Agenda Item 7.0

Report of the Nursing Practice Committee

BRN Board Meeting | May 23-24, 2024

Nursing Practice Committee
May 23-24. 2024

Table of Contents

7.1 **Information Only:** Advisory Committee Updates **3**
- **7.1.1** Nurse Practitioner Advisory Committee (NPAC)
- **7.1.2** Nurse-Midwifery Advisory Committee (NMAC)
- **7.1.3** Clinical Nurse Specialist Advisory Committee (CNSAC)
- **7.1.4** Certified Registered Nurse Anesthetist Advisory Committee (CRNAAC)
- **7.1.5** Nursing Education and Workforce Advisory Committee (NEWAC)

7.2 **Discussion and Possible Action:** Regarding the NEWAC recommendations on proposed draft regulatory language for standards on simulation in clinical education **5**

7.3 **Discussion and possible action:** Regarding the NPAC and NMAC recommendations on proposed draft regulatory language to amend the Recommended Guidelines for Disciplinary Orders and Conditions of Probation **51**

7.4 **Information only:** Overview of Certified Registered Nurse Anesthetist (CRNA) scope of practice and oversight **55**

Agenda Item 7.1

Information Only:
Advisory Committee Updates

BRN Board Meeting | May 23-24, 2024

BOARD OF REGISTERED NURSING
Agenda Item Summary

AGENDA ITEM: 7.1
DATE: May 23-24, 2024

ACTION REQUESTED: **Information only:** Advisory committee updates

- Nurse Practitioner Advisory Committee (NPAC)
- Nurse-Midwifery Advisory Committee (NMAC)
- Clinical Nurse Specialist Advisory Committee (CNSAC)
- Certified Registered Nurse Anesthetist Advisory Committee (CRNAAC)
- Nursing Education and Workforce Advisory Committee (NEWAC)

REQUESTED BY: Mary Fagan, PhD, RN, NEA-BC
Chair, Nursing Practice Committee

BACKGROUND:

Loretta Melby, Executive Officer, will provide updates on the activities of the advisory committees.

RESOURCES:

NEXT STEPS:

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT: McCaulie Feusahrens
Chief of the Licensing Division
California Board of Registered Nursing
Mccaulie.feusahrens@dca.ca.gov

Agenda Item 7.2

Discussion and Possible Action:
Regarding the NEWAC Recommendations on Proposed Draft Regulatory Language for Standards on Simulation in Clinical Education

BRN Board Meeting | May 23-24, 2024

BOARD OF REGISTERED NURSING
Agenda Item Summary

AGENDA ITEM: 7.2
DATE: May 23-24, 2024

ACTION REQUESTED: **Discussion and possible action:** Regarding the NEWAC recommendations on proposed draft regulatory language for standards on simulation in clinical education

REQUESTED BY: Mary Fagan, PhD, RN, NEA-BC
Chair, Nursing Practice Committee

BACKGROUND:

On March 30, 2023, NEWAC approved the creation of a subcommittee to study and recommend standards for simulated clinical experiences. The subcommittee met with simulation experts from across California to evaluate the INACSL, NCSBN, and SSH standards. This information was first brought in front of NEWAC on Sept. 28, 2023, where the members voted to accept the simulation report and consider the regulations after discussing them more in the next NEWAC meeting.

On March 7, 2024, this subcommittee proposed regulatory language to the NEWAC. The committee motioned to move it forward to the Nursing Practice Committee as a starting point for further discussion and consideration. There was consensus that should the BRN create regulations, the regulations should be a modified version of the National Council of State Boards of Nursing Model Rules Language for Prelicensure RN Programs (2016).

During the Nursing Practice Committee (NPC) meeting on April 18, 2024, the members voted to approve to the NEWAC recommendations on proposed draft regulatory language for standards on simulation in clinical education and authorize Board staff to initiate drafting regulatory language for revisions and/or additions to California Code of Regulations (CCR), title 16, Article 3 Prelicensure Nursing Programs.

The proposed regulatory language submitted by NEWAC is included on the following page. Additionally, NPC members requested supplemental information during the April meeting and this information follows the proposed regulatory language.

RESOURCES:

NCSBN model rules can be found on page 10 of this document: https://www.ncsbn.org/public-files/16_Simulation_Guidelines.pdf

NEXT STEPS:

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT: McCaulie Feusahrens
Chief of the Licensing Division
California Board of Registered Nursing
mccaulie.feusahrens@dca.ca.gov

DRAFT

Section XXXX DEFINITIONS
(a) “Simulation” means a technique to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner. (Gaba, 2004)
(b) “Prebriefing” means a process which involves preparation and briefing (INACSL, 2021)
(c) “Debriefing” means an activity that follows a simulation experience, is led by a facilitator, encourages participant’s reflective thinking, and provides feedback regarding the participant’s performance.
(d) “Psychological Safety” means a feeling (explicit or implicit) within a simulation-based activity that participants are comfortable participating, speaking up, sharing thoughts, and asking for help as needed without concern for retribution or embarrassment. (Lioce et al., 2020)

Section XXXX SIMULATION IN PRELICENSURE NURSING EDUCATION
(a) A prelicensure nursing education program (“program”) may use simulation to meet the program objectives pursuant to the allowable hours defined in Business and Professions Code Section 2786. A program that uses simulation shall adhere to the standards set in this section.
(b) If a program uses simulation, the program shall provide evidence of compliance to the Board of Nursing that these standards have been met.
(1) If the program has received endorsement from the International Nursing Association for Clinical Simulation and Learning, or successor organization or accreditation from the Society of Simulation in Healthcare, or successor organization, , the BRN shall accept, without requiring additional documentation or action, INACSL endorsement or SSH accreditation as meeting any simulation requirements set forth by the BRN.
(2) If the endorsement or accreditation lapses, or the program has not received endorsement or accreditation then the program must meet the requirements listed in subsections (c) through (l).
(c) The program shall have an organizing framework that provides adequate fiscal, human, and material resources to support the simulation activities.
(d) Simulation activities shall be managed by an individual who is academically and experientially qualified. The individual shall demonstrate continued expertise and competence in the use of simulation while managing the program.
(e) There shall be a budget that will sustain the simulation activities and training of the faculty.
(f) The program shall have appropriate facilities for conducting simulation. This shall include educational and technological resources and equipment to meet the intended objectives of the simulation.
(g) Faculty involved in simulations, both didactic and clinical, shall have training in the use of simulation.
(h) Faculty involved in simulations, both didactic and clinical, shall engage in on-going professional development in the use of simulation.
(i) The program shall demonstrate that the simulation activities are linked to programmatic outcomes.
(j) The program shall have written policies and procedures on the following:
(1) Short-term and long-term plans for integrating simulation into the curriculum;
(2) Method of Prebriefing: Preparation and Briefing and debriefing each simulated activity;
(3) Establishing and maintaining psychological safety
(4) During and post-simulation processes for minimizing, mitigating, and intervening if strong negative emotional responses (e.g., post-traumatic stress and debilitating anxiety) occur; and
(5) Plan for orienting faculty to simulation.
(k) The program shall develop criteria to evaluate the simulation activities.
(l) Students shall evaluate the simulation experience on an ongoing basis.
(3) The nursing education consultants shall receive education on simulation that includes, but is not limited to, national or international simulation standards, evaluation of simulation programs, and current best practices on simulation as a pedagogy.

The Shifting Ecosystem of Simulation Psychological Safety

Susan Eller, PhD, RN, CHSE, FSSH

October 19, 2023

Acknowledgment

Disclosures

- Faculty, The Debriefing Academy

Objectives

Explore the complex ecosystem of psychological safety and navigate some of the challenges:

- Influences of previous relationships
- Impacts of negative behaviors during observation
- Enhance the delivery of constructive feedback

Research Problem

"Be curious – not judgmental"

Significance

REPLACEMENT OF CLINICAL HOURS WITH SIMULATION

SIMULATION USED FOR HIGH-STAKES ASSESSMENTS

SIMULATION FOR TRANSITION INTO NURSING PRACTICE

Psychologically Safe Learning Environment

"A feeling or climate whereby the learner can feel valued and comfortable yet still speak up and takes risks without fear of retribution, embarrassment, judgment or consequences either to themselves or others, thereby promoting learning and innovation." (Turner & Harder, 2018, p. 49)

Context

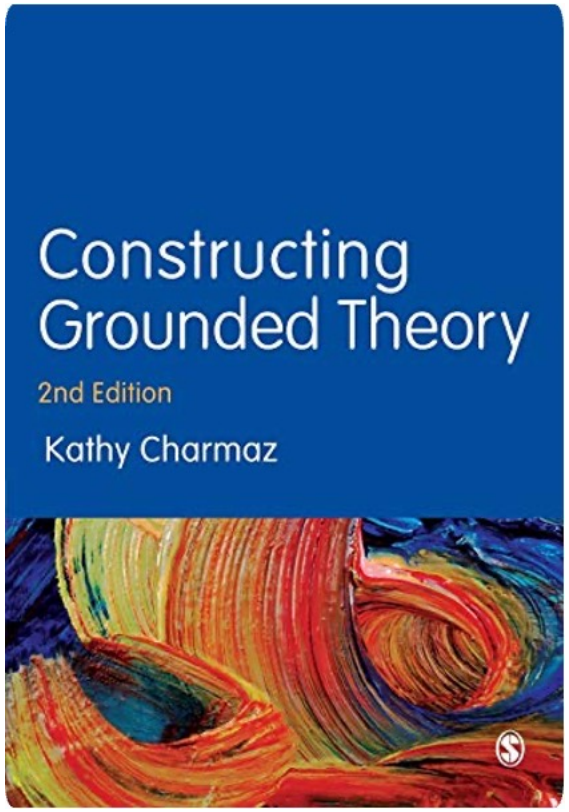
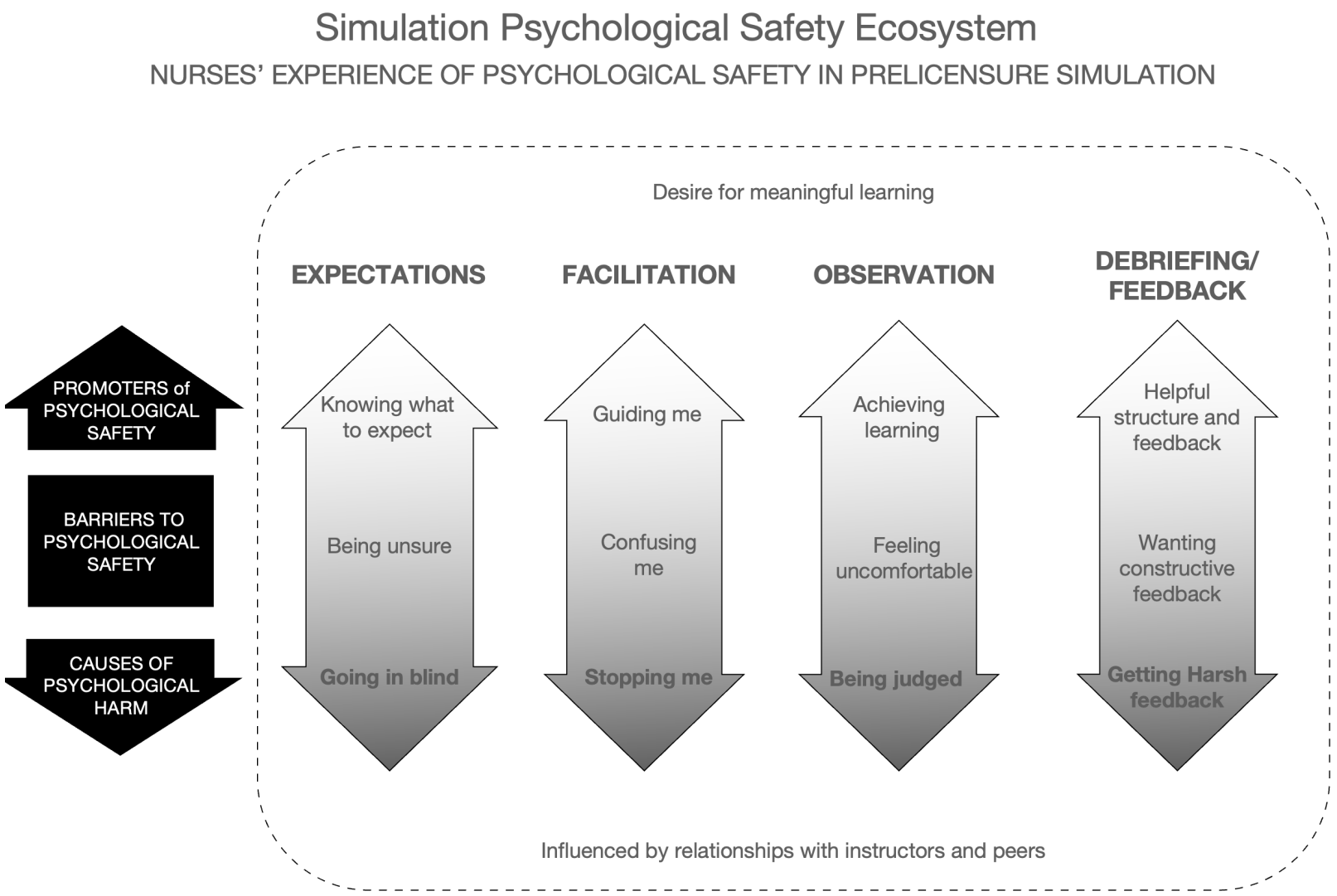


Table 1. Pseudonyms and Demographic Characteristics of Participants

Pseudonym	Gender	Age Range	Ethnicity	Type of Nursing Program and Location
"Lei"	Female	25-34	Asian	ABSN, Washington DC
"Kai"	Male	18-24	Asian	BSN, San Francisco
"Ivy"	Female	25-24	Caucasian	MSN Entry, Sacramento
"Sophia"	Female	18-24	Hispanic	BSN, San Jose
"Maya"	Female	18-24	South Asian	BSN, Los Angeles
"Emma"	Female	18-24	Caucasian	BSN, San Francisco
"Julie"	Female	25-34	Caucasian	ABSN, Sacramento
"Javier"	Male	25-34	Hispanic	MSN Entry, Boston
"Valerie"	Female	18-24	Caucasian	ABSN, Springfield (MO)
"Bailey"	Female	18-24	Caucasian	BSN, Boston
"Amy"	Female	25-34	Caucasian	MSN Entry, Chicago
"Priya"	Female	18-24	South Asian	BSN, Chicago
"Tessa"	Female	25-34	Caucasian	MSN Entry, Chicago
"Rebecca"	Female	18-24	Caucasian	BSN, Normal (IL)
"Sabrina"	Female	18-24	Caucasian	BSN, Normal (IL)
"Jade"	Female	25-34	Asian	MSN Entry, Chicago
"Molly"	Female	25-34	Caucasian	ABSN, Miami

Bachelor of Science in Nursing—BSN
Master of Science in Nursing—MSN
Accelerated Bachelor of Science in Nursing—ABSN

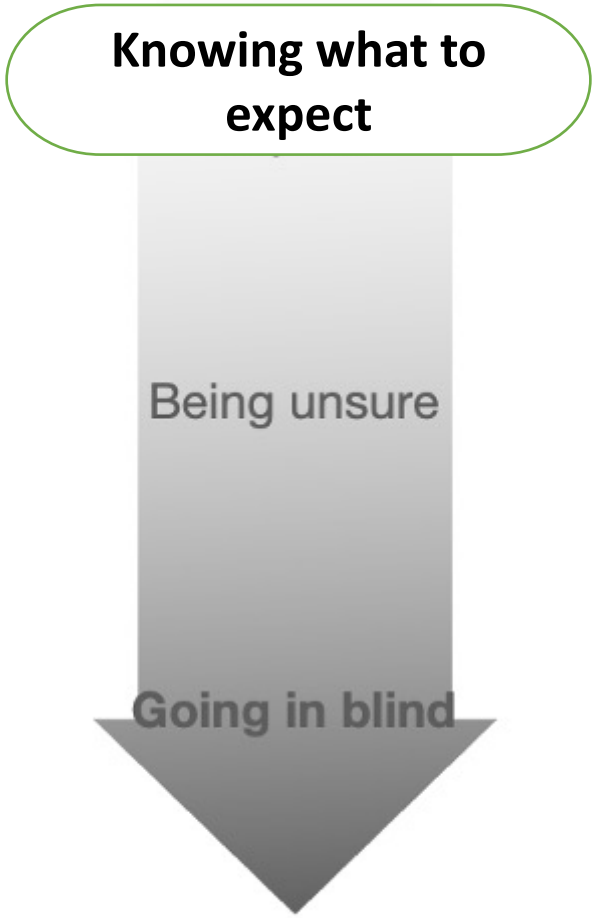
My Theory


Simulation Psychological Safety Ecosystem
NURSES' EXPERIENCE OF PSYCHOLOGICAL SAFETY IN PRELICENSURE SIMULATION
PROMOTERS of PSYCHOLOGICAL SAFETY
BARRIERS TO PSYCHOLOGICAL SAFETY
CAUSES OF PSYCHOLOGICAL HARM
Desire for meaningful learning
EXPECTATIONS
FACILITATION
OBSERVATION
DEBRIEFING/ FEEDBACK
Knowing what to expect
Being unsure
Going in blind
Guiding me
Confusing me
Stopping me
Achieving learning
Feeling uncomfortable
Being judged
Helpful structure and feedback
Wanting constructive feedback
Getting Harsh feedback
Influenced by relationships with instructors and peers

