter 6, Section 74707 (b) (Skilled Nursing Services)

Attachment 4

BVNPT APPROVED PSYCHIATIC TECHNICIAN PROGRAMS¹

1. Cuesta College (CCC)*

The Psychiatric Technician Program (PSYT) prepares students to utilize the nursing process in the *provision of care and treatment to individuals with mental and/or intellectual impairment* under the supervision of a physician, psychologist and/or registered nurse. Psychiatric Technicians *participate in rehabilitation and treatment programs, assist patients with activities of daily living, and administer medications and treatments.*

The Cuesta Psychiatric Technician courses are taught at the training facilities of the *Department of State Hospitals - Atascadero (DSH-A) in Atascadero, CA*, located half way between Cuesta's San Luis Obispo and Paso Robles campuses. Hands-on internship experience is part of the training.

The program will also provide you with the foundational knowledge and skill sets needed to administer medications, conduct relationship development and participate in group therapy.²

2. Cypress College (CCC)*

A Psychiatric Technician is a licensed member of the professional health services team who *works with individuals who are mentally ill and/or developmentally disabled.* Psychiatric Technicians *find jobs training developmentally disabled individuals in the community or at developmental centers, and caring for mentally ill people in the prison health system or private and state mental hospitals.*³

3. Gurnick Academy Concord

Psychiatric Technicians (PTs) are valued members of today's healthcare team. *They provide care for clients who have mental illnesses and developmental disabilities.* They work under the supervision of a director, such as a physician, psychologist, rehabilitation therapist, social worker, registered nurse, or other professional. *Psychiatric Technicians observe patient behavior, record their condition, help admit and discharge patients, help patients with daily activities such as eating and bathing, and monitor patients' vital signs.*⁴

4. Hacienda La Puente Adult Education

Summary Report for:
29-2053.00 - Psychiatric Technicians

Care for individuals with mental or emotional conditions or disabilities, following the instructions of physicians or other health practitioners. Monitor patients' physical and emotional well-being and report

¹ <https://bvnpt.ca.gov/applicants/program/psychiatric-technician-programs.shtml>, Mission College has provisional approval only.

² <https://www.cuesta.edu/academics/scimath/nah/alliedhealthdept/psychtech/psychtech-catalog.html>, Expires 02/01/21 (Emphasis added)

³ <https://www.cypresscollege.edu/academics/divisions-special-programs/health-science/psychiatric-technology/>, Psychiatric Technology, Expires 8/25/22(Emphasis added)

⁴ <https://www.gurnick.edu/psychiatric-technician-program/>. (Emphasis added)

to medical staff. May participate in rehabilitation and treatment programs, help with personal hygiene, and administer oral or injectable medications.⁵

5. Mission College

Career/Transfer Opportunities: Currently, skilled licensed psychiatric technicians are in high demand both locally and statewide. Career opportunities include the following: *training developmentally disabled individuals in the community or developmental centers, and providing care for mentally ill people in the prison health system, private and municipal acute mental health facilities.*⁶

6. Mt. San Antonio (CCC)*

The Psychiatric Technician Program enables the student to gain the knowledge of basic nursing skills, mental health principles and psychodynamics *that contribute to the student's comprehension and understanding of the mentally disordered and/or developmentally disabled client.*⁷

7. Napa Valley College (CCC)*

Psychiatric Technician. Licensed Psychiatric Technicians are active members of interdisciplinary teams *in the forefront of care and treatment of Californians with mental illnesses or developmental disabilities.* This is a profession that attracts those who truly want to help improve the quality of life for some of the neediest individuals in today's society.

Career Opportunities. Entry-level pay in California varies from \$3,000 to \$5,800/month, depending on certification or degree completion status. There is a shortage of trained and experienced psych techs in California, with constant demand in the public sector. *Most jobs are concentrated near state hospitals such as Napa State Hospital and Sonoma Developmental Center, but there are many other jobs available within the prison systems, private mental health care facilities and also hospitals are recognizing the use of Psychiatric Technicians on mental health units.*⁸

8. Porterville College (CCC)*

Psychiatric Technology includes the study of the *developmentally disabled, the mentally ill and basic nursing skills.* Courses included are: Fundamentals of Nursing, Medical/Surgical Nursing, Growth and Development, Communications, Developmental Disabilities and Psychiatric Nursing.

This is a three semester certificate program with classes beginning each semester. The program includes classes on the college campus plus *clinical training at Porterville Developmental Center, local mental health clinics, and other approved facilities.* Individuals who successfully complete this program are eligible to take the examination to become a Licensed Psychiatric Technician.

Program Learning Outcomes: Provider of Client Care: The Psychiatric Technician graduate will be able to provide safe client care by determining appropriate nursing interventions to clients with psychiatric

⁵ <https://hlpae-hlpusd-ca.schoolloop.com/gepsychtech>, Program graduates are employed in the following fields: O*Net OnLine link to Summary Report for Psychiatric Technicians, Expires 8/25/22.

⁶ <http://www.missioncollege.edu/catalog/pt.pdf>, Provisional Approval, Expires 11/16/19. (Emphasis added)

⁷ <https://www.mtsac.edu/mental-health/psychiatric/>, Expires 5/13/20. (Emphasis added)

⁸ <http://www.napavalley.edu/academics/HealthOccupations/PTEC/Pages/default.aspx>. Napa Valley College has 2 approved programs, "Traditional" and "Fast Track", Expires 7/28/22. (Emphasis added)

disorders and/or developmental disabilities. The care provided is characterized by consistent critical thinking and problem solving skills, clinical competence within the scope of practice, accountability, effective communication skills, respect for diverse cultures, a commitment to caring, and client education.⁹

9. San Bernardino Valley College (CCC)*

The Psychiatric Technology program is a one-year vocational program that prepares students to work with emotionally, mentally and developmentally disabled clients in a variety of community agencies.¹⁰

Nature of the Work: Psychiatric Technicians care for developmentally disabled, mentally disabled or emotionally disturbed individuals. They work with a team that may include psychiatrists, psychologists, psychiatric nurses, social workers, and therapists. In addition to helping clients/patients to dress, bathe, groom themselves, and eat, socialize with them and lead them in educational and recreational activities. Psychiatric technicians may play card games or other games with patients, watch television with them, or participate in group activities, such as playing sports or going on field trips. They observe clients/patients and report and document any physical or behavioral signs that might be important for the care of clients/patients. They escort/accompany patients to and from therapy and treatment. Because they have such close contact with clients/patients, psychiatric technicians can have a great deal of influence on their outlook and treatment outcomes.¹¹

10. San Joaquin Delta College (CCC)*

A Psychiatric Technician is trained to *care for mentally disordered and developmentally disabled clients*. As a licensed psychiatric technician, you will work under the direction of a physician, psychologist, rehabilitation therapist, social worker, registered nurse or other professional personnel.¹²

11. Santa Rosa Junior College (CCC)*

Psychiatric Technicians perform services for the mentally ill, emotionally disturbed, or developmentally disabled. Under the direction of a physician, psychiatrist, or registered nurse, these services involve nursing and therapeutic procedures in *the areas of interpersonal relationships, rehabilitation of the patient, and teaching social skills, as well as carrying out treatment measures prescribed by a physician or psychiatrist*. Treatment measures include basic nursing care, administration of oral and injectable medications, use of specialized machinery and/or instruments and documentation of observations and care in nursing record.

⁹ <https://www.portervillecollege.edu/general-education/psychiatric-technology-ca>, Expires 6/19/23. (Emphasis added)

¹⁰ <https://www.valleycollege.edu/academic-career-programs/degrees-certificates/psychiatric-technology/>, Expires 2/7/22. (Emphasis added)

¹¹ <https://www.valleycollege.edu/~Media/Files/SBCCD/SBVC/academic-divisions/science/psychiatric-technology/2Typical%20Task%20-%20Psychiatric%20Technology%20Program.pdf>, Expires 2/7/22. (Emphasis added)

¹² <https://www.deltacollege.edu/program/psychiatric-technician>, Expires 9/9/20. (Emphasis added)

Employment can be found at *state developmental centers and psychiatric and correctional facilities*. In addition, program graduates find opportunities in *private institutions and county psychiatric and addiction treatment centers*.¹³

12. West Hills College Coalinga (CCC)*

West Hills' Psychiatric Technician program aims to prepare students for *employment in state hospitals or rehabilitation and treatment centers*. Students will learn basic nursing skills and psychiatric principles in order to interact with and care for individuals.¹⁴

13. Yuba College (CCC)*

Yuba College offers a Psychiatric Technology program at the Marysville Campus. Classes start in the Fall semester, and the program consists of four full semester and one summer session. The program includes *clinical experience, under the direct supervision of a clinical instructor, in agencies that provide services to the developmentally, mentally, and physically disabled*.¹⁵

* California Community College program.

¹³<https://portal.santarosa.edu/SRWeb/ProgramOfStudyPrinterFriendly.aspx?ProgramType=1&Program=003030&Version=04>, Psychiatric Technician Certificate, at 1. Expires 6/19/23.(Emphasis added)

¹⁴ <https://www.westhillscollge.com/coalinga/degrees-and-certificates/psychiatric-technician/>, Expires 6/28/22. (Emphasis added)

¹⁵ <https://yc.yccd.edu/academics/career-technical-education/psych-tech/>, Expires 5/11/21. (Emphasis added)

Attachment 5

- **Health Workforce Initiative of the California Community Colleges**

Psychiatric technicians work with people *who have emotional or mental illness or developmental disabilities*. They care for and interact with patients under the supervision of psychiatrists, psychologists, psychiatric registered nurses and therapists. Psychiatric technicians *help patients dress, bathe, groom and eat*. In addition, they socialize with patients and lead them in their daily recreation, work and treatment activities. This may include playing games, doing crafts and assisting in therapy programs. *They also perform simple nursing tasks, such as taking temperatures, giving medications and accompanying patients to and from patient care units for examination and treatment*. Most important, psychiatric technicians act as companions and helpers to patients who are isolated from the outside world. They observe patients and report any physical or behavioral changes to the professional staff.

*Most psychiatric technicians work for state hospitals. Some work in psychiatric units in general hospitals, private psychiatric hospitals or community mental health centers.*¹

- **American Association of Psychiatric Technicians**

Psychiatric Technicians *provide care for mentally disordered or developmentally disabled clients*. The term "Psychiatric Technician" includes a variety of employees with bachelors degrees or less who are providing direct care to those in need. Some examples of job titles are words such as psychiatric, mental health, or behavioral health, followed by technician, aide, worker, counselor, assistant or associate.

The Psychiatric Technician utilizes scientific and technical expertise, and manual skills to provide care and training *for clients with mental disorders and developmental disabilities*. Psychiatric technicians work in hospitals or group homes and state mental hospitals. *Duties include watching and reporting patient behavior, monitoring vital signs, and helping with basic needs, such as bathing, dressing, and feeding.*²

- **Bureau of Labor Statistics**

Occupational Employment and Wages, May 2018. *29-2053 Psychiatric Technicians: Care for individuals with mental or emotional conditions or disabilities*, following the instructions of physicians or other health practitioners. Monitor patients' physical and emotional well-being and report to medical staff. May participate in rehabilitation and treatment programs, help with personal hygiene, and administer oral or injectable medications.³

- **BVNPT**

An entry-level health care provider who is responsible for care of mentally disordered and developmentally disabled clients.

A psychiatric technician practices under the direction of a physician, psychologist, rehabilitation therapist, social worker, registered nurse or other professional personnel.

The licensee is not an independent practitioner.

- Where are PTs employed?

¹ <https://ca-hwi.org/directory/programs/psychiatric-technician>. (Emphasis added)

² <https://psychtechs.org/>. (Emphasis added)

³ <https://www.bls.gov/oes/current/oes292053.htm>, March 2019 Updated. (Emphasis added)

- State Hospitals
- Day Treatment Centers
- Developmental Centers
- Correctional Facilities
- Psychiatric Hospitals & Clinics
- Psychiatric Technician Programs
- Geropsychiatric Centers
- Residential Care Facilities
- Vocational Training Centers⁴

⁴ https://www.bvnpt.ca.gov/licensees/psychiatric_technician.shtml, 1. What is a psychiatric technician (PR)?, 25. Where are PTs employed?

Attachment 6

Date: 2/13/07

Title: **Psych Tech vs. Licensed Vocational Nurse (LVN)**

The information included in this paper is provided as general information only. This information should not be considered complete or dispositive guidance for legal or regulatory compliance. The specific application of laws and regulations to an organization requires a careful consideration of all the relevant facts and circumstances and may require assistance of competent legal counsel.

Question:

Can we use a Psych Tech in place of an LVN in our home health agency?

Answer:

Neither Title 22, nor the Medicare COPs allow for this. Title 22 Section 74631 states that a "Licensed vocational nurse means a person licensed as such by the California Board of Vocational Nursing and Psychiatric Technician Examiners." Similarly, the Medicare COPs, section 484.4 states that a "Practical (vocational) Nurse is a person who is licensed as a practical (vocational) nurse by the State in which practicing." In many cases, home health regulations are vague, leaving room for interpretation-- but not in this case.

Though the scope of practice for a Psych Tech and an LVN is very similar, the educational and experiential requirements for eligibility of licensure are different. According to the regulations governing these two professions, the two programs are not interchangeable.

Please see links to the regulations below:

<http://www.bvnpt.ca.gov/pdf/ptregs.pdf> Psych Tech regulations

<http://www.bvnpt.ca.gov/pdf/vnregs.pdf> LVN regulations

Attachment 7

**SUPERIOR COURT OF CALIFORNIA
COUNTY OF SACRAMENTO**

**DATE/TIME : JULY 14, 2005
JUDGE : JUDY HERSHER
REPORTER : NONE**

**DEPT. NO : 16
CLERK : D. AHEE
BAILIFF : J. TRAVIS**

**CALIFORNIA NURSES ASSOCIATION,
Petitioner,**

**PRESENT:
PAMELA ALLEN**

VS. Case No.: 00AS00900

**TERESA BELLO-JONES, in her official capacity,
CALIFORNIA BOARD OF VOCATIONAL NURSING AND
PSYCHIATRIC TECHNICIANS, et al,
Respondent.**

**JESSICA AMGWERD
JANICE LACHMAN**

Nature of Proceedings: COURT'S RULING UNDER SUBMISSION

The Court grants CNA's request for a peremptory writ of mandate commanding Respondents to set aside the amended Regulations, and for a permanent Injunction enjoining the implementation and enforcement of the amended Regulations. The Court denies CNA's request for declaratory relief in respect to the October 29, 2001, Advice Letter.

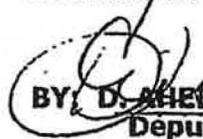
Background Facts and Procedure

This case involves challenges to the validity of (I) a formal regulation purportedly expanding the scope of practice of Licensed Vocational Nurses to include the administration of intravenous medications in certain clinical settings; and (II) alleged "underground regulations" which expand the scope of authority of Licensed Vocational Nurses to include performance of registered nursing functions of patient assessment and access to central intravenous lines.

Prior to 1999, California regulations governing the practice of Licensed Vocational Nurses ("LVNs") did not permit LVNs to administer medication

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**BY:  D. AHEE
Deputy Clerk**

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Intravenously. In or about June 1999, the Board of Vocational Nursing and Psychiatric Technicians ("Board") recommended amending the regulations to permit specially trained LVNs to administer intravenously substances which are routinely given during the course of hemodialysis, pheresis, and blood bank procedures. At a meeting on November 16, 2001, the Board adopted proposed changes to the California Code of Regulations, title 16, sections 2542, 2542.1, 2547, 2547.1 (the "Regulations"), which would have allowed LVNs to administer specified Intravenous medications in hemodialysis, pheresis and blood bank settings under certain conditions. On February 28, 2002, the Board submitted the amended regulations to the OAL for review and approval.

On April 12, 2002, OAL disapproved the Board's proposed regulatory action based on the following three grounds: (1) the proposed regulations enlarge the scope of practice of the LVN and appear to be inconsistent with the Vocational Nursing Practice Act; (2) the Regulations require that a registered nurse or licensed physician be in the "immediate vicinity" of the LVN when the procedure is performed, but the term "immediate vicinity" was not defined and was found to be susceptible to differing interpretations by affected persons; and (3) the micro-cassette recordings of the public hearing included in the rulemaking file was mostly inaudible and there was no transcript or minutes in the file. Notwithstanding OAL's denial, OAL's Decision of Disapproval of Regulatory Action included the following statement:

"We realize that Business and Professions Code section 2860.5 was last amended in 1974, and that modern medical technology has advanced considerably since then. Old definitions and understandings may need to be changed if medical and nursing practice have evolved to the point where professionals in the field would consider such medications as an integral component or ingredient of intravenous fluids. If the Board can supplement the record with facts, studies, expert opinion or other information that tends to show this evolution in nursing practice, these regulations could be resubmitted within 120 days of receipt of this decision for further OAL review and consideration."

On June 5, 2002, in response to the OAL's Decision of Disapproval, the Board proposed modifications to the Regulations and added documents to the

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rulemaking record for the proposed regulatory amendments. To address OAL's other concerns, the Board relied upon a legal memorandum entitled Authority for Intravenous Therapy Regulatory Amendment. It modified the text of the Regulations to provide that the definition of "immediate vicinity" shall be set forth in the standardized procedures of the facility, and to address the issue of missing or defective documents, the Board prepared minutes of the public hearing of April 17, 2001. After giving notice of the proposed modifications to the Regulations, the Board received comments and prepared a Supplement to Final Statement of Reasons.

On June 28, 2002, the Board adopted proposed amendments to sections 2542, 2542.1, 2547, and 2547.1 of the California Code of Regulations. As before, the proposed amendments would allow LVNs who are Board-certified in intravenous therapy to administer "specified intravenous medications" in hemodialysis, pheresis, and blood bank procedures" under certain conditions. On December 13, 2002, the Board submitted its proposed Regulations to the Office of Administrative Law. The amended Regulations were approved by the OAL on January 29, 2003.

On February 24, 2003, Petitioner CNA filed a Complaint for Declaratory and Injunctive Relief against four defendants: Teresa Bello-Jones, the Board, Ruth Ann Terry, and the California Board of Registered Nursing. CNA's Complaint challenged the regulations permitting LVNs to administer medications intravenously. The Complaint also challenged two "underground regulations" allegedly promulgated by the Board in a October 29, 2001, letter to the California Dialysis Council.

On March 21, 2003, CNA filed a First Amended Complaint. A demurrer to the First Amended Complaint was sustained with leave to amend on June 13, 2003.

On June 22, 2003, CNA filed a Second Amended Complaint against the original four defendants. Defendants Ruth Ann Terry and the California Board of Registered Nursing filed a demurrer to the Second Amended Complaint, which was sustained without leave to amend on October 9, 2003. Defendants Ruth Ann Terry and the California Board of Registered Nursing were dismissed with prejudice on October 15, 2003.

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In or about April 2004, CNA requested a preliminary injunction to halt implementation of the Regulations. CNA's request for preliminary injunctive relief was denied.

On January 20, 2005, CNA filed its Petition for Writ of Mandamus and Third Amended Complaint for Declaratory and Injunctive Relief to Invalidate and Enjoin Regulatory Action in Excess of Statutory Authority (the "Petition").

Discussion

CNA brings this Petition to prevent what it claims is an unauthorized expansion of the scope of practice of LVNs to permit LVNs to perform various nursing functions heretofore exclusively within the authority and scope of registered nurses.

CNA's Petition alleges three causes of action. The First Cause of Action, for Writ of Mandate, alleges that the Regulations authorizing LVNs to administer IV medications are invalid for failure to comply with the Administrative Procedures Act. The Second Cause of Action seeks temporary and permanent injunctive relief to enjoin the Regulations and thereby prohibit the administration of IV medications by LVNs. The Third Cause of Action seeks a declaratory judgment that the Board lacks the authority to amend the Regulations to expand the scope of LVN practice to include the administration of IV medications. The Third Cause of Action for declaratory relief also challenges an October 29, 2001, Advice Letter from the Board to the California Dialysis Council on the grounds: (i) the letter constitutes an "underground regulation" not enacted in conformance with the Administrative Procedures Act; and (ii) the Board's advice in the letter that LVNs are permitted central line access and to perform assessments on hemodialysis patients is contrary to existing law.

A. Standard of Review

When a court inquires into the validity of a quasi-legislative administrative regulation, the scope of review is limited. (*Cal. Assn. of Psychology Providers v. Rank* (1990) 51 Cal.3d 1, 11.) The court's task is to determine whether the regulation is (1) within the scope of the authority conferred by the statute, and

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(2) reasonably necessary to effectuate the purposes of the statute. (*Ralphs Grocery Co. v. Reimel* (1968) 69 Cal.2d 172, 175; *Agricultural Labor Relations Bd. v. Superior Court* (1976) 16 Cal.3d 392, 411.)

Judicial review of quasi-legislative acts generally consists of an examination of the proceedings before the agency to determine whether its actions were arbitrary, capricious, or entirely lacking in evidentiary support, or whether the agency failed to follow the procedures and give the notices required by law. (*Rank, supra*, at p.11.)

When, however, a regulation is challenged as inconsistent with the terms or intent of the authorizing statute, the standard of review is different. (*Id.*) In determining whether a regulation is within the scope of the authority conferred by a statute, a court does not defer to an agency's view because the court, not the agency, has final responsibility for the interpretation of the law under which the regulation was issued. (*Yamaha Corp. v. State Bd. of Equalization* (1998) 19 Cal.4th 1, 11 fn.4.) If the court determines that a challenged administrative action was not authorized by or is inconsistent with acts of the Legislature, that action is void. (*American Ins. Assn. v. Garamendi* (2005) 127 Cal.App.4th 228, 236; see also Gov. Code §§ 11350, 11342.1, 11342.2.)

The California Supreme Court has summarized the standard courts must apply when reviewing an agency's interpretation of a statute as follows:

"Courts must, in short, independently judge the text of the statute, taking into account and respecting the agency's interpretation of its meaning, of course, whether embodied in a formal rule or less formal representation. Where the meaning and legal effect of a statute is the issue, an agency's interpretation is one among several tools available to the court. Depending on the context, it may be helpful, enlightening, even convincing. It may sometimes be of little worth. Considered alone and apart from the context and circumstances that produce them, agency interpretations are not binding or necessarily even authoritative. To quote the statement of the Law Revision Commission in a recent report, 'the standard of judicial review of an agency interpretation of law is the independent judgment of the court, giving deference to the determination of the

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agency appropriate to the circumstances of the agency action."
(*Yamaha, supra*, at p.8 [citations omitted].)

B. Were the Amended Regulations Adopted in Accordance with the Law?

According to CNA, the amended Regulations exceed the scope of the Board's authority under the Vocational Nursing Practice Act (Bus. & Prof. Code §§ 2840 et seq.). Specifically, CNA contends the Regulations violate section 2860.5(c) of the Act. Thus, the Court is called upon to interpret the intent of that statute.

To determine legislative intent, the Court turns first to the actual language of the statute. If the words of the statute are clear, a court should not add to or alter them to accomplish a purpose that does not appear on the face of the statute or from its legislative history. (*Herman v. Los Angeles County Metropolitan Transportation Authority* (1999) 71 Cal.App.4th 819; 826.) But if the meaning of the words is not clear, courts must take the second step and refer to the legislative history. The final step, which should be taken only if the first two steps fail to reveal clear meaning, is to apply reason, practicality, and common sense to the language at hand. (*Id.*) The Court applies these rules of construction to the facts and the statute at issue here.

Business and Professions Code section 2860.5 sets forth the scope of practice of LVNs. It provides:

"A licensed vocational nurse when directed by a physician and surgeon may do all of the following:

(a) Administer medications by hypodermic injection.

(b) Withdraw blood from a patient, if prior thereto such nurse has been instructed by a physician and surgeon and has demonstrated competence to such physician and surgeon in the proper procedure to be employed when withdrawing blood, or has satisfactorily completed a prescribed course of instruction approved by the

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board, or has demonstrated competence to the satisfaction of the board.

(c) Start and superimpose intravenous fluids if all of the following additional conditions exist:

(1) The nurse has satisfactorily completed a prescribed course of instruction approved by the board or has demonstrated competence to the satisfaction of the board.

(2) The procedure is performed in an organized health care system in accordance with the written standardized procedures adopted by the organized health care system as formulated by a committee which includes representatives of the medical, nursing, and administrative staffs. "Organized health care system," as used in this section, includes facilities licensed pursuant to Section 1250 of the Health and Safety Code, clinics, home health agencies, physician's offices, and public or community health services. Standardized procedures so adopted will be reproduced in writing and made available to total medical and nursing staffs."

The Board contends that under the plain language of the statute, the phrase "intravenous fluids" must be construed to include "medications that can be administered intravenously." According to the Board, if the Legislature had intended to exclude "medications" from the definition of "intravenous fluids," this would have been clearly stated in the statute. Because it was not, the Board contends, the Legislature must have intended the definition of "intravenous fluids" to have a broad meaning to allow for the expanding nature of the LVN profession. Therefore, the Board argues, the amended Regulations are within the scope of the authority conferred by the statute and it is unnecessary to refer to the legislative history of the statute.

The Court, however, does not find the statutory language to be free of ambiguity. To the contrary, the Legislature's use of the word "medications" in subsection (a) but not in subsection (c) renders the statute ambiguous on its

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face. Was subsection (a) added to limit the circumstances under which LVNs may administer medication to hypodermic injections, or merely to clarify that LVNs shall be authorized to give hypodermic injections containing medications in addition to administering intravenous fluids?

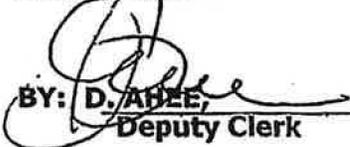
The Court is unable to answer this question by looking at the face of the statute. Neither the term "intravenous fluid," nor the term "medication" is defined by the Vocational Nursing Practice Act, so the Court must resort to the "ordinary, everyday" meaning of such terms. (*Herman, supra*, at p.826.) The Board contends that the ordinary, everyday meaning of the term "fluid" is a substance tending to flow or conform to the outline of its container, and that the term "intravenous fluids" includes any fluid that can be administered intravenously, including "fluids" of medications. The Board further contends that the ordinary, everyday meaning of the word "medication" includes substances used as a remedial treatment of a mental or bodily disorder, and that, under this definition, nutrients, electrolytes, and other fluids are all "medications." (*See AG 601-02.*)

However, as documented in the OAL's Decision of Disapproval, medical dictionaries and reference sources generally distinguish between the terms "intravenous fluids" and "medications" by separating the words by an "and," "or," a comma, or other distinguishing words (e.g., "The label of each container of fluid or medication . . ."). This suggests that, at least in the medical community, the term "intravenous fluids" does not necessarily include "medications." (*See AG 575-76.*)

In its Supplement to Final Statement of Reasons, the Board contended that LVNs were authorized to administer medications intravenously by section 2860.5(a) because the term "hypodermic injection" includes "intravascular" injections. (AG 643.) The Court is not persuaded by this argument. First, it is dubious that the ordinary, everyday meaning of a "hypodermic injection" in 1974 included intravascular injections. (*See, e.g., AG 575, 907.*) Second, this interpretation renders the statute absurd in that it would authorize an LVN to administer *medications* intravenously without condition, but would authorize LVNs to administer *fluids* intravenously only if the nurse has satisfactorily completed a prescribed course of instruction and demonstrated competence and

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the procedure is performed in an organized health care system in accordance with written standardized procedures. (See Bus. & Prof. Code § 2860.5(a), (c).)

Similarly, the Court is unable to rely on the principle of statutory construction that a specific provision relating to a particular subject governs as against a general provision, (*People v. Superior Court* (2002) 28 Cal.4th 798, 809), because it is unclear from the face of the statute whether subsection (a) was intended as a specific limitation on when LVNs may administer medications, or as general authorization for them to administer hypodermic injections.

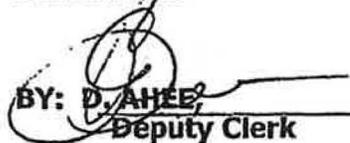
Construing the statute in the context of the overall statutory scheme is similarly unavailing. (*CEJA v. J.R. Wood, Inc.* (1987) 196 Cal.App.3d 1372, 1375 [holding that a statute is required to be construed in context, keeping in mind the nature and purpose of the statutory scheme of which it is a part].)

It is true that the statutory framework authorizes unlicensed hemodialysis technicians to administer medications intravenously under some circumstances. (See Health & Safety Code § 1794.14(d); Bus. & Prof. Code §§ 1247.2, 1247.3.) The Board contends that because the Legislature authorized unlicensed technicians to administer medications, it also must have intended for Licensed Vocational Nurses to be authorized to do so. However, this does not necessarily follow. First, the Hemodialysis Technician Training Act is a wholly unrelated statute; there are any number of reasons why the Legislature might permit unlicensed hemodialysis technicians to administer medications in hemodialysis settings but preclude Licensed Vocational Nurses from doing so. Second, the Hemodialysis Technician Training Act was enacted more than 13 years after AB 3618. Thus, even if the Hemodialysis Technician Training Act could be construed as evidence that the Legislature was willing to permit personnel other than licensed RNs to administer medications intravenously in 1987, this sheds no light on what the Legislature intended when it enacted AB 3618 in 1974.

Finally, in response to the argument that the Legislature would have expressly prohibited intravenous medications if it had so intended, the Court notes that one could just as easily assert that the absence of authorization to administer intravenous medications is conspicuous and suggests the Legislature did not intend LVNs to have such authority.

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In sum, the Court is unable to resolve these conflicts and therefore concludes the statute is ambiguous.

Case law holds that if the meaning of the words of a statute are not clear, the second step of statutory interpretation is to refer to the legislative history. (*Herman v. Los Angeles County Metropolitan Transportation Authority* (1999) 71 Cal.App.4th 819, 826.) In this case, the legislative history shows that section 2860.5(c) was not intended to include medications.

Section 2860.5 was last amended in 1974 by AB 3618. The April 4, 1974, proposed version of subsection 2 of the bill provided:

Sec. 2. Section 2860.5 of the Business and Professions Code is amended to read:

A licensed vocational nurse when directed by a physician and surgeon may do all of the following:

(a) Administer medications by hypodermic injection.

...

(c) *Start and superimpose intravenous fluids, and administer medications, as part of intravenous therapy. The above may only be done if prior thereto such nurse has completed a prescribed course of instruction by the board and demonstrated competence and demonstrated understanding of the effect of such medications and appropriate action to be taken if untoward reaction occurs.* (AG 923-924.)

CNA opposed the April 4, 1974, version of AB 3618 because, among other reasons, CNA wanted "to strike the LVNs authority to 'administer medications'" as part of intravenous therapy. (AG 926.) The Legislature subsequently amended AB 3618 on June 5, 1974, specifically to delete the language that would have given LVNs the authority to administer medications as part of intravenous therapy. (AG 921-22, 924-25.) As amended, the bill provided:

Section 1. Section 2860.5 of the Business and Professions Code is amended to read:

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2860.5. A licensed vocational nurse when directed by a physician and surgeon may do all of the following:

(a) Administer medications by hypodermic injection.

...
(c) ~~Start and superimpose intravenous fluids, and administer medication, as part of intravenous therapy. The above may only be done if prior thereto such nurse has completed a prescribed course of instruction by the board and demonstrated competence and demonstrated understanding of the effect of such medications and appropriate action to be taken if untoward reaction occurs if all of the following additional conditions exist:~~

(1) The nurse has satisfactorily completed prescribed course of instruction approved by the board or has demonstrated competence to the satisfaction of the board.

(2) The procedure is performed in an organized health care system in accordance with written standardized procedures adopted by the health care system as formulated by the committee which includes representatives of the medical, nursing, and administrative staffs. . . ." (AG 924-925.)

It thus appears that the Legislature amended the bill to delete the language that would have included administration of intravenous medications within the LVN scope of practice. The amended bill was passed by the Assembly and the Senate and signed into law by the Governor on September 23, 1974. (AG 929.)

The general rule is that when the Legislature has rejected a specific provision which was part of an act when originally introduced, the law as enacted should not be construed to contain that provision.¹ (*Ventura v. City of San Jose*

¹ This rule has some exceptions. For instance, it does not apply if the specific language is replaced by general language that includes the specific instance. (*California Ass'n of Psychology Providers v. Rank* (1990) 51 Cal.3d 1, 17-18.) The example given in *Rank* is that if a bill were introduced dealing with "teachers' salaries in Los Angeles County," then amended to deal with "teachers' salaries" generally, the court would not construe it to apply to all counties except Los Angeles. (*Id.*) This exception might apply here if the term "intravenous fluids" were construed to

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(1984) 151 Cal.App.3d 1076, 1080.) Accordingly, this Court concludes that because the Legislature deleted the language authorizing LVNs to administer medications intravenously, the statute cannot be construed to contain that provision.

The Board's early interpretation of the statute also appears to support the conclusion that LVNs were not authorized to administer IV medications. In a Notice from the Board issued on or about March 10, 1978, the Board stated the following:

"It has been brought to the attention of the Board that there may be Licensed Vocational Nurses employed in facilities who are administering intravenous medications. This notice is being sent in order to reach those facilities that are permitting the L.V.N.s to perform this illegal procedure.

"The regulations define those intravenous solutions that L.V.N.s are permitted to start and superimpose. Medications are not included since this was not the intent of the law. Therefore, it must be pointed out that the L.V.N. is not permitted by law to administer intravenous medications, add medications to an intravenous solution, or start and/or superimpose solutions that contain medications." (Declaration of Pamela Allen, Ex. A-1.)

The Board has attempted to explain its 1978 interpretation of "the law" as a reference to the Board's then-existing regulations, which excluded medications from the definition of intravenous fluids, rather than a reference to the statute itself. The Court finds this argument unpersuasive in light of the fact that elsewhere in the Notice, the Board appeared to distinguish "the law" (i.e., the statute) from its regulations: "The Board is concerned that Licensed Vocational

include "medications." As discussed above, there is no indication that the Legislature interpreted "intravenous fluids" in such a manner, or that the Legislature deleted the reference to IV medications because it believed such words were superfluous. To the contrary, the only evidence suggests the reference to IV medications was deleted in response to objections by CNA that LVNs should not be authorized to administer medications as part of IV therapy. Accordingly, the Court concludes that the exception discussed in *Rank* does not apply in this case.

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 Sacramento**

BY: D. AHEE,
 Deputy Clerk

CASE NUMBER: 00AS00900**DEPARTMENT: 16****CASE TITLE: CNA V. BELLO JONES****PROCEEDINGS: COURTS RULING UNDER SUBMISSION**

Nurses practice within the scope of the law and regulations" If "law" were intended to encompass the Board's regulations, this latter reference to "regulations" would have been superfluous.

Subsequent legislative attempts to interpret or amend section 2860.5 also appear to support the Court's interpretation. In 1980, Assemblyman Alatorre requested a formal opinion from the Legislative Counsel of California asking the specific question, "May the Board of Vocational Nurse and Psychiatric Technician Examiners authorize, by regulation, licensed vocational nurses to administer medications by intravenous injection?" (AG 905-907.) The response by Legislative Counsel provides, in relevant part:

"We think it is clear that the Legislature has, by the provisions of Section 2860.5, limited licensed vocational nurses, insofar as the administration of medications by injection are concerned, to that of the hypodermic injection method and has limited the use of intravenous method to that of the starting and superimposing of intravenous fluids under specified conditions.

"Thus, a regulation of the [BVNPT] which would authorize licensed vocational nurses to administer medications by intravenous injection would be authority which is beyond that authorized by Section 2860.5 and, as such, would be invalid." (*Id.*)

While Opinions of the Legislative Counsel, like opinions of the Attorney General, are not binding, the California Supreme Court has held that in the absence of controlling authority, they are persuasive. (*Cal. Assn. of Psychology Providers v. Rank* (1990) 51 Cal.3d 1, 17; see also *Eu v. Chacon* (1976) 16 Cal.3d 465, 470 ["Although a legislative expression of the intent of an earlier act is not binding on the courts . . . that expression may properly be considered together with other factors in arriving at the true legislative intent existing when the prior act was passed."].)

In response to the Legislative Counsel's Opinion, Assemblyman Alatorre introduced legislation (AB 642) in the 1981-82 legislative session that would have "authorize[d] a licensed vocational nurse to start and superimpose intravenous fluids containing medications under specified conditions." (AG 908-910, 915-

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918.) AB 642 was sponsored by the Board. In a January 22, 1983 letter to hospital administrators, the Board stated:

"The Board of Vocational Nurse and Psychiatric Technician Examiners sponsored AB 642 authored by Assemblyman Richard Alatorre in the 1981-82 legislative session. This measure would have expanded the scope of Practice of Licensed Vocational Nurses and authorized them to administer certain intravenous medications after successful completion of a course of instruction approved by the Board. This legislation failed in the Senate Finance Committee." (Declaration of Pamela Allen, Ex. A-3.)

