

Annual Position Statement Review
Agenda Items under 7.4.1-7.4.3

Summary of Request:

Board Position Statements are reviewed on an annual basis. This report contains the recommendations of staff with regard to the revision or combination of existing statements, and development of new Board Position Statements for nurses.

Historical Perspective:

Board position statements do not have the force of law, but are a means of providing direction for nurses on issues of concern to the Board relevant to protection of the public. Board position statements are reviewed annually for relevance and accuracy to current practice, the NPA, and Board rules. Input on changes was requested from the Board's NPAC committee inclusive of current statements, one new statement, and one significantly revised statement. No significant comments or concerns were received from the committee members.

Attached are copies of all current position statements (ATTACHMENT #1), with recommended changes. For ease of discussion, position statement changes have been divided into categories based on what aspect(s) of the position statement is/are being proposed for change. A copy of all position statements in numeric order is also attached.

Only two position statements are significant changes from the current documents. Position Statement 15.2 "Role of the Licensed Vocational Nurse in the Pronouncement of Death" incorporates the previous BVNE FAQ on this same subject. The position statement updates the previous FAQ by adding clarifications on specifics of documentation (ie: presumptive and conclusive signs of death), as well as relevant statutes (Health and Safety Code) and BNE Rules.

Position Statement 15.8 *Roles of LVNs & RNs in Administration and Management of Moderate Sedation* has been extensively rewritten and expanded to cover evolving changes in practice that are impacting nurses. This includes physicians who increasingly want to use anesthetic agents (capable of producing deep sedation within a narrow dose range) on non-intubated patients, as well as the Board's continuing position that moderate sedation is beyond the scope of practice for LVNs.

The remainder of the position statements either have no change or only non-substantive changes (such as "Texas Board of Medical Examiners" to "Texas Medical Board (TMB)."

Position Statements for 2006 are as follows:

7.4.1 Current Position Statements With No Changes or Non-Substantive Updates Only

- 15.1 Nurses Carrying Out Orders From Physician's Assistants
- 15.3 LVNs Engaging in Intravenous Therapy, Venipuncture, or PICC Lines
- 15.4 Educational Mobility
- 15.5 Nurses with the Responsibility for Initiating Physician Standing Orders
- 15.6 Board Rules Associated with Alleged Patient Abandonment

- 15.7 The Roles of LVNs & RNs in Management and/or Administration of Medications via Epidural or Intrathecal Catheter Routes
- 15.9 Performance of Laser Therapy by RNs or LVNs
- 15.10 Continuing Education: Limitations for Expanding Scope of Practice
- 15.11 Delegated Medical Acts
- 15.12 Use of American Psychiatric Associations Diagnoses by LVNs, RNs, or APNs
- 15.13 Roles of LVNs & RNs As School Nurses
- 15.14 Duty of the LVN and/or RN in Any Practice Setting
- 15.15 Board's Jurisdiction Over Nursing Titles and Practice
- 15.16 Development of Additional Nursing Education Programs
- 15.17 BNE/ Board of Pharmacy (TSBP) Joint Position Statement: Medication Errors
- 15.18 Nurses Carrying Out Orders from Advance Practice Nurses
- 15.19 Nurses Carrying out Orders from Pharmacists for Drug Therapy Management
- 15.20 Registered Nurses in the Management of an Unwitnessed Arrest
- 15.21 Application of Safe Harbor Peer Review to LVNs
- 15.22 APNs Providing Medical Aspects of Care of Themselves or Others With Whom There is a Close Personal Relationship
- 15.23 The RNs Use of Complementary Modalities
- 15.24 Nurses Engaging in Reinsertion of Permanently Placed Feeding Tubes

7.4.2 New LVN Position Statement (Revised from BVNE FAQ)

- 15.2 Role of the Licensed Vocational Nurse in the Pronouncement of Death {replaces previous LVN FAQ on the same subject}

7.4.3 New Position Statement Replacing Previous P.S. 15.8 *Administration of Moderate Sedation by the Registered Nurse*

- 15.8 ~~Administration of Moderate Sedation by the Registered Nurse~~ Roles of LVNs & RNs in Administration and Management of Moderate Sedation {also replaces previous LVN FAQ on Role of LVN in Conscious Sedation}

Pros and Cons

Pros: Adoption of the proposed changes to current and proposed position statements will provide guidance to nurses based on current practice standards, and will offer clarification for frequently asked questions. As this information is available on the BNE web page, it can be readily accessed without the delays that could occur were it necessary to speak with board staff via phone or e-mail for this same information.

Cons: If revisions are not implemented, these position statements may not accurately reflect current practice, and will lack the clarification being sought with the revisions.

Recommendations:

Move to adopt revisions and changes to position statements as presented under Agenda Items 7.4.1-7.4.3, with allowance for non-substantive word editing for purposes of clarity as may be deemed necessary by Board counsel.

ATTACHMENT #1
Board of Nurse Examiners
Position Statements
January 2006 Revisions

Table of Contents:

- 15.1 Nurses Carrying Out Orders From Physician’s Assistants
- 15.2 The Role of the Licensed Vocational Nurse in the Pronouncement of Death [****NEW****]
- 15.3 LVNs Engaging in Intravenous Therapy, Venipuncture, or PICC Lines
- 15.4 Educational Mobility
- 15.5 Nurses with the Responsibility for Initiating Physician Standing Orders
- 15.6 Board Rules Associated With Alleged Patient “Abandonment”
- 15.7 The Role of LVNs & RNs in Management and/or Administration of Medications via Epidural or Intrathecal Catheter Routes
- 15.8 ~~Administration of Moderate Sedation by the Registered Nurse~~ Roles of LVNs & RNs in Administration and Management of Moderate Sedation [****NEW/REPLACEMENT****]
- 15.9 Performance of Laser Therapy by RNs or LVNs
- 15.10 Continuing Education: Limitations for Expanding Scope of Practice
- 15.11 Delegated Medical Acts
- 15.12 Use of American Psychiatric Association Diagnoses by LVNs, RN or APNs
- 15.13 Role of the LVNs & RNs As School Nurses
- 15.14 Duty of a Nurse in Any Practice Setting
- 15.15 Board’s Jurisdiction Over Nursing Titles and Practice
- 15.16 Development of Nursing Education Programs
- 15.17 Board of Nurse Examiners/Board of Pharmacy: Joint Position Statement on Medication Errors
- 15.18 Nurses Carrying Out Orders from Advance Practice Nurses
- 15.19 Nurses Carrying Out Orders from Pharmacists for Drug Therapy Management
- 15.20 Registered Nurses in the Management of an Unwitnessed Arrest in a Resident in a Long Term Care Facility
- 15.21 ~~Application of Safe Harbor Peer Review to LVNs~~ [deleted 01/05]
- 15.22 APNs Providing Medical Aspects of Care for Themselves or Others With Whom There is a Close Personal Relationship
- 15.23 The RN's Use of Complementary Modalities
- 15.24 Nurses Engaging In Reinsertion of Permanently Placed Feeding Tubes

1 **15.1 Nurses Carrying out Orders from Physician’s Assistants**

2
3 The Nursing Practice Act includes the “administration of medications or treatments ordered by a physician,
4 podiatrist or dentist” as part of the practice of nursing. There are no other health care professionals listed. The
5 Board recognizes that in some practice settings nurses work in collegial relationships with physician assistants
6 (PAs) who may relay a physician’s order for a client being cared for by a Nurse.

7
8 A Nurse may carry out a physician’s order for the administration of treatments or medications relayed by a
9 physician assistant (PA) when that order originates with the PA’s supervising physician. Supervision must be
10 continuous but does not require the physical presence of a supervising physician at the place where the PA
11 services are performed provided a supervising physician is readily available by telecommunications. The
12 supervising physician should have given notice to the facility that he/she is registered with the Texas Medical
13 Board (TMB)~~Board of Medical Examiners (BME)~~ as the supervising physician for the PA and that he/she has
14 authorized the PA to relay orders. The PA must be licensed or registered by the TMB ~~BME~~. A list of physician
15 assistants credentialed by the medical staff and policies directing their practice should be available to the nursing
16 staff.

17
18 The order relayed by the PA may originate from a protocol; if the order originates from a protocol, the PA may
19 select specific tasks or functions required to implement the protocol, provided they are within the scope of the
20 protocol. The protocol must be signed by the supervising physician and must be on file and available to the
21 nursing staff at the facility, agency, or organization in which it is carried out. If the tasks or functions ordered fall
22 outside the scope of the protocol, the PA must consult with the physician to obtain a verbal order before the nurse
23 may carry out the order.

24
25 As with any order, the Nurse must seek clarification if he/she believes the order or treatment is inaccurate, non-
26 efficacious or contraindicated by consulting with the PA and physician as appropriate.

27 (Board Action, 01/1994; Revised 01/05)
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32 **15.2 The Role of the Licensed Vocational Nurse in the Pronouncement of Death**

33
34 *****NEW*****

35
36 LVNs do not have the authority to legally determine death, diagnose death, or otherwise pronounce death in the
37 State of Texas. Regardless of practice setting, the importance of initiating CPR in cases where no clear Do Not
38 Resuscitate (DNR) orders exist is imperative. The BNE has investigated cases involving the failure of a LVN to
39 initiate CPR in the absence of a DNR order.
40

41 It is within the LVN scope of practice as defined by Rule 217.11(1)-(2) (effective 9/28/04) and the *Interpretive*
42 *Guideline for LVN Scope of Practice under Rule 217.11(link)* for a LVN to gather data and perform a **focused**
43 assessment regarding a patient, to recognize significant changes in a patient’s condition, and to report said data
44 and observation of significant changes to the physician. The LVN’s focused assessment should include nursing
45 observations to determine the presence or absence of the following presumptive or conclusive signs of death:
46

47 **Presumptive Signs of Death**

- 48 The patient is unresponsive,
 - 49 The patient has no respirations,
 - 50 The patient has no pulse,
 - 51 Patient’s pupils are fixed and dilated,
- 52

1 The patient's body temperature indicates hypothermia: skin is cold relative to the patient's
2 baseline skin temperature,
3 The patient has generalized cyanosis, and
4

5 **Conclusive Sign of Death**

6
7 There is presence of livor mortis (venous pooling of blood in dependent body parts causing
8 purple discoloration of the skin which does blanch with pressure).
9

10 Upon reporting his/her clinical findings to the physician, and in accordance with facility policy, the LVN may
11 accept reasonable physician's orders regarding the care of the client; however, a LVN may not accept an order
12 that would require the LVN to "pronounce death," or to complete the state-required "medical certification" of a
13 death that occurs without medical attendance.
14