Core Category: Simulation Psychological Safety Ecosystem

"Psychological safety is not stable, but rather a dynamic and fragile perception". (Kolbe et al., 2020)

Expectations

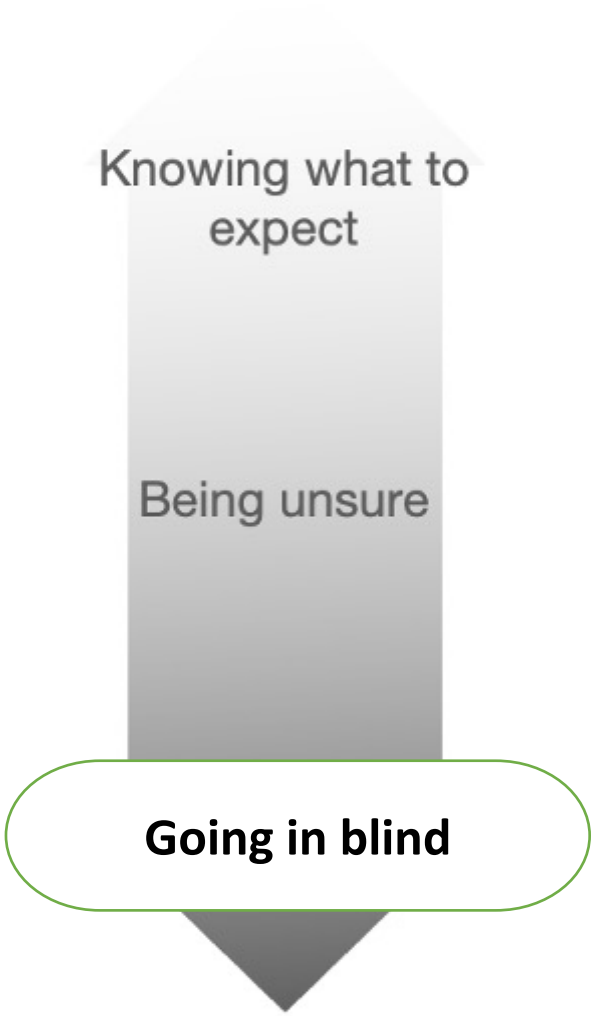


"We were very well prepped for what was going on in the room. They showed us where the medications and supplies were kept…we were familiar with everything" (Molly)

Expectations

”They did not tell us the goals, …maybe 15 minutes later if we finally said what they wanted they would stop the sim” (Kai)

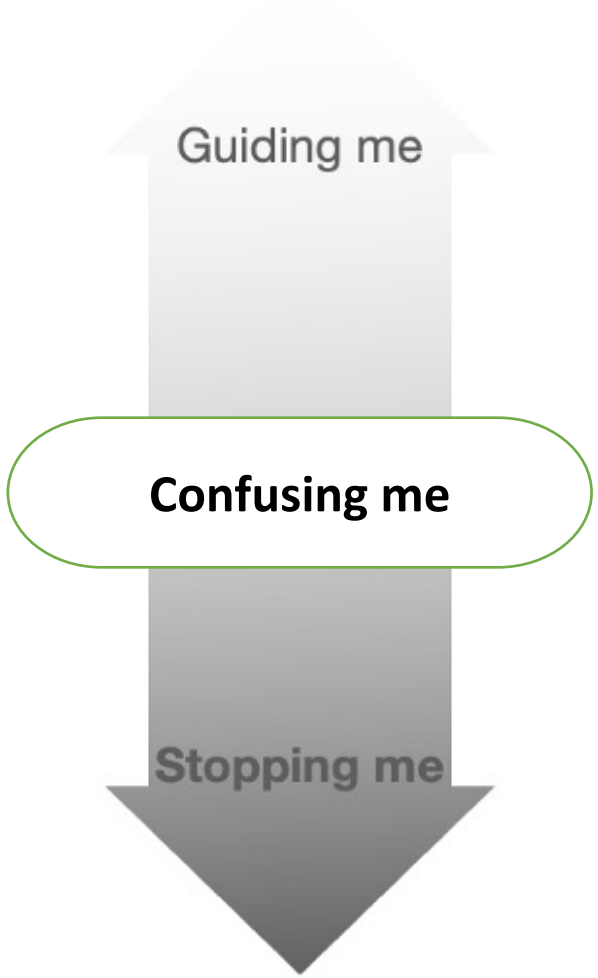
Expectations



“They didn’t tell us the goals of the sim… and I walked into a mannequin squeezing out a baby head and screaming in pain. Going in so blind with such little data ...is just kind of paralyzing” (Julie)

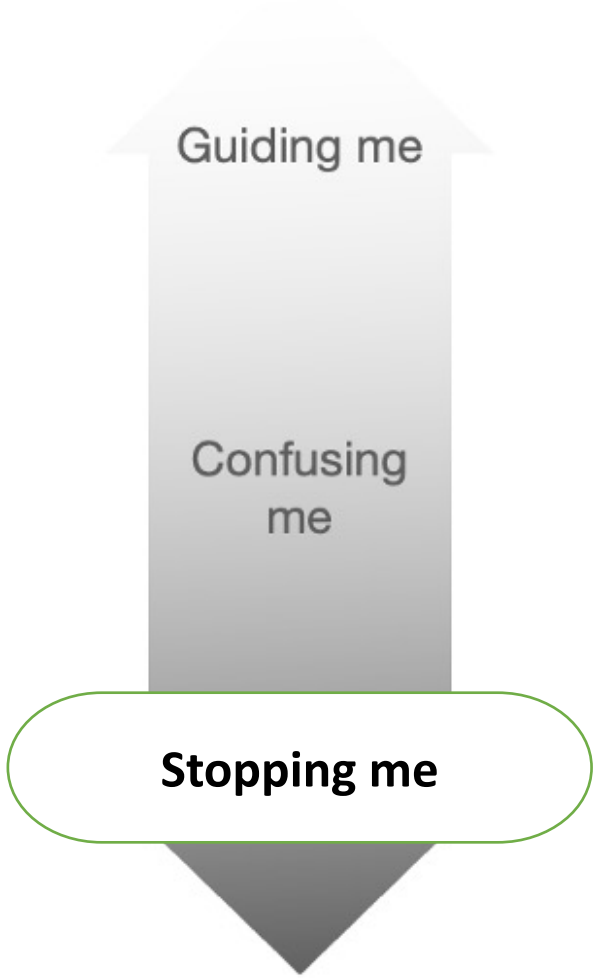
Facilitation

“When you're struggling, when you really don't know what you're going to do, the simulation instructor would just come in and start giving you helpful hints” (Maya)



Facilitation

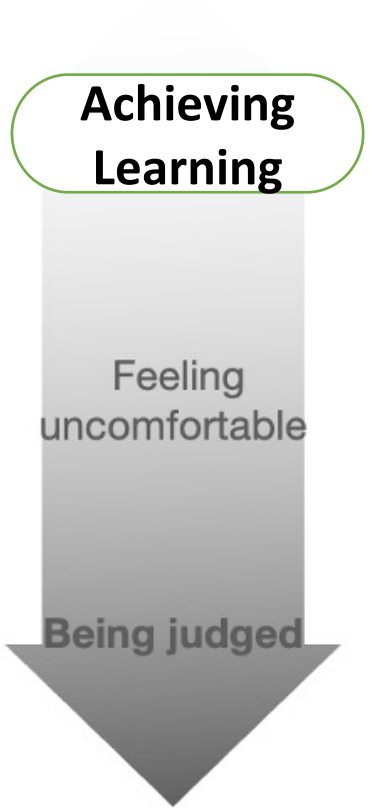
“You don’t have to walk us through it … but it would be good to get hints, especially if it is going off course” (Sabrina)



Facilitation

“I went to administer the medication and she grabbed my arm, stopping me…it was pretty intimidating…

after the scenario I had to excuse myself and cry in the bathroom” (Bailey)

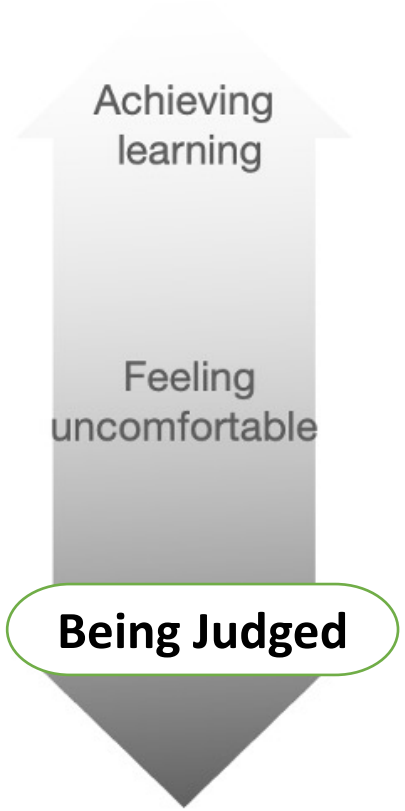


Observation

"As a viewer it was very informative because we are able to learn from four scenarios while only being an active participant in one" (Tessa)

Observation

"The other students were sitting in a room – maybe judging me, maybe not judging me... I was not a fan of that" (Amy)



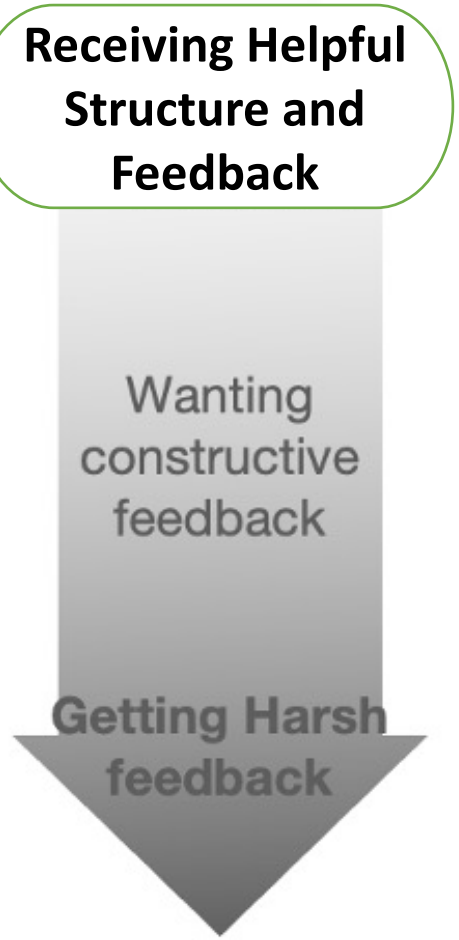
Observation

“Being in the simulation and knowing that someone is watching you is scary…

sometimes you can actually hear the yelling from the instructors or peers… was humiliating” (Sophia)

Debriefing

“What I found super helpful was when we discussed things that were noticed amongst the group and not as an individual…it felt more comfortable to learn because they wouldn’t mention one person” (Javier)

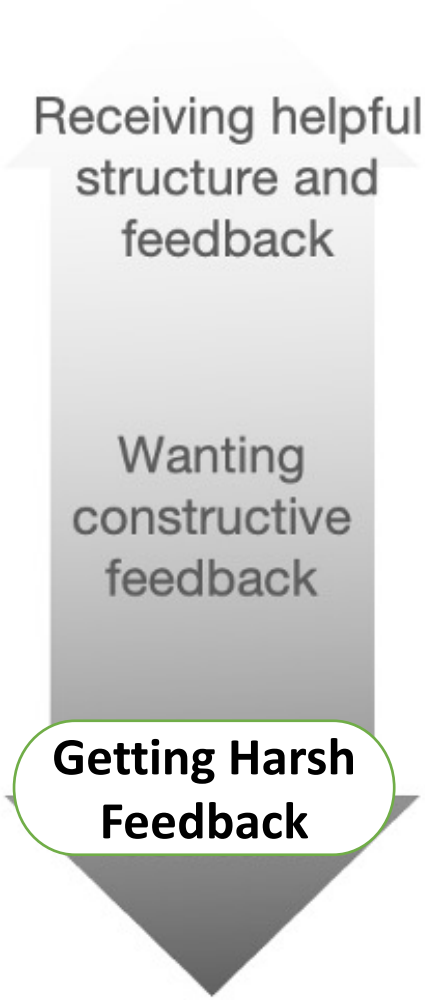


Debriefing

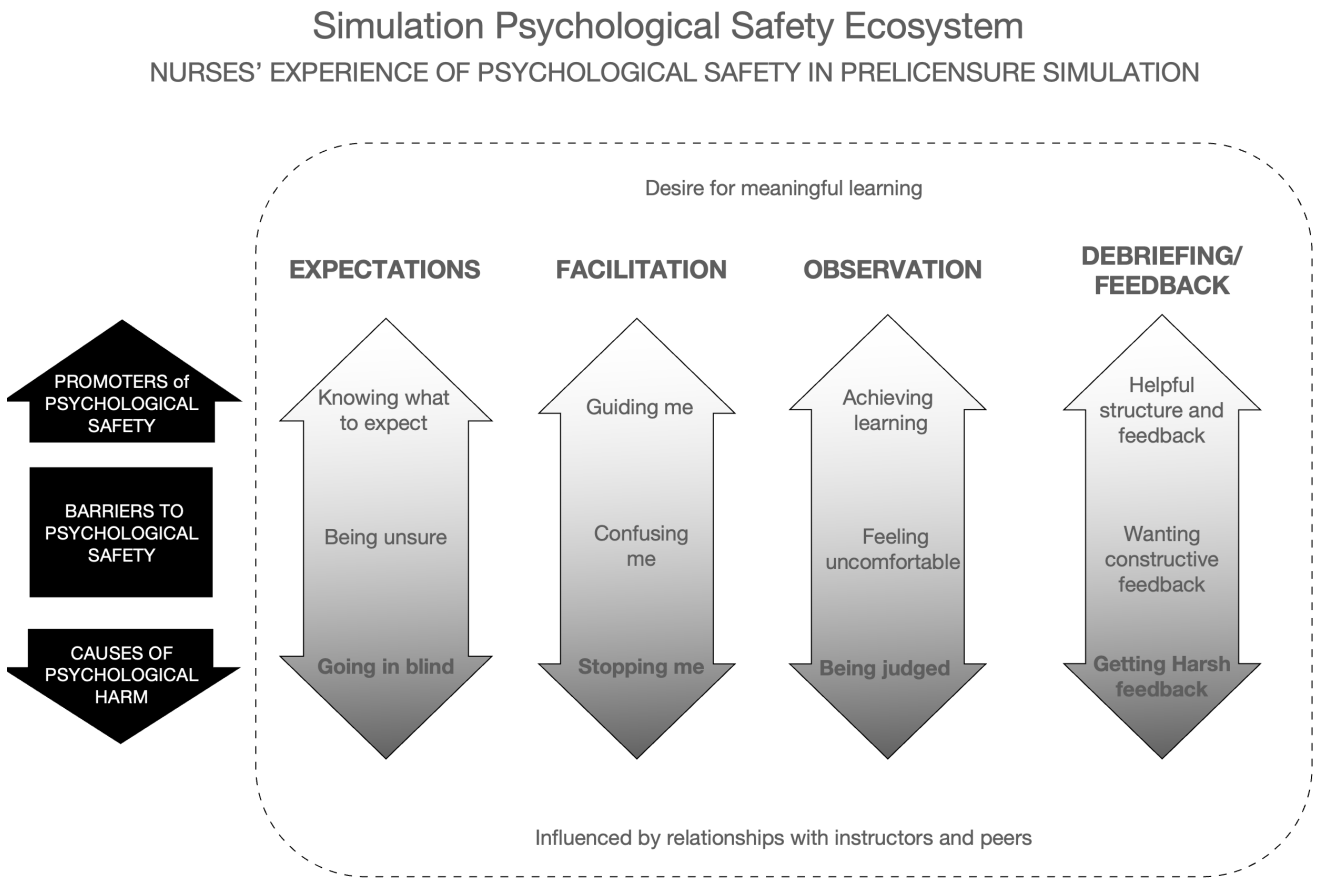
“Our instructor encouraged us to say one thing, but sometimes it was just a fluffer” (Lei)