The Legislature's failure to enact an amendment to a statutory scheme generally provides little guidance on the issue of legislative intent. (*American Ins. Assn. v. Garamendi* (2005) 127 Cal.App.4th 228, 246.) This is because the Legislature's failure to amend a statute evokes conflicting inferences. (*Id.*) However, when determining whether an administratively promulgated rule is consistent with controlling legislation, legislative rejection of an authorizing statute may prove more persuasive. (*Id.*) The Legislature is presumed to act with knowledge of an agency's administrative interpretation of the statute, and it is reasonable to assume the Legislature would have taken corrective action had it disagreed with the existing administrative interpretation. (*Jones v. Pierce* (1988) 199 Cal.App.3d 736, 745-46.) Thus, the Legislature's failure to change the law lends credence to the Board's administrative construction at the time AB 642 was rejected. Moreover, the Board's attempt to obtain legislative amendment of the governing statute can be construed as an implicit admission that legislative authorization was needed. (*Garamendi, supra*, at p.246.)

Respondent Board argues that notwithstanding this legislative history, the Court should defer to the Board's current interpretation of the statute. The Board cites cases holding that where an agency is charged with enforcing a statute, its interpretation of the statute should be entitled to "great weight." (Opposition, p.11 [citing *Lusardi Construction Co. v. Calif. Occupational Safety & Health App. Bd.* (1991) 1 Cal.App.4th 639, 645; *Pacific Legal Foundation v. Unemployment Ins. Appeals Bd.* (1981) 29 Cal.3d 101, 111; *Sheyko v. Saenz* (2003) 112 Cal.App.4th 675, 686].) The Board contends the Court should defer to the agency's interpretation even if such interpretation is not consistent with

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the agency's prior interpretation. The Board cites cases holding that "[e]ven when an agency adopts a new interpretation of a statute and rejects an old, a court must continue to apply a deferential standard of review. . . ." (*See, e.g., Henning v. Industrial Welfare Commn.* (1988) 46 Cal.3d 1262, 1270.) In the abstract, this appears to be a correct statement of the law. However, there is an exception to this general rule.

As held by the Supreme Court in the *Henning* case, which was relied upon by the Board: "When as here the construction in question is not 'a contemporaneous interpretation' of the relevant statute and in fact 'flatly contradicts the position which the agency had enunciated at an earlier date, closer to the enactment of the . . . statute[,] it cannot command significant deference." (*Id.* at p.1278.) This point was reiterated by the Supreme Court in *Yamaha Corp. of America v. State Board of Equalization* (1998) 19 Cal.4th 1, 14, which held that the weight given to an agency's interpretation of a statute "will depend upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade" (*See also Brewer v. Patel* (1993) 20 Cal.App.4th 1017, 1022 [finding no reason to defer to Labor Commissioner's interpretation of regulation where interpretation was contrary to plain meaning of statute and inconsistent with Commissioner's own prior interpretation of the rule]; *Whitcomb Hotel, Inc. v. California Emp. Commn.* (1944) 24 Cal.2d 753, 757 ["At most administrative practice is a weight in the scale, to be considered but not to be inevitably followed . . .".].)

In this case, the evidence shows that the Board's current interpretation of the statute is of recent origin, and is not consistent with the Board's earlier interpretation of the statute, which the Board made much closer in time to when the statute was enacted. Therefore, the Board's interpretation is not entitled to the deference that it otherwise would be due.

In any event, whatever the force of administrative construction, relevant case law establishes that final responsibility for interpretation of the law rests with the court. The Court concludes that the Board's interpretation of section 2860.5 is erroneous. As construed by this Court, section 2860.5 prohibits the Board to adopt a regulation authorizing LVNs to administer intravenous medications. Therefore, the amendments to California Code of Regulations, title

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16, sections 2542, 2542.1, 2547, and 2547.1, allowing LVNs to administer IV medications must be enjoined as inconsistent with the Vocational Nursing Practice Act.

C. Does the Board's October 29, 2001, Letter to the California Dialysis Council Constitute an Underground Regulation?

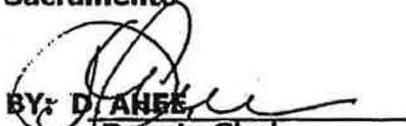
On October 29, 2001, the Board responded by letter to an "inquiry" from the California Dialysis Council ("CDC") asking whether LVNs were authorized to initiate dialysis via a central line catheter and to perform patient assessments for the purposes of determining treatment. In its letter, the Board stated that LVNs "are permitted central line access," and that LVNs "can perform basic assessment, or data collection." There is no dispute that these interpretative statements were not adopted in accordance with the APA procedures. Thus, CNA correctly contends that if the interpretations qualify as "regulations" within the meaning of Government Code § 11342.6, the regulations are invalid. (*California Advocates for Nursing Home reform v. Bonta* (2003) 106 Cal.App.4th 498, 507.)

The Court is not persuaded that the Board's statement in the October 29 letter that "LVNs are permitted central line access" constitutes a regulation subject to the APA. The APA defines "regulation" to include "every rule, regulation, order, or standard of general application or the amendment, supplement, or revision of any rule, regulation, order, or standard adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it, or to govern its procedure." (Gov. Code § 11342.600.) A regulation subject to the APA has two principal identifying characteristics. First, the agency must intend its rule to apply generally, rather than in a specific case. Second, the rule must "implement, interpret, or make specific the law enforced or administered by [the agency], or . . . govern [the agency's] procedure." (*Bonta, supra*, at pp.506-07 [citing *Tidewater Marine Western, Inc. v. Bradshaw* (1996) 14 Cal.4th 557, 571].)

CNA apparently contends that the Board's statement constitutes a "regulation" because it appears to conflict with a June 23, 1993, letter from the Board stating that LVNs may change site dressings but that "[n]o other procedures or manipulation of central lines are permitted." (Declaration of

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Pamela Allen, Ex.A-4.) However, the June 23 letter appears to have been responding to a question about bolus or "push" administration into central lines and the language must be read in this context. Moreover, section 2860.5 expressly authorizes LVNs to "start and superimpose intravenous fluids" if certain conditions are met, and does not limit LVNs to accessing secondary infusion lines. Accordingly, the Court interprets the statement in the Board's October 29 letter as a statement of existing law and not as a new "regulation" within the meaning of the APA.

Similarly, the Court is not persuaded that the Board's statement in the October 29 letter that "the LVN can perform basic assessment or data collection" is an underground regulation. The letter merely reiterates what Regulation 2518.5 already provides, namely, that the scope of LVN practice includes "basic assessment (data collection)." (See 16 C.C.R. § 2518.5.)

The statements in the Board's October 29 letter do not constitute underground regulations.

D. Conclusion

The Court finds that the amended Regulations must be set aside because the Regulations are not within the scope of the authority conferred by the statute.

Accordingly, the Court grants CNA's request for a peremptory writ of mandate commanding Respondents to set aside the Regulations, and for a permanent injunction enjoining the implementation and enforcement of the Regulations. Respondents shall file a return to the peremptory writ of mandate within 30 days after it is served on them describing what steps they have taken to comply with the writ. The Court denies CNA's request for declaratory relief in respect to the October 29, 2001, Advice Letter.

CNA is directed to prepare a formal judgment, attaching the Court's ruling as an exhibit, and a writ of mandate consistent with the ruling; submit them to opposing counsel for approval as to form; and thereafter submit them to the Court for signature and entry of judgment in accordance with Rule of Court 391.

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Any request for fees or costs shall comply with the Code of Civil Procedure and all state and local rules.

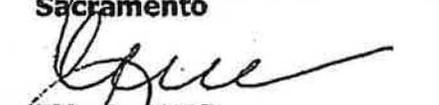
Dated: July 14, 2005



Judy Hersher,
Judge of the Superior Court,
State of California

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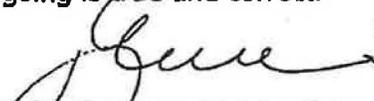
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**CERTIFICATE OF SERVICE BY MAILING
(C.C.P. SEC 1013QA(3))**

I, the Clerk of the Superior Court of California, County of Sacramento, certify that I am not a party to this cause, and on the date shown below I served the foregoing MINUTE ORDER by depositing true copies thereof, enclosed in separate, sealed envelopes with the postage fully prepaid, in the United States Mail at Sacramento, California, each of which envelopes was addressed respectively to the persons and addressed shown. I, the undersigned deputy clerk, declare under penalty of perjury that the foregoing is true and correct.

Dated: July 14, 2005



D. Ahee, Deputy Courtroom Clerk

California Nurses Association
Legal Department
Pamela Allen
2000 Franklin Street, Suite 300
Oakland, CA 94612

JESSICA M. AMGWERD
California Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550

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Deputy Clerk

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SUPERIOR COURT OF THE STATE OF CALIFORNIA
COUNTY OF SACRAMENTO

CALIFORNIA NURSES ASSOCIATION,

Petitioner and Plaintiff,

vs.

TERESA BELLO-JONES, in her official
capacity, CALIFORNIA BOARD OF
VOCATIONAL NURSING AND
PSYCHIATRIC TECHNICIANS,

Respondents and Defendants.

Case No.: 03AS00990

PEREMPTORY WRIT OF MANDATE

Case Filed: February 24, 2003

Judge: Hon. Judy Holzer Hersher

To Respondents Teresa Bello-Jones and Board of Vocational Nursing and Psychiatric
Technicians:

WHEREAS on 8-17-03, judgment was entered in this action, ordering that a
peremptory writ of mandate be issued from this Court,

THEREFORE, YOU ARE HEREBY COMMANDED, to rescind the amendments to title
16, California Code of Regulations §§ 2542, 2542.1, 2547 and 2547.1 that were effective
February 28, 2003, and to refrain from implementing or enforcing the terms of said amendments
and shall, instead, implement and enforce the terms of title 16, California Code of Regulations
§§ 2542, 2542.1, 2547 and 2547.1 as they existed prior to the February 28, 2003 amendments;

1 AND ARE HEREBY FURTHER COMMANDED, within thirty days from the date that a
2 copy of this writ is served on you, to file a return to this peremptory writ of mandate describing
3 what steps have been taken to comply with the writ

4
5 DATED: 11-2-05



[Signature], Clerk

6
7 By: D. Akers
8 Deputy

9
10 LET THE FOREGOING WRIT ISSUE.

11
12 DATED: _____
13 Honorable Judge Holzer Hersher
14 Judge of the Superior Court



CALIFORNIA
NURSES
ASSOCIATION

A Voice for Nurses - A Vision for Healthcare
www.calnurse.org

November 22, 2005

By Hand Delivery

Diane Ahee, Clerk to
The Honorable Judy Holzer Hersher
Sacramento County Superior Court
Department 16
720 Ninth Street
Sacramento, CA 95814

RE: *California Nurses Association v. Teresa Bello-Jones, et al.*
Sacramento Superior Court Case Number: 03AS00990

Dear Ms. Ahee:

On August 15, 2005, in accordance with Judge Hersher's instruction in her ruling in the above-referenced case dated July 14, 2005, I sent the original plus one copy each for execution by the Court of a proposed Final Judgment and a proposed Peremptory Writ of Mandate. As I indicated at that time, drafts of both of those documents had been provided to and approved as to form by Jessica Amgwerd, counsel for the respondents.

Judge Hersher signed the Final Judgment on August 17, but there was a delay in our receiving a copy, apparently due to confusion caused by the fact that some of the Court's records had the case number misidentified as 03AS00900, rather than the correct Case No. of 03AS00990.

We still have not received the signed Peremptory Writ of Mandate. I am enclosing herewith two clean copies of the proposed Peremptory Writ of Mandate for the Court's consideration, in the event the originals have been misplaced. I am also enclosing a self-addressed, stamped envelope for return of an executed copy, assuming the Court signs the Writ as drafted.

Once the Writ issues, I will prepare, file and serve a Notice of Entry of Judgment Granting Peremptory Writ, which should bring this case to a close.

☐ CNA OAKLAND
HEADQUARTERS
2000 Franklin St., Ste. 300
Oakland, CA 94612
(510) 273-2200
Fax: (510) 663-1625

☐ CNA SACRAMENTO
1107 9th Street, Ste 900
Sacramento, CA 95814
(916) 446-5021
Fax: (916) 446-6319

☐ CNA SANTA CLARA
1961 Pruneridge Ave., # B
Santa Clara, CA 95050
(408) 920-0290
Fax: (408) 920-0362

☐ CNA FRESNO
125 E. Barstow, Ste 112
Fresno, CA 93710
(559) 248-1948
Fax: (559) 248-9220

☐ CNA GLENDALE
425 West Broadway, Ste 111
Glendale, CA 91204
(818) 240-1900
Fax: (818) 240-8336

☐ CNA SAN DIEGO
3160 Camino del Rio So., # 305
San Diego, CA 92108
(619) 516-4917
Fax: (619) 516-4922

Letter to Diane Ahee
November 22, 2005
Page 2

I very much appreciate your time and assistance in this matter. Please contact me at (510) 273-2271 if you have any questions or require revision of the enclosed proposed Writ.

Very truly yours,

CALIFORNIA NURSES ASSOCIATION
LEGAL DEPARTMENT



Pamela Allen
Legal Counsel

Enclosures

cc: Jessica M. Amgwerd, Deputy Attorney General

Attachment 8

RECEIVED
 JUN 28 2013
 CDPH L&C
 Santa Rosa D.O.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
 DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050360	(X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/30/2011
NAME OF PROVIDER OR SUPPLIER Marin General Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 250 Bon Air Rd, Greenbrae, CA 94904-1702 MARIN COUNTY	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
	<p>The following reflects the findings of the Department of Public Health during an inspection visit:</p> <p>Complaint Intake Number CA00269065, CA00276079, CA00274284 - Substantiated</p> <p>Representing the Department of Public Health: Surveyor ID # 27294, HFEN</p> <p>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.</p> <p>Health and Safety Code Section 1280.1(c): For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient.</p> <p>Penalty number 110009908</p> <p>A 001 Informed Adverse Event Notification</p> <p>Health and Safety Code Section 1279.1(c), "The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made"</p> <p>The CDPH verified that the facility informed the patient or the party responsible for the patient of the adverse event by the time the report was made.</p> <p>A 010 1280.1(a) Health & Safety Code 1280</p>		<p>The following constitutes Marin General Hospital's plan of correction of the alleged deficiencies cited by the California Department of Public Health in the Statement of Deficiencies from State 2567 dated 5/29/2013. Preparation and/or execution of this evidence of corrective action does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. It has been prepared and/or executed solely because it is required by State law.</p> <p>Immediately after the event an investigation commenced.</p> <p>The involved Registered Nurses (RN) and Respiratory Therapist (RT) were interviewed for their accounting of the event. Hospital management carefully reviewed and documented its review of any allegations made as to employees to determine whether any disciplinary or corrective action was warranted as to acts or omissions by or related to such employees. These reviews were completed as to the RN employees on 5/11/2011 and the RT on 5/12/11. Employee matters are reviewed under the policies and procedures of the</p>

7/14/11

Event ID: LHIM11 5/29/2013 3:21:27PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [Signature] TITLE: Assistant Quality Mgmt. Dir. (X8) DATE: 6/25/13

By signing this document, I am acknowledging receipt of the entire citation packet. Page(s) 1 thru 9

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State-2587 Plan of correction submitted Page 1 of 9

\$ Accepted. Facility informed 6/27/13

B. Hets. H.F.E.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/30/2011
NAME OF PROVIDER OR SUPPLIER Marin General Hospital			STREET ADDRESS, CITY, STATE ZIP CODE 250 Bon Air Rd, Greenbrae, CA 94904-1702 MARIN COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
	<p>(a) Subject to subdivision (d), prior to the effective date of regulations adopted to implement Section 1280.3, if a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand dollars (\$25,000) per violation.</p> <p>This RULE is not met as evidenced by:</p> <p>E 1158 T22 DIV5 CH1 ART6 70493(a) Intensive Care Services General Requirements</p> <p>(a) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate. Policies and procedures shall include, but not be limited to:</p> <p>This RULE is not met as evidenced by: See Tag 1159, 1160, and 1164.</p> <p>E 1159 T22 DIV5 CH1 ART6 70493(a) (3) Intensive Care Services General Requirements</p> <p>(3) Routine procedures.</p>		<p>Department of Human Resources. These include a system of progressive disciplinary action for which the Executive Director of Human Resources is ultimately responsible. As required by the Respiratory Care Board the RT was reported to the licensing agency. Complete records of any such actions taken at the time are maintained and are available for on-site inspection in the Office of the Executive Director of Human Resources. In addition, management conducted an overall review of the applicable policies, procedures, bylaws and rules and regulations and any amendments thereto undertaken by the Department of Human Resources to ensure that the allegations contained in the deficiency report were adequately addressed by these policies.</p> <p>The policy and procedure entitled Patient Care Protocol Intubation, Assisting with, was revised to include time frames for assessment and reassessment of the patient during the intubation process by nursing and respiratory therapy. The policy was revised further to include a time-out procedure and assurance of adequate ventilation post-intubation. The time-out process includes documenting the</p>	9/1/11	

Event ID: LH1M11

5/29/2013

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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/30/2011
NAME OF PROVIDER OR SUPPLIER Marin General Hospital			STREET ADDRESS, CITY, STATE, ZIP CODE 250 Bon Air Rd, Greenbrae, CA 94904-1702 MARIN COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
	<p>This RULE is not met as evidenced by:</p> <p>See Tag 1158, 1160, and 1164</p> <p>E 1160 122 DIV5 CH1 ART8 70493(a) (4) Intensive Care Services General Requirements</p> <p>(4) Emergency procedures</p> <p>This RULE is not met as evidenced by:</p> <p>See Tag 1155, 1159, and 1164</p> <p>E 1164 T22 DIV5 CH1 ART6 70495(a) (1) Intensive Care Service Staff</p> <p>(a) A physician with training in critical care medicine shall have overall responsibility for the intensive care service. This physician or his designated alternate shall be responsible for</p> <p>The hospital violated the regulation by failing to implement intensive care policies and procedures when the respiratory therapist and three registered nurses did not provide reassessment and did not provide continued ongoing assessments with documentation of respiratory care given, including the intubation procedure, and Patient 11's response to the procedure according to the acute care hospital's policies and procedures. These failures contributed to Patient 11's death. These failures of the violations of Section, 70493(a), 70493(a) (3), 70493(a) (4) and 70495(a) (1) of Title 22 of the California Code of Regulations and was a deficiency</p>		<p>size and placement of the endotracheal tube, securing the endotracheal tube, connecting the patient to the ventilator, observations of pulmonary, cardiovascular and neurological status (e.g., observing the patient flow loop, chest rise, bilateral breath sounds, patient volume, and peak inspiration pressure, verifying pulse oximetry), observing heater settings and humidification, setting alarms, documentation and labeling of documents. The policy was approved by Nursing on 8/5/2011, the Medical Executive Committee on 8/15/2011 and the Quality and Patient Safety Committee on 8/23/2011. It is approved by the Board of Directors on 9/1/2011.</p> <p>The ventilator flow sheet was revised to include the RT and RN signature verifications of participation in the time-out checklist. This checklist is currently incorporated into the electronic health record (HER). The time-out process includes noting the size and placement of the endotracheal tube, securing the endotracheal tube, connecting the patient to the ventilator, observing pulmonary, cardiovascular, and neurological status (e.g., observing the patient flow loop, chest rise, bilateral</p>	7/14/11	

Event ID: LHIM11

5/29/2013

3:21 27PM

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/30/2011
NAME OF PROVIDER OR SUPPLIER Marin General Hospital			STREET ADDRESS, CITY, STATE, ZIP CODE 250 Bon Air Rd, Greenbrae, CA 94904-1702 MARIN COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
	<p>that caused, or was likely to cause, serious injury and death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code 12801(a)</p> <p>Findings</p> <p>A medical chart review was conducted on 06/30/11 that indicated Patient 11 was a 52 year old female admitted to the facility on [REDACTED] 11, with diagnoses including respiratory failure due to pneumonia, kidney failure, seizure disorder, and sepsis. She required a ventilator (a mechanical device used to provide artificial ventilations breaths) as Patient 11 was unable to breathe on her own</p> <p>During an interview on 06/30/11 at 10:45 a.m., Licensed Nurse L stated Patient 11 had been in the Intensive Care Unit (ICU) since [REDACTED] and had been on a ventilator most of that time. There had been a few attempts to wean Patient 11 from the ventilator without success. She stated on [REDACTED] 11, the decision was made to try again to wean Patient 11 off the ventilator. Patient 11 was extubated around 10 a.m., and placed on bi-pap (a non-invasive form of breathing assistance) but continued to have difficulty breathing throughout the day. The decision was made to re-intubate Patient 11 and put her back on the ventilator. Licensed Nurse L stated Respiratory Therapist K and Physician I (who performed the intubation) and herself were present in the room. The whole procedure took about 5 minutes and was completed at 5:08 p.m. The intubation procedure went well and Licensed Nurse L gave report to Licensed Nurse N. Licensed Nurse</p>		<p>breath sounds, patient volume, and peak inspiration pressure, verifying pulse oximetry), observing heater settings and humidification, setting alarms, documentation and labeling of documents.</p> <p>All respiratory therapists were trained on the time-out checklist and Ventilator Flow sheet revision by 5/19/2011.</p> <p>Ventilator competency for RT's is done at hire and each time a new ventilator series is purchased or leased. Competencies are filed in the employee's personnel file. The competency requires a sign-off by the RT Manager or designated RT evaluator.</p> <p>All RNs in ICU complete a ventilator competency on hire. The competency includes a case study, written test questions and the time-out checklist. When the time-out procedure was developed RNs in ICU, ED, NICU, and Nursing Supervisors completed a competency. The competency requires a sign-off by the nurse evaluator.</p> <p>A time-out tool was developed to perform on the intubated patient after connection to the ventilator. The tool consists of 12</p>	7/14/11	

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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/30/2011
NAME OF PROVIDER OR SUPPLIER Marin General Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 250 Bon Air Rd, Greenbrae, CA 94904-1702 MARIN COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	L stated when she left the room Respiratory Therapist K was taping the endotracheal tube (ET) and then connected the ventilator to the ET tube. She stated at that point the x-ray technician had arrived to do a chest x-ray, so they left the room including Respiratory Therapist K. Licensed Nurse L stated she did not know where Respiratory Therapist K went, and she did not see him again until 5:20-5:24 p.m. when they called the code. Licensed Nurse L stated she had not looked at the ventilator monitor until she returned to the room at 5:20 p.m. She stated it was then she looked at the monitor and saw no respiratory wave forms. The monitor read "waiting to be connected to patient." She also stated none of the ventilator alarms had sounded which indicated to her that the ventilator was not working. Licensed Nurse L stated the respiratory therapists are responsible for the functioning of the ventilators, including setting the alarms. Patient 11's cardiac monitor alarmed at 5:20 p.m. The monitor indicated Patient 11's heart rate to be low, in the 40's (normal range 60 - 80's) and her oxygen levels were about 60% (normal range- 95%-100%). Licensed Nurse L and Physician I, who were at the desk ran to the room and noted the ventilator monitor screen read "waiting to be connected to patient," which meant the ventilator was on "stand by" mode and was not providing breaths to Patient 11. Physician I immediately disconnected the ventilator from the endotracheal tube and initiated bag/mask manual breathing, and a chemical code was called (only emergency medications were given). The code was started at 5:24 p.m. and ended at 5:37 p.m. resulting in Patient 11's death. When Licensed		assessment items to ensure proper oxygenation of the patient. The time-out checklist was laminated and placed on every ventilator by 5/19/2011. The RT completes the time-out verification process using the checklist immediately after the patient is attached to the ventilator. The time-out checklist and signature verification for RT and RN's was implemented starting on 6/1/11 by Respiratory Therapy. Staff received education on the new requirements, including, assessments and reassessments time frames and documentation (RNs in ICU on 6/17/2011, RNs in NICU and ED by 7/14/2011.) RNs and RTs were educated to the practice change prior to the approval of the policy due to the significance of the event. Documentation of signature verification of the checklist process by both RT and RN's is in the HER. "Critical Care Services- Patient Care Protocol - Respiratory Care Standards" and ICU Plan of Provision of Care" documentation requirements were also covered. <u>Responsible Person</u> Vice President, Nursing Services	7/14/11 7/14/11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/30/2011
NAME OF PROVIDER OR SUPPLIER Marin General Hospital			STREET ADDRESS, CITY, STATE, ZIP CODE 250 Bon Air Rd, Greenbrae, CA 94904-1702 MARIN COUNTY		
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	<p>Nurse L was asked what the nurses' responsibilities were post-intubation, she stated the primary nurse should make sure the chest rises and falls, listen to the lung sounds, observe the ventilator monitor to make sure it is providing ventilations to the patient, observe respiratory wave forms on the monitor, make sure ET tube is secure, make sure oxygen levels are within normal limits</p> <p>During an interview on 06/30/11 at 10:15 a.m., Physician I stated that after Patient 11 was intubated, he and Respiratory Therapist K checked the lung sounds and checked the carbon dioxide (CO2) monitor and everything was okay so he instructed Respiratory Therapist K to connect the ventilator to Patient 11's ET tube. Physician I stated he then left the room, and went back to the desk to complete his charting. Physician I stated he did not look at the ventilator monitor at that time. He stated usually the respiratory therapist stays in the room to make sure the ventilator is functioning properly.</p> <p>During an interview on 07/05/11 at 2 p.m., Licensed Nurse M stated that he was helping Licensed Nurse N reposition Patient 11 on [REDACTED] 11 after the post intubation chest x-ray. Licensed Nurse M was asked if he had looked at the ventilator monitor or checked to see if Patient 11 was breathing he stated he had not, until Physician I and Licensed Nurse L came back into the room. When asked what were nurses' responsibilities post-intubation, Licensed Nurse M stated to listen to the patients' breath sounds, make sure the ventilator is giving ventilations to the patient, observe the patient's</p>		<p><u>Monitoring</u></p> <p>The Manager, Respiratory Care or designee is auditing all ventilator cases for RT and RN compliance with signature verification of the time-out checklist. Immediate action is taken by the nurse manager and the respiratory manager with non-compliant staff, including appropriate re-education or discipline. Data is analyzed and reported to the Performance Improvement Committee quarterly or more frequently if indicated for action of any identified trends.</p> <p>The respiratory therapists were re-educated regarding charting on all respiratory patients and the need to monitor closely for respiratory failure according to department policy "Respiratory Care Services Manual for Critical Care Department" page 4; and the new requirements for the Ventilator Flow Sheet on 6/15/2011. Charting is done at least every 2 hours on all ventilated patients, or any time the RT has an encounter with the patient and when any change in patient status occurs.</p> <p>Information Systems collaborated with nursing and respiratory</p>	<p>7/14/11</p> <p>9/26/11</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050380	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/30/2011
NAME OF PROVIDER OR SUPPLIER Marin General Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 250 Bon Air Rd, Greenbrae, CA 94904-1702 MARIN COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	<p>chest for rise and fall, look at the ventilator monitor for respiratory waves, and monitor blood pressure, heart rate, respiratory rate, and oxygen levels.</p> <p>Dunnig an interview on 07/25/11 at 2:45 p.m., Licensed Nurse N stated she had not assessed Patient 11's breathing after the ventilator was connected, but she had listened to Patient 11's lung sounds immediately following the intubation while Respiratory Therapist K was still providing manual breathing for Patient 11</p> <p>During additional interview on 08/30/11 at 10:00 a.m., Administrative Staff A stated Respiratory Therapist K no longer worked at the hospital. Several attempts (06/30/11, 07/05/11 and 07/22/11) were made by telephone to contact Respiratory Therapist K without success. Administrative Staff A stated that on [REDACTED] 11 the ventilator in question was examined by the hospital's biomedical engineers and the company who serviced the ventilators and was found to be in good working condition.</p> <p>During an interview on 07/06/11 at 2:45 p.m., Administrative Staff J stated their own investigation revealed the thermometer probe had been removed from the ventilator and the tubing had not been recapped which alerted the ventilator to go on stand-by mode.</p> <p>During observation on 07/06/11 at 3:00 p.m., Administrative Staff J demonstrated how the ventilators are checked for proper functioning. It was noted that when the cap was open on the</p>		<p>therapy staff to help facilitate documentation with the new electronic medical record by building screens that include all required documentation for the time-out procedure and documentation on the ventilator flow sheet to reduce inconsistencies. The implementation of an electronic health record for nursing and clinical ancillary services was completed 9/26/2011.</p> <p>In the interim (July 2011 until 9/26/11 a monitoring process was established (see below "Monitoring") and feedback and/or disciplinary action forthcoming to clinicians who are deficient on this standard.</p> <p><u>Responsible Person</u> Manager, Respiratory Care</p> <p><u>Monitoring</u> The Manager, Respiratory Care or designee is auditing all Ventilator Flow Sheets and counsels respiratory staff for compliance. Disciplinary action and/or education will be taken for repeated episodes of non-compliance. Data is analyzed and reported to the Performance Improvement Committee quarterly</p>	9/26/11

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NAME OF PROVIDER OR SUPPLIER Marin General Hospital			STREET ADDRESS, CITY, STATE, ZIP CODE 250 Bon Air Rd, Greenbrae, CA 94904-1702 MARIN COUNTY		
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	<p>thermometer probe tubing, the ventilator stopped and the monitor repeatedly flashed in large yellow letters, "waiting to connect to patient." When Administrative Staff J was asked if there was a ventilator check off sheet used when the ventilators were checked prior to use, she stated before the incident with Patient 11 the check off was done by memory.</p> <p>The Respiratory Therapist flow sheet dated [REDACTED] 11 indicated that Respiratory Therapist K's had only documented on Patient 11 on [REDACTED] 11 at 7:30 a.m. No other documentation was found.</p> <p>During interview on 07/05/11 at 10:00 a.m., Respiratory Therapist O stated they are required to document on the respiratory flow sheet and the ventilator flow sheet every two hours and as needed. This was confirmed also by Administrative Staff J, who stated she did not know why Respiratory Therapist K had only documented once on [REDACTED] 11.</p> <p>The Hospital's Critical Care Services - Patient Care Protocol- Respiratory Care Standards, dated 02/2000, indicated that the RN/RT were to reassess and document lung sounds before and after procedure, patient's skin color before and after the procedure.</p> <p>The Respiratory Care Services Manual for the Critical Care Department dated 03/2008, indicated on page 4, that the patient was to be monitored closely for respiratory failure.</p>		<p>or more frequently by the Manager, Respiratory Care if indicated for action of any identified trends.</p> <p>The Chief Medical Officer met with the involved physician after the event to discuss the ventilator event.</p> <p>As part of the intubation process, the intubating physician will ensure correct tube placement, as well as ventilation and oxygenation of the patient.</p> <p>Following completion of the intubation process, when the patient is immediately connected to a mechanical ventilator, unless called out of the room for an urgent patient care need, the physician will remain in the room during the time-out check list procedure for verification of ventilation and oxygenation of the patient.</p> <p>When a physician is called out for an urgent patient need, the responsible RT or RN will verbally verify post-ventilator patient ventilation and oxygenation to the intubating physician as soon as possible. The RT documents on the ventilator tab in the electronic record that the physician's participation in the time-out or</p>	<p>7/14/11</p> <p>12/6/11</p> <p>12/6/11</p> <p>12/6/11</p>	

Event ID: LHM11

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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
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NAME OF PROVIDER OR SUPPLIER Marin General Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 250 Bon Air Rd, Greenbrae, CA 94904-1702 MARIN COUNTY		
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	<p>The Hospital's Critical Care Patient Care Protocol for Assisting with Intubation, dated 03/2010; page 2, indicated that pre-procedure and post-procedure assessments should be documented and also the patient's response to the procedure, as well as re-assessments of pulmonary, cardiovascular, and neurological status. No timeframes for re-assessment were specified in the document.</p> <p>The Hospital's ICU Plan of Provision of Care, dated 2001, indicated a RN will complete a patient reassessment at least every 15 minutes and with changes in patient conditions and will assure the patient's safety throughout their stay</p> <p>Therefore, the hospital violated the regulation by failing to implement intensive care policies and procedures when respiratory therapist and the three registered nurses did not provide reassessment and continued ongoing assessments with documentation of respiratory care given, including the intubation procedure and Patient 11's response to the procedure, according to the acute care hospitals' policies and procedures. These failures contributed Patient 11's death. This failure was a violation of Section, 70493(a), 70493(a) (3), 70493(a) (4) and 70495(a) (1) of Title 22 of the California Code of Regulations and was a deficiency that caused, or was likely to cause, serious injury and death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code 1280.1(a)</p>		<p>verbal communication that the patient is adequately ventilated.</p> <p>A memo from the Chief of Staff went out to all involved physicians on 12/6/2011 listing the changes made to the electronic medical record for the documentation required for physician participation in the time-out process for patient who are immediately connected to mechanical ventilation after intubation.</p> <p><u>Responsible Person</u> Manager, Respiratory Services</p> <p><u>Monitoring</u> The Manager, Respiratory Services or designee reviews the checklist on the ventilator tab of the electronic medical record to ensure the physician's participation is documented. Data is analyzed and reported to the Performance Improvement Committee, Chief of Staff, members of the Medical Executive Committee, and Chair, Pulmonary Division for non-compliance. A percentage of compliance is reported to the Medical Executive Committee monthly for action of any identified trends and will be addressed</p>	12/6/11

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NAME OF PROVIDER OR SUPPLIER Marin General Hospital			STREET ADDRESS, CITY, STATE, ZIP CODE 250 Bon Air Rd, Greenbrae, CA 94904-1702 MARIN COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
	<p>The Hospital's Critical Care Patient Care Protocol for Assisting with Intubation, dated 03/2010; page 2, indicated that pre-procedure and post-procedure assessments should be documented and also the patient's response to the procedure, as well as re-assessments of pulmonary, cardiovascular, and neurological status. No timeframes for re-assessment were specified in the document.</p> <p>The Hospital's ICU Plan of Provision of Care, dated 2001, indicated a RN will complete a patient reassessment at least every 15 minutes and with changes in patient conditions and will assure the patient's safety throughout their stay</p> <p>Therefore, the hospital violated the regulation by failing to implement intensive care policies and procedures when respiratory therapist and the three registered nurses did not provide reassessment and continued ongoing assessments with documentation of respiratory care given, including the intubation procedure and Patient 11's response to the procedure according to the acute care hospitals' policies and procedures. These failures contributed Patient 11's death. This failure was a violation of Section, 70493(a), 70493(a) (3), 70493(a) (4) and 70495(a) (1) of Title 22 of the California Code of Regulations and was a deficiency that caused, or was likely to cause, serious injury and death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code 1280 1(a).</p>		<p>through the Medical Staff ongoing professional performance evaluation process.</p> <p>Immediately after the event the ventilator was sequestered and placed out of service. Biomedical Engineering completed an evaluation on 5/5/2011. The manufacturer was contacted and completed an inspection and testing of the ventilator on 5/6/2011. The results of both evaluations indicated there was no ventilator malfunction. To prevent pieces being removed from cleaned ventilators not in use a new process was initiated.</p> <p>Ventilators are cleaned in the patient room with a disposable 2-minute germicidal wipe after use and brought to the Respiratory Services workroom where they are cleaned again with a spray enzyme cleaner. A label is attached after the cleaning process is completed. The label includes the name of the respiratory therapist who cleaned and tested the ventilator, verification the ventilator passed the System Safety Test (SST), and the date the cleaning and test were completed.</p>	<p>7/14/11</p> <p>11/28/11</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/30/2011
NAME OF PROVIDER OR SUPPLIER Marin General Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 250 Bon Air Rd, Greenbrae, CA 94904-1702 MARIN COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	<p>The Hospital's Critical Care Patient Care Protocol for Assisting with Intubation, dated 03/2010; page 2, indicated that pre-procedure and post-procedure assessments should be documented and also the patient's response to the procedure, as well as re-assessments of pulmonary, cardiovascular, and neurological status. No timeframes for re-assessment were specified in the document.</p> <p>The Hospital's ICU Plan of Provision of Care, dated 2001, indicated a RN will complete a patient reassessment at least every 15 minutes and with changes in patient conditions and will assure the patient's safety throughout their stay.</p> <p>Therefore, the hospital violated the regulation by failing to implement intensive care policies and procedures when respiratory therapist and the three registered nurses did not provide reassessment and continued ongoing assessments with documentation of respiratory care given, including the intubation procedure and Patient 11's response to the procedure according to the acute care hospitals' policies and procedures. These failures contributed Patient 11's death. This failure was a violation of Section, 70493(a), 70493(a) (3), 70493(a) (4) and 70495(a) (1) of Title 22 of the California Code of Regulations and was a deficiency that caused, or was likely to cause, serious injury and death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code 1280.1(a)</p>		<p>The SST is a 6 point check that tests the function of the following: flow sensor; circuit pressure; system leak test; expiratory filter; circuit resistance; and compliance and calibration. The results of the SST are stored in the ventilator's memory.</p> <p>Upon completion of the cleaning, testing, and labeling of the ventilator a plastic cover is placed over the machine.</p> <p>As an additional safety measure, custom plastic covers with locks were obtained.</p> <p><u>Responsible Person</u> Manager, Respiratory Services</p> <p><u>Monitoring</u> If a label is not present on a ventilator when the plastic cover is removed, the ventilator is retested before use.</p> <p>A log was developed to ensure all ventilators are cleaned and tested.</p> <p>Data is analyzed and reported to the Performance Improvement Committee quarterly or more frequently if indicated for action of any identified trends.</p>	11/28/11 11/14/11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/04/2008
NAME OF PROVIDER OR SUPPLIER GROSSMONT HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 5555 GROSSMONT CENTER DRIVE, LA MESA, CA 91942 SAN DIEGO COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
	<p>The following reflects the findings of the California Department of Public Health during an Entity Reported Incident investigation.</p> <p>Complaint No: CA 145843 Category: State Monitoring, Death General</p> <p>Representing the California Department of Public Health was [REDACTED], HFEN.</p> <p>1280 1(a) HSC Section 1280 If a licensee of a health facility licensed under subdivision (a), (b), or (f) of Sections 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand (\$25,000) per violation.</p> <p>1280 1 (c) HSC Section 1280 For purposes of the section, "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause serious injury or death to the patient.</p> <p>DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY</p> <p>T22 DIV5 CH1 ART6-70617(a) Respiratory Care Service General Requirements</p> <p>(a) Written policies and procedures shall be developed and maintained by the person</p>				