15 The BNE has no jurisdiction over physician practice, facility policies, or the laws regulating pronouncement of
16 death in Texas. Additional information on Texas regulations regarding pronouncement of death may be found in
17 Chapters 193 and 671 of the Texas Health and Safety Code, as well as through the Department of State Health
18 Services. A LVN is not responsible for the actions of a physician who elects to pronounce death by remote-
19 means. Physicians are licensed by, and must comply with, rules promulgated by the Texas Medical Board as well
20 as other laws applicable to the physician's practice setting.
21

22 **References:** Texas Statutes, Health and Safety Code; <http://www.capitol.state.tx.us/statutes/>

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24 [BVNE Statement adopted June 1999; revised BNE statement January 2006]
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29 **15.3 LVNs Engaging in Intravenous Therapy, Venipuncture, or PICC Lines**

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31 The basic educational curriculum for Licensed Vocational Nurses (LVNs) does not mandate teaching of
32 principles and techniques of insertion for peripheral intravenous catheters, or the administration of fluids and
33 medications via the intravenous route. Knowledge and skills relating to maintaining patency and performing
34 dressing changes of central line intravenous catheters is also not mandated as part of basic LVN education. As
35 such, basic competency in management of intravenous lines/intravenous therapy is not a given for any specific
36 LVN licensee.
37

38 **Applicable Nursing Standards**

39
40 LVN practice is guided by the Nursing Practice Act (NPA) and Board Rules. Rule 217.11, Standards of Nursing
41 Practice, is the rule most often applied to nursing practice issues. Two standards applicable in nearly all practice
42 scenarios include:

- 43 ● 217.11(1)(B) implement measures to promote a safe environment for clients and others, and
- 44 ● 217.11(1)(T) accept only those assignments that take into consideration client safety and that are
45 commensurate with the nurse's educational preparation, experience, knowledge, and physical and emotional
46 ability.
47

48
49 Additional standards in Rule 217.11 that may be applicable when a LVN chooses to engage in an IV therapy-
50 related task include (but are not limited to):
51
52

- 1 ● (1)(C) Know the rationale for and effects of medications and treatments and shall correctly administer the
- 2 same,
- 3 ● (1)(D) Accurately and completely report and document: (i) ..client status....(ii) nursing care rendered...(iii)
- 4 physician, dentist or podiatrist orders...(iv) administration of medications and treatments....(v) client
- 5 response(s)....,
- 6 ● (1)(G) Obtain instruction and supervision as necessary when implementing nursing procedures or practices,
- 7 ● (1)(H) Make a reasonable effort to obtain orientation/training for competency when encountering new
- 8 equipment and technology or unfamiliar care situations,
- 9 ● (1)(R) Be responsible for one's own continuing competence in nursing practice and individual professional
- 10 growth,
- 11 ● (2)(A)"Shall utilize a systematic approach to provide individualized, goal-directed nursing care ...[(i)-(v)],
- 12 and
- 13 ● (2)(C) ...perform other acts that require education and training as prescribed by board rules and policies,
- 14 commensurate wit the LVN's experience, continuing education, and demonstrated LVN competencies.
- 15

16 The Board's "Interpretive Guideline for LVN Scope of Practice Under Rule 217.11" [ftp://www.bne.state.tx.us/](ftp://www.bne.state.tx.us/lvn-guide.pdf)

17 [lvn-guide.pdf](ftp://www.bne.state.tx.us/lvn-guide.pdf) provides additional clarification of the Standards Rule as it applies to LVN Scope of Practice.

18 Instruction and skill evaluation relating to LVNs performing insertion of peripheral IV catheters and/or

19 administering IV fluids and medications as prescribed by an authorized practitioner may allow a LVN to expand

20 his/her scope of practice to include intravenous therapy.

21

22 It is the opinion of the Board that the LVN shall not engage in IV therapy related to either peripheral or central

23 venous catheters, including venipuncture, administration of IV fluids, and/or administration of IV push

24 medications, until successful completion of a validation course that instructs the LVN in the knowledge and

25 skills applicable to the LVN's IV therapy practice. The BNE does not define or set qualifications for an "IV

26 Validation Course" or for "LVN IV certification." The LVN who chooses to engage in intravenous therapy must

27 first have been instructed in the principles of intravenous therapy congruent with prevailing nursing practice

28 standards.

30 **Insertion of PICC Lines**

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32 The Board has further determined that the one-year vocational nursing program does not provide the Licensed

33 Vocational Nurse (LVN) with the educational foundation to assure client safety in insertion of Peripherally

34 Inserted Central-line Catheters (PICC lines) inclusive of vein selection, insertion/advancement of the catheter,

35 determining placement, and monitoring of the client for untoward reactions in relation to catheter insertion. The

36 Board's Interpretive Guideline for LVN Scope of Practice under Rule 217.11, further maintains that continuing

37 education that falls short of achieving licensure as a registered nurse would be insufficient to assure vocational

38 nurse competency and patient safety with regard to insertion of PICC lines. Therefore, it is the Board's position

39 that insertion of PICC lines is beyond the scope of practice for LVNs.

41 **Administration of IV Fluids and Medications**

42

43 The ability of a LVN to administer specific IV fluids or drugs, to prepare and/or administer IV "piggy-back" or

44 IV "push" medications, or to monitor and titrate "IV drip" medications of any kind is up to facility policy. The

45 LVN's practice relative to IV therapy must also comply with any other regulations that may exist under the

46 jurisdiction of other regulatory agencies or entities. The LVN who accepts an assignment to engage in any aspect

47 of intravenous therapy is responsible for adhering to the NPA and Board rules, particularly §217.11 Standards of

48 Nursing Practice, including excerpted standards listed above and any other standards or rules applicable to the

49 individual LVN's practice.

1 All nursing actions related to peripheral and/or central intravenous lines, as well as IV administration of
2 medications, must be completed in accordance with the orders of the prescribing practitioner, as well as written
3 policies, procedures and job descriptions approved by the health care employer.
4

5 (Board Action: 06/1995; Revised 09/1999; Revised 01/2005)
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8 9 **15.4 Educational Mobility**

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11 The Board of Nurse Examiners supports educational mobility for nurses prepared at the VN, ADN, Diploma and
12 BSN levels and encourages the elimination of needless repetition of experiences or time penalties. Furthermore,
13 the Board encourages existing nursing education programs approved by the Board of Nurse Examiners to
14 develop articulation arrangements that specify their policies regarding transfer of academic credits to facilitate
15 educational mobility, especially in underserved areas of the state.

16 (Board Action 01/1989, Revised 01/1992, Revised 01/2005)
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19 20 **15.5 Nurses with Responsibility for Initiating Physician Standing Orders**

21
22 According to the Texas Nursing Practice Act [Tex. Occ. Code Ann. §301.002(3)], the term “Nurse” means “a
23 person required to be licensed under this chapter to engage in professional or vocational nursing.” The practice
24 of either professional or vocational nursing frequently involves implementing orders from a physician, podiatrist,
25 dentist, or psychologist. Timely interventions for various patient populations can be facilitated through the use of
26 physician’s standing orders that authorize the nurse to carry out specific orders for a patient presenting with a
27 condition or symptoms addressed in the standing orders.
28

29 The specifics of how authorization occurs for a LVN or RN to implement a set of standard physician’s orders are
30 defined in the Texas Medical Board’s (TMB) Board of Medical Examiners (BME) Rule 193 (22 Tex. Admin.
31 Code §§193.1-193.11) relating to physician delegation. This rule holds out two (2) methods by which nurses may
32 follow a pre-approved set of orders for treating patients:
33

- 34 1) Standing Delegation Orders; and/or
 - 35 2) Standing Medical Orders.
- 36

37 These terms are defined in 22 Tex. Admin. Code §193.2 as follows:
38

39 (12) Standing delegation order - Written instructions, orders, rules, regulations, or procedures prepared by a
40 physician and designed for a patient population with specific diseases, disorders, health problems, or sets of
41 symptoms. Such written instructions, orders, rules, regulations or procedures shall delineate under what set of
42 conditions and circumstances action should be instituted. These instructions, orders, rules, regulations or
43 procedures are to provide authority for and a plan for use with patients presenting themselves prior to being
44 examined or evaluated by a physician to assure that such acts are carried out correctly and are distinct from
45 specific orders written for a particular patient, and shall be limited in scope of authority to be delegated as
46 provided in §193.4 of this title (relating to Scope of Standing Delegation Orders). As used in this chapter,
47 standing delegation orders do not refer to treatment programs ordered by a physician following examination or
48 evaluation by a physician, nor to established procedures for providing of care by personnel under direct, personal
49 supervision of a physician who is directly supervising or overseeing the delivery of medical or health care. Such
50 standing delegation orders should be developed and approved by the physician who is responsible for the
51 delivery of medical care covered by the orders. Such standing delegation orders, at a minimum, should:
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- 1 (A) include a written description of the method used in developing and approving them and any revision thereof;
2 (B) be in writing, dated, and signed by the physician;
3 (C) specify which acts require a particular level of training or licensure and under what circumstances they are
4 to be performed;
5 (D) state specific requirements which are to be followed by persons acting under same in performing particular
6 functions;
7 (E) specify any experience, training, and/or education requirements for those persons who shall perform such
8 orders;
9 (F) establish a method for initial and continuing evaluation of the competence of those authorized to perform
10 same;
11 (G) provide for a method of maintaining a written record of those persons authorized to perform same;
12 (H) specify the scope of supervision required for performance of same, for example, immediate supervision of a
13 physician;
14 (I) set forth any specialized circumstances under which a person performing same is to immediately
15 communicate with the patient's physician concerning the patient's condition;
16 (J) state limitations on setting, if any, in which the plan is to be performed;
17 (K) specify patient record-keeping requirements which shall, at a minimum, provide for accurate and detailed
18 information regarding each patient visit; personnel involved in treatment and evaluation on each visit;
19 drugs, or medications administered, prescribed or provided; and such other information which is routinely
20 noted on patient charts and files by physicians in their offices; and
21 (L) provide for a method of periodic review, which shall be at least annually, of such plan including the effective
22 date of initiation and the date of termination of the plan after which date the physician shall issue a new
23 plan.

24
25 **(13) Standing medical orders** - Orders, rules, regulations or procedures prepared by a physician or approved by
26 a physician or the medical staff of an institution for patients which have been examined or evaluated by a
27 physician and which are used as a guide in preparation for and carrying out medical or surgical procedures or
28 both. These orders, rules, regulations or procedures are authority and direction for the performance for certain
29 prescribed acts for patients by authorized persons as distinguished from specific orders written for a particular
30 patient.