Debriefing

“He barely said good things – just this was wrong and that was wrong…but didn’t explain what was wrong about it – you just feel bad” (Emma)



Mediating Variables



Meaningful learning

I think that simulation offers …chances to work out the kinks in transferring over what you've learned in school to actually putting it into work…that was always the best way when I learned something (Jade)

Relationships - peers

“It really depends on how well they know their classmates …for people who didn't have good relationships.. it was a very, very stressful scenario versus someone who had a really close-knit group” (Tessa)

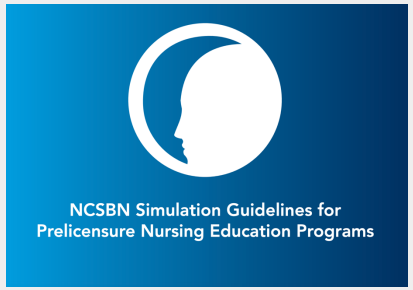
Relationships - Instructor

“I didn't necessarily have the best relationship with that clinical instructor that term as well. So, for me, I guess I'm going into it already in kind of an upset situation” (Ivy)

Going Forward

STOP PRELICENSURE STUDENT ABUSE IN SIMULATION

🔗Focus, 🔗SIM Nurse, 🔗Simzine10



Ensure Instructor Qualifications

Follow up to the NSBN study reported that up to 71% of simulation facilitators in prelicensure programs were not certified (Rutherford-Hemming et al., 2016)

Proactively Manage Relationships

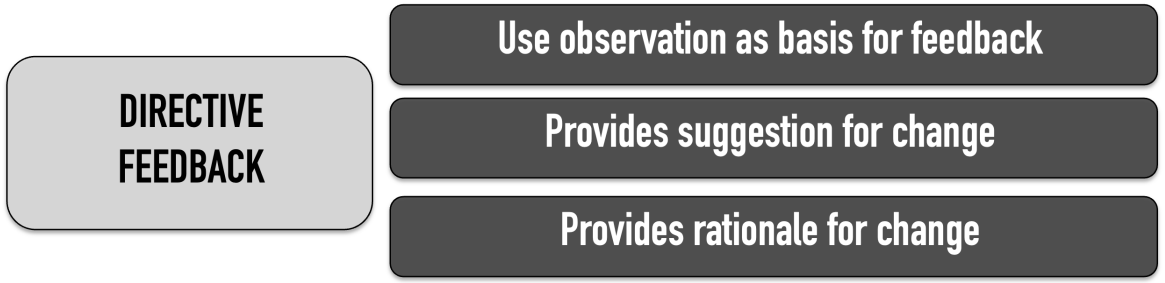
"It was better when we had the same people who went through simulation together instead of different groups every time" (Maya)

Instill Observation Skills

"As observers, we were told to write down a few things that you thought went well and a few things you thought they might change" (Priya)

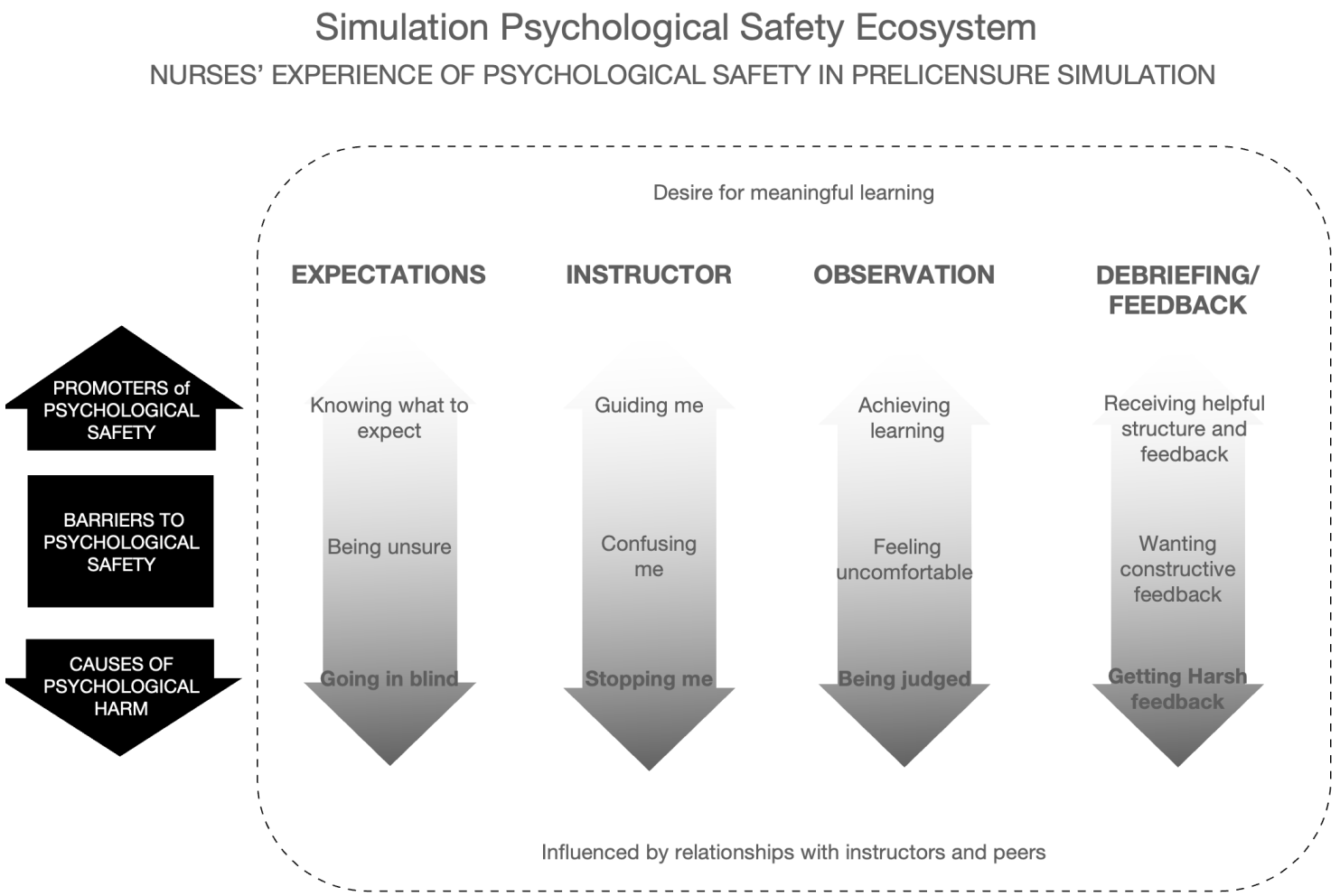
Provide Constructive Feedback Training

"It is kind of an uncomfortable situation to be in to give feedback to your peers … It is a skill that would be useful to have forever - I wish they had given us instruction on it" (Rebecca).



The Debriefing Academy (2020)

Evolving Model



SimHuddle

MAHALO!
THANK YOU!

References

FOR QUESTIONS AND COMMENTS, CONTACT ME at:
seller62@Stanford.edu

Clinical Simulation in Nursing (2023) 85, 101484

Clinical Simulation in Nursing

www.elsevier.com/locate/ecsn

Editorial

The Silent Epidemic: Addressing the Abuse of Prelicensure Nursing Students in Simulation

Recently, there has been a surge in discussions surrounding student abuse in simulation in nursing education. It is disheartening to acknowledge that this is happening to learners, yet, regrettably, it does not come as a complete surprise. With the increasing integration of simulation into prelicensure nursing programs, there emerges a parallel rise in opportunities for poorly trained educators to traumatize students intentionally or inadvertently under the guise of "nursing education." Before entering into this discussion, it is important to state that THIS MUST STOP IMMEDIATELY. The well-being of our learners should never be compromised for the sake of education.

There is an abundance of literature on bullying in nursing, including nursing students. In Canada, it is estimated that 50%-80% of undergraduate students experience bullying to some degree (Smith, Gillespie, Brown, & Grubb, 2016). Given student reports of mistreatment and abuse in simulation, it is evident that this has extended in that learning environment as well. Prelicensure nursing students have shared experiences of verbal and emotional abuse, unrealistic expectations, and inadequate debriefing sessions that leave them feeling demoralized and defeated. Verbal abuse from instructors, such as harsh criticism and demeaning language, not only undermines the students' confidence but also hinders their ability to learn and perform at their best. Unrealistic expectations, whether in terms of workload or complexity of scenarios, contribute to a toxic learning environment that fosters anxiety rather than growth. The lack of constructive debriefing exacerbates these issues, as students are left without the opportunity to understand their mistakes, learn from them, and build resilience. This mistreatment cannot continue, nor does it prepare students for the realities of nursing practice.

The consequences of abuse in simulation scenarios extend beyond the immediate emotional distress experienced by students. In a recent literature review addressing bullying and incivility in clinical nursing education (Alberts, 2022), the authors indicate that such mistreatment can lead to increased levels of stress, anxiety, and burnout, negatively impacting students' mental health. Moreover, the abuse may erode the students' confidence in their abilities, hindering their overall academic and clinical performance. As these students progress into their nursing careers, the lingering effects of abuse can manifest as a lack of self-assurance and reluctance to assert themselves in high-pressure situations, potentially compromising patient care.

One of the main reasons that is often raised as being behind the abuse in simulation is the lack of standardized training for educators, or poorly trained educators. While many possess clinical expertise, not all educators are equipped with the pedagogical skills and sensitivity required to create a positive and constructive learning environment. Institutions must prioritize the development or support of comprehensive training programs that address both the technical and interpersonal aspects of simulation education. The recent Healthcare Simulation Standards of Best Practice™ Professional Development (INACSL Standards Committee et al., 2021) clearly highlights the process and need for education and training for those involved in simulation-based learning. If institutions tout that they are adhering to these best practices, they need to ensure that they are requiring and providing professional development opportunities for their faculty.

The abuse of prelicensure nursing students in simulation is a grave concern that demands immediate attention. As advocates for quality education and compassionate patient care, we must collectively condemn mistreatment in all its

https://doi.org/10.1016/j.ecns.2023.101484

forms and work toward creating an environment where students feel valued, supported, and inspired to become competent and compassionate healthcare professionals. The future of nursing depends on the cultivation of a positive learning environment, one where the next generation of nurses can thrive, confident in their abilities and dedicated to providing excellent patient care.

Nicole Harder, RN, PhD, CHSE, CCSNE
Editor-in-Chief, Clinical Simulation in Nursing, Associate Professor College of Nursing, Mindermar Professor in Human Patient Simulation, Rady Faculty of Health Sciences, University of Manitoba, Winnipeg, Manitoba, Canada
E-mail address: nicole.harder@umanitoba.ca

References

Alberts, H. (2022). Addressing bullying and incivility in clinical nursing education. *Teaching and Learning in Nursing*, *17*, 433-437.

Smith, C., Gillespie, G., Brown, K., & Grubb, P. (2016). Seeing students squirm: Nursing students' experiences of bullying behaviors during clinical rotations. *Journal of Nursing Education*, *55*(9), 505-513.

INACSL Standards Committee Hallmark, B., Brown, M., Peterson, D. T., Fey, M., & Morse, C. (2021). Healthcare Simulation Standards of Best Practice™ Professional Development. *Clinical Simulation in Nursing*, *58*, 5-8.

Nurse Education Today 122 (2023) 105712

Contents lists available at ScienceDirect

Nurse Education Today

journal homepage: www.elsevier.com/locate/nedt

Research article

Psychological safety in simulation: Perspectives of nursing students and faculty

Sufia Turner [a,*], Nicole Harder [a], Donna Martin [a], Lawrence Gillman [b]

[a] College of Nursing, Rady Faculty of Health Sciences, University of Manitoba, Helen Glass Centre for Nursing, 89 Curry Place, Winnipeg, Manitoba R3T 2N2, Canada
[b] Rady Faculty of Health Sciences, University of Manitoba, Winnipeg, Manitoba, Department of Surgery, Canada

ARTICLE INFO

Keywords:
Simulation
Undergraduate nursing students
Psychological safety
Nursing students

ABSTRACT

Background: As simulation education continues to grow, more consideration has been given to creating and maintaining a psychologically safe simulation learning environment. It is known that failing to provide psychological safety can lead to feelings of incompetence and a lack of confidence with students. However, it is essential to understand what makes and maintains psychological safety in simulation from both student and facilitator's perspectives. In further understanding psychological safety, nursing educators can challenge students to think beyond that of task attainment and into the deeper realm of critical thinking and critical reflection.
Objectives: The aim of this study was to understand students' and facilitators perspectives of psychological safety in simulation.
Methods: Participants in this qualitative interpretive description study were seven students and four faculty that were chosen using convenience sampling. The data was collected over a 2-week period where semi-structured interviews were used to collect the participants perspectives. Data analysis was continuous and iterative and used inductive analysis.
Results: There were two student themes which focused on the student-facilitator interaction: 1) dynamic interaction, 2) student self-efficacy. The facilitators results showed two themes which focused on 1) simulation design and 2) trust.
Conclusion: Diverging thoughts are present between faculty and students in what constitutes psychological safety. In describing both the similarities and differences, we have a better understanding on how to create and maintain psychological safety thereby, providing students with the best learning experience possible.

1. Introduction

Creating and maintaining psychological safety in all phases of simulation-based education (SBE) is a core element for quality learning activities (Daniels et al., 2021). As simulation can be anxiety and stress producing, this can impact nursing students' performance in simulation (Kang and Min, 2019; Turner and Harder, 2018), and negatively influence learning behaviours and outcomes (Daniels et al., 2021). Psychological safety is defined as "a feeling (explicit or implicit) within a simulation-based activity that participants are comfortable participating, speaking up, sharing thoughts, and asking for help as needed without concern for retribution or embarrassment" (Lioce et al., 2020, p. 38). Failure to provide a psychologically safe learning environment can lead to repeated *micro-risks* which can develop into larger feelings of incompetence and underperformance (Bynum and Haque, 2016; Lepnurm et al., 2009; Newman et al., 2017).

Even when simulation facilitators believe that they have created a psychologically safe environment, it is the learners' perspective of psychological safety that ultimately determines whether this has been achieved or not. In this qualitative interpretive description study, the authors explore the concept of psychological safety from the perspective of both the facilitators and the learners in SBE. In doing so, we have found that there are diverging thoughts between what facilitators believe constitutes psychological safety, and what learners feel during simulation. Simulation outcomes extend beyond task attainment, however without a psychologically safe learning environment, learners often are unable to progress beyond this and achieve the learning outcomes of the simulation. Understanding the difference in perspectives between learner and facilitator regarding the psychological safe learning environment is foundational for all simulationists and is the purpose of this

* Corresponding author.
E-mail address: sufia.turner@umanitoba.ca (S. Turner).

https://doi.org/10.1016/j.nedt.2023.105712
Received 8 July 2022; Received in revised form 5 December 2022; Accepted 7 January 2023
Available online 13 January 2023

qualitative research study.

2. Literature review

Recently, simulationists have been exploring the purposeful integration of psychological safety in SBE. Evidence points to how simulation facilitators can influence the psychological safety of the simulation (Johnson et al., 2020; Kolbe et al., 2015) and identify factors that are intrinsic to the learner that affects their feelings of psychological safety (Kang and Min, 2019; Nielsen and Harder, 2013). Some authors have stated that much of the psychological safety literature focuses on the negative experiences that learners have in simulation, and assume that simply removing negative behavioural approaches (e.g. criticism and judgement) will create a psychologically safe environment (Tsuei et al., 2019). This approach does not explore the positive behaviours that promote psychological safety.

It is impossible for simulationists to be able to predict whether all simulation participants will feel safe in simulation; however, it is necessary that they attempt to create and maintain a psychologically safe environment that fosters confidence in learners to take personal risks during simulation without fear of reprisal (Turner and Harder, 2018). Learning in simulation is more than a cognitive task and includes psychological and emotional factors that affect the individuals participating in the SBE (Lateef and Lin, 2020). Various means to achieve psychological safety in simulation are highlighted in the literature, including the physical environment, the facilitators' demeanor and body language (Kolbe et al., 2019), room set up and location of the debrief (Abatzis and Littlewood, 2015; Cantrell, 2008), psychological safety in prebriefing (Roh et al., 2018), student perceptions of psychological safety (Stephen et al., 2020) and faculty perceptions of psychological safety (Kostovich et al., 2020).