Event ID:IGVW11

8/14/2008

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
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NAME OF PROVIDER OR SUPPLIER GROSSMONT HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 5555 GROSSMONT CENTER DRIVE, LA MESA, CA 91942 SAN DIEGO COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
	<p>Continued From page 1</p> <p>responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate</p> <p>Based on interview and record review the facility failed to have a policy and procedure in place to ensure safe transition of care of a ventilator dependent patient from the respiratory therapist to nursing staff. This failure resulted in the death of the patient.</p> <p>Findings:</p> <p>Patient A was a 45-year-old male brought into the emergency room (ER) of the facility on 3/21/08 by the paramedics at approximately 2:48 a.m. according to the ER notes. The patient initially presented with signs and symptoms of a stroke. The paramedics reported that the patient had a syncopal (fainting) episode at home and was unable to lift his right arm. At 3:14 a.m., the nurse documented that the patient was awake and oriented x 3 (person, place, and time) speech was clear and coherent with no facial droop, no drift, or drop of any extremity, and equal grips.</p> <p>At 3:43 a.m., the patient was noted to have snoring respirations, severely slurred speech, unable to follow commands well and had an episode of vomiting per the ER nurses notes. At 3:45 a.m. Patient A was noted to have changes on his EKG (electrocardiogram). The EKG changes indicated</p>				

Event ID:IGWW11

8/14/2008

1:56:50PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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(X6) DATE

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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/04/2008
NAME OF PROVIDER OR SUPPLIER GROSSMONT HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 5555 GROSSMONT CENTER DRIVE, LA MESA, CA 91942 SAN DIEGO COUNTY		
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	<p>Continued From page 3</p> <p>ventilation /breathing)...the patient was being prepped and draped in the usual sterile fashion. After I retrieved my lead and came in the room, it was noted the patient was acutely bradycardic. I noticed then, as we were draping the patient, that the patient's ventilator was placed on standby. It was unclear about the duration of this event, and emergently the patient was disconnected from the mechanical ventilator and was manually ventilated with an Ambu bag. There was no pulse at this time...we then started CPR (cardiopulmonary resuscitation). I initially placed one venous sheath, as there was no pulse present, and suddenly the power went out at that moment..."</p> <p>Cardiopulmonary resuscitation was instituted but there was a failure to revive the patient. After approximately 31 minutes, according to the Code Blue Record, Patient A was pronounced dead at 5:34 a.m.</p> <p>According to an interview on 4/4/08 at 3:10 p.m. with Respiratory Technician (RT) "W," the emergency room ventilator (vent) had been taken to the Cath lab, the settings had been dialed in, and the Cath Lab vent was placed on "stand by." RT "W" stated that the "stand by" mode is much like having a car in "idle," it's ready to go but you need to push the pedal to get it moving. RT "W" stated the stand by button needs to be pushed again in order to activate the ventilator. RT "W" stated that the RT working the morning of 3/21/08 (RT "X") could not recall if he had taken the ventilator out of "stand by" mode after transferring Patient A from the portable transport vent to the Cath lab vent the</p>				

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	<p>Continued From page 4</p> <p>morning of 3/21/08. He stated that after connecting Patient A to the Cath lab vent RT "X" was called back to the ER for a pediatric code.</p> <p>RT "W" stated that there is no written policy for respiratory staff to provide a verbal report to the nursing staff regarding the care and function of the ventilator. Facility administrative staff confirmed this on 4/4/08. RT "W" stated that it is understood that RT staff must do a visual and verbal check off with the nurse before leaving the Cath lab. There was no documentation in the medical record to indicate that Patient A had been assessed after connection to the ventilator in the Cath lab, or that anyone had verified the vent was turned on.</p> <p>On 4/4/08 at 4:25 p.m., Immediate Jeopardy was called as the facility failed to have a system in place to ensure safe transition of care of patients who are receiving mechanical ventilation.</p> <p>The Immediate Jeopardy was abated on 4/4/08 at 5:10 p.m., after the Department had received an acceptable plan of correction from facility administrative staff.</p>				

Event ID:IGVW11

8/14/2008

1:56:50PM

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NAME OF PROVIDER OR SUPPLIER LUCILE SALTER PACKARD CHILDREN'S HOSP AT STANFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 726 WELCH ROAD, PALO ALTO, CA 94304 SANTA CLARA COUNTY		
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	<p>The following reflects the findings of the California Department of Public Health during an Entity Self Reported event visit.</p> <p>For Entity Self Reported event CA00131082 regarding State Monitoring, oxygen line used for wrong gas/toxic substance, a State deficiency was identified (see California Code of Regulations, Title 22, Section 70617(a)).</p> <p>Inspection was limited to the specific Entity Self Reported event investigated and does not represent the findings of a full inspection of the hospital.</p> <p>Representing the California Department of Public Health was [REDACTED] Health Facilities Evaluator Nurse.</p> <p>The above regulation was not met as evidenced by:</p> <p>DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY.</p> <p>70617(a) Respiratory Care Service General Requirements</p> <p>(a) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.</p> <p>Based on interviews, record and document review, the hospital failed to implement their policies and procedures for the storage and assembly of</p>			

Event ID:9EQ811

5/8/2008

11:16:37AM

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	<p>Continued From page 1</p> <p>nitrogen gas used for the Nitrogen blend procedure for one patient (A). The hospital failed to ensure diagrams accurately illustrated the setup of the nitrogen gas for the ventilator.</p> <p>Patient A, a nine day old infant, had a diagnosis of Epstein's anomaly, a rare congenital defect of the heart involving the tricuspid valve which pumps blood through the heart's upper chamber. Patient A was admitted to the Neonatal Intensive Care Unit (NICU) for cardiac evaluation and treatment. The record documented he was placed on the heart transplant recipient list on 10/12/07.</p> <p>The physician documented on the History Progress Record dated 10/16/07 at 4:00 a.m. the following: The patient "returned from the catheterization (cath) lab after stent replacement... for severe Epstein's anomaly before heart transplant. Patient was stable during the procedure according to anesthesia....Tried to place patient on Nitrogen to decrease over circulation and decrease high SAT's (oxygen in the blood) but every time put on a ventilator, rapid bradycardia (low heart rate) followed by profound desaturation.... One episode of brady to 54- gave chest compressions x 3 (~ 30 seconds) until bagging (providing ventilation manually) brought HR and SAT up.... Stabilized on ventilator once Nitrogen taken out of circuit...."</p> <p>On 11/05/07 at 12:30 p.m. the respiratory therapy manager (RTM) was interviewed. He stated the Nitrogen Blend procedure is used to decrease atmospheric oxygen to decrease oxygenation to the pulmonary system and increase systemic</p>				

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	<p>Continued From page 2</p> <p>circulation. The goal is for the patient to receive 16% to 18% oxygen (O2) instead of 21%, which is received in room air.</p> <p>The RTM stated this procedure is used for heart transplant patients. The hospital uses the equipment 10 or less times a year. He stated on 10/16/07 the respiratory equipment used to blend nitrogen for Patient A was incorrectly assembled by the respiratory therapist 1 (RT 1).</p> <p>He stated the hospital had five setups for nitrogen administration and they were to be ready for use at all times. Only one could be located in the respiratory department on 10/16/07 because of new construction being done. He said the equipment used for Patient A had been disassembled; the hoses used in Nitrogen delivery were not connected before use, as per policy. The connectors to the hoses that were supposed to be noninterchangeable had been removed which allowed the hoses to be connected incorrectly.</p> <p>The Nursing Neonatal Intensive Care Flow Sheet dated 10/16/07 from 2:25 a.m. to 3:50 a.m. documented the patient was removed from the ventilator and had to be manually ventilated a total of five times when the nitrogen was added to the patient ventilator circuit. The patient's heart rated dropped as low as 62 beats per minute (normal range is 100 to 160 for a newborn). The O2 Sat dropped as low as 56 percent. The record documented the goal for the patient's O2 Sat was 75 to 85 percent.</p>				

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	<p>Continued From page 3</p> <p>The hospital policy and procedure on Nitrogen Blend documented the following: "all equipment (blender, regulators etc.- except hood or ventilator), when not at bedside, should be stored together in the department." The hospital failed to follow their policy on storage of equipment.</p> <p>The above policy also documented the equipment should include a modified blender, H- cylinder of 100% medical grade nitrogen, nitrogen tank regulator (to check pressure in tank), and 2 alarmed oxygen analyzers capable of monitoring oxygen concentrations of less than 20.9%.</p> <p>On 11/09/07 at 9:00 a.m. RT 1 who set up the nitrogen blend equipment was interviewed by telephone. She stated the following: On 10/16/07 she was told Patient A was being transferred from the cardiac cath lab in 10 minutes and would need to be on the nitrogen blend. She got the equipment from the respiratory department. The equipment had a clear plastic bag over it which is placed by the technicians to signify it is assembled and ready for use. She later discovered the bag was placed over the machine to protect it from dust during construction, but was not assembled.</p> <p>RT 1 stated when she took the plastic bag off the equipment the two hoses were hanging on the side of the machine instead of being connected to the blender. She had never set up the equipment so she had to rely on a diagram. The adaptors to connect the hoses to the blender inlets had been removed. The regulators, flowmeters and the analyzers needed for the equipment set up were</p>				

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	<p>Continued From page 4</p> <p>not in the bag used to store these items. The hospital failed to implement their policy on equipment to be available for the nitrogen blend procedure.</p> <p>RT 1 stated each time the nitrogen was used the patient immediately had significant changes so the patient was removed from the ventilator and the patient was hand bagged. RT 2 found an analyzer to use but the readings were questionable so he looked for another analyzer which could not be found until the procedure was stopped. RT 1 stated, "analyzers are hard to come by." The nitrogen was removed when RT 2 discovered the hoses to the blender had been incorrectly connected.</p> <p>RT 1 stated the diagram she used to set up the equipment was drawn backwards so she incorrectly connected the hose with the 100% nitrogen to the room air inlet side of the blender instead of the oxygen inlet. She connected the compressed air hose to the oxygen inlet side of the blender instead of the room air inlet. Instead of 100% nitrogen blended to less than 40% and 21% compressed air, the patient received 100% nitrogen and an undetermined percentage of oxygen. She stated she reported the above to the physicians and to the department manager immediately.</p> <p>The hospital policy and procedures for Nitrogen Blend documented, "diagrams depicting set ups for the ventilator...should be available with the equipment...." On 11/16/07 the Nitrogen Vent Setup diagram was reviewed. The diagram illustrated the hose from the nitrogen tank</p>				

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	<p>Continued From page 5</p> <p>connected to inlet on the left side of the blender and the hose for compressed air connected the inlet on the right side of the blender. The hospital failed to have diagrams that accurately depicted correct set ups for the nitrogen blend procedure.</p> <p>On 11/14/07 at 10:45 a.m. the NICU attending physician was interviewed by telephone. He stated he was called at home around 3:00 a.m. on 10/16/07 because the staff was having difficulty stabilizing the patient on the ventilator. After attempts to place the patient on the ventilator were unsuccessful RT 2 stated, "I am not sure the nitrogen set up is correct." RT 1 pulled the nitrogen out and the patient was able to be stabilized with oxygen Sats in the mid 80's. When asked if the above incident had a potential for harm the physician stated, "potentially it could have been a disaster, a catastrophe."</p> <p>On 11/14/07 at 12 noon RT 2 was interviewed by telephone. He stated on 10/16/07 he was called to assist RT 1. He stated the equipment for the nitrogen set up was in "pieces." There was no analyzer with the equipment so he found one in another location. The analyzer when connected showed oxygen readings in the teens and dropping to zero.</p> <p>RT 2 stated he left to find a second analyzer and when it was connected it gave the same readings. He then realized the set up must be wrong so he removed the nitrogen and notified the physician who was at the bedside.</p>			

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	<p>Continued From page 6</p> <p>On 11/16/07 at 12 noon a licensed nurse (LN) was interviewed by telephone. She stated she was at Patient A's bedside on 10/16/07 during the time the nitrogen blend procedure was administered. She stated the patient was stable on the "conventional ventilator" but became bradycardic (slow heart rate) and his oxygen Sat's dropped when he was placed on the ventilator with nitrogen added. The patient needed to be taken off the ventilator with nitrogen and hand bagged "multiple times." When the nitrogen was removed and the patient was placed back on the "conventional ventilator" he appeared to stabilize.</p>			

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Attachment 2

**BOARD OF REGISTERED NURSING**

P O Box 944210, Sacramento, CA 94244-2100

TDD (916) 322-1700

Telephone (916) 322-3350

www.m.ca.gov



Ruth Ann Terry, MPH, RN
Executive Officer

STATEMENT ON SUPERVISION OF LVNs IN DIALYSIS SETTINGS

Background

The Board of Registered Nursing (BRN) has received inquiries from nursing organizations and individual nurses about the legal scope of practice for an RN who may be asked to: delegate to the LVN patient assessment for the purpose of determining a treatment; delegate to the LVN intravenous medication administration as the treatment; and direct the LVN to administer intravenous medication through a central line. These questions have arisen in part due to practices at free standing dialysis facilities.

Business and Profession Code, Section 2725, Nursing Practice Act, authorizes registered nurses to assess patients, determine abnormality, implement a medical treatment plan, refer, report, or implement a standardized procedure, and administer medication by all routes. California Code of Regulations 1443.5 (4) states that the RN *delegates tasks to subordinates based on the legal scope of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.*

Interpretation

The BRN's interpretation of law governing the practice of registered nursing is that the RN function of assessment to determine abnormality, determine the appropriate treatment, and implement a treatment for the abnormality such as administration of an intravenous medication for a hemodialysis patient **cannot** be delegated by the RN to the LVN. The RN is not authorized under the Nursing Practice Act to delegate or supervise the LVN administering intravenous medication. The BRN continues to interpret the law that RNs can delegate and supervise Intravenous Therapy certified LVNs in accord with Business and Professions Code, Section 2860.5 and California Code of Regulations, Article 8, Section 2542, which gives certified LVNs the authority to superimpose intravenous solutions of electrolytes, nutrients, vitamins, blood and blood products.

**BOARD OF REGISTERED NURSING**

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Ruth Ann Terry, MPH, RN
Executive Officer

April 11, 2001

Teresa Bello-Jones, R.N., J.D.
Executive Officer
Board of Vocational Nursing and Psychiatric Technicians
2535 Capitol Oaks Drive, Suite 205
Sacramento, CA 95833

Dear Ms. Bello-Jones:

We have reviewed the BVNPT's regulatory proposal to adopt Sections 2542.6 and 2547.6 related to vocational nurses administering intravenous medications. The proposal permits licensed vocational nurses, under specified conditions, to infuse intravenous medications that are integral to hemodialysis, pheresis, or blood bank procedures.

The Board of Registered Nursing is unable to support adoption of the proposed regulations. The regulatory proposal is inconsistent with the Nursing Practice Act (NPA), which regulates registered nurse practice. Furthermore, we believe the proposal lacks statutory authority and clarity, and is inconsistent with existing BVNPT regulations.

Inconsistency with NPA & CCR: Business and Professions Code (B&P), Section 2725, authorizes registered nurses to assess patients, determine abnormality, implement a medical treatment plan, refer, report, or implement a standardized procedure, and administer medication by all routes. California Code of Regulations (CCR), Section 1443.5(4), states that *the registered nurse delegates tasks to subordinates based on the legal scope of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.*

The BRN's interpretation of laws governing the practice of registered nursing is that the RN function of assessment to determine abnormality, determine the appropriate treatment, and implement a treatment for the abnormality such as administration of an intravenous medication for hemodialysis patient cannot be delegated by the RN to the LVN. The RN is not authorized by the NPA to delegate or supervise the LVN in administering intravenous medications. RNs may delegate to and supervise Intravenous (IV) Certified LVNs the tasks of starting and superimposing intravenous solutions of electrolytes, nutrients, vitamins, blood, and blood products. B&P Code Section 2860.5 and CCR Section 2542 specifically authorizes the IV certified LVN to perform these tasks.

(See attached BRN Advisory, "Statement of Supervision of LVNs in Dialysis Settings".)

Attachment 3

OFFICE OF THE ATTORNEY GENERAL
State of California

GEORGE DEUKMEJIAN
Attorney General

:
OPINION :

of :
GEORGE DEUKMEJIAN :
Attorney General :
CLAYTON P. ROCHE :
Deputy Attorney General :

No. CV 78/63
APRIL 18, 1979

THE HONORABLE MICHAEL R. BUGGY, R.N., EXECUTIVE SECRETARY, BOARD OF REGISTERED NURSING, has requested an opinion on the following questions:

- "1. Can psychiatric technicians be placed in a position where they are supervising registered nurses?
- "2. Can a psychiatric technician overrule a nursing decision made by a registered nurse?
- "3. Can a psychiatric technician perform those nursing functions which have not been delegated by a registered nurse?"

The conclusions are:

1. Psychiatric technicians may be placed in a position where they are supervising registered nurses.

2. Psychiatric technicians may overrule nursing decisions made by a registered nurse so long as such nursing decisions are ones which fall within the scope of the licensing provisions for psychiatric technicians.

3. Psychiatric technicians may perform nursing functions which have not been delegated by a registered nurse so long as such nursing functions are ones which fall within the scope of the licensing provisions for psychiatric technicians.

ANALYSIS

The reason for this request for our opinion is to a degree summarized by the requester in his supplemental "views letter" as follows: 1/

"The Board [of Registered Nursing] continues to be concerned about the quality of nursing care being given to the patients in the state hospitals and is of the opinion that the psychiatric technician is not legally permitted nor adequately educated to supervise the practice of nursing."

The concerns of the Board of Registered Nursing, however, go beyond the scope of this office's functions. Our role is solely to determine the question whether a psychiatric technician may legally supervise a registered nurse, and to what extent. Whether a registered nurse has a superior educational background to that of a psychiatric technician is not pertinent to our inquiry if the Legislature in fact has decreed that psychiatric technicians may supervise registered nurses in certain situations. Likewise the level of care being given patients at state hospitals is not pertinent to our inquiry. That is essentially an administrative and policy question which is determined by a combination of factors. These factors would include such matters as the laws relating to the licensure of the various disciplines which treat such patients and staffing decisions made by the appropriate departmental directors within budgetary limitations. And finally, the conclusion we ultimately reach is not that psychiatric technicians may supervise the practice of nursing, but that psychiatric technicians may, under appropriate circumstances, supervise registered nurses who are performing services, nursing or otherwise, which a psychiatric technician may also legally perform.

We note also at the outset that the request is couched in very general terms. No particular type of "supervision" is delineated for our decision, though that term has various connota-

1. In reaching our conclusions herein we have carefully considered the views received from the requester, and additionally those received from or on behalf of 1) the Board of Vocational Nurse and Psychiatric Technician Examiners, 2) the California Association of Human Services Technologists, 3) the California Medical Association, 4) the California Nurses Association, 5) the Department of Consumer Affairs, 6) the Department of Developmental Services, and 7) the Department of Mental Health.

tions both within and outside a hospital setting. For example, both registered nurses and psychiatric technicians provide care to patients under a treatment regimen prescribed by a physician. (Bus. & Prof. Code, §§ 2725, subd. (b), 4502, subd. (b).) 2/ To the extent that they are under the direction and control of a physician in this regard, nurses and psychiatric technicians are in a sense under the "supervision" of the prescribing physician. However, this clearly is not the type of supervision with which we are concerned herein. Also, psychiatric technicians may legally be placed in administrative positions as "program managers" in state hospitals, where the particular program would be staffed by all disciplines including registered nurses. (Welf. & Inst. Code, §§ 4308, 4488.) 3/ This general "administrative" type of super-

2. All section references are to the Business and Professions Code unless otherwise indicated.

3. For example, section 4308 of the Welfare and Institutions Code provides in part as to the staffing of state hospitals under the jurisdiction of the Director of Mental Health:

"The standards for the professional qualifications of a program director shall be established by the Director of Mental Health for each patient program. The director shall not adopt any regulations which prohibit a licensed psychiatrist, psychologist, psychiatric technician, or clinical social worker from employment in a patient program in any professional, administrative, or technical position; provided, however, that the program director of a medical-surgical unit shall be a licensed physician.

"If the program director is not a physician, a physician shall be available to assume responsibility for all those acts of diagnosis, treatment, or prescribing or ordering of drugs which may only be performed by a licensed physician."

A similar provision is found in section 4488 of the Welfare and Institutions Code with respect to hospitals under the Department of Developmental Services. Interestingly, in those hospitals a psychiatric technician may even be clinical director of the hospital.

vision necessarily is not the type the requester has in mind, since the law specifically contemplates and permits this. Accordingly, it would appear that the requester envisions "supervision" in the more traditional sense. This would be where an individual has the authority to assign tasks to others and then continuously monitors the activities of the subordinates, with the power to direct and control the manner in which the assignments are carried out. This type of supervision would be "immediate supervision," or could be once, twice or many times removed in a direct "chain of command."

1. Can Psychiatric Technicians Supervise Registered Nurses?

The first question presented is whether psychiatric technicians may legally supervise the activities of registered nurses. We conclude that a psychiatric technician may do so provided that the activities supervised are those which a psychiatric technician may himself perform under his own licensing law. We believe this conclusion flows from an examination of the language of both the Psychiatric Technicians Law (§ 4500 et seq.) and the Nursing Practice Act, (§ 2700 et seq.) taken in their historical perspective.

The Psychiatric Technicians Law was initially enacted in 1959 after extensive legislative hearings. Its purpose was to grant professional status to the large number of individuals who were working in that civil service classification in state hospitals, and the relatively smaller number of individuals who were performing similar duties in the private sector. (See Subcommittee Report on Psychiatric Technicians (1959) Appendix to Sen. J. (1959 Reg. Sess.)) The law was initially a "certification law" (see Stats. 1959, ch. 1851, § 1, p. 4402 et seq.), but in 1963 was amended to provide for the licensing of psychiatric technicians (see Stats. 1968, ch. 1323, § 8, p. 2503 et seq.). Significantly, at the time the law as initially passed, psychiatric technicians were acting in supervisory roles in state hospitals. For example, at the senate subcommittee hearings held in 1959 one psychiatric technician testified that she had been in charge of the "Chronic Disturbed Unit" for six years, which had 130 patients and 38 employees. She was a "charge technician." Another testified that as a "supervising psychiatric technician" he had 15 wards, approximately a thousand patients, and approximately 64 to 100 technicians under him. Finally, another, who was an "area supervisor," testified as to the role of psychiatric technicians, including intensive observation of patients over a 24 hour period, taking blood and preparing specimens, taking and testing urine specimens, taking blood pressures, providing the ordinary nursing care, and weighing and measuring the patient's food intake and output, etc. (Subcommittee Report, op. cit. supra., at pp. 41-47.).

Section 4502 of the Psychiatric Technicians Act, as enacted in 1959, defined a psychiatric technicians as follows:

"As used in this chapter, 'psychiatric technician' means any person who, under the direction of a licensed physician or psychiatrist or a registered professional nurse, performs services in caring for and treatment of the mentally ill or mentally retarded for compensation or personal profit, which services:

'(a) Involve responsible nursing and therapeutic procedures for such mentally ill or mentally retarded patients requiring interpersonal and technical skills in the observation and recognition of symptoms and reactions of such patients, and the accurate recording of the same, and the carrying out of treatments and medications as prescribed by a licensed physician or psychiatrist; and

'(b) Require the application of such techniques and procedures as involve understanding of cause and effect and the safeguarding of life and health of the patient and others; and

'(c) Require the performance of such other duties as are necessary to facilitate rehabilitation of the patient or are necessary in the physical, therapeutic, and psychiatric care of the patient; and

'(d) Require the application of principles of treatment based upon biological, physical, and social sciences.'" (Emphasis added.)

Thus, in 1959 when the Psychiatric Technicians Law was enacted, it is clear that psychiatric technicians performed a certain level of responsible nursing services. It is also abundantly clear that psychiatric technicians were not "locked in" at the lowest level of practice, but could progress to responsible supervisory positions. Did section 4502, as originally enacted, intend to change this? It could be argued that the introductory paragraph of section 4502 was intended to do so in requiring practice under the direction of a physician or psychiatrist or registered nurse. However, we conclude that such was not the intent of the Legislature.

In construing a statute "it is proper to consider the history and purpose of the enactment[]." (Stafford v. Realty Bond Service Corp. (1952) 39 Cal.2d 797, 805; see also, e.g., People v. Ventura Refining Co. (1928) 204 Cal 286, 291, and State Compensation Ins. Fund v. Workers' Comp. Appeals Bd. (1979) 88 Cal.App.3d 43, 53. As already noted, the history of the Psychiatric Technicians Law demonstrates that its purpose was basically to grant professional status to the thousands of such persons who were staffing state hospitals, and was not to change existing staffing procedures at such hospitals. A reading of the Senate Interim Committee Report, cited above, discloses no evidence of any dissatisfaction with the use of psychiatric technicians in supervisory positions. In fact, all the testimony was laudatory of the role of the psychiatric technician in state hospitals. Additionally, material furnished to us by the Department of Developmental Services discloses that psychiatric technicians continued in responsible supervisory roles under the then existing civil service classifications after enactment of the law. Thus, the contemporaneous administrative construction of the statute (§ 4502, as enacted in 1959) by those responsible for its implementation indicated that no change in the law was intended with respect to the supervisory role of psychiatric technicians. "[W]hen an administrative agency is charged with enforcing a particular statute, its interpretation of the statute will be accorded great respect by the courts 'and will be followed if not clearly erroneous.'" (Judson Steel Corp. v. Workers' Comp. Appeals Bd. (1979) 22 Cal.3d 658, 668.) Apparently, insofar as section 4502 indicated that psychiatric technicians would be under the direction of a registered nurse, this was complied with by continuing the practice that the classification "Superintendent of Nursing Services" be a registered professional nurse, with Assistant Superintendents of Nursing Services being either Psychiatric Technicians or Registered Nurses. 4/

In short, when the Psychiatric Technicians Law was enacted in 1959, psychiatric technicians held responsible supervisory positions in state hospitals. There is nothing in the history of the act or its implementation which indicates that it was intended to change the existing organization and operation of the state hospital system.

Of additional significance is the fact that in 1959 the Legislature apparently saw no need to amend the Nursing

4. Our source is materials furnished by the Department of Developmental Services indicating that the "Superintendent of Nursing Services" classification requiring an "R.N." was established on 5/7/42 and abolished 10/17/73.

Practice Act to except psychiatric technicians from the licensing requirements of that act. It was not until 1971, or 12 years later, that the Nursing Practices Act was amended to even mention psychiatric technicians by the amendment of section 2728 of that act, and the addition of section 2728.5 thereto. Yet those who argue that a psychiatric technician may not supervise a registered nurse rely heavily upon the wording of section 2728. However, before we analyze section 2728 and 2728.5 of the Nursing Practice Act, we believe a further discussion of historical background is pertinent.

In 1959, when the Psychiatric Technicians Law was enacted, psychiatric technicians had been acting in supervisory roles on "residential or behavioral wards," for almost two decades. We are advised with regard to the situation in 1959 and also with regard to changes which occurred around 1960 as follows:

"Until the mid part of the century, the hospitals were primarily organized around the residential care model and very few Registered Nurses were employed. In the late 1950s, as hospitals were organizing around the medical model, the number of Registered Nurses began increasing but their assignments were predominately within physical care units. The Psychiatric Technician continued to function as level-of-care staff as well as supervising psychiatric and behavioral units.

"In 1960, hospitals still had their behavioral programs staffed exclusively by Psychiatric Technicians. Registered Nurses began to be used on the behavioral wards along with Psychiatric Technicians even though these wards were supervised by Senior Psychiatric Technicians. Such supervision by Senior Psychiatric Technicians was not inconsistent with the civil service classification which provided for: . . .supervising nursing care on a ward for mentally ill or deficient. In 1969 and 1970, the specification was revised and each time continued to provide for: . . . giving and supervising a basic level of general and psychiatric nursing care. The Senior Psychiatric Technician I (shift charge) is supervised by the Senior Psychiatric

Technician II or Registered Nurse III (unit manager) who is allowed (according to the class specification) overall responsibility of unit management and supervision." 5/

Thus, about 1960, psychiatric technicians began supervising registered nurses. Or stated otherwise, the state hospital system began using psychiatric technicians and registered nurses interchangeably on non-medical units. 6/ A 1968 organizational

5. Views letter received by this office from Department of Developmental Services. See also views letter, California Association of Human Services Technologists (CAHST) indicating that psychiatric technicians have been supervising registered nurses for at least 15 years.

6. For instance, the views letter received by this office from CAHST points this out as follows:

"Three other objective sources comment on PT-RN comparability -- (Source: Appendix D. Volume 1, Staffing Standards for Public Mental Hospitals, Report to the Senate by the California Commission on Staffing Standards, California Department of Mental Hygiene, February 1967.)

'Registered nurses and psychiatric technicians show sufficiently similar behavior that one may conclude they are used interchangeably. The small differences (about 10%) are in medication, charting, and conferring with off-ward and other personnel which is done slightly more by registered nurses and is balanced by more psychiatric technician time in daily living activities.'

"(Source: Nursing Education in California, Coordinating Council for Higher Education, July 1966.)

'However, civil service categories of Psychiatric Technicians are equivalent to those of RNs. (Underlining is ours). If a Psychiatric Technician stays in the civil service system long enough and passes appropriate civil service examinations, he may be promoted to the equivalent of categories established for charge nurses and other supervisory personnel."

chart supplied to us by the Department of Developmental Services for a state hospital sets forth beneath the positions of Superintendent, Associate Superintendent and Superintendent of Nursing Services in a direct line of authority the following

Fn. 6 Cont'd.

"Source: Statement to Mr. Samuel J. Leask, President, California State Personnel Board, by Mr. Leland F. Erbacher, Chief, Bureau of Personnel, California Department of Mental Hygiene, May 3, 1967.)

'In summary, the organization and staffing of our hospitals gives Psychiatric Technicians and Registered Nurses in State service a unique relationship. This relationship can only continue to be reflected adequately in terms of dollar value of services by increasing Psychiatric Technician salaries and Registered Nurse salaries the same number of salary steps. This is particularly essential at the level of Assistant Superintendent of Nursing Services which the Board staff in past years has agreed represents the same level of responsibility regardless of whether a specific position is filled by a nurse or a Psychiatric Technician.'

"The suggested recognition of comparability expressed in terms of dollar value was confirmed by the legislature in the form of SB 481 (Marks) Chapter 1479 two years later which appropriated \$3,676,633 for salary equity of which \$1,833,317 was approved by the Governor. The bill was an emergency measure to be given immediate affect [sic]."

positions, which were positions filled by either psychiatric technicians or registered nurses: 1) Assistant Supervisor of Nursing Services; 2) Nursing Supervisor; 3) Ward Charge; 4) Shift Lead; and 5) Registered Nurses and Psychiatric Technicians at the ward level.

Returning to sections 2728 and 2728.5 after this further historical background, we believe some statutory background as to these sections is now pertinent. Section 2728 was contained in the Nursing Practice Act when that act was enacted in 1939. (Stats. 1939, ch. 807, § 2, p. 2350). As originally enacted it provided:

"If adequate medical and nursing supervision by a professional nurse or nurses is provided, nursing service may be given by attendants in institutions under the jurisdiction of or subject to visitation by the State Department of Public Health or the State Department of Institutions.

"The Director of Institutions shall determine what shall constitute adequate medical and nursing supervision in any institution under the jurisdiction of the State Department of Institutions." 7/

Thus, under adequate supervision by professional nurses, hospital attendants were permitted to provide "nursing service" in virtually any hospital or clinic, public or private, with respect to any type patient. Thereafter section 2728 was amended in 1957 to reflect the reorganization of the State Department of Institutions into the Department of Mental Hygiene and the Department of Corrections. Paragraph one was amended to include these two new departments; paragraph two was amended to include only the Department of Mental Hygiene, and its

7. Interestingly, between the years 1937 and 1947 there was a certificated group called "trained attendants." These "trained attendants" were obviously to be found in all types of hospital settings, since section 4519 required applicants to be examined in "elementary anatomy and physiology, hygiene, diet for the sick, nursing methods in the care of the sick, including children and aged people, and obstetrics. (See generally, Stats. 1937, ch. 417, pp. 1377-1378, as repealed by Stats. 1947, ch. 234, § 1, p. 805).

director (Stats. 1957, ch. 558, § 1, pp. 1649-1650). 8/ However, not until 1971 9/ was the Nursing Practice Act amended to allude to psychiatric technicians for the first time. Statutes of 1971, Chapter 1007, amended section 2728 and added section 2728.5 to read as follows:

"2728. If adequate medical and nursing supervision by a professional nurse or nurses is provided, nursing service may be given by

8. The background supplied to us by the Director of Developmental Services shows a progression in state hospitals from "Hospital Attendant" to "Psychiatric Technicians." Thus he states in his views letter:

"Prior to 1951, the classification of 'Psychiatric Technician' was not in existence. The predominant class used in State hospitals was Hospital Attendant. Although the incumbents had only 45 hours of in-service training, the duties performed by the Hospital Attendant included administration of medication and treatment usually under the supervision of a psychiatrist. In 1951, the title of Hospital Attendant was changed to Psychiatric Technician and over the next years the amount of formal training was increased and the Psychiatric Technician developed into a licensed clinical profession."

We would presume that until the Psychiatric Technician Law was passed in 1959, a psychiatric technician would have been an "attendant" within the meaning of the Nursing Practice Act. The former act would then have removed psychiatric technicians from the scope of the latter act in 1959.

9. In the interim, section 4502 had been amended several times to read as it presently does (Stats. 1968, ch. 1323, § 2, pp. 2501-2502; Stats, 1970, ch. 1058, § 2, pp. 1889-1890). It now reads:

"As used in this chapter, 'psychiatric technician' means any person who, for compensation or personal profit, implements procedures and techniques which involve understanding of cause and effect and which are used in the care, treatment, and rehabilitation of mentally ill, emotionally disturbed, or mentally retarded persons and who has one or more of the following:

attendants or psychiatric technicians in institutions under the jurisdiction of or subject to visitation by the State Department of Public Health, the State Department of Mental Hygiene or the Department of Corrections. Services so given by a

Fn. 9 Cont'd.

(a) Direct responsibility for administering or implementing specific therapeutic procedures, techniques, treatments, or medications with the aim of enabling recipients or patients to make optimal use of their therapeutic regime, their social and personal resources, and their residential care.