31
32 A third term, "Protocols", is defined narrowly by the TMB BME and applies to RNs with advanced practice
33 authorization (APN) from the BNE, or to Physician Assistants only:

34
35 **(10) Protocols** - Delegated written authorization to initiate medical aspects of patient care including authorizing
36 a physician assistant or advanced practice nurse to carry out or sign prescription drug orders pursuant to the
37 Medical Practice Act, Texas Occupations Code Annotated, §§157.051-157.060 and §193.6 of this title (relating
38 to the Delegation of the Carrying Out or Signing of Prescription Drug Orders to Physician Assistants and
39 Advanced Practice Nurses). The protocols must be agreed upon and signed by the physician, the physician
40 assistant and/or advanced practice nurse, reviewed and signed at least annually, maintained on site, and must
41 contain a list of the types or categories of dangerous drugs available for prescription, limitations on the number
42 of dosage units and refills permitted, and instructions to be given the patient for follow-up monitoring or contain
43 a list of the types or categories of dangerous drugs that may not be prescribed. Protocols shall be defined to
44 promote the exercise of professional judgment by the advanced practice nurse and physician assistant
45 commensurate with their education and experience. The protocols used by a reasonable and prudent physician
46 exercising sound medical judgment need not describe the exact steps that an advanced practice nurse or a
47 physician assistant must take with respect to each specific condition, disease, or symptom.

48
49 By definition, both vocational and professional nursing "exclude acts of medical diagnosis or prescription of
50 therapeutic or corrective measures" (Tex. Occ. Code Ann. §301.002(2) and (5). ~~Though not specified in the NPA~~
51 ~~at this time, the same principle applies to vocational nursing.~~ Based on the above definitions in the TMB BME
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1 rules, RNs who do not have advanced practice authorization from the BNE may not utilize “protocols” to carry
2 out physician orders. Likewise, vocational nurses (LVNs) are also prohibited from utilizing protocols as defined
3 by the TMB BME, as neither LVNs nor RNs may engage in acts that require independent medical judgment.
4 A nurse responsible for initiating physician’s standing medical orders or standing delegation orders may select
5 specific tasks or functions for patient management, including the administration of a medication required to
6 implement the selected order provided such selection is within the scope of the standing orders. The selection of
7 such tasks or functions for patient management constitutes a nursing decision that may be carried out by a LVN
8 or RN. In addition, this position statement should not be construed to preclude the use of the term “protocol” for
9 a standard set of orders covering the monitoring and treatment of a given clinical condition (e.g., insulin
10 protocol, heparin protocol, ARDS protocol, etc.) provided said standard orders meet the requirements for standing
11 delegation or standing medical orders as defined by the TMB BME.

12
13 The written standing orders under which nurses function shall be commensurate with each nurse’s educational
14 preparation and experience. The nurse initiating any form of standing orders must act within the scope of the
15 Nursing Practice Act, Board Rules and Regulations, and any other applicable local, state, or federal laws.
16 (Board Action 7/1988, Revised 1/1992, Revised 7/2001; Revised 01/2005)
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18 19 20 **15.6 Board Rules Associated With Alleged Patient “Abandonment”**

21
22 The Board of Nurse Examiners for the State of Texas (BNE or Board), in keeping with its mission to protect the
23 public health, safety, and welfare, holds nurses accountable for providing a safe environment for clients and
24 others over whom the nurse is responsible [Rule 217.11(1)(B)]. Though the Nursing Practice Act (NPA) and
25 Board Rules do not define the term “*abandonment*,” the Board has investigated and disciplined nurses in the
26 past for issues surrounding the concept of *abandonment* as it relates to *the nurse’s duty to the patient*. The
27 Board’s position applies to licensed nurses (LVNs and RNs), including RN’s with advanced practice
28 authorization (Nurse Practitioners, Clinical Nurse Specialists, Nurse Midwives, and Certified Registered Nurse
29 Anesthetists) in Texas.
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31 **Nurse’s Duty To A Patient**

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33 All nurses, regardless of practice setting or position title/role, are required to adhere to the NPA and Board Rules.
34 The “core” rules relating to nursing practice, however, are Rules 217.11, Standards of Nursing Practice, and
35 217.12, Unprofessional Conduct. The standard upon which other standards are based is 217.11(1)(B) “...maintain
36 a safe environment for clients and others.” This standard supersedes any physician’s order or facility’s policy, and
37 has previously been upheld in a landmark case, *Lunsford v. Board of Nurse Examiners*, 648 S.W. 2d 391 (Tex.
38 App. — Austin 1983). The concept of the nurse’s duty to maintain client safety also serves as the basis for
39 behavior that could be considered unprofessional conduct by a nurse.
40

41 Patients under the care of a nurse are vulnerable by virtue of illness, injury, and/or the dependent nature and
42 unequal power base of the nurse-patient relationship. Persons who are especially vulnerable include the elderly,
43 children, the mentally ill, sedated and anesthetized patients, those whose mental or cognitive ability is
44 compromised, and patients who are physically disabled, immobilized, restrained, or secluded. It is this dual-
45 vulnerability (client status and nurse’s power base) that creates the nurse’s duty to protect the client. The
46 distinction between a nurse leaving employment versus a nurse violating a duty to a patient through leaving an
47 assignment is often confused. The first is an employment issue, the other is potentially a licensure issue.
48

49 There is also no routine answer to the question, “*When does the nurse’s duty to a patient begin?*” The nurse’s
50 duty is not defined by any single event such as clocking in or taking report. From a BNE standpoint, the focus for
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1 disciplinary sanctions is on the relationship and responsibility of the nurse to the patient, not to the employer or
2 employment setting.

3 4 **Employment Issues**

5
6 Though the Board has no jurisdiction over employers or employment-related issues, other laws regulating facility
7 licensure may apply certain responsibilities to the employer for provision of client safety, such as development of
8 effective patient care systems or provision of adequate numbers of qualified staff. Specific requirements for a
9 given facility may be obtained by contacting the applicable licensing authority for the institution.

10
11 The Board believes that the following additional examples of employment issues would not typically involve
12 violations of the NPA or Board Rules:

- 13
14 ● Resignation without advance notice, assuming the nurse's current patient care assignment and/or work shift
15 has been completed.
16 ● Refusal to work additional shifts, either "doubles" or extra shifts on days off.
17 ● Other work-related issues, such as frequent absenteeism or tardiness, or conflicts between staff/employees.

18
19 The Board believes nurses should be vigilant and exercise good professional judgment when accepting
20 assignments that may be requested by employers who need nurses to fill vacant shifts for licensed nursing staff,
21 or other staffing-related situations. *Clear communication* between staff and supervisors is essential to arrive at
22 solutions that best focus on patient care needs without compromising either patient safety or a nurse's license.

23 24 **Licensure Issues**

25
26 As previously noted, the rules most frequently applied to nursing practice concerns are Rule 217.11 *Standards of*
27 *Nursing Practice*, and Rule 217.12 *Unprofessional Conduct*. In relation to questions of "abandonment," standard
28 217.11(1)(I) holds the nurse responsible to "notify the appropriate supervisor when leaving a nursing
29 assignment." This standard should not be mis-interpreted to mean that the nurse may simply notify the supervisor
30 that he/she is leaving the premises, regardless of whether or not another qualified licensed nurse is available to
31 assume care of the nurse's patients. Specific procedures to follow in a given circumstance (nurse becomes ill,
32 family emergency, etc.) should be delineated in facility policies (over which the Board has no jurisdiction).
33 Some actions may be more obvious examples of unprofessional conduct that could result in sanctions on the
34 nurse's license. Examples of conduct that could lead to Board action on the nurse's license may include:

- 35
36 ● Sleeping on the job, which effectively makes the nurse unavailable to observe the patient or respond to the
37 patient's needs, even though the nurse is physically present.
38 ● Simply walking off the job in mid-shift without notifying anyone, and without regard for patient safety;
39 ● Failing to initiate or complete an agreed assignment when the nurse is the sole care provider, and/or the nurse
40 is a consultant or supervisor in a home or homelike setting; and/or failing to notify a supervisor in a timely
41 manner that the assignment will not be done, and/or falsifying records to the effect that the missed nursing
42 visit was indeed completed ; and/or
43 ● Leaving the assigned patient care area and remaining gone/unavailable for a period of time such that the care
44 of any/all patients may be compromised due to lack of available licensed staff.

45
46 The Board may impose sanctions on a nurse's license for actions that potentially place patients at risk for harm,
47 or when harm has resulted because a nurse violated his/her duty to the client by leaving a patient care assignment
48 in a manner inconsistent with the Board Rules.

1 **Board Disciplinary Actions**

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3 Complaints of “patient abandonment” when it is obvious from the allegation that it is an employment issue will
4 not be investigated by the Board. In these circumstances, however, both parties (the nurse and the employer) may
5 be advised to strive for alternate solutions to avoid similar situations in the future.

6
7 Some general factors that would be considered in investigating a complaint of leaving an assignment by a nurse
8 would include, but not be limited to:

- 9
- 10 • the extent of dependency or disability of the patient;
 - 11 • stability of the patient;
 - 12 • the length of time the patient was deprived of care;
 - 13 • any harm to the patient/level of risk of harm to the patient;
 - 14 • steps taken by the nurse to notify a supervisor of the inability to provide care;
 - 15 • previous history of leaving a patient-care assignment;
 - 16 • other unprofessional conduct in relation to the practice of nursing;
 - 17 • general nurse competency regarding adherence to minimum nursing standards.
- 18

19 As with all allegations received by the Board, the alleged conduct by a nurse will be thoroughly investigated to
20 determine what, if any, violations of the NPA and rules have occurred. If evidence of violations exists, the Board
21 must then determine what level of sanction is appropriate to take on the nurse’s license, and what specific
22 stipulation requirements will be applied. Depending upon the case analysis, Board actions may range from the
23 case being closed with no findings or action, all the way to suspension and/or revocation/voluntary surrender of
24 the nurse’s license.

