

# BOUNDARIES OF SCOPE OF PRACTICE AND NURSING PEER REVIEW

NEXT CHALLENGE. NEXT LEVEL.

**NEXSEN | PRUET**

SCONL/ASHRM MEMBERS MEETING

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# SCOPE OF PRACTICE

## AMERICAN NURSE'S ASSOCIATION CODE OF ETHICS

- ▶ 7.2 Advancing the profession by developing, maintaining, and implementing professional standards in clinical, administrative, and educational practice - Standards and guidelines reflect the practice of nursing grounded in ethical commitments and a body of knowledge. Professional standards and guidelines for nurses must be developed by nurses and reflect nursing's responsibility to society. It is the responsibility of nurses to identify their own scope of practice as permitted by professional practice standards and guidelines, by state and federal laws, by relevant societal values, and by the Code of Ethics.
- ▶ Important because the SCBoN has adopted the ANA Code of Ethics by regulation. S.C. Code Regs. § 91-32.

# SCOPE OF PRACTICE

## PRACTICE OF NURSING

- ▶ The scope of nursing practice is set forth by statute and regulation.
- ▶ The practice of nursing means the provision of services for compensation, except as provided in this chapter, that assists persons and groups to obtain or promote optimal health. Nursing practice requires the use of nursing judgment. Nursing judgment is the logical and systematic cognitive process of identifying pertinent information and evaluating data in the clinical context in order to produce informed decisions, which guide nursing actions. Nursing practice is provided by advanced practice registered nurses, registered nurses, and licensed practical nurses. The scope of nursing practice varies and is commensurate with the educational preparation and demonstrated competencies of the person who is accountable to the public for the quality of nursing care. Nursing practice occurs in the state in which the recipient of nursing services is located at the time nursing services are provided. S.C. Code Ann. § 40-33-20(46)

# SCOPE OF PRACTICE

## PRACTICE OF PRACTICAL NURSING

- ▶ Practice of Practical Nursing: means the performance of health care acts that require knowledge, judgment, and skill and must be performed under the supervision of an advanced practice registered nurse, registered nurse, licensed physician, licensed dentist, or other practitioner authorized by law to supervise LPN practice. The practice of practical nursing includes, but is not limited to:
  - ▶ (a) collecting health care data to assist in planning care of persons;
  - ▶ (b) administering and delivering medications and treatments as prescribed by an authorized licensed provider;
  - ▶ (c) implementing nursing interventions and tasks;
  - ▶ (d) providing basic teaching for health promotion and maintenance;
  - ▶ (e) assisting in the evaluation of responses to interventions;

# SCOPE OF PRACTICE

## PRACTICE OF PRACTICAL NURSING

- ▶ (f) providing for the maintenance of safe and effective nursing care rendered directly or indirectly;
- ▶ (g) participating with other health care providers in the planning and delivering of health care;
- ▶ (h) delegating nursing tasks to qualified others; and
- ▶ (i) performing additional acts that require special education and training and that are approved by the board including, but not limited to, intravenous therapy and other specific nursing acts and functioning as a charge nurse. S.C. Code Ann. § 40-33-20(47)

# SCOPE OF PRACTICE

## PRACTICE OF REGISTERED NURSING

- ▶ Practice of Registered Nursing means “Practice of registered nursing” means the performance of health care acts in the nursing process that involve assessment, analysis, intervention, and evaluation. This practice requires specialized independent judgment and skill and is based on knowledge and application of the principles of biophysical and social sciences. The practice of registered nursing includes, but is not limited to:
  - ▶ (a) assessing the health status of persons and groups;
  - ▶ (b) analyzing the health status of persons and groups;
  - ▶ (c) establishing outcomes to meet identified health care needs of persons and groups;
  - ▶ (d) prescribing nursing interventions to achieve outcomes;
  - ▶ (e) implementing nursing interventions to achieve outcomes;

# SCOPE OF PRACTICE

## PRACTICE OF REGISTERED NURSING

- ▶ (f) administering and delivering medications and treatments prescribed by an authorized licensed provider;
- ▶ (g) delegating nursing interventions to qualified others;
- ▶ (h) providing for the maintenance of safe and effective nursing care rendered directly or indirectly;
- ▶ (i) providing counseling and teaching for the promotion and maintenance of health;
- ▶ (j) evaluating and revising responses to interventions, as appropriate;
- ▶ (k) teaching and evaluating the practice of nursing;
- ▶ (l) managing and supervising the practice of nursing;
- ▶ (m) collaborating with other health care professionals in the management of health care;

# SCOPE OF PRACTICE

## PRACTICE OF REGISTERED NURSING

- ▶ (n) participating in or conducting research, or both, to enhance the body of nursing knowledge;
- ▶ (o) consulting to improve the practice of nursing; and
- ▶ (p) performing additional acts that require special education and training and that are approved by the board. S.C. Code Ann. § 40-33-20(48).



# SCOPE OF PRACTICE

## ADVANCE PRACTICE NURSING

- ▶ “Advanced Practice Registered Nurse” or “APRN” means a registered nurse who is prepared for an advanced practice registered nursing role by virtue of additional knowledge and skills gained through an advanced formal education program of nursing in a specialty area that is approved by the board. The categories of APRN are nurse practitioner, certified nurse-midwife, clinical nurse specialist, and certified registered nurse anesthetist. An advanced practice registered nurse shall hold a doctorate, a post-nursing master's certificate, or a minimum of a master's degree that includes advanced education composed of didactic and supervised clinical practice in a specific area of advanced practice registered nursing. In addition to those activities considered the practice of registered nursing, an APRN may perform delegated medical acts. S.C. Code Ann. § 40-33-20(5).