(b) Direct responsibility for the application of interpersonal and technical skills in the observation and recognition of symptoms and reactions of recipients or patients, for the accurate recording of such symptoms and reactions, and for the carrying out of treatments and medications as prescribed by a licensed physician and surgeon or a psychiatrist.

"The psychiatric technician in the performance of such procedures and techniques is responsible to the director of the service in which his duties are performed. The director may be a licensed physician and surgeon, psychiatrist, psychologist, rehabilitation therapist, social worker, registered nurse, or other professional personnel.

"Nothing herein shall authorize a licensed psychiatric technician to practice medicine or surgery or to undertake the prevention, treatment or cure of disease, pain, injury, deformity, or mental or physical condition in violation of the law." (Emphasis added.)

psychiatric technician shall be limited to services which he is authorized to perform by his license as a psychiatric technician.

"The Director of Mental Hygiene shall determine what shall constitute adequate medical and nursing supervision in any institution under the jurisdiction of the State Department of Mental Hygiene." (Emphasis added.)

"2727.5. Except for those provisions of law relating to directors of nursing services, nothing in this chapter or any other provision of law shall prevent the utilization of a licensed psychiatric technician in performing services used in the care, treatment, and rehabilitation of mentally ill, emotionally disturbed, or mentally retarded persons within the scope of practice for which he is licensed in facilities under the jurisdiction of or licensed by the Department Mental Hygiene or the Department of Public Health, or their successor agency or agencies, that he is licensed to perform as a psychiatric technician, including any nursing services under Section 2728, in facilities under the jurisdiction of the Department of Mental Hygiene." (Emphasis added) 10/

As noted, those who argue that a psychiatric technician may not supervise a registered nurse rely heavily, if not primarily, upon the language of section 2728. They additionally rely upon the present wording of section 4502 to the extent that that section gives a psychiatric technician "direct responsibility" for various functions. They argue that such language negates the legal ability of a psychiatric technician to act as a supervisor. This latter argument, of course, would mean that a psychiatric technician not only could not supervise registered nurses but could not supervise psychiatric technicians as well. We reject these arguments for a number of reasons.

The argument that section 2728 precludes a psychiatric technician from supervising a registered nurse relies upon

10. These sections have been amended several times to reflect the subsequent reorganizations of the functions of the then Department of Public Health and the Department of Mental Hygiene, which now repose in the Departments of Health Services, Mental Health and Developmental Services.

the premise that the language of that section states and requires that psychiatric technicians must be supervised by registered nurses when providing any nursing services. Or stated otherwise, section 2728 provides an exception to the Nursing Practice Act for psychiatric technicians, as long as they are supervised by registered nurses. This argument is not persuasive for a number of reasons:

1. This argument ignores the fact that for decades psychiatric technicians had been supervising other psychiatric technicians as to "nursing services." These nursing services properly fell within the ambit of their traditional hospital functions, and subsequently within the ambit of their certification and licensing laws. It also ignores the fact that for about ten years before section 2728 was amended, psychiatric technicians had been supervising those registered nurses who were being used interchangeably with psychiatric technicians on non-medical wards.

2. This argument ignores the fact that section 2728 essentially gives something to psychiatric technicians. As already noted, for 12 years psychiatric technicians had been providing "nursing services" which fell within the scope of their practice as to those persons designated to be within the scope of their act. Such persons were those who were and are "mentally ill, emotionally disturbed, or mentally retarded." Section 2728 would then seem to have been unnecessary legislation unless the reason was to expand the scope of what a psychiatric technician may legally do. As noted above, section 2728 as first enacted basically permitted the "supervised" rendering of nursing services by hospital attendants as to any type of patient in any type of hospital. When this is considered, it is seen that section 2728 really grants psychiatric technicians the power to render supervised "nursing services" in virtually any hospital for any type of patient provided that the services are the type provided for in their own licensing act. In short, section 2728 provides that a psychiatric technician is not restricted to caring for persons who are "mentally ill, emotionally disturbed or mentally retarded" if he is adequately supervised. 11/

3. Finally, the argument ignores the provisions of section 2728.5. It is this section, and not section 2728 which really provides the exception to the Nursing Practices Act for psychiatric

11. Interestingly, on January 28, 1977 the Counsel for the Department of Consumer Affairs rendered his opinion to the effect that section 2728 permits "services" by a psychiatric technician as to patients other than those in the three specified categories found in their act. (Legal Op. 77-7.)

technicians, if needed. 12/ The language of section 2728.5 to the effect that "nothing in this chapter . . . prevents . . . , etc" makes this clear. However, it is not that language, but the introductory phrase "[e]xcept for those provisions of law relating to directors of nursing services" which is the most significant. In fact, that phrase, when read in its historical perspective, virtually conclusively answers affirmatively the question whether psychiatric technicians may supervise other psychiatric technicians, or even those registered nurses who are providing the same type of patient care. As to the meaning of the introductory phrase, an examination of the law discloses a number of situations where administrative regulations have been enacted with respect to "directors of nursing services," and which require that such positions be filled by a registered nurse. (See Cal. Admin. Code, tit. 22, § 70215, general acute care hospital; § 71215, acute psychiatric hospital; § 72323, skilled nursing facility.) Additionally, at this point in time (1971) the superintendent or supervisor of nursing services in state hospitals had been

12. The absence of the proviso for 12 years casts serious doubt upon such need.

The views submitted by the California Nurses Association attempt to explain away the presence of section 2728.5 in the law as follows:

"Section 2728.5 was apparently placed in the Nursing Practice Act to reiterate that the provisions of the Act should not be interpreted as preventing the performance by psychiatric technicians of the services they are authorized to perform under sections 2728 and 4502."
(Emphasis added.)

Such argument ignores the cardinal rule of statutory construction that a statute should be construed to avoid making some of the words surplusage. (People v. Gilbert (1969) 1 Cal. 3d 475, 480. Sections 2728.5's role merely as "reiteration" of a rule would render the whole section surplusage. Such argument also ignores the introductory phrase of section 2728.5. That phrase, when put in its historical perspective, indicates that psychiatric technicians may continue as supervisors, contrary to the possible opposite inference which might arise from reading section 2728 above. See further the discussion ante and infra on this point, and the argument also raised by the California Nurses Association, and others, that only registered nurses may supervise nursing services by virtue of not only section 2728, but the present wording of 4502 and the case law and opinions of this office.

Such argument also would fail to give section 2728 any independent significance.

a registered nurse. Psychiatric technicians were limited to advancement only to the position of assistant supervisor of nursing services under civil service provisions. Thus, although section 2728.5 is not the most clearly drafted section, 13/ it is seen that it has independent significance, and it is not a mere reiteration of portions of section 2728.

What then was the purpose of section 2728.5 which was enacted 1) 12 years after the Psychiatric Technicians Law was enacted, and 2) 20 years after the establishment of supervisory psychiatric technicians' classes in state hospitals, and 3) 10 years after the initiation of the practice of placing registered nurses under the supervision of psychiatric technicians in "residential or behavioral" wards?

The opening phrase is the clue. That phrase would not have been necessary unless the section was intended to mean that psychiatric technicians were to continue to be utilized in state hospitals in supervisory roles. Section 2728.5 then sets forth its limitation, which is that nothing should prevent the "utilization" of psychiatric technicians within the scope of their usual practice, (which section 2728 had expanded somewhat with respect to the classes of patients.) 14/ Stated otherwise, it appears that section 2728.5 was intended to maintain the status quo with regard to the usual scope of practice of psychiatric technicians.

13. For example, the last clause in the section would appear to be redundant and searching for something to modify. An examination of Assembly Bill Number 1076, 1971 Regular Session, discloses that this is the result of the piecemeal amendment of the section as it progressed through the Legislature.

14. Also, insofar as one might point out that section 2728, paragraph two, alludes solely to hospitals under the jurisdiction of the Department of Mental Hygiene; that therefore, one would normally only expect to find persons therein who were "mentally ill, emotionally disturbed, or mentally retarded, we conclude that the Director of Mental Hygiene could determine that, insofar as Section 2728 might require adequate nursing supervision by a registered nurse for such patients, this was satisfied by the continued requirements that the supervisor of nursing services in state hospitals be a registered nurse. Also, patients in state hospitals have not necessarily been restricted to the three categories set forth in section 4502. See 62 Ops.Cal.Atty.Gen. 21 (1979), Opinion No. 78/98, dated January 5, 1979.

That this is the case is graphically demonstrated by the earlier versions of section 2728.5 as it progressed through the Legislature. For example, the bill as amended on May 26, 1971, provided that section 2728.5 should read as follows:

"Sec. 2. Section 2728.5 is added to the Business and Professions Code, to read:

"2728.5. Nothing in this chapter or any other provision of law shall prevent the utilization of a licensed psychiatric technician in performing services in facilities under the jurisdiction of or licensed by any agency that is the successor the Department of Mental Hygiene or the Department of Public Health, or their successor agency or agencies, that he currently performs in facilities under the jurisdiction of or licensed by the Department of Mental Hygiene or the Department of Public Health."

There were three successive amendments to the bill thereafter. For example, the June 30, 1971 amendment first declared the necessity to insure that directors of nursing services were to be excepted from the scope of a psychiatric technician's practice. That version read:

"Section 2728.5 is added to the Business and Professions Code, to read:

Nothing Except for those provisions of law relating to directors of nursing services, nothing in this chapter or any other provision of law shall prevent the utilization of a licensed psychiatric technician in performing services in facilities under the jurisdiction of or licensed by the Department of Mental Hygiene or the Department of Public Health, or their successor agency or agencies, that he currently performs in facilities under the jurisdiction of the Department of Mental Hygiene."

Successive amendments, however, changed the plain language used to that of a more legalized format. Also, more caveats were added. However, the thrust of the bill could not have been much clearer when examined as above, that is, to maintain at least the status quo with respect to psychiatric technicians.

The various versions of a bill as it progressed through the Legislature may be used in ascertaining the legislative intent. (See Prudential Insurance Co. v. Workers' Comp. Appeals Bd. (1978) 22 Cal.3d 776, 782-783; Bragg v. City of Auburn (1967) 253 Cal.App.2d 50, 52-53; Dami v. Dept. of Alcoholic Div. Control (1959) 176 Cal.App.2d 144, 148-149; 59 Ops.Cal.Atty.Gen. 266, 270-271 (1976).) We conclude from an examination of these changes, when compared with the final version of the statute, that section 2728.5 was intended to insure that the scope of practice of psychiatric technicians with respect to those for whom they normally provided care (mentally ill, etc.) was not altered by the enactment of section 2728, or any other law. As described at length above, the scope of that practice included responsible supervision of other psychiatric technicians, and registered nurses who performed comparable service.

We will, however, address several other contentions which have been advanced to support the argument that psychiatric technicians may not supervise registered nurses. One contention is that section 4502 was amended in 1968 to provide that a psychiatric technician has "direct responsibility" for providing the services enumerated in section 4502 (see text of section at note 9, supra); that, therefore, such language precludes supervision, which is the indirect providing of services. However, considering the history of the use of psychiatric technicians as supervisors for decades before this 1968 amendment, we believe another reason for the use of this language must be sought. It is to be recalled that, as originally enacted, section 4502 placed the psychiatric technician's practice "under the direction of a licensed physician or psychiatrist or a registered professional nurse." The section now contains no such language, but makes the psychiatric technician responsible "to the director of the service in which his duties are performed," who "may be a licensed physician and surgeon, psychiatrist, psychologist, rehabilitation therapist, social worker, registered nurse, or other professional personnel." We believe that this addition of the language "direct responsibility" was intended to upgrade psychiatric technicians, to provide specifically that they performed their services pursuant to their own professional licensing laws, and not derivatively through others. The expansion of the language to include numerous disciplines other than physicians, psychiatrists and nurses, indicates the change in the mode of treatment in recent years under the "program management" concept. This expansion of disciplines also militates against the concept that psychiatric technicians must always be responsible to registered nurses, one of the "linchpins" for the various arguments that psychiatric

technicians may not supervise registered nurses. 15/

Another variation of this "direct versus indirect" argument emanates from the Nursing Practice Act, case law, and opinions of this office. Section 2725 defines the practice of nursing as including "direct and indirect patient care services." In 59 Ops.Cal.Atty.Gen. 537 (1976) this office held that "supervision" fell within the meaning of "indirect" patient care. This was significant in determining if the Board of Registered Nursing had jurisdiction to discipline one of its licensees for inadequate supervision of other nurses. In I.L. 74-26, this office considered a number of questions relating to the inability of psychiatric technicians to delegate functions to unlicensed personnel. This letter opinion relied heavily upon Magit v. Board of Medical Examiners (1961) 57 Cal.2d 74 16/ in holding, inter alia, that psychiatric technicians could not delegate their professional duties to unlicensed "center technicians." This letter opinion is sometimes cited for the proposition that the "direct responsibility" language of section 4502 means a psychiatric technician must personally perform all services. Therefore, so goes the argument, a psychiatric technician who acts in a supervisory capacity is illegally practicing nursing by rendering indirect patient services. A fortiori, a psychiatric technician may not supervise a registered nurse.

This argument, of course, ignores the history of the Psychiatric Technicians Law to the effect that psychiatric technicians have supervised others, including registered nurses, for many years, and that that law was enacted and amended in this historical context. Additionally, this argument does not disclose

15. The "upgrading" construction of the 1970 amendment is fortified by an examination of Statutes of 1968, Chapter 1323, where it is seen that in 1963 the statute still provided for practice under the direction of a physician, psychiatrist or registered nurse yet provided that their practice would require "close work" with all the disciplines enumerated in the present section.

In short, as of 1970, the "accountability" of a psychiatric technician solely to an M.D. or an R.N. was eliminated from the statute, weakening the argument that psychiatric technicians must be supervised by R.N.s

16. The Magit case held that a licensed physician, in such case an anesthesiologist, could not delegate his medical functions (administration of anesthetics) to unlicensed persons, no matter how competent such persons might be.

that in I.L. 74-26 this office held only that a psychiatric technician could not delegate duties to an unlicensed person (as in Magit, supra). That this is clear is exemplified in the following quote from that opinion (Id. at p. 5).

" . . . Thus, keeping in mind that there are no other subordinate healing art licensees to whom the described functions and responsibilities could be delegated and the fact that the psychiatric technician is responsible to his director of service for the performances of his duties, it must be concluded that unless the described functions and responsibilities are being performed by other authorized licensed personnel, a psychiatric technician in being directly responsible for his functions and responsibilities must be presumed to be personally responsible for performing his duties."
(First emphasis added.)

This language is consistent with the idea that a psychiatric technician may delegate responsibilities to another psychiatric technician, or registered nurse, or even a physician. It in no way holds that a psychiatric technician must always personally perform his duties. 17/ Nor is it contrary to Magit v. Board of Medical Examiners, supra, 57 Cal.2d 74 to conclude that a psychiatric technician may supervise other personnel who are also licensed. We essentially so held in our 1974 letter opinion.

Accordingly, it is concluded from an examination of the historical background of the Psychiatric Technicians Law, its

17. The confusion may have been engendered because conclusion three, at page one of the opinion, is not as complete as the analysis. It states:

"3. The term "direct responsibility" as used in section 4502 requires a psychiatric technician to personally perform the described functions and responsibilities."

See, however, conclusion 2 to that letter opinion, at page one:

"2. The described functions and responsibilities performed by licensed psychiatric technicians under section 4502 cannot be delegated unless delegated to someone licensed to perform those functions."

administrative construction and the amendments thereto read in juxtaposition with the Nursing Practice Act, that psychiatric technicians may supervise registered nurses within the scope of the practice of a psychiatric technician. We realize the line is vague as to those nursing services a psychiatric technician may perform. However, that fact would not justify holding that a psychiatric technician must always remain at the lowest level of patient care service, when, as a matter of administrative practice, psychiatric technicians and registered nurses have been used interchangeably both at the ward level and as supervisors for over 15 years.

In so concluding, we of course are in no way holding that a psychiatric technician may act as a supervisor of a medical-unit, where intensive nursing service is required. And it is our understanding that psychiatric technicians have never been so utilized, but that registered nurses are properly assigned such supervisory roles.

2. Can Psychiatric Technicians Overrule A Nursing Decision?

The foregoing analysis should make it clear that when a psychiatric technician performs a basic level of nursing care in a state hospital or similar institution, he does so under his own licensing act, the Psychiatric Technicians Law, and not at the sufferance of the Nursing Practice Act, although the two acts may overlap to some degree. This has been graphically demonstrated by the fact that for 12 years the Nursing Practice Act did not even allude to psychiatric technicians as a limited exception to its licensing requirements. (Cf. Mains v. Bd. of Barber Examiners (1967) 249 Cal.App.2d 459, 463, overlap between practice of barbering and cosmetology; Lehmann v. Dalis (1953) 119 Cal.App.2d 152, 154, overlap between practice of architecture and civil engineering.)

The second question presented is whether a psychiatric technician may overrule a "nursing decision." No particular nursing decision is presented for resolution. However, in that 1) psychiatric technicians may legally perform certain nursing services, and 2) psychiatric technicians may supervise other psychiatric technicians, or other licensees such as registered nurses performing the same services, it follows that a psychiatric technician could overrule a "nursing decision" if such a decision falls within the purview of the licensing provisions of the Psychiatric Technician Law. If the "nursing decision" is one beyond the legal competence of a psychiatric technician, the opposite conclusion would follow.

In so concluding, we again realize that the line may be difficult to draw or ascertain. This problem, if it is a problem, is one which should be directed to the Legislature.

In so concluding, we note that in reality this may be more an administrative problem than a legal problem - that is - to have an immediate and effective appeal by a registered nurse when a decision she makes is overruled by a supervising psychiatric technician. This procedure should also insure that there would be no reprisals for its use. Such a procedure would then provide the registered nurse at the ward care level assurance that the supervisor is not acting beyond his or her legal competence. 18/

3. Can A Psychiatric Technician Perform Those Nursing Functions Which Have Not Been Delegated By a Registered Nurse?

The third question presented is whether a psychiatric technician may perform nursing functions which have not been delegated by a registered nurse.

It should be clear from the discussion on question one above that the Psychiatric Technicians Law has contemplated this result from its enactment in 1959. Psychiatric technicians have been legally supervising other psychiatric technicians and registered nurses under that act for approximately two decades. That act permits psychiatric technicians to perform a certain level of nursing services with respect to patients who are "mentally ill, emotionally disturbed or mentally retarded." So long as the parameters of that act are not exceeded, it follows that such nursing functions need not be delegated by a registered nurse. In short, the Psychiatric Technicians Law and the Nursing Practice Act overlap -- the former is not subservient to the latter. As held in the analogous situation in Lehmann v. Dalis, supra, 119 Cal.App.2d at page 154: "[t]o the extent that architectural services and civil engineering services overlap, they may be rendered either by a licensed architect or by a registered civil engineer." Likewise, to the extent that the Psychiatric Technicians Law and

18. For example, the views letter submitted to this office by the Department of Mental Health stated:

"Question number (2) is handled by an appeal process system within the State hospital. If a decision is made by a supervisor and the working staff does not agree with that decision, the staff has the right to appeal through the hospital chain of command. This appeal process is available on a twenty-four hour basis and it includes the hospital executive director. The Department cannot conceive of a situation so drastic that the working staff could not place a telephone call to the appropriate party for a decision. This then means that both psychiatric technicians and registered nurses can avail themselves to [sic] the hospital appeal process."

the Nursing Practice Act overlap, the overlapping services may be performed by either a psychiatric technician or a registered nurse.

Accordingly, a psychiatric technician may perform nursing services which have not been delegated by a registered nurse so long as such nursing services fall within the scope of the licensing provisions for psychiatric technicians.

SUMMARY

The psychiatric technician evolved as a civil service classification in 1951 from the previous position of hospital attendant in the state hospital system.

In 1959, after extensive legislative hearings, the Legislature enacted the Psychiatric Technicians Law to grant professional status to psychiatric technicians. It was initially a "certification law," but in 1968 became a "licensing law."

At the time the Psychiatric Technicians Law was enacted, psychiatric technicians had worked not only the ward level, but had held responsible supervisory positions supervising other psychiatric technicians. There is no indication in the legislative history of the law that the Legislature was dissatisfied with this or intended to change it. In fact, the administrative construction of the statute by those required to implement it was otherwise, since they continued to permit psychiatric technicians to fill supervisory positions, to include the position of Assistant Supervisor of Nursing Services.

The Psychiatric Technicians Law as initially enacted provided in section 4502 that the psychiatric technician performed his services under the direction of a physician or psychiatrist or registered nurse. As originally enacted, the law provided that such services included "responsible nursing services," and enumerated (as it now does) many services which traditionally have been basic nursing services. The Psychiatric Technicians Law was amended in 1968, and became a licensing act. The 1968 amendments to section 4502 retained the language regarding the performance of services under direction of a physician or a psychiatrist or a registered nurse, but added language that in performing their patient services, psychiatric technicians would be required to work closely with many disciplines, to wit, "licensed physicians and surgeons, psychiatrists, psychologists, rehabilitation therapists, social workers, registered nurses, and other personnel."

In 1970, the Psychiatric Technicians Law was again amended. The language requiring services to be rendered under

the direction of a physician or psychiatrist or a registered nurse was deleted, and the psychiatric technician was given "direct responsibility" for the performance of his services, with, however, ultimate responsibility to the director of his service. The "director of service" was to be and is defined as any of the many disciplines enumerated in the 1968 amendment, ^{as} forth above. The 1970 amendment also continued in section 4502 the language which it has had from its inception that a psychiatric technician will be "carrying out treatments and medications as prescribed by a licensed physician or surgeon or a psychiatrist."

Thus, the Psychiatric Technicians Law itself has never provided that a psychiatric technician must always be supervised by a registered nurse, and the language that he must be under the direction of a physician or psychiatrist or a registered nurse in performing all services was deleted in 1970.

Insofar as the Nursing Practice Act is concerned, it was not until 1971 that it even mentioned psychiatric technicians. Thus, for 12 years, psychiatric technicians practiced as a certificated profession, and subsequently as a licensed profession with no indication that they did so at the sufferance of the Nursing Practice Act, or only as delegates of nurses. In 1971 the Nursing Practice Act was amended so as to amend section 2728 thereof and to add section 2728.5 thereto. Section 2728, which had since 1939 basically provided that "hospital attendants" could provide nursing services in any hospital with respect to any type of patient, if adequate medical or nursing supervision was provided, was amended to include psychiatric technicians so long as the nursing services they provided were of the type falling within the scope of their own licensing law.

Although many argue that the wording of section 2728 means that psychiatric technicians may only provide nursing services under the supervision of a registered nurse, such an inference is not persuasive for several reasons. First of all, section 2728 must have been intended to grant psychiatric technicians something, since for 12 years they had already had been providing the "services" specified in section 2728 under their own certification and, later, licensing law. In short, section 2728 would have been unnecessary legislation unless it was intended to increase the scope of practice for psychiatric technicians. Secondly, an analysis of section 2728.5 demonstrates that section 2728 was clearly not intended to restrict the psychiatric technicians' powers in any way. Section 2728.5 provides that, insofar as psychiatric technicians had been rendering patient care to the "mentally ill, emotionally disturbed and mentally retarded," the status quo was to be maintained. This status quo included supervision of other

psychiatric technicians and registered nurses. This being so, the true intent of the amendment to section 2728 appears to have been to remove any restrictions upon psychiatric technicians as to the type of patient for whom they may provide care.

From the foregoing analysis, it follows that psychiatric technicians may supervise registered nurses within the proper scope of the psychiatric technician's practice. It also follows that, within that proper scope of their practice, psychiatric technicians may overrule "nursing decisions." Finally, it follows from the above analysis, that psychiatric technicians practice under their own licensing provisions, which happen to overlap with the Nursing Practice Act. Therefore, they may perform nursing services within the proper scope of that practice without a delegation therefor from a registered nurse.

If the scope of such practice is too vague and uncertain, it would appear that the solution is either an administrative problem to be resolved within the hospital organizational structure, or is a problem to be directed to the Legislature for clarification.

* * *

Attachment 4



BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR.
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MEMORANDUM

DATE	February 8, 2019
TO	Board Members
FROM	Vicki Lyman Assistant Executive Officer
SUBJECT	Licensing Division Report

STAFFING UPDATE:

Since the last Board Meeting, there are four Licensing Services Technician vacancies and one Staff Services Analyst vacancy. Interviews will be held in late February/early March to fill these five vacancies. Vicky Saavedra, one of the evaluation analysts accepted a newly created position in the Administration and Support Services Unit as of February 11th. The Board is fortunate to retain her institutional knowledge and provide a promotional opportunity.

CE AUDIT UPDATE:

The CE Audit cannot move forward until the Licensing vacancies are filled and the new team members receive adequate training. Without the proper resources, the audit will fail. We anticipate starting the audit in late March/early April.

LICENSING STATICS:

Board members received the Licensing Division Statistical Data – Executive Summary with the other Board materials. These comprehensive Licensing statistics show the difference between 2017 and 2018. Two areas are highlighted as challenges: the number of incoming telephone calls/calls answered and processing times for equivalency applications. As mentioned in the Executive Summary, the Organizational Change Management team is presenting their findings/recommendations regarding all Licensing processes to the Executive Officer and Assistant Executive Officer in late February. This information will be shared at the next Licensing Committee meeting.



Licensing Division Statistical Data

January 1, 2017 thru December 31, 2018

Executive Summary

Background

The Board of Vocational Nursing and Psychiatric Technicians (BVNPT) started reorganizing the Licensing Division (Licensing) in March 2018. The desired outcome of the reorganization is having the correct processing functions in the correct units and increasing the number of team members answering incoming telephone calls and processing applications.

Before the reorganization, the reception team answered all incoming telephone calls, responded to general BVNPT emails, assisted applicants and licensees at the public counter and reviewed online renewals. Each function is licensing related. However, this team was organizationally assigned to Administration and Support Services which provided oversight for personnel, budgets, and other tasks supporting BVNPT. The reorganization moved the reception team to Licensing.

The reorganization became effective in late October 2018 as each step had to be reviewed and approved by the Department of Consumer Affairs' (DCAs) Office of Human Resources (OHR). The reception team members were reclassified from Office Technicians (OTs) to Program Technician IIs (PT IIs) for consistency since most of the Licensing positions are PT IIs. Each duty statement is updated to reflect the new classification and additional duties. Additionally, the Bargaining Units (BUs) had to be notified and approve the position reclassifications, and the team members were given a 30-day notice of the reclassification and subsequent move to Licensing.

From January 2018 thru December 31, 2018, the five-member reception team changed dramatically. One team member took an assignment in BVNPT's Enforcement Division, two were promoted to analyst positions with other agencies, one returned to a previous position and one retired. A new team member started in November and another started in December. Currently, these two new team members are doing an outstanding job. Recruiting team members is challenging and takes several months, and our Licensing Manager and Supervisor are doing their best to build a dedicated and hardworking team.

Statistical Highlights

There are 63 sets of statistical data in this Executive Summary representing the period from January 1, 2017 through December 31, 2018. Highlights include areas with outstanding progress and areas with room for improvement with explanations for both.

Thirteen of the data sets depict processing times while 50 depict number of items received, processed and/or issued. The data sets reflect both in-house and online processing. The online services reduce processing times even though team members still "touch" the items.

The two biggest challenges for Licensing are reducing/answering the number of incoming telephone calls and reducing the amount of time to process equivalency applications.

Certain events impact the number of incoming telephone calls. For example, the abrupt closure of a vocational nursing (VN) or psychiatric technician (PT) program increases incoming telephone calls as frantic students call BVNPT for answers.

(Continue to next page)

Incoming Telephone Calls to BVNPT

Year	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
2018	29,472	25,305	32,723	18,723	14,076	12,049	11,983	17,989	19,070	19,526	8,267	6,696	215,879
2017	45,669	22,847	11,990	9,269	9,315	10,148	11,485	19,494	20,275	31,455	34,783	25,477	252,207

A significant event impacting incoming calls occurred in December 2016, when BVNPT mailed 52,000 letters to licensees for an unsuccessful Continuing Education (CE) Audit. This impact was felt throughout 2017, and BVNPT finally terminated work on the audit after all Licensing functions were impaired. Work backlogs continued throughout the first quarter of 2018, and in November 2018, the number of incoming calls decreased by 57 percent from the previous month and decreased 76 percent from November 2017. December 2018 shows a decrease of 19 percent from the previous month and a 73 percent decrease from the previous year. Overall, there were 36,328 fewer incoming calls in 2018 which is a 14 percent decrease. These high numbers also reflect the phenomenon of repetitive hang ups. Applicants/licensees call in, are on hold in the queue for up to an hour, hang up, and call again. Then repeat the cycle. The Licensing staff's hard work in reducing processing backlogs contributes to the decrease the number of incoming telephone calls to BVNPT.

Incoming Telephone Calls Answered

Year	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
2018	2,051	1,944	1,913	2,354	2,579	2,158	2,197	1,811	1,259	1,478	2,516	2,234	24,494
2017	2,687	2,045	3,368	3,387	3,447	2,620	2,338	2,663	1,591	1,693	1,224	1,610	28,673

The challenge continues as we look at the actual number of incoming telephone calls answered in 2017 and 2018. There are five team members assigned to answering the telephones, plus responding to general BVNPT emails, assisting applicants and licensees at the public counter and reviewing online renewals. In 2018, there were 4,179 less calls answered which we attribute to absences (vacation and illness) and vacancies. When a new team member is hired, it takes considerable time and training to bring the team member up to speed to answer specific licensing questions. Currently, there are three vacancies on the reception team and other Licensing team members assist as they can. If team members are pulled from other processing functions, backlogs start and the number of incoming calls increases. The remedy is fully staffing, training and retaining the reception team. Once this team is fully staffed and trained, the "on hold" queue in the telephone system can be reconfigured and more callers will be placed on hold.

The next Licensing challenge is processing VN/PT equivalency applications received online and via mail (in house). The processing times listed in the charts represent the time in weeks it takes to process the applications. For example, if a VN

application is submitted in December 2018, it will take the analyst approximately 43 weeks to process the applications received in December 2018. The length of time to process applications is based on the complexity of the documents related to the application, the amount of time the applicant and schools take to provide the required documents, and the amount of time needed to analyze and verify the documents.

In 2017 the new Licensing Manager discovered that PT IIs were processing VN/PT equivalency applications. Due to the complexity of the applications, all equivalency applications were pulled from the PT IIs and reassigned to the Licensing analysts. Moving forward, all equivalency applications are assigned to the **three** analysts which dramatically increased the processing time. The processing time for VN equivalency applications went from an average of 22 weeks in 2017 to an average of 40 weeks in 2018. The number of PT equivalency applications received is less and the processing times dramatically improved.

VN Equivalency Applications Processing Time in Weeks - Online and In House

Year	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
2018	31.70	35.50	40.00	40.00	38.00	38.00	39.60	41.60	43.00	42.00	43.00	43.00
2017	20.25	21.50	22.75	23.80	28.00	17.35	18.00	18.00	20.00	22.00	25.00	28.00

PT Equivalency Applications Processing Time in Weeks - Online and In House

Year	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
2018	16.10	19.10	23.60	23.00	22.50	10.00	5.60	2.40	1.00	0.40	0.50	0.20
2017	8.00	12.50	15.50	16.25	10.40	4.25	4.80	6.00	10.00	15.60	18.10	22.10

VN Equivalency Applications Received - Online and In House

Year	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
2018	143	136	158	150	156	143	126	168	147	170	115	125	1,737
2017	133	147	173	132	174	156	161	157	149	170	116	108	1,776

PT Equivalency Applications Received - Online and In House

Year	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
2018	0	4	3	1	0	1	0	1	3	0	4	2	19
2017	0	4	0	0	3	2	5	6	4	4	4	0	32

These two challenges continue to be a top priority for Licensing. Rebuilding the reception team after the vacancies and training the team will improve the number of calls answered and improve BVNPT's customer satisfaction. Additional customer service training will be scheduled for all Licensing team members in March 2019.

The challenge with the processing times for equivalency applications underwent an in-depth review by DCA's Organizational Change Management (OCM) team. The OCM team is presenting their findings/recommendations to the Executive Officer and Assistant Executive Officer in late February. The Licensing Committee will receive this information at their next meeting. This information will also be provided to the entire Board at the May Board meeting.

In October 2018, the NECs surveyed 152 schools to determine the projected number of students graduating in November and December 2018 and January 1 thru December 31, 2019. A total of 124 schools responded. The number of projected graduates is listed in the table. The Licensing Division is using this information to anticipate workload as graduations impact several areas in Licensing. Specifically, there will be an increase in the number of incoming telephone calls, faxes, emails and mail, examination requests, examination retakes and initial applications. The cashiers will also be affected if applicants do not use the online services.

This information is also shared with the Enforcement Division since some applicants may need a background review.

Number of Projected Graduates from Schools (124 schools reported – 28 schools did not report):

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2019	468	346	496	540	767	554	601	711	615	506	474	795	6,873
Total 2018											441	963	1,404

There are two notable improvements listed below. The remainder of the Executive Summary contains all data sets for Licensing and begins on page 6.