25 **Safe Harbor Peer Review**

26
27
28 If a nurse feels he/she is being asked to accept an assignment that would potentially cause the nurse to violate
29 his/her duty to a patient, the nurse may be able to invoke “safe harbor,” depending on whether or not the nurse’s
30 employer meets requirements that would make it mandatory for the employer to have a peer review plan in place.
31 This is established in the NPA, Chapter 303 *Peer Review*([link](#)), and in Rule 217.20 *Safe Harbor Peer*
32 *Review*([link](#)). Safe Harbor has two effects related to the nurse’s license:

- 33
- 34 (1) It is a means by which a nurse can request a peer review committee determination of a specific situation in
35 relation to the nurse’s duty to a patient; and
 - 36
37 (2) It affords the nurse immunity from Board action against the nurse’s license if the nurse invokes Safe Harbor
38 in accordance with Rule 217.20. For the nurse to activate this immunity status, the nurse must notify the
39 assigning supervisor at the time the assignment request is made, and the nurse must submit the required
40 information in writing as specified in Rule 217.20(c)(3)(A-D) or on the Board’s Safe Harbor form (sections
41 2.1-2.8).
- 42

43 For more information about Safe Harbor, see “related links” at the end of this article.

44
45 **Links to Related Articles**(all of the following are located on the Board’s web page):

- 46
- 47 • ~~RN Update, October 2000: “What does the Board consider as abandonment?”~~
 - 48 • ~~RN Update, January 2001: “How many consecutive hours or shifts can a nurse work?”~~
 - 49 • RN Update, January 2002: “RN & Nurse Manager Responsibilities Related to Staffing Issues”
 - 50 • Safe Harbor Form <http://www.bne.state.tx.us/Safe.htm>
 - 51 • FAQ on Overtime/Hours of Work <http://www.bne.state.tx.us/faq-practice.htm#overtime>
- 52

- FAQ on Peer Review <ftp://www.bne.state.tx.us/PeerReview-FAQs.pdf>
- FAQ on Staffing Ratios <http://www.bne.state.tx.us/faq-practice.htm#Staffing>
- FAQ on Floating <ftp://www.bne.state.tx.us/floating.pdf>
- RN Update, July 2002: Overview of TDH Staffing Plans and CNO Requirement Rules

(Adopted 01/2005)

15.7 The Role of LVNs & RNs in Management and/or Administration of Medications via Epidural or Intrathecal Catheter Routes

Role of the LVN:

The LVN can provide basic nursing care to patients with epidural or intrathecal catheters. It is the opinion of the Board that the licensed vocational nurse shall not be responsible for the management of a patient's epidural or intrathecal catheter including administration of any medications via either epidural or intrathecal catheter routes. Management of epidural or intrathecal catheters requires the mastery of complex nursing knowledge and skills that are beyond the competencies of the vocational nursing program or a continuing education course.

Role of the RN:

The Board has determined that it may be within the scope of practice of a registered professional nurse to administer analgesic and anesthetic agents via the epidural or intrathecal routes for purposes of pain control. As with all areas of nursing practice, the RN must apply the Nursing Practice Act (NPA) and Board Rules to the specific practice setting, and must utilize good professional judgment in determining whether or not to engage in a given patient-care related activity.

The Board believes that only licensed anesthesia care providers as described by the American Society of Anesthesiologists and the American Association of Nurse Anesthetists, as authorized by applicable laws should perform insertion and verification of epidural or intrathecal catheter placement. Consistent with state law, the attending physician or the qualified provider must order the drugs, dosages, and concentrations of medications to be administered to the patient through the catheter. These interventions are beyond the scope of the registered professional nurse in that independent medical judgment and formal advanced education and skills training are required to achieve and maintain competence in performing these procedures.

RNs who choose to engage in administration of properly ordered medications via the epidural or intrathecal routes must have documentation that the RN has participated in educational activities to gain and maintain the knowledge and skill necessary to safely administer and monitor patient responses, including the ability to:

- Demonstrate knowledge of the anatomy, physiology, and pharmacology of patients receiving medications via the epidural or intrathecal routes;
- Anticipate and recognize potential complications of the analgesia relative to the type of infusion device and catheter used;
- Recognize emergency situations and institute appropriate nursing interventions to stabilize the client and prevent complications;
- Implement appropriate nursing care of patients to include:
 - a) observation and monitoring of sedation levels and other patient parameters;
 - b) administration and effectiveness of medication, catheter maintenance and catheter placement checks;

- c) applicable teaching for both patients and their family/significant others related to expected patient outcomes/responses and possible side effects of the medication or treatment; and
- d) knowledge and skill to remove catheters when applicable.

Appropriate nursing policies and procedures that address the education and skills of the RN and nursing care of the patient should be developed to guide the RN in the administration of epidural and/or intrathecal medications. RNs and facilities should consider evidence-based practice guidelines put forth by professional specialty organizations(s), such as the American Association of Nurse Anesthetists and the American Society of Anesthesiologists when developing appropriate guidance for the RN in a particular practice setting. For example, the Association of Women's Health, Obstetric and Neonatal Nurses' (AWHONN) has a clinical position statement on "The Role of the Registered Nurse in the Care of Pregnant Women Receiving Analgesia/Anesthesia by Catheter Techniques (Epidural, Intrathecal, Spinal, PCEA Catheters." This nationally recognized practice guideline states that it is beyond the scope of practice of the obstetrical nurse to institute or change the rate of continuous infusions via epidural or intrathecal catheters. The American Association of Nurse Anesthetists has a similar position.

The Board also encourages the use of the BNE's "Six Step Decision Making Model for Determining Nursing Scope of Practice" <ftp://www.bne.state.tx.us/dectree.pdf>. Finally, standing medical orders approved by the medical and/or anesthesia staff of the facility should include, but not necessarily be limited to, the following:

1. The purpose and goal of treatment;
2. The dosage range of medication to be administered including the maximum dosage;
3. Intravenous access Treatment of respiratory depression and other side effects including an order for a narcotic antagonist;
4. Options for inadequate pain control; and
5. Physician/CRNA availability and back-up.

(LVN role: BVNE 1994; Revised BNE 01/05) (RN role: BNE 06/1991; rev 01/03; rev 01/04; rev 01/05)

15.8 Roles of LVNs & RNs in Administration and Management of Moderate Sedation {NEW/REPLACEMENT}

*Note: This position statement is **not** intended to apply to either:*

- (1) The practice of the registered nurse who holds authorization to practice as an advanced practice nurse in the role and specialty of nurse anesthetist (CRNA) functioning within his/her authorized scope of practice, or to
- (2) The registered nurse practicing in an acute care setting, such as critical care, where the patient in question is intubated, receiving mechanical ventilatory support, and continuously monitored by the patient care RN.

Role of the LVN:

The administration of pharmacologic agents via IV or other routes for the purpose of achieving moderate sedation requires mastery of complex nursing knowledge, advanced skills, and the ability to make independent nursing judgments during an unstable and unpredictable period for the patient. It is the opinion of the Board that the one-year vocational nursing program does not provide the Licensed Vocational Nurse (LVN) with the educational foundation to assure patient safety for optimal anesthesia care inclusive of both the administration of pharmacologic agents intended to induce moderate sedation and/or assessment and monitoring of the patient receiving moderate (conscious) sedation.

1 In line with Rule 217.11 *Standards of Nursing Practice*, the Board's *Interpretive Guideline for LVN Scope of*
2 *Practice under Rule 217.11* <ftp://www.bne.state.tx.us/lvn-guide.pdf>, and Board Position Statement 15.10
3 *Continuing Education: Limitations for Expanding Scope of Nursing Practice* [http://www.bne.state.tx.us/](http://www.bne.state.tx.us/position.htm#15.10)
4 [position.htm#15.10](http://www.bne.state.tx.us/position.htm#15.10), the Board also maintains that continuing education that falls short of achieving licensure as
5 a registered nurse would be insufficient to assure vocational nurse competency and patient safety with regard to
6 both medication administration and patient monitoring associated with moderate sedation.

7 Though the Board cannot dictate physician practice, it is the Board's position that a LVN cannot administer
8 medications or monitor patients receiving moderate sedation as a delegated medical act.

9 10 **Role of the RN or non-CRNA Advanced Practice Nurse:**

11
12 Though optimal anesthesia care is best provided by qualified certified registered nurse anesthetists (CRNAs) or
13 anesthesiologists, the Board recognizes that the demand in the practice setting necessitates provision of moderate
14 sedation by registered nurses and non-CRNA advanced practice nurses in certain practice situations.

15
16 All licensed nurses practicing in Texas are required to "know and comply" with the Nursing Practice Act (NPA)
17 and Board Rules. Rule 217.11(1)(B) requires the nurse to "maintain a safe environment for clients and others."
18 This standard establishes the nurse's duty to the patient/client, which supercedes any physician order or any
19 facility policy. **This "duty" to the patient** requires the nurse to use good professional judgement when choosing
20 to assist or engage in a given procedure. [See Position Statement 15.14 Duty of a Nurse In Any Practice Setting
21 [http://www.bne.state.tx.us/position.htm#15.14.](http://www.bne.state.tx.us/position.htm#15.14)]

22
23 As the NPA and rules are not prescriptive to specific tasks a nurse may or may not perform, a RN or non-CRNA
24 advanced practice nurse should consider evidence-based practice guidelines put forth by professional
25 organizations with clinical expertise in the administration of pharmacologic agents used for sedation/anesthesia
26 as well as advanced airway management and cardiovascular support. A number of professional specialty
27 organizations have well-defined standards and recommendations for ongoing nursing education and competency
28 assessment related to administration and monitoring of patients receiving moderate sedation.

29
30 These organizations include the American Association of Nurse Anesthetists (AANA), the American Nurses
31 Association (ANA), the Association of PeriOperative Registered Nurses (AORN), and the Association of
32 Women's Health, Obstetric and Neonatal Nurses (AWHONN) The AWHONN position statement is also
33 endorsed by the American Association of Critical Care Nurses (AACN). Statements published by the American
34 Society of Anesthesiologists (ASA) also support the positions of the above nursing organizations. The Board
35 advises the nurse use caution in applying moderate sedation standards of any individual or specialty group who
36 are not also experts in the field of advanced airway management/anesthesia. The Board encourages the use of
37 the BNE's "Six Step Decision Making Model for Determining Nursing Scope of Practice" [ftp://](ftp://www.bne.state.tx.us/dectree.pdf)
38 www.bne.state.tx.us/dectree.pdf.

39
40 Employing institutions should develop policies and procedures to guide the RN or non-CRNA advanced practice
41 nurse in administration of medications and patient monitoring associated with moderate sedation. Policies and
42 procedures should include but not be limited to:

- 43
44
- 45 • Performance of a pre-sedation health assessment by the individual ordering the sedation and the nurse
46 administering the sedation
 - 47 • Guidelines for patient monitoring, drug administration, and a plan for dealing with potential complications or
48 emergency situation developed in accordance with currently accepted standards of practice
 - 49 • Accessibility of emergency equipment and supplies
 - 50 • Documentation and monitoring of the level of sedation and physiologic measurements (e.g. blood pressure,
51 oxygen saturation, cardiac rate and rhythm)
- 52

- Documentation/evidence of initial education and training and ongoing competence of the RN administering and/or monitoring patients receiving moderate sedation

Use of Specific Pharmacologic Agents

It is up to facilities and physicians to determine specific pharmacologic agents to be used to induce moderate sedation. The Board advises the RN or non-CRNA advanced practice nurse use caution, however, in deciding whether or not s/he has the competency to administer the specific pharmacologic agents ordered by the physician. What is within the scope of practice for one RN is not necessarily within the scope of practice for another RN. (See references to § 217.11 & Six-Step Decision-Making Model above). With regard to this issue, the Board recommends the RN also take into consideration:

- 1) Availability of and knowledge regarding the administration reversal agents for the pharmacologic agents used; and
- 2) If reversal agents do not exist for the pharmacologic agents used or the criteria outlined in (1) above are not met, then the nurse must consider his/her individual knowledge, skills, and abilities to rescue a patient from unintended deep sedation/anesthesia using advanced life support airway management equipment and techniques.

