The Board of Registered Nursing (BRN) is a consumer protection agency within the state Department of Consumer Affairs (DCA). Pursuant to the Nursing Practice Act, Business and Professions Code section 2700 et seq., BRN licenses registered nurses (RNs) and certifies nurse-midwives (CNMs), nurse practitioners (NPs), nurse anesthetists (NAs), public health nurses (PHNs), and clinical nurse specialists (CNSs). BRN also establishes accreditation requirements for California nursing schools and reviews nursing school criteria; receives and investigates complaints against its licensees; and takes disciplinary action as appropriate. BRN’s regulations implementing the Nursing Practice Act are codified in Division 14, Title 16 of the California Code of Regulations (CCR). BRN licenses approximately 265,000 RNs and certifies 13,000 advanced practice nurses.

By law, the nine-member Board consists of three public members, three RNs actively engaged in patient care, one licensed RN administrator of a nursing service, one nurse educator, and one licensed physician. All serve four-year terms. BRN, which is currently staffed by 95 people, is financed by licensing fees and receives no allocation from the general fund. BRN’s budget for fiscal year 2001–02 totals $14,034,000.

At this writing, the Board consists of only seven members (five is the minimum to establish a quorum); Governor Gray Davis has not yet appointed members to fill the slots of two practicing RNs whose terms ended on June 1, 1999 and whose statutory “grace years” ended on June 1, 2000. Public member Seth Liebman’s regular term expired on June 1, 2000. He continues to serve until the expiration of his grace year, which ends on May 31, 2001; the Assembly Speaker is responsible for appointing his replacement. LaFrancine Tate is BRN’s newest member. She was appointed in 1999 as a public member by Senate President pro Tempore John Burton to fill an unexpired term, then reappointed in June 2000 for a full term. Tate is the special assistant to the executive administrator of San Francisco General Hospital.

Based on an assessment of enrollment, retirement, and immigration rates of nurses into California, the state will experience a shortage of over 25,000 nurses by 2006—a shortfall that will directly affect the health care needs of Californians in the very near future.

In June 2000, the Scott Commission released its final report and recommendations. Preliminarily, the Commission highlighted several facts that illustrate the severity of the nursing shortage in California:

• Based on an assessment of enrollment, retirement, and immigration rates of nurses into California, the state will experience a shortage of over 25,000 nurses by 2006—a shortfall that will directly affect the health care needs of Californians in the very near future.

• In 1997, 8.5% of RN slots among all California employment sectors were vacant. Among acute care hospital employers, the mean vacancy rate for RNs was 10.6%.

• A national sample of RNs conducted in 1996 indicated that California had 566 working RNs per 100,000 population. This proportion is the lowest in the nation, and is 232 working RNs per 100,000 population below the national average.

• California’s nursing workforce is aging. A 1997 BRN survey indicated that the mean age of working RNs was 44.6 years of age, with 30% of the workforce over the age of 50 and only 10% of nurses under the age of 30.

• California relies heavily on migration of personnel in specialized fields such as nursing. Currently, 50% of California’s RNs were educated in another state or country. However, enrollments in schools of nursing are decreasing nationally, and...
The Commission made seven key findings:

1. The changing demographics and growth of the state's population indicate a need for an increased number and changed mix of RNs and specialty nurses. The report noted that California's population is expected to increase by 52% between 2000 and 2025, with half the increase to come from foreign migration. The Commission concluded that "the capacity of California's public and private educational system is unable to produce an adequate supply of nurses. There is also evidence surfacing of declining enrollments in nursing programs and a lack of a coordinated recruitment strategy to encourage students to apply for admission to nursing programs."

2. The nursing workforce is disproportionately balanced with respect to age and other demographic factors. The fact that more than 30% of California's nursing workforce is over 50 and only 10% is under 30 "predisposes the state to an impending departure of its largest and most skilled workforce segment, including a large segment of nursing educators. Shortly, this will result in the departure of a significant number of nurses trained in certain specialties and deplete the supply of faculty preparing future RNs, leaving a smaller population of providers to care for a burgeoning population of patients as the babyboomer generation reaches Medicare eligibility in 2011."

3. The acuity of patients in hospitals and the community has resulted in an increased demand for highly skilled RNs and additional RNs prepared at the baccalaureate and master's degree levels. According to the Scott Commission, managed care penetration and the growth of outpatient/ambulatory care facilities have moved many less acute patients out of the hospital. Thus, the intensity of inpatient care provided in hospitals has increased (often requiring RNs with more educational preparation to manage the care of patients needing complex health care), while the demand for RNs with administrative and other skills in the outpatient setting is also growing.

4. State-supported nursing programs require additional resources to increase the education of RNs (like other high-cost programs). The CCC, CSU, and UC systems will need strategic programs funding to meet the state's workforce needs.

5. Clinical placement opportunities need to be developed before nurse training programs can be expanded significantly. Clinical experience, or on-the-job experience, is required for graduation and for licensure, and many schools of nursing have difficulty in placing their students in health care agencies. The health care industry must work with higher education to expand clinical placement opportunities before clinical programs can be expanded significantly.

