Louisiana State Board of Nursing
Practice Committee Meeting Minutes
April 25, 2007

Call to Order

The meeting of the Louisiana State Board of Nursing Practice Committee was called to order by James Harper, Chair, at 9:00 a.m. on April 25, 2007 in the Shelton Room of the Cook Conference Center & Hotel, located at 3848 W. Lakeshore Dr., Baton Rouge, LA 70808.

Roll Call

Committee Members Present
James Harper, MSN, APRN, CFNP, Chair
Gerald Bryant, MSN, RN
Michelle Oswalt, MSN, APRN, CRNA
Frankie Rosenthal, MSN, APRN, CNS

Non-voting Committee Member Present
Deborah Olds, BSN, RN
Alan Ostrowe, M.D.

Non-voting Board Members Excused
William LaCorte, M.D.

Staff Present
Barbara L. Morvant, MN, RN, Executive Director
Margaret Griener, MPH, APRN, PNP, Director, Credentialing & Practice
Brenda Kelt, Licensing Analyst

Guests

Joni Nickens, APRN, FNP, Louisiana Association of Nurse Practitioners (LANP)
Joe Ann Clark, Executive Director, Louisiana State Nursing Association (LSNA)
Lucie Agosta, APRN, CNS, ANP, FNP, Women's Hospital
Lori Denstel, RN, Women's Hospital
Cheri Johnson, RN, BSN, Women's Hospital, Director of Obstetrical Services
Patricia Johnson, RN, Women's Hospital

Reorder Agenda

James Harper, Committee Chair, reordered the agenda.

Motion

by G. Bryant, seconded, that the chair be allowed to reorder the agenda.

Vote

Bryant - yes, Oswalt – yes, Rosenthal - yes. Motion carried.

Review of Minutes

The Committee reviewed the minutes of the January 23, 2007 Practice Committee meeting.

Motion

by G. Bryant, seconded, that the Committee approve the minutes of the January 23, 2007 Practice Committee.

Vote

Bryant - yes, Oswalt – yes, Rosenthal - yes. Motion carried.

Old Business
Agenda item 4.1

Agenda item 4.1: DHH (Department of health and Hospitals) submitted a request for changes to the document previously approved by the board regarding the implementation of rules to allow medication administration by trained direct service workers (DHH).

M. Griener stated she had contacted Dena Vogel with DHH by phone and email regarding this agenda item and was advised that she is no longer assigned to this project. Ms. Vogel advised that the new person handling this is Ms. Kathy Kliebert, the Assistant Secretary for the Office for Citizens with Development Disabilities and she confirmed that she had contacted Ms. Kliebert regarding this issue. Ms. Griener advised that we had not received contact from Ms. Kliebert's office to determine if they now want to withdraw their request for changes.

B. Morvant stated that LSBN has already accepted the rules as presently drafted; we have been waiting for DHH to accept the rules. B. Morvant advised that she will attempt to contact Ms. Kliebert.

J. Harper advised that no motion or action will be issued by the committee on this issue at this time.

New Business

Agenda item 5.1

Agenda item 5.1: Whether it is within the scope of practice for a qualified RN to perform a medical screening exam (MSE) to rule out Labor per the Emergency Medical Treatment and Labor Act (EMTALA)
(Woman's Hospital in Baton Rouge)

P. Johnson stated that based on the last committee meeting, they had attempted to obtain information regarding this issue from our Board of Nursing website, but advised that they were unable to find information regarding actual opinions rendered on this issue by other Boards on the web. P. Johnson advised that it is their understanding that the practice of RNs performing a medical exam to rule out labor is acceptable in other states and is a regular practice at facilities in Louisiana.

M. Griener reported that the issue with the other states is not whether they allow their RNs to do this task, but that the Nurse Practice Acts in the other states who allow this practice does not state that only an Advanced Practice Registered Nurse can perform a medical diagnosis as our Louisiana Nurse Practice Act states. M. Griener advised that the issue would be whether the determination of labor, or false labor, is a medical diagnosis or not.

C. Johnson advised that the RNs are not making this decision independently, but relaying their assessment findings for the patient to the physician. These are established patients who have a relationship with their physician throughout their pregnancy. For those patients who come in and do not have an assigned physician, a physician would need to come in and see those unassigned patients.

M. Oswalt asked if the nurses were then doing a nursing assessment to determine and rule out labor.

C. Johnson confirmed that, yes, they would consider it a nursing assessment in relaying the findings to the physician. C. Johnson advised that at Woman's Hospital has pretty advanced technology and the nurse is monitoring the patient using an electronic fetal monitor.

