LOUISIANA STATE BOARD OF NURSING
3510 NORTH CAUSEWAY BOULEVARD, SUITE 601
METAIRIE, LOUISIANA 70002

MINUTES OF THE JANUARY 25, 2004

LSBN COMMITTEE ON NURSING PRACTICE

Call to Order: Frankie Rosenthal, Chairperson, called the meeting of the LSBN Committee on Practice to order at 9:00 a.m. on Tuesday, January 25, 2005 in Suite 601 Board Room of the Board's office.

Roll Call:

Present:
Frankie Rosenthal, MSN, RN, CNS, CNA Chairperson
Deborah Olds, MS, RN, Committee Member
Deborah A. Ford, MSN, RN, CAN, Committee Member
James Harper, RN, MSN, CFNP, Committee Member

Board Members:
Patricia Bourgeois, MSN, CNS, President (entered at 9:35 a.m.)
Nora F. Steele, DNS, RN, C, PNP (entered at 10:50 a.m.)
Tommie Ashby, RN, BSN (entered at 12:05 p.m.)

Absent:
William LaCorte, MD
Alan Ostrowe, MD

Staff:
Pat Ladner, MN, RN, Nursing Consultant for Practice
Barbara Morvant, MN, RN, Executive Director (entered at 9:35 a.m.)
Cynthia Morris, Assistant Executive Director
Peggy Griener, APRN, Credentialing Manager
Linda Hines, Licensing Analyst (until 10:30 a.m.)
Helen Forrest, Compliance Supervisor, Recorder

Guest:
Laura Musgrove, North Monroe Medical Center
Catherine Wattingny, LA School Nurses Organization
Joni Nickens, LANP
LaVonne Smith, LSUHSC/DOE
Sam Mayes, Millennium Medical Products
Brandon Chapman, Millennium Medical Products
Jon Montgomery, Millennium Medical Products
Ann Burgin, LSU/Earl K. Long
Catherine Gaston, LSU/Earl K. Long
Dil? E?, ENDS
Andrea Norman, OLOL, Pediatric ER
Lisa A. Kelly, OLOL, ER
Deborah Ritter, Synergy
Dotty Martino, Epilepsy Foundation
Laura Ross, RRMC/LAENA

Michael J. Jennings, Southwest Medical Center
Deborah Spell, Southwest Medical Center
Shawn Lacombe, RRMC/ LA Emergency Nurses Association
Dawn McKeown, LA Emergency Nurses Association
Melissa Kelly, LA Emergency Nurses Association
Judith Brobst, LA Emergency Nurses Association
Kayla Lone, LA Emergency Nurses Association
Alicia Dean, Charity Hospital
Linda Horn-Thompson, Woman's Hospital
Joan Manzelle, East Jefferson General Hospital
Lisa Hickey, East Jefferson General Hospital
Gaynell Grerg, Charity Hospital
Anna Robinson, East Jefferson General Hospital
Mary Z. Kotumaun, MCLNO
Mark P. ?, MCLNO
Alida Wagler, Jeff Parish Public School System
Carol Koneci, Jeff Parish Public School System
Julie Bounds, LANA
Pat Newman, LANA
Ellis Wells, VAMC/LANA
C. _____

Minutes: The minutes of the October 26, 2004 Practice Committee meeting was distributed for review prior to the December 2004 Board meeting.

Motions: by D. Olds, seconded by D. Ford, that in reference to agenda item 3 that the Practice Committee minutes of October 26, 2004 be accepted as written: D. Olds, Yes; D. Ford, Yes; J. Harper, Yes; F. Rosenthal, Yes.

Motion: by D. Ford, seconded by J. Harper, to reorder the agenda to accommodate guests: D. Olds, Yes; D. Ford, Yes; J. Harper, Yes; F. Rosenthal, Yes.

Anodyne Therapy: 6.1 Request submitted by Deborah Ritter, Clinical Director of Wound Care, Synergy Healthcare Group petitioning an opinion from the Board regarding the Registered Nurse using Anodyne Therapy in both clinical and home health settings.

