**244 CMR 3.00: REGISTERED NURSE AND LICENSED PRACTICAL NURSE**

**Testimony**

**Anne Harris Sheetz, MPH, RN, Board Certified-Advanced Nursing Executive**

Thank you for inviting testimony on 244 CMR 3.00: Registered Nurse and Licensed Practical Nurse. As a way of introduction, I am board certified as an Advanced Nurse Executive, and have served as the Director of Pediatric Nursing at the Massachusetts General Hospital (which include two intensive care units) for fifteen years and the Director of School Health Services at the Massachusetts Department of Public Health for twenty-three years. In that role I crafted 105 CMR 210:000, the Regulations Governing the Administration of Prescription Medications in Public and Private Schools.

In reading the regulations, I was extremely surprised and concerned about many issues, the major being the blurring of the Registered Nurse and Licensed Practical Nurse roles, and extending delegation of nursing activities, especially medication administration, to unlicensed personnel. At a time when dramatic changes are impacting the delivery of health care, such as actual care becoming more complex, a vast array of potentially dangerous medications being prescribed, increasing concern about medication errors, and cost cutting often eroding safety standards, these regulations seem to defy logic.

Regulations should have their main goal the setting of standards to make health care safe for the public we serve. I am confused by the intent of the revisions and fear major unintended consequences for patient care. Therefore, I am testifying in **strong opposition** to the proposed changes. I will confine my testimony to two major areas (although there are many details which should be addressed):

* Changes in the role of the Licensed Practical Nurse
* Delegation of medication administration to unlicensed personnel.

**The Role of the Licensed Practical Nurses:** If I am correct in reading the regulations, there is little difference between the role of the RN and LPN. Yet in reality there is a major difference in their educational background. The RN has three to four years of professional education, requires a more rigorous examination for licensure and is trained in critical thinking, education, leadership, and a wide range of planning, as well as physical and psychological assessment skills. The LPN, in contrast, has one year of technical training which permits him/her to provide services that do not require in-depth assessment and planning. In short, these two professionals are not the same. To include both in activities requiring assessment is unfair to both the nurse and the public being served.

Furthermore, if the differences are not clarified, institution accountants and budget personnel are well positioned to substitute the lesser cost LPNs for RNs. In all settings this is concerning, but even more so in the secondary and tertiary hospitals. Do we really expect LPNs to provide the care, oversight and critical thinking required for a post-operative, emergency or other acute or semi-acute care for a client? Do we expect a nurse with one-year education to oversee unlicensed personnel in completing “nursing activities” when she/he has not had the training to teach and supervise them? As a former nursing director, I know the limitations to the LPN role and have always encouraged the staff to further their education and degrees, obtaining the necessary knowledge and skills to serve the public in acute and semi acute settings. Furthermore, delegation of nursing activities by LPNs should not be permitted, especially in the area of medications.

**Permission to Delegate Nursing Activities including Medication:** I assume the regulations would permit delegation of medication in any setting: tertiary and secondary hospitals, nursing homes and community clinics. As a former nursing supervisor in a tertiary care center, this is not safe---for adults, as well as children. I saw few, if any, safeguards and restrictions in the regulations as written. For example, there is no definition of medication. (Does the delegation include intravenous and intramuscular medications?)

Popular opinion erroneously suggests that medication administration is merely the “popping of a pill.” It is much more than that. Today’s patients have a vast array of complex conditions requiring incredible attention to detail and comprehensive knowledge of pharmaceuticals. Medication orders and container labels need to be assessed for accuracy. The nurse must have knowledge about their effects, contraindications and interactions with other medications. An omission, overdose or under-dose can mean the difference between life and death. Failure to identify an untoward side effect and take corrective action can also be life threatening. Also many medications require an adjustment based on lab results or other issues. For example, insulin is adjusted based on carbohydrate ingestion and blood glucose levels. Unlicensed personnel cannot be expected to assess these indicators, calculate the dosage and administer the medication safely. And I as a nurse would not be comfortable in overseeing them.

