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RI Senate Committee  
Health & Human Services  
82 Smith Street  
Providence RI, 02903

**Re: Written Testimony in Opposition to 2026 – S 3184**

**Relating to Businesses and Professions – Nurses**

Chairperson and Members of the Committee,

Thank you for the opportunity to submit testimony in opposition to 2026 – S 3184, legislation proposing restrictions on the administration of anesthetic agents by registered nurses (RNs) and advanced practice registered nurses (APRNs), other than CRNAs.

My name is Cassandra Algier, I am a master's prepared Registered Nurse with 14 years of experience, mostly in the Emergency Department. I currently am a Nurse Professional Development Specialist Manager for Education for a multi-hospital system, overseeing the Emergency Departments (EDs) Intensive Care Units (ICUs) and Critical Transport Nurses.

In this role, I provide education, competencies, and participate in policy writing. All of which are heavily influenced by the State Nurse Practice Act, regulatory requirements from multiple regulatory bodies, and any pertinent legislation.

I agree that patient safety is a shared priority, however, this bill presents significant risks to timely care delivery in emergency and critical care settings and may unintentionally compromise patient outcomes rather than improve them.

Emergency Departments (EDs) and Intensive Care Units (ICUs) function in highly time-sensitive environments where rapid clinical decision-making and early intervention are essential to preserving life and preventing deterioration. Although the bill includes limited exceptions for "critical life-saving situations," the restrictive language surrounding anesthetic administration creates ambiguity that may delay care while clinicians attempt to interpret compliance during emergent circumstances. In critical

care and emergency medicine, even brief delays in sedation, airway facilitation, or stabilization can significantly increase morbidity and mortality. I question the understanding of impact those who proposed this bill have regarding Critical Care and Emergency Medicine.

This legislation disproportionately impacts access to care. Many Rhode Island hospitals—particularly community and resource-limited facilities—do not have immediate, 24/7 on-site access to anesthesia providers or CRNAs in the ED. Under this bill, patients who require urgent procedural sedation or airway management may experience unnecessary delays or transfers, further straining an already overburdened emergency care system and worsening crowding and throughput challenges statewide. A simple example of this would be an orthopedic injury requiring procedural sedation but not requiring the OR. Facilities have policies that outline what constitutes as procedural sedation, these policies list parameters for monitoring, requirements of the RNs who may administer and monitor the procedure. Often these procedures happen in the ED with an ED Physician, an ED RN, and the Orthopedic team for reduction. ED and Critical Care nurses are competency verified, and have special training for these exact situations, including how to respond if at any time during the procedure the airway becomes compromised. This bill would delay care, requiring someone who has an orthopedic injury to wait for the availability of a CRNA or Anesthesia, this delay in reduction can result in increased morbidity, including chronic pain, reduced mobility, delayed or poor healing, and in the case of open fractures higher risk of infection.

Notably, the bill narrowly specifies the ED and ICU as the relevant “critical care settings,” while failing to address other high-acuity areas where similar emergencies occur, such as step-down units, procedural areas, or interfacility transport environments. This selective scope introduces inconsistency and confusion in clinical operations and does not reflect the realities of modern acute-care delivery. To give an example, if a patient is on an intermediate level of care floor, and the RN notices that they are decompensating on the overnight shift, when Anesthesia has left for the day, many times smaller hospitals rely on ED providers to come up and manage the airway. This then puts the provider in a situation where they must weigh the legal repercussions, though the situation is headed to be life threatening, it may not be there yet. The language in this bill binds the hands of the helpers who know that early intervention, before the situation becomes imminently life threatening, is best for patient desirable patient outcomes.

Equally concerning is that this proposal legislates scope-of-practice determinations through statute rather than relying on the expertise of the Rhode Island Board of Nursing, the appropriate regulatory body charged with defining nursing practice, competencies, education, and safeguards. Scope of practice decisions are best guided by clinical evidence, evolving standards of care, and professional regulation—not fixed legislative language that may lack flexibility as practice and education evolve.

In practice today, RNs and APRNs working in emergency and critical care settings administer these medications under established hospital policies, credentialing processes, physician oversight, and rigorous competency validation. These safeguards already exist and are continuously monitored at institutional and regulatory levels. Replacing this framework with statutory limitations risks undermining safe, effective team-based care.

For these reasons, I respectfully urge the Committee to oppose 2026 – S 3184 and instead refer concerns about anesthetic administration to the Board of Nursing, where they can be thoughtfully reviewed, updated, and regulated in a manner that protects patient safety without restricting timely access to care in emergency and critical care environments.

Thank you for your consideration and for your continued commitment to the health and safety of Rhode Island residents.

Respectfully submitted,  
*Cassandra Algier, MSN, RN, CEN*