L. Denstel stated that the results of the electronic fetal monitor can be accessed remotely by the physician via the internet.

C. Johnson stated that once the patient arrives, there is a baseline assessment done, a period of monitoring, and then another assessment performed to determine if there has been any change in frequency of contractions.

J. Harper asked for an approximation of the time period is all of this is performed.

C. Johnson stated that a minimum of an hour, but sometimes two to four hours. It depends on the frequency of the contractions and condition of the cervix. Sometimes a patient is monitored all night or all day long.

J. Harper asked if these patients bypass the emergency room.

C. Johnson stated that in most general hospitals, patients coming in with labor pains are evaluated in the labor and delivery floor because fetal monitoring is required to perform a good assessment.

J. Harper asked for clarification regarding the patients coming to the labor and delivery floor for monitoring with labor pains, whether a physician or nurse practitioner is coming in to see the patient for a face to face evaluation during the monitoring period.

C. Johnson explained that the RN is monitoring the patient with the fetal monitor and the physician can access the results with their home PC or laptop during the monitoring.

L. Agosta added that Woman's Hospital has Nurse Practitioners that are available 24 hours a day, 7 days a week within the hospital setting who can consult if requested by a physician. The Nurse Practitioner routinely sees the unassigned patients that come into the hospital and do not have an assigned physician.

J. Harper requested clarification as to why the Nurse Practitioners are not performing the medical screening to rule out labor if they are in the hospital.

P. Johnson advised that if a patient arrives at the hospital in possible labor and do not have a physician and haven't had prenatal care, then the Nurse Practitioner always sees those patients together with a physician. But for a private patient who already has a relationship with an assigned physician during pregnancy, then the physician may or may not ask for a Nurse Practitioner to see the patient when they arrive at the hospital. P. Johnson added that the private physician is always available by phone for the RN, and a Nurse Practitioner is always available if needed.

J. Harper asked for clarification regarding the determination made by the physician.. Obviously their condition has changed since the patient's last visit. P. Johnson stated that the physician is usually seeing his/her patient every month throughout the pregnancy, and every week toward the end of the pregnancy, and the electronic fetal monitor is very accurate in providing information regarding active labor. The RN in the labor and delivery floor is certified to interpret electronic fetal monitoring and

abnormal positions, so they are working in concert together with the assigned physician.

P. Johnson explained that there has been discussion that because of the Board's interpretation that if the nurse does the assessment and calls the physician and the physician makes the decision to send the patient home, does that meet the criteria for medical screening. The real question seems to be what constitutes a medical screening. Does a medical screening require a physician to personally come in and exam the patient, or is it acceptable for a properly trained registered nurse to perform the assessment in collaboration with the physician. P. Johnson stated that there was a lot of discussion on this after the September 12, 2002 Opinion was rendered by the Board regarding Medical Screening Exam performed by a "Qualified Medical Personnel", and what that meant to Woman's Hospital in this setting.

M. Griener quoted the September 12, 2002 Board opinion (npop 02.09):

> "It is not within the authorized scope of practice for a registered nurse to perform an appropriate medical screening exam (MSE) for the purpose of determining if an emergency medical condition (EMC) exists; the Board reaffirms it's previous opinion (96.18) that it is within the scope of practice for a registered nurse qualified in emergency care with documented knowledge, skills, and abilities to triage (access the health status of an individual to determine a non-emergent status and to formulate nursing diagnosis based on health care needs to serve as the basis for indicating nursing care or for which referral to appropriate medical or community resources for the non-emergent health status) provided that triage guidelines are in place to assist the registered nurse with appropriate referrals approved by the agency's emergency medical director."

Ms. Griener asked the representative of Woman's Hospital to advise if they felt this opinion covered their practice in this area.

Discussion ensued regarding the issue of triage in the labor and delivery suite as opposed to the Emergency Department.

G. Bryant commented that if triage is to determine whether or not there is an emergency, then the assessment would truly be considered medical screening.

J. Harper pointed out that if a patient coming in with labor pains automatically bypasses the emergency room, then the nurses in the labor and delivery floor are acting as the first line of assessment of the patient, so the nurses are deeming if it's an emergency situation or not. J. Harper asked with this in mind, how could this practice of an RN taking vitals and assessing a patient to determine if they are in labor not be considered a type of triage.

P. Johnson stated that the labor assessment is done over a period of time as explained, it is not a quick assessment for determining immediate order of care which is more of what a triage nurse would perform.

At 9:20 am Dr. Alan Ostrowe joined the committee meeting.