6. As with other programs where graduate and professional training is required, increased financial aid is needed to increase nursing enrollments.

7. California requires a system to address efficient statewide workforce planning and production of RNs and other workforce professions. "The state lacks efficient means through educational financing policies and recruitment strategies to attract and retain an adequate nursing workforce....significant resources will be necessary to address both nursing and other health workforce needs." Because this issue impacts public health and involves a potential commitment of state funds, the Commission suggested that the Governor may wish to convene a task force.

The Scott Commission also made six recommendations:

1. The state should develop a comprehensive long-term strategic plan to recruit, prepare, and retain nurses in our health care system, including but not limited to providing necessary funding for nursing programs in the CCC, CSU, and UC systems.

2. Higher education should, upon receipt of necessary resources, enhance enrollment opportunities and progress to degree for students interested in pursuing nursing careers.

3. The state should fully fund the Cal Grant program to provide the number of grants equal to 25% of the high school graduating class, and should consider creating a new grant program for California's graduate and professional students.

4. The health care industry and higher education should find ways to expand delivery of prelicensure RN nursing education and specialty education.

5. The state should support initiatives to enhance student academic preparation and recruitment efforts by all segments of higher education.

6. The state should support the continued work of the CSPCN and the California Postsecondary Education Commission, working with the health care industry and education segments, to promote efficient statewide workforce planning and production of RNs.
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Several of these recommendations have been incorporated into pending legislation (see 2001 LEGISLATION).

**Minimum Nurse-to-Patient Ratios**

According to many nurses, the willingness of RNs to work in hospitals is negatively impacted—thus aggravating the RN vacancy rate in these facilities—by working conditions that include low pay, long shifts, mandatory overtime, and excessive nurse-to-patient ratios that they believe threaten patient safety. In 1999, the California Nurses Association (CNA) sponsored AB 394 (Kuehl) (Chapter 945, Statutes of 1999), which (as amended by AB 1760 (Kuehl)—see 2000 LEGISLATION) requires the Department of Health Services (DHS) to adopt regulations establishing "minimum, specific, and numerical licensed nurse-to-patient ratios by licensed nurse classification and by hospital unit" for all licensed hospitals by January 1, 2002. The statute (Health and Safety Code section 1276.4) further specifies that the ratios "shall constitute the minimum number of registered and licensed nurses that shall be allocated. Additional staff shall be assigned in accordance with a documented patient classification system for determining nursing care requirements, including the severity of the illness, the need for specialized equipment and technology, the complexity of clinical judgment needed to design, implement, and evaluate the patient care plan and the ability for self-care, and the licensure of the personnel required for care." According to CNA, AB 394 is the first statute in the nation to mandate the number of nurses to patients in hospitals.

At this writing, however, it appears unlikely that DHS will meet its statutory deadline—even as extended to January 1, 2002 under AB 1760 (Kuehl). DHS has yet to even publish its proposed nurse-to-patient ratio regulations, and informal testimony submitted by interested parties suggests that the sides are far apart and that the rulemaking process will be controversial. Hospitals and HMOs concerned about the cost of adding nursing personnel have suggested, for example, one nurse for every six emergency room patients, whereas CNA has recommended a 1:3 ratio in emergency rooms. Overall, the California Healthcare Association, which represents hospitals, has suggested that a 1:4 ratio is needed in only four types of hospital units, with ratios ranging from 1:6 to 1:12 in other areas; CNA suggests a 1:4 ratio in 11 of 18 medical units. Because California is the first state to require development of such ratios, it has no model to follow; thus, DHS has reportedly contracted with researchers at UC Davis to create benchmark ratios based on current practices at a sample of hospitals statewide.

**NCLEX-RN Task Force Releases Report**

In February 1999, BRN established the NCLEX-RN Task Force because of rising concern about California's declining pass rate on this national nursing licensure test—another factor which has aggravated California's nursing shortage. In particular, BRN wanted to take a closer look at the increasing number of California prelicensure nursing programs with a pass rate of 70% or less for first-time test takers. BRN asked the task force to (1) identify factors that increase and decrease the NCLEX-RN pass rates for first-time takers; (2) describe factors that appear to improve the potential for graduates of nursing programs to pass the NCLEX-RN exam on the first attempt; (3) provide recommendations to BRN and California prelicensure programs to improve the NCLEX-RN pass rate; and (4) identify research questions for the Research Committee of the exam’s owner, the National Council of State Boards of Nursing (NCSBN) to consider. [17:1 CRLR 51; 16:2 CRLR 42]

In October 2000, the task force published its findings in a report entitled “The Problem and the Plan,” which was accepted by BRN at its December 2000 meeting. According to the report, the characteristics that are most significant in affecting students’ ability to pass the exam on the first attempt include: (1) English spoken as a second language, (2) employment for 20 or more hours per week, (3) the presence of pressing family responsibilities, and (4) academic policies that permit students to withdraw from prerequisite science courses when they are failing and then retake those courses multiple times. In addition, the task force identified other factors that have affected the pass rate: (5) a delay of five months or more after graduation in taking the exam; (6) limited knowledge by nursing faculty of the NCLEX-RN test plan; and (7) regulatory changes that have precluded community colleges from using supplemental selection criteria in making admissions decisions in nursing programs—which may have resulted in the admission of poorly-prepared candidates.