Throughout the literature, what is noticeably absent are comparison studies of students' and faculty perspectives of psychological safety (Kostovich et al., 2020; Stephen et al., 2020). As we continue to explore and uncover the importance of psychologically safe learning environments, it is key that we understand how this is experienced from the perspective of all simulation participants. More recently, additional literature has emerged that focuses on psychological safety in the virtual learning environments (Dale-Tam et al., 2021; Goldsworthy and Verkuyl, 2021); however, this literature also misses the opportunity to thoroughly explore the experiences of learners and facilitators in SBE. With much of the literature focusing on the theory or beliefs of the facilitators to create a psychologically safe learning environment (Roh et al., 2018; Rudolph et al., 2014), we are missing the voices of the learners who benefit from creating these environments.

3. Theoretical framework

The framework guiding this study was the National League of Nursing (NLN) Jeffries Simulation Theory. This theory was chosen as it includes all areas of simulation design and implementation and implies that psychological safety is required to have the desired learning outcomes from the simulation. The theory examines the relationship between the learner, facilitator, and the simulation educational strategies used, all within the greater context of the simulation environment itself. Each component of the theory, from the background, design of the simulation, the simulation experience and the outcomes all rely on psychological safety as a key component. Psychological safety is not something that can be intermittently inserted into a simulation, but rather, it is imbedded in all components of the NLN Jeffries Simulation Theory (2016) and remains essential for successful outcomes. In simulation, as in the NLN Jeffries Simulation Theory, there is a cyclical interconnectedness that is essential for successful simulations. Should one area fail to create psychological safety for a nursing student, then the overall outcomes are at risk.

4. Research methods and procedures

4.1. Design

This qualitative study used interpretive description, and integrated inductive reasoning with constructivist thinking (Thorne, 2016). The philosophical underpinnings of interpretive description ensure a coherence that allows this study to be established separately as an interpretive description study as not all nursing inquiry can be categorized into the traditional qualitative approaches (Thorne, 2016) such as grounded theory, ethnography or narrative research. Rather the foundation of interpretive description provides an alternative way researchers could generate knowledge while still utilizing aspects of grounded theory. Given that the researcher had several years of experience and knowledge within the field of simulation, development, pedagogy and simulation facilitation, this methodology aligned well in that the researcher could apply prior knowledge and experience to the data collection, analysis and overall interpretation process. This design process also aligned with the study purpose as interpretive description is grounded in the belief that people's experiences are shaped by their perspectives as well as cultural and social forces.

4.2. Participants

Following ethics approval and institutional access, recruitment began at a large education institution in Western Canada by utilizing convenience sampling. For recruitment of the student participants, as part of their curriculum they recently participated in nursing simulations and therefore had a unique experience that would help better understand their perspectives on psychological safety. Faculty had also recently completed facilitating simulations and were also in a position of having fresh perspectives. All participants were emailed invitations to participate in the study by the administration support along with posters advertising the study in the faculty and student common areas. Inclusion criteria were students enrolled in the third year of the undergraduate nursing program, and the faculty who facilitated simulation in the third year of the undergraduate program.

4.3. Data collection

Data collection included one on one, face-to-face interviews that ranged from 27 to 53 min and were transcribed verbatim, short demographic questionnaires and researcher reflexive journaling. Reflexive journaling of the researcher was used as another source of data and was included in the data analysis process as it allows for a circular relationship between the investigator and the research data (Munhall, 2012). Following the eleventh interview, it was determined that there was repetition within the interviews and the researcher's reflexive journal, thereby concluding that sufficient information was obtained to answer the study question (Malterud et al., 2016). According to Malterud et al. (2016), information power assists with identifying the sample size when items such as the aim, specificity, application of theory, strength of the dialogue, and case analysis are considered, which was the process followed in this study.

4.4. Data analysis

Data analysis was a continuous and iterative process which used inductive analysis, open and axial coding (Thorne, 2016) conducted by the authors. Open coding was conducted by reading the transcripts line-by line and finding similarities and differences in the data. This was proceeded by labeling the code which enabled the researchers to sort through the data and uncover any underlying meanings within the text (Morse and Field, 1995). To improve the coding process, the text was read in its entirety and the researchers then reflected upon the whole of the text. The researchers then reengaged with the data to recognize

categories within the data set (Morse and Field, 1995). To enhance the recognition of categories, ongoing engagement with the data occurred, to test, confirm, explore and expand on the basic conceptualizations from the text (Thorne, 2016). Axial coding started when the data was categorized which involved identifying the relationships between the codes in the data. The connections between the categories began to emerge and patterns and linkages could be seen (Thomas, 2006). The initial categories were broad in nature so that large amounts of data could be sorted into groups and eventually combined to create a few main themes from the data set (Morse and Field, 1995) which generates the results and discussion.

After preliminary themes, categories, and sub-categories emerged from the student transcripts and the investigators reflexive journals, focus then switched to the faculty transcripts and corresponding investigator reflexive journal entries. Transcripts from the student group and faculty group were independently analyzed, and codes and themes were created for each group.

4.5. Trustworthiness

Trustworthiness was managed by using the Lincoln and Guba's framework (Polit and Beck, 2017). Peer debriefing was used to ensure credibility. Dependability was addressed by establishing an audit trail by reviewing de-identified transcripts and reviewing researcher reflexive journals. The reflexive journals also provided insight into interpretations and understandings of the analysis process. Confirmability was completed by reviewing the data with the research team regarding the initial analysis meaning, relevance and accuracy through preliminary axial coding, categorizing and through conversations to build initial themes or review themes and categories seen in the data.

4.6. Simulation study procedure

The study procedure followed the research guidelines for health care simulation research by Cheng et al. (2016). Students were orientated to the mannequins and simulation environment, and the scenarios were designed using the Healthcare Simulation Standards of Best Practice™ (International Nursing Association for Clinical Simulation and Learning (INACSL) Standards Committee, 2021). The students had participated in several previous simulations, and were interviewed at the end of the term. Learning objectives were provided to students via their clinical course syllabus. The scenarios were designed using the INACSL Standards of Best Practice. The students had participated in several simulations, which included maternity-based simulation, pediatric simulations and palliative simulations. The focus of the simulations that were used was based on clinical scenarios were important for students to experience prior to graduating but generally focused on teamwork, the occasional technical skill like medication administration and communication. Due to the nature of this study in that students likely brought prior experiences in simulation to the interview, no specific scenario was used prior to the interview. Pre-learning activities consisted of reviewing the patient chart and completing a client case summary. The students came to the simulation lab in groups of four and participated as an active participant in one simulation and observed another simulation. Each simulation totalled 1 h and 45 min, and included a prebrief (20 min), followed by the active simulation (20 min), and then the debriefing (40–45 min). None of the simulations were recorded. Debriefing for Meaningful Learning (Dreifuerst, 2015) was used as the debriefing framework, and was conducted in a location away from the simulation environment. At the end of the simulation day, the students were provided with a short questionnaire/evaluation that helped with quality control and faculty provided another announcement regarding confidentiality of simulation scenarios.

5. Findings

Seven students and four faculty volunteered to participate and were interviewed (n = 11). Table 1 is a description of the student sample and Table 2 is a description of the facilitator demographics. The mean interview duration for students was 31.14 min with a standard deviation of 10.16. The mean interview duration for the facilitators was 29.25 min with a standard deviation of 3.34.

5.1. Student findings

Two major themes emerged from the student transcripts and corresponding reflective journals: 1) dynamic interaction and 2) self-efficacy. The first theme of the dynamic interactions was comprised of three elements including faculty relationships, support, and communication. The elements cannot stand alone but are closely interrelated and make up the theme.

5.1.1. Theme 1: dynamic interactions

The theme of dynamic interaction was a combination of the students' relationships and communication with a facilitator. Depending on the type of relationship, positive or negative, impacted a student's sense of psychological safety within the simulation. Relationships were also cultivated through communication between the faculty and the student. The way in which a faculty member or simulation facilitator approached the students in the simulation, provided verbal feedback, as well as their non-verbal reactions influenced the students' sense of psychological safety.

A previous relationship with faculty where the faculty were aware of the students' clinical abilities positively impacted the students' overall perception of psychological safety. When students believed that faculty were previously aware of their clinical abilities, should a mistake happen in simulation, this was not a complete representation of their abilities. The students did not feel judged based solely on their performance in simulation.

> "*[…] so even before getting into a sim, knowing that person and having some sort of relationship with them […] calms you down, gives you reassurance that okay, she wouldn't lie to me.*"
>
> Student 4

When the relationship between the students and the faculty was perceived as negative by the students (e.g. failure in a previous course), it was difficult for the students to receive feedback in a constructive manner. The students felt uncomfortable and judged from past performances thereby did not take any risks, did not engage and/or participate in the simulation which shaped their own and that of their group's ability to learn from the simulation.

Table 1
Student demographics.

Demographic characteristics of sample ($N = 7$)		
Characteristic	Frequency	%
Sex		
Female	6	85.70 %
Male	1	14.30 %
Age, years		
19–25	3	43.00 %
26–35	3	43.00 %
>35	1	14.00 %
Highest level of education		
High school or equivalent	4	57.14 %
Bachelor's degree	2	28.57 %
Other certification/diploma	1	14.29 %

Table 2
Facilitator demographics.

Demographic characteristics of the sample ($N = 4$)		
Characteristic	Frequency	%
Sex		
Female	4	100 %
Male	0	
Age, years		
35–45	2	50 %
>45	2	50 %
Highest level of education		
Bachelor's degree	1	25 %
Master's degree	3	75 %
Length as a nursing education		
0–5 years		
6–10 years	2	50 %
11–15 years	1	25 %
16–20 years	1	25 %
Length in teaching simulation		
0–4 years	2	50 %
4–8 years	1	25 %
>8 years	1	25 %

The type of relationship between the students and the faculty affected the way the students asked for support or the perception of support in the simulation. If students were not feeling supported during the active simulation or debrief, they were less likely to seek clarification or help during the simulation and waited for the faculty member to prompt them. When a student had a negative previous relationship (e.g. previously performed poorly in their course), or had perceived conflict with a facilitator, the student may not be open to the learning experience of the simulation itself.

> "*…if I've had a conflict with an instructor who is now watching me perform in simulation…it kind of takes away from the experience, because you're too focused on doing what you've got to do just to get out of there …*"
>
> Student 1

Further, the way a facilitator communicated in a simulation influenced students' perception of psychological safety. Participating students identified effective communication as positive communication where the language was not overly critical, judgemental or negative in nature. Regardless of the intent of the feedback, the way in which it is relayed to the students had implications on how the feedback was received.

5.1.2. Theme 2: student self-efficacy

The second theme identified was student self-efficacy or students' beliefs in themselves and their ability to perform within the simulation. Students identified their confidence, preparation and ability to manage their anxiety as contributing factors to their self-efficacy. However, the majority of the students expressed feelings of being unsure. Being unsure made it difficult for them to trust their instincts, assessments, knowledge and abilities. When a student felt unsure or less confident in their own knowledge or abilities, their perception of psychological safety decreased. Additionally, students would revert back to the feeling of being judged or have concern about making a mistake which prevented them from feeling safe in the environment.

> "*…they tell you, 'we're not testing you, this is just for your learning experience,' but it's always in the back of your mind, 'Oh, I'm being judged, I'm doing this wrong.'*"
>
> Student 4

As the students' confidence increased with being prepared, so too did their comfort to take risks within the simulation environment. Therefore, preparation was perceived to positively influence not only a student's confidence and anxiety, but also their ability to take risks, make mistakes and learn from the experiences.

5.2. Faculty findings

The faculty transcripts and corresponding journal entries yielded two major themes. The first theme was simulation design: "safe bubble" which contained two categories, modifiable factors, which included design characteristics that faculty had control over, and non-modifiable factors, which were the factors they did not have control over. The second theme that emerged was trust. In the following section, we present these two themes.

5.2.1. Theme 1: simulation design

Faculty perspectives were that psychological safety was something that was created, with simulation design as being key in creating and maintaining psychological safety in simulation. There were two main categories identified: (a) modifiable factors that were composed of the different simulation design characteristics and (b) non-modifiable factors which was represented factors that faculty were unable to control or modify.

5.2.1.1. Category 1: modifiable factors. The category of modifiable factors included design characteristics that faculty could alter or change in the simulation. The design characteristics were factored into the different phases of simulation.

Confidentiality had been integrated throughout the simulation program. Facilitator 3 used the phrase "safe bubble" to describe acknowledging that what happens during simulation was to remain confidential. The faculty felt that if the students had a space in which they could make mistakes and learn from, that constituted psychological safety.

The prebrief phase was described by the faculty as an important component that increased the students' psychological safety. The faculty felt that the process of the prebrief helped with decreasing anxiety, re-establishing the expectations and objectives for the simulations and gets the students prepared by re-establishing the focus of the simulation. Facilitator 4 states that they reiterate the important design characteristics, as it demonstrates to the students that as a facilitator, they prioritize the importance of psychological safety in the simulation experience.

> "*Psychological safety is so huge, […], it goes through the whole process from prebriefing and prep […] to confidentiality and the fiction contract and saying, you know, I'm going to try my best but I'm human too and some of these things may not be as real as possible but I want you to play along with us*"
>
> Facilitator 4

Finally, the debrief is another simulation design element that the faculty believed impacted psychological safety in simulation. In the debriefing, faculty can assess how the students are feeling and through their interactions, can identify whether the students appear comfortable and engaged. One facilitator felt the debrief was the facilitators way of thanking the students for taking risks, being vulnerable and engaged in the simulation. Facilitators can reiterate and bolster psychological safety in the debrief by focusing on the learning and meeting the simulation objectives.

> "*The debrief contributes to psychological safety[…] it's the 'thank you' for putting the risk in, now let's look at what that risk brought you in terms of learning […].*"
>
> Facilitator 4

5.2.1.2. Category 2: non-modifiable factors. The non-modifiable factors were what simulation faculty identified as elements that they were unable to predict and were outside of the faculty members' control. These non-modifiable factors included the individuality of the student and the students' background, and history in previous simulations.

> "*And I wonder if psychological safety is not the same for everybody, it really depends on their background, what they come with, whether or not they trust us to actually be, you know, true to our word that we're not going to tell anybody that it's not going to impact their future learning.*"
> Facilitator 3

5.2.2. Theme 2: trust

The second theme was trust and how an environment of trust was created. The faculty perceived that trust was created through how they communicated verbally and non-verbally. Additionally, using preparation materials, and prompts and cues during the simulation, the faculty shared that this could impact students' perception of trust and support in simulation.

Faculty highlighted the importance of consistency among faculty in relation to their approach with students during all phases of the simulation. This consistent approach was believed to influence trust by students and subsequently, their feelings of psychological safety. The faculty felt if trust was not developed between the facilitator and student through communication both verbal and non-verbal, then the student may not feel psychologically safe; therefore, not comfortable taking risks or speaking up. If that trust is not present with the simulation experience students might guard their actions and thoughts as a form of self-preservation thereby missing out on a rich learning experience.

> "*…they're not going to feel comfortable in the situation at all and it's going to be very disjointed. They're going to be guarding what they're saying, what they're doing and as opposed to actually being in the role…*"
> Facilitator 2

6. Discussion

Looking through the lens of the NLN Jeffries Simulation Theory, the findings of this study are discussed according to background, design, and the simulation experience. The faculty perceptions of psychological safety primarily stemmed from the background and design of the simulation while the students' perceptions focused on the dynamic interaction between the student and facilitator as well as the simulation experience.

6.1. Design characteristics

In this study, faculty identified that the design characteristics were important in creating the psychologically safe environment for students. Preparation was addressed by both the students and the faculty. Providing preparatory material decreased students' anxiety but did not eliminate it completely (Sharoff, 2015; Tyerman et al., 2019). Further, faculty in this study felt that an effective prebrief that included reviewing the objectives and expectations, and the confidentiality clause prior to the simulation helped students feel more prepared and comfortable in the simulation itself. Roh et al., 2018 found that students who received a structured prebriefing prior to simulation showed higher team psychological safety (Roh et al., 2018). Whereas, Sharoff (2015) found that prebriefing engaged and empowered participants in their learning experience. Prebriefing is important to establish psychological safety.

A positive or trusting relationship was another design characteristic which both students and faculty felt was essential in the creation and maintenance of psychological safety. Faculty perceived that it was important to establish trust by telling students that "what happens in sim, stays in sim". Contrarily, the students felt that although statements of confidentiality were expressed, there was mistrust in the believability of those words. Rudolph et al. (2014) stated that transparency about *what and with whom* information regarding the simulation will be shared will help build trust. In this study, students felt that the *with whom* was important as there was a fear of their performance being disclosed with their clinical instructors. Therefore, explicitly outlining the confidentiality, discussing what and with whom information will be shared will begin the establishment of psychological safety.