# SCOPE OF PRACTICE

## PRACTICE OUTSIDE OF THE SCOPE OF PRACTICE

- ▶ Upon finding misconduct the board may cancel, fine, suspend, revoke, issue a public reprimand or a private reprimand, or restrict, including probation or other reasonable action such as requiring additional education and training, the authorization to practice of a person who has:
- ▶ (21) practiced outside the scope of the license by assuming duties and responsibilities without adequate education as determined by the board. S.C. Code Ann. § 40-33-110.

# BOUNDARIES OF SCOPE OF PRACTICE

- ▶ The SCBoN provides a scope of practice decision tree for use in cases where a nurse questions whether certain practices are within the scope of licensure.
- ▶ See:  
<http://www.llr.state.sc.us/pol/nursing/PStatements/ScopeofPracticeDecisionTreeApproved072910.pdf>.
- ▶ Advisory Opinions address scope of practice questions:  
<http://www.llr.state.sc.us/POL/Nursing/index.asp?file=AdvisoryOp/AOIndex.htm>.

# SCOPE OF PRACTICE

## WHEN THE SCOPE OF PRACTICE IS IN QUESTION

- ▶ The SCBoN has a process by which nurses may submit a question regarding scope of practice to the Practice & Standards Committee.
- ▶ Asks: (1) Licensure level; (2) statement of the question (“is it within the scope of practice . . .”); (3) describe the practice in question; (4) identify references to the Nurse Practice Act or Advisory Opinions; (5) If any professional nursing organization has opined over the practice; (6) if the employing organization has policies or procedures; (7) description of the environment where/circumstances under which the practice will be conducted; (8) type of education, training, skills assessment will be provided; (9) are in or out-of-state nurses performing this practice and where; (10) why nurses should engage in this practice; (11) reasons nurses should not engage in this practice; & (12) a summary of the organization’s discussions and challenges in coming to a decision on the practice.
- ▶ The form can be found at <http://www.llr.state.sc.us/POL/Nursing/pdf/Nursing%20Scope%20of%20Practice%20Opinion%20Request%20Form.pdf>.

# SPECIAL SCOPE OF PRACTICE ISSUES

## DELEGATION OF NURSING TASKS

- ▶ Delegation of nursing tasks to unlicensed assistive personnel. (Position Statement 7/29/2010; Updated 11/14);
- ▶ Must not delegate assessment, evaluation, planning and matters of nursing judgment.
- ▶ Rule 1: Know and Observe Authority Parameters:
  - ▶ The ability of a UPA to perform a delegated nursing task must be outlined in an employer's policies and procedures or the UAP's job description.
  - ▶ MUST: Appropriately assign AND supervise.
  - ▶ Misconduct to assign unqualified persons to perform nursing care functions, tasks, or responsibilities or fail to effectively supervise persons to whom nursing functions are delegated or assigned. S.C. Code Ann. § 40-30-110(23).

# SPECIAL SCOPE OF PRACTICE ISSUES

## DELEGATION OF NURSING TASKS

- ▶ Rule 2: Perform a Thorough Assessment
  - ▶ 1. whether the client's condition is stable and predictable;
  - ▶ 2. the nature and complexity of the nursing task (including the environment in which the task will be performed);
  - ▶ 3. the risk to the client if the task is done inappropriately or incorrectly;
  - ▶ 4. the necessary knowledge, skills and abilities needed to perform the task;
  - ▶ 5. the competency of the UAP;
  - ▶ 6. whether the outcome anticipated is stable and predictable; and
  - ▶ 7. the number of UAPs that can safely be supervised by the licensed nurse.

# SCOPE OF PRACTICE

## DELEGATION OF NURSING TASKS

- ▶ Plan of instruction for a UAP to perform nursing tasks:
  - ▶ 1. step-by-step instruction and rationale for the task;
  - ▶ 2. observation of the UAP in performing the task to evaluate competency and to assure accuracy and safety;
  - ▶ 3. provision of written instructions as a reference,
  - ▶ 4. a plan for emergency intervention;
  - ▶ 5. a plan for ongoing supervision and evaluation of client outcomes by the licensed nurse,
  - ▶ 6. documentation of initial competency of the UAP and periodic re-evaluation of competency; and
  - ▶ 7. documentation of the instruction provided.

# SCOPE OF PRACTICE

## DELEGATION OF NURSING TASKS

- ▶ Rule 3: Delegate Nursing Tasks Judiciously.
- ▶ Rule 4: Maintain Accountability:
  - ▶ 1. frequent contact with the UAP to determine client responses to care (contact must always be available by telecommunication);
  - ▶ 2. regular collection of data of the patient by the licensed nurse to determine progress toward goals of care;
  - ▶ 3. regular review of collected data and assessment of the patient by the registered nurse
  - ▶ 4. a plan for backup supervision; and
  - ▶ 5. a plan for intervening in an emergency situation.



# SCOPE OF PRACTICE

## DELEGATION OF NURSING TASKS

- ▶ **Delegation Decision Check List for South Carolina's Licensed Nurses (All answers must be "Yes")**
- ▶ Does the SC Nurse Practice Act support the delegation?
- ▶ Is the task within your scope of practice?
- ▶ Does your job description support the delegation?
- ▶ Are you competent to carry out the delegation process?
- ▶ Does the assessment of the patient's overall health condition performed by the registered nurse responsible for and/or supervising the patient's care support the delegation?
- ▶ Can the task be performed without repeated on-going nursing assessment?

# SCOPE OF PRACTICE

## DELEGATION OF NURSING TASKS

- ▶ Is the outcome of the task predictable?
- ▶ Can the task be safely performed according to exact, unchanging directions?
- ▶ Can the task be performed without complex observations or critical decisions?
- ▶ Does the task recur frequently in the daily care of the patient or is the task necessary for treatment of a medical emergency?
- ▶ Does the task require little or no modification from one client-care situation to another?