The task force made recommendations targeted at each group involved in this issue—nursing students and NCLEX-RN candidates, nursing faculty, nursing program administrators, BRN, and NCSBN. As to BRN, the task force suggested that the Board (1) seek funding for a research project “to develop techniques for identifying high-risk-for-failure nursing students so effective remediation strategies can be offered by the college or university”; (2) develop a database of variables relating to candidate performance, such as the type of educational program attended, GPA, and various demographic characteristics; (3) continue monitoring nursing programs with low pass rates and provide feedback and consultation as appropriate; and (4) research the reading comprehension level of California prelicensure students and its impact on passing the NCLEX-RN test on the first attempt.

In the meantime, California’s NCLEX pass rates still lag behind the national average and are declining even further. BRN created its task force because of statistics indicating that the
pass rate for California first-time examinees dropped by 3.74% between October 1, 1996 and September 30, 1998 (from 87.7% to 83.96%), while the national decline was less precipitous during the same period (from 87.7% to 85.3%). Between April 1, 1999 and March 31, 2000, California’s first-time pass rate dropped to 82.77%, while the national pass rate was 84.77%. Similarly, during calendar year 2000, California’s first-time pass rate declined further to 82.08%, while the national pass rate was 83.84% during the same time period.

“Advisory Statements”

Over the past several years, the Board has approved a series of “advisory statements” and “policy statements” regarding various aspects of its regulatory jurisdiction. All such statements are posted on the Board’s Web site and published in its licensee newsletter, The BRN Report. To the extent that these statements summarize and restate existing law, they are appropriate. To the extent they go further and represent the Board’s interpretation of the law or BRN’s regulations, however, they are required to be formally adopted as regulations under the rulemaking process of the Administrative Procedure Act in order to be enforceable. The following “advisory statements” and “policy statements” were approved by BRN in recent months:

◆ Nurse-Midwifery. At its February 2, 2001 meeting, the Board approved two advisory statements concerning nurse-midwifery. The first defines the certified nurse-midwife as “an individual educated in the disciplines of registered nursing and nurse-midwifery who possesses evidence of certification issued by the California Board of Registered Nursing.” Nurse-midwifery practice is “the independent, comprehensive management of women’s health care in a variety of settings focusing particularly on pregnancy, childbirth, the postpartum period, care of the infant, and the family planning and gynecological needs of women throughout the life cycle.” A second advisory statement entitled “An Explanation of Standardized Procedure Requirements for Certified Nurse-Midwife Practice” describes the legal requirements for CNMs to perform functions which are considered the practice of medicine, through the mechanism of standardized procedures. Such standardized procedures must be devised collaboratively by nursing, medicine, and administration in the organized health care system where they will be utilized. The advisory statement lists the medical functions for which standardized procedures must be formulated (medical diagnosis, severing and penetrating tissue, and furnishing drugs and devices) and sets forth guidelines for developing standardized procedures.

◆ Chlamydia Treatment by NPs and CNMs. Also at its February 2001 meeting, BRN approved an advisory statement entitled “Nurse Practitioners and Certified Nurse-Midwives Treating the Patient and Now Their Partners for Chlamydia.” Effective January 1, 2001, SB 648 (Ortiz) (Chapter 835, Statutes of 2000) adds chlamydia to the list of “venereal diseases” in section 120500 of the Health and Safety Code, and permits NPs acting pursuant to Business and Professions Code section 2836.1 and CNMs acting pursuant to Business and Professions Code section 2746.51 to furnish, dispense, or provide prescription antibiotics to the sexual partner(s) of patients diagnosed with chlamydia without direct examination of those partners (see 2000 LEGISLATION). The purpose of this advisory statement is to make NPs and CNMs aware of this change in the law.

◆ Supervision of LVNs in Dialysis Settings. At its September 8, 2000 meeting, BRN considered a proposed “policy statement” setting forth its interpretation of the law governing the RN’s ability to delegate certain functions in the dialysis setting—including accessing central lines and administration of intravenous medication—to licensed vocational nurses (LVNs).

According to Board staff, the agency that regulates LVNs—the Board of Vocational Nursing and Psychiatric Technicians (BVNPT)—has historically stated that LVNs are not legally authorized to access central intravenous catheters and may not administer intravenous medication. However, in June 1999, BVNPT issued a “position statement” of its own finding that LVNs who are certified by BVNPT in intravenous therapy and blood withdrawal are permitted to infuse intravenous medications that are integral to hemodialysis, pheresis, or blood bank procedures under certain conditions (including the presence of a physician or RN “in the immediate vicinity”).