While debriefing is an integral part of simulation learning (Kim and De Gagne, 2018), the students and faculty in this study attributed a greater importance to psychological safety than to the debriefing itself, as without psychological safety, the debriefing would not be as valuable and reflective of the simulation. Emphasis was put on how the facilitator created and maintained a psychologically safe environment before and during the debriefing, rather than the way in which the simulation was debriefed. This is paramount because with so much emphasis on debriefing and debriefing frameworks, this study shows that psychological safety relies more heavily on the humanistic interaction of the debrief than the debriefing itself.

6.2. Simulation experience

The simulation experience in the NLN Jeffries Simulation Theory includes the facilitator, the student, the interaction between the two and the education strategies used in the simulation (Jeffries, 2016). In our study, the magnitude in which the facilitator can impact a simulation and the students' perception of psychological safety was identified. Intrinsic to the relationship between the facilitator and the student is trust. As trust is an implicit antecedent for psychological safety (Turner and Harder, 2018), it is placed at the center of the dynamic interactions between student and facilitator. Without trust, there is no relationships, risk taking, collaboration, or learning, which is in essence psychological safety itself (Turner and Harder, 2018). Communication, both verbal and non-verbal, were identified by faculty and students as important in building trust and establishing psychological safety. It is not enough to state that the simulation is a safe place to learn, rather the facilitator needs to understand the significance of all their interactions with students, and how this affects learner engagement and the psychological safety of the simulation (Luctkar-Flude et al., 2017).

Self-efficacy was considered a significant factor in the students' perception of psychological safety. In a concept analysis on self-efficacy, Zulkosky (2009) summarized that a low sense of self-efficacy is associated with stress, depression, anxiety and helplessness (Zulkosky, 2009). Strong self-efficacy can increase a person's self-confidence and success by their ability to take on new challenges and tasks (Karabacak et al., 2019).

The non-modifiable factors that the faculty identified makes an important distinction regarding what each student brings to the simulation experience. Students identified factors such as their own confidence, ability to manage their anxiety, relationships with their peers and/or the facilitator. Conversely, faculty identified factors for students as the students' individual learning style and previous experience and exposure to simulation. This study's findings supported Wickers (2010) assertion that a person's individual traits could impact their own perception of psychological safety.

There is limited literature that describes the psychological safety of the individual in simulation. Turner and Harder (2018) asserted that personal confidence may be needed for a learner to feel psychologically safe, whereas Newman et al. (2017) discussed the individual in the context of team differences with psychological safety. Kolbe et al. (2019) included three characteristics needed for psychological safety in the individual; a proactive personality which is the ability to not allow external forces to alter behaviour; emotional stability which means the ability and self-assurance to feel calm, relaxed and stable; and finally, a learning orientation which is described as the internal motivation to

develop new skills and constantly learn and grow (Kolbe et al., 2019). What has emerged from this study is that psychological safety is something to be created through all phases of simulation, and that despite educators' attempting to imbed psychological safety within the design characteristics, the student as an individual may still not feel entirely psychologically safe. This area needs to be better understood.

6.3. Limitations

There were several limitations to this study. This study used convenience sampling which could result in commonalities about a phenomenon and could produce participants who had extreme feelings which could also bias the results. Due to the sensitive nature of the topic, less-confident students or those who do not feel psychologically safe within the institution may not have participated in the study. Therefore, there is need for large scale research on this topic to further analyze these findings. This study was conducted at a single site, with a traditional undergraduate nursing program which limits the generalizability. The students and the facilitators in this study were not paired together, so the students may or may not have had a simulation facilitated by one of the facilitators interviewed. The students were at the end of their school term, therefore, this delay in timing by 2–3 weeks from when they participated in the simulation and data collection may have skewed the interviews responses. Finally, the demographic identified predominantly female, additional studies with a more even gender distribution would enhance the overall study results.

7. Future research

This study was an initial study that compared the perceptions of psychological safety from both the students' and instructors' perspectives. As such, it raised additional questions which can provide opportunities for further research in this area. We would be interested in further exploring the positive/negative relationships between students and faculty to see how there could be potential growth that comes from learning from mistakes made in all learning environments. We would also like to explore how the inclusion criteria could be modified to include dyads that experienced the same simulation activities, not from an entire nursing program. Additional questions also include: Does the level of training/faculty development of the instructor in simulation/debriefing affect the psychological safety of the learner? Does the clinical context of the simulation affect psychological safety of the learner? Is there a correlation between the student confidence level and their perception of psychological safety? This is evidently an area that requires much more exploration.

8. Conclusion

Psychological safety is a concept that is used to create an atmosphere that is safe for learners in simulation to take risks and/or feel comfortable making mistakes. In nursing simulation education, research has found that psychological safety is beneficial to student learning and their overall ability to make and learn from their mistakes. Frequently, simulation faculty believes that they have created a psychologically safe learning environment, however this belief may not be shared by the simulation participants. This study has provided insight into both the perceptions of students and faculty in relation to psychological safety in simulation and has highlighted the gaps in perceptions between students and faculty.

CRediT authorship contribution statement

Sufia Turner: Conceptualization, Methodology, Validation, Formal analysis, Investigation, Data curation, Writing – original draft, Writing – review & editing, Visualization, Funding acquisition. **Nicole Harder:** Conceptualization, Methodology, Validation, Formal analysis, Data curation, Writing – original draft, Writing – review & editing, Supervision, Project administration, Funding acquisition. **Donna Martin:** Conceptualization, Methodology, Validation, Formal Analysis, Data Curation, Writing – Review & Editing, Supervision. **Lawrence Gillman:** Conceptualization, Methodology, Validation, Formal analysis, Data curation, Writing – review & editing, Supervision.

Declaration of competing interest

There are no conflicts of interest to declare.

Acknowledgements

I would like to thank Sigma Thea Tau International, Xi Lambda Chapter and the Irene E. Nordwich Foundation Scholarships for the generous funding and support of this study.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.nedt.2023.105712.

References

Abatzis, V.T., Littlewood, K.E., 2015. Debriefing in simulation and beyond. Int. Anesthesiol. Clin. 53 (4), 151–162. https://doi.org/10.1097/AIA.0000000000000070.

Bynum, W., Haque, T., 2016. Risky business: psychological safety and the risks of learning medicine. J. Grad. Med. Educ. 8, 780–782. https://doi.org/10.4300/JGME-D-16-00549.1.

Cantrell, M.A., 2008. The importance of debriefing in clinical simulations. Clin. Simul. Nurs. 4 (2), e19–e23. https://doi.org/10.1016/j.ecns.2008.06.006.

Cheng, Kessler, D., Mackinnon, R., Chang, T.P., Nadkarni, V.M., Hunt, E.A., Duval-Arnould, J., Lin, Y., Cook, D.A., Pusic, M., Hui, J., Moher, D., Egger, M., Auerbach, M., 2016. Reporting guidelines for health care simulation research: extensions to the CONSORT and STROBE statements. Simul. Healthc. 11 (4), 238–248. https://doi.org/10.1097/SIH.0000000000000150.

Dale-Tam, J., Thompson, K., Dale, L., 2021. Creating psychological safety during a virtual simulation session. Clin. Simul. Nurs. 57, 14–17. https://doi.org/10.1016/j.ecns.2021.01.017.

Daniels, A., Morse, C., Breman, R., 2021. Psychological safety in simulation-based prelicensure nursing education: a narrative review. Nurse Educ. 46 (5), 99–102. https://doi.org/10.1097/NNE.0000000000001057.

Dreifuerst, 2015. Getting started with debriefing for meaningful learning. Clinical Simulation in Nursing 11 (5), 268–275. https://doi.org/10.1016/j.ecns.2015.01.005.

Goldsworthy, S., Verkuyl, M., 2021. Facilitated virtual synchronous debriefing: a practice approach. Clin. Simul. Nurs. 59, 81–84. https://doi.org/10.1016/j.ecns.2021.06.002.

INACSL Standards Committee, 2021. Healthcare simulation standards of best practiceTM. Clin. Simul. Nurs. 58, 66. https://doi.org/10.1016/j.ecns.2021.08.018.

Jeffries, P.R. (Ed.), 2016. The NLN Jeffries Simulation Theory. Wolters Kluwer, Philadelphia, PA.

Johnson, Scott, A.L., Franks, L., 2020. Impact of standardized patients on first semester nursing students self-confidence, satisfaction, and communication in a simulated clinical case. SAGE Open Nursing 6, 1–7. https://doi.org/10.1177/2377960820930153.

Kang, S.J., Min, H.Y., 2019. Psychological safety in nursing simulation. Nurse Educ. 44 (2), E6–E9. https://doi.org/10.1097/NNE.0000000000000571.

Karabacak, U., Unver, V., Ugur, E., Kocatepe, V., Ocaktan, N., Ates, E., Uslu, Y., 2019. Examining the effect of simulation based learning on self-efficacy and performance of first-year nursing students. Nurse Educ. Pract. 36, 139–143. https://doi.org/10.1016/j.nepr.2019.03.012.

Kim, S.S., De Gagne, J.C., 2018. Instructor-led vs. Peer-led debriefing in preoperative care simulation using standardized patients. Nurse Educ. Today 71, 34–39. https://doi.org/10.1016/j.nedt.2018.09.001.

Kolbe, M., Eppich, W., Rudolph, J., Meguerdichian, M., Catena, H., Cripps, A., Cheng, A., 2019. Managing psychological safety in debriefings: a dynamic balancing act. BMJ Simul. Technol. Enhanced Learn. 0, 1–8. https://doi.org/10.1136/bmjstel-2019-000470.

Kolbe, M., Grande, B., Spahn, D., 2015. Briefing and debriefing during simulation-based training and beyond: content, structure, attitude and setting. Best Pract. Res. Clin. Anaesthesiol. 29, 87–96. https://doi.org/10.1016/j.bpa.2015.01.002.

Kostovich, C., O'Rourke, J., Stephen, L., 2020. Establishing psychological safety in simulation: faculty perceptions. Nurse Educ. Today 91, 104468. https://doi.org/10.1016/j.nedt.2020.104468.

Lateef, F., Lin, Y., 2020. Maximizing learning and creativity: understanding psychological safety in simulation-based learning. J. Emerg. TraumaShock 13 (1), 5–14. https://doi.org/10.4103/JETS.JETS_96_19.

Lepnurm, R., Lockhart, W., Keegan, D., 2009. A measure of daily distress in practising medicine. Can. J. Psychiatr. 54 (3), 170–180. https://doi.org/10.1177/070674370905400305.

Terminology and Concepts Working Group, 2020. In: Lioce, L., Lopreiato, J., Downing, D., Chang, T.P., Robertson, J.M., Anderson, M., Diaz, D.A., Spain, A.E. (Eds.), Healthcare Simulation Dictionary –Second Edition. Agency for Healthcare Research and Quality, Rockville, MD. https://doi.org/10.23970/simulationv2. September 2020. AHRQ Publication No. 20-0019.

Luctkar-Flude, M., Wilson-Keates, B., Tyerman, J., Larocque, M., Brown, C.A., 2017. Comparing instructor-led versus student-led simulation facilitation methods for novice nursing students. Clin. Simul. Nurs. 13 (6), 264–269. https://doi.org/10.1016/j.ecns.2017.03.002.

Malterud, K., Siersma, V.D., Guassora, A.D., 2016. Sample size in qualitative interview studies: guided by information power. Qual. Health Res. 26 (13), 1753–1760. https://doi.org/10.1177/1049732315617444.

Morse, J.M., Field, P.A., 1995. Qualitative Research Methods for Health Professionals, 2nd ed. Sage Publications.

Munhall, P.L., 2012. Nursing Research: A Qualitative Perspective, (5th ed.). Jones and Bartlett Learning.

Newman, A., Donohue, R., Eva, N., 2017. Psychological safety: a systematic review of the literature. Hum. Resour. Manag. Rev. 27 (3), 521–535. https://doi.org/10.1016/j.hrmr.2017.01.001.

Nielsen, B., Harder, N., 2013. Causes of student anxiety during simulation: what the literature says. Clin. Simul. Nurs. 9 (11), e507–e512. https://doi.org/10.1016/j.ecns.2013.03.003.

Polit, D.F., Beck, C.T., 2017. Nursing Research: Generating and Assessing Evidence for Nursing Practice, (10th ed.). Lippincott Williams & Wilkins.

Roh, Y.S., Ahn, J.W., Kim, E., Kim, J., 2018. Effects of prebriefing on psychological safety and learning outcomes. Clin. Simul. Nurs. 25 (C), 12–19. https://doi.org/10.1016/j.ecns.2018.10.001.

Rudolph, W.J., Raemer, B.D., Simon, B.R., 2014. Establishing a safe container for learning in simulation: the role of the presimulation briefing. Simul. Healthc. 9 (6), 339–349. https://doi.org/10.1097/SIH.0000000000000047.

Sharoff, L., 2015. Simulation: pre-briefing preparation, clinical judgement and reflection. What is the connection? J. Contemp. Med. 5 (2), 88–101. https://doi.org/10.16899/ctd.49922.

Stephen, L., Kostovich, C., O'Rourke, J., 2020. Psychological safety in simulation: prelicensure nursing students' perceptions. Clin. Simul. Nurs. 47, 25–31. https://doi.org/10.1016/j.ecns.2020.06.010.

Thomas, D.R., 2006. A general inductive approach for analyzing qualitative evaluation data. Am. J. Eval. 27 (2), 237–246. https://doi.org/10.1177/1098214005283748.

Thorne, S., 2016. Interpretive Description: Qualitative Research for Applied Practice, (2nd ed.). Taylor & Francis.

Tsuei, S., Lee, D., Ho, C., Regehr, G., Nimmon, L., 2019. Exploring the construct of psychological safety in medical education. Acad. Med. 94 (11), 28–35. https://doi.org/10.1097/ACM.0000000000002897.

Turner, S., Harder, N., 2018. Psychological safe environment: A Concept Analysis. Clin. Simul. Nurs. 18, 47–55. https://doi.org/10.1016/j.ecns.2018.02.004.

Tyerman, J., Luctkar-Flude, M., Graham, L., Coffey, S., Olsen-Lynch, E., 2019. A systematic review of health care presimulation preparation and briefing effectiveness. Clin. Simul. Nurs. 27, 12–25. https://doi.org/10.1016/j.ecns.2018.11.002.

Wickers, M.P., 2010. Establishing the climate for a successful debriefing. Clin. Simul. Nurs. 6 (3), e83–e86. https://doi.org/10.1016/j.ecns.2009.06.003.

Zulkosky, K., 2009. Self-efficacy: a concept analysis. Nurs. Forum 44 (2), 93–102. https://doi.org/10.1111/j.1744-6198.2009.00132.x.

Agenda Item 7.3

Discussion and Possible Action:
Regarding the NPAC and NMAC Recommendations on Proposed Draft Regulatory Language to Amend the Recommended Guidelines for Disciplinary Orders and Conditions of Probation

BRN Board Meeting | May 23-24, 2024

BOARD OF REGISTERED NURSING
Agenda Item Summary

AGENDA ITEM: 7.3
DATE: May 23-24, 2024

ACTION REQUESTED: **Discussion and possible action:** Regarding the NPAC and NMAC recommendations on proposed draft regulatory language to amend the Recommended Guidelines for Disciplinary Orders and Conditions of Probation

REQUESTED BY: Mary Fagan, PhD, RN, NEA-BC
Chair, Nursing Practice Committee

BACKGROUND:

During the NMAC and NPAC meetings on March 26, 2024, the members discussed proposed regulation text to update Probation Condition #8 under the "Introductory Language and Standard Probation Conditions" section of the current Disciplinary Guidelines document.

During NMAC discussions, members requested clarifying supervision language for minimum, moderate, and maximum and using terminology that is used in practice. For example, direct supervising patient care would mean in room, present clinical setting would mean a broader location but not necessarily in the room, readily available could mean offsite, etc. NMAC also discussed, adding the financial relationship under the approval criteria when the language speaks to not having a personal or familial relationship and had a broader discussion regarding responsible party for payment of the monitor.

These recommendations/discussion topics were shared with the NPAC members during their meeting and NPAC agreed with the recommendations. Both committees voted to move the language forward to the Nursing Practice Committee, incorporate changes discussed as well as any changes recommended by the Nursing Practice Committee, and present the updated language at the next meeting for further review and discussion.

During the Nursing Practice Committee meeting on April 18, 2024, the members voted to approve to NPAC and NMAC recommendations on proposed draft regulatory language to amend the Recommended Guidelines for Disciplinary Orders and Conditions of Probation and authorize Board staff to initiate drafting regulatory language for revisions and/or additions to California Code of Regulations (CCR), title 16, Article 3 Prelicensure Nursing Programs.