# SCOPE OF PRACTICE

## DELEGATION OF NURSING TASKS

- ▶ Is the task safe and not threatening to the patient's life or well-being?
- ▶ Are there agency policies, procedures and/or protocols in place to support delegation of this task/activity?
- ▶ Is there a UAP available who is willing to accept the delegation?
- ▶ Does the job description of the UAP being considered for the delegated task support the delegation? Has the UAP being considered for the delegated task demonstrated appropriate knowledge, skills and abilities to accept the delegation?

# SCOPE OF PRACTICE

## DELEGATION OF NURSING TASKS

- ▶ Does the ability and availability of the UAP being considered for the delegated task match the needs of the patient?
- ▶ Is appropriate staffing available for monitoring, supervision and evaluation of the UAP?
- ▶ <http://www.llr.state.sc.us/POL/Nursing/PStatements/DelegationPositionStatementApproved072910.pdf>
- ▶ It is considered misconduct to assign unqualified persons to perform nursing care functions, tasks, or responsibilities or fail to effectively supervise persons to whom nursing functions are delegated or assigned. S.C. Code Ann. § 40-33-110(23).

# SCOPE OF PRACTICE

## DELEGATION OF NURSING TASKS

- ▶ What happens when a physician delegates a nursing task under 40-47-30 (5) which states that a licensed physician is not prohibited from delegating tasks to unlicensed personnel in the physician's employ and on the premises if:
  - ▶ (a) the task is delegated directly to unlicensed personnel by the physician and not through another licensed practitioner;
  - ▶ (b) the task is of a routine nature involving neither the special skill of a licensed person nor significant risk to the patient if improperly done;
  - ▶ (c) the task is performed while the physician is present on the premises and in such close proximity as to be immediately available to the unlicensed person if needed;
  - ▶ (d) the task does not involve the verbal transmission of a physician's order or prescription to a licensed person if the licensed person requires the order or prescription to be in writing; and
  - ▶ (e) the unlicensed person wears an appropriate badge denoting to a patient the person's status. The unlicensed person shall wear a clearly legible identification badge or other adornment at least one inch by three inches in size bearing the person's first name at a minimum and staff position. The identification badge must be worn in a manner so that it is clearly visible to patients at all times.

# SCOPE OF PRACTICE

## INDEPENDENT PRACTICE OF THE APRN

- ▶ August 12, 2011 White Paper on APRNs by the Advanced Practice Committee of the SCBoN.
- ▶ Recommends allowing APRNs to practice to the fullest extent based on their education, experience and training.
  - ▶ Master's degree or doctorate;
  - ▶ Comply with all National Certification requirements for CNE and practice in approved certifying organizations:  
<http://www.llr.state.sc.us/POL/Nursing/PDF/Board%20Approved%20Advanced%20Practice%20Certification%20Organizations.pdf>);
  - ▶ Complete twenty (20) hours of continuing education in pharmacotherapeutics and two (2) hours in controlled substances every two (2) years to retain prescriptive authority.

# SCOPE OF PRACTICE

## INDEPENDENT PRACTICE OF THE APRN

- ▶ Other considerations include:
  - ▶ Differences in the cost of education of a physician v. APRN
  - ▶ Affordability of APRN vs. physician
  - ▶ Access: Increase need for primary care providers with Health Care Reform
  - ▶ Quality: Cites studies that show exceptional quality of care provided by APRNs and no significant differences between APRNs and physicians with complications.
  - ▶ Safety: Cites studies that show APRNs more conservative & cautious and that no data that restrictions improve safety.
  - ▶ Effectiveness

# SCOPE OF PRACTICE

## INDEPENDENT PRACTICE OF THE APRN

- ▶ Impediments identified in the white paper include:
  - ▶ Statutes and regulations requiring protocol approval and general supervision of performance of delegated medical tasks;
    - ▶ Includes forty-five (45) mile restriction & limit of three (3) APRNs /physician
  - ▶ Institutional policies requiring physician involvement and oversight;
  - ▶ Inability to order disability stickers/certify disability, DME, home health care, hospice care/certification, Schedule II controlled substances, long term care/certification, physical therapy, etc.;
  - ▶ Inability to enroll in some payment/reimbursement systems; and
  - ▶ Inability to obtain hospital privileges.



# SCOPE OF PRACTICE

## WHITE PAPER RECOMMENDATIONS

- ▶ Authorize APRNs to practice to the fullest extent based on their education and training;
- ▶ Remove all requirements and references to physician supervision;
- ▶ Expand prescribing to include Schedule II controlled substances;
- ▶ Remove all references to delegated acts;
- ▶ Redefine delegated acts as APRN acts;
- ▶ Remove all references to a protocol/guideline agreement and replace with evidence based guidelines;

# SCOPE OF PRACTICE

## WHITE PAPER RECOMMENDATIONS (CONT'D)

- ▶ Remove all references to a ratio of APRNs to physician;
- ▶ Remove all references to a mileage requirement for APRNs practicing at a distance from physicians;
- ▶ Insert words “autonomous practice” for APRNs in the law;
- ▶ Re-define APRNs as autonomous providers;
- ▶ Delete any references to a physician supervisor listed on the anesthesia record; and
- ▶ Delete any references to physician signature on APRN documents for licensure and or practice.

# SCOPE OF PRACTICE

## APRNS – HOUSE BILL 3078

- ▶ As a practical matter accomplishes most of recommendations (except defines APRNs as “autonomous practitioners”).
- ▶ Allows NP, CNM, or CNS to “provide non-controlled prescription drugs at an entity that provides free medical services for indigent patients.” S.C. Code Ann. §40-33-45.
- ▶ Allows NP and CNM to certify that a student is unable to attend school but may benefit from home instruction. S.C. Code Ann. §40-33-46.
- ▶ Allows a NP and CNM to orally or in writing refer a patient to a physical therapist for treatment. S.C. Code Ann. §40-33-47 (See also S.C. Code Ann. §40-45-110(A)(4) – requires order of a physician or dentist).