Anodyne therapy is the brand name for the device that delivers monochromatic infrared photo energy through contact with the skin; it is an adjunctive therapy for patients with wounds, lymphedema, or neuropathic pain. The infrared light dilates the surrounding blood vessels increasing circulation and the light releases a chemical called nitric oxide from the hemoglobin of the blood and possibly surrounding tissue.

In the home setting the treatments are performed three times a week for four weeks and the patient is taught to perform the therapy. Pads are placed over the area of treatment and the machine is pre-set as prescribed by an authorized prescriber. This therapy is contraindicated where there is an active

malignancy or for patients who are pregnant. The only adverse side effect is *redness* caused by leaving the device on too long.

The petitioner indicated that a certified wound nurse could safely teach RNs how to use the therapy and the sales representative stated that the FDA has approved Anodyne for diabetic neuropathy. A letter confirming FDA approval is forthcoming and will be filed with these minutes. It was clarified that there are two types of devices to deliver the infrared light: non-adjustable infrared light device for home use, the setting are preset and the adjustable device that the physical therapist uses in the clinic setting.

Motion: by D. Ford, seconded by D. Olds, that in reference to agenda item 6.1 and in accordance with R.S. 37:913(14)(l) it is within the scope of practice for the RN to administer a monochromatic infrared photo energy treatment for indicated conditions, such as wound healing, in the clinical and home settings provided the RN has documented knowledge, skills and abilities: D. Olds, Yes; D. Ford, Yes; J. Harper, Yes; F. Rosenthal, Yes.

On-Q Soaker Catheter: 6.2 The Clinical Educator, Linda Horn-Thompson, GYN/Oncology, Woman's Hospital, submitted a request to petition the Board for an opinion regarding the removal of an ON-Q Soaker Catheter by the RN.

The ON-Q Soaker Catheter is the brand name for a narcotic-free post-surgical pain relief system that has been approved by the FDA to deliver anesthetic agents to the surgical wound site. Clinical trails have documented a decrease in the amount of narcotics used post-operatively to control pain. The surgeon places the catheter subcutaneously before closing the incision and the catheter is held in place with a transparent dressing. Patients have been taught how to remove the catheter. If the patient complains of a metallic taste it usually indicates that the catheter has migrated.

Motion: by D. Olds, seconded by D. Ford, in reference to agenda item 6.2 and in accordance with R.S. 37:913(14)(l) that it is within the scope of practice of the RN to remove the narcotic-free post-surgical pain relief systems such as the "ON-Q Soaker Catheter" provided the RN has documented knowledge, skills, and abilities: D. Olds, Yes; D. Ford, Yes; J. Harper, Yes; F. Rosenthal, Yes.

Fetal Fibronectin: 6.3 A petition was submitted to the Board by the Department Head New Family Center, St. Tammany Parish Hospital, for an opinion regarding RN performing a vaginal speculum examination for the purpose of fetal fibronectin sampling on a preterm labor patient in the labor and delivery setting. When the Practice Committee recommendation was presented to the Board at the re-scheduled September Board meeting representative for East Jefferson General Hospital (EJGH) requested a reversal of the Committee's recommendation. The Board sent the request back to the Practice Committee for additional study. Letters were reviewed from Stephen Champlin, M.D., Chief of OB/GYN, EJGH regarding RNs trained in speculum exam may

perform the test; the second letter was from Gary Dildy, III, M.D., Professor, LSUHSC at EFGH stating that trained RNs can safely perform the test and the EJGH policy delineates when the test should not be performed.

H. Robinson, RN, EJGH stated that sampling must be performed in a timely fashion, prior to other tests such as the digital and/or vaginal exam and ultrasound. The L & D nurse is in telephone contact with the physician who orders the test. If the fetal fibronectin is found in the vagina it indicates a break in the membranes and pre-term labor between weeks 24-34 when the fetal fibronectin should

Motion: by D. Ford, seconded by D. Olds, in reference to agenda item 6.3 and in accordance with R.S. 37:913(14)(l) that it is within the scope of practice of a RN to perform a fetal fibronectin specimen collection via a speculum examination provided said nurse has appropriate knowledge, skills, and abilities in the clinical inpatient institution provided protocols are in place: D. Olds, Yes; D. Ford, Yes; J. Harper, Yes; F. Rosenthal, Yes.