J. Nickens stated that it is the position of LANP that it is not within the scope of practice of a Registered Nurse (RN) to provide medical diagnosis. She suggests that Woman's Hospital would need to reword their request. J. Nickens pointed out that even though Woman's Hospital has advanced technology and training, if their request for opinion is approved as currently written, it would apply statewide for all facilities not all of which have the same standards or resources. This would raise public safety issues.

C. Johnson requested assistance from the committee and Board in rewording their request.

G. Bryant suggested they look at the Board Opinion issued on May 27, 1996 (npop96.15) issued to Ms. Donna Carter with Minden Medical Center as a guide since it speaks to the process followed and studied, yet avoids using the wording "medical screening exam". The opinion instead states:

> "It is within the scope of practice for a qualified obstetrical registered nurse to perform a nursing assessment, including vaginal examination, and discharge the patient home provided…"

P. Johnson stated that was one of her questions originally in that the 2002 opinion seemed to negate the earlier 1996 opinion.

B. Morvant advised that two things that happened during that period. First, the Nurse Practice Act changed to license Advanced Practice Registered Nurses. Then the EMTALA regulations were adopted by the Federal government.

J. Harper asked that since we can't obviously change it to medical diagnosis, which no one seems to be suggesting, then is a ruling needed from the committee on the request as written.

B. Morvant stated that the dilemma is that a Registered Nurse (RN) can not make a medical diagnosis for a medical prescription. If the committee determines that only an APRN should be performing this function, then the previous opinion would be upheld. If the committee believes that it's safe, and that you can draw a line that this is not a medical diagnosis, or not medical prescriptive, then it would need to be defined and have to go through rule change and public process rather than just issuing an opinion in order to safeguard the public. But the committee could not state that it is appropriate for an RN to issue a medical diagnosis.

J. Harper requested a clarification of the process being discussed.

P. Johnson explained the following example. A patient arrives at the hospital with contractions. The RN first calls the patient's assigned physician to let him/her know that the patient came in. The RN does an assessment of vital signs and puts an electronic fetal monitor on the patient. The RN checks and assesses the reading from the fetal monitor and calls the physician back after some time has passed and relays that there has been no cervical change or acceleration and advising the physician whether she believes the patient is in labor. At that time the physician can access the fetal monitoring by remote to verify the assessment

and decide to admit her for further monitoring, or discharge her. So let's say they discharge the patient. The question being asked is, does Woman's Hospital meet the EMTALA laws to provide medical screening.

J. Harper noted that with the example given, it was not the RN who made the decision to discharge the patient.

P. Johnson confirmed that the RN would have obtained physician's orders to discharge.

J. Harper asked then, why this would be an issue needed an opinion.

P. Johnson explained that she understands that in the CMS/DHH view this is performing a medical screening under EMTALA. DHH has stated that in the Board's interpretation that they are not performing a medical screening.

P. Griener asked if they are transferring patients to another facility who present with symptoms of labor.

P. Johnson answered no, that any patient that comes into Woman's Hospital with labor pains will be admitted or discharged.

B. Morvant asked who has accountability for the medical screening. Is it clearly understood that the physician is still accountable for that medical screening, or does the RN have to sign something regarding the screening.

P. Johnson advised that there is currently no requirement that anyone sign a medical screening. This could be created as a procedure, but it's not needed presently. The technology that Woman's Hospital has allows the physician to access the readings of the fetal monitoring themselves by remote.

J. Harper pointed out that the technology utilized by physicians at Woman's Hospital is not available statewide and that the Board can not make an isolated opinion based on what one facility.

G. Bryant agreed, but added that the process of a patient arriving with labor pains, bypassing the emergency room, and being assessed by RNs to communicate with physicians for determination of release or admit, is being performed statewide in even the smaller rural hospitals that do not have the same technology. Everyone agrees that we can not accept the use of the wording "medical screening exam".

Discussion ensued regarding the issue of medical screening versus medical diagnosis.

A.Ostrowe stated that the process as described by the representatives of Woman's Hospital is already being done statewide, but that they need to take out the "medical screening" wording from their request. RNs are trained to make assessments and call the physician to relay their observations, and let the physician make the call on the patient's care. Physicians work hard to provide the best patient care in whatever arena they practice which requires a team approach, and RNs are very much a part of the team.

C. Johnson stated that DHH's interpretation of the 9/12/2002 opinion (npop02.09) is that process we follow does not meet the EMTALA requirements for medical screening exam.