The proposed regulatory language presented to NMAC and NPAC is included after this AIS.

RESOURCES:

BRN Disciplinary Guidelines: https://www.rn.ca.gov/pdfs/enforcement/discguide.pdf

https://govt.westlaw.com/calregs/Document/IF5EF36F34C8111EC89E5000D3A7C4BC3?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)

§ 1444.5. Disciplinary Guidelines.

In reaching a decision on a disciplinary action under the administrative adjudication provisions of the Administrative Procedure Act (Government Code Section 11400 et seq.), the board shall consider the disciplinary guidelines entitled: "Recommended Guidelines for Disciplinary Orders and Conditions of Probation" (10/02), which are hereby incorporated by reference. Deviation from these guidelines and orders, including the standard terms of probation, is appropriate where the board, in its sole discretion, determines that the facts of the particular case warrant such a deviation--for example: the presence of mitigating factors; the age of the case; evidentiary problems.

Notwithstanding the disciplinary guidelines, any proposed decision issued in accordance with the procedures set forth in Chapter 5 (commencing with section 11500) of Part 1 of Division 3 of Title 2 of the Government Code that contains any finding of fact that the licensee engaged in any acts of sexual contact, as defined in subdivision (c) of Section 729 of the Business and Professions Code, with a patient, or has committed an act or been convicted of a sex offense as defined in Section 44010 of the Education Code, shall contain an order revoking the license. The proposed decision shall not contain an order staying the revocation of the license.

Nursing Practice Act - Business and Professions Code (BPC), Division 2, Chapter 6:
https://leginfo.legislature.ca.gov/faces/codes_displayexpandedbranch.xhtml?tocCode=BPC&division=2.&title=&part=&chapter=&article=&nodetreepath=4

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=BPC&sectionNum=2837.102.

BPC 2837.102(a):
(a) The board shall establish a Nurse Practitioner Advisory Committee to advise and make recommendations to the board on all matters relating to nurse practitioners, including, but not limited to, education, appropriate standard of care, and other matters specified by the board. The committee shall provide recommendations or guidance to the board when the board is considering disciplinary action against a nurse practitioner.

NEXT STEPS:

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT:
McCaulie Feusahrens
Chief of the Licensing Division
California Board of Registered Nursing
mccaulie.feusahrens@dca.ca.gov

DRAFT

Probation Condition #8 – Supervision

*[proposed added text is denoted in underline formatting at subdivision (e)]***(8) SUPERVISION -** Respondent shall obtain prior approval from the Board regarding respondent's level of supervision and/or collaboration before commencing or continuing any employment as a registered nurse, or education and training that includes patient care.

Respondent shall practice only under the direct supervision of a registered nurse in good standing (no current discipline) with the Board of Registered Nursing, unless alternative methods of supervision and/or collaboration (e.g., with an advanced practice nurse or physician) are approved.

Respondent's level of supervision and/or collaboration may include, but is not limited to the following:

(a) Maximum - The individual providing supervision and/or collaboration is present in the patient care area or in any other work setting at all times.

(b) Moderate - The individual providing supervision and/or collaboration is in the patient care unit or in any other work setting at least half the hours respondent works.

(c) Minimum - The individual providing supervision and/or collaboration has person-to-person communication with respondent at least twice during each shift worked.

(d) Home Health Care - If respondent is approved to work in the home health care setting, the individual providing supervision and/or collaboration shall have person-to-person communication with respondent as required by the Board each workday. Respondent shall maintain telephone or other telecommunication contact with the individual providing supervision and/or collaboration as required by the Board during each workday. The individual providing supervision and/or collaboration shall conduct, as required by the Board, periodic, on-site visits to patients' homes visited by the respondent with or without respondent present.

(e) Independent Practitioner - If the respondent is certified by the Board as an advanced practice registered nurse and authorized to practice without standardized procedures in an independent setting, the Board may, upon review of pertinent information, require the respondent, during probation, to establish a practice setting where a Board-approved advanced practice registered nurse or physician and surgeon can provide supervision to the respondent, as specified by the Board. The respondent shall not resume practice in an independent setting until the Board confirms in writing this requirement has been met.

In its approval of a supervising practitioner, the criteria considered by the Board may include, but is not limited to, the following:

1. The practitioner is trained in the same specialty or content area as the respondent.

2. The practitioner's license is in good standing (no current or pending discipline) with the issuing board.

3. The practitioner does not a have a close personal or familial relationship with the licensee.

The respondent's level of supervision may include, but is not limited to the following:

1. Maximum - The individual providing supervision is present in the independent setting at all times.

2. Moderate - The individual providing supervision is present in the independent setting at least half the hours respondent works.

3. Minimum - The individual providing supervision has person-to-person communication with respondent at least twice during each shift worked.

Agenda Item 7.4

Information Only:
Overview of Certified Registered Nurse Anesthetist (CRNA) Scope of Practice and Oversight

BRN Board Meeting | May 23-24, 2024

BOARD OF REGISTERED NURSING
Agenda Item Summary

AGENDA ITEM: 7.4
DATE: May 23-24, 2024

ACTION REQUESTED: **Information only:** Overview of Certified Registered Nurse Anesthetist (CRNA) scope of practice and oversight.

REQUESTED BY: Loretta Melby, RN, MSN
Executive Officer

BACKGROUND:
The Certified Registered Nurse Anesthetist (CRNA) is an advanced practice nurse who has met standards for certification from the Board consistent with the standards of the National Board of Certification and Recertification for Nurse Anesthetists, who is licensed to practice nurse anesthesia by the BRN. The utilization of a nurse anesthetist to provide anesthesia services is at the discretion of the physician, dentist or podiatrist. These services are delivered during the perianesthesia time period which includes pre-operative, intra-operative, and post-operative care that encompasses presurgical testing where the patient is evaluated for their ability to tolerate an anesthetic through delivery of anesthesia and emerging from anesthesia where the patient is monitored and cared for until they are stable enough to safely transfer to other areas for care or is discharged.

The general scope of practice for CRNAs is governed by BPC 2725. Anesthesia services can be provided in California by a nurse anesthetist when requested by a physician and without physician supervision or a requirement for standardized procedures.

RESOURCES:
Nursing Practice Act, Article 7 (Nurse Anesthetists) - Business and Professions Code sections 2825-2833.6:
https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=BPC&division=2.&title=&part=&chapter=6.&article=7.

Business and Professions Code section 2725:
https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=BPC&sectionNum=2725.

NEXT STEPS:

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT: McCaulie Feusahrens
Chief of the Licensing Division
California Board of Registered Nursing
mccaulie.feusahrens@dca.ca.gov

67 Ops. Cal. Atty. Gen. 122 (Cal.A.G.), 1984 WL 162046

Office of the Attorney General

State of California
Opinion No. 83-1007
April 5, 1984

***1** THE HONORABLE PAUL B. CARPENTER
MEMBER OF THE CALIFORNIA SENATE

THE HONORABLE PAUL B. CARPENTER, MEMBER OF THE CALIFORNIA SENATE, has requested an opinion on the following question:

May a Certified Registered Nurse Anesthetist lawfully administer regional anesthetics pursuant to a "standardized procedure."

CONCLUSION

A Certified Registered Nurse Anesthetist may lawfully administer a regional anesthetic when ordered by and within the scope of licensure of a physician, dentist, podiatrist or clinical psychologist but not pursuant to a "standardized procedure."

ANALYSIS

We are asked whether a Certified Registered Nurse Anesthetist may lawfully administer regional anesthetics under a standardized procedure established pursuant to section 2725 [1] of the Nursing Practice Act.

Chapter 696, Statutes of 1983, added article 7 (commencing with § 2825) entitled "Nurse Anesthetists" to the Nursing Practice Act. Section 2826(a) defines nurse anesthetist to mean "a person who is a registered nurse, licensed by the board and who has met standards for certification from the board." Section 2830 provides that the Board of Registered Nursing (the board) "shall issue a certificate to practice nurse anesthesia to any person who qualifies under this article and is licensed pursuant to the provisions of this chapter." Section 2833.3 provides that nothing in the article "shall be construed to limit a certified nurse anesthetist's ability to practice nursing." Section 2833.5 provides:
"Except as provided in Section 2725 and in this section, the practice of nurse anesthetist does not confer authority to practice medicine or surgery."

Section 2833.6 provides: "This chapter is not intended to address the scope of practice of, and nothing in this chapter shall be construed to restrict, expand, alter, or modify the existing scope of practice of, a nurse anesthetist." Thus article 7 simply provides for the certification of qualified registered nurses as "nurse anesthetists" and does not add to or subtract from the authority the nurse anesthetist has as a registered nurse. This leaves the scope of practice of the Certified Nurse Anesthetist the same as it was before certification. It means that the scope of practice of the nurse anesthetist is the same as the scope of practice of the nurse anesthetist if the same as the cope of practice authorized by his or her license as a registered nurse. Accordingly we are relegated to the Nursing Practice Act and the scope of the practice of nursing to determine whether a certified registered nurse anesthetist may administer regional anesthetics. The use of nurses to administer anesthetics has had a turbulent history in California law. We turn now to an outline of that history to better understand the recent revisions of section 2725 which defines the practice of nursing.

***2** In the depths of the great depression one Dagmar Nelson was employed as a registered nurse in a Los Angeles hospital. She was assigned to the operating room with the duty of administering general anesthetics to patients undergoing surgery. William v. Chalmers-Francis, M.D., sought to enjoin this practice claiming that Dagmar's duties constituted the illegal practice of medicine in violation of the Medical Practice Act. Judgment denying the injunction was appealed to the California Supreme Court.

At the time in question California statutes provided for the licensing of registered nurses but did not define or restrict their functions. The Supreme Court noted that the well-supported findings showed conclusively that everything Dagmar had done in the operating room was done under the immediate direction and supervision of the operating surgeon and his assistants. The court then stated that the evidence had established that administration of anesthetics by nurses under the immediate direction and supervision of the operating surgeon was the uniformly-accepted practice and procedure in operating rooms. The court stated twice in its opinion that such practice was not diagnosing or prescribing within the meaning of the Medical Practice Act. [2] The court then declared that "it is the legally established rule that they [the nurses engaged in such practices] are but carrying out the orders of the physicians to whose authority they are subject. The surgeon has the power, and therefore the duty, to direct the nurse and her actions during the operation." The court affirmed the judgment. (Chalmers-Francis v. Nelson (1936) 6 Cal.2d 402.)

In 1939 the Legislature enacted Business and Professions Code sections 2725 and 2726 to read as follows:
"2725. The practice of nursing within the meaning of this chapter is the performing of professional services requiring technical skills and specific knowledge based on the principles of scientific medicine, such as are acquired by means of a prescribed course in an accredited school of nursing as defined herein, and practiced in conjunction with curative or preventive medicine as prescribed by a licensed physician and the application of such nursing procedures as involve understanding cause and effect in order to safeguard life and health of a patient and others.

"A professional nurse, within the meaning of this chapter, is a person who has met all the legal requirements for licensing as a registered nurse in the State and who for compensation or personal profit engages in nursing as the same is hereinabove defined.

"2726. This chapter confers no authority to practice medicine or surgery or to undertake the prevention, treatment or cure of disease, pain, injury, deformity, or mental or physical condition in violation of any provision of law." (Stats. 1939, ch. 807, p. 2349, § 2.)

In 1961 the case of Magit v. Board of Medical Examiners (1961) 57 Cal.2d 74 was decided by the California Supreme Court. In that case Dr. Magit, a director and chief anesthesiologist in a Beverly Hills hospital employed three foreign physicians who were expert anesthetists but were not licensed to practice medicine in California. He employed them to administer anesthetics in the hospital pursuant to his authorization. The Board of Medical Examiners found that Dr. Magit aided and abetted the three physicians in the unlicensed practice of medicine and surgery in the hospital, that he was guilty of unprofessional conduct and revoked his license to practice medicine in California. Dr. Magit appealed.

***3** The court first decided that administration of anesthetics constituted the practice of medicine and surgery under the Medical Practice Act. In this regard the court observed:
"Our statutes do not specifically provide that one who administers anesthetics must have a license to practice medicine or any of the other healing arts. Whether the administration of anesthetics by the three unlicensed persons was illegal and made Dr. Magit guilty of unprofessional conduct depends primarily upon whether it constituted the practice of 'any system or mode of treating the sick or afflicted' within the meaning of sections 2141 and 2392. If the administration of anesthetics does not come under these provisions, everyone would be free to administer them since there is no other statutory restriction which would apply. Those who administer anesthetics 'use drugs or what are known as medical preparations in or upon human beings' and, in administering spinal or epidural anesthetics, they 'penetrate the tissues of human beings' within the meaning of section 2137 of the code, which includes the quoted terms in setting forth the practice authorized by a physician's and surgeon's certificate. The application of anesthetics is obviously an integral part of the surgical treatment which it facilitates, and it falls directly within the language of sections 2141 and 2392. [3]

"Moreover, the code speaks of anesthetics in a manner which indicates a legislative intent that their use be considered as coming within the practice of medicine. Section 2192 includes in the curriculum required of applicants for a physicians' and surgeon's certificate adequate instruction in 'surgery, including ... [a]nesthesia,' and section 2139 provides that no chiropodist shall 'use an anesthetic other than local.' Section 2139, of course, is not intended to prohibit chiropodists from performing acts generally permitted to be done by everyone, and since it precludes a chiropodist from administering general, spinal, or epidural anesthetics, it clearly indicates that the right to give such anesthetics is restricted. (Cf. State v. Catellier, 63 Wyo. 123 [179 P.2d 203, 218] [construing Wyoming statute similar to § 2139].)

"In accord with the conclusion that anesthetization constitutes a mode of treating the sick is People v. Nunn, 65 Cal.App.2d 188, 190 [150 P.2d 479], which affirmed an osteopathic physician's conviction of conspiracy to cause a chiropractor to practice as a surgeon and to administer drugs. The opinion sets forth among the incriminating facts the administration of anesthetics by the chiropractor in the presence of the osteopath who knew that the chiropractor 'had no license to administer the anesthetic, apply the hypodermic needle or give any drug that comes within materia medica.' The desirability of restricting the right to administer anesthetics was recognized in Painless Parker v. Board of Dental Examiners, 216 Cal. 285, 295, where this court said: 'The right to administer anesthetics which produce local or general insensibility to pain, or drugs which may produce total or semi-unconsciousness, or otherwise affect the nervous system, should be withheld not only from all persons who are not highly skilled in the knowledge of and the use of said drugs, but also from persons who cannot produce evidence of good moral character."

***4** The court in Magit next considered certain exceptions to the rule that unlicensed persons may not practice medicine. At page 62 the court observed:
"Under some circumstances, persons not licensed to practice medicine in California may legally perform some medical acts, including the administration of anesthetics. For example, sections 2147-2147.6 of the Business and Professions Code permit certain persons engaged in medical study and teaching at approved hospitals to perform acts which constitute treatment of the sick, but no such exemption is applicable to the activities of Rios, Celori, and Ozbey at the Doctors Hospital, which concededly was not approved for the training of students or interns. Another example is found in Chalmers-Francis v. Nelson (1936) 6 Cal.2d 402, where it was held that a licensed registered nurse should not be restrained from administering general anesthetics in connection with operations under the immediate direction and supervision of the operating surgeon and his assistants.

"At the time of the Chalmers-Francis case the statutes provided for the licensing of nurses but did not define or restrict their functions. In the absence of a statutory definition the court looked to the existing custom and practice concerning the administration of anesthetics by nurses. It has generally been recognized that the functions of nurses and physicians overlap to some extent, and a licensed nurse, when acting under the direction and supervision of a licensed physician, is permitted to perform certain tasks which, without such direction and supervision, would constitute the illegal practice of medicine or surgery. [5] [4] No custom concerning the giving of anesthetics by persons other than licensed nurses was considered in the opinion, and the court did not discuss whether the administration of anesthetics by nurses or others constituted the practice of medicine. The decision was thus based on the special status of a licensed nurse and has no application to others.