Metal Sutures/Wires: 6.4 The Ambulatory Director submitted a request on behalf of the MD Oral Surgery Staff of LSUHSC/Earl K. Long Medical Center to petition the Board for an opinion regarding the RN, LPN, and/or nursing assistants being allowed to remove metal sutures/wires securing the mouth closed and those that are securing arch bars.

The practice setting is an oral surgery clinic and the M.D. would assess healing of the fracture and "order" the removal of the metal sutures/wires. After the removal the M.D. would re-evaluate the patient. The complications following removal are bleeding from the gums and the patient swallowing or aspirating a piece of the metal suture. The M.D. or R. N. are physically present in the clinic.

In 1997 the Board rendered an opinion that it was within the scope of practice for an EN to remove sutures/staples and to delegate to an LPN and/or unlicensed nursing personnel with documented knowledge, skills, and abilities, after the RN has assesses the incision.

Motion: by D. Ford, seconded by D. Olds, in reference to agenda item 6.4 and in accordance with R.S. 37:913(14)(l) that it is within the scope of practice for a RN to remove metal sutures/wires that secure arch bars and those that are securing the mouth closed. The RN may delegate to the LPN the removal of said metal sutures/wires provided the RN is physically present in the clinic during the removal and there is documentation on file regarding the LPN's knowledge, skills, and abilities: D. Olds, Yes; D. Ford, Yes; J. Harper, Yes; F. Rosenthal, Yes.

Fetus Presentation

in Labor and Delivery: 6.5 The Nursing Director of Women's Services, North Monroe Medical Center, submitted a request to petition to the Board for an opinion related to the RN performing an ultrasound to determine fetus presentation in labor and delivery. It was noted that this is the first request of the Board to rule on the scope of practice of an RN performing an ultrasound test.

Discussion focused on bedside versus department ultrasounds and the scope of practice of an RN determining presentation of the fetus by ultrasound, the RN is not licensed to interpret the ultrasound. Most often the physician is not in the hospital and determination of fetal presentation would be the responsibility of the RN.

Motion: by D. Ford, seconded by J. Harper, that agenda item 6.5 be tabled until such time as petitioner and/or Board staff can present requirements for ultrasound proficiency and training, and to survey other states' regarding this matter: D. Olds, Yes; D. Ford, Yes; J. Harper, Yes; F. Rosenthal, Yes.

Rectal Diastat, School Setting: 5.3 Reconsideration of Board's opinion (99.17) regarding delegation of rectal Diastat, school setting

The Practice Committee conducted a survey in 2003 and determined that rectal Diastat is not considered an emergency drug, the majority of other states require nurses to administer the drug; therefore the Board up-held it's previous opinion that rectal Diastat can not be delegated to trained unlicensed personnel. Based on a request for reconsideration of the Board's opinion, the Committee established a sub-group to develop a clinical protocol and elicited the assistance of LaVonne Smith, LSUHSC to conduct a survey regarding the number of LA students receiving Diastat.

Lavonne Smith reported on the results of the Survey regarding the number of Louisiana Students Receiving Rectal Diastat. Of the 67 LEAs in the state 38 responded to the survey; 23 of the 38 parishes reported that there are 88 students with Diastat orders to be administered at school, see attachment 1. The orders vary in the time frame for administration after onset from one minute to 10 minutes, 2 orders did not specify a time frame. Of the 88 students with orders for Diastat, 17 students received /diastat during the 2003-2004 school year and 11 students received Diastat in the 2004-2005 school year as of January 24, 2005. Twenty-three reported instructed to call 911 when a student has a seizure. Of the 38 reporting LEAs, 11 have emergency equipment at school, 23 said no; and 4 LEAs reported that it was necessary to use the emergency equipment.

The Committee reviewed the clinical protocol by sections. Following a detailed discussion of the protocol, the Committee determined that staff should develop a declaratory statement from the key concepts of the protocol, ensuring compliance with the Law and the Board's rules on delegation such as complex versus non-complex.