# SCOPE OF PRACTICE

## APRNS – HOUSE BILL 3078

- ▶ The State, a political subdivision of the State, a commission, a clinic, or a board administering relief, social security, *health insurance*, or health services under the laws of this State may not deny to the recipients or beneficiaries of their assistance or services the freedom to choose the provider of care or service that is within the scope of practice of a nurse practitioner or certified nurse midwife licensed by the board. S.C. Code Ann. §40-33-48
- ▶ Deletes from the definition of “additional acts” the following:  
~~“Additional acts that constitute delegated medical acts must be agreed to jointly by both the Board of Nursing and the Board of Medical Examiners and must be promulgated by the Board of Nursing in regulation.”~~ S.C. Code Ann. §40-33-20(3).

# SCOPE OF PRACTICE

## APRNS – HOUSE BILL 3078

- ▶ Modifies the definition of “Advance Practice Registered Nurse as follows: In addition to those activities considered the practice of registered nursing, ~~an APRN may perform delegated medical acts~~ a nurse practitioner, certified nurse midwife, and a clinical nurse specialist may practice to the full extent of their education and training. S.C. Code Ann. §40-33-20(5).
- ▶ Deletes the definition of: '~~Agreed to jointly~~' means the ~~agreement by the Board of Nursing and Board of Medical Examiners on delegated medical acts which nurses perform and which are promulgated by the Board of Nursing in regulation.~~ S.C. Code Ann. §40-33-20(6).
- ▶ Deletes the definition of: '~~Approved written protocols~~' means ~~specific statements developed collaboratively by a physician or the medical staff and a NP, CNM, or CNS that establishes physician delegation for medical aspects of care, including the prescription of medications.~~ S.C. Code Ann. §40-33-20(10).

# SCOPE OF PRACTICE

## APRNS – HOUSE BILL 3078

- ▶ ~~Modifies the definition of Clinical Nurse Specialist as follows: A CNS who performs delegated medical acts is required to have physician support and to practice within approved written protocols. A CNS who does not perform delegated medical acts is not required to have physician support or to practice within approved written protocols as provided in Section 40-33-34. S.C. Code Ann. §40-33-20(21).~~
- ▶ ~~Deletes 'Delegated medical acts' means additional acts delegated by a physician or dentist to the NP, CNM, or CNS and may include formulating a medical diagnosis and initiating, continuing, and modifying therapies, including prescribing drug therapy, under approved written protocols as provided in Section 40-33-34. Delegated medical acts must be agreed to jointly by both the Board of Nursing and the Board of Medical Examiners. Delegated medical acts must be performed under the general supervision of a physician or dentist who must be readily available for consultation. S.C. Code Ann. §40-33-20(23)~~

# SCOPE OF PRACTICE

## APRNS – HOUSE BILL 3078

- ▶ ~~Deletes from the definition of Nurse Practitioner the following: Nurse practitioners who perform delegated medical acts must have a supervising physician or dentist who is readily available for consultation and shall operate within the approved written protocols. S.C. Code Ann. §40-33-20(41).~~
- ▶ ~~Deletes 'Readily available' means the physician must be in near proximity and is able to be contacted either in person or by telecommunications or other electronic means to provide consultation and advice to the nurse practitioner, certified nurse-midwife, or clinical nurse specialist performing delegated medical acts. When application is made for more than three NP's, CNM's, or CNS's to practice with one physician, or when a NP, CNM, or CNS is performing delegated medical acts in a practice site greater than forty-five miles from the physician, the Board of Nursing and Board of Medical Examiners shall each review the application to determine if adequate supervision exists. S.C. Code Ann. §40-33-20(52).~~

# SCOPE OF PRACTICE

## APRNS – HOUSE BILL 3078

- ▶ **Modifies 40-33-34 Performance of delegated medical acts; qualifications; protocols; prescriptive authorization; anesthesia care** as follows: ~~(C)(1) — A licensed nurse practitioner, certified nurse-midwife, or clinical nurse specialist must provide evidence of approved *written protocols*, as provided in this section. A licensed NP, CNM, or CNS performing delegated medical acts must do so under the general supervision of a licensed physician or dentist who must be readily available for consultation.~~
- ~~▶ (2) — When application is made for *more than three* NP's, CNM's, or CNS's to practice with one physician or when a NP, CNM, or CNS is performing delegated medical acts in a practice site greater than *forty-five miles* from the supervising physician, the Board of Nursing and Board of Medical Examiners shall each review the application to determine if adequate supervision exists.~~
- ~~▶ (D)(1) — Delegated medical acts performed by a nurse practitioner, certified nurse-midwife, or clinical nurse specialist must be performed pursuant to an approved *written protocol* between the nurse and the physician and must include, but is not limited to~~
- ~~▶ (a) — this general information: (i) name, address, and South Carolina license number of the nurse; (ii) name, address, and South Carolina license number of the physician;~~



# SCOPE OF PRACTICE

## APRNS – HOUSE BILL 3078

- ~~▶ (iii) nature of practice and practice locations of the nurse and physician; (iv) date the protocol was developed and dates the protocol was reviewed and amended; (v) description of how consultation with the physician is provided and provision for backup consultation in the physician's absence;~~
- ~~▶ (b) this information for delegated medical acts: (i) the medical conditions for which therapies may be initiated, continued, or modified; (ii) the treatments that may be initiated, continued, or modified; (iii) the drug therapies that may be prescribed; (iv) situations that require direct evaluation by or referral to the physician.~~
- ~~▶ (2) The original protocol and any amendments to the protocol must be reviewed at least annually, dated and signed by the nurse and physician, and made available to the board for review within seventy-two hours of request. Failure to produce protocols upon request of the board is considered misconduct and subjects the licensee to disciplinary action. A random audit of approved written protocols must be conducted by the board at least biennially.~~
- ~~▶ (3) Licensees who *change practice settings or physicians* shall notify the board of the change within fifteen business days and provide verification of approved written protocols. NP's, CNM's, and CNS's who discontinue their practice shall notify the board within fifteen business days.~~