M. Griener advised that the issue is the term "qualified medical personnel" (QMP). It's not that the practice Woman's Hospital is performing is not appropriate. The request being made of this committee is to have your RNs in labor and delivery to be determined as "qualified medical personnel" under the EMTALA rule. In the state of Louisiana, the Nurse Practice Act only allows an Advanced Practice Registered Nurse to make a medical diagnosis, which precludes RNs in becoming a QMP. This is a statutory issue, not an issue of whether your RNs provide good care or if the physician has access to the testing results.

F. Rosenthal read for the committee the current administrative policy No. 134 originally dated 1/1991 and most recent revision 10/2002 from Woman's Hospital Administrative Policy Manual for Emergency Medical Treatment and Active Labor Act (EMTALA), which states:

> Policy –
> Each individual who comes to Woman's Hospital and requests (or a request is made on the individual's behalf) an examination or treatment for a medical condition will received an assessment by a Registered Nurse to determine whether the potential for an emergency medical condition exists. If an emergency medical condition exists, further medical examination and treatment as required to stabilize the medical condition within the staff and facilities available at the hospital will be provided.
>
> Objective –
> To comply with EMTALA guidelines.

This current policy does not state that the RN is the one making the medical diagnosis.

Discussion ensued regarding the process for evaluating patients who present to the hospital who are unassigned.

C. Johnson advised that the "unassigned" patient is a high risk patient without previous prenatal care, and they are being seen by a Nurse Practitioner. Most of our Medicaid patients have a physician and have received some prenatal care. Woman's Hospital sees about 65% Medicaid patients in Labor and Delivery, about 90% of those have prenatal care and a physician.

J. Harper asked for clarification on the sole factor whether the APRN or MD needs to see that patient.

P. Johnson advised that when the patient arrives at the hospital, she is asked if she has a physician or been seeing a physician for prenatal care. If the patient advises the name of a physician, we contact the physician to advise the patient is here and get instructions. If the patient advises 'no' she has no physician, or is from out of

town, then she is assessed by a Nurse Practitioner. The actual nursing evaluation is the same, but the private patient would have been receiving regular prenatal care for any other conditions such as hypertension. The majority of unassigned patients who arrive at Woman's Hospital have had little or no prenatal care and are higher risk.

A. Ostrowe suggested that in Board consider an opinion in allowing a nurse to make an assessment, first change the wording to be "nursing assessment" instead of medical screening exam, then limit the practice to a specific designation level of that obstetrical unit.

P. Johnson advised that Woman's Hospital is a level 3.

Discussion ensued regarding the leveling of obstetrical care and the outcomes for low-birth weight babies in hospitals > Level 3.

J. Nickens suggested that Woman's Hospital withdraw their request for an opinion on this issue until it can be rewritten in order to go through rules change.

M. Griener reminded everyone that the Board already has an existing opinion that it is not within the scope of practice for a Registered Nurse (RN) to act as a Qualified Medical Personnel for performing a medical screening exam.

G. Bryant suggested that a task force be established to work on rule change to address the issue of a Registered Nurse (RN) participating in the assessment of a patient to rule out labor.

Motion by F. Rosenthal, seconded, that the Practice Committee recommend to the Board the establishment of a Task Force to identify the RN role in the assessment to determine/certify false labor. The Task Force to include:

- Board Member as Chair, and two Board Members to sit on Task Force (Gerald Bryant, James Harper, and Deborah Olds)
- One (1) RN from Woman's Hosptial
- Two (2) APRNs, one a Women's Healthcare Nurse Practitioner (WHNP) and the second a Certified Nurse Midwife (CNM)
- One (1) RN from LSNA
- One (1) Obstetrical staff Registered Nurse
- One (1) Obstetrician, recommended by LSMS
- One (1) MD, recommended by the LA Medical Board
- One (1) Nursing Administrator, recommended by LONE

Vote Bryant - yes, Oswalt – yes, Rosenthal - yes. Motion carried.

Agenda item 5.2 Agenda item 5.2: Whether it is within the scope of practice for a qualified RN to delegate to an LPN the monitoring of a patient on a fixed rate, (not titrated) vasoactive drip on a volumetric pump provided said LPN has completed training and has documented competency validation to do so, and provided the hospital has written policies and procedures outlining the above. (Dopamine, Dobutrex, Natrecor) (River Parishes Hospital)

J. Harper advised that the Petitioner contacted the Board this morning and requested that this issue be tabled for a future committee meeting.

Adjournment The Committee adjourned at 10:45 a.m.

Submitted by: Margaret M Griener

Margaret Griener, Director - Credentialing and Practice

Approved 7/24/2007