"Three years after the Chalmers-Francis decision, a number of provisions concerning nursing were added to the code, among which were sections 2725 and 2726. Section 2725 defines the practice of nursing and shows a legislative intent that a nurse may, under the direction of a licensed physician, perform services which require technical skill and medical knowledge. Section 2726 states that the chapter dealing with nursing does not confer any authority to practice medicine or surgery. These sections must be construed together, and when this is done it is clear that section 2726 does not mean that nurses are precluded from performing all acts which are medical or surgical in character but, rather, that they would be guilty of illegally practicing medicine or surgery only if their conduct in performing such acts did not come within the permissible scope of a nurse's functions as defined in section 2725. The definition of section 2725 is so broad that the administration of certain forms of anesthetics by a registered nurse, acting under the immediate direction and supervision of a licensed physician, may come within its scope. To what extent and under what conditions it authorizes nurses to perform such acts is not before us, and we need note only that any authority

they may have in this field is derived from their special statutory position and does not affect the authority of others. Obviously, the Chalmers-Francis decision related only to the then existing practice and to the particular general anesthetics in use at that time, and it is not controlling with respect to any other anesthetic or any other method of producing anesthesia.

***5** "In the absence of some statutory basis of an exception, such as those with respect to nurses and persons engaged in medical study or teaching, one who is not licensed to practice medicine or surgery cannot legally perform acts which are medical or surgical in character, and supervision does not relieve an unauthorized person from penal liability for the violation of statutes which, like section 2141 of the code, prohibit the unlicensed practice of medicine."

In 1972 this office issued an opinion published in 56 Ops.Cal.Atty.Gen. 1 concluding that a registered nurse could not lawfully administer spinal, epidural or regional anesthesia or analgesia and that in administering general anesthetics a registered nurse must be supervised by a licensed physician or dentist. The opinion was based on the language of the Magit case limiting the reach of the Chalmers-Francis case to general anesthesia.

The next significant development in the law defining the practice of nursing was the revision of sections 2725 and 2726 in 1974. That revision commenced with the introduction of AB 3124 by Assemblyman Gordon Duffy sponsored by the California Nurses Association. As introduced AB 3124 provided:
"2725. In amending this section at the 1973-74 session, the Legislature recognizes that nursing is a dynamic field, the practice of which is continually evolving to include more sophisticated patient care activities.

"The practice of nursing within the meaning of this chapter means helping people cope with those difficulties in daily living which are associated with their actual or potential health or illness problems or the treatment thereof, and includes all of the following:

"(a) Any procedure which may be performed by a person licensed pursuant to chapter 6.5 (commencing with Section 2840). [Re licensed vocational nurses.]

"(b) The planning and performance of direct and indirect patient care services that insure the safety, comfort, personal hygiene, and protection of patients, and the performance of disease prevention and restorative measures.

"(c) The planning and performance of direct and indirect patient care services, including, but not limited to, the administration of medication and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen prescribed by a physician, dentist or podiatrist.

"(d) The performance of basic medical care, testing, and prevention procedures, including but not limited to, skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.

"(e) Observation of signs and symptoms of illness, reaction to treatment, general behavior, or general physical condition and (1) determination of whether such signs, symptoms, reactions, behavior or general appearance exhibit abnormal characteristics; and (2) implementation, based on observed abnormalities, of appropriate reporting, referral, emergency treatment, or standardized appropriate procedures or changes in treatment regimen."

***6** Section 2 of the original bill would have repealed section 2726 which then read:
"2726. This chapter confers no authority to practice medicine or surgery or to undertake the prevention, treatment or cure of disease, pain, injury, deformity, or mental or physical condition in violation of any provision of law."

The California Nurses Association submitted a "Supportive Statement for AB 3124" which included the following comments regarding its provisions as originally introduced. Comment on the first two paragraphs reads:
"This is a broad, general and comprehensive definition of nursing to be followed by a specific description of functions within that definition. The bill states that the definition of nursing includes '... all of the following.' The reasons for making the list of defined functions all inclusive are:

"1. To define what a person licensed under the law is able to do which would otherwise be in violation of the Medical Practice Act:

"2. To define explicitly what other people cannot do if they are not licensed as registered nurses; and

"3. To provide guidance to the licensing board in determining what should be included in an approved education program to assure that licensees are able to perform in the manner described."

The California Nurses Association comment on subdivisions (b), (c), (d) and (e) read:
(b) "This describes the traditional, unique, and long established nursing functions that do not depend on physician direction."

(c) "This defines the traditional and long established nursing functions that do depend on physician direction."

(d) "It is envisioned that under this provision nurses will function under protocols established within an agency or institution jointly by medical and nursing staff."

(e) "This paragraph describes current practice regarding nursing assessment, decision-making and intervention."

The California Nurses Association comment on the repeal of section 2726 reads:
"AB 3124 removes this restrictive language from the current Nurse Practice Act. As medicine and nursing have evolved and continue to evolve, nurses have moved and will continue to move into areas previously considered medical practice. Many tasks that physicians are asking and expecting nurses to do today are considered medical acts (i.e., defibrillation, removal of sutures, withdrawing arterial blood and testing for blood gases, starting IVs). As long as this language remains it creates questions as to what nurses are authorized to do that is otherwise prohibited by the Medical Practice Act."

These comments of the California Nurses Association are significant in explaining the origin of certain language and its purpose when AB 3124 was first introduced. Our task now is to ascertain the intent and purpose of the Legislature with respect to the version which was finally enacted into law. More indicative of legislative intent is the Analysis of AB 3124 prepared by the staff of the Assembly Committee on Health. That analysis stated (inter alia):
***7** "AB 3124 is essentially an attempt to change the description of nursing practice from a very general and rather ambiguous definition to a more detailed and specific description. The language of AB 3124 has been hammered out in discussions between the California Hospital Association, California Medical Association, California Nurses Association and other interested parties, including the respective license boards. With one exception (see Comments) the author's amendments to the bill reflect general agreement of the parties.

"COMMENTS: 1. Unfortunately, even this attempt at spelling out the definition of nursing carries with it certain ambiguities. Perhaps this is unavoidable without a detailed, step-by-step listing of every technical procedure that nurses shall be allowed to perform. In any case, the following points may require clarification:

"a. The language on page 2, lines 17-21 [that part of the second paragraph preceding subdivision (a) in the original version of AB 3124 as quoted above], is very broad, and could include the rendering of well-meaning assistance to an ill person by any unlicensed person.

"b. The functions that are described on lines 25 through 39 [subdivisions (b) through (d) quoted above] are not well delineated. For example, on lines 28 and 29 [in subdivision (b)], 'disease prevention and restorative measures' appear similar to the notion of 'basic health care' on line 36 [in subdivision (d)].

"2. Subdivision (e) on page 2 of the bill is perhaps the most substantive feature of this bill, since it sets forth the basic circumstances under which a nurse would independently initiate procedures in rendering care to a patient, based upon the nurse's own judgment at the time. The specific clause upon which most discussion has focused is 'implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedure, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.' This means that the independence of the nurse will be a direct function of what these 'standardized procedures' are. AB 3124 does not contain a definition of 'standardized procedures.'

"3. In its original form this bill deleted the current provision in the law which prohibits nurses from practicing medicine. The authors amendments restore this prohibition. Instead, the amendments clarify this prohibition to remove language which, if left in the law, would contradict the basic the basic description of nursing as provided in this bill."

Amendments to AB 3124 deleted the first subdivision referring to licensed vocational nurses, restored section 2726 in abbreviated form and made other changes and additions to AB 3124 before its final enactment as chapter 355, Statutes of 1974. Furthermore another bill (AB 2879) was enacted in the same session as chapter 913, Statutes of 1974, which changed subdivision (c) and the definition of standardized procedures. The end product of the 1974 session of the Legislature amended sections 2725 and 2726 to read as follows:

***8** "2725. In amending this section at the 1973-74 session, the Legislature recognizes that nursing is a dynamic field, the practice of which is continually evolving to include more sophisticated patient care activities. It is the intent of the Legislature in amending this section at the 1973-74 session to provide clear legal authority for functions and procedures which have common acceptance and usage. It is the legislative intent also to recognize the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions within organized health care systems which provide for collaboration between physicians and registered nurses. Such organized health care systems include, but are not limited to, health facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, clinics, home health agencies, physicians' offices, and public or community health services.

"The practice of nursing within the meaning of this chapter means those functions helping people cope with difficulties in daily living which are associated with their actual or potential health or illness problems or the treatment thereof which require a substantial amount of scientific knowledge or technical skill, and includes all of the following:

"(a) Direct and indirect patient care services that insure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.

"(b) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen prescribed by a physician, dentist, or podiatrist.

"(c) The performance, according to standardized procedures, of basic health care, testing, and prevention procedures, including, but not limited to, skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.

"(d) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (1) determination of whether such signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics: and (2) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.

" 'Standardized procedures', as used in this section, means either of the following:

"(1) Policies and protocols developed by a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code through collaboration among administrators and health professionals including physicians and nurses.

"(2) Policies and protocols developed through collaboration among administrators and health professionals, including physicians and nurses, by an organized health care system which is not a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code. Such policies and protocols shall be subject to any guidelines for standardized procedures which the Board of Medical Examiners and the Board of Nursing Education and Nurse Registration may jointly promulgate; and if promulgated shall be administered by the Board of Nursing Education and Nurse Registration.

***9** "Nothing in this section shall be construed to require approval of standardized procedures by the Board of Medical Examiners or the Board of Nursing Education and Nurse Registration.

"2726. Except as otherwise provided herein, this chapter confers no authority to practice medicine or surgery."

In an unpublished opinion issued in 1976 (Opn. No. I.L. 76-186 formerly CV $^{76}/_{77}$ I.L.) this office concluded that the revision of section 2725 in 1974 had not changed our prior opinion in 56 Ops.Cal.Atty.Gen. 1 that registered nurses were not authorized to administer spinal, regional or epidural anesthesia. In that opinion we stated:
"The declared legislative intent in amending section 2725 as expressed in the section itself was to recognize 'the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions.' (Emphasis added.)

"The 'overlapping function' language appears to have been taken from Magit v. Board of Medical Examiners, supra, 57 Cal.2d at 83. It could thus be inferred that the legislative intent, in authorizing additional sharing of functions, was to permit registered nurses to administer those forms of anesthesia which Chalmers had not authorized them to administer. For reasons discussed below, such an inference is inappropriate.

"It is implicit in the revision of section 2726 that the Nursing Practice Act now authorizes nurses to perform some procedures previously confined to the practice of medicine or surgery. Furthermore section 2726 provided no authority to practice medicine or surgery, whereas section 2726 now bars the practice of medicine or surgery by nurses, except as provided in the Nursing Practice Act.

"Furthermore, section 2726 formerly prohibited a nurse from undertaking the prevention, treatment or cure of pain. No such limitation is contained in section 2726 as presently enacted. In fact, section 2725(b) specifically authorizes a nurse to administer medications necessary to implement a treatment and anesthesia constitutes a mode of surgical treatment. [10] [5]

"In light of the preamble to section 2725, and in light of section 2726, the provision in section 2725(b) that nurses may administer 'medication prescribed by a physician' might have supported the conclusion that nurses could administer spinal, regional and epidural anesthesia. [11] [6] Subsequent developments, however, compel a different result."

Our conclusion was based upon the passage of the Nurse Anesthetist Act (Assembly Bill 942) in 1975 and its veto by the Governor. We pointed to section 2831.2 of the proposed Act which read:
" 'In addition to nursing activities authorized pursuant to Section 2725 ... a nurse anesthetist may administer an anesthetic agent or agents, may terminate anesthesia, and may report and record a patient's condition under anesthesia.' [14 7] (Emphasis added.)"

We reasoned that:
"This language clearly indicates that the Legislature itself did not believe that section 2725 authorized the administration of all forms of anesthesia by nurses or nurse anesthetists, regardless of any interpretation to which sections 2725 and 2726 might otherwise reasonably be susceptible."

***10** Chapter 1161, Statutes of 1978, amended the last two sentences of section 2725 to change the names of regulatory agencies. The "Board of Medical Examiners" was changed to the "Division of Allied Health Professions of the Board of Medical Quality Assurance" and the "Board of Nursing Education and Nurse Registration" was changed to "Board of Registered Nursing." No other changes were made by the 1978 amendment.

The latest amendments to section 2725 were enacted by chapter 406, Statutes of 1980. The words "including basic health care" were inserted in the basic definition of the practice of nursing. Subdivision (b) was amended to change the words "prescribed by a physician" to "ordered by and within the scope of licensure of a physician" and clinical psychologists were added to the professions listed therein. Subdivision (c) was amended by deleting the words "according to standardized procedures, of basic health care, testing, and prevention procedures, including but not limited to" skin tests, etc. Section 2725 now reads:
"In amending this section at the 1973-74 session, the Legislature recognizes that nursing is a dynamic field, the practice of which is continually evolving to include more sophisticated patient care activities. It is the intent of the Legislature in amending this section at the 1973-74 session to provide clear legal authority for functions and procedures which have common acceptance and usage. It is the legislative intent also to recognize the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions within organized health care systems which provide for collaboration between physicians and registered nurses. Such organized health care systems include, but are not limited to, health facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, clinics, home health agencies, physicians' offices, and public or community health services."

"The practice of nursing within the meaning of this chapter means those functions including basic health care, which help people cope with difficulties in daily living which are associated with their actual or potential health or illness problem or the treatment thereof which require a substantial amount of scientific knowledge or technical skill, and includes all the following:

"(a) Direct and indirect patient care services that insure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.

"(b) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.

***11** "(c) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.

"(d) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (1) determination of whether such signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics;

and (2) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures."

" 'Standardized procedures', as used in this section, means either of the following:

"(1) Policies and protocols developed by a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code through collaboration among administrators and health professionals including physicians and nurses;

"(2) Policies and protocols developed through collaboration among administrators and health professionals, including physicians and nurses, by an organized health care system which is not a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code. Such policies and protocols shall be subject to any guidelines for standardized procedures which the Division of Allied Health Professions of the Board of Medical Quality Assurance and the Board of Registered Nursing may jointly promulgate; and if promulgated shall be administered by the Board of Registered Nursing.

"Nothing in this section shall be construed to require approval of standardized procedures by the Division of Allied Health Professions of the Board of Medical Quality Assurance or the Board of Registered Nursing."

The second paragraph of section 2725 provides a basic definition of the practice of nursing with examples of services included in the definition. The basic definition includes within the practice of nursing any function which meets a three pronged test:

(1) The function must help people cope with the difficulties of daily living.

(2) The function must be associated with their actual or potential health or illness problems or the treatment thereof.

(3) The function must require a substantial amount of scientific knowledge or technical skill.

The basic definition is very broad. The functions of any health care professional clearly meet the three pronged test in section 2725. Diagnosing the most obscure illness or performing the most delicate surgery would satisfy this basic definition of the practice of nursing. Does this mean that the Legislature intended to authorize registered nurses to perform all the functions being performed by all health care professionals, including physicians, surgeons, dentists, podiatrists, psychologists, chiropractors and pharmacists? We think not.

In the first place such an intent would fly in the face of section 2726 enacted as part of the same statute which enacted the basic definition. Section 2726 declared that "this chapter [the Nursing Practice Act] confers no authority to practice medicine or surgery" "[e]xcept as otherwise provided herein." It is difficult to reconcile section 2726 with the broad scope of the basic definition of the practice of nursing contained in section 2725. Had the Legislature intended to authorize registered nurses to perform all the functions of other health professionals as the three pronged test suggests there would have been no reason to enact section 2726.

***12** In the second place an intent to grant registered nurses the authority to perform all the functions of other health professionals would be inconsistent with the Legislature's purpose and intent expressed in the first paragraph of section 2725. The intent to permit additional sharing of functions between physicians and registered nurses within organized health care systems implies that there are and will continue to be some functions which will not be shared by the two professions.

Finally, the concept of the "standardized procedures" developed through collaboration of administrators, physicians and nurses in organized health care systems to which certain functions of registered nurses must conform denotes a form of control over such functions which is at odds with the notion that the authority of physicians and nurses are equivalent.

If the practice of nursing is not as all encompassing as the three pronged test of the basic definition suggests, what then limits such practice? The answer is found in the examples which accompany the basic definition.

At the end of the basic definition in section 2725 the words "and includes all the following:" appear, followed by subdivisions (a) through (d). The term "includes" is ordinarily a word of enlargement and not of limitation and the statutory definition of a thing as "including" certain things does not necessarily place thereon a meaning limited to the inclusions. (Paramount Gen. Hosp. Co. v. National Medical Enterprises, Inc. (1974) 42 Cal.App.3d 496, 501.) Whether the word "includes" used in a statute is used as a word of enlargement or limitation depends on the intention of the Legislature. (Coast Oyster Co. v. Perluss (1963) 218 Cal.App.2d 492, 501.) We have found nothing in section 2725 or the Nursing Practice Act to suggest that the Legislature intended the word "includes" at the end of the basic definition in section 2725 to be a word of limitation, limiting the basic definition to those things mentioned in subdivisions (a) through (d). We conclude therefore that it was used in its ordinary sense as a word of enlargement. (Paramount Gen. Hosp. Co. v. National Medical Enterprises, Inc., supra.)
"To ascertain the meaning of the statute, the phrases used therein must be construed in connection with the phrases with which they are associated, and particular expressions qualify those which are general (maxim of ejusdem generis, as codified, sec. 3534, Civ.Code; ...) " (In re Marquez (1935) 3 Cal.2d 625, 629.)