# SCOPE OF PRACTICE

## APRNS – HOUSE BILL 3078

- ▶ (E)(1) A NP, CNM, or CNS who applies for prescriptive authority:
  - ▶ (a) must be licensed by the board as a nurse practitioner, certified nurse- midwife, or clinical nurse specialist;
  - ▶ (b) shall submit a completed application on a form provided by the board;
  - ▶ (c) shall submit the required fee;
  - ▶ (d) shall provide evidence of completion of forty-five contact hours of education during the time of the organized educational program in pharmacotherapeutics acceptable to the board, within two years before application or shall provide evidence of prescriptive authority in another state meeting twenty hours in pharmacotherapeutics acceptable to the board, within two years before application;
  - ▶ (e) shall provide at least fifteen hours of education in controlled substances acceptable to the board as part of the twenty hours required for prescriptive authority if the NP, CNM, or CNS has equivalent controlled substance prescribing authority in another state;
  - ▶ (f) shall provide at least fifteen hours of education in controlled substances acceptable to the board as part of the forty-five contact hours required for prescriptive authority if the NP, CNM, or CNS initially is applying to prescribe in Schedules ~~III~~ II through V controlled substances.

# SCOPE OF PRACTICE

## APRNS – HOUSE BILL 3078

- ▶ Further modifies 40-33-34 (FD)(1) Authorized prescriptions by a nurse practitioner, certified nurse-midwife, or clinical nurse specialist with [prescriptive authority](#):
- ▶ (a) must comply with all applicable state and federal laws;
- ▶ (b) ~~is limited to drugs and devices utilized to treat common well-defined medical problems within the specialty field of the nurse practitioner or clinical nurse specialist, as authorized by the physician and listed in the approved [written protocols](#). The Board of Nursing, Board of Medical Examiners, and Board of Pharmacy jointly shall establish a listing of classifications of drugs that may be authorized by physicians and listed in approved written protocols;~~
- ▶ ~~(c) do not include prescriptions for Schedule II controlled substances; however, Schedules III through V controlled substances may be prescribed if listed in the approved written protocol and as authorized by Section 44-53-300;~~
- ▶ ~~(d) must be signed by the NP, CNM, or CNS with the prescriber's identification number assigned by the board and all prescribing numbers required by law. The prescription form~~

# SCOPE OF PRACTICE

## APRNS – HOUSE BILL 3078

- ▶ must include the name, address, and phone number of the NP, CNM, or CNS ~~and physician~~ and must comply with the provisions of Section 39-24-40. A prescription must designate a specific number of refills and may not include a nonspecific refill indication;
- ▶ (ec) must be documented in the patient record of the practice and must be available for review and audit purposes.
- ▶ (2) A NP, CNM, or CNS who holds prescriptive authority may request, receive, and sign for professional samples, ~~except for controlled substances in [Schedule II](#), and may distribute professional samples to patients as listed in the approved [written protocol](#),~~ subject to federal and state regulations.
- ▶ (GE) Prescriptive authorization may be terminated by the board if a NP, CNM, or CNS with prescriptive authority has: (1) not maintained certification in the specialty field; (2) failed to meet the education requirements for pharmacotherapeutics; (3) ~~prescribed outside the scope of the approved [written protocols](#);~~

# SCOPE OF PRACTICE

## APRNS – HOUSE BILL 3078

- ▶ Deletes from S.C. Code Ann. § 40-47-20:
- ▶ ~~(4) 'Agreed to jointly' means the agreement by the Board of Nursing and Board of Medical Examiners on delegated medical acts that nurses perform and that are promulgated by the Board of Nursing in regulation.~~
- ▶ ~~(5) 'Approved written protocols' means specific statements developed collaboratively by the physician or the medical staff and the advanced practice registered nurse (NP, CNM, or CNS) that establish physician delegation for medical aspects of care, including the prescription of medications.~~
- ▶ ~~(14) 'Delegated medical acts to the APRN' means additional acts delegated by a physician or dentist to the Advanced Practice Registered Nurse (NP, CNM, or CNS) which may include formulating a medical diagnosis and initiating, continuing, and modifying therapies, including prescribing drug therapy, under approved written protocols as provided in Section 40-33-34 and Section 40-47-195. Delegated medical acts to the APRN (NP, CNM, or CNS) must be agreed to jointly by both the Board of Nursing and the Board of Medical Examiners. Delegated medical acts to the APRN (NP, CNM, or CNS) must be performed under the general supervision of a physician or dentist who must be readily available for consultation.~~

# SCOPE OF PRACTICE

## APRNS – HOUSE BILL 3078

- ~~▶ (43) 'Readily available' means the physician must be in near proximity and is able to be contacted either in person or by telecommunications or other electronic means to provide consultation and advice to the practitioner performing delegated medical acts. When application is made for more than the equivalent of three full-time NPs, CNMs, or CNSs to practice with one physician, or when a NP, CNM, or CNS is performing delegated medical acts in a practice site greater than forty-five miles from the physician, the Board of Nursing and the Board of Medical Examiners shall review the application to determine if adequate supervision exists.~~

# SCOPE OF PRACTICE

## APRNS – HOUSE BILL 3078

- ▶ Modifies 40-47-195 **Supervising physicians; scope of practice guidelines:** (A) A licensee who supervises another practitioner shall hold a permanent, active, unrestricted authorization to practice in this State and be currently engaged in the active practice of their respective profession or shall hold an active unrestricted academic license to practice medicine in this State.
- ▶ ~~(B) Pursuant to this chapter, only licensed physicians may *supervise* another practitioner who performs delegated medical acts in accordance with the practitioner's applicable scope of professional practice authorized by state law. It is the supervising physician's responsibility to ensure that delegated medical acts to the APRN (NP, CNM, or CNS) or other practitioners are performed under approved *written scope of practice guidelines or approved written protocol* in accordance with the applicable scope of professional practice authorized by state law. A copy of approved *written scope of practice guidelines or approved written protocol*, dated and signed by the supervising physician and the practitioner, must be provided to the board by the supervising physician within seventy-two hours of request by a representative of the department or board.~~