RNs or non-CRNA Advanced Practice Nurses Administering Propofol, Ketamine, or Other Anesthetic Agents to Non-Intubated Patients

Of concern to the Board is the growing number of inquiries related to RNs and non-CRNA advanced practice nurses administering Propofol, Ketamine, or other drugs commonly used for anesthesia purposes to non-intubated patients for the purpose of moderate sedation in a variety of patient care settings. It is critical for any RN who chooses to engage in moderate sedation to appreciate the differences between *moderate sedation* and *anesthesia*.

Moderate Sedation Versus Anesthesia

According to the professional literature “moderate sedation” is defined as a medication-induced, medically controlled state of depressed consciousness. Included in the literature from various professional organizations is the caveat that, while under moderate sedation, the patient at all times retains the ability to independently and continuously maintain a patent airway and cardiovascular function, and is able to respond meaningfully and purposefully to verbal commands, with or without light physical stimulation. Reflex withdrawal to physical stimulation is not considered a purposeful response. Loss of consciousness for patients undergoing moderate sedation should not be the goal and thus pharmacologic agents used should render this result unlikely. If the patient requires painful or repeated stimulation for arousal and/or airway maintenance, this is considered deep sedation. In a state of deep sedation, the patient’s level of consciousness is depressed, and the patient is likely to require assistance to maintain a patent airway. If this occurs, the This situation in a patient who is not appropriately monitored and/or who does not have appropriate airway support, may result a life-threatening emergency for the patient. This is not consistent with the concept of moderate sedation as defined in this position statement or the professional literature.

Although Propofol is classified as a sedative/hypnotic, according to the manufacturer’s product information, it is intended for use as an anesthetic agent or for the purpose of maintaining sedation of an intubated, mechanically

1 ventilated patient. The product information brochure for Propofol further includes a warning that “only persons
2 trained to administer general anesthesia should administer propofol for purposes of general anesthesia or for
3 monitored anesthesia care/sedation. The clinical effects for patients receiving anesthetic agents such as Propofol
4 may vary widely within a negligible dose range. Though reportedly “short-acting”, it is also noteworthy that there
5 are **no** reversal agents for Propofol.
6

7 The Board defines “monitored anesthesia care” in Rule 221.1(9) as:
8

9 “. . . situations where a patient undergoing a diagnostic or therapeutic procedure receives doses of medication
10 that create a risk of loss of normal protective reflexes or loss of consciousness and the patient remains able to
11 protect the airway for the majority of the procedure. If for an extended period of time the patient is rendered
12 unconscious and/or loses normal protective reflexes, then anesthesia care shall be considered a general
13 anesthetic.”
14

15 The patient receiving anesthetic agents is at increased risk for loss of consciousness and/or normal protective
16 reflexes, regardless of who is administering this medication. Again, this is not consistent with the concept of
17 moderate sedation outlined in the professional literature.
18

19 Though the RN or non-CRNA advanced practice nurse may have completed continuing education in advanced
20 cardiac life support (ACLS) and practiced techniques during the training program, this process does not ensure
21 ongoing expertise in airway management and emergency intubation. The American Heart Association (AHA)
22 cautions ACLS providers about attempting tracheal intubation in an emergency situation since *“Repeated safe
23 and effective placement of the tracheal tube, over the wide range of patient and environmental conditions
24 encountered in resuscitation, requires considerable skill and experience. Unless initial training is sufficient and
25 ongoing practice and experience are adequate, fatal complications may result.”*¹
26
27

28 It is also important to note that no continuing education program, including ACLS programs, will ensure that the
29 RN or non-CRNA advanced practice nurse has the knowledge, skills and abilities to rescue a patient from deep
30 sedation or general anesthesia. Furthermore, it is the joint position of the AANA and ASA that, “because
31 sedation is a continuum, it is not always possible to predict how an individual patient will respond.” These
32 organizations state that anesthetic agents, including induction agents, should be administered only by qualified
33 anesthesia providers who are trained in the administration of general anesthesia.
34
35

36 Therefore, it is the position of the Board that the administration of anesthetic agents (e.g. propofol, brevitil,
37 ketamine, and etomidate) is outside the scope of practice for RNs and non-CRNA advanced practice nurses
38 **except** in the following situations:
39

- 40 • when assisting in the physical presence of a CRNA or anesthesiologist
- 41 • when administering these medications as part of a clinical experience within an advanced educational
42 program of study that prepares the individual for licensure as a nurse anesthetist (i.e. when functioning as a
43 student nurse anesthetist)
- 44 • when administering these medications to patients who are intubated and mechanically ventilated in critical
45 care settings
- 46 • when assisting an individual qualified in airway management during emergency intubation procedures
47
48
49

50 While the physician or other health care provider performing the procedure may possess the necessary
51 knowledge, skills and abilities to rescue a patient from deep sedation and general anesthesia, it is not prudent to
52

1 presume this physician/practitioner will be able to leave the surgical site or abandon the procedure to assist in
2 rescuing the patient.
3

4 If the RN or non-CRNA advanced practice nurse chooses to provide moderate sedation to non-intubated patients,
5 he/she must have demonstrated the following competencies:
6

- 7 • advanced life support, *with an emphasis on current competency in population specific airway management.*
- 8
- 9 • knowledge of anatomy, physiology, pharmacology, oxygen delivery, cardiac arrhythmia recognition and
10 complications related to moderate sedation and medications
- 11
- 12 • knowledge of medications to include but not be limited to side effects, toxic effects, allergic reactions,
13 desired effects, unusual/unexpected effects, reversal agents, and changes in the patient's condition that
14 contraindicates continued administration of the medication
- 15
- 16 • knowledge, skills and abilities to identify deviations from the norm, including but not limited to thorough
17 patient assessment skills
- 18
- 19 • knowledge of the indications for and contraindications to moderate sedation

20 The Board again stresses that the nurse's duty to assure patient safety [Rule 217.11(1)(B)] is an independent
21 obligation under his/her professional licensure that supercedes any physician order or facility policy.^{2,3} It is
22 important to note that the nurse's duty to the patient obligates him/her to decline orders for medications or doses
23 of medications that have the potential to cause the patient to reach a deeper level of sedation or anesthesia. The
24 nurse's duty is outlined in detail in Board Position Statement 15.14 *Duty of a Nurse In Any Practice Setting.*
25

27 ¹ American Heart Association in collaboration with International Liaison Committee on Resuscitation, Guidelines 2003 for
28 Cardiopulmonary Resuscitation and Emergency Cardiovascular Care: International Consensus on Science, Part 3: Adult Basic Life
29 Support. *Circulation*. 2003; 102(suppl I):page I-100.

30 ²American Association of Nurse Anesthetists and American Society of Anesthesiologists. Joint Position Statement, May, 2004,
31 "AANA-ASA Joint Statement Regarding Propofol Administration" http://www.aana.com/news/2004/news050504_joint.asp

32 ³ Lunsford vs. BNE, 1983, 648 S.W. 391, Tex. App-Austin 1983
33 (Board Action 01/1992; revised 01/2003; revised 01/2004; revised 1/2006)
34

37 **15.9 Performance of Laser Therapy by RNs or LVNs**

38
39 The Board of Nurse Examiners (BNE) recognizes that the use of laser therapy and the technology of lasers has
40 changed rapidly since their introduction for medical use. Nurses fulfill many important roles in the use of laser
41 therapies. These roles and functions change based upon the type of procedure and the setting in which the
42 treatment occurs. It is not within the scope of nursing practice to perform the delivery of laser energy on a patient
43 as an independent nursing function.
44

45 The Texas Medical Board's (TMB) Board of Medical Examiner's (BME) Rule 193.11, "Use of Lasers"
46 [22TAC§193.1, Jan 2004], permits physician delegation of "non-ablative" laser procedures, and establishes
47 specific training, ongoing competency review, and procedural guidelines for delegates who perform non-ablative
48 laser procedures as delegated medical acts. RNs (including Advanced Practice Nurses practicing within their
49 educated role and specialty) or LVNs who choose to administer laser therapy under physician delegation must
50 know and comply with the provisions set forth in the ~~BME's~~ TMB's rules for delegates, as well as the Nursing
51 Practice Act (NPA) and Rules of the BNE.
52

1 The Board of Medical Examiners' TMB's Rule on "Use of Lasers" [22TAC§193.11], for performance of "non-
2 ablative" laser procedures under the delegation of the physician includes, but is not limited to, the following
3 definitions and requirements:
4

5 A. *The use of lasers/pulsed light devices for the purpose of treating a physical disease, disorder, deformity or*
6 *injury shall constitute the practice of medicine pursuant to §151.002(a)(13) of the Medical Practice Act.*

7
8 B. *Definitions:*

9 (1) *Advanced health practitioner—An advanced health practitioner is a physician assistant or an advanced*
10 *practice nurse.*

11
12 (2) *Non-ablative treatment—Non-ablative treatment shall include any laser/intense pulsed light treatment*
13 *that is not expected or intended to remove, burn, or vaporize the epidermal surface of the skin. This shall*
14 *include treatments related to laser hair removal.*

15
16 (3) *On-site supervision—On-site supervision shall mean continuous supervision in which the individual is in*
17 *the same building.*

18
19 (4) *Physician—A physician licensed by the Texas State Board of Medical Examiners.*

20
21 C. *The use of lasers/pulsed light devices for non-ablative procedures cannot be delegated to non-physician*
22 *delegates, other than an advanced health practitioner, without the delegating/supervising physician*
23 *being on-site and immediately available.*

24
25 D. *The use of lasers/pulsed light devices for ablative procedures may only be performed by a physician.*

26
27 E. *If the physician does not provide on-site supervision during a non-ablative treatment, the on-site*
28 *supervision may be delegated to an advanced health practitioner.*

29
30 F. ***Educational requirements for delegates.*** *A physician may delegate non-ablative procedures to a*
31 *qualified delegate. The physician must ensure that the delegate complies with paragraphs (1) - (5) of this*
32 *subsection prior to performing the non-ablative procedure in order to properly assess the delegate's*
33 *competency.*

34 (1) *The delegate has completed and is able to document clinical and academic training in the subjects*
35 *listed in subparagraphs (A) - (G) of this paragraph:*

36 (A) *fundamentals of laser operation;*

37 (B) *bioeffects of laser radiation on the eye and skin;*

38 (C) *significance of specular and diffuse reflections;*

39 (D) *non-beam hazards of lasers;*

40 (E) *non-ionizing radiation hazards;*

41 (F) *laser and laser system classifications; and*

42 (G) *control measures.*

43
44 (2) *The delegate has read and signed the facility's policies and procedures regarding the safe use of*
45 *non-ablative devices.*

46
47 (3) *The delegate has received or participated in at least 16 hours of documented initial training in the*
48 *field of non-ablative devices.*
49
50
51
52

1 (4) *The delegate has attended at least eight hours of additional hours of documented training*
2 *annually in the field of non-ablative procedures.*

3
4 (5) *The delegate has completed at least ten procedures of precepted training for each non-ablative*
5 *procedure to assess competency.*

6
7 Additional criteria applicable to the nurse who elects to accept physician delegation in the use of non-ablative
8 laser therapy include:

- 9 (1) Appropriate education related to use of laser technologies for medical purposes, including laser safety
10 standards of the American National Standards Institute and FDA intended-use labeling parameters;
11
12 (2) The nurse's education and skill assessment is documented in his/her personnel record;
13
14 (3) The procedure has been ordered by a currently licensed physician, podiatrist, or dentist or by an
15 Advanced Health Practitioner working in collaboration with one of the aforementioned practitioners; and
16
17 (4) Appropriate medical, nursing, and support service back up is available, since remedies for untoward
18 effects of laser therapy may go beyond the scope of practice of the nurse performing the procedure.