At its September 2000 meeting, BRN entertained considerable public comment in support of the performance of these procedures by LVNs, primarily due to the shortage of RNs available to perform them. However, the proposed advisory statement considered by BRN in September opined that the RN is not authorized under the Nursing Practice Act to delegate or supervise the administration of intravenous medication or therapeutic agents through peripheral, central venous, or any other venous access lines by LVNs. According to the proposed statement, the RN functions of assessment to determine abnormality, determination of appropriate treatment, and implementation of a treatment for the abnormality (such as administration of an intravenous medication for a dialysis patient) may not be delegated or assigned by an RN to an LVN. However, the Board deferred action in September 2000 in order to consider modifications.

At its February 2001 meeting, BRN approved a revised “policy statement” opining that the Nursing Practice Act does not authorize RNs to delegate or supervise an LVN administering intravenous medication. However, the statement clarifies that “BRN continues to interpret that RNs can delegate and supervise Intravenous Therapy certified LVNs in accord with Business and Professions Code section 2860.5 and California Code of Regulations, Article 8, section 2542, which gives certified LVNs the authority to superimpose intravenous solutions of electrolytes, nutrients, vitamins, blood, and blood products.”
◆ **Acceptance and Implementation of Orders.** At its September 8, 2000 meeting, BRN approved revisions to its advisory statement entitled “Acceptance and Implementation of Orders.” The statement generally explains that RNs may legally accept and implement medical orders given by a physician, dentist, podiatrist, or clinical psychologist within the lawful scope of their license. In 1997, BRN revised its advisory statement to permit RNs to additionally accept certain medical orders from clinical pharmacists in licensed health care facilities and other specified settings, in accordance with 1995 changes to the pharmacy law; these orders are considered to be orders transmitted from a physician to a nurse through a clinical pharmacist (as an agent of the physician). As of January 1, 2000, AB 261 (Lempert) (Chapter 375, Statutes of 1999) amended Business and Professions Code section 4052 to expand the type of settings in which clinical pharmacists may lawfully function [17:1 CRLR 64]; thus, BRN expanded its advisory statement to permit RNs to accept and implement transmitted medical orders from clinical pharmacists in these settings.

◆ **Delegation of Nursing Tasks to Unlicensed Assistive Personnel.** BRN’s 1994 advisory statement on unlicensed assistive personnel (UAP) provides guidance to RNs in deciding whether to assign nursing tasks to UAP. Section 2725.3 of the Business and Professions Code—added by AB 394 (Kuehl) (Chapter 945, Statutes of 1999)—prohibits a hospital from assigning UAP to perform nursing functions in place of RNs and prevents UAP from performing those procedures even under the direct clinical supervision of an RN when such procedures require a substantial amount of scientific knowledge and technical skills. [17:1 CRLR 51–52] At its February 4, 2000 meeting, BRN revised its UAP advisory statement to reflect the provisions of AB 394.

◆ **RN Supervision of Medical Assistants.** At its February 4, 2000 meeting, BRN approved revisions to its advisory statement entitled “RN Supervision of Medical Assistants.” The statement was updated to reflect Medical Board of California policy regarding medical assistants (MAs)—unlicensed persons who may perform certain administrative, clerical, and technical support services to physicians and podiatrists in certain settings pursuant to Business and Professions Code sections 2069-71 and sections 1366–1366.4, Title 16 of the CCR. In its advisory statement, BRN reaffirmed its position that RNs are permitted to train MAs and to supervise them in the performance of technical support services as directed by a physician or podiatrist.

◆ **NPs’ Authority to Dispense and Order Drugs.** At its February 4, 2000 meeting, BRN approved a new advisory statement regarding NP practice entitled “NPs’ New Authority to Provide Medications.” The statement explains the provisions of AB 1545 (Correa) (Chapter 914, Statutes of 1999) and SB 816 (Escutia) (Chapter 741, Statutes of 1999), both of which were signed into law by Governor Davis in October 1999. [17:1 CRLR 52] Collectively, these statutes enhance the scope of practice of NPs by permitting NPs functioning pursuant to a standardized procedure or protocol to order drugs (including controlled substances); dispense drugs (including controlled substances) to a patient in primary, community, or free clinics; and sign for delivery or receipt of drug samples provided by pharmaceutical companies. When an NP writes a prescription for a patient, the NP’s name (as well as the physician’s name) must appear on the medication label on the container. Further, NPs who order controlled substances must obtain a registration number from the U.S. Drug Enforcement Administration (DEA).

Also pursuant to SB 816 (Escutia), BRN revised its 1997 advisory statement entitled “Criteria for Furnishing Number Utilization by NPs.” Prior to January 2000, Business and Professions Code section 2836.1 authorized NPs to obtain and use a furnishing number from BRN in order to “furnish” drugs and devices (including controlled substances) to patients. However, the DEA determined that California’s pre-2000 law did not afford NPs “prescriptive” authority, which is required in order to obtain a DEA registration number. SB 816 (Escutia) amended the earlier law to clarify that an NP’s “drug order” (when issued pursuant to a standardized procedure or protocol) must be treated in the same manner as a prescription written by the supervising physician, and to require an NP who has a furnishing number from BRN to also obtain a DEA registration number to “order” controlled substances. The advisory statement was revised to become consistent with the statutory change.