# SCOPE OF PRACTICE

## APRNS – HOUSE BILL 3078

- ~~▶ (C) In *evaluating a written guideline or protocol*, the board and supervising physician shall consider the:~~
  - ~~▶ (1) training and experience of the supervising physician;~~
  - ~~▶ (2) nature and complexity of the delegated medical acts being performed;~~
  - ~~▶ (3) geographic proximity of the supervising physician to the supervised practitioner; when the supervising physician is to be more than forty-five miles from the supervised practitioner, special consideration must be given to the manner in which the physician intends to monitor the practitioner, and prior board approval must be received for this practice; and~~
  - ~~▶ (4) number of other practitioners the physician supervises. Reference must be given to the number of supervised practitioners, as prescribed by law. When the supervising physician assumes responsibility for more than the number of practitioners prescribed by law, special consideration must be given to the manner in which the physician intends to monitor, and prior board approval must be received for this practice."~~



# SCOPE OF PRACTICE

## APRNS – HOUSE BILL 3078

- ▶ Modifies 44-71-20(4): "(4) 'Hospice facility' means an institution, place, or building in which a licensed hospice provides room, board, and appropriate hospice services on a twenty-four hour basis to individuals requiring hospice care pursuant to the orders of a physician or a nurse practitioner."

# SCOPE OF PRACTICE

APRNS – HOUSE BILL 3078

- ▶ Adds nurse practitioner, certified nurse midwife, or clinical nurse specialist to the professionals who can certify a handicapped placard to S.C. Code 56-3-1960

# SCOPE OF PRACTICE

## APRNS – SENATE BILL 246

- ▶ S.246:
  - ▶ Allows APRNs (NPs, CNM, CNS) to formulate a medical diagnosis and initiate, continue and modify therapies, including prescribing drug therapy without approved written protocols and without the general supervision of a licensed physician or dentist;
  - ▶ Removes the forty-five mile limitation for supervising physician;
  - ▶ While the foregoing APRNs still may not prescribe Schedule II controlled substances, the APRNs are permitted to sign for and distribute professional samples for Schedule II controlled substances.

# SCOPE OF PRACTICE

## APRNS – SENATE BILL 246

- ▶ 40-33-34(C)(1) retains the requirements for:
  - ▶ Approved written protocols; and
  - ▶ General supervision while performing delegated medical acts.
- ▶ Where does “formulating medical diagnosis, initiating, continuing and modifying therapies” without general supervision end and performing delegated medical acts under written protocols and general physician supervision begin?
- ▶ Creates ambiguity and potential liability:
  - ▶ How does the APRN define the scope of practice?
  - ▶ Potential for licensure actions/civil liability for the MD and the APRN.

# SCOPE OF PRACTICE

AND TO MAKE THINGS EVEN MORE CONFUSING . . .

- ▶ “Two significant changes are being considered by national credentialing, education accrediting and state licensing bodies tentatively set to be implemented in 2015: The implementation of a nationwide regulatory consensus model that will bring homogeneity to licensing qualification requirements and scope of practice for APRNs in all states and territories; and the establishment of the DNP (Doctor of Nursing Practice) as the educational requirement for APRN national certification and state licensure.” <http://www.graduatenuresingedu.org/2015-proposed-changes/>
- ▶ Stay tuned!

# SCOPE OF PRACTICE

## TAKE AWAYS

- ▶ Scope of Practice:
  - ▶ Potential disciplinary actions if practice outside of the applicable scope/do not comply with legal requirements;
  - ▶ Potential for civil liability if practice outside the applicable scope of practice and injury results.
  - ▶ *McMillan v. Durant*, 312 S.C. 200, 439 S.E.2d 829 (S.C.1993): a case discussing negligence in the nursing context.
    - ▶ Establishes that nurses are subject to a national standard of care;
    - ▶ Establishes that a physician may present expert testimony as to the standard of care for nursing.

# SCOPE OF PRACTICE

## TAKE AWAYS

- ▶ Liability involving APRNs:
  - ▶ APRN negligence:
    - ▶ APRNs are held to a higher standard of care due to advanced training and education;
    - ▶ APRNs held to the standard of a reasonably prudent APRN under the same or similar circumstances.
  - ▶ Potential for physician liability for negligent supervision
- ▶ Independent practice increases liability
- ▶ May affect professional liability coverage

# NURSING PEER REVIEW

- ▶ Historically, nurses have been evaluated by the nurse's immediate supervising nurse generally against the particular job description for the role the nurse has in the organization.
- ▶ Now, organizations are considering the use of “peer review” concepts to evaluate the performance of nurses.



# NURSING PEER REVIEW

- ▶ Considerations include:
  - ▶ Ongoing performance review:
    - ▶ Quality
    - ▶ Safety
    - ▶ Outcomes
  - ▶ Focused performance review:
    - ▶ Just Culture concepts
      - ▶ System/Processes/Procedures
      - ▶ Individual Practitioner/Duties (Outcome-Based/Procedure-Based/Risk-Based)

# NURSING PEER REVIEW

## CONSIDERATIONS

- ▶ Single reviewer
- ▶ Review by a panel:
  - ▶ Who is on the panel?
    - ▶ Supervisors/Managers
    - ▶ True peers (LPNs; RNs; APRNs)
    - ▶ Other healthcare disciplines
    - ▶ Outside individuals
      - ▶ Experts
      - ▶ Patients/family
        - ▶ Where and when?

# NURSING PEER REVIEW

## LEGAL CONSIDERATIONS

- ▶ What protections do we have?
- ▶ How do we obtain and maintain those protections?