The Committee thanked L. Smith for conducting the survey in a timely fashion and the members of the sub-group for the development of the clinical protocol.

Motion: by D. Ford, seconded by J. Harper, that agenda item 5.2 be tabled until Board staff can develop a declaratory statement and that 2 issues be referred to presenters: 911 issue and observation after administration of Diastat: D. Olds, Yes; D. Ford, Yes; J. Harper, Yes; F. Rosenthal, Yes.

Announcement: by B. Morvant, that P. Ladner will be retiring from the Board March 1, 2005 and that this will be her last Nursing Practice Committee meeting.

Declaratory Statement:

4.2 Declaratory Statement on the Role and Scope of practice of the Registered Nurse in the Administration of Medication and Monitoring of Patients During the Levels of Sedation (Minimal, Moderate, Deep, and Anesthesia) as Defined Herein

Staff reported on the Board mailing that included a copy of the position statements of the following organizations: ANA; AANA; ASA; ACR; ACEP; AAP; JCAHO; and a letter from a CRNA and the Emergency Nurses Association regarding Emergency Nursing Pediatric Course (these statements will be filed with the official Board copy of the minutes). The areas under review by the Committee were identified: the educational preparation of RNs administering/monitoring conscious sedation to pediatric patients, venous access requirements for pediatric patients, and the use of the ASA classification system. The RN's scope of practice has already been determined by the Board. The Committee decided to study and make a recommendation to the Board on each separate item under review.

M. Kelly, LA Emergency Nurses Association, addressed the letter from the Emergency Nurses Association requesting that the Board's statement accept the Emergency Nursing Pediatric Course (ENPC) as another course acceptable in providing an appropriate knowledge base for nurses caring for pediatric patients receiving conscious sedation. D. Ford cited postion statements from the professional organizations addressing ACLS/PALS:
AANA: Demonstrate competency, through ACLS or PCLS, in airway management and resuscitation appropriate to the age of the patient (AANA, 2003, p.2).
AAP: Sedative and anxiolytic medications should only be administered by or in the presence of individuals skilled in airway management and cardiopulmonary resuscitation (AAP, 2002, p. 836).
ACR: It is recommended that an individual with pediatric advanced-life-support skills be on-site (ACR Practice Guidelines, 2002, p.302).
ASA: At least one individual capable of establishing a patent airway and positive pressure ventilation, as well as a means for summoning additional assistance should be present whenever sedation/analgesia are administered (ASA Practice Guidelines, 2002, p. 12).

The other statements were silent on the training of personnel to provide emergency measures.

Discussion focused on the need to list all acceptable programs in the statement: PALS, NRP (neonatal resuscitation program), and ENPC.

Motion: by D. Ford, seconded by D. Olds, in reference to agenda item 4.2 that the Declaratory Statement be amended to include ENPC, NRP as indicated for appropriate age groups; defer to the Board staff for specific wording of the statement: D. Olds, Yes; D. Ford, Yes; J. Harper, Yes; F. Rosenthal, Yes.

Mike Jennings, physician, Southwest Medical Center, addressed concern for requiring venous access. M. Kelly stated that intravenous access for pediatric patients was not necessary since nurses were competent to implement intraosseous needle placement as necessary.

D. Ford cited position statements from the professional organizations addressing venous access:

AANA: Venous access shall be maintained for all patients having sedation and analgesia (AANA, 2003, p.2).

ACR: In patients receiving intravenous medications for sedation and analgesia, vascular access shall be maintained whenever possible throughout the procedure and until the patient is no longer at risk for cardiorespiratory depression. In patients who have received sedation and analgesia by nonintravenous routes or whose intravenous line has become dislodged, obstructed, or infiltrated, the clinician shall determine the advisability of establishing or re-establishing intravenous access on a case-by-case basis. In all instances, an individual with the skills to establish intravenous access shall be immediately available (ACR Practice Guidelines, 2002, p. 304).

ASA: In patients who have received sedation/analgesia by non-intravenous routes, or whose intravenous line has become dislodged or blocked, practitioners should determine the advisability of establishing intravenous access on a case-by-case basis. In all instances, an individual with the skills to establish intravenous access should be immediately available (ASA Practice Guideline, 2002, p. 15).