◆ **Pain Assessment.** AB 791 (Thomson, Migden) (Chapter 403, Statutes of 1999) added section 1254.7 to the Health and Safety Code. Section 1254.7 requires licensed health facilities to include pain as an item to be assessed at the same times as vital signs are taken, and to ensure that pain assessment is performed in a manner appropriate to the patient and noted in the patient’s chart in a manner consistent with other vital signs. [17:1 CRLR 41–42] At its February 4, 2000 meeting, BRN adopted an advisory statement entitled “Pain Assessment: The Fifth Vital Sign” in response to this new legislation. The statement addresses the legislative mandate for health facilities to assess pain regularly as a part of routine vital signs assessment. It also sets forth BRN’s interpretation of the pain management standard of practice.

◆ **Complementary and Alternative Therapies.** At its February 4, 2000 meeting, BRN approved an advisory statement entitled “Complementary and Alternative Therapies in Registered Nursing Practice.” This statement expresses the Board’s opinion that complementary and alternative therapies fall within the scope of nursing practice, thus requiring the RN to be knowledgeable and competent in these areas so as to be able to provide information to patients about complementary and alternative procedures. Nevertheless, the statement cautions that the more complex complementary and alternative therapies should be practiced only after additional education and may require separate licensure or certification.
Criteria for “Substantial Relationship”

On June 30, 2000, BRN published notice of its intent to amend section 1444, Title 16 of the CCR, which identifies those crimes or acts that are considered to be “substantially related to the qualifications, functions, or duties” of RNs for purposes of license denial or discipline. The regulatory proposal would update and expand the list of crimes and acts that are “substantially related” and may lead to license denial or discipline. Under the proposed amendment, the following acts are considered “substantially related”: (1) assaultive or abusive conduct including but not limited to those violations listed in Penal Code section 11160(d); (2) failure to comply with any mandatory reporting requirements; (3) theft, dishonesty, fraud, or deceit; and (4) any conviction or act subject to an order of sex offender registration pursuant to Penal Code section 290. Following an August 14, 2000 public hearing, the Board adopted the proposed language and forwarded it to the Office of Administrative Law (OAL), where it is pending at this writing.

Reinstatement of Expired Licenses

Under existing section 1419.3(b), Title 16 of the CCR, an RN whose license has been expired for eight or more years must pass an examination to determine current clinical knowledge and fitness to resume the practice of nursing in this state. However, licensure applicants who have valid RN licenses from other states (and who do not possess California licenses) are eligible for California licensure by “endorsement,” meaning they must demonstrate compliance with certain educational requirements but do not have to take the exam.

On March 9, 2001, BRN published notice of its intent to amend section 1419.3(b) to offer eight-year renewal applicants with expired licenses the option of licensure by endorsement. The proposed regulatory amendments would require eight-year renewal applicants who have an active RN license in another state or U.S. territory to meet requirements comparable to those applicants for licensure by endorsement (without taking the exam). After an April 24, 2001 public hearing, BRN slightly modified the language of section 1419.3(b) to clarify that a licensee may renew a license that has been expired for more than eight years by paying the renewal and penalty fees specified in section 1417 and providing evidence that he/she holds a current, valid, active, and clear RN license in another state, a United States territory, or Canada, or by passing the Board’s current examination for licensure. At this writing, the supplemental comment period on the modified version of section 1419.3(b) ends on May 29, 2001.

Update on Other Board Rulemaking Proceedings

The following is an update on BRN rulemaking proceedings described in more detail in Volume 17, No. 1 (Winter 2000) of the California Regulatory Law Reporter.

Disciplinary Guidelines. On June 14, 2000, OAL approved BRN’s amendment to section 1444.5, Title 16 of the CCR, which previously required the Board—in reaching a disciplinary decision—to rely on the June 1997 version of its disciplinary guidelines. The amendment substitutes BRN’s September 1999 version of the guidelines in place of the June 1997 version. [17:1 CRLR 50]

Criteria for Evaluation of Equivalent Military Training and Experience. On March 9, 2000, OAL approved BRN’s amendment to section 1418, Title 16 of the CCR, which sets forth the criteria BRN uses to evaluate whether experience and education gained during armed services duty by an applicant for RN licensure is equivalent to that required by California law. Under the previous version of the regulation, military applicants for RN licensure in California who completed a course of instruction that was required to achieve certain ratings were deemed to have completed coursework equivalent to the Board’s requirements for licensure. However, BRN determined that the coursework required to achieve those ratings is not equivalent to the educational requirements for California licensure. Further, military applicants for RN licensure in California score significantly lower on the licensing examination than applicants who have completed a nursing program in California. Thus, the Board amended section 1418 so that a military applicant must meet the qualifications set forth in Business and Professions Code section 2736.5 and complete a course of instruction that provides the knowledge and skills necessary to function in accordance with the minimum standards for competency set forth in section 1443.5, Title 16 of the CCR, and that contains the theoretical content and clinical experience specified in section 1426, subsections (c)(1) through (e)(7) in order to be deemed to have completed the course of instruction prescribed by the Board for licensure. [17:1 CRLR 50–51]