# Improvements to South Carolina: Peer Review Statute

- ▶ On June 26, 2012, Governor Haley signed into law amendments to the South Carolina Peer Review Statute. Any investigations undertaken to examine an event occurring on or after June 26, 2012 will be subject to the newly amended Statute.
- ▶ So how does this affect a hospital's peer review efforts?



# Topics Addressed

- ▶ What are the 2012 amendments to the South Carolina “Peer Review” Law?
- ▶ How do the amendments in the Peer Review Law affect immunities for participating in the “Peer Review” process?
- ▶ How do the amendments in the Peer Review Law change how a hospital treats “Peer Review” information?



# Key Issues in Peer Review

- ▶ Promote quality health care by supporting effective peer review.
- ▶ The process must provide a forum that assures open, frank and critical discussion.
- ▶ Incorporate Just Culture concepts:
  - ▶ Fairness
  - ▶ Open dialogue
  - ▶ Just result
- ▶ The process must assure that such discussions remain privileged and confidential.
- ▶ The privilege is NOT absolute . . . More later

# Who is Protected?

- ▶ “There is no monetary liability on the part of and no cause of action for damages arising against . . .”



- ▶ Pre-Amendment: NARROW
- ▶ An appointed member of a committee of a medical staff of a licensed hospital, provided the medical staff operates pursuant to written bylaws that have been approved by the governing board of the hospital
- ▶ A 2009 Circuit Court Order held that because the committee was multidisciplinary (not solely physicians) & had non-hospital members, the privilege did not apply

# Who is Protected?

- ▶ Post-Amendment: MUCH BROADER
  - ▶ All hospital employees (including nurses) and medical staff
  - ▶ Directors (governing body) and Officers
  - ▶ Hospital subsidiaries and parent corporations
  - ▶ Healthcare and Hospital systems (nursing homes; hospice; home health; urgent care; etc.)
  - ▶ Physician practices owned by hospitals (& the hospital's parent and/or subsidiaries)
  - ▶ Any committee member of a licensed hospital (standing or ad hoc)
  - ▶ External reviewers
  - ▶ Witnesses



# Immunity is contingent upon . . .

- ▶ Pre-Amendment: if the committee member acts without malice, has made a reasonable effort to obtain the facts relating to the matter under consideration, and acts in the belief that the action taken by him is warranted by the facts known to him.

# Immunity is contingent upon . . .

- ▶ Post-Amendment: any act or proceeding undertaken or performed without malice, made after reasonable effort to obtain the facts, and the action taken was in the belief that it is warranted by the facts known . . .

# Malice Standard

- ▶ Malice: “common law actual malice”
  - ▶ actuated by ill will in what he or she did;
  - ▶ with design to causelessly and wantonly injure plaintiff; or
  - ▶ statements were published with such recklessness as to show conscious indifference towards plaintiff's rights
- ▶ Hainer v. American Medical Intern., Inc., 328 S.C. 128, 492 S.E.2d 103 (S.C.1997) – case involving malice in the nursing context.

# Upshot?

- ▶ Review your peer review processes to assure the appropriate standards are reflected;
- ▶ Follow your peer review provisions; and
- ▶ Document, Document, Document . . .
- ▶ Document, Document, Document . . .
- ▶ Document, Document, Document . . .
- ▶ Document, Document, Document . . .



# What is Confidential?

- ▶ Pre-Amendment: Only data and information acquired by a “committee of the medical staff”
  - ▶ Scope typically limited to review of physician’s competence or conduct - Not other clinicians
  - ▶ Courts (2009 & 2010) were requiring hospitals to produce malpractice plaintiffs information relating to sentinel event investigations/root cause analysis & incident reports because the documents were created outside of a “committee of the medical staff.”

# What is Confidential?

- ▶ Post-Amendment - All information and proceedings gathered by a committee of a hospital were already protected, but the amended statute expands confidentiality to all proceedings and information relating to:
  - ▶ Sentinel event investigations and root cause analyses (document review by TJC, DNV does not waive confidentiality);
  - ▶ Investigations into the competence or conduct of hospital employees, agents, or medical staff relating to the quality of patient care, including any related disciplinary proceedings or fair hearings;
  - ▶ Quality assurance reviews;
  - ▶ Medical staff credentialing processes;
  - ▶ Reports by a hospital to its insurance carriers;

# What is Confidential?

- ▶ Reviews or investigations to evaluate the quality of care provided by hospital employees (including nurses), agents, or members of the hospital's medical staff;
- ▶ Reports or statements (including, but not limited to) National Practitioner Data Bank and the SC Board of Medical Examiners providing analysis relating to the quality of care provided by hospital employees, agents, or members of the hospital's medical staff;
- ▶ Incident or occurrence reports and related investigations;
- ▶ Reports to DHEC (licensed hospital) not a waiver of confidentiality; and
- ▶ Reports to accrediting bodies not a waiver of confidentiality.

# What isn't Confidential?

- ▶ Data that is otherwise available from original sources
- ▶ The outcome of a practitioner's application for medical staff membership
- ▶ The outcome of a practitioner's request for clinical privileges or the list of clinical privileges requested



# Who controls the confidentiality?

- ▶ When can Peer Review Confidentiality be Waived?
- ▶ Pre-Amendment
  - ▶ Unclear who had the right to waive confidentiality
- ▶ Post-Amendment
  - ▶ When both the hospital and the affected person waive the confidentiality in writing
  - ▶ When either the hospital or the affected party are opposing parties in the civil litigation

# Importance of Maintaining Confidentiality

- ▶ To maintain the protection afforded by the new Peer Review Law YOU MUST NOT DISCLOSE THE PROTECTED INFORMATION OUTSIDE THE BOUNDARIES IDENTIFIED IN THE STATUTE.
- ▶ Like any privilege, if you disclose the privileged information to a third party, the privilege is waived and the information is discoverable; AND



# Importance of Maintaining Confidentiality

- ▶ YOU RISK LOSING PROTECTION FROM LIABILITY
- ▶ YOU RISK YOUR LOSING YOUR HOSPITAL'S LIABILITY PROTECTION
- ▶ UPSHOT: ZIP IT.