19 As in carrying out any delegated medical act, the RN is expected to comply with the Nursing Practice Act and
20 the Board's Rules and Regulations.

21
22 (Board Action, 05/1992; revised 11/1997; revised 01/2003; revised 04/2004)
23
24

25
26 **15.10 Continuing Education: Limitations for Expanding Scope of Practice**
27 **Foundation for Initial Licensure and/or APN authorization:**
28

29
30 The Board's Advisory Committee on Education states in its *"Differentiated Entry Level Competencies of*
31 *Graduates of Texas Nursing Programs, Vocational (VN), Diploma/Associate Degree(Dip/AND), Baccalaureate*
32 *(BSN), September 2002"*([link](#)) that: "The curricula of each of the nursing programs differ, resulting in
33 differentiated entry level competencies of graduates....The competencies of each educational level build upon the
34 previous level." On a national level, the National Council of State Boards of Nursing, Inc. (NCSBN) develops
35 and administers two national nurse licensure examinations; the National Council Licensure Examination for
36 Practical Nurses (NCLEX-PN®), and the National Council Licensure Examination for Registered Nurses
37 (NCLEX-RN®). These two examinations are used by all U.S. state and territorial boards of nursing to test entry-
38 level nursing competence of candidates for licensure as Registered Nurses and as Licensed Practical/Vocational
39 Nurses.
40

41 Recognition as an advanced practice nurse in Texas requires completion of a master's or post-master's advanced
42 practice program as well as national certification in the advanced role and specialty. To gain recognition as an
43 advanced practice nurse in Texas, the nurse must first be licensed as a RN in Texas or have a valid unencumbered
44 RN license from a compact state. The nurse must then submit an application to the Board for "authorization" in
45 the advanced practice role and specialty.
46

47
48 **Limitations of "Continuing Education"**
49

50 The nursing shortage is creating ever greater challenges for those who must fill nursing vacancies at all levels —
51 LVNs, RNs, and Advanced Practice Nurses (APNs) in various specialties. As efforts to invent new ways to fill
52

1 this growing void expand, the Board is receiving a growing number of calls to clarify the term “continuing
2 education” in relation to how far a nurse can expand his/her practice with informal continuing education
3 offerings.

4
5 The formal education for entry into nursing practice in Texas is differentiated between vocational and
6 professional (registered) nursing. Formalized education for advanced practice also requires completion of a
7 formal program of education in the advanced practice role and specialty at the master’s or post-master’s level.

8
9 The Board believes that for a nurse to successfully make a transition from one level of nursing practice to the
10 next requires the completion of a formal program of education as defined in the applicable board rule. The Board
11 also believes that completion of on-going, informal continuing education offerings, such as workshops or on-line
12 offerings in a specialty area, serve to expand and maintain the competency of the nurse at the current level of
13 licensure/recognition. No amount of informal or on-the-job-training can qualify a LVN to perform the same level
14 of care as the RN. Likewise, the RN cannot engage in aspects of care that require independent medical
15 judgement in a given APN role and specialty without the formal education, national certification, and proper
16 authorization in that advanced practice nurse role and specialty.

17
18 For example, a LVN with 10 years of home care experience cannot perform the comprehensive assessment and
19 initiate the nursing care plan on a patient newly admitted to the LVN’s home care agency’s service. This is
20 precluded in both BNE Rule 217.11 as well as in the home care regulations. Attending a workshop and/or
21 spending time under the supervision of a RN does not qualify the LVN to engage in practice that is designated in
22 rule as being exclusive to the next level of licensure.

23
24 Therefore, any nurse, regardless of experience, who engages in nursing practice that would otherwise require a
25 higher level of licensure or a different level of authorization is practicing outside of his/her scope of practice, and
26 may be subject to disciplinary action congruent with the NPA and Rules applicable to LVNs, RNs, and/or RNs
27 with APN authorization in a given role/specialty.

28
29 (Adopted 01/2005)

30
31
32
33 **15.11 Delegated Medical Acts**

34
35 In carrying out orders from physicians, podiatrists, or dentists for the administration of medications or
36 treatments, nurses are usually engaged in the practice of vocational or professional nursing in accordance with
37 the applicable licensure of the individual nurse. In carrying out some physician orders, however, LVNs or RNs
38 may perform acts not usually considered to be within the scope of vocational or professional nursing practice,
39 respectively. Such tasks are delegated and supervised by physicians, podiatrists, or dentists. RNs who lack
40 authorization as advanced practice nurses in a specified role and specialty, and LVNs may not engage in “acts of
41 medical diagnosis or prescription of therapeutic or corrective measures” [NPA, Section 301.002(2) and (5)] as
42 these acts require independent medical judgment, which is beyond the scope of practice of the vocational or
43 registered nurse .

44
45 In carrying out the delegated medical function, the nurse is expected to comply with the Standards of Nursing
46 Practice just as if performing a nursing procedure. The Board’s position is that a LVN or RN may carry out a
47 delegated medical act if the following criteria are met:

- 48
49 1. The nurse has received appropriate education and supervised practice, is competent to perform the procedure
50 safely, and can respond appropriately to complications and/or untoward effects of the procedure (refer to
51 Standards in Rule 217.11(1)(C), (1)(T), (1)(G), (1)(M), (1)(N), and (1)(R);
52

- 1 2. The nurse's education and skills assessment are documented in his/her personnel record;
- 2
- 3 3. The nursing and medical staffs have collaborated in the development of written policies/procedures/practice
- 4 guidelines for the delegated acts, these are available to nursing staff practicing in the facility, and the
- 5 guidelines are reviewed annually, if applicable;
- 6
- 7 4. The procedure has been ordered by an appropriate licensed practitioner; and
- 8
- 9 5. Appropriate medical and nursing back-up is available.

10 The Board recognizes that nursing practice is dynamic and that acts which today may be considered delegated
11 medical acts may in the future be considered within the scope of either vocational or professional nursing
12 practice. The Board, therefore, advises nurses that they must comply with the Board's Standards of Nursing
13 Practice and any other applicable regulations when carrying out nursing and/or delegated medical acts.

14
15 (Board Action 09/1993, rev. 03/94, rev. 01/2001; rev. 01/2003; rev. 01/2004; rev. 01/2005)
16
17

18 19 **15.12 Use Of American Psychiatric Association Diagnoses by LVNS, RNs, or APNs**

20
21 The Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses are multi-disciplinary psychiatric
22 diagnoses used for the purpose of applying objective criteria, establishing a practice framework and
23 communicating findings with other health care professionals. The current version, DSM-IV-TR (Fourth Edition,
24 Text Revision) is scheduled to be replaced by the DSM-V (Fifth Edition) in the 2006-2007 time frame.
25

26 In accordance with the Nursing Practice Act (NPA), Section 301.002(2) and (5), acts of medical diagnosis or
27 prescription of therapeutic or corrective measures are beyond the scope of practice for licensed vocational nurses
28 as well as registered nurses who are not Board authorized in an appropriate Advanced Practice Nurse (APN) role
29 and speciality.
30

31 The use of DSM-IV Diagnoses by a Registered Nurse recognized by the Board as an Advanced Practice Nurse in
32 the role and specialty of either a Clinical Nurse Specialist (CNS) in Psychiatric/Mental Health Nursing or as a
33 Psychiatric/Mental Health Nurse Practitioner is authorized provided he/she is acting within the scope of his/her
34 advanced practice role and specialty and that the diagnoses utilized are appropriate for the individual APN's
35 advanced education, experience, and scope of practice. APNs must also utilize protocols or other written
36 authorization when providing medical aspects of care in compliance with Rule 221 "Advanced Practice Nurses."
37 When patient problems are identified that are outside the CNS'/NP's scope of practice or expertise, a referral to
38 the appropriate medical provider is indicated.
39

40 (Board Action, 09/1996; revised 01/2005)
41
42

43 44 **15.13 Role Of LVNs and RNs As School Nurses**

45
46 The BNE recognizes that the youth of Texas are our most valuable natural resource. The BNE acknowledges that
47 although students come to school with complex and diverse health care needs, they should be provided an
48 education in the least restrictive environment. The BNE recognizes that the school children of Texas have the
49 right to receive safe, appropriate, specialized health services that may be required to assure the child's inclusion
50 in the school environment.
51
52

1 **Registered Nurses in the School Setting**

2
3 The Board of Nurse Examiners (BNE) believes that school nursing is a professional registered nursing (RN)
4 specialty. School nursing involves the identification, prevention and intervention to remedy or modify students’
5 health needs. The RN has the educational preparation and critical thinking skills as well as clinical expertise
6 which are essential to nursing in the school setting. These activities involve the comprehensive assessment of the
7 nursing/health care needs of the student, the development of a plan of care, implementation of the plan, and
8 evaluation of the outcomes. The provision of these services by the RN contributes directly to the students’
9 education and to the successful outcome of the educational process. These essential components of professional
10 nursing practice are the responsibility of the RN in compliance with Rule 217.11(3)(A).
11

12 **Vocational Nurses in the School Setting**

13
14 The clinically intensive vocational nursing program curriculum prepares entry level nurses to provide direct patient
15 care to acutely and chronically ill clients/patients in structured health settings (such as acute care and long-term
16 care) who are experiencing conditions with predictable health outcomes. The *Differentiated Entry Level*
17 *Competencies (DELIC)* define a “structured” setting as “a geographical and/or situational environment where the
18 policies, procedures, and protocols for provision of health care are established and in which there is recourse to
19 assistance and support from the full scope of nursing expertise.” Thus, school settings do not qualify as
20 “structured” healthcare settings, and LVN curriculum is not designed to provide competencies in complex
21 independent judgment and decision-making skills.
22