ACEP: Intravenous access should be established and maintained when intravenous procedural sedation and analgesia is provided; the need for intravenous access when procedural sedation and analgesia is provided by intramuscular, oral, nasal, or rectal drug administration is dependent on the dose used and patient comorbidity (ACEP Clinical Policy, 1998, p. 666)

JCAHO: Appropriate equipment to administer intravenous fluids and drugs, including blood and blood components, is available as needed (JCAHO, 2004, PC.13.20.5).

AORN: IV access line should be established before moderate sedation/analgesia (AORN, 2002 Standards, p. 189 Practice V.2)

The other statements were silent of the issue of venous access.

Motion: by D. Olds, seconded by D. Ford, that in reference to agenda item 4.2 that venous access shall be maintained for patients having sedation and analgesia or as deemed appropriate by the authorized prescriber: D. Olds, Yes; D. Ford, Yes; J. Harper, Yes; F. Rosenthal, Yes.

Debra Spell and Mike Jennings addressed the issue of using the ASA classification system for all levels of sedation. D. Ford cited the following position statements:

ACR: Infants and children who are ASA class I or II qualify foe sedation/analgesia when imaging procedures are required (ACR Practice Guideline, 2002, p. 302).
AORN; Indication of the patient's appropriateness for the procedure also should include the ASA physical status classification. Patients classified as P1 or P2 are considered appropriate for RN-monitored moderate sedation/analgesia. Patients with a classification of P3 may be appropriate and should be evaluated on an individual basis. Any ASA physical status classification higher than P3 is considered inappropriate doe RN monitoring during moderate sedation/analgesia (AORN, 2002 Standards, p. 189 Practice IV.2).

D. Ford reported that the other statements were silent on the use of the ASA classification system.
Julia Bounds, CRNA, President, LANA addressed he concerns in her letter regarding RNs administering anesthetic agents. It was pointed out by the Committee that the statement addresses more than RNs administering anesthetic agents but the monitoring of patients receiving analgesia.

Motion: by D. Ford, seconded by D. Olds, in reference agenda item 4.2 that the declaratory statement be amended to qualify deep sedation/analgesia; defer to Board staff for wording: D. Olds, Yes; D. Ford, Yes; J. Harper, Yes; F. Rosenthal, Yes.

Motion: by D. Ford, seconded by D. Olds, in reference to agenda item 4.2 that the declaratory statement be amended to include intent of Procedural Sedation in title and defer to Board staff for appropriate language.

Julia Bounds and Pat Newman, two CRNAs representing LANA expressed concern for RNs administering anesthetic agents and monitoring patients in deep sedation. Open dialogue took place between the CRNAs, the Committee members and the remaining guests regarding the role of the RN and the responsibility of the institution in procedural sedation.

APRN Scope of Practice: 4.1 APRN scope of practice requests

P. Griener distributed an article entitled *Scope of Practice and the Nurse Practitioner: Regulation, Competency, Expansion, and Evolution* that evaluates the current mechanisms for credentialing and recognizing scope of practice for nurse practitioners.

Old Business:

Nurse Practice Opinions: 5.1 Nurse practice opinions rendered prior to 1995

Staff reported that within the up-coming all practice opinions will be readied for website accessing. A disclaimer statement has been developed and sent to the Board's counsel for review.

Analgesic Doses of Anesthetic Agents (SB 387): 5.2 Board's rules regarding registered nurses administering analgesic doses of anesthetic agents (SB 387)

Staff distributed the rules as published in the *Louisiana Register* Vol. 31, No. 1, January 20, 2005.

Announcements: None

Motion: by J. Harper, seconded by D. Ford to adjourn the meeting:
D. Olds, Yes; D. Ford, Yes; J. Harper, Yes; F. Rosenthal, Yes.

Adjournment: The meeting of the Nursing Practice Committee adjourned at 2:35 p.m.

Submitted: Pat Ladner, MN, RN Date: February 10, 2005

Approved: Date