Qualifications for Nurse-Midwifery Certification. On January 25, 2000, OAL approved BRN’s amendments to section 1460, Title 16 of the CCR, which establishes the requirements for RNs seeking to be certified in nurse-midwifery. An applicant for certification to practice midwifery must be a licensed RN and a graduate of a Board-approved educational program in nurse-midwifery. In the alternative, an RN applicant who has not graduated from a BRN-approved educational program may still be eligible for certification through an “equivalency” pathway as set forth in section 1460. The amendments deleted two of the previous four equivalency pathways because the Board believes that they are outdated or do not meet the Board’s minimum educational standards. [17:1 CRLR 51]

Online License Renewal System

On January 7, 2001, BRN became one of the first state agencies to offer an online license renewal system. At the Board’s April 27, 2001 meeting, Executive Officer Ruth Ann Terry announced that, as of April 20, 765 RNs had used the new online system to renew their licenses.

The next phase of online services will include address changes, renewals for all RNs and advance practice nurses, and requests for duplicate licenses. In the future, the Board
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will also consider whether to allow online filing of applications to repeat the examination for initial RN licensure.

2000 LEGISLATION

AB 1760 (Kuehl). AB 394 (Kuehl) (Chapter 945, Statutes of 1999) required DHS to adopt regulations establishing minimum nurse-to-patient ratios for use in general acute care hospitals, acute psychiatric hospitals, and special hospitals by January 1, 2001 (see MAJOR PROJECTS). Governor Davis signed AB 394 on the condition that then-Assemblymember Kuehl carry legislation in 2000 extending DHS’ deadline by one year. [17:1 CRLR 51-52] As introduced January 18, 2000, AB 1760 is an urgency bill that extends DHS’ deadline to adopt the ratios to January 1, 2002. Governor Davis signed AB 1760 on July 21, 2000 (Chapter 148, Statutes of 2000).

SB 468 (Ortiz), as amended August 29, 2000, includes chlamydia within the definition of “venereal disease” in Health and Safety Code section 120500, and permits physicians who diagnose chlamydia in an individual patient to prescribe, dispense, furnish, or otherwise provide prescription antibiotic drugs to that patient’s sexual partner(s) without examination of that patient’s partner(s). The bill also authorizes certain other qualified health professionals (including NPs and CNMs) to dispense, furnish, or otherwise provide prescription antibiotic drugs to the partner(s) of a patient with a diagnosed sexually transmitted chlamydia infection without examination of the patient’s sexual partner(s). Governor Davis signed this bill on September 28, 2000 (Chapter 835, Statutes of 2000).

AB 2888 (Committee on Consumer Protection, Governmental Efficiency and Economic Development), as amended August 22, 2000, makes various changes in the laws governing professions and vocations regulated by DCA agencies. As to BRN, the bill amends Business and Professions Code section 2733 to authorize the Board to issue a temporary clinical nurse specialist certificate for a six-month period to an RN who meets the criteria specified in section 2732.1, and amends section 2761(j) to authorize the Board to take disciplinary action against any person who holds himself/herself out as a CNS unless that person is so certified by BRN. The Governor signed AB 2888 on September 18, 2000 (Chapter 385, Statutes of 2000).

AB 2516 (Thomson). Under existing law, the Health Professions Education Foundation (administered by the Office of Statewide Health Planning and Development) is authorized to solicit and receive private sector funds and make recommendations concerning the disbursement of those funds in the form of loans or scholarships to students from underrepresented groups participating in the Registered Nurse Education Program. Participants in this program agree in writing prior to graduation to serve in an eligible county health facility or a health manpower shortage area, as designated by the OSHPD Director. As amended June 14, 2000, this bill extends participation in the program to students who agree in writing prior to graduation to serve in an “eligible state-operated health facility,” defined to mean a state-operated health facility that has been determined by OSHPD to have a nursing vacancy rate greater than noncounty health facilities located in the same health facility planning area. AB 2516 was signed by Governor Davis on September 7, 2000 (Chapter 360, Statutes of 2000).

SB 1549 (Pooshigian), as amended June 14, 2000, requires the State Department of Education to develop and recommend for adoption to the State Board of Education, on or before June 15, 2001, regulations regarding the administration of medication to students in public schools. These regulations are to be developed in consultation with parents, representatives of the medical and nursing professions, and other individuals jointly designated by the Superintendent of Public Instruction, the Advisory Commission on Special Education, and the Department of Health Services. The bill permits BRN to designate a liaison to consult with the Board of Education in the adoption of these regulations. SB 1549 was signed by Governor Davis on August 31, 2000 (Chapter 281, Statutes of 2000).