- The was a 30 percent decrease in the number of applicants/licensees visiting the BVNPT offices in 2018. This can be attributed to the reduced backlogs. (Page 12)
- In 2018, there 42,583 fewer pieces of incoming mail which is a 54 percent decrease in the amount of incoming mail. The CE Audit of December 2016 greatly impacted the first half of 2017. BVNPT hopes to increase online services in 2019 and further decrease the amount of incoming mail. (Page 13)

**BVNPT Licensing Division Statistics
January 2017 thru December 2018
Vocational Nurses and Psychiatric Technicians**

VN Examination Request Received:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	576	654	600	679	892	489	531	609	563	653	590	858	7,694
Total 2017	449	648	691	504	893	590	535	900	603	642	491	770	7,716

PT Examination Requests Received:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	74	15	11	3	60	13	47	65	55	12	11	110	476
Total 2017	68	15	8	3	81	5	79	50	55	9	8	116	497

VN Examination Retakes:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	448	420	453	421	433	378	363	700	409	422	331	301	5,079
Total 2017	419	414	514	388	454	390	405	423	437	401	375	330	4,950

PT Examination Retakes:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	28	32	29	35	24	35	26	51	30	29	23	21	363
Total 2017	30	27	35	34	32	31	26	33	17	34	22	23	344

VN Interim Permits Issued:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	20	15	14	10	18	11	15	20	11	13	3	12	162
Total 2017	15	14	9	15	16	17	18	17	28	7	11	16	183

PT Interim Permits Issued:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	0	0	0	1	3	0	3	0	0	0	0	11	18
Total 2017	0	0	0	0	0	0	0	0	0	0	0	0	0

VN Examination Results:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	662	661	913	850	919	858	984	969	818	831	781	843	10,089
Total 2017	656	772	1179	773	863	916	941	952	916	889	803	758	10,418

PT Examination Results:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	40	49	85	97	62	50	60	57	50	77	63	36	726
Total 2017	42	44	49	77	68	55	75	66	59	46	66	55	702

VN Initial Applications Received:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	508	490	619	655	548	623	578	953	551	603	497	527	7,152
Total 2017	581	502	605	639	519	546	517	646	624	582	488	490	6,739

PT Initial Applications Received:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	17	28	33	54	48	26	30	51	27	35	45	23	417
Total 2017	24	28	17	31	49	26	38	31	29	34	41	27	375

VN Endorsements Received:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	46	48	53	49	47	63	43	88	59	44	35	36	611
Total 2017	49	43	65	42	46	52	56	63	61	83	37	41	638

PT Endorsements Received:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	0	0	0	0	0	0	0	0	0	0	0	0	0
Total 2017	0	1	0	0	0	0	1	0	0	0	1	0	3

VN Verification Letters Received:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	191	173	153	165	202	165	177	159	154	150	171	135	1,995
Total 2017	127	162	208	185	172	176	158	181	133	180	116	107	1,905

PT Verification Letters Received:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	0	1	2	1	0	1	1	0	0	0	1	0	7
Total 2017	0	0	0	0	0	0	0	1	1	0	0	0	2

VN Licenses Issued:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	349	442	368	825	917	626	528	933	541	612	498	447	7,086
Total 2017	589	595	658	596	571	397	554	635	506	723	477	547	6,848

PT Licenses Issued:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	24	16	29	60	47	32	30	57	28	35	38	36	432
Total 2017	22	27	33	27	51	28	25	36	50	30	38	31	398

VN Renewals Received:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	4,472	3,647	4,018	3,618	3,674	3,718	3,899	6,828	3,941	4,404	4,081	3,778	50,078
Total 2017	3,924	3,856	4,416	3,762	3,945	3,943	3,509	3,926	4,151	4,109	3,938	3,740	47,219

PT Renewals Received:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	384	376	372	346	361	351	401	614	356	383	368	358	4,670
Total 2017	320	356	384	410	356	411	378	430	347	383	382	333	4,490

**BVNPT Licensing Division Statistics
January 2017 thru December 2018
Vocational Nurses and Psychiatric Technicians – Processing Times in Weeks**

VN School Applications – Online:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
Total 2018	4.40	3.70	1.70	1.00	0.40	0.50	0.10	0.30	0.10	0.00	0.00	0.20
Total 2017	4.50	4.00	4.25	2.00	2.75	1.50	1.50	1.30	1.00	3.40	2.80	5.50

PT School Applications – Online:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
Total 2018	5.10	5.20	4.90	1.00	0.50	1.00	1.30	0.80	0.20	0.70	0.20	0.32
Total 2017	3.75	11.50	10.50	7.00	2.00	1.50	1.40	1.50	5.50	10.00	7.00	3.00

VN School Applications – In House:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
Total 2018	1.70	3.00	1.70	1.80	1.00	1.00	0.30	0.20	0.10	0.20	0.30	0.20
Total 2017	8.50	8.75	6.50	4.00	3.60	2.70	1.80	1.30	1.30	2.80	3.00	2.00

PT School Applications – In House:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
Total 2018	5.10	5.20	4.70	1.00	5.00	0.80	1.70	0.70	0.70	0.70	0.30	0.20
Total 2017	4.50	7.00	8.50	6.00	1.00	2.00	1.70	3.50	7.50	7.80	4.50	2.70

PT Re-Examination:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
Total 2018	5.00	2.40	2.50	1.00	1.10	1.10	1.50	1.00	0.90	1.00	0.60	0.50
Total 2017	3.50	5.75	7.00	3.00	4.00	2.25	2.00	1.50	5.50	5.10	3.30	1.80

VN Equivalency – Online and In House:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
Total 2018	31.70	35.50	40.00	40.00	38.00	38.00	39.60	41.60	43.00	42.00	43.00	43.00
Total 2017	20.25	21.50	22.75	23.80	28.00	17.35	18.00	18.00	20.00	22.00	25.00	28.00

PT Equivalency – Online and In House:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
Total 2018	16.10	19.10	23.60	23.00	22.50	10.00	5.60	2.40	1.00	0.40	0.50	0.20
Total 2017	8.00	12.50	15.50	16.25	10.40	4.25	4.80	6.00	10.00	15.60	18.10	22.10

VN Verification – Online:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
Total 2018	15.20	19.20	16.60	1.80	0.50	0.90	1.20	0.80	1.20	0.90	0.70	1.00
Total 2017	14.50	13.00	7.00	2.80	4.10	3.60	4.70	6.00	10.00	8.50	12.00	13.00

VN Verification – In House:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
Total 2018	13.90	16.50	15.30	2.10	1.60	1.90	1.70	1.70	1.50	1.90	1.60	2.80
Total 2017	13.00	12.75	8.00	7.25	6.50	5.50	3.50	4.50	8.00	7.00	9.00	12.00

VN Endorsements – Online:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
Total 2018	2.60	2.90	4.00	1.00	0.60	1.00	1.00	1.60	1.20	1.20	1.70	3.70
Total 2017	2.25	1.25	0.08	1.00	1.00	1.00	1.00	1.00	1.00	1.30	2.00	1.00

VN Endorsements – In House:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
Total 2018	1.40	1.90	2.00	1.00	2.00	0.70	1.00	1.60	1.20	1.20	1.70	3.70
Total 2017	3.25	4.25	4.75	2.60	2.10	1.70	2.00	1.00	1.00	1.00	2.00	2.00

VN Initial Licensure:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
Total 2018	1.40	1.90	2.00	1.00	2.00	0.70	1.00	1.60	1.20	0.90	1.00	0.80
Total 2017	3.25	4.25	4.75	2.60	2.10	1.70	2.00	1.00	1.00	1.00	2.00	2.00

PT Initial Licensure:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
Total 2018	3.40	0.60	1.30	1.00	5.00	1.10	1.30	0.60	0.50	0.80	0.50	0.30
Total 2017	5.00	5.50	4.25	1.80	1.40	1.25	1.70	2.40	6.40	1.40	2.50	2.40

Name Changes:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	19	36	24	25	39	14	24	27	40	121	107	149	625
Total 2017	46	64	33	37	36	23	33	23	38	27	34	19	413

Address Changes:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	806	1,306	1,022	929	961	870	751	795	591	763	569	518	9,881
Total 2017	1,500	1,727	1,881	1,331	1,345	1,402	1,215	1,307	508	721	642	458	14,037

Number of Projected Graduates from Schools (124 schools reported – 28 schools did not report):

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2019	468	346	496	540	767	554	601	711	615	506	474	795	6,873
Total 2018											441	963	1,404

**BVNPT Licensing Division Statistics
January 2017 thru September 2018
Public Counter and Customer Service**

Applicants/Licensees Assisted at the Public Counter:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	449	364	440	151	56	440	306	289	281	308	242	217	3,543
Total 2017	990	515	426	352	368	338	315	384	363	406	343	309	5,109

Temporary Licenses Issued at the Public Counter:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	30	36	62	152	57	9	6	16	0	4	2	7	381
Total 2017				38	30	24	36	39	50	36	26	27	306

Incoming Emails to the General BVNPT Email Box:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	2,051	1,483	1,832	1,548	1,426	1,449	1,462	1,690	1,484	1,646	1,253	1,228	18,552
Total 2017	2,846	2,237	1,921	890	974	1,050	1,051	1,393	1,264	1,807	2,758	1,445	19,636

Incoming Telephone Calls:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	29,472	25,305	32,723	18,723	14,076	12,049	11,983	17,989	19,070	19,526	8,267	6,696	215,879
Total 2017	45,669	22,847	11,990	9,269	9,315	10,148	11,485	19,494	20,275	31,455	34,783	25,477	252,207

Incoming Calls Answered:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	2,051	1,944	1,913	2,354	2,579	2,158	2,197	1,811	1,259	1,478	2,516	2,234	24,494
Total 2017	2,687	2,045	3,368	3,387	3,447	2,620	2,338	2,663	1,591	1,693	1,224	1,610	28,673

Average Time on Hold in Minutes:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
On Hold 2018	39.75	36.75	42.50	32.75	29.75	32.50	32.25	42.00	50.00	49.25	24.25	25.75
On Hold 2017	30.00	36.50	22.25	19.50	20.50	27.25	27.00	31.50	43.50	46.00	54.00	43.00

**BVNPT Administrative and Support Services Statistics
January 2017 thru December 2018**

Incoming Mail:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	2,878	2,566	2,717	3,274	3,060	3,060	2,913	2,657	3,085	3,254	3,226	2,556	35,246
Total 2017	34,241	5,787	4,747	4,598	4,533	4,135	4,565	3,748	3,129	3,629	2,719	1,998	77,829

Cashiering**In House Processed Payments - VN Renewal:**

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	209	445	1,037	644	140	71	165	181	119	171	158	136	3,476
Total 2017	344	121	285	271	117	167	203	213	194	220	202	188	2,525

Online Processed Payments - VN Renewal:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	3,052	2,671	2,843	2,632	2,193	1,431	2,144	3,157	2,978	3,257	3,198	3,231	32,787
Total 2017	2,985	2,302	2,703	2,305	2,017	1,276	1,915	2,651	2,745	2,623	2,697	2,497	28,716

In House Processed Payments - PT Renewal:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	26	37	112	69	14	11	18	12	15	27	14	15	370
Total 2017	46	20	23	22	10	22	24	15	21	28	20	17	268

Online Processed Payments - PT Renewal:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	294	275	298	275	240	157	245	304	292	281	307	301	3,269
Total 2017	267	229	274	269	199	144	218	313	251	268	271	258	2,961

In House Processed Payments - VN Examinations:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	229	232	284	225	358	190	207	227	132	231	179	137	2,631
Total 2017	694	320	514	703	295	492	260	305	264	306	189	209	4,551

Online Processed Payments - VN Examinations:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	336	326	343	381	556	319	282	519	386	408	354	660	4,870
Total 2017	251	281	295	283	489	361	330	452	333	331	332	555	4,293

In House Processed Payments - PT Examinations:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	53	6	8	1	29	4	21	3	29	1	3	24	182
Total 2017	27	4	45	2	4	32	73	22	29	6	2	7	253

Online Processed Payments - PT Examinations:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	22	10	4	1	39	9	27	28	6	16	8	87	257
Total 2017	10	6	3	1	48	4	7	27	27	2	7	112	254

In House Processed Payments - VN Reexaminations:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	145	143	109	120	124	91	107	96	89	127	79	59	1,289
Total 2017	155	74	151	316	109	153	91	116	114	91	87	89	1,546

Online Processed Payments - VN Reexaminations:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	331	294	349	328	340	288	288	357	314	313	262	238	3,702
Total 2017	305	286	362	282	347	291	334	321	326	326	295	252	3,727

In House Processed Payments - PT Reexaminations:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	15	20	15	16	13	18	15	12	13	17	11	13	178
Total 2017	10	15	55	19	27	29	22	29	15	24	13	14	272

Online Processed Payments - PT Reexaminations:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	9	15	11	18	12	14	14	14	13	19	11	3	153
Total 2017	4	2	6	13	7	9	4	5	5	11	8	9	83

In House Processed Payments - VN Interim Permit:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	5	4	2	2	4	2	3	2	1	2	2	0	29
Total 2017	3	3	1	3	11	8	1	3	10	3	5	1	52

Online Processed Payments - VN Interim Permit:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	15	8	11	8	15	12	0	9	9	10	2	9	108
Total 2017	23	16	10	11	11	9	17	13	21	4	6	13	154

In House Processed Payments - VN Verification:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	70	61	59	69	107	62	68	81	48	41	64	34	764
Total 2017	4	7	3	166	103	97	59	66	54	79	47	34	719

Online Processed Payments - VN Verification:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	105	79	85	83	96	87	87	104	88	101	92	77	1,084
Total 2017	11	15	18	95	76	91	89	91	76	84	68	51	765

In House Processed Payments - VN Initial Licensure:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	56	43	63	79	77	48	51	47	30	40	41	28	603
Total 2017	27	110	146	60	83	101	59	80	56	73	47	53	895

Online Processed Payments - VN Initial Licensure:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	450	437	515	571	475	563	525	581	513	561	450	490	6,131
Total 2017	465	430	535	559	453	454	484	567	556	512	432	436	5,883

In House Processed Payments - PT Initial Licensure:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	1	2	5	1	8	2	3	5	1	6	3	4	41
Total 2017	7	5	9	3	10	3	9	2	3	1	7	4	63

Online Processed Payments - PT Initial Licensure:

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total 2018	16	26	16	50	43	23	28	32	25	30	41	20	350
Total 2017	14	22	14	26	41	23	34	29	26	33	34	23	319

Attachment 5

AGENDA ITEM 20.C



BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

Board of Vocational Nursing and Psychiatric Technicians
2535 Capitol Oaks Dr Suite 205 Sacramento CA 95833-2945
Phone: (916) 263-7827 Fax: (916) 263-7857 www.bvnpt.ca.gov



DATE: January 25, 2018
TO: Education Committee Members
FROM: Board Staff
SUBJECT: Proposed Regulatory Action to Amend California Code of Regulations (CCR) Title 16, Division 25, Chapter 1, Article 5, Section 2530 for (VN) and Chapter 2, Article 5, Section 2585 for (PT)

BACKGROUND

Board of Vocational Nursing and Psychiatric Technicians (Board) pass rates for first time test taker candidates rank among the lowest in the nation. For example, California's VN pass rates ranked between 47th and 50th out of 50 states over the past 10 years, making this issue a strong concern regarding the safety and the protection of the public.

At their meeting on November 17, 2017, the Board voted on the motion: **To amend CCR sections 2530 (VN) and 2585 (PT) be amended and that a pass rate percentage of a least 75% be adopted.**

By comparison, Texas counts pass rate percentage during the examination year. Texas Administration Code, Title 22, Part 11, Chapter 214, Rule § 214.4(2)(A) states:

(2) NCLEX-PN® Pass Rates. The annual NCLEX-PN® examination pass rate for each vocational nursing education program is determined by the percentage of first time test-takers who pass the examination during the examination year.

(A) Eighty percent (80%) of first-time NCLEX-PN® candidates are required to achieve a passing score on the NCLEX-PN® examination during the examination year.

At the upcoming February 2018 Board Meeting, the committee will recommend revised language to CCR sections 2530(l) for VN and 2585(l) for PT.

Using CCR § 2530(l) for VN as an example, staff recommends revising language as follows:

Current language:	The program shall maintain a yearly average minimum pass rate on the licensure examination that does not fall below 10 percentage points of the state average pass rate for first time candidates of approved vocational nursing schools for the same period.
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Proposed revised language:	The program shall maintain a yearly average minimum pass rate <u>percentage of at least 75%</u> on the licensure examination that does not fall below 10 percentage points of the state average pass rate for first time candidates of approved vocational nursing schools for the same period.
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EDUCATION COMMITTEE MEETING – JANUARY 25, 2018

Currently, VN and PT programs may be placed on provisional status if they fail to maintain the required pass rate for eight consecutive quarters.

At the upcoming February 2018 Board Meeting, the committee will recommend proposed revised language to CCR sections 2530(l)(1) for VN and 2585(l)(1) for PT for review and adoption. This is how it will look for the VN code, and the corresponding change for the PT regulation will be presented for the final vote in February:

Current language:	Failure to maintain the required yearly average minimum pass rate for two years or eight consecutive quarters may be cause to place a program on provisional approval.
Option 1 revised language:	Failure to maintain the required yearly average minimum pass rate <u>percentage</u> for two years or eight consecutive quarters <u>one year or the four most recent quarters in which the program had first-time test takers</u> may be cause to place a program on provisional approval.
Option 2 revised language:	Failure to maintain the required yearly average minimum pass rate <u>percentage</u> for two <u>one</u> years or eight <u>four</u> consecutive quarters may be cause to place a program on provisional approval.
Option 3 revised language:	Failure to maintain the required yearly average minimum pass rate <u>percentage</u> for two years or eight consecutive quarters <u>in a calendar year</u> may be cause to place a program on provisional approval.

IMPLEMENTATION OF REVISED LANGUAGE

Board staff recommends implementation of Option 1 for the following reasons:

- ❖ The newly proposed regulations would hold VN and PT programs to a **consistently higher pass rate standard than the current regulations**. Programs would be required to maintain pass rate percentages of at least 75% every quarterly-period of time. This is in strong contrast to comparable states that calculate program pass rate percentages of at least 80% based on a one-year period of time.
- ❖ After the implementation of the new regulations, VN and PT programs, regardless of their approval status, would be given a period of two years to reach compliance. Thereafter, the new regulations would apply.

- ❖ There would be no need for “grandfathering in”, as all VN and PT programs, including those on provisional status, would have the first two years to reach compliance.
- ❖ Board staff recommends implementation to begin after the first quarter after the regulation is enacted and monitoring of the outcomes to be ongoing.



BOARD OF REGISTERED NURSING

**LEGISLATIVE COMMITTEE
 MEETING MINUTES**

DATE: October 17, 2019

TIME: 12:11 p.m.

LOCATION: Bakersfield Marriott at the Convention Center, Salon A
 801 Truxtun Avenue
 Bakersfield, California 93301

MEMBERS PRESENT: Donna Gerber, Chair
 Michael Jackson
 Trande Phillips

MEMBERS ABSENT: **Imelda Ceja-Butkiewicz**

STAFF PRESENT: Dr. Joseph Morris, Executive Officer
 Evon Lenerd, Assistant Executive Officer
 Thelma Harris, Chief of Legislation
 Ann Salisbury, Legal Counsel

8.0 Call to Order, Roll Call, Establishment of a Quorum, and Approval of Minutes:
 Donna Gerber called the meeting to order at 12:11 p.m. following the conclusion of the Education/Licensing Committee.

8.0.1 Review and Vote on Whether to Approve Previous Meeting’s Minutes:
 ➤ August 15, 2019

Motion: Michael Jackson to Approve the Minutes of August 15, 2019			
Second: Trande Phillips			
DG: Abstain	MJ: Yes	TP: Yes	

8.1 Discussion of Bills of Interest to the Board of Registered Nursing(Board) and Recommendation that the Board Adopt or Modify positions on the Bills Introduced during the 2019-2020 Legislative Session

Due to the timing in the legislative session, there were no bills presented for consideration. The members were referred to the tables of Bill Status for those bills recently chaptered.

8.2 Public Comment for Items Not on the Agenda; Items for a Future Agenda

Kathy Hughes, SEIU Nurse Alliance re SB 227: Thanks the Board for its support of this bill.

8.3 The meeting adjourned at 12:17 p.m.

Submitted by: Thelma Harris
Thelma Harris, Chief of Legislation

Approved by: Donna Gerber
Donna Gerber, Chair

BOARD OF REGISTERED NURSING
Legislative Committee
Agenda Item Summary

AGENDA ITEM: 8.1
DATE: March 12, 2020

ACTION REQUESTED: **Discussion of Bills of Interest to the Board of Registered Nursing (Board) and Possible Vote to Recommend that the Board Adopt or Modify Positions on Bills Introduced during the 2019-2020 Legislative Session, Including But Not Limited To the Following Bills:**

REQUESTED BY: Donna Gerber, Chair, Legislative Committee

BACKGROUND: Bills of interest for the 2019-2020 legislative session are listed on the attached tables.

Bold denotes a new bill for Committee or Board consideration, is one that has been amended since the last Committee or Board meeting, or is one about which the Board has taken a position and may wish to discuss further and restate or modify its position.

An analysis of and the bill text for these bills are included for further review.

NEXT STEPS: Present recommendations to the Board

FINANCIAL IMPLICATIONS, IF ANY: As reflected by the proposed legislation

PERSON TO CONTACT: Thelma Harris, RN, PHN, MSN
Chief of Legislation
(916) 574-7600

2020 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICE OF THE ASSEMBLY CHIEF CLERK AND THE OFFICE OF THE SECRETARY OF THE SENATE
Revised 10-18-19

DEADLINES

- Jan. 1** Statutes take effect (Art. IV, Sec. 8(c)).
- Jan. 6** Legislature reconvenes (J.R. 51(a)(4)).
- Jan. 10** Budget must be submitted by Governor (Art. IV, Sec. 12(a)).
- Jan. 17** Last day for **policy committees** to hear and report to **fiscal committees** fiscal bills introduced in their house in the odd-numbered year (J.R. 61(b)(1)).
- Jan. 20** Martin Luther King, Jr. Day.
- Jan. 24** Last day for any committee to hear and report to the **floor** bills introduced in that house in the odd-numbered year. (J.R. 61(b)(2)). Last day to submit **bill requests** to the Office of Legislative Counsel.
- Jan. 31** Last day for each house to pass bills introduced in that house in the odd-numbered year (J.R. 61(b)(3)) (Art. IV, Sec. 10(c)).

JANUARY							
	S	M	T	W	TH	F	S
				1	2	3	4
Wk. 1	5	6	7	8	9	10	11
Wk. 2	12	13	14	15	16	17	18
Wk. 3	19	20	21	22	23	24	25
Wk. 4	26	27	28	29	30	31	

FEBRUARY							
	S	M	T	W	TH	F	S
Wk. 4							1
Wk. 1	2	3	4	5	6	7	8
Wk. 2	9	10	11	12	13	14	15
Wk. 3	16	17	18	19	20	21	22
Wk. 4	23	24	25	26	27	28	29

MARCH							
	S	M	T	W	TH	F	S
Wk. 1	1	2	3	4	5	6	7
Wk. 2	8	9	10	11	12	13	14
Wk. 3	15	16	17	18	19	20	21
Wk. 4	22	23	24	25	26	27	28
Wk. 1	29	30	31				

APRIL							
	S	M	T	W	TH	F	S
Wk. 1				1	2	3	4
Spring Recess	5	6	7	8	9	10	11
Wk. 2	12	13	14	15	16	17	18
Wk. 3	19	20	21	22	23	24	25
Wk. 4	26	27	28	29	30		

MAY							
	S	M	T	W	TH	F	S
Wk. 4						1	2
Wk. 1	3	4	5	6	7	8	9
Wk. 2	10	11	12	13	14	15	16
Wk. 3	17	18	19	20	21	22	23
No Hrgs.	24	25	26	27	28	29	30
Wk. 4	31						

- Feb. 17** Presidents' Day.
- Feb. 21** Last day for bills to be **introduced** (J.R. 61(b)(4), J.R. 54(a)).

Mar. 27 Cesar Chavez Day observed.

- Apr. 2** **Spring Recess** begins upon adjournment (J.R. 51(b)(1)).
- Apr. 13** Legislature reconvenes from Spring Recess (J.R. 51(b)(1)).
- Apr. 24** Last day for **policy committees** to hear and report to fiscal committees **fiscal bills** introduced in their house (J.R. 61(b)(5)).
- May 1** Last day for **policy committees** to hear and report to the floor **nonfiscal** bills introduced in their house (J.R. 61(b)(6)).
- May 8** Last day for **policy committees** to meet prior to June 1 (J.R. 61(b)(7)).
- May 15** Last day for **fiscal committees** to hear and report to the **floor** bills introduced in their house (J.R. 61 (b)(8)). Last day for **fiscal committees** to meet prior to June 1 (J.R. 61 (b)(9)).
- May 25** Memorial Day.
- May 26-29** **Floor session only.** No committee may meet for any purpose except for Rules Committee, bills referred pursuant to Assembly Rule 77.2, and Conference Committees (J.R. 61(b)(10)).
- May 29** Last day for each house to pass bills introduced in that house (J.R. 61(b)(11)).

*Holiday schedule subject to final approval by Rules Committee.

2020 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICE OF THE ASSEMBLY CHIEF CLERK AND THE OFFICE OF THE SECRETARY OF THE SENATE
Revised 10-18-19

JUNE							
	S	M	T	W	TH	F	S
Wk. 4		1	2	3	4	5	6
Wk. 1	7	8	9	10	11	12	13
Wk. 2	14	15	16	17	18	19	20
Wk. 3	21	22	23	24	25	26	27
Wk. 4	28	29	30				

- June 1** Committee meetings may resume (J.R. 61(b)(12)).
- June 15** Budget Bill must be passed by midnight (Art. IV, Sec. 12(c)).
- June 25** Last day for a legislative measure to qualify for the Nov. 3 General Election ballot (Elections Code Sec. 9040).
- June 26** Last day for **policy committees** to hear and report **fiscal bills** to fiscal committees (J.R. 61(b)(13)).

JULY							
	S	M	T	W	TH	F	S
Wk. 4				1	2	3	4
Summer Recess	5	6	7	8	9	10	11
Summer Recess	12	13	14	15	16	17	18
Summer Recess	19	20	21	22	23	24	25
Summer Recess	26	27	28	29	30	31	

- July 2** Last day for **policy committees** to meet and report bills (J.R. 61(b)(14)).
Summer Recess begins upon adjournment, provided Budget Bill has been passed (J.R. 51(b)(2)).
- July 3** Independence Day observed.

AUGUST							
	S	M	T	W	TH	F	S
Summer Recess							1
Wk. 1	2	3	4	5	6	7	8
Wk. 2	9	10	11	12	13	14	15
No Hrgs.	16	17	18	19	20	21	22
No Hrgs.	23	24	25	26	27	28	29
No Hrgs.	30	31					

- Aug. 3** Legislature reconvenes from **Summer Recess** (J.R. 51(b)(2)).
- Aug. 14** Last day for **fiscal committees** to meet and report bills (J.R. 61(b)(15)).
- Aug. 17 – 31** **Floor session only.** No committee may meet for any purpose except Rules Committee, bills referred pursuant to Assembly Rule 77.2, and Conference Committees (J.R. 61(b)(16)).
- Aug. 21** Last day to **amend** bills on the floor (J.R. 61(b)(17)).
- Aug. 31** Last day for each house to pass bills (Art. IV, Sec 10(c), J.R. 61(b)(18)).
Final Recess begins upon adjournment (J.R. 51(b)(3)).

IMPORTANT DATES OCCURRING DURING FINAL RECESS

2020

- Sept. 30 Last day for Governor to sign or veto bills passed by the Legislature before Sept. 1 and in the Governor's possession on or after Sept. 1 (Art. IV, Sec. 10(b)(2)).
- Oct. 1 Bills enacted on or before this date take effect January 1, 2021. (Art. IV, Sec. 8(c)).
- Nov. 3 General Election.
- Nov. 30 Adjournment *sine die* at midnight (Art. IV, Sec. 3(a)).
- Dec. 7 2021-22 Regular Session convenes for Organizational Session at 12 noon. (Art. IV, Sec. 3(a)).

2021

- Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).

*Holiday schedule subject to final approval by Rules Committee.

BOARD OF REGISTERED NURSING
Assembly Bills 2019-2020
Status Update
March 12, 2020

BILL #	AUTHOR/ BILL SPONSOR	SUBJECT	COM POSITION/ date	BOARD POSITION/ date	BILL STATUS as of March 12, 2020
AB 329	Rodriguez/ CENA	Hospitals: assaults and batteries	Watch 3/14/19	Watch 4/11/19	Senate PubSafety
AB 362	Eggman/ DPA; HRC	Controlled substances: overdose prevention program	Information 5/9/19	Watch 4/11/19	Senate Health
AB 613	Low	Professions and vocations: regulatory fees	Watch 3/14/19	Watch 4/11/19	Senate BP&ED
AB 732	Bonta	County jails: prisons: incarcerated pregnant persons	Watch 3/14/19	Watch 4/11/19	Assembly APPR
AB 890	Wood	Nurse practitioners: scope of practice: unsupervised practice	Oppose unless amended 5/9/19	Oppose unless amended 6/13/19	Assembly APPR
AB 1145	Cristina Garcia	Child abuse: reportable conduct	Watch 3/14/19	Watch 4/11/19	Assembly APPR
AB 1544	Gipson	Community Paramedicine or Triage to Alternate Destination Act	Oppose 8/15/19		Senate Inactive File
AB 1616	Low	Department of Consumer Affairs: boards: expunged convictions			
AB 1759	Salas	Health care workers: rural and underserved areas			
AB 1909	Gonzalez	Healing arts licensees: virginity examinations or tests			
AB 1917	Ting	Budget Act of 2020			
AB 1928	Kiley/Melendez	Employment standards: independent contractors and employees			
AB 1998	Low	Dental Practice Act: unprofessional conduct: patient of record			
AB 2028	Aguilar-Curry	State agencies: meetings			
AB 2185	Patterson/Gallagher	Professions and vocations: applicants licensed in other states: reciprocity			
AB 2549	Salas	Department of Consumer Affairs: temporary licenses			

BOARD OF REGISTERED NURSING
Assembly Bills 2019-2020
Status Update
March 12, 2020

<u>AB 2704</u>	Ting	Healing Arts: licenses: data collection			
<u>AB 3016</u>	Dahle	Board of Registered Nursing: online license verification			
<u>AB 3244</u>	Flora	Nursing, vocational nursing, and psychiatric technicians: schools: examination fraud			

BOARD OF REGISTERED NURSING
Assembly Bills 2019-2020
Status Update
March 12, 2020

BILL #	AUTHOR/ BILL SPONSOR	SUBJECT	COM POSITION/ date	BOARD POSITION/ date	BILL STATUS as of Oct 4, 2019

AMENDED IN ASSEMBLY APRIL 22, 2019

AMENDED IN ASSEMBLY APRIL 3, 2019

CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL

No. 890

Introduced by Assembly Member Wood
(Coauthors: Assembly Members Aguiar-Curry, Eggman, Friedman,
Gallagher, and Gipson)

(Coauthors: Senators Caballero, Hill, Leyva, and Stone)

February 20, 2019

An act to amend Sections 650.01 and 805 of, and to add ~~Sections 2837.1 and 2837.2 to,~~ *Article 8.5 (commencing with Section 2837.100) to Chapter 6 of Division 2 of,* the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 890, as amended, Wood. Nurse practitioners: scope of practice: unsupervised practice.

Existing law, the Nursing Practice Act, provides for the certification and regulation of nurse practitioners by the Board of Registered Nursing. Existing law authorizes the implementation of standardized procedures that authorize a nurse practitioner to perform certain acts that are in addition to other authorized practices, including certifying disability after performing a physical examination and collaboration with a physician and surgeon. A violation of the act is a misdemeanor.

This bill would *establish the Advanced Practice Registered Nursing Board within the Department of Consumer Affairs, which would consist of 9 members. The bill would authorize a nurse practitioner who holds a certification as a nurse practitioner from a national certifying body*

recognized by the board who practices in certain settings *or organizations* to perform specified functions without supervision by a physician and surgeon, including ordering and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and administering controlled substances.

The bill would also authorize a nurse practitioner who holds ~~a~~ *an active certification as a nurse practitioner from a national certifying body recognized* issued by the board to practice without supervision by a physician and surgeon *outside of specified settings or organizations* in accordance with specified conditions and requirements if the nurse practitioner ~~has successfully completed~~ *meets specified education and other requirements, including completion of a transition to practice program, practice, as defined by the bill, and a supervising physician and surgeon at the facility at which the nurse practitioner completed the transition to practice program attests to the board that the nurse practitioner is proficient in competencies established by the board by regulation.* *bill. The bill would authorize the board, upon application, to issue an inactive certificate.*

Existing law makes it unlawful for specified healing arts practitioners, including physicians and surgeons, psychologists, and acupuncturists, to refer a person for certain services, including laboratory, diagnostic nuclear medicine, and physical therapy, if the physician and surgeon or their immediate family has a financial interest with the person or in the entity that receives the referral. A violation of those provisions is a misdemeanor and subject to specified civil penalties and disciplinary action.

This bill would make those provisions applicable to a nurse practitioner practicing pursuant to the bill's provisions.

Existing law provides for the professional review of specified healing arts licentiates through a peer review process and defines "licentiate" for those purposes.

This bill would include as a licentiate a nurse practitioner practicing pursuant to the bill's provisions.

Because the bill would expand the scope of crimes, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 650.01 of the Business and Professions
2 Code is amended to read:
3 650.01. (a) Notwithstanding Section 650, or any other
4 provision of law, it is unlawful for a licensee to refer a person for
5 laboratory, diagnostic nuclear medicine, radiation oncology,
6 physical therapy, physical rehabilitation, psychometric testing,
7 home infusion therapy, or diagnostic imaging goods or services if
8 the licensee or their immediate family has a financial interest with
9 the person or in the entity that receives the referral.
10 (b) For purposes of this section and Section 650.02, the
11 following shall apply:
12 (1) “Diagnostic imaging” includes, but is not limited to, all
13 X-ray, computed axial tomography, magnetic resonance imaging
14 nuclear medicine, positron emission tomography, mammography,
15 and ultrasound goods and services.
16 (2) A “financial interest” includes, but is not limited to, any
17 type of ownership interest, debt, loan, lease, compensation,
18 remuneration, discount, rebate, refund, dividend, distribution,
19 subsidy, or other form of direct or indirect payment, whether in
20 money or otherwise, between a licensee and a person or entity to
21 whom the licensee refers a person for a good or service specified
22 in subdivision (a). A financial interest also exists if there is an
23 indirect financial relationship between a licensee and the referral
24 recipient including, but not limited to, an arrangement whereby a
25 licensee has an ownership interest in an entity that leases property
26 to the referral recipient. Any financial interest transferred by a
27 licensee to any person or entity or otherwise established in any
28 person or entity for the purpose of avoiding the prohibition of this
29 section shall be deemed a financial interest of the licensee. For
30 purposes of this paragraph, “direct or indirect payment” shall not
31 include a royalty or consulting fee received by a physician and
32 surgeon who has completed a recognized residency training
33 program in orthopedics from a manufacturer or distributor as a
34 result of their research and development of medical devices and
35 techniques for that manufacturer or distributor. For purposes of

1 this paragraph, “consulting fees” means those fees paid by the
2 manufacturer or distributor to a physician and surgeon who has
3 completed a recognized residency training program in orthopedics
4 only for their ongoing services in making refinements to their
5 medical devices or techniques marketed or distributed by the
6 manufacturer or distributor, if the manufacturer or distributor does
7 not own or control the facility to which the physician is referring
8 the patient. A “financial interest” shall not include the receipt of
9 capitation payments or other fixed amounts that are prepaid in
10 exchange for a promise of a licensee to provide specified health
11 care services to specified beneficiaries. A “financial interest” shall
12 not include the receipt of remuneration by a medical director of a
13 hospice, as defined in Section 1746 of the Health and Safety Code,
14 for specified services if the arrangement is set out in writing, and
15 specifies all services to be provided by the medical director, the
16 term of the arrangement is for at least one year, and the
17 compensation to be paid over the term of the arrangement is set
18 in advance, does not exceed fair market value, and is not
19 determined in a manner that takes into account the volume or value
20 of any referrals or other business generated between parties.

21 (3) For the purposes of this section, “immediate family” includes
22 the spouse and children of the licensee, the parents of the licensee,
23 and the spouses of the children of the licensee.

24 (4) “Licensee” means a physician, as defined in Section 3209.3
25 of the Labor Code, or a nurse practitioner practicing pursuant to
26 Section ~~2837.1 or 2837.2~~ *2837.104 or 2837.105*.

27 (5) “Licensee’s office” means either of the following:

28 (A) An office of a licensee in solo practice.

29 (B) An office in which services or goods are personally provided
30 by the licensee or by employees in that office, or personally by
31 independent contractors in that office, in accordance with other
32 provisions of law. Employees and independent contractors shall
33 be licensed or certified when licensure or certification is required
34 by law.

35 (6) “Office of a group practice” means an office or offices in
36 which two or more licensees are legally organized as a partnership,
37 professional corporation, or not-for-profit corporation, licensed
38 pursuant to subdivision (a) of Section 1204 of the Health and Safety
39 Code, for which all of the following apply:

1 (A) Each licensee who is a member of the group provides
2 substantially the full range of services that the licensee routinely
3 provides, including medical care, consultation, diagnosis, or
4 treatment through the joint use of shared office space, facilities,
5 equipment, and personnel.

6 (B) Substantially all of the services of the licensees who are
7 members of the group are provided through the group and are
8 billed in the name of the group and amounts so received are treated
9 as receipts of the group, except in the case of a multispecialty
10 clinic, as defined in subdivision (l) of Section 1206 of the Health
11 and Safety Code, physician services are billed in the name of the
12 multispecialty clinic and amounts so received are treated as receipts
13 of the multispecialty clinic.

14 (C) The overhead expenses of, and the income from, the practice
15 are distributed in accordance with methods previously determined
16 by members of the group.

17 (c) It is unlawful for a licensee to enter into an arrangement or
18 scheme, such as a cross-referral arrangement, that the licensee
19 knows, or should know, has a principal purpose of ensuring
20 referrals by the licensee to a particular entity that, if the licensee
21 directly made referrals to that entity, would be in violation of this
22 section.

23 (d) No claim for payment shall be presented by an entity to any
24 individual, third party payer, or other entity for a good or service
25 furnished pursuant to a referral prohibited under this section.

26 (e) No insurer, self-insurer, or other payer shall pay a charge or
27 lien for any good or service resulting from a referral in violation
28 of this section.

29 (f) A licensee who refers a person to, or seeks consultation from,
30 an organization in which the licensee has a financial interest, other
31 than as prohibited by subdivision (a), shall disclose the financial
32 interest to the patient, or the parent or legal guardian of the patient,
33 in writing, at the time of the referral or request for consultation.

34 (1) If a referral, billing, or other solicitation is between one or
35 more licensees who contract with a multispecialty clinic pursuant
36 to subdivision (l) of Section 1206 of the Health and Safety Code
37 or who conduct their practice as members of the same professional
38 corporation or partnership, and the services are rendered on the
39 same physical premises, or under the same professional corporation
40 or partnership name, the requirements of this subdivision may be

1 met by posting a conspicuous disclosure statement at the
2 registration area or by providing a patient with a written disclosure
3 statement.

4 (2) If a licensee is under contract with the Department of
5 Corrections or the California Youth Authority, and the patient is
6 an inmate or parolee of either respective department, the
7 requirements of this subdivision shall be satisfied by disclosing
8 financial interests to either the Department of Corrections or the
9 California Youth Authority.