**Experience in Developing the Regulations Governing the Administration of Prescription Medication in Public and Private Schools:** In 1993 I was tasked with writing medication regulations for public and private schools (105 CMR 210.000) There was much pressure to include delegation as at that time there were about 900 school nurses; now there are more than 2400. Delegation was by no means an optimal way of caring for the more than 27% of students with chronic care illnesses. Studies in other states have shown that medication errors in schools are three times more likely when administered by unlicensed personnel than by nurses.[[1]](#endnote-1)

In writing the regulations, we were acutely aware of our responsibility for the safety of the Commonwealth’s 1.2 million students. We were also aware that each word matters----and if we were not specific, the regulations could lead to unintended consequences. We also knew we needed the assistance of an array of stakeholders---nurses, physicians, parents, educators, school administrators, to name a few. In contrast to today’s draft, ours was a long, open and inclusive process

We crafted the regulations in such a way that school nurses could only delegate to unlicensed personnel as a back-up should the nurse be busy with an emergency, etc. The regulations were not meant to provide an opening for school officials to downsize the numbers of school nurses. In contrast to the draft regulations we are addressing today, we were cognizant that any discussion of delegation could open the door to reducing professional nursing staff and allowing unlicensed, minimally trained personnel to be substituted in the care of our youth.

When writing the school medication regulations, we included the following safeguards:

* A lengthy preface listed the goal of the regulations (safety nd access), as well as precise definitions, e.g., medication, school nurse, etc. This is missing is the current BORN draft.
* School nurses were and are required to have a baccalaureate of science in nursing or a masters in nursing upon entry. (More than 56% of school nurses currently have a master’s degree.) LPNs may not hold the title of school nurse.
* A registration process with the Massachusetts Department of Public Health for school districts wishing to delegate prescription medications (as required by MGL 94c) was established. For delegation of general medications, an annual application was required. An expedited two-year registration was required for training of unlicensed personnel to administer epinephrine to individuals (with diagnosed life threatening allergies) experiencing a life threatening allergic event.
* School committees, superintendents, school nurses, and school physicians were required to sign off on any application for delegation. This meant a presentation by the school nurse in a public forum. *Of note is that most school committees decided to employ more professional school nurses rather than subject the school district to potential liability.*
* If a school district did decide to apply for registration to delegate as a back-up for the school nurses, the applications were reviewed annually to determine a number of factors, including whether there was a reduction in school nursing staff—in which case, the registration did not go forward. In addition, districts had to have comprehensive medication policies in place and meet certain ratios of school nurses to students in order to provide for adequate supervision.
* A school nurse had to be onsite in the district whenever a delegated medication is administered by an unlicensed staff member.
* Only the professional school nurse could determine what medications could be delegated, to what student (parental permission) and by whom. Except for epinephrine by auto-injector to a student with a previously diagnosed life threatening allergy, all injectable medications were excluded from delegation.
* A reporting mechanism to the Department was in place for any errors resulting in a student requiring medical care or hospitalization.

Our experience in developing the school regulations demonstrated the need for (a) precise language, (b) recognition of the school nurse’s role as the manager of the program, (c) a careful avoidance of unintended consequences and (d) the need for ongoing involvement of nurses and other stakeholders to develop a product which could achieve dual goals of being safe and practical. To date the school medication regulations have been amended twice, mainly to address emerging issues of life threatening allergies. Approximately 2.6 million medication dosages are administered annually in Massachusetts schools.

My hope is that the changes in 244 CMR 3.00 will be reviewed and reworked to achieve the same goals of safety. However, I am unclear as to what the goals are. For example, is there a particular setting to which they are aimed, e.g., home care? If so, separate regulations for safe standards in that setting should be crafted with input from all important stakeholders.

The draft regulations as written will very probably lead to unintended consequences of decreasing the standards of nursing care in all settings. Of particular concern is they open the door for cost cutting and substitution of unlicensed personnel for trained professionals—and an increase in medication errors. On a personal note, if these regulations are promulgated, I will advise young nurses in my family to practice in states other than Massachusetts. These nurses really want to be well educated professionals with skills and knowledge in both mental and physical health to care for vulnerable people. They do not want to spend their time trying to prevent errors by unlicensed personnel.

As an experienced professional nurse and leader, I ask the Department to revisit these draft regulations with consultation from a wide range of nurses and stakeholders. In this process several questions should be asked: What are they intended to do? Does not the public deserve skilled professional nursing care rather than the limited task-based training of unlicensed personnel? How can we achieve our ultimate goal and responsibility as public servants—optimal patient care and safety?

Again, thank you for the opportunity to testify.

Anne Harris Sheetz, MPH, RN, NEA-BC

16 Hancock Street

Boston, MA 02114

annesheetz@comcast.net

1. http://ismp.org/Newsletters/consumer/Issues/20120301.asp [↑](#endnote-ref-1)