AB 675 (Thomson), as amended in September 1999, would have required DHS to make unannounced visits to acute care hospitals; required the Department to obtain and make available to the public any documents relating to a hospital’s certification for participation in the Medicare or Medicaid programs, unless the disclosure of such documents is expressly prohibited by federal law or state law; and required DHS to obtain and make available to the public documents demonstrating compliance with regulations regarding adequate staffing of health facilities. Governor Davis vetoed AB 675 on September 12, 2000. In his veto message, the Governor stated: “This provision places the Department in conflict with federal guidelines which state that DHS has no authority or jurisdiction to provide these documents to the public. Additionally, AB 675 contains no appropriation for the increased staffing and associated costs to the Department to conduct additional unannounced surveys of hospitals.”

The following bills died in committee or otherwise failed in 2000: SB 146 (Solis), which would have prohibited compulsory overtime for RNs after the conclusion of the RN’s applicable daily work schedule and after 40 hours in a workweek, except during a declared state of emergency; AB 389 (Jackson), which would have required the Chancellor of the California Community Colleges to award grants to community college districts for the purpose of developing curricula and pilot programs that provide training to licensed nurses in the specialty areas of critical care, emergency, obstetrics, pediatrics, neonatal intensive care, and operating room nursing; and AB 932 (Keeley), which would have required a residential care facility for the elderly (RCFE) that has at least three residents with specified medical conditions to contract with a full-time or part-time licensed nurse to perform certain training and consultation functions, and would have re-
programs that provide training to licensed nurses, including pose. The bill would also require that the funds appropriated million from the general fund to the Chancellor for this pur-
and development of new qualified RNs, and appropriate $5
would require the CCC Chancellor to facilitate the education
state grant funds.

Specifically, the Act would create the Registered Nurs-
ing Enhancement Grant Program, to be administered by OSHPD, which would make grants to RN programs in Cali-
foria to increase the number of registered nursing students; and establish the Registered Nursing Enhancement Program Policy Commission (RNEPPC) to make recommendations to OSHPD on Grant Program expenditures and to ensure that those expenditures are for the sole purpose of developing new nursing programs and recruitment and retention of RN students and faculty. RNEPPC would establish grant funding criteria, identify underserved areas in which to encourage RN Grant Program loan recipients to serve, and provide an annual report to the OSHPD director.

This bill would also create the Registered Nursing Loan Forgiveness Program (RNLFIP), which would provide loans to nursing students and graduates of RN programs who agree to practice in an underserved area in California for five years. This bill would appropriate $122.3 million from the general fund to OSHPD to administer the Grant Program and the RNLFIP. [S. Appr]

◆ AB 87 (Jackson), as introduced January 8, 2001, would require the Chancellor of the California Community Colleges to award grants to community college districts (during years in which funding is provided in the budget bill or in another measure) for the purpose of developing curricula and pilot programs that provide training to licensed nurses, including training in the nursing specialty areas of critical care, emergency, obstetrics, pediatrics, neonatal intensive care, and operating room nursing. The grants would be awarded upon application to districts that have made certain findings and have identified hospital partners that will provide a match for the state grant funds. [A. Appr]

◆ SB 664 (Poochigian), as amended April 17, 2001, would require the CCC Chancellor to facilitate the education and development of new qualified RNs, and appropriate $5 million from the general fund to the Chancellor for this purpose. The bill would also require that the funds appropriated for purposes of the bill be expended only for the use of hospit-al and clinical facilities, laboratory equipment, and supplies necessary to improve nursing skills. [S. Ed]

◆ SB 457 (Scott), as introduced February 22, 2001, would require the CCC and CSU chancellors to standardize all nurs-
ing program prerequisites on a statewide basis between the two systems, enter into transfer agreements between all of the CSU campuses and all community colleges statewide, and create and implement a statewide nursing program vacancy information system. [S. Ed]

SB 349 (Committee on Business and Professions). Existing law requires BRN to provide for an analysis of the practice of entry level registered nursing at least every eight years; the analysis must be used in the determination of subjects required to be completed at nursing school for licensure as a registered nurse. As amended March 26, 2001, SB 349 would require the analysis to be of all registered nurses and to be completed every three years. The bill would require that the results of the analysis also be utilized in determining required subjects for validation of the licensing examination and for assessment of the current practice of nursing. [S. Appr]

SB 1027 (Romero), as amended April 18, 2001, is a re-
introduction of SB 146 (Solis) (see above) that would prohibit compulsory overtime for public and private industry RNs or health care industry employees after the conclusion of an employee’s applicable daily work schedule and after 40 hours in a workweek, except during a declared state of emergency (provided that the employer has made reasonable efforts to fill staffing needs through alternative means). This bill would also prohibit an employer from coercing an RN or health care employee to work overtime, and from retaliating or discrimi-nating against such an employee for refusing to work over-
time. An employer violating the provisions of this bill would be subject initially to a $50 civil penalty for each hour or fraction thereof that the RN or health care employee is re-
quired to work overtime. Subsequent violations would sub-
ject the employer to a civil penalty of $100 for each hour or fraction thereof. This bill would not apply to nurse-midwives, nurse anesthetists, or nurse practitioners. [S. Appr]