10 (g) A violation of subdivision (a) shall be a misdemeanor. The
11 Medical Board of California shall review the facts and
12 circumstances of any conviction pursuant to subdivision (a) and
13 take appropriate disciplinary action if the licensee has committed
14 unprofessional conduct. Violations of this section may also be
15 subject to civil penalties of up to five thousand dollars (\$5,000)
16 for each offense, which may be enforced by the Insurance
17 Commissioner, Attorney General, or a district attorney. A violation
18 of subdivision (c), (d), or (e) is a public offense and is punishable
19 upon conviction by a fine not exceeding fifteen thousand dollars
20 (\$15,000) for each violation and appropriate disciplinary action,
21 including revocation of professional licensure, by the Medical
22 Board of California or other appropriate governmental agency.

23 (h) This section shall not apply to referrals for services that are
24 described in and covered by Sections 139.3 and 139.31 of the
25 Labor Code.

26 (i) This section shall become operative on January 1, 1995.

27 SEC. 2. Section 805 of the Business and Professions Code is
28 amended to read:

29 805. (a) As used in this section, the following terms have the
30 following definitions:

31 (1) (A) "Peer review" means both of the following:

32 (i) A process in which a peer review body reviews the basic
33 qualifications, staff privileges, employment, medical outcomes,
34 or professional conduct of licentiates to make recommendations
35 for quality improvement and education, if necessary, in order to
36 do either or both of the following:

37 (I) Determine whether a licentiate may practice or continue to
38 practice in a health care facility, clinic, or other setting providing
39 medical services, and, if so, to determine the parameters of that
40 practice.

- 1 (II) Assess and improve the quality of care rendered in a health
2 care facility, clinic, or other setting providing medical services.
- 3 (ii) Any other activities of a peer review body as specified in
4 subparagraph (B).
- 5 (B) “Peer review body” includes:
- 6 (i) A medical or professional staff of any health care facility or
7 clinic licensed under Division 2 (commencing with Section 1200)
8 of the Health and Safety Code or of a facility certified to participate
9 in the federal Medicare program as an ambulatory surgical center.
- 10 (ii) A health care service plan licensed under Chapter 2.2
11 (commencing with Section 1340) of Division 2 of the Health and
12 Safety Code or a disability insurer that contracts with licentiates
13 to provide services at alternative rates of payment pursuant to
14 Section 10133 of the Insurance Code.
- 15 (iii) Any medical, psychological, marriage and family therapy,
16 social work, professional clinical counselor, dental, midwifery, or
17 podiatric professional society having as members at least 25 percent
18 of the eligible licentiates in the area in which it functions (which
19 must include at least one county), which is not organized for profit
20 and which has been determined to be exempt from taxes pursuant
21 to Section 23701 of the Revenue and Taxation Code.
- 22 (iv) A committee organized by any entity consisting of or
23 employing more than 25 licentiates of the same class that functions
24 for the purpose of reviewing the quality of professional care
25 provided by members or employees of that entity.
- 26 (2) “Licentiate” means a physician and surgeon, doctor of
27 podiatric medicine, clinical psychologist, marriage and family
28 therapist, clinical social worker, professional clinical counselor,
29 dentist, licensed midwife, physician assistant, or nurse practitioner
30 practicing pursuant to ~~Section 2837.1 or 2837.2.~~ *2837.104 or*
31 *2837.105.* “Licentiate” also includes a person authorized to practice
32 medicine pursuant to Section 2113 or 2168.
- 33 (3) “Agency” means the relevant state licensing agency having
34 regulatory jurisdiction over the licentiates listed in paragraph (2).
- 35 (4) “Staff privileges” means any arrangement under which a
36 licentiate is allowed to practice in or provide care for patients in
37 a health facility. Those arrangements shall include, but are not
38 limited to, full staff privileges, active staff privileges, limited staff
39 privileges, auxiliary staff privileges, provisional staff privileges,
40 temporary staff privileges, courtesy staff privileges, locum tenens

1 arrangements, and contractual arrangements to provide professional
2 services, including, but not limited to, arrangements to provide
3 outpatient services.

4 (5) “Denial or termination of staff privileges, membership, or
5 employment” includes failure or refusal to renew a contract or to
6 renew, extend, or reestablish any staff privileges, if the action is
7 based on medical disciplinary cause or reason.

8 (6) “Medical disciplinary cause or reason” means that aspect
9 of a licentiate’s competence or professional conduct that is
10 reasonably likely to be detrimental to patient safety or to the
11 delivery of patient care.

12 (7) “805 report” means the written report required under
13 subdivision (b).

14 (b) The chief of staff of a medical or professional staff or other
15 chief executive officer, medical director, or administrator of any
16 peer review body and the chief executive officer or administrator
17 of any licensed health care facility or clinic shall file an 805 report
18 with the relevant agency within 15 days after the effective date on
19 which any of the following occur as a result of an action of a peer
20 review body:

21 (1) A licentiate’s application for staff privileges or membership
22 is denied or rejected for a medical disciplinary cause or reason.

23 (2) A licentiate’s membership, staff privileges, or employment
24 is terminated or revoked for a medical disciplinary cause or reason.

25 (3) Restrictions are imposed, or voluntarily accepted, on staff
26 privileges, membership, or employment for a cumulative total of
27 30 days or more for any 12-month period, for a medical disciplinary
28 cause or reason.

29 (c) If a licentiate takes any action listed in paragraph (1), (2),
30 or (3) after receiving notice of a pending investigation initiated
31 for a medical disciplinary cause or reason or after receiving notice
32 that their application for membership or staff privileges is denied
33 or will be denied for a medical disciplinary cause or reason, the
34 chief of staff of a medical or professional staff or other chief
35 executive officer, medical director, or administrator of any peer
36 review body and the chief executive officer or administrator of
37 any licensed health care facility or clinic where the licentiate is
38 employed or has staff privileges or membership or where the
39 licentiate applied for staff privileges or membership, or sought the

1 renewal thereof, shall file an 805 report with the relevant agency
2 within 15 days after the licentiate takes the action.

3 (1) Resigns or takes a leave of absence from membership, staff
4 privileges, or employment.

5 (2) Withdraws or abandons their application for staff privileges
6 or membership.

7 (3) Withdraws or abandons their request for renewal of staff
8 privileges or membership.

9 (d) For purposes of filing an 805 report, the signature of at least
10 one of the individuals indicated in subdivision (b) or (c) on the
11 completed form shall constitute compliance with the requirement
12 to file the report.

13 (e) An 805 report shall also be filed within 15 days following
14 the imposition of summary suspension of staff privileges,
15 membership, or employment, if the summary suspension remains
16 in effect for a period in excess of 14 days.

17 (f) A copy of the 805 report, and a notice advising the licentiate
18 of their right to submit additional statements or other information,
19 electronically or otherwise, pursuant to Section 800, shall be sent
20 by the peer review body to the licentiate named in the report. The
21 notice shall also advise the licentiate that information submitted
22 electronically will be publicly disclosed to those who request the
23 information.

24 The information to be reported in an 805 report shall include the
25 name and license number of the licentiate involved, a description
26 of the facts and circumstances of the medical disciplinary cause
27 or reason, and any other relevant information deemed appropriate
28 by the reporter.

29 A supplemental report shall also be made within 30 days
30 following the date the licentiate is deemed to have satisfied any
31 terms, conditions, or sanctions imposed as disciplinary action by
32 the reporting peer review body. In performing its dissemination
33 functions required by Section 805.5, the agency shall include a
34 copy of a supplemental report, if any, whenever it furnishes a copy
35 of the original 805 report.

36 If another peer review body is required to file an 805 report, a
37 health care service plan is not required to file a separate report
38 with respect to action attributable to the same medical disciplinary
39 cause or reason. If the Medical Board of California or a licensing
40 agency of another state revokes or suspends, without a stay, the

1 license of a physician and surgeon, a peer review body is not
2 required to file an 805 report when it takes an action as a result of
3 the revocation or suspension. If the California Board of Podiatric
4 Medicine or a licensing agency of another state revokes or
5 suspends, without a stay, the license of a doctor of podiatric
6 medicine, a peer review body is not required to file an 805 report
7 when it takes an action as a result of the revocation or suspension.

8 (g) The reporting required by this section shall not act as a
9 waiver of confidentiality of medical records and committee reports.
10 The information reported or disclosed shall be kept confidential
11 except as provided in subdivision (c) of Section 800 and Sections
12 803.1 and 2027, provided that a copy of the report containing the
13 information required by this section may be disclosed as required
14 by Section 805.5 with respect to reports received on or after
15 January 1, 1976.

16 (h) The Medical Board of California, the California Board of
17 Podiatric Medicine, the Osteopathic Medical Board of California,
18 and the Dental Board of California shall disclose reports as required
19 by Section 805.5.

20 (i) An 805 report shall be maintained electronically by an agency
21 for dissemination purposes for a period of three years after receipt.

22 (j) No person shall incur any civil or criminal liability as the
23 result of making any report required by this section.

24 (k) A willful failure to file an 805 report by any person who is
25 designated or otherwise required by law to file an 805 report is
26 punishable by a fine not to exceed one hundred thousand dollars
27 (\$100,000) per violation. The fine may be imposed in any civil or
28 administrative action or proceeding brought by or on behalf of any
29 agency having regulatory jurisdiction over the person regarding
30 whom the report was or should have been filed. If the person who
31 is designated or otherwise required to file an 805 report is a
32 licensed physician and surgeon, the action or proceeding shall be
33 brought by the Medical Board of California. If the person who is
34 designated or otherwise required to file an 805 report is a licensed
35 doctor of podiatric medicine, the action or proceeding shall be
36 brought by the California Board of Podiatric Medicine. The fine
37 shall be paid to that agency but not expended until appropriated
38 by the Legislature. A violation of this subdivision may constitute
39 unprofessional conduct by the licentiate. A person who is alleged
40 to have violated this subdivision may assert any defense available

1 at law. As used in this subdivision, “willful” means a voluntary
2 and intentional violation of a known legal duty.

3 (l) Except as otherwise provided in subdivision (k), any failure
4 by the administrator of any peer review body, the chief executive
5 officer or administrator of any health care facility, or any person
6 who is designated or otherwise required by law to file an 805
7 report, shall be punishable by a fine that under no circumstances
8 shall exceed fifty thousand dollars (\$50,000) per violation. The
9 fine may be imposed in any civil or administrative action or
10 proceeding brought by or on behalf of any agency having
11 regulatory jurisdiction over the person regarding whom the report
12 was or should have been filed. If the person who is designated or
13 otherwise required to file an 805 report is a licensed physician and
14 surgeon, the action or proceeding shall be brought by the Medical
15 Board of California. If the person who is designated or otherwise
16 required to file an 805 report is a licensed doctor of podiatric
17 medicine, the action or proceeding shall be brought by the
18 California Board of Podiatric Medicine. The fine shall be paid to
19 that agency but not expended until appropriated by the Legislature.
20 The amount of the fine imposed, not exceeding fifty thousand
21 dollars (\$50,000) per violation, shall be proportional to the severity
22 of the failure to report and shall differ based upon written findings,
23 including whether the failure to file caused harm to a patient or
24 created a risk to patient safety; whether the administrator of any
25 peer review body, the chief executive officer or administrator of
26 any health care facility, or any person who is designated or
27 otherwise required by law to file an 805 report exercised due
28 diligence despite the failure to file or whether they knew or should
29 have known that an 805 report would not be filed; and whether
30 there has been a prior failure to file an 805 report. The amount of
31 the fine imposed may also differ based on whether a health care
32 facility is a small or rural hospital as defined in Section 124840
33 of the Health and Safety Code.

34 (m) A health care service plan licensed under Chapter 2.2
35 (commencing with Section 1340) of Division 2 of the Health and
36 Safety Code or a disability insurer that negotiates and enters into
37 a contract with licentiates to provide services at alternative rates
38 of payment pursuant to Section 10133 of the Insurance Code, when
39 determining participation with the plan or insurer, shall evaluate,

1 on a case-by-case basis, licentiates who are the subject of an 805
2 report, and not automatically exclude or deselect these licentiates.

3 ~~SEC. 3.—Section 2837.1 is added to the Business and Professions~~
4 ~~Code, to read:~~

5 ~~2837.1. (a) Notwithstanding any other law, a nurse practitioner~~
6 ~~who holds a certification as a nurse practitioner from a national~~
7 ~~certifying body recognized by the board may perform the functions~~
8 ~~specified in subdivision (c) without supervision by a physician~~
9 ~~and surgeon if the nurse practitioner meets all of the requirements~~
10 ~~of this article and practices in one of the following settings in which~~
11 ~~one or more physicians and surgeons are concurrently practicing~~
12 ~~with the nurse practitioner:~~

13 ~~(1) A clinic, as defined in Section 1200 of the Health and Safety~~
14 ~~Code.~~

15 ~~(2) A health facility, as defined in Section 1250 of the Health~~
16 ~~and Safety Code.~~

17 ~~(3) A facility described in Chapter 2.5 (commencing with~~
18 ~~Section 1440) of Division 2 of the Health and Safety Code.~~

19 ~~(4) A medical group practice, including a professional medical~~
20 ~~corporation, as defined in Section 2406, another form of~~
21 ~~corporation controlled by physicians and surgeons, a medical~~
22 ~~partnership, a medical foundation exempt from licensure, or another~~
23 ~~lawfully organized group of physicians and surgeons that provides~~
24 ~~health care services.~~

25 ~~(b) An entity described in subdivisions (1) to (4), inclusive, of~~
26 ~~subdivision (a) shall not interfere with, control, or otherwise direct~~
27 ~~the professional judgment of a nurse practitioner functioning~~
28 ~~pursuant to this section in a manner prohibited by Section 2400 or~~
29 ~~any other law.~~

30 ~~(c) In addition to any other practices authorized by law, a nurse~~
31 ~~practitioner who meets the requirements of this section may~~
32 ~~perform the following functions without the supervision of a~~
33 ~~physician and surgeon in accordance with their education and~~
34 ~~training:~~

35 ~~(1) Conduct an advanced assessment.~~

36 ~~(2) Order and interpret diagnostic procedures.~~

37 ~~(3) Establish primary and differential diagnoses.~~

38 ~~(4) Prescribe, order, administer, dispense, and furnish therapeutic~~
39 ~~measures, including, but not limited to, the following:~~

1 ~~(A) Diagnose, prescribe, and institute therapy or referrals of~~
2 ~~patients to health care agencies, health care providers, and~~
3 ~~community resources.~~

4 ~~(B) Prescribe, administer, dispense, and furnish pharmacological~~
5 ~~agents, including over-the-counter, legend, and controlled~~
6 ~~substances.~~

7 ~~(C) Plan and initiate a therapeutic regimen that includes ordering~~
8 ~~and prescribing nonpharmacological interventions, including, but~~
9 ~~not limited to, durable medical equipment, medical devices,~~
10 ~~nutrition, blood and blood products, and diagnostic and supportive~~
11 ~~services, including, but not limited to, home health care, hospice,~~
12 ~~and physical and occupational therapy.~~

13 ~~(5) After performing a physical examination, certify disability~~
14 ~~pursuant to Section 2708 of the Unemployment Insurance Code.~~

15 ~~(6) Delegate tasks to a medical assistant pursuant to Sections~~
16 ~~1206.5, 2069, 2070, and 2071, and Article 2 (commencing with~~
17 ~~Section 1366) of Chapter 3 of Division 13 of Title 16 of the~~
18 ~~California Code of Regulations.~~

19 ~~(d) A nurse practitioner shall refer a patient to a physician and~~
20 ~~surgeon or other licensed health care provider if a situation or~~
21 ~~condition of a patient is beyond the scope of the education and~~
22 ~~training of the nurse practitioner.~~

23 ~~(e) A nurse practitioner practicing under this section shall~~
24 ~~maintain professional liability insurance appropriate for the practice~~
25 ~~setting.~~

26 ~~SEC. 4. Section 2837.2 is added to the Business and Professions~~
27 ~~Code, to read:~~

28 ~~2837.2. (a) Notwithstanding any other law, a nurse practitioner~~
29 ~~who holds an active certification by a national certifying body~~
30 ~~recognized by the board may practice without supervision by a~~
31 ~~physician and surgeon if, in addition to satisfying the requirements~~
32 ~~of this article, the nurse practitioner satisfies both of the following~~
33 ~~requirements:~~

34 ~~(1) The nurse practitioner has successfully completed a transition~~
35 ~~to practice program.~~

36 ~~(2) A supervising physician and surgeon at the clinic, facility,~~
37 ~~or medical group attests under penalty of perjury to the board that~~
38 ~~the nurse practitioner has successfully completed the transition to~~
39 ~~practice program and is proficient in the competencies identified~~
40 ~~by the board to practice pursuant to this section.~~

1 (b) A nurse practitioner authorized to practice pursuant to this
2 section shall comply with all of the following:

3 (1) The nurse practitioner, consistent with applicable standards
4 of care, shall practice within the scope of their clinical and
5 professional training and within the limits of their knowledge and
6 experience.

7 (2) The nurse practitioner shall consult and collaborate with
8 other healing arts providers based on the clinical condition of the
9 patient to whom health care is provided.

10 (3) The nurse practitioner shall establish a plan for referral of
11 complex medical cases and emergencies to a physician and surgeon
12 or other appropriate healing arts providers.

13 (e) For purposes of this section, “transition to practice program”
14 means a program in which additional clinical experience and
15 mentorship are provided to prepare a nurse practitioner to practice
16 without the routine presence of a physician and surgeon. A
17 transition to practice program shall meet all of the following
18 requirements:

19 (1) The transition to practice program shall consist of a minimum
20 of three years or 4,600 hours.

21 (2) The transition to practice program shall require proficiency
22 in competencies identified by the board by regulation.

23 (3) The transition to practice program is conducted in one of
24 the settings specified in paragraphs (1) to (4), inclusive, of
25 subdivision (a) of Section 2837.1 in which one or more physicians
26 and surgeons practices concurrently with the nurse practitioner.

27 (d) A nurse practitioner practicing under this section shall
28 maintain professional liability insurance appropriate for the practice
29 setting.

30 SEC. 3. Article 8.5 (commencing with Section 2837.100) is
31 added to Chapter 6 of Division 2 of the Business and Professions
32 Code, to read:

33
34 *Article 8.5. Advanced Practice Registered Nurses*

35
36 2837.100. *It is the intent of the Legislature that the*
37 *requirements under this article shall not be undue or unnecessary*
38 *burden to licensure or practice. The requirements are intended to*
39 *ensure the new category of licensed nurse practitioners have the*

1 *least restrictive amount of education, training, and testing*
2 *necessary to ensure competent practice.*

3 2837.101. (a) *There is in the Department of Consumer Affairs*
4 *the Advanced Practice Registered Nursing Board consisting of*
5 *nine members.*

6 (b) *For purposes of this article, “board” means the Advanced*
7 *Practice Registered Nursing Board.*

8 (c) *This section shall remain in effect only until January 1, 2026,*
9 *and as of that date is repealed.*

10 2837.102. *Notwithstanding any other law, the repeal of Section*
11 *2837.101 renders the board or its successor subject to review by*
12 *the appropriate policy committees of the Legislature.*

13 2837.103. (a) (1) *Until January 1, 2026, four members of the*
14 *board shall be licensed registered nurses who shall be active as*
15 *a nurse practitioner and shall be active in the practice of their*
16 *profession engaged primarily in direct patient care with at least*
17 *five continuous years of experience.*

18 (2) *Commencing January 1, 2026, four members of the board*
19 *shall be nurse practitioners licensed under this chapter.*

20 (b) *Three members of the board shall be physicians and*
21 *surgeons licensed by the Medical Board of California or the*
22 *Osteopathic Medical Board of California. At least one of the*
23 *physician and surgeon members shall work closely with a nurse*
24 *practitioner. The remaining physician and surgeon members shall*
25 *focus on primary care in their practice.*

26 (c) *Two members of the board shall represent the public at large*
27 *and shall not be licensed under any board under this division or*
28 *any board referred to in Section 1000 or 3600.*

29 2837.104. (a) (1) *Notwithstanding any other law, a nurse*
30 *practitioner who holds a certification as a nurse practitioner from*
31 *a national certifying body recognized by the board may perform*
32 *the functions specified in subdivision (c) without supervision by a*
33 *physician and surgeon if the nurse practitioner meets all of the*
34 *requirements of this article and practices in one of the following*
35 *settings or organizations in which one or more physicians and*
36 *surgeons practice with the nurse practitioner:*

37 (A) *A clinic, as defined in Section 1200 of the Health and Safety*
38 *Code.*

39 (B) *A health facility, as defined in Section 1250 of the Health*
40 *and Safety Code.*

1 (C) A facility described in Chapter 2.5 (commencing with
2 Section 1440) of Division 2 of the Health and Safety Code.

3 (D) A medical group practice, including a professional medical
4 corporation, as defined in Section 2406, another form of
5 corporation controlled by physicians and surgeons, a medical
6 partnership, a medical foundation exempt from licensure, or
7 another lawfully organized group of physicians and surgeons that
8 provides health care services.

9 (2) In health care agencies that have governing bodies, as
10 defined in Division 5 of Title 22 of the California Code of
11 Regulations, including, but not limited to, Sections 70701 and
12 70703 of Title 22 of the California Code of Regulations, the
13 following apply:

14 (A) A nurse practitioner shall adhere to all bylaws.

15 (B) A nurse practitioner shall be eligible to serve on medical
16 staff and hospital committees. A nurse practitioner who is not the
17 holder of an active certificate pursuant to Section 2837.105 shall
18 not serve as chair of medical staff committees.

19 (C) A nurse practitioner shall be eligible to attend meetings of
20 the department to which the nurse practitioner is assigned. A nurse
21 practitioner who is not the holder of an active certificate pursuant
22 to Section 2837.105 shall not vote at department, division, or other
23 meetings.

24 (b) An entity described in subparagraphs (A) to (D), inclusive,
25 of paragraph (1) of subdivision (a) shall not interfere with, control,
26 or otherwise direct the professional judgment of a nurse
27 practitioner functioning pursuant to this section in a manner
28 prohibited by Section 2400 or any other law.

29 (c) In addition to any other practices authorized by law, a nurse
30 practitioner who meets the requirements of this section may
31 perform the following functions without the supervision of a
32 physician and surgeon in accordance with their education and
33 training:

34 (1) Conduct an advanced assessment.

35 (2) Order and interpret diagnostic procedures.

36 (3) Establish primary and differential diagnoses.

37 (4) Prescribe, order, administer, dispense, and furnish
38 therapeutic measures, including, but not limited to, the following:

1 (A) Diagnose, prescribe, and institute therapy or referrals of
2 patients to health care agencies, health care providers, and
3 community resources.

4 (B) Prescribe, administer, dispense, and furnish
5 pharmacological agents, including over-the-counter, legend, and
6 controlled substances.

7 (C) Plan and initiate a therapeutic regimen that includes
8 ordering and prescribing nonpharmacological interventions,
9 including, but not limited to, durable medical equipment, medical
10 devices, nutrition, blood and blood products, and diagnostic and
11 supportive services, including, but not limited to, home health
12 care, hospice, and physical and occupational therapy.

13 (5) After performing a physical examination, certify disability
14 pursuant to Section 2708 of the Unemployment Insurance Code.

15 (6) Delegate tasks to a medical assistant pursuant to Sections
16 1206.5, 2069, 2070, and 2071, and Article 2 (commencing with
17 Section 1366) of Chapter 3 of Division 13 of Title 16 of the
18 California Code of Regulations.

19 (d) A nurse practitioner shall refer a patient to a physician and
20 surgeon or other licensed health care provider if a situation or
21 condition of a patient is beyond the scope of the education and
22 training of the nurse practitioner.

23 (e) A nurse practitioner practicing under this section shall
24 maintain professional liability insurance appropriate for the
25 practice setting.

26 2837.105. (a) Notwithstanding any other law, the following
27 apply to a nurse practitioner who is actively licensed under this
28 article and who holds an active certification issued by the board
29 under this section:

30 (1) The nurse practitioner may practice without supervision by
31 a physician and surgeon outside of the settings or organizations
32 specified under subparagraphs (A) to (D), inclusive, of paragraph
33 (1) of subdivision (a) of Section 2387.104.

34 (2) Subject to subdivision (g) and any applicable conflict of
35 interest policies of the bylaws, the nurse practitioner shall be
36 eligible for membership of an organized medical staff.

37 (3) Subject to subdivision (g) and any applicable conflict of
38 interest policies of the bylaws, a nurse practitioner member may
39 vote at meetings of the department to which nurse practitioners
40 are assigned.

1 ***(b) The board shall issue a certificate to practice outside of the***
2 ***settings and organizations specified under subparagraphs (A) to***
3 ***(D), inclusive, of paragraph (1) of subdivision (a) if, in addition***
4 ***to satisfying the requirements of this article, the nurse practitioner***
5 ***satisfies all of the following requirements:***

6 ***(1) The nurse practitioner meets one of the following:***

7 ***(A) Holds a Doctorate of Nursing Practice degree (DNP) and***
8 ***holds active national certification in a nurse practitioner role and***
9 ***population foci by a national certifying body recognized by the***
10 ***board.***

11 ***(B) Holds a Master of Science degree in Nursing (MSN) and***
12 ***holds active national certification in a nurse practitioner role and***
13 ***population foci by a national certifying body recognized by the***
14 ***board and has two years of licensed practice as a nurse***
15 ***practitioner.***

16 ***(2) The nurse practitioner has successfully completed a***
17 ***transition to practice.***

18 ***(c) (1) Upon application of an applicant who meets the***
19 ***requirements for a certificate under this section, the board shall***
20 ***issue an inactive certificate.***

21 ***(2) Upon application of a holder of a certificate issued pursuant***
22 ***to this section, the board shall change the status of an active***
23 ***certificate to inactive.***

24 ***(3) The holder of an inactive certificate shall not engage in any***
25 ***activity for which an active certificate under this section is required***
26 ***and is not otherwise subject to the provisions of this section.***

27 ***(4) Upon application of the holder of a certificate issued***
28 ***pursuant to this section, the board shall change the status of an***
29 ***inactive certificate to active if the holder's license is in good***
30 ***standing and the holder pays the renewal fee.***

31 ***(d) A nurse practitioner authorized to practice pursuant to this***
32 ***section shall comply with all of the following:***

33 ***(1) The nurse practitioner, consistent with applicable standards***
34 ***of care, shall practice within the scope of their clinical and***
35 ***professional education and training and within the limits of their***
36 ***knowledge and experience.***

37 ***(2) The nurse practitioner shall consult and collaborate with***
38 ***other healing arts providers based on the clinical condition of the***
39 ***patient to whom health care is provided.***

1 (3) *The nurse practitioner shall establish a plan for referral of*
2 *complex medical cases and emergencies to a physician and surgeon*
3 *or other appropriate healing arts providers.*

4 (e) *For purposes of this section, “transition to practice” means*
5 *additional clinical experience and mentorship are provided to*
6 *prepare a nurse practitioner to practice without the routine*
7 *presence of a physician and surgeon. A transition to practice shall*
8 *meet all of the following requirements:*

9 (1) *The transition to practice shall consist of a minimum of three*
10 *years or 4,600 hours.*

11 (2) *The transition to practice shall require proficiency in*
12 *competencies identified by the board by regulation.*

13 (3) *The transition to practice is conducted in one of the settings*
14 *or organizations specified in subparagraphs (A) to (D), inclusive,*
15 *of paragraph (1) of subdivision (a) of Section 2837.104 in which*
16 *one or more physicians and surgeons practice with the nurse*
17 *practitioner.*

18 (4) *After the nurse practitioner satisfies paragraph (1) of this*
19 *subdivision, the nurse practitioner shall pass an objective*
20 *examination developed and administered by the board. The*
21 *examination shall test the competencies identified under paragraph*
22 *(2) of this subdivision.*

23 (f) *A nurse practitioner practicing under this section shall*
24 *maintain professional liability insurance appropriate for the*
25 *practice setting.*

26 (g) *For purposes of this section, corporations and other artificial*
27 *legal entities shall have no professional rights, privileges, or*
28 *powers.*

29 (h) *Subdivision (g) shall not apply to a nurse practitioner if any*
30 *of the following apply:*

31 (1) *The certificate issued pursuant to this section is inactive,*
32 *surrendered, revoked, or otherwise restricted by the board.*

33 (2) *The nurse practitioner is employed pursuant to the*
34 *exemptions under Section 2401.*

35 ~~SEC. 5.~~

36 SEC. 4. No reimbursement is required by this act pursuant to
37 Section 6 of Article XIII B of the California Constitution because
38 the only costs that may be incurred by a local agency or school
39 district will be incurred because this act creates a new crime or
40 infraction, eliminates a crime or infraction, or changes the penalty

1 for a crime or infraction, within the meaning of Section 17556 of
2 the Government Code, or changes the definition of a crime within
3 the meaning of Section 6 of Article XIII B of the California
4 Constitution.

O

ASSEMBLY BILL

No. 2185

Introduced by Assembly Members Patterson and Gallagher

February 11, 2020

An act to add Section 117 to the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

AB 2185, as introduced, Patterson. Professions and vocations: applicants licensed in other states: reciprocity.

Existing law establishes the Department of Consumer Affairs, which is composed of boards that license and regulate various professions and vocations to ensure that certain businesses and professions that have potential impact upon the public health, safety, and welfare are adequately regulated. Existing law makes a violation of some of those licensure provisions a crime.

Existing law authorizes certain boards, for purposes of reciprocity, to waive examination or other requirements and issue a license to an applicant who holds a valid license in another state and meets specified other requirements, including, among others, a license to practice veterinary medicine.

This bill would require each board within the department to issue a license to an applicant in the discipline for which the applicant applies if the person currently holds a license in good standing in another state in the discipline and practice level for which the person applies and if the person meets specified requirements, including that the person has held the license and has practiced in the licensed field in the other state for at least 3 of the last 5 years and pays all applicable fees. By expanding the applicants who are authorized to be licensed and may be

prosecuted for a violation of those licensure provisions constituting a crime, the bill would impose a state-mandated program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 117 is added to the Business and
2 Professions Code, to read:

3 117. (a) Notwithstanding any law, each board within the
4 department shall issue a license in the discipline for which the
5 applicant applies if the applicant meets all of the following
6 requirements:

7 (1) The person is a resident in this state or is married to, or is
8 in a domestic partnership or other legal union with, an active duty
9 member of the Armed Forces of the United States who is assigned
10 to a duty station in this state under official active duty military
11 orders.

12 (2) The person currently holds a license in good standing in
13 another state in the discipline and practice level for which the
14 person is applying.

15 (3) The person has held the license and has practiced in the
16 licensed field in the other state for at least three of the last five
17 years.

18 (4) The person has not had any disciplinary actions imposed
19 against their license and has not had a license in the discipline for
20 which the person is applying revoked or suspended in any other
21 state.

22 (5) The person submits verification that they have satisfied all
23 education, work, examination, and other requirements for licensure
24 in the other state in which the person holds a license in good
25 standing.

26 (6) The person would not be denied licensure under any other
27 provision of this code, including, but not limited to, disqualification
28 for criminal history relating to the license sought.

1 (7) The person pays all applicable fees for licensure.

2 (8) If required by the board, the person has passed a California
3 jurisprudence and ethics examination or other examination
4 otherwise required for applicants by the board on the statutes and
5 regulations relating to the license.

6 (b) This section shall not supersede any other reciprocity
7 agreement, compact membership, or statute that provides
8 reciprocity for a person who holds a valid license in another state.

9 (c) Notwithstanding any law, the fees, fines, penalties, or other
10 money received by a board pursuant to this section shall not be
11 continuously appropriated and shall be available only upon
12 appropriation by the legislature.

13 SEC. 2. No reimbursement is required by this act pursuant to
14 Section 6 of Article XIII B of the California Constitution because
15 the only costs that may be incurred by a local agency or school
16 district will be incurred because this act creates a new crime or
17 infraction, eliminates a crime or infraction, or changes the penalty
18 for a crime or infraction, within the meaning of Section 17556 of
19 the Government Code, or changes the definition of a crime within
20 the meaning of Section 6 of Article XIII B of the California
21 Constitution.

ASSEMBLY BILL

No. 2549

Introduced by Assembly Member Salas

February 19, 2020

An act to amend Sections 115.6 and 5132 of the Business and Professions Code, relating to professions and vocations, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 2549, as introduced, Salas. Department of Consumer Affairs: temporary licenses.

Under existing law, the Department of Consumer Affairs, which is under the control of the Director of Consumer Affairs, is comprised of various boards, as defined, that license and regulate various professions and vocations. Existing law requires a board within the department to issue, after appropriate investigation, certain types of temporary licenses to an applicant if the applicant meets specified requirements, including that the applicant supplies evidence satisfactory to the board that the applicant is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in this state under official active duty military orders and the applicant holds a current, active, and unrestricted license that confers upon the applicant the authority to practice, in another state, district, or territory of the United States, the profession or vocation for which the applicant seeks a temporary license from the board.

This bill would expand that requirement to issue temporary licenses to include licenses issued by the Dental Hygiene Board of California, the California State Board of Pharmacy, and the California Board of

Accountancy, and certain registered dental assistant licenses issued by the Dental Board of California. The bill would specifically direct revenues from fees for temporary licenses issued by the California Board of Accountancy to be credited to the Accountancy Fund, a continuously appropriated fund. By establishing a new source of revenue for a continuously appropriated fund, the bill would make an appropriation.

Vote: majority. Appropriation: yes. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 115.6 of the Business and Professions
- 2 Code is amended to read:
- 3 115.6. (a) A board within the department shall, after
- 4 appropriate investigation, issue the following eligible temporary
- 5 licenses to an applicant if the applicant meets the requirements set
- 6 forth in subdivision (c):
- 7 (1) Registered nurse license by the Board of Registered Nursing.
- 8 (2) Vocational nurse license issued by the Board of Vocational
- 9 Nursing and Psychiatric Technicians of the State of California.
- 10 (3) Psychiatric technician license issued by the Board of
- 11 Vocational Nursing and Psychiatric Technicians of the State of
- 12 California.
- 13 (4) Speech-language pathologist license issued by the
- 14 Speech-Language Pathology and Audiology and Hearing Aid
- 15 Dispensers Board.
- 16 (5) Audiologist license issued by the Speech-Language
- 17 Pathology and Audiology and Hearing Aid Dispensers Board.
- 18 (6) Veterinarian license issued by the Veterinary Medical Board.
- 19 (7) All licenses issued by the Board for Professional Engineers,
- 20 Land Surveyors, and Geologists.
- 21 (8) All licenses issued by the Medical Board of California.
- 22 (9) All licenses issued by the Podiatric Medical Board of
- 23 California.
- 24 (10) *Registered dental assistant license or registered dental*
- 25 *assistant in extended functions license issued by the Dental Board*
- 26 *of California.*
- 27 (11) *All licenses issued by the Dental Hygiene Board of*
- 28 *California.*

1 (12) All licenses issued by the California State Board of
2 Pharmacy.

3 (13) All licenses issued by the California Board of Accountancy.
4 Revenues from fees for temporary licenses issued under this
5 paragraph shall be credited to the Accountancy Fund in
6 accordance with Section 5132.

7 (b) The board may conduct an investigation of an applicant for
8 purposes of denying or revoking a temporary license issued
9 pursuant to this section. This investigation may include a criminal
10 background check.

11 (c) An applicant seeking a temporary license pursuant to this
12 section shall meet the following requirements:

13 (1) The applicant shall supply evidence satisfactory to the board
14 that the applicant is married to, or in a domestic partnership or
15 other legal union with, an active duty member of the Armed Forces
16 of the United States who is assigned to a duty station in this state
17 under official active duty military orders.

18 (2) The applicant shall hold a current, active, and unrestricted
19 license that confers upon the applicant the authority to practice,
20 in another state, district, or territory of the United States, the
21 profession or vocation for which the applicant seeks a temporary
22 license from the board.

23 (3) The applicant shall submit an application to the board that
24 shall include a signed affidavit attesting to the fact that the
25 applicant meets all of the requirements for the temporary license
26 and that the information submitted in the application is accurate,
27 to the best of the applicant's knowledge. The application shall also
28 include written verification from the applicant's original licensing
29 jurisdiction stating that the applicant's license is in good standing
30 in that jurisdiction.

31 (4) The applicant shall not have committed an act in any
32 jurisdiction that would have constituted grounds for denial,
33 suspension, or revocation of the license under this code at the time
34 the act was committed. A violation of this paragraph may be
35 grounds for the denial or revocation of a temporary license issued
36 by the board.

37 (5) The applicant shall not have been disciplined by a licensing
38 entity in another jurisdiction and shall not be the subject of an
39 unresolved complaint, review procedure, or disciplinary proceeding
40 conducted by a licensing entity in another jurisdiction.