23
24 The provision of nursing care when provided by a Licensed Vocational Nurse (LVN) in a school setting should be
25 under the supervision of the RN. The RN, in compliance with the BNE’s Standards of Nursing Practice [Rule
26 217.11], assigns those aspects and activities to the LVN that are within the LVN’s educational preparation and
27 demonstrated competency to provide. The RN monitors, coordinates, and evaluates the provision of health
28 services necessary to meet individual student health needs essential in achieving educational objectives.
29

30 **RN Delegation to Unlicensed Personnel**

31
32 Due to the growing number of students entering the school system with special health care needs, the BNE
33 recognizes that not all health-related services can be provided by a RN or LVN. Therefore, the RN may delegate
34 tasks in the school setting in compliance with the BNE’s Delegation Rules 224 and 225. School is considered an
35 independent living environment as defined in Rule 225; however, acute or emergency situations in the school
36 setting may be delegated in accordance with Rule 224 as applicable. For example, emergency administration of
37 Epi-pens, Glucagon, and Diastat may be administered by an unlicensed person under § 224.6(4) in order to
38 stabilize the child and prevent complications from delaying treatment. The decision to delegate a specific task is
39 always at the discretion of the RN in accordance with § 224.8(b)(1)(C) or § 225.9(c).
40

41 **Other Laws Impacting School Health Care**

42
43 In a school setting, the administration of medication may be assigned to an unlicensed person by the public
44 school official in accordance with the rules of the Texas Education Code. The RN’s obligation under § 225.13 is
45 to (1) verify the training of the unlicensed person, and (2) verify the competency of the UAP to perform the task.
46 If the RN is unable to assure (1) and (2) have been met, the RN must (3) notify the public school official of the
47 situation.
48

49 **Summary:**

50
51 Given the complexity, the current number, and the future projections of increasing numbers of children entering
52 the school system with complex nursing and health-related needs, the BNE believes that the RN must establish a

1 an individualized nursing care plan for each child as applicable. The RN may be assisted by LVNs and unlicensed
2 assistive personnel in the delivery of services to ensure the delivery of safe, effective health care to the school
3 children of Texas.

4
5 (Adopted 11/1996, revised 11/1997; revised 01/2003; revised 01/2005)
6

7 8 9 **15.14 Duty of a Nurse in any Practice Setting**

10 In a time when cost consciousness and a drive for increasing productivity have brought about the reorganization
11 and restructuring of health care delivery systems, the effects of these new delivery systems on the safety of
12 clients/patients have placed a greater burden on the licensed vocational nurse (LVN) and the registered
13 professional nurse (RN) to consider the meaning of licensure and assurance of quality care that it provides.

14
15 In the interest of fulfilling its mission to protect the health, safety, and welfare of the people of Texas through the
16 regulation of nurses, the Board of Nurse Examiners (BNE), through the Nursing Practice Act and Board Rules,
17 emphasizes the nurse's responsibility and duty to the client/patient to provide safe, effective nursing care.
18 Specifically, the following portions of the Board Rules underscore the duty and responsibilities of the LVN and/
19 or the RN to the client/patient:
20

- 21 ● The Standards of Nursing Practice differentiate the roles of the LVN and the RN in accepting nursing care
22 assignments, assuring a safe environment for patients, and obtaining instruction and supervision as needed
23 (Rule 217.11); and
 - 24 ● In *Lunsford v. Board of Nurse Examiners*, 648 S.W. 2d 391 (Tex. App.—Austin, 1983), the court in affirming
25 the disciplinary action of the Board, held that a nurse has a duty to the patient which cannot be superseded by
26 hospital policy or physician's order.
 - 27 ● The Board's Disciplinary Sanction Policies discuss expectations of all nurses regarding behaviors that are
28 consistent with the Board's rules on Good Professional Character, §§ 213.27-213.29. These policies explain
29 the client's vulnerability and the nurse's "power" differential over the client by virtue of the client's status
30 (with regard to age, illness, mental infirmity, etc) and by the nature of the nurse:client relationship (where the
31 client typically defers decisions to the nurse, and relies on the nurse to protect the client from harm).
 - 32 ● The delegation rules guide the RN in delegation of tasks to unlicensed assistive personnel who are utilized to
33 enhance the contribution of the RN to the client's/patient's well being. When performing nursing tasks, the
34 unlicensed person cannot function independently and functions only under the RN's delegation and
35 supervision. Through delegation the RN retains responsibility and accountability for care rendered (Rules
36 224 and 225). The Board may take disciplinary action against the license of a RN or RN administrator for
37 inappropriate delegation
 - 38 ● RNs with advanced practice authorization from the Board must comply with the same rules applicable to
39 other RNs. In addition, rules specific to advanced practice nursing Chapters 221 & 222 must also be
40 followed.
 - 41 ● Each nurse must be able to support how his/her clinical judgments and nursing actions were aligned with the
42 NPA and Board Rules. The Board recommends nurses use the Six-Step Decision-Making Model for
43 Determining Nursing Scope of Practice when trying to determine if a given task is within the individual
44 nurse's abilities. Congruence with standards adopted by national nursing specialty organizations may further
45 serve to enhance and support the nurse's decision to perform a particular task.
- 46
47
48
49
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52

1 The nurse, by virtue of a rigorous process of education and examination leading to either LVN or RN licensure, is
2 accountable to the Board to assure that nursing care meets standards of safety and effectiveness.

3
4 Therefore, it is the position of the Board that each licensed nurse upholds his/her duty to maintain client safety
5 by practicing within the parameters of the NPA and Board Rules as they apply to each licensee.

6 (Adopted 01/2005)
7
8
9

10 11 **15.15 Board's Jurisdiction Over Nursing Titles And Practice**

12 An individual who holds licensure as a licensed vocational nurse or as a registered professional nurse in Texas is
13 responsible and accountable to adhere to the Nursing Practice Act and Board Rules which have the force of law
14 with regard to licensed nursing practice in the state of Texas. Standards of Nursing Practice (§217.11(1)(T))
15 require that each nurse practice within the level of his/her educational preparation, experience, knowledge, and
16 physical and emotional ability. The Standards of Nursing Practice establish the nurse's duty to the client. This
17 "duty" requires the nurse to intervene appropriately to protect and promote the health and well being of the client
18 or others for whom the nurse is responsible [§217.11(1)(B)].
19
20

21 **RNs Functioning in LVN Positions/ RNs or LVNs Functioning in Unlicensed Positions**

22 The Nursing Practice Act (NPA) and Board Rules do not preclude a RN from seeking employment in lower
23 positions (such as LVN, unlicensed, or technical positions), with purportedly fewer responsibilities. The Board
24 holds a licensed registered professional nurse, who is working in a lower level position, responsible and
25 accountable to the level of education and competency of a RN. Likewise, a LVN working as an unlicensed
26 person is responsible and accountable to the educational preparation and knowledge of a LVN. This expectation
27 does not apply to individuals formerly licensed as LVNs or RNs whose nursing license has been retired, placed
28 on inactive status, surrendered, or revoked.
29
30

31 **Use of the Title "LVN" or "RN" when Providing Related Services**

32 The use of the titles "Licensed Vocational Nurse," "LVN," or "Registered Nurse," "RN," or any designation
33 tending to imply that one is a licensed nurse is limited to those individuals appropriately licensed by the Board.
34 The use of titles implying that an individual holds licensure as a nurse in the State of Texas is restricted by law
35 (Tex. Occ. Code Ann. § 301.351, and Board Rule, 22 Tex. Admin. Code § 217.10). Use of any protected nursing
36 title by an individual who is not duly licensed as either a LVN or RN in Texas, or who does not hold a valid
37 compact license to practice nursing poses a potential threat to public safety related to this act of deception and
38 misrepresentation to the public who may be seeking the services of a licensed nurse.
39
40

41 In the opinion of the Board, the expressed or implied use of the title "LVN," or "RN," or any other title that
42 implies nursing licensure requires compliance with the NPA and Board Rules. As stated in Rule 217.11(1)(A),
43 the nurse is accountable to adhere to any state, local, or federal laws impacting the nurse's practice setting.
44

45 (Board Action 09/1998; rev. 01/2001; rev. 01/2003; rev. 01/2004; rev. 01/2005)
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1 **15.16 Development of Nursing Education Programs**

2
3 Approval of nursing education programs is one of the primary functions that the Board of Nurse Examiners
4 (BNE) performs in order to fulfill its mission to protect and promote the welfare of the people of Texas. The
5 Board has the responsibility and legal authority to decide whether a proposed new nursing education program
6 can meet the Board’s established minimum standards for educational programs. These standards require adequate
7 human, fiscal, and physical resources to initiate and sustain a program that prepares graduates to practice
8 competently and safety as nurses.
9

10 The Board recognizes that when health care facilities experience difficulties in recruiting and retaining sufficient
11 nurses, educational institutions and facilities within the affected geographical region frequently respond to this
12 workforce need by proposing to develop new nursing education programs.
13

14 **Guidelines for Establishing a New Vocational or Professional Nursing Education Program:**

15
16 A proposal to establish a new vocational nursing education program or a new professional nursing education
17 program must follow Rules & Regulations Chapter 214 for Vocational Nursing Education and Chapter 215 for
18 Professional Nursing Education. The institution seeking to establish the new nursing education program must
19 have the appropriate accreditation/approval and the proposal must be prepared by a nurse with educational
20 credentials and experience as outlined in the above mentioned rules. The proposal should include, but not be
21 limited to, extensive rationale which supports establishing the new nursing education program with demographic
22 and community data, employment needs for nurses in the area, evidence of support from stakeholders, and
23 acceptable curricular items as identified in the guidelines.
24

25
26 Guidelines for developing a proposal to establish a new vocational or professional nursing education program are
27 available on the BNE website (<http://www.bne.state.tx.us>) under ~~Table of Contents, then Education:~~ [Nursing](#)
28 [Education Information](#).
29

30 **Process for Proposal Approval/Denial:**

31
32 The process for proposal approval/denial may take up to one year after the initial contact is made with the BNE.
33 A proposal may require several revisions before it is acceptable to be presented to the Board at a regularly
34 scheduled Board meeting. After the proposal is determined to be ready to be presented to the Board, a
35 preliminary survey visit will be conducted by Board staff. A public hearing will be held at the Board meeting
36 prior to the Board’s discussion and decision. The Board may approve the proposal and grant initial approval to
37 the new program, may defer action on the proposal, or may deny further consideration of the proposal. An initial
38 approval fee shall be assessed following approval of the proposal [Rule 223.1(a)(9)].
39

40 **New Professional Nursing Education Programs:**

41
42 Analysis of data collected between 1988-1999 revealed that the professional nursing education programs which
43 were opened during that time had been associated with redistribution of students and faculty among nursing
44 education programs and competition for clinical affiliate placements, all of which may have compromised the
45 outcomes of established programs.
46

47
48 Six years after this analysis, these issues are still pertinent. An adequate number of experienced qualified faculty
49 candidates is limited across the state. Faculty with no teaching experience require extensive mentoring ~~in the~~
50 ~~faculty role~~ by seasoned faculty members; ~~This which can~~ This ~~can~~ consumption of time and energy and must be
51
52

1 considered in the allocation of workload. Full-time faculty members also need scheduled time for faculty
2 organization meetings, curriculum and program planning, evaluation and revision.