# NURSING PEER REVIEW

- ▶ Raises issues with the potential for a “panel” discussion that includes non-hospital related individuals including the patient/patient’s family.
- ▶ Can the hospital maintain liability protections with third parties being part of the process?
- ▶ Your peer review processes should be reviewed by counsel to take the best advantage of potential protections.

# Courts Allowed More Discretion

Pre-Amendment: if a party refused a discovery request under the peer review privilege and the court held a private review determining that the confidentiality did not apply, the court was required to furnish the documents to the requesting party.

Post-Amendment: if the trial court determines after a private review that the confidentiality does not apply, the court may order that the documents be provided to the requesting party

# Immediate Appeal of Court Orders to Produce Protected Information Allowed

Pre-Amendment: Under a previous South Carolina Supreme Court ruling, a court order ordering that protected information be provided to a third party could not be appealed immediately.

Post-Amendment: Now, a court order ordering that protected information be provided to a third party can be appealed immediately, and the order is suspended upon the appeal's filing.



# Provides for Non-Confidentiality of Inconsistent Witness Statements

Pre-Amendment: Silent

Post-Amendment: The court will be allowed in camera review to determine whether prior statements are inconsistent with the trial testimony offered in the case. If the testimony is determined to be inconsistent, the court shall order that the prior statement of fact be given to the moving party.

# Upshot with all of these changes?

- ▶ Hospitals Generally: Take advantage of this new protection/privilege:
  - ▶ Assure that all reviews/investigations (“acts or proceedings”) conducted (“undertaken or performed”) at the hospital are done:
    - ▶ Without malice
    - ▶ After reasonable effort to obtain the facts; and
    - ▶ Any action as a result was taken in the belief that it is warranted by the facts known arising out of and relating to a BROAD range of issues:



# Broad Range of Issues Affected:

- ▶ Sentinel event investigations and root cause analyses
- ▶ Investigations into the competence or conduct of hospital employees, agents, or medical staff relating to the quality of patient care, including any related disciplinary proceedings or fair hearings
- ▶ Quality assurance reviews
- ▶ Medical staff credentialing process
- ▶ Reports by a hospital to its insurance carriers
- ▶ Reviews or investigations to evaluate the quality of care provided by hospital employees, agents, or members of the hospital's medical staff
- ▶ Reports or statements (including, but not limited to) National Practitioner Data Bank and the SC Board of Medical Examiners providing analysis relating to the quality of care provided by hospital employees, agents, or members of the hospital's medical staff
- ▶ Incident or occurrence reports and related investigations

# Beyond the Issues Affecting Nursing:

- ▶ Administration
- ▶ Human Resources
- ▶ Quality and Safety
- ▶ Organizational Performance Improvement
- ▶ Risk Management
- ▶ Legal
- ▶ Facility Security

# Review/Revise processes/ policies/procedures

- ▶ Sentinel event policies/procedures
- ▶ Investigations of Employee related quality of care issues
- ▶ IOP/Quality of Care/Safety reviews
- ▶ Risk management reviews/reports to insurance companies
- ▶ Processes that result in/arise from incident reports (HUGE!!)
- ▶ LLR reports: Language in the statute mentions only the BoME specifically, so there is a question.

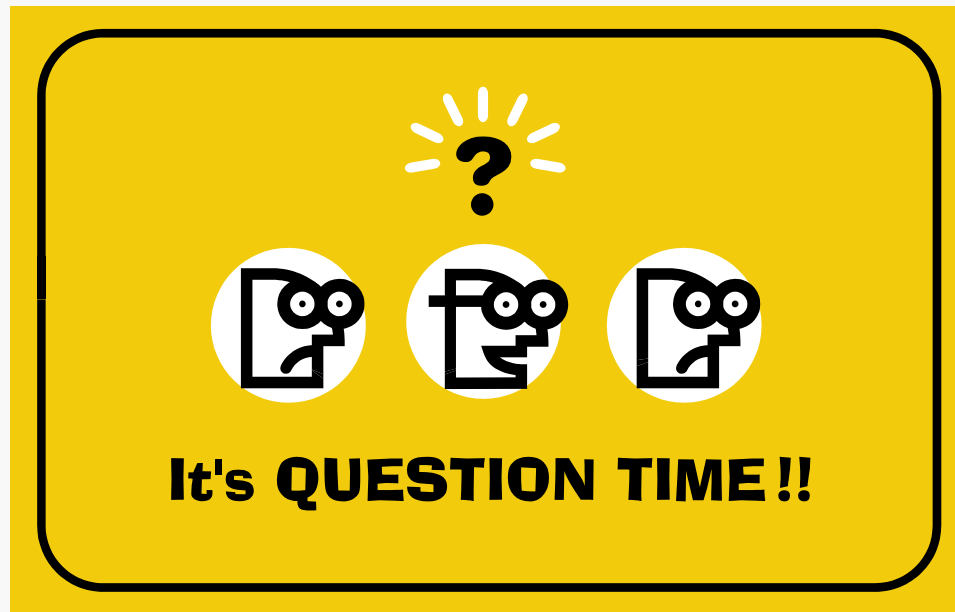


# Changes Affecting Nursing

- ▶ Review policies/procedures related to the evaluation and peer review processes
- ▶ Review Policies & Procedures on Professional Practice Evaluations:
  - ▶ Focused Professional Practice Evaluations
  - ▶ Ongoing Professional Practice Evaluations

# Changes Affecting Nursing

- ▶ Reports to the National Practitioner Data Bank are protected
- ▶ Arguments can be made that all legally required reports to the State Boards are protected, and not just BoME reports
- ▶ ALL investigations are protected



NEXT CHALLENGE. NEXT LEVEL.  
NEXSEN | PRUET

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