1 (6) The applicant shall, upon request by a board, furnish a full
2 set of fingerprints for purposes of conducting a criminal
3 background check.

4 (d) A board may adopt regulations necessary to administer this
5 section.

6 (e) A temporary license issued pursuant to this section may be
7 immediately terminated upon a finding that the temporary
8 licenseholder failed to meet any of the requirements described in
9 subdivision (c) or provided substantively inaccurate information
10 that would affect the person's eligibility for temporary licensure.
11 Upon termination of the temporary license, the board shall issue
12 a notice of termination that shall require the temporary
13 licenseholder to immediately cease the practice of the licensed
14 profession upon receipt.

15 (f) An applicant seeking a temporary license as a civil engineer,
16 geotechnical engineer, structural engineer, land surveyor,
17 professional geologist, professional geophysicist, certified
18 engineering geologist, or certified hydrogeologist pursuant to this
19 section shall successfully pass the appropriate California-specific
20 examination or examinations required for licensure in those
21 respective professions by the Board for Professional Engineers,
22 Land Surveyors, and Geologists.

23 (g) A temporary license issued pursuant to this section shall
24 expire 12 months after issuance, upon issuance of an expedited
25 license pursuant to Section 115.5, or upon denial of the application
26 for expedited licensure by the board, whichever occurs first.

27 SEC. 2. Section 5132 of the Business and Professions Code is
28 amended to read:

29 5132. (a) All moneys received by the board under this chapter
30 from any source and for any purpose *and from a temporary license*
31 *issued under Section 115.6* shall be accounted for and reported
32 monthly by the board to the Controller and at the same time the
33 moneys shall be remitted to the State Treasury to the credit of the
34 Accountancy Fund.

35 ~~The~~

36 (b) *The* secretary-treasurer of the board shall, from time to time,
37 but not less than once each fiscal year, prepare or have prepared
38 on ~~his or her~~ *their* behalf, a financial report of the Accountancy
39 Fund that contains information that the board determines is
40 necessary for the purposes for which the board was established.

1 ~~The~~
2 (c) *The* report of the Accountancy Fund, which shall be
3 published pursuant to Section 5008, shall include the revenues and
4 the related costs from examination, initial licensing, license
5 renewal, citation and fine authority, and cost recovery from
6 enforcement actions and case settlements.

O

ASSEMBLY BILL

No. 3016

Introduced by Assembly Member Megan Dahle

February 21, 2020

An act to add Section 2718 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 3016, as introduced, Megan Dahle. Board of Registered Nursing: online license verification.

The Nursing Practice Act provides for the licensure and regulation of nurses by the Board of Registered Nursing within the Department of Consumer Affairs. Existing law also requires the board to issue temporary or expedited licenses to specified applicants who hold a current, active, and unrestricted license in another state, district, or territory of the United States, in the profession or vocation for which the applicant seeks a license from the board.

This bill would require the board, in consultation with the department, to develop recommendations for the implementation of the Nursys online license verification system in the licensure process for licenses administered by the board, and would require the board to implement those recommendations within a reasonable period.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 2718 is added to the Business and
- 2 Professions Code, to read:

1 2718. (a) The board, in consultation with the department, shall
2 develop recommendations for the implementation of the Nursys
3 online license verification system in the licensure process for
4 licenses administered by the board.

5 (b) The board shall implement the recommendations within a
6 reasonable period upon completion of the development of those
7 recommendations.

Introduced by Senator MoorlachFebruary 18, 2020

An act to add Article 1.5 (commencing with Section 2720) to Chapter 6 of Division 2 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1053, as introduced, Moorlach. Licensed registered nurses and licensed vocational nurses: Nurse Licensure Compact.

Existing law, the Nursing Practice Act, provides for the licensure and regulation of the practice of nursing by the Board of Registered Nursing. The Vocational Nursing Practice Act provides for the licensure and regulation of vocational nurses by the Board of Vocational Nursing and Psychiatric Technicians of the State of California.

This bill would enact the Nurse Licensure Compact, under which the Board of Registered Nursing would be authorized to issue a multistate license that would authorize the holder to practice as a registered nurse or a licensed vocational nurse, as applicable, in all party states under a multistate licensure privilege, as specified. The bill would designate the Board of Registered Nursing as the licensing board for purposes of the compact and would require the board to participate in a coordinated licensure information system that would include all of the licensure and disciplinary history of all licensed registered nurses and licensed vocational nurses. The bill would provide that the president of the Board of Registered Nursing shall be the administrator of the compact for the state and shall be a member of an entity known as the Interstate Commission of Nurse Licensure Compact Administrators. The bill would authorize the commission to adopt rules that have the force and effect of law.

By authorizing out-of-state licensees to practice in this state under the multistate compact privilege created by the bill, the bill would expand the scope of the criminal provisions of the Nursing Practice Act and Vocational Nursing Practice Act, thereby imposing a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Article 1.5 (commencing with Section 2720) is
2 added to Chapter 6 of Division 2 of the Business and Professions
3 Code, to read:

4
5 Article 1.5. Nurse Licensure Compact
6

7 2720. The Nurse Licensure Compact is hereby enacted into
8 law with all other participating states.

9 2721. (a) The Board of Registered Nursing is hereby
10 designated as the licensing entity for purposes of the compact.

11 (b) The president of the Board of Registered Nursing shall be
12 the administrator of the compact for the state.

13 2722. If any provision in the compact is contrary to the United
14 States Constitution or the California Constitution, or conflicts with
15 any state or federal statute or regulation, the provision is void and
16 unenforceable.

17 2723. The provisions of the Nurse Licensure Compact are as
18 follows:

19
20 **ARTICLE I**
21 **Findings and Declaration of Purpose**
22

23 a. The party states find that:

1 1. The health and safety of the public are affected by the degree
2 of compliance with and the effectiveness of enforcement activities
3 related to state nurse licensure laws;

4 2. Violations of nurse licensure and other laws regulating the
5 practice of nursing may result in injury or harm to the public;

6 3. The expanded mobility of nurses and the use of advanced
7 communication technologies as part of our nation’s health care
8 delivery system require greater coordination and cooperation
9 among states in the areas of nurse licensure and regulation;

10 4. New practice modalities and technology make compliance
11 with individual state nurse licensure laws difficult and complex;

12 5. The current system of duplicative licensure for nurses
13 practicing in multiple states is cumbersome and redundant for both
14 nurses and states; and

15 6. Uniformity of nurse licensure requirements throughout the
16 states promotes public safety and public health benefits.

17 b. The general purposes of this Compact are to:

18 1. Facilitate the states’ responsibility to protect the public’s health
19 and safety;

20 2. Ensure and encourage the cooperation of party states in the
21 areas of nurse licensure and regulation;

22 3. Facilitate the exchange of information between party states
23 in the areas of nurse regulation, investigation and adverse actions;

24 4. Promote compliance with the laws governing the practice of
25 nursing in each jurisdiction;

26 5. Invest all party states with the authority to hold a nurse
27 accountable for meeting all state practice laws in the state in which
28 the patient is located at the time care is rendered through the mutual
29 recognition of party state licenses;

30 6. Decrease redundancies in the consideration and issuance of
31 nurse licenses; and

32 7. Provide opportunities for interstate practice by nurses who
33 meet uniform licensure requirements.

34
35 **ARTICLE II**
36 **Definitions**

37
38 As used in this Compact:

39 a. “Adverse action” means any administrative, civil, equitable
40 or criminal action permitted by a state’s laws which is imposed

1 by a licensing board or other authority against a nurse, including
2 actions against an individual’s license or multistate licensure
3 privilege such as revocation, suspension, probation, monitoring
4 of the licensee, limitation on the licensee’s practice, or any other
5 encumbrance on licensure affecting a nurse’s authorization to
6 practice, including issuance of a cease and desist action.

7 b. “Alternative program” means a non-disciplinary monitoring
8 program approved by a licensing board.

9 c. “Coordinated licensure information system” means an
10 integrated process for collecting, storing and sharing information
11 on nurse licensure and enforcement activities related to nurse
12 licensure laws that is administered by a nonprofit organization
13 composed of and controlled by licensing boards.

14 d. “Current significant investigative information” means:

15 1. Investigative information that a licensing board, after a
16 preliminary inquiry that includes notification and an opportunity
17 for the nurse to respond, if required by state law, has reason to
18 believe is not groundless and, if proved true, would indicate more
19 than a minor infraction; or

20 2. Investigative information that indicates that the nurse
21 represents an immediate threat to public health and safety
22 regardless of whether the nurse has been notified and had an
23 opportunity to respond.

24 e. “Encumbrance” means a revocation or suspension of, or any
25 limitation on, the full and unrestricted practice of nursing imposed
26 by a licensing board.

27 f. “Home state” means the party state which is the nurse’s
28 primary state of residence.

29 g. “Licensing board” means a party state’s regulatory body
30 responsible for issuing nurse licenses.

31 h. “Multistate license” means a license to practice as a registered
32 or a licensed practical/vocational nurse (LPN/VN) issued by a
33 home state licensing board that authorizes the licensed nurse to
34 practice in all party states under a multistate licensure privilege.

35 i. “Multistate licensure privilege” means a legal authorization
36 associated with a multistate license permitting the practice of
37 nursing as either a registered nurse (RN) or LPN/VN in a remote
38 state.

39 j. “Nurse” means RN or LPN/VN, as those terms are defined by
40 each party state’s practice laws.

- 1 k. “Party state” means any state that has adopted this Compact.
- 2 l. “Remote state” means a party state, other than the home state.
- 3 m. “Single-state license” means a nurse license issued by a party
4 state that authorizes practice only within the issuing state and does
5 not include a multistate licensure privilege to practice in any other
6 party state.
- 7 n. “State” means a state, territory or possession of the United
8 States and the District of Columbia.
- 9 o. “State practice laws” means a party state’s laws, rules and
10 regulations that govern the practice of nursing, define the scope
11 of nursing practice, and create the methods and grounds for
12 imposing discipline. “State practice laws” do not include
13 requirements necessary to obtain and retain a license, except for
14 qualifications or requirements of the home state.

15
16 **ARTICLE III**
17 **General Provisions and Jurisdiction**
18

- 19 a. A multistate license to practice registered or licensed
20 practical/vocational nursing issued by a home state to a resident
21 in that state will be recognized by each party state as authorizing
22 a nurse to practice as a registered nurse (RN) or as a licensed
23 practical/vocational nurse (LPN/VN), under a multistate licensure
24 privilege, in each party state.
- 25 b. A state must implement procedures for considering the
26 criminal history records of applicants for initial multistate license
27 or licensure by endorsement. Such procedures shall include the
28 submission of fingerprints or other biometric-based information
29 by applicants for the purpose of obtaining an applicant’s criminal
30 history record information from the Federal Bureau of Investigation
31 and the agency responsible for retaining that state’s criminal
32 records.
- 33 c. Each party state shall require the following for an applicant
34 to obtain or retain a multistate license in the home state:
 - 35 1. Meets the home state’s qualifications for licensure or renewal
36 of licensure, as well as, all other applicable state laws;
 - 37 2. i. Has graduated or is eligible to graduate from a licensing
38 board-approved RN or LPN/VN prelicensure education program;
39 or

- 1 ii. Has graduated from a foreign RN or LPN/VN prelicensure
2 education program that (a) has been approved by the authorized
3 accrediting body in the applicable country and (b) has been verified
4 by an independent credentials review agency to be comparable to
5 a licensing board-approved prelicensure education program;
- 6 3. Has, if a graduate of a foreign prelicensure education program
7 not taught in English or if English is not the individual's native
8 language, successfully passed an English proficiency examination
9 that includes the components of reading, speaking, writing and
10 listening;
- 11 4. Has successfully passed an NCLEX-RN® or NCLEX-PN®
12 Examination or recognized predecessor, as applicable;
- 13 5. Is eligible for or holds an active, unencumbered license;
- 14 6. Has submitted, in connection with an application for initial
15 licensure or licensure by endorsement, fingerprints or other
16 biometric data for the purpose of obtaining criminal history record
17 information from the Federal Bureau of Investigation and the
18 agency responsible for retaining that state's criminal records;
- 19 7. Has not been convicted or found guilty, or has entered into
20 an agreed disposition, of a felony offense under applicable state
21 or federal criminal law;
- 22 8. Has not been convicted or found guilty, or has entered into
23 an agreed disposition, of a misdemeanor offense related to the
24 practice of nursing as determined on a case-by-case basis;
- 25 9. Is not currently enrolled in an alternative program;
- 26 10. Is subject to self-disclosure requirements regarding current
27 participation in an alternative program; and
- 28 11. Has a valid United States Social Security number.
- 29 d. All party states shall be authorized, in accordance with existing
30 state due process law, to take adverse action against a nurse's
31 multistate licensure privilege such as revocation, suspension,
32 probation or any other action that affects a nurse's authorization
33 to practice under a multistate licensure privilege, including cease
34 and desist actions. If a party state takes such action, it shall
35 promptly notify the administrator of the coordinated licensure
36 information system. The administrator of the coordinated licensure
37 information system shall promptly notify the home state of any
38 such actions by remote states.
- 39 e. A nurse practicing in a party state must comply with the state
40 practice laws of the state in which the client is located at the time

1 service is provided. The practice of nursing is not limited to patient
2 care, but shall include all nursing practice as defined by the state
3 practice laws of the party state in which the client is located. The
4 practice of nursing in a party state under a multistate licensure
5 privilege will subject a nurse to the jurisdiction of the licensing
6 board, the courts and the laws of the party state in which the client
7 is located at the time service is provided.

8 f. Individuals not residing in a party state shall continue to be
9 able to apply for a party state’s single- state license as provided
10 under the laws of each party state. However, the single-state license
11 granted to these individuals will not be recognized as granting the
12 privilege to practice nursing in any other party state. Nothing in
13 this Compact shall affect the requirements established by a party
14 state for the issuance of a single-state license.

15 g. Any nurse holding a home state multistate license, on the
16 effective date of this Compact, may retain and renew the multistate
17 license issued by the nurse’s then-current home state, provided
18 that:

19 1. A nurse, who changes primary state of residence after this
20 Compact’s effective date, must meet all applicable Article III.c.
21 requirements to obtain a multistate license from a new home state.

22 2. A nurse who fails to satisfy the multistate licensure
23 requirements in Article III.c. due to a disqualifying event occurring
24 after this Compact’s effective date shall be ineligible to retain or
25 renew a multistate license, and the nurse’s multistate license shall
26 be revoked or deactivated in accordance with applicable rules
27 adopted by the Interstate Commission of Nurse Licensure Compact
28 Administrators (“Commission”).

29
30 **ARTICLE IV**

31 **Applications for Licensure in a Party State**

32
33 a. Upon application for a multistate license, the licensing board
34 in the issuing party state shall ascertain, through the coordinated
35 licensure information system, whether the applicant has ever held,
36 or is the holder of, a license issued by any other state, whether
37 there are any encumbrances on any license or multistate licensure
38 privilege held by the applicant, whether any adverse action has
39 been taken against any license or multistate licensure privilege

1 held by the applicant and whether the applicant is currently
2 participating in an alternative program.

3 b. A nurse may hold a multistate license, issued by the home
4 state, in only one party state at a time.

5 c. If a nurse changes primary state of residence by moving
6 between two party states, the nurse must apply for licensure in the
7 new home state, and the multistate license issued by the prior home
8 state will be deactivated in accordance with applicable rules
9 adopted by the Commission.

10 1. The nurse may apply for licensure in advance of a change in
11 primary state of residence.

12 2. A multistate license shall not be issued by the new home state
13 until the nurse provides satisfactory evidence of a change in
14 primary state of residence to the new home state and satisfies all
15 applicable requirements to obtain a multistate license from the
16 new home state.

17 d. If a nurse changes primary state of residence by moving from
18 a party state to a non-party state, the multistate license issued by
19 the prior home state will convert to a single-state license, valid
20 only in the former home state.

21

22 **ARTICLE V**

23 **Additional Authorities Invested in Party State Licensing**
24 **Boards**

25

26 a. In addition to the other powers conferred by state law, a
27 licensing board shall have the authority to:

28 1. Take adverse action against a nurse’s multistate licensure
29 privilege to practice within that party state.

30 i. Only the home state shall have the power to take adverse action
31 against a nurse’s license issued by the home state.

32 ii. For purposes of taking adverse action, the home state licensing
33 board shall give the same priority and effect to reported conduct
34 received from a remote state as it would if such conduct had
35 occurred within the home state. In so doing, the home state shall
36 apply its own state laws to determine appropriate action.

37 2. Issue cease and desist orders or impose an encumbrance on a
38 nurse’s authority to practice within that party state.

39 3. Complete any pending investigations of a nurse who changes
40 primary state of residence during the course of such investigations.

1 The licensing board shall also have the authority to take appropriate
2 action(s) and shall promptly report the conclusions of such
3 investigations to the administrator of the coordinated licensure
4 information system. The administrator of the coordinated licensure
5 information system shall promptly notify the new home state of
6 any such actions.

7 4. Issue subpoenas for both hearings and investigations that
8 require the attendance and testimony of witnesses, as well as, the
9 production of evidence. Subpoenas issued by a licensing board in
10 a party state for the attendance and testimony of witnesses or the
11 production of evidence from another party state shall be enforced
12 in the latter state by any court of competent jurisdiction, according
13 to the practice and procedure of that court applicable to subpoenas
14 issued in proceedings pending before it. The issuing authority shall
15 pay any witness fees, travel expenses, mileage and other fees
16 required by the service statutes of the state in which the witnesses
17 or evidence are located.

18 5. Obtain and submit, for each nurse licensure applicant,
19 fingerprint or other biometric-based information to the Federal
20 Bureau of Investigation for criminal background checks, receive
21 the results of the Federal Bureau of Investigation record search on
22 criminal background checks and use the results in making licensure
23 decisions.

24 6. If otherwise permitted by state law, recover from the affected
25 nurse the costs of investigations and disposition of cases resulting
26 from any adverse action taken against that nurse.

27 7. Take adverse action based on the factual findings of the remote
28 state, provided that the licensing board follows its own procedures
29 for taking such adverse action.

30 b. If adverse action is taken by the home state against a nurse's
31 multistate license, the nurse's multistate licensure privilege to
32 practice in all other party states shall be deactivated until all
33 encumbrances have been removed from the multistate license. All
34 home state disciplinary orders that impose adverse action against
35 a nurse's multistate license shall include a statement that the nurse's
36 multistate licensure privilege is deactivated in all party states during
37 the pendency of the order.

38 c. Nothing in this Compact shall override a party state's decision
39 that participation in an alternative program may be used in lieu of
40 adverse action. The home state licensing board shall deactivate

1 the multistate licensure privilege under the multistate license of
2 any nurse for the duration of the nurse’s participation in an
3 alternative program.

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8

ARTICLE VI
Coordinated Licensure Information System and Exchange
of Information

9 a. All party states shall participate in a coordinated licensure
10 information system of all licensed registered nurses (RNs) and
11 licensed practical/vocational nurses (LPNs/VNs). This system will
12 include information on the licensure and disciplinary history of
13 each nurse, as submitted by party states, to assist in the
14 coordination of nurse licensure and enforcement efforts.

15 b. The Commission, in consultation with the administrator of
16 the coordinated licensure information system, shall formulate
17 necessary and proper procedures for the identification, collection
18 and exchange of information under this Compact.

19 c. All licensing boards shall promptly report to the coordinated
20 licensure information system any adverse action, any current
21 significant investigative information, denials of applications (with
22 the reasons for such denials) and nurse participation in alternative
23 programs known to the licensing board regardless of whether such
24 participation is deemed nonpublic or confidential under state law.

25 d. Current significant investigative information and participation
26 in nonpublic or confidential alternative programs shall be
27 transmitted through the coordinated licensure information system
28 only to party state licensing boards.

29 e. Notwithstanding any other provision of law, all party state
30 licensing boards contributing information to the coordinated
31 licensure information system may designate information that may
32 not be shared with non-party states or disclosed to other entities
33 or individuals without the express permission of the contributing
34 state.

35 f. Any personally identifiable information obtained from the
36 coordinated licensure information system by a party state licensing
37 board shall not be shared with non-party states or disclosed to other
38 entities or individuals except to the extent permitted by the laws
39 of the party state contributing the information.

1 g. Any information contributed to the coordinated licensure
2 information system that is subsequently required to be expunged
3 by the laws of the party state contributing that information shall
4 also be expunged from the coordinated licensure information
5 system.

6 h. The Compact administrator of each party state shall furnish
7 a uniform data set to the Compact administrator of each other party
8 state, which shall include, at a minimum:

- 9 1. Identifying information;
10 2. Licensure data;
11 3. Information related to alternative program participation; and
12 4. Other information that may facilitate the administration of
13 this Compact, as determined by Commission rules.

14 i. The Compact administrator of a party state shall provide all
15 investigative documents and information requested by another
16 party state.

17
18 **ARTICLE VII**

19 **Establishment of the Interstate Commission of Nurse**
20 **Licensure Compact Administrators**
21

22 a. The party states hereby create and establish a joint public
23 entity known as the Interstate Commission of Nurse Licensure
24 Compact Administrators.

- 25 1. The Commission is an instrumentality of the party states.
26 2. Venue is proper, and judicial proceedings by or against the
27 Commission shall be brought solely and exclusively, in a court of
28 competent jurisdiction where the principal office of the
29 Commission is located. The Commission may waive venue and
30 jurisdictional defenses to the extent it adopts or consents to
31 participate in alternative dispute resolution proceedings.
32 3. Nothing in this Compact shall be construed to be a waiver of
33 sovereign immunity.

34 b. Membership, Voting and Meetings
35 1. Each party state shall have and be limited to one administrator.
36 The head of the state licensing board or designee shall be the
37 administrator of this Compact for each party state. Any
38 administrator may be removed or suspended from office as
39 provided by the law of the state from which the Administrator is
40 appointed. Any vacancy occurring in the Commission shall be

1 filled in accordance with the laws of the party state in which the
2 vacancy exists.

3 2. Each administrator shall be entitled to one (1) vote with regard
4 to the promulgation of rules and creation of bylaws and shall
5 otherwise have an opportunity to participate in the business and
6 affairs of the Commission. An administrator shall vote in person
7 or by such other means as provided in the bylaws. The bylaws may
8 provide for an administrator's participation in meetings by
9 telephone or other means of communication.

10 3. The Commission shall meet at least once during each calendar
11 year. Additional meetings shall be held as set forth in the bylaws
12 or rules of the commission.

13 4. All meetings shall be open to the public, and public notice of
14 meetings shall be given in the same manner as required under the
15 rulemaking provisions in Article VIII.

16 5. The Commission may convene in a closed, nonpublic meeting
17 if the Commission must discuss:

18 i. Noncompliance of a party state with its obligations under this
19 Compact;

20 ii. The employment, compensation, discipline or other personnel
21 matters, practices or procedures related to specific employees or
22 other matters related to the Commission's internal personnel
23 practices and procedures;

24 iii. Current, threatened or reasonably anticipated litigation;

25 iv. Negotiation of contracts for the purchase or sale of goods,
26 services or real estate;

27 v. Accusing any person of a crime or formally censuring any
28 person;

29 vi. Disclosure of trade secrets or commercial or financial
30 information that is privileged or confidential;

31 vii. Disclosure of information of a personal nature where
32 disclosure would constitute a clearly unwarranted invasion of
33 personal privacy;

34 viii. Disclosure of investigatory records compiled for law
35 enforcement purposes;

36 ix. Disclosure of information related to any reports prepared by
37 or on behalf of the Commission for the purpose of investigation
38 of compliance with this Compact; or

39 x. Matters specifically exempted from disclosure by federal or
40 state statute.

1 6. If a meeting, or portion of a meeting, is closed pursuant to
2 this provision, the Commission's legal counsel or designee shall
3 certify that the meeting may be closed and shall reference each
4 relevant exempting provision. The Commission shall keep minutes
5 that fully and clearly describe all matters discussed in a meeting
6 and shall provide a full and accurate summary of actions taken,
7 and the reasons therefor, including a description of the views
8 expressed. All documents considered in connection with an action
9 shall be identified in such minutes. All minutes and documents of
10 a closed meeting shall remain under seal, subject to release by a
11 majority vote of the Commission or order of a court of competent
12 jurisdiction.

13 c. The Commission shall, by a majority vote of the
14 administrators, prescribe bylaws or rules to govern its conduct as
15 may be necessary or appropriate to carry out the purposes and
16 exercise the powers of this Compact, including but not limited to:

- 17 1. Establishing the fiscal year of the Commission;
- 18 2. Providing reasonable standards and procedures:
 - 19 i. For the establishment and meetings of other committees; and
 - 20 ii. Governing any general or specific delegation of any authority
21 or function of the Commission;
- 22 3. Providing reasonable procedures for calling and conducting
23 meetings of the Commission, ensuring reasonable advance notice
24 of all meetings and providing an opportunity for attendance of
25 such meetings by interested parties, with enumerated exceptions
26 designed to protect the public's interest, the privacy of individuals,
27 and proprietary information, including trade secrets. The
28 Commission may meet in closed session only after a majority of
29 the administrators vote to close a meeting in whole or in part. As
30 soon as practicable, the Commission must make public a copy of
31 the vote to close the meeting revealing the vote of each
32 administrator, with no proxy votes allowed;
- 33 4. Establishing the titles, duties and authority and reasonable
34 procedures for the election of the officers of the Commission;
- 35 5. Providing reasonable standards and procedures for the
36 establishment of the personnel policies and programs of the
37 Commission. Notwithstanding any civil service or other similar
38 laws of any party state, the bylaws shall exclusively govern the
39 personnel policies and programs of the Commission; and

- 1 6. Providing a mechanism for winding up the operations of the
- 2 Commission and the equitable disposition of any surplus funds
- 3 that may exist after the termination of this Compact after the
- 4 payment or reserving of all of its debts and obligations;
- 5 d. The Commission shall publish its bylaws and rules, and any
- 6 amendments thereto, in a convenient form on the website of the
- 7 Commission.
- 8 e. The Commission shall maintain its financial records in
- 9 accordance with the bylaws.
- 10 f. The Commission shall meet and take such actions as are
- 11 consistent with the provisions of this Compact and the bylaws.
- 12 g. The Commission shall have the following powers:
- 13 1. To promulgate uniform rules to facilitate and coordinate
- 14 implementation and administration of this Compact. The rules
- 15 shall have the force and effect of law and shall be binding in all
- 16 party states;
- 17 2. To bring and prosecute legal proceedings or actions in the
- 18 name of the Commission, provided that the standing of any
- 19 licensing board to sue or be sued under applicable law shall not
- 20 be affected;
- 21 3. To purchase and maintain insurance and bonds;
- 22 4. To borrow, accept or contract for services of personnel,
- 23 including, but not limited to, employees of a party state or nonprofit
- 24 organizations;
- 25 5. To cooperate with other organizations that administer state
- 26 compacts related to the regulation of nursing, including but not
- 27 limited to sharing administrative or staff expenses, office space or
- 28 other resources;
- 29 6. To hire employees, elect or appoint officers, fix compensation,
- 30 define duties, grant such individuals appropriate authority to carry
- 31 out the purposes of this Compact, and to establish the
- 32 Commission's personnel policies and programs relating to conflicts
- 33 of interest, qualifications of personnel and other related personnel
- 34 matters;
- 35 7. To accept any and all appropriate donations, grants and gifts
- 36 of money, equipment, supplies, materials and services, and to
- 37 receive, utilize and dispose of the same; provided that at all times
- 38 the Commission shall avoid any appearance of impropriety or
- 39 conflict of interest;

1 8. To lease, purchase, accept appropriate gifts or donations of,
2 or otherwise to own, hold, improve or use, any property, whether
3 real, personal or mixed; provided that at all times the Commission
4 shall avoid any appearance of impropriety;

5 9. To sell, convey, mortgage, pledge, lease, exchange, abandon
6 or otherwise dispose of any property, whether real, personal or
7 mixed;

8 10. To establish a budget and make expenditures;

9 11. To borrow money;

10 12. To appoint committees, including advisory committees
11 comprised of administrators, state nursing regulators, state
12 legislators or their representatives, and consumer representatives,
13 and other such interested persons;

14 13. To provide and receive information from, and to cooperate
15 with, law enforcement agencies;

16 14. To adopt and use an official seal; and

17 15. To perform such other functions as may be necessary or
18 appropriate to achieve the purposes of this Compact consistent
19 with the state regulation of nurse licensure and practice.

20 h. Financing of the Commission

21 1. The Commission shall pay, or provide for the payment of, the
22 reasonable expenses of its establishment, organization and ongoing
23 activities.

24 2. The Commission may also levy on and collect an annual
25 assessment from each party state to cover the cost of its operations,
26 activities and staff in its annual budget as approved each year. The
27 aggregate annual assessment amount, if any, shall be allocated
28 based upon a formula to be determined by the Commission, which
29 shall promulgate a rule that is binding upon all party states.

30 3. The Commission shall not incur obligations of any kind prior
31 to securing the funds adequate to meet the same; nor shall the
32 Commission pledge the credit of any of the party states, except
33 by, and with the authority of, such party state.

34 4. The Commission shall keep accurate accounts of all receipts
35 and disbursements. The receipts and disbursements of the
36 Commission shall be subject to the audit and accounting procedures
37 established under its bylaws. However, all receipts and
38 disbursements of funds handled by the Commission shall be audited
39 yearly by a certified or licensed public accountant, and the report

1 of the audit shall be included in and become part of the annual
2 report of the Commission.

3 i. Qualified Immunity, Defense and Indemnification

4 1. The administrators, officers, executive director, employees
5 and representatives of the Commission shall be immune from suit
6 and liability, either personally or in their official capacity, for any
7 claim for damage to or loss of property or personal injury or other
8 civil liability caused by or arising out of any actual or alleged act,
9 error or omission that occurred, or that the person against whom
10 the claim is made had a reasonable basis for believing occurred,
11 within the scope of Commission employment, duties or
12 responsibilities; provided that nothing in this paragraph shall be
13 construed to protect any such person from suit or liability for any
14 damage, loss, injury or liability caused by the intentional, willful
15 or wanton misconduct of that person.

16 2. The Commission shall defend any administrator, officer,
17 executive director, employee or representative of the Commission
18 in any civil action seeking to impose liability arising out of any
19 actual or alleged act, error or omission that occurred within the
20 scope of Commission employment, duties or responsibilities, or
21 that the person against whom the claim is made had a reasonable
22 basis for believing occurred within the scope of Commission
23 employment, duties or responsibilities; provided that nothing herein
24 shall be construed to prohibit that person from retaining his or her
25 own counsel; and provided further that the actual or alleged act,
26 error or omission did not result from that person’s intentional,
27 willful or wanton misconduct.

28 3. The Commission shall indemnify and hold harmless any
29 administrator, officer, executive director, employee or
30 representative of the Commission for the amount of any settlement
31 or judgment obtained against that person arising out of any actual
32 or alleged act, error or omission that occurred within the scope of
33 Commission employment, duties or responsibilities, or that such
34 person had a reasonable basis for believing occurred within the
35 scope of Commission employment, duties or responsibilities,
36 provided that the actual or alleged act, error or omission did not
37 result from the intentional, willful or wanton misconduct of that
38 person.

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ARTICLE VIII

Rulemaking

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- a. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in this Article and the rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment and shall have the same force and effect as provisions of this Compact.
- b. Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.
- c. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least sixty (60) days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a notice of proposed rulemaking:
 - 1. On the website of the Commission; and
 - 2. On the website of each licensing board or the publication in which each state would otherwise publish proposed rules.
- d. The notice of proposed rulemaking shall include:
 - 1. The proposed time, date and location of the meeting in which the rule will be considered and voted upon;
 - 2. The text of the proposed rule or amendment, and the reason for the proposed rule;
 - 3. A request for comments on the proposed rule from any interested person; and
 - 4. The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.
- e. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions and arguments, which shall be made available to the public.
- f. The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment.
- g. The Commission shall publish the place, time and date of the scheduled public hearing.
 - 1. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing. All hearings will be recorded, and a copy will be made available upon request.
 - 2. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the

1 convenience of the Commission at hearings required by this
2 section.

3 h. If no one appears at the public hearing, the Commission may
4 proceed with promulgation of the proposed rule.

5 i. Following the scheduled hearing date, or by the close of
6 business on the scheduled hearing date if the hearing was not held,
7 the Commission shall consider all written and oral comments
8 received.

9 j. The Commission shall, by majority vote of all administrators,
10 take final action on the proposed rule and shall determine the
11 effective date of the rule, if any, based on the rulemaking record
12 and the full text of the rule.

13 k. Upon determination that an emergency exists, the Commission
14 may consider and adopt an emergency rule without prior notice,
15 opportunity for comment or hearing, provided that the usual
16 rulemaking procedures provided in this Compact and in this section
17 shall be retroactively applied to the rule as soon as reasonably
18 possible, in no event later than ninety (90) days after the effective
19 date of the rule. For the purposes of this provision, an emergency
20 rule is one that must be adopted immediately in order to:

- 21 1. Meet an imminent threat to public health, safety or welfare;
- 22 2. Prevent a loss of Commission or party state funds; or
- 23 3. Meet a deadline for the promulgation of an administrative
24 rule that is required by federal law or rule.

25 1. The Commission may direct revisions to a previously adopted
26 rule or amendment for purposes of correcting typographical errors,
27 errors in format, errors in consistency or grammatical errors. Public
28 notice of any revisions shall be posted on the website of the
29 Commission. The revision shall be subject to challenge by any
30 person for a period of thirty (30) days after posting. The revision
31 may be challenged only on grounds that the revision results in a
32 material change to a rule. A challenge shall be made in writing,
33 and delivered to the Commission, prior to the end of the notice
34 period. If no challenge is made, the revision will take effect without
35 further action. If the revision is challenged, the revision may not
36 take effect without the approval of the Commission.

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ARTICLE IX
Oversight, Dispute Resolution and Enforcement

1 a. Oversight

2 1. Each party state shall enforce this Compact and take all actions
3 necessary and appropriate to effectuate this Compact’s purposes
4 and intent.

5 2. The Commission shall be entitled to receive service of process
6 in any proceeding that may affect the powers, responsibilities or
7 actions of the Commission, and shall have standing to intervene
8 in such a proceeding for all purposes. Failure to provide service
9 of process in such proceeding to the Commission shall render a
10 judgment or order void as to the Commission, this Compact or
11 promulgated rules.

12 b. Default, Technical Assistance and Termination

13 1. If the Commission determines that a party state has defaulted
14 in the performance of its obligations or responsibilities under this
15 Compact or the promulgated rules, the Commission shall:

16 i. Provide written notice to the defaulting state and other party
17 states of the nature of the default, the proposed means of curing
18 the default or any other action to be taken by the Commission; and

19 ii. Provide remedial training and specific technical assistance
20 regarding the default.

21 2. If a state in default fails to cure the default, the defaulting
22 state’s membership in this Compact may be terminated upon an
23 affirmative vote of a majority of the administrators, and all rights,
24 privileges and benefits conferred by this Compact may be
25 terminated on the effective date of termination. A cure of the
26 default does not relieve the offending state of obligations or
27 liabilities incurred during the period of default.

28 3. Termination of membership in this Compact shall be imposed
29 only after all other means of securing compliance have been
30 exhausted. Notice of intent to suspend or terminate shall be given
31 by the Commission to the governor of the defaulting state and to
32 the executive officer of the defaulting state’s licensing board and
33 each of the party states.

34 4. A state whose membership in this Compact has been
35 terminated is responsible for all assessments, obligations and
36 liabilities incurred through the effective date of termination,
37 including obligations that extend beyond the effective date of
38 termination.

39 5. The Commission shall not bear any costs related to a state
40 that is found to be in default or whose membership in this Compact

1 has been terminated unless agreed upon in writing between the
2 Commission and the defaulting state.

3 6. The defaulting state may appeal the action of the Commission
4 by petitioning the U.S. District Court for the District of Columbia
5 or the federal district in which the Commission has its principal
6 offices. The prevailing party shall be awarded all costs of such
7 litigation, including reasonable attorneys’ fees.

8 c. Dispute Resolution

9 1. Upon request by a party state, the Commission shall attempt
10 to resolve disputes related to the Compact that arise among party
11 states and between party and non-party states.

12 2. The Commission shall promulgate a rule providing for both
13 mediation and binding dispute resolution for disputes, as
14 appropriate.