AB 269 (Correa), as amended April 5, 2001, would cre-
ate the Division of Enforcement Oversight within DCA. Un-
der the direction of the DCA Director, the Division would monitor and evaluate the consumer complaint and discipline system of each DCA board (including BRN). Further, the bill would require the executive officer of each DCA board to be appointed by a three-member panel comprised of a representa-tive of the board, the DCA Director, and the Governor’s appointments secretary. [A. B&P]

AB 68 (Migden), as amended March 29, 2001, would require DHS to license private duty nursing agencies that pro-
vide, or arrange for the provision of, private duty nursing services to persons in their permanent or temporary place of resi-
dence or other community-based settings. The bill would also prohibit an entity from providing such services without first obtaining a private duty nursing or home health agency li-
cense. [S. H&HS]
HEALTH CARE REGULATORY AGENCIES

AB 1643 (Negrete McLeod), as amended April 24, 2001, would prohibit an employment agency that procures temporary employment for long-term health care employers (including a nurses’ registry) from referring licensed nursing staff or certified direct care staff for employment without first conducting a personal interview of the individual, verifying the experience, training, and references of the individual, and verifying that the individual is in good standing with the appropriate licensing or certification board, including verification that the person has successfully secured a criminal record clearance. [A. Health]

AB 1075 (Shelley), as amended April 18, 2001, would require every skilled nursing facility to meet specified minimum staff-to-patient ratios with regard to “direct caregivers” (including RNs) commencing January 1, 2002. The bill would require each facility to post the mandated staffing ratio requirements, and make a violation of these provisions subject to citation and fine. The bill would require DHS, no later than January 1, 2006 and every five years thereafter, to consult with designated entities to determine the sufficiency of these staffing standards; adopt regulations to increase the minimum staffing ratios to adequate levels, as necessary; and examine the effectiveness of the implementation and enforcement of this bill. [A. Appr]

SB 111 (Alpert). Under existing law, medical assistants (MAs) are unlicensed entry-level health care personnel who are authorized to perform certain tasks in nonprofit licensed community clinics and other health care settings (except acute care hospitals) within their scope of practice as established by the Medical Board of California. NPs, CNMs, and physician assistants (PAs) are authorized to train, supervise, and assign tasks to MAs, so long as the tasks are within the scope of practice of the MA; however, MAs are authorized to perform services only when a physician is physically present at the office or clinic. As amended April 17, 2001, SB 111 would authorize NPs, CNMs, and PAs to supervise MAs in certain types of DHS-licensed clinics when the physician is not at the clinic site. [A. Health]

SB 298 (Figueroa), as amended April 17, 2001, would authorize CNMs to furnish or order controlled substances listed on Schedules III, IV, and V in the California Controlled Substance Act. AB 1545 (Correa) (Chapter 914, Statutes of 1999) and SB 816 (Escutia) (Chapter 741, Statutes of 1999) gave similar authorization to NPs and PAs (see MAJOR PROJECTS). [S. B&P]

RECENT MEETINGS

At its December 1999 meeting, BRN reelected Mary Jo Gorney-Moreno, Ph.D., RN, as president and elected Sandra Erickson, CRNA, as vice-president.

At BRN’s April 2000 meeting, Executive Officer Ruth Ann Terry announced that the Board was close to transitioning from manual fingerprinting of licensure applicants to the electronic method called “Live Scan.” Utilizing this new process, the Board will receive criminal history results on licensure applicants from the Department of Justice in a matter of weeks rather than months. [17:1 CRLR 54]

At BRN’s June 2000 meeting, Executive Officer Terry presented several other innovations in licensing technology to be used by BRN. The Statewide Licensing Match System is a program that prevents the issuance or renewal of permanent professional licenses to individuals who are delinquent in their court-ordered child support payments. Ms. Terry also provided the Board with an update on NURSYS, a Web-based application that will replace NCSBN’s existing disciplinary databank and be used for license verifications from five states.

At its September 2000 meeting, BRN reviewed its enforcement program statistics from fiscal year 1999–2000. During that year, the Board received 1,514 complaints, opened 1,099 investigations, referred 312 completed investigations to the Attorney General’s Office for the filing of an accusation, and filed 204 accusations and 27 statements of issues (license denial pleadings). The Board took a total of 147 disciplinary actions, including 68 revocations, 50 probations, 19 license surrenders, and 10 other orders. Of the 147 disciplinary actions, 40 were default decisions and 65 were reached by stipulation; only 42 cases actually went to hearing.

At its December 2000 meeting, BRN elected Sandra Erickson, CRNA, as president and Sharon Ecker, RN, as vice-president.

FUTURE MEETINGS

2001: June 28–29 in Sacramento; September 6–7 in Emeryville; November 29–30 in Riverside.

2002: January 31–February 1 in San Francisco; April 18–19 in Burbank; June 13–14 in Sacramento; September 5–6 in Emeryville; December 5–6 in Palm Springs.