This rule of construction has been stated and explained as follows:
"Where general words follow specific words in an enumeration describing the legal subject, the general words are construed to embrace only objects similar in nature to those objects enumerated by the preceding specific words. Where the opposite sequence is found, i.e., specific words following a general, the doctrine is equally applicable, restricting application of the general term to things that are similar to those enumerated.

***13** "The doctrine of ejusdem generis is an attempt to reconcile an incompatibility between specific and general words in view of other rules of construction that all words in a statute are given effect, if possible; that parts of a statute are to be construed together; and that the legislature is presumed not to have used superfluous words. If the general words are given their full and natural meaning, that is, the meaning they would receive in the abstract, they would include the objects designated by the specific words, making the latter superfluous. If, on the other hand, the series of specific words is given its full and natural meaning, the general words are redundant in part. The rule accomplishes the purpose of giving effect to both the particular and the general words, by treating the particular words as indicating the class, and the general words as extending the provisions of the statute to everything embraced in that class, though not specifically named by the particular words.

"The resolution of this conflict by ascribing to the series its natural meaning and by restricting the meaning of the general words to things ejusdem generis [meaning literally, "of the same kind"] with the series is justified on the ground that had the legislature intended the general words to be used in their unrestricted sense, it would have made no mention of the particular words, but would have used only one compendious expression." (Southerland, Statutory Construction, 4th ed, § 47.17.)

The maxim of ejusdem generis must be applied with caution. It is only a rule of construction to aid in the ascertainment of legislative intention and will not be applied to defeat that intention. (People v. Silver (1940) 16 Cal.2d 714, 721.) It is applicable only where the persons and things specifically enumerated have common characteristics. (Miller v. McKinnon (1942) 20 Cal.2d 83, 94.) Like all rules of construction it applies only when there is some ambiguity in the statute which creates a need for construction.

Section 2725 appears to be a good candidate for application of the ejusdem generis maxim. The conflicts between the breadth of the basic definition and other provisions of the same section as well as with section 2726 which have been pointed out create an ambiguity which must be resolved by interpretation. The practices specified in subdivisions (a), (b), (c) and (d) of section 2725 share the common characteristics of providing health care services to patients and potential patients of an intermediate nature. This is consistent with the Legislature's expressed intention of "recognizing the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions within organized health care systems." Applying the maxim we construe the basic definition of the practice of nursing in section 2725 to include only those functions which are like those specifically enumerated in subdivisions (a), (b), (c) and (d).

***14** Thus the fact that the administration of a regional anesthetic by a registered nurse meets the three pronged test of the basic definition of nursing, it does not follow that section 2725 authorizes a registered nurse to administer regional anesthetics. We must examine the functions described in subdivisions (a) through (d) to determine whether the function in question, here, the administration of regional anesthetics, is either included in subdivisions (a) through (d) or if not, whether it is like any of those functions and thus by either route comes within the statutory definition of the practice of nursing.

Before turning to an examination of subdivisions (a), (b), (c) and (d) of section 2725 to determine whether any of them authorize nurses to administer regional anesthesia we pause to explain our understanding of the meaning of the terms anesthesia and regional anesthesia and the manner in which the same are administered.
"Anesthesia is defined as a loss of all modalities of sensation. Anesthesiology, the practice of anesthesia, may be defined as the art and science of relieving pain and anxiety while at the same time maintaining the vital activities of the body during surgery. Surgical anesthesia requires a loss of sensation with mental and muscular relaxation sufficient to permit surgical procedures to be performed." (Attorney's Textbook of Medicine, 3rd ed., by Roscoe N. Gray, M.D., vol. 3, ¶ 58.00.)

We assume the question refers to the administration of drugs by a nurse anesthetist to produce anesthesia in a patient undergoing surgery. We are therefore not concerned with the administration of drugs in contexts other than as incidental to a surgical procedure. As the court observed in Magit, supra, at page 81, "[t]he application of anesthetics is obviously an integral part of the surgical treatment which it facilitates."

In footnote 2 of 56 Ops.Cal.Atty.Gen. 1, 4 we set forth the various kinds of anesthesia and their definitions as follows:
" 'If the drug blocking the conduction is applied directly to the operating field (e.g., a drop of cocaine in the eye) it is called topical anesthesia; if injected into the operating area, local anesthesia. Injection around the nerves leading from the operating field is called nerve block. If the drug is placed in proximity to nerves close to where they enter the coverings of the spinal cord, it is called epidural anesthesia and if it is injected into the space within the sheath enveloping the spinal cord, it is spinal anesthesia.

" 'If the brain itself is influenced by drugs, so that a painful stimulus is not felt as such, the state is called analgesia. If the drug produces unconsciousness as well, it is general anesthesia.' (Lawyers' Medical Cyclopedia, sec. 25.3, p. 568.)

" 'The term regional anesthesia signifies that only a portion of the body is made anesthetic. The term conduction anesthesia is also used to describe this type of anesthesia because the conduction of nerve impulses to and from a particular portion of the body is stopped. Included under this method are topical and local anesthesia, nerve-blocking anesthesia, and spinal anesthesia.' (Lawyers' Medical Cyclopedia, sec. 25.26, p. 607.)"

***15** Thus we consider the term regional anesthesia to refer to those forms which make only a portion of the body anesthetic including local, spinal, and epidural anesthesia.

We turn now to an examination of subdivisions (a), (b), (c) and (d) of section 2725 for specific functions of nurses, which, together with all functions of a like nature comprise the lawful practice of nursing. Each subdivision is examined for its relevance to the administration of anesthetics by nurses.

Subdivision (a) provides:
"(a) Direct and indirect patient care services that insure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures."

This language, incorporated in the original AB 3124 in 1974 was intended by its sponsor, the California Nurses Association, to describe "the traditional, unique and long established nursing functions that do not depend on physician direction." The Legislature appears to have acquiesced in that description since no change was made in the language. So understood, subdivision (a) would not encompass the administration of anesthetics.

Subdivision (b) of section 2725 provides:
"(b) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure, of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code."

We have previously recognized that a drug used upon a human being to produce anesthesia to facilitate surgery or other medical procedures was a "medication and therapeutic agent" within the meaning of subdivision (b). (64 Ops.Cal.Atty.Gen. 240, 250 and fn. 5 (1981); 65 Ops.Cal.Atty.Gen. 427, 432-433 (1982).) Subdivision (b) provides express authority for a registered nurse to administer an anesthetic when it is ordered by a physician, dentist, podiatrist or clinical psychologist acting within the scope of his or her license. As we pointed out in 64 Ops.Cal.Atty.Gen. 240, 252 the authority granted by subdivision (b) is limited to orders by the doctor made on an individualized patient basis and is based upon the doctor's judgment as to the treatment necessary for a particular patient. Once the doctor has evaluated the patient's condition there is nothing in the statute which would limit the orders which the doctor might give a nurse as to the kind of medications and therapeutic agents to use to implement a course of treatment. Nothing in subdivision (b) suggests any statutory basis for concluding that registered nurses may lawfully administer general anesthetics but not regional anesthetics. That distinction which originated in the Magit case dicta limiting the Chalmers-Francis case to its facts was effectively eliminated by the enactment of subdivision (b). We conclude that a registered nurse may lawfully administer an anesthetic, general or regional, under the authority of subdivision (b) of section 2725 when a physician, dentist, podiatrist or clinical psychologist, acting within the scope of his or her license, orders such nurse to administer the same to a particular patient. In reaching this conclusion we note that the revision of section 2725 in 1974 effectively overrules our 1972 opinion published in 56 Ops.Cal.Atty.Gen. 1. With respect to our 1976 unpublished opinion (No. I.L. 76-188), we believe the reliance placed therein upon the actions taken with respect to a bill which never became the law to negate the express authority found in section 2725(b) was mistaken and for that reason the conclusion reached in that opinion is disapproved.

***16** Subdivision (c) of section 2725 provides:
"(c) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries."

None of these functions would appear to involve the administration of anesthetics.

Subdivision (d) of section 2725 provides:
"(d) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (1) determination of whether such signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics; and (2) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures."

The wording of subdivision (d) is little changed from subdivision (e) in the original version of AB 3124 in 1974 except that a definition of standardized procedures has been added to the section. The California Nurses Association commented that this subdivision "describes current practice regarding nursing assessment, decision-making, and intervention." The Analysis of AB 3124 by the Assembly Health Committee observed that this subdivision "is perhaps the most substantive feature of this bill, since it sets forth the basic circumstances under which a nurse would independently initiate procedures in rendering care to a patient, based upon the nurse's own judgment at the time." The committee analysis further observed that "the independence of the nurse will be a direct function of what these 'standardized procedures' are" and pointed out the need to define the term.

How does subdivision (d) of section 2725 relate to the administration of anesthetics by a nurse anesthetist to facilitate surgery by a physician? It would appear anomalous for the nurse anesthetist to administer an anesthetic in accordance with a "standardized procedure" as defined, rather than in accordance with the orders of the physician who is performing the surgery. This would mean that the manner in which the anesthetic is administered by the nurse anesthetist would be governed by the "policies and protocols" developed through collaboration among administrators and health professionals, including physicians and nurses by an organized health care system. We doubt that the Legislature intended to remove the control over an integral part of the surgical procedure from the physician responsible for the surgery and place it in the hands of a nurse acting in accordance with a standardized procedure. Standardized procedures were meant to govern the nurse's actions in situations when the physician responsible for the patient's care is absent and they do not apply when the responsible physician is present and orders a different procedure. This does not mean that the physician responsible for the patient's surgery may not direct the nurse anesthetist by means of some written instructions. It does mean that the physician responsible for the surgery retains control over the actions of the nurses involved in the surgery, including the nurse anesthetist, in spite of any standardized procedures which may have been developed. This is necessary to permit the physician to react to conditions which develop in the patient's best interest, which conditions may not have been foreseen at the time the standardized procedures for nurses were developed.

***17** We are bolstered in this interpretation of subdivision (d) of section 2725 by another rule of statutory construction. As recently stated by our Supreme Court:
"When used in a statute words must be construed together in context, keeping in mind the nature and obvious purpose of the statute where they appear, and the various parts of a statutory enactment must be harmonized by considering the particular clause or section in the context of the statutory framework as a whole." (People v. Black (1982) 32 Cal.3d 1, 5.)

In 64 Ops.Cal.Atty.Gen. 240, 250-251, we observed:
"Subdivision (d) authorizes nurses to perform procedures according to 'standardized procedures,' but is silent as to whether those procedures might entail the administering, furnishing or prescribing of drugs. Subsection (b), in contrast addresses that matter. It provides that the practice of nursing includes the function of the 'administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention or rehabilitative regimen ordered by a physician. ... (§ 2725, subd. (b).) thus, whatever the outer limits of the general authorization for nurses to perform health care functions according to 'standardized procedures' pursuant to subdivision (d) might be, they are circumscribed by the specific limitations contained in subdivision (b) by which a treatment regimen may only be undertaken as ordered by a physician. (Citations.) No mention is made for a registered nurse to otherwise administer medications, even under 'standardized procedures' and the authority to perform functions pursuant to the latter does not expressly extend to the 'administration of medications and therapeutic agents.' Indeed, the 5 year old authority in subdivision (c) for nurses to perform 'basic health care, testing and prevention procedures' according to 'standardized procedures' was deleted in 1980.

"We are convinced that the 'standardized procedures' mechanism does not accommodate the requirements set forth in subdivision (b). We perceive its specific mention that nurses may administer medications 'necessary to implement a regimen ordered by a physician' to be indicative of a legislative intent that (1) a course of treatment involving medications be based on a physician's judgment in each individual case and (2) that that treatment be only as ordered by the physician. A physician must ascertain the relevant facts about a patient to enable him to make a diagnosis and provide a course of treatment, and this must be done on an individualized patient basis. (Cf. § 2242, formerly § 2399.5; Health & Saf.Code § 11210.) A physician cannot

delegate to a nurse his authority to diagnose and to direct a course of treatment that he deems appropriate although he may utilize the services of others to help him ascertain the facts and to carry out his ordered treatment. (Cf. 45 Ops.Cal.Atty.Gen. 116, 117 (1965).) In the performance of functions under 'standardized procedures' however, it is the registered nurse and not the physician who makes the assessment of the patient's condition, discerns abnormalities and then takes action according to a protocol established by a 'standardized procedure.' Although the establishment of a protocol takes place through collaboration with physicians, we do not consider that participation to be tantamount to their 'ordering' a course of treatment involving medication within the meaning of subdivision (b). There is certainly no express or implied indication that a protocol should serve as such and its general nature is at odds with the notion of an order for medication, i.e., a prescription, expressed elsewhere in the Codes, involving as it does direction for medication given on an individualized patient basis."

***18** We conclude that a registered nurse and thus a Certified Registered Nurse Anesthetist may lawfully administer a regional anesthetic when ordered by and within the scope of licensure of a physician, dentist, podiatrist or clinical psychologist but not pursuant to a "standardized procedure" as defined in section 2725.

JOHN K. VAN DE KAMP
Attorney General
JACK R. WINKLER
Assistant Attorney General

Footnotes

1 All section references are to the Business and Professions Code unless otherwise indicated.

2 Section 17 of the Medical Practice Act then provided in part:

"Sec. 17. Any person who shall practice or attempt to practice, or who advertises or holds himself out as practicing, any system or mode of treating the sick or afflicted in this State, or who shall diagnose, treat, operate for, or prescribe for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other mental or physical condition of any person, without having at the time of so doing a valid unrevoked certificate as provided in this act ..., shall be guilty of a misdemeanor. ..." (Stats. 1933, ch. 499, p. 1276, § 2.)

3 Business and Professions Code sections 2141 and 2392 then provided:

Section 2141. "Any person, who practices or attempts to practice, or who advertises or holds himself out as practicing, any system or mode of treating the sick or afflicted in this State, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other mental or physical condition of any person, without having at the time of so doing a valid, unrevoked certificate as provided in this chapter, is guilty of a misdemeanor."

Section 2392. "The employing, directly or indirectly, of any suspended, or unlicensed practitioner in the practice of any system or mode of treating the sick or afflicted or in the aiding or abetting of any unlicensed person to practice any system or mode of treating the sick or afflicted constitutes unprofessional conduct within the meaning of this chapter."

4 Footnote 5 in the Magit case reads:

"In Lesnik and Anderson, Nursing Practice and the Law (2d ed. 1955) pp. 277-279, it is said that nurses perform many functions that are medical acts, and, in the absence of statute, custom and usage generally will control the nature and

scope of medical acts performed by them. Among the minimum requirements for a nurse's authority to perform such acts are that she proceed under the order and direction or supervision of a licensed physician and that she comprehend the cause and effect of the order."

5 Footnote 10 reads:

"10. It also constitutes the practice of medicine. Magit v. Board of Medical Examiners, supra, 57 Cal.2d at 81."

6 Footnote 11 reads:

"11. Section 2725(c) also provides that nurses may perform 'according to standardized procedures, of basic health care, testing, and prevention procedures, ...' such as skin tests, immunization techniques and blood withdrawals. Section 2725(d) authorizes nurses to observe 'signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, ...' and to implement standardized procedures or changes in treatment 'based on observed abnormalities. ...' These subsections clearly authorized functions involving far less skill and risk than the administration of regional, spinal or epidural anesthesia.

"Section 2725 also provides that the Legislature intended to provide 'clear legal authority for functions and procedures which have common acceptance and usage.' It is common nationally for certified nurse anesthetists to administer all forms of anesthesia (see AANA Fact Book, American Association of Nurse Anesthetists, April 1974), but this office has been informed by the California Association of Nurse Anesthetists that it is not commonly accepted procedure throughout California. Certainly, it would be an anomaly to permit the administration of regional, spinal and epidural anesthesia by nurse anesthetists in some areas or facilities of this State, but to consider it the illegal practice of medicine elsewhere."

7 Footnote 14 reads:

"14. Section 2831.5 of the Bill also provided that after July 1, 1976, no nurse other than a Board-certified nurse anesthetist could administer anesthesia. Rather than implying that nurses could previously administer all forms of anesthesia, section 2831.5 is simply consistent with an intent that after July 1, 1976, Chalmers, supra, would effectively be overruled."

67 Ops. Cal. Atty. Gen. 122 (Cal.A.G.), 1984 WL 162046

End of Document