15 3. In the event the Commission cannot resolve disputes among
16 party states arising under this Compact:

17 i. The party states may submit the issues in dispute to an
18 arbitration panel, which will be comprised of individuals appointed
19 by the Compact administrator in each of the affected party states
20 and an individual mutually agreed upon by the Compact
21 administrators of all the party states involved in the dispute.

22 ii. The decision of a majority of the arbitrators shall be final and
23 binding.

24 d. Enforcement

25 1. The Commission, in the reasonable exercise of its discretion,
26 shall enforce the provisions and rules of this Compact.

27 2. By majority vote, the Commission may initiate legal action
28 in the U.S. District Court for the District of Columbia or the federal
29 district in which the Commission has its principal offices against
30 a party state that is in default to enforce compliance with the
31 provisions of this Compact and its promulgated rules and bylaws.
32 The relief sought may include both injunctive relief and damages.
33 In the event judicial enforcement is necessary, the prevailing party
34 shall be awarded all costs of such litigation, including reasonable
35 attorneys’ fees.

36 3. The remedies herein shall not be the exclusive remedies of
37 the Commission. The Commission may pursue any other remedies
38 available under federal or state law.

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ARTICLE X

Effective Date, Withdrawal and Amendment

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a. This Compact shall become effective and binding on the earlier of the date of legislative enactment of this Compact into law by no less than twenty-six (26) states or December 31, 2018. All party states to this Compact, that also were parties to the prior Nurse Licensure Compact, superseded by this Compact, (“Prior Compact”), shall be deemed to have withdrawn from said Prior Compact within six (6) months after the effective date of this Compact.

b. Each party state to this Compact shall continue to recognize a nurse’s multistate licensure privilege to practice in that party state issued under the Prior Compact until such party state has withdrawn from the Prior Compact.

c. Any party state may withdraw from this Compact by enacting a statute repealing the same. A party state’s withdrawal shall not take effect until six (6) months after enactment of the repealing statute.

d. A party state’s withdrawal or termination shall not affect the continuing requirement of the withdrawing or terminated state’s licensing board to report adverse actions and significant investigations occurring prior to the effective date of such withdrawal or termination.

e. Nothing contained in this Compact shall be construed to invalidate or prevent any nurse licensure agreement or other cooperative arrangement between a party state and a non-party state that is made in accordance with the other provisions of this Compact.

f. This Compact may be amended by the party states. No amendment to this Compact shall become effective and binding upon the party states unless and until it is enacted into the laws of all party states.

g. Representatives of non-party states to this Compact shall be invited to participate in the activities of the Commission, on a nonvoting basis, prior to the adoption of this Compact by all states.

**ARTICLE XI
Construction and Severability**

1 This Compact shall be liberally construed so as to effectuate the
2 purposes thereof. The provisions of this Compact shall be
3 severable, and if any phrase, clause, sentence or provision of this
4 Compact is declared to be contrary to the constitution of any party
5 state or of the United States, or if the applicability thereof to any
6 government, agency, person or circumstance is held invalid, the
7 validity of the remainder of this Compact and the applicability
8 thereof to any government, agency, person or circumstance shall
9 not be affected thereby. If this Compact shall be held to be contrary
10 to the constitution of any party state, this Compact shall remain in
11 full force and effect as to the remaining party states and in full
12 force and effect as to the party state affected as to all severable
13 matters.

14 SEC. 2. No reimbursement is required by this act pursuant to
15 Section 6 of Article XIII B of the California Constitution because
16 the only costs that may be incurred by a local agency or school
17 district will be incurred because this act creates a new crime or
18 infraction, eliminates a crime or infraction, or changes the penalty
19 for a crime or infraction, within the meaning of Section 17556 of
20 the Government Code, or changes the definition of a crime within
21 the meaning of Section 6 of Article XIII B of the California
22 Constitution.

Introduced by Senator Dodd
(Principal coauthor: Assembly Member Burke)

February 20, 2020

An act to amend Sections 650.01, 2746.2, 2746.5, 2746.51, and 2746.52 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1237, as introduced, Dodd. Nurse-midwives: scope of practice.

(1) Existing law, the Nursing Practice Act, establishes the Board of Registered Nursing within the Department of Consumer Affairs for the licensure and regulation of the practice of nursing. A violation of the act is a crime. Existing law requires the board to issue a certificate to practice nurse-midwifery to a person who, among other qualifications, meets educational standards established by the board or the equivalent of those educational standards. Existing law authorizes a certified nurse-midwife, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn. Existing law defines the practice of nurse-midwifery as the furthering or undertaking by a certified person, under the supervision of licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal. Existing law requires all complications to be referred to a physician immediately. Existing law excludes the assisting of childbirth by any artificial, forcible, or mechanical means, and the performance of any version from the definition of the practice of nurse-midwifery.

The bill would delete the condition that a certified nurse-midwife practice under the supervision of a physician and surgeon and would

instead authorize a certified nurse-midwife to attend cases of normal pregnancy and childbirth and to provide prenatal, intrapartum, and postpartum care, including gynecologic and family-planning services, interconception care, and immediate care of the newborn, consistent with standards adopted by a specified professional organization, or its successor, as approved by the board. The bill would delete the above-described provisions defining the practice of nurse-midwifery, and instead would provide that the practice of nurse-midwifery includes consultation, comanagement, or referral, as those terms are defined by the bill, as indicated by the health status of the patient and the resources and medical personnel available in the setting of care, subject to specified conditions, including that a patient is required to be transferred from the primary management responsibility of the nurse-midwife to that of a physician and surgeon for the management of a problem or aspect of the patient's care that is outside the scope of the certified nurse-midwife's education, training, and experience. The bill would authorize a certified nurse-midwife to attend pregnancy and childbirth in an out-of-hospital setting if specified conditions are met, including that the gestational age of the fetus is within a specified range. Under the bill, a certified nurse-midwife would not be authorized to assist childbirth by vacuum or forceps extraction, or to perform any external cephalic version. The bill would require a certified nurse-midwife to maintain clinical practice guidelines that delineate the parameters for consultation, comanagement, referral, and transfer of a patient's care, and to document all consultations, referrals, and transfers in the patient record. The bill would require a certified nurse-midwife to refer all emergencies to a physician and surgeon immediately, and would authorize a certified nurse-midwife to provide emergency care until the assistance of a physician and surgeon is obtained.

(2) Existing law authorizes the board to appoint a committee of qualified physicians and nurses, including, but not limited to, obstetricians and nurse-midwives, to develop the necessary standards relating to educational requirements, ratios of nurse-midwives to supervising physicians, and associated matters. Existing law, additionally, authorizes the committee to include family physicians.

This bill would specify the name of the committee as the Nurse-Midwifery Advisory Committee. The bill would delete the provision including obstetricians on the committee, and would require a majority of the members of the committee to be nurse-midwives. The bill would delete the provision including ratios of nurse-midwives to

supervising physicians and associated matters in the standards developed by the committee, and would instead include standards related to all matter related to the practice of midwifery.

(3) Existing law authorizes a certified nurse-midwife to furnish drugs or devices, including controlled substances, in specified circumstances, including if drugs or devices are furnished or ordered incidentally to the provision of care in specified settings, including certain licensed health care facilities, birth centers, and maternity hospitals provided that the furnishing or ordering of drugs or devices occur under physician and surgeon supervision.

This bill would delete the condition that the furnishing or ordering of drugs or devices occur under physician and surgeon supervision, and would authorize a certified nurse-midwife to furnish drugs or devices when care is rendered in a out-of-hospital setting, as specified. The bill would authorize a certified nurse-midwife to procure supplies and devices, obtain and administer diagnostic tests, order laboratory and diagnostic testing, and receive reports, as specified. The bill would make it a misdemeanor for a certified nurse-midwife to refer a person for specified laboratory and diagnostic testing, home infusion therapy, and imaging goods or services if the certified nurse-midwife or their immediate family member has a financial interest with the person receiving a referral. By expanding the scope of a crime, the bill would impose a state-mandated local program.

(4) Existing law authorizes a certified nurse-midwife to perform and repair episiotomies and repair lacerations of the perineum in specified health care facilities only if specified conditions are met, including that the protocols and procedures ensure that all complications are referred to a physician and surgeon immediately, and that immediate care of patients who are in need of care beyond the scope of practice of the certified nurse midwife, or emergency care for times when the supervising physician and surgeon is not on the premises.

This bill would delete those conditions, and instead would require a certified nurse-midwife performing and repairing lacerations of the perineum to ensure that all complications are referred to a physician and surgeon immediately, and that immediate care of patients who are in need of care beyond the scope of practice of the certified nurse midwife, or emergency care when a physician and surgeon is not on the premises.

(5) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
 State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. The Legislature hereby finds and declares the
 2 following:

3 (a) There is a maternity care workforce crisis in California. At
 4 least nine counties have no obstetrician at all, and many more
 5 counties fall below the national average for obstetricians. This will
 6 worsen to the point of critical shortage if the state refuses to take
 7 steps to innovatively address this issue.

8 (b) While California has made great strides in reducing maternal
 9 mortality overall, there still remains a large disparity for Black
 10 and indigenous birthing people, and other birthing people of color.
 11 The maternal mortality rate for black women in California is still
 12 three to four times higher than white women. One avoidable death
 13 or near miss is one too many.

14 (c) Structural, systemic, and interpersonal racism, and the
 15 resulting economic and social inequities are the root cause of racial
 16 disparities in health care. This is a complex problem requiring
 17 multiple, innovative strategies in order to turn the tide. Midwifery
 18 care has been named by leading organizations as one of these
 19 innovative strategies.

20 (d) National and international studies show that wherever
 21 midwifery is scaled up and integrated successfully into the overall
 22 health system, regardless of the country or region’s income level,
 23 the well-being of birthing people and babies is increased, including
 24 reductions in racial disparities, maternal mortality and morbidity,
 25 and neonatal mortality and prematurity.

26 (e) A study supported by the California Health Care Foundation
 27 shows that increasing the percentage of pregnancies with
 28 midwife-led care from the current level of about 9 percent to 20
 29 percent over the next 10 years could result in \$4 billion in cost
 30 savings and 30,000 fewer preterm births.

1 (f) Nurse-midwives attend 50,000 births a year in California
2 and are currently underutilized and prevented from expanding.
3 Reducing unnecessary cesarean section alone could save \$80
4 million to \$440 million annually in California.

5 (g) Outdated laws around the supervision of nurse-midwives
6 and other regulatory barriers directly prevent the expansion of the
7 nurse-midwifery profession, and have resulted in concentrating
8 nurse-midwives in geographic areas where physicians physically
9 practice. This severely reduces access and worsens “maternity
10 deserts” and health provider shortage areas.

11 (h) California is the only western state that still requires
12 nurse-midwives to have physician permission to practice and one
13 of only four states in the nation that still requires this. Forty-six
14 other states have removed the outdated requirement for physician
15 supervision.

16 (i) Bodily autonomy including the choice of health care provider
17 and the personalized, shared involvement in health care decisions
18 is key to reproductive rights. Racial and other disparities in health
19 care cannot be reduced without adherence to this concept.

20 (j) Every person is entitled to access dignified, person-centered
21 childbirth and health care, regardless of race, gender, age, class,
22 sexual orientation, gender identity, ability, language proficiency,
23 nationality, immigration status, gender expression, religion,
24 insurance status, or geographic location.

25 (k) The core philosophy of nurse-midwifery is to provide
26 patient-centered, culturally sensitive, holistic care, all of which
27 are key to reducing disparities in maternal health care.

28 SEC. 2. Section 650.01 of the Business and Professions Code
29 is amended to read:

30 650.01. (a) Notwithstanding Section 650, or any other
31 provision of law, it is unlawful for a licensee to refer a person for
32 laboratory, diagnostic nuclear medicine, radiation oncology,
33 physical therapy, physical rehabilitation, psychometric testing,
34 home infusion therapy, or diagnostic imaging goods or services if
35 the licensee or ~~his or her~~ *their* immediate family has a financial
36 interest with the person or in the entity that receives the referral.

37 (b) For purposes of this section and Section 650.02, the
38 following shall apply:

39 (1) “Diagnostic imaging” includes, but is not limited to, all
40 X-ray, computed axial tomography, magnetic resonance imaging

1 nuclear medicine, positron emission tomography, mammography,
2 and ultrasound goods and services.

3 (2) A “financial interest” includes, but is not limited to, any
4 type of ownership interest, debt, loan, lease, compensation,
5 remuneration, discount, rebate, refund, dividend, distribution,
6 subsidy, or other form of direct or indirect payment, whether in
7 money or otherwise, between a licensee and a person or entity to
8 whom the licensee refers a person for a good or service specified
9 in subdivision (a). A financial interest also exists if there is an
10 indirect financial relationship between a licensee and the referral
11 recipient including, but not limited to, an arrangement whereby a
12 licensee has an ownership interest in an entity that leases property
13 to the referral recipient. Any financial interest transferred by a
14 licensee to any person or entity or otherwise established in any
15 person or entity for the purpose of avoiding the prohibition of this
16 section shall be deemed a financial interest of the licensee. For
17 purposes of this paragraph, “direct or indirect payment” shall not
18 include a royalty or consulting fee received by a physician and
19 surgeon who has completed a recognized residency training
20 program in orthopedics from a manufacturer or distributor as a
21 result of ~~his or her~~ *their* research and development of medical
22 devices and techniques for that manufacturer or distributor. For
23 purposes of this paragraph, “consulting fees” means those fees
24 paid by the manufacturer or distributor to a physician and surgeon
25 who has completed a recognized residency training program in
26 orthopedics only for ~~his or her~~ *their* ongoing services in making
27 refinements to ~~his or her~~ *their* medical devices or techniques
28 marketed or distributed by the manufacturer or distributor, if the
29 manufacturer or distributor does not own or control the facility to
30 which the physician is referring the patient. A “financial interest”
31 shall not include the receipt of capitation payments or other fixed
32 amounts that are prepaid in exchange for a promise of a licensee
33 to provide specified health care services to specified beneficiaries.
34 A “financial interest” shall not include the receipt of remuneration
35 by a medical director of a hospice, as defined in Section 1746 of
36 the Health and Safety Code, for specified services if the
37 arrangement is set out in writing, and specifies all services to be
38 provided by the medical director, the term of the arrangement is
39 for at least one year, and the compensation to be paid over the term
40 of the arrangement is set in advance, does not exceed fair market

1 value, and is not determined in a manner that takes into account
2 the volume or value of any referrals or other business generated
3 between parties.

4 (3) For the purposes of this section, “immediate family” includes
5 the spouse and children of the licensee, the parents of the licensee,
6 and the spouses of the children of the licensee.

7 (4) “Licensee” means a physician as defined in Section 3209.3
8 of the Labor-Code: *Code or a certified nurse-midwife as described*
9 *in Article 2.5 (commencing with Section 2746) of Chapter 6.*

10 (5) “Licensee’s office” means either of the following:

11 (A) An office of a licensee in solo practice.

12 (B) An office in which services or goods are personally provided
13 by the licensee or by employees in that office, or personally by
14 independent contractors in that office, in accordance with other
15 provisions of law. Employees and independent contractors shall
16 be licensed or certified when licensure or certification is required
17 by law.

18 (6) “Office of a group practice” means an office or offices in
19 which two or more licensees are legally organized as a partnership,
20 professional corporation, or not-for-profit corporation, licensed
21 pursuant to subdivision (a) of Section 1204 of the Health and Safety
22 Code, for which all of the following apply:

23 (A) Each licensee who is a member of the group provides
24 substantially the full range of services that the licensee routinely
25 provides, including medical care, consultation, diagnosis, or
26 treatment through the joint use of shared office space, facilities,
27 equipment, and personnel.

28 (B) Substantially all of the services of the licensees who are
29 members of the group are provided through the group and are
30 billed in the name of the group and amounts so received are treated
31 as receipts of the group, except in the case of a multispecialty
32 clinic, as defined in subdivision (l) of Section 1206 of the Health
33 and Safety Code, physician services are billed in the name of the
34 multispecialty clinic and amounts so received are treated as receipts
35 of the multispecialty clinic.

36 (C) The overhead expenses of, and the income from, the practice
37 are distributed in accordance with methods previously determined
38 by members of the group.

39 (c) It is unlawful for a licensee to enter into an arrangement or
40 scheme, such as a cross-referral arrangement, that the licensee

1 knows, or should know, has a principal purpose of ensuring
2 referrals by the licensee to a particular entity that, if the licensee
3 directly made referrals to that entity, would be in violation of this
4 section.

5 (d) No claim for payment shall be presented by an entity to any
6 individual, third party payer, or other entity for a good or service
7 furnished pursuant to a referral prohibited under this section.

8 (e) No insurer, self-insurer, or other payer shall pay a charge or
9 lien for any good or service resulting from a referral in violation
10 of this section.

11 (f) A licensee who refers a person to, or seeks consultation from,
12 an organization in which the licensee has a financial interest, other
13 than as prohibited by subdivision (a), shall disclose the financial
14 interest to the patient, or the parent or legal guardian of the patient,
15 in writing, at the time of the referral or request for consultation.

16 (1) If a referral, billing, or other solicitation is between one or
17 more licensees who contract with a multispecialty clinic pursuant
18 to subdivision (l) of Section 1206 of the Health and Safety Code
19 or who conduct their practice as members of the same professional
20 corporation or partnership, and the services are rendered on the
21 same physical premises, or under the same professional corporation
22 or partnership name, the requirements of this subdivision may be
23 met by posting a conspicuous disclosure statement at the
24 registration area or by providing a patient with a written disclosure
25 statement.

26 (2) If a licensee is under contract with the Department of
27 Corrections or the California Youth Authority, and the patient is
28 an inmate or parolee of either respective department, the
29 requirements of this subdivision shall be satisfied by disclosing
30 financial interests to either the Department of Corrections or the
31 California Youth Authority.

32 (g) A violation of subdivision (a) shall be a misdemeanor. ~~The~~
33 *In the case of a licensee who is a physician and surgeon, the*
34 *Medical Board of California shall review the facts and*
35 *circumstances of any conviction pursuant to subdivision (a) and*
36 *take appropriate disciplinary action if the licensee has committed*
37 *unprofessional conduct. In the case of a licensee who is a certified*
38 *nurse-midwife, the Board of Registered Nursing shall review the*
39 *facts and circumstances of any conviction pursuant to subdivision*
40 *(a) and take appropriate disciplinary action if the licensee has*

1 *committed unprofessional conduct.* Violations of this section may
2 also be subject to civil penalties of up to five thousand dollars
3 (\$5,000) for each offense, which may be enforced by the Insurance
4 Commissioner, Attorney General, or a district attorney. A violation
5 of subdivision (c), (d), or (e) is a public offense and is punishable
6 upon conviction by a fine not exceeding fifteen thousand dollars
7 (\$15,000) for each violation and appropriate disciplinary action,
8 including revocation of professional licensure, by the Medical
9 Board of ~~California~~ *California, the Board of Registered Nursing,*
10 or other appropriate governmental agency.

11 (h) This section shall not apply to referrals for services that are
12 described in and covered by Sections 139.3 and 139.31 of the
13 Labor Code.

14 (i) This section shall become operative on January 1, 1995.

15 SEC. 3. Section 2746.2 of the Business and Professions Code
16 is amended to read:

17 2746.2. ~~Each~~ *An* applicant shall show by evidence satisfactory
18 to the board that they have met the educational standards
19 established by the board or have at least the equivalent thereof.
20 The board may appoint ~~a committee of qualified physicians and~~
21 ~~nurses, including, but not limited to, obstetricians and~~
22 ~~nurse-midwives,~~ *the Nurse-Midwifery Advisory Committee* to
23 develop the necessary standards relating to educational
24 ~~requirements, ratios of nurse-midwives to supervising physicians,~~
25 ~~and associated matters.~~ *requirements and all matters related to*
26 *the practice of nurse-midwifery.* The committee may ~~also include~~
27 *include, but not be limited to, qualified nurses and qualified*
28 *physicians and surgeons, including, but not limited to, family*
29 *physicians. A majority of the members of the committee shall be*
30 *nurse-midwives.*

31 SEC. 4. Section 2746.5 of the Business and Professions Code
32 is amended to read:

33 2746.5. (a) *For purposes of this section, the following*
34 *definitions apply:*

35 (1) *“Consultation” means a request for the professional advice*
36 *or opinion of a physician or another member of a health care team*
37 *regarding a patient’s care while maintaining primary management*
38 *responsibility for the patient’s care.*

39 (2) *“Comanagement” means the joint management by a certified*
40 *nurse-midwife and a physician and surgeon, of the care of a patient*

1 *who has become more medically, gynecologically, or obstetrically*
2 *complicated.*

3 (3) *“Referral” means the direction of a patient to a physician*
4 *and surgeon or healing arts licensee for management of a*
5 *particular problem or aspect of the patient’s care.*

6 (4) *“Transfer” means the transfer of primary management*
7 *responsibility of a patient’s care from a certified nurse-midwife*
8 *to another healing arts licensee or facility.*

9 (b) ~~The certificate to practice nurse-midwifery authorizes the~~
10 ~~holder, under the supervision of a licensed physician and surgeon,~~
11 ~~holder to attend cases of normal pregnancy and childbirth and to~~
12 ~~provide prenatal, intrapartum, and postpartum care, including~~
13 ~~gynecologic and family-planning care, for the mother, services,~~
14 ~~interconception care, and immediate care for the newborn.~~
15 ~~newborn, consistent with the Core Competencies for Basic~~
16 ~~Midwifery Practice adopted by the American College of~~
17 ~~Nurse-Midwives, or its successor national professional~~
18 ~~organization, as approved by the board.~~

19 (c) *A certified nurse-midwife shall, in the practice of*
20 *nurse-midwifery, emphasize informed consent, preventive care,*
21 *and early detection and referral of complications to physicians*
22 *and surgeons.*

23 ~~(b)~~

24 (d) ~~As used in this chapter, the practice of nurse-midwifery~~
25 ~~constitutes the furthering or undertaking by any certified person,~~
26 ~~under the supervision of a licensed physician and surgeon who has~~
27 ~~current practice or training in obstetrics, to assist a woman in~~
28 ~~childbirth so long as progress meets criteria accepted as normal.~~
29 ~~All complications shall be referred to a physician immediately.~~
30 ~~The practice of nurse-midwifery does not include the assisting of~~
31 ~~childbirth by any artificial, forcible, or mechanical means, nor the~~
32 ~~performance of any version: includes consultation, comanagement,~~
33 ~~or referral as indicated by the health status of the patient and the~~
34 ~~resources and medical personnel available in the setting of care,~~
35 ~~subject to the following:~~

36 ~~(e) As used in this article, “supervision” shall not be construed~~
37 ~~to require the physical presence of the supervising physician.~~

38 ~~(d) A certified nurse-midwife is not authorized to practice~~
39 ~~medicine and surgery by the provisions of this chapter.~~

1 ~~(e) Any regulations promulgated by a state department that~~
2 ~~affect the scope of practice of a certified nurse-midwife shall be~~
3 ~~developed in consultation with the board.~~

4 (1) (A) *The certificate to practice nurse-midwifery authorizes*
5 *the holder to work collaboratively with a physician and surgeon*
6 *to comanage care for a patient with more complex health needs.*

7 (B) *The scope of comanagement may encompass the physical*
8 *care of the patient, including birth, by the certified nurse-midwife,*
9 *according to a mutually agreed upon plan of care with the*
10 *physician and surgeon.*

11 (C) *If the physician and surgeon must assume a lead role in the*
12 *care of the patient due to an increased risk status, the certified*
13 *nurse-midwife may continue to participate in physical care,*
14 *counseling, guidance, teaching, and support, according to a*
15 *mutually agreed upon plan.*

16 (2) *After a certified nurse-midwife refers a patient to a physician*
17 *and surgeon, the certified nurse-midwife may continue care of the*
18 *patient during a reasonable interval between the referral and the*
19 *initial appointment with the physician and surgeon.*

20 (3) (A) *A patient shall be transferred from the primary*
21 *management responsibility of the nurse-midwife to that of a*
22 *physician and surgeon for the management of a problem or aspect*
23 *of the patient's care that is outside the scope of the certified*
24 *nurse-midwife's education, training, and experience.*

25 (B) *A patient that has been transferred from the primary*
26 *management responsibility of a certified nurse-midwife may return*
27 *to the care of the certified nurse-midwife after resolution of any*
28 *problem that required the transfer or that would require transfer*
29 *from the primary management responsibility of a nurse-midwife.*

30 (e) *The certificate to practice nurse-midwifery authorizes the*
31 *holder to attend pregnancy and childbirth in an out-of-hospital*
32 *setting if all of the following conditions apply:*

33 (1) *Neither of the following are present:*

34 (A) *A preexisting maternal disease or condition creating risks*
35 *higher than that of a low-risk pregnancy or birth, based on current*
36 *evidence and accepted practice.*

37 (B) *Disease arising from or during the pregnancy creating risks*
38 *higher than that of a low-risk pregnancy or birth, based on current*
39 *evidence and accepted practice.*

40 (2) *There is a singleton fetus.*

- 1 (3) *There is cephalic presentation at the onset of labor.*
2 (4) *The gestational age of the fetus is at least 37 completed*
3 *weeks of pregnancy and less than 42 completed weeks of pregnancy*
4 *at the onset of labor.*
5 (5) *Labor is spontaneous or induced in an outpatient setting.*
6 (f) *The certificate to practice nurse-midwifery does not authorize*
7 *the holder of the certificate to assist childbirth by vacuum or*
8 *forceps extraction, or to perform any external cephalic version.*
9 (g) *A certified nurse-midwife shall maintain clinical practice*
10 *guidelines that delineate the parameters for consultation,*
11 *comanagement, referral, and transfer of a patient's care.*
12 (h) *A certified nurse-midwife shall document all consultations,*
13 *referrals, and transfers in the patient record.*
14 (i) (1) *A certified nurse-midwife shall refer all emergencies to*
15 *a physician and surgeon immediately.*
16 (2) *A certified nurse-midwife may provide emergency care until*
17 *the assistance of a physician and surgeon is obtained.*

18 SEC. 5. Section 2746.51 of the Business and Professions Code
19 is amended to read:

20 2746.51. (a) Neither this chapter nor any other ~~provision of~~
21 law shall be construed to prohibit a certified nurse-midwife from
22 furnishing or ordering drugs or devices, including controlled
23 substances classified in Schedule II, III, IV, or V under the
24 California Uniform Controlled Substances Act (Division 10
25 (commencing with Section 11000) of the Health and Safety Code),
26 when all of the following apply:

27 (1) The drugs or devices are furnished or ordered incidentally
28 to the provision of any of the following:

29 (A) Family planning services, as defined in Section 14503 of
30 the Welfare and Institutions Code.

31 (B) Routine health care or perinatal care, as defined in
32 subdivision (d) of Section 123485 of the Health and Safety Code.

33 (C) Care rendered, consistent with the certified nurse-midwife's
34 educational preparation or for which clinical competency has been
35 established and maintained, to persons within a facility specified
36 in subdivision (a), (b), (c), (d), (i), or (j) of Section 1206 of the
37 Health and Safety Code, a clinic as specified in Section 1204 of
38 the Health and Safety Code, a general acute care hospital as defined
39 in subdivision (a) of Section 1250 of the Health and Safety Code,
40 a licensed birth center as defined in Section 1204.3 of the Health

1 and Safety Code, or a special hospital specified as a maternity
2 hospital in subdivision (f) of Section 1250 of the Health and Safety
3 Code.

4 *(D) Care rendered in an out-of-hospital setting pursuant to*
5 *subdivision (e) of Section 2746.5.*

6 (2) The ~~furnishing or ordering of~~ drugs or devices ~~are furnished~~
7 ~~or ordered~~ by a certified nurse-midwife *are* in accordance with
8 standardized procedures or protocols. For purposes of this section,
9 standardized procedure means a document, including protocols,
10 developed *in collaboration with*, and approved ~~by the supervising~~
11 *by a* physician and surgeon, the certified nurse-midwife, and the
12 facility administrator ~~or his or her~~ *their* designee. The standardized
13 procedure covering the furnishing or ordering of drugs or devices
14 shall specify all of the following:

15 (A) Which certified nurse-midwife may furnish or order drugs
16 or devices.

17 (B) Which drugs or devices may be furnished or ordered and
18 under what circumstances.

19 ~~(C) The extent of physician and surgeon supervision.~~

20 ~~(D)~~

21 (C) The method of periodic review of the certified
22 nurse-midwife's competence, including peer review, and review
23 of the provisions of the standardized procedure.

24 (3) If Schedule II or III controlled substances, as defined in
25 Sections 11055 and 11056 of the Health and Safety Code, are
26 furnished or ordered by a certified nurse-midwife, the controlled
27 substances shall be furnished or ordered in accordance with a
28 patient-specific protocol approved ~~by the treating or supervising~~
29 *a* physician and surgeon. For Schedule II controlled substance
30 protocols, the provision for furnishing the Schedule II controlled
31 substance shall address the diagnosis of the illness, injury, or
32 condition for which the Schedule II controlled substance is to be
33 furnished.

34 ~~(4) The furnishing or ordering of drugs or devices by a certified~~
35 ~~nurse-midwife occurs under physician and surgeon supervision.~~
36 ~~For purposes of this section, no physician and surgeon shall~~
37 ~~supervise more than four certified nurse-midwives at one time.~~
38 ~~Physician and surgeon supervision shall not be construed to require~~
39 ~~the physical presence of the physician, but does include all of the~~
40 ~~following:~~

1 ~~(A) Collaboration on the development of the standardized~~
2 ~~procedure or protocol.~~

3 ~~(B) Approval of the standardized procedure or protocol.~~

4 ~~(C) Availability by telephonic contact at the time of patient~~
5 ~~examination by the certified nurse-midwife.~~

6 (b) (1) The furnishing or ordering of drugs or devices by a
7 certified nurse-midwife is conditional on the issuance by the board
8 of a number to the applicant who has successfully completed the
9 requirements of paragraph (2). The number shall be included on
10 all transmittals of orders for drugs or devices by the certified
11 nurse-midwife. The board shall maintain a list of the certified
12 nurse-midwives that it has certified pursuant to this paragraph and
13 the number it has issued to each one. The board shall make the list
14 available to the California State Board of Pharmacy upon its
15 request. Every certified nurse-midwife who is authorized pursuant
16 to this section to furnish or issue a drug order for a controlled
17 substance shall register with the United States Drug Enforcement
18 Administration.

19 (2) The board has certified in accordance with paragraph (1)
20 that the certified nurse-midwife has satisfactorily completed a
21 course in pharmacology covering the drugs or devices to be
22 furnished or ordered under this section, including the risks of
23 addiction and neonatal abstinence syndrome associated with the
24 use of opioids. The board shall establish the requirements for
25 satisfactory completion of this paragraph.

26 ~~(3) A physician and surgeon may determine the extent of~~
27 ~~supervision necessary pursuant to this section in the furnishing or~~
28 ~~ordering of drugs and devices.~~

29 ~~(4)~~

30 (3) A copy of the standardized procedure or protocol relating
31 to the furnishing or ordering of controlled substances by a certified
32 nurse-midwife shall be provided upon request to any licensed
33 pharmacist who is uncertain of the authority of the certified
34 nurse-midwife to perform these functions.

35 ~~(5)~~

36 (4) Certified nurse-midwives who are certified by the board and
37 hold an active furnishing number, who are currently authorized
38 through standardized procedures or protocols to furnish Schedule
39 II controlled substances, and who are registered with the United
40 States Drug Enforcement Administration shall provide

1 documentation of continuing education specific to the use of
2 Schedule II controlled substances in settings other than a hospital
3 based on standards developed by the board.

4 (c) Drugs or devices furnished or ordered by a certified
5 nurse-midwife may include Schedule II controlled substances
6 under the California Uniform Controlled Substances Act (Division
7 10 (commencing with Section 11000) of the Health and Safety
8 Code) under the following conditions:

9 (1) The drugs and devices are furnished or ordered in accordance
10 with requirements referenced in paragraphs (2) ~~to (4), inclusive,~~
11 *and* (3) of subdivision (a) and in paragraphs (1) ~~to (3), inclusive,~~
12 *and* (2) of subdivision (b).

13 (2) When Schedule II controlled substances, as defined in
14 Section 11055 of the Health and Safety Code, are furnished or
15 ordered by a certified nurse-midwife, the controlled substances
16 shall be furnished or ordered in accordance with a patient-specific
17 protocol approved by ~~the treating or supervising~~ a physician and
18 surgeon.

19 (d) Furnishing of drugs or devices by a certified nurse-midwife
20 means the act of making a pharmaceutical agent or agents available
21 to the patient in strict accordance with a standardized procedure
22 or protocol. Use of the term “furnishing” in this section shall
23 include the following:

24 (1) The ordering of a drug or device in accordance with the
25 standardized procedure or protocol.

26 (2) Transmitting an order of a supervising physician and
27 surgeon.

28 (e) “Drug order” or “order” for purposes of this section means
29 an order for medication or for a drug or device that is dispensed
30 to or for an ultimate user, issued by a certified nurse-midwife as
31 an individual practitioner, within the meaning of Section 1306.03
32 of Title 21 of the Code of Federal Regulations. Notwithstanding
33 any other provision of law, (1) a drug order issued pursuant to this
34 section shall be treated in the same manner as a prescription of the
35 supervising physician; (2) all references to “prescription” in this
36 code and the Health and Safety Code shall include drug orders
37 issued by certified nurse-midwives; and (3) the signature of a
38 certified nurse-midwife on a drug order issued in accordance with
39 this section shall be deemed to be the signature of a prescriber for
40 purposes of this code and the Health and Safety Code.

1 (f) Notwithstanding any other law, a certified nurse-midwife
2 may directly procure supplies and devices, obtain and administer
3 diagnostic tests, order laboratory and diagnostic testing, and
4 receive reports that are necessary to their practice as a certified
5 nurse-midwife within their scope of practice.

6 SEC. 6. Section 2746.52 of the Business and Professions Code
7 is amended to read:

8 2746.52. (a) Notwithstanding Section 2746.5, the certificate
9 to practice nurse-midwifery authorizes the holder to perform and
10 repair episiotomies, and to repair first-degree and second-degree
11 lacerations of the perineum, in a licensed acute care hospital, as
12 defined in subdivision (a) of Section 1250 of the Health and Safety
13 Code, and a licensed alternate birth center, as defined in paragraph
14 (4) of subdivision (b) of Section 1204 of the Health and Safety
15 Code, but only if all of the following conditions are met: *perineum*.

16 (a) ~~The supervising physician and surgeon and any backup~~
17 ~~physician and surgeon is credentialed to perform obstetrical care~~
18 ~~in the facility.~~

19 (b) ~~The episiotomies are performed pursuant to protocols~~
20 ~~developed and approved by all of the following:~~

21 (1) ~~The supervising physician and surgeon.~~

22 (2) ~~The certified nurse-midwife.~~

23 (3) ~~The director of the obstetrics department or the director of~~
24 ~~the family practice department, or both, if a physician and surgeon~~
25 ~~in the obstetrics department or the family practice department is~~
26 ~~a supervising physician and surgeon, or an equivalent person if~~
27 ~~there is no specifically identified obstetrics department or family~~
28 ~~practice department.~~

29 (4) ~~The interdisciplinary practices committee, if applicable.~~

30 (5) ~~The facility administrator or his or her designee.~~

31 (e) ~~The protocols, and the procedures which shall be developed~~
32 ~~pursuant to the protocols, shall relate to the performance and repair~~
33 ~~of episiotomies and the repair of first-degree and second-degree~~
34 ~~lacerations of the perineum, and shall do all of the following:~~

35 (b) *A certified nurse-midwife performing and repairing*
36 *first-degree and second-degree lacerations of the perineum shall*
37 *do both of the following:*

38 (1) Ensure that all complications are referred to a physician and
39 surgeon immediately.

1 (2) Ensure immediate care of patients who are in need of care
2 beyond the scope of practice of the certified nurse midwife, or
3 emergency care for times when ~~the supervising~~ a physician and
4 surgeon is not on the premises.

5 ~~(3) Establish the number of certified nurse-midwives that a~~
6 ~~supervising physician and surgeon may supervise.~~

7 SEC. 7. No reimbursement is required by this act pursuant to
8 Section 6 of Article XIII B of the California Constitution because
9 the only costs that may be incurred by a local agency or school
10 district will be incurred because this act creates a new crime or
11 infraction, eliminates a crime or infraction, or changes the penalty
12 for a crime or infraction, within the meaning of Section 17556 of
13 the Government Code, or changes the definition of a crime within
14 the meaning of Section 6 of Article XIII B of the California
15 Constitution.

O