3
4 (Board Action 07/2000; revised 01/2004; revised 01/2005)
5

6
7
8 **15.17 Board of Nurse Examiners/Board of Pharmacy: Joint Position Statement on Medication Errors**
9

10 Medication errors occur when a drug has been inappropriately prescribed, dispensed, or administered.
11 Medication errors are a multifaceted problem which may occur in any health care setting. Consistent with their
12 common mission to promote and protect the welfare of the people of Texas, the Board of Nurse Examiners and
13 the Board of Pharmacy issued this joint statement for the purpose of increasing awareness of some of the factors
14 which contribute to medication errors. The Boards note that there are numerous publications available which
15 examine the many facets of this problem, and agree that all elements must be examined in order to identify and
16 successfully correct the problem. This position paper has been jointly developed because the Boards
17 acknowledge the interdisciplinary nature of medication errors and the variety of settings in which these errors
18 may occur. These settings may include hospitals, community pharmacies, doctors' offices/clinics, long-term care
19 facilities, clients' homes, and other locations.
20

21 Traditionally, medication errors have been attributed to the individual practitioner. However, reports such as the
22 recently published Institute of Medicine's "To Err Is Human: Building a Safer Health System," suggest the
23 majority of medical errors do not result from individual recklessness, but from basic flaws in the way the health
24 system is organized. It is the joint position of the Boards that a comprehensive and varied approach is necessary
25 to reduce the occurrence of errors. The Boards agree that the comprehensive approach includes three major
26 elements: (1) the individual professional's knowledge of practice; (2) resources available to the professional; and
27 (3) systems designs, problems and failures. Each of these three elements of this comprehensive approach are
28 discussed below.
29

30 Professional competence has long been targeted as a source of health care professional errors. To reduce the
31 probability of errors, all professionals must accept only those assignments for which they have the appropriate
32 education and which they can safely perform. Professionals must continually expand their knowledge and remain
33 current in their specialty, as well as be alerted to new medications, technologies and procedures in their work
34 settings. Professionals must be able to identify when they need assistance, and then seek appropriate instruction
35 and clarification. Professionals should evaluate strengths and weaknesses in their practice and strive to improve
36 performance. This ultimate accountability on the part of individual practitioners is a critical element in reducing
37 the incidence of medication errors.
38

39 The second element (resources available to all professionals) centers on the concept of team work and the work
40 environment. The team should be defined as all health care personnel within any setting. Health care
41 professionals must not be reluctant to seek out and utilize each other as resources. This is especially important
42 for the new professional and/or the professional in transition. Taking the time to learn about the resources
43 available in any practice setting is the individual professional's responsibility, and can help decrease the
44 occurrence of medication errors. Adequate staffing and availability of experienced professionals are key factors
45 in the delivery of safe effective medication therapy. In addition, health care organizations have the responsibility
46 to develop complete and thorough orientation for all employees, maintain adequate and updated policies and
47 procedures as guidelines for practice, and offer relevant opportunities for continuing staff development.
48

49 Analysis of the third element (systems designs, problems and failures) may demand creative and/or innovative
50 thinking specific to each setting as well as a commitment to guarantee client safety. Systems which may have
51
52

1 been in place for a long period of time may need to be re-examined for effectiveness. New information and
 2 technological advances must always be taken into account, and input should be solicited from all professionals.
 3 In addition, the system should contain a comprehensive quality program for the purpose of detecting and
 4 preventing problems and failures. The quality program must encourage all health care professionals to be alert
 5 for problems encountered in their daily tasks and to advocate for changes when necessary. In addition, the quality
 6 program should include a method of reporting all errors and problems within the system, a system for tracking
 7 and analysis of the errors, and an interdisciplinary review of the incident(s). Eliminating systems problems is
 8 vital in promoting optimal performance. The table on the following page, while not an exhaustive list, specifies
 9 areas which can be reviewed when medication errors occur. These areas encompass all three of the
 10 aforementioned contributing elements to the problem of medication errors and can be applied to individuals or
 11 systems. Communication is a common thread basic to all of these factors. Effective verbal or written
 12 communication is fundamental to successfully resolving breakdowns, either individual or system wide, that
 13 frequently contribute to medication errors.

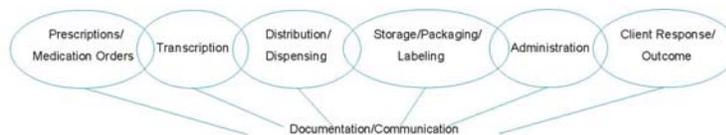
14
 15 The Boards agree that health care regulatory entities must remain focused on public safety. It is imperative that
 16 laws and rules are relevant to today's practice environment and that appropriate mechanisms are in place to
 17 address medication errors. The complex nature of the problem requires that there be a comprehensive approach
 18 to reducing these errors. It is vital to the public welfare that medication errors be identified, addressed, and
 19 reduced.

20
 21 (Board Action 10/2000)
 22

23 *References*

24
 25 Institute of Medicine. (1999). To err is human: Building a safer health system. Washington, D.C.: National
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 28 safety. Sentinel Event Alert, [On-line]. Available: jcaho.org/edu_pub/sealert/sea11.html.
 29 Leape, L. L. (1994). Error in medicine. *Journal of the American Medical Association*, 272(23), 1851-1857.
 30 Nursing Practice Act, Texas Occupations Code, Chapters 301 and 303.
 Texas Pharmacy Act, Texas Occupations Code, Chapters 551 - 566.

31 Position Statement 15.17 Table: Factors Contributing to Medication Errors



32
 33 Schematization of a chain representing the interdependent nature of these elements:
 34
 35 a weakness in any link impacts the entire system

Prescriptions/ Medication Orders	Transcription	Distribution/ Dispensing	Storage/Packaging/ Labeling	Administration	Client Response/ Outcome
<ul style="list-style-type: none"> - Accurate assessments - Awareness of allergies, contraindications, & drug reactions/ interactions - Correct drug/dose/route of administration - Clear and legible documentation of order 	<ul style="list-style-type: none"> - Clarification of orders (written/ verbal) if needed - Clear and legible handwriting - Accurate and complete transcription (e.g. MAR, Kardex, Computer) - Proofreading of all transcription 	<ul style="list-style-type: none"> - Clarification of orders if needed - Correct client/ drug/dose/route - Checking expiration dates - Medication preparations (mixing of intravenous solutions, correct pill count) - Clear and legible audit trail - Client teaching and verification of understanding 	<ul style="list-style-type: none"> - Careful review of instructions for use/warnings precautions - Checking expiration dates - Storage to avoid inadvertent mix-ups/location of bottles which are similar in appearance - Accurate/legible and complete labeling on original containers - Careful attention to floor stock expiration dates/mixing instructions 	<ul style="list-style-type: none"> - Assessment of client status - Five rights of medication administration - Right patient - Right medication - Right dose - Right time - Right route - Client teaching & verification of understanding - Accurate documentation of medication administration (MAR/client records/ narcotics log) 	<ul style="list-style-type: none"> - Assessment of efficacy/adverse reactions - Client compliance - Documentation

1 **15.18 Nurses Carrying Out Orders From Advanced Practice Nurses**

2
3 Advanced practice nurses (APNs) are registered nurses who hold authorization from the board to practice as
4 advanced practice nurses based on completion of an advanced educational program acceptable to the Board. The
5 term includes a nurse practitioner, nurse-midwife, nurse anesthetist, and a clinical nurse specialist. The advanced
6 practice nurse is prepared to practice in an expanded role to provide health care to individuals, families, and/or
7 groups in a variety of settings, including, but not limited to, homes, hospitals, institutions, offices, industry, schools,
8 community agencies, public and private clinics, and private practice. The advanced practice nurse acts
9 independently and/or in collaboration with other health care professionals in the delivery of health care services.
10 Advanced practice nurses utilize mechanisms, including Protocols or other written authorization, that provide them
11 with the authority to provide medical aspects of care, including the ordering of dangerous drugs, controlled
12 substances, or devices that bear or are required to bear the legend: “Caution: federal law prohibits dispensing
13 without a prescription” or “RX only” or any other legend that complies with federal law. The Protocols or other
14 written authorization may vary in complexity based on the educational preparation and advanced practice
15 experience of the individual advanced practice nurse. Protocols or other written authorization are not required to
16 describe the exact steps that an advanced practice nurse must take with respect to each specific condition,
17 disease, or symptom. Protocols or other written authorization are not required for nursing aspects of care.

18
19 The Board recognizes that in many settings, nurses and advanced practice nurses work together in a collegial
20 relationship. A nurse may carry out an advanced practice nurse’s order in the management of a patient, including,
21 but not limited to, the administration of treatments, orders for laboratory or diagnostic testing, or medication
22 orders. A physician is not required to be physically present at the location where the advanced practice nurse is
23 providing care. The order is not required to be countersigned by the physician. The advanced practice nurse must
24 function within the accepted scope of practice of the role and specialty in which he/she has been authorized by
25 the Board.

26
27 As with any order, the nurse must seek clarification if he/she believes the order is inappropriate, inaccurate,
28 nonefficacious or contraindicated by consulting with the advanced practice nurse or the physician as appropriate.
29 The Nurse carrying out an order from an advanced practice nurse is responsible and accountable for his/her
30 actions just as he/she would be with any physician order.

31
32 (Board Action, 01/2001; Revised 01/05)

33
34
35
36 **15.19 Nurses Carrying out Orders from Pharmacists for Drug Therapy Management**

37
38 In response to Senate Bill 659 enacted in 1995 during the 74th Legislative Session, the Texas State Board of
39 Pharmacy and the Texas ~~State Board of Medical Examiners~~ Medical Board (TMB) entered into a joint rule-
40 making effort to elaborate the processes by which a pharmacist could engage in drug therapy management
41 (DTM) as delegated by a physician. The result of this joint effort was the adoption of rules by both the Pharmacy
42 Board [22 TAC §295.13, 1997], and the ~~Board of Medical Examiner’s~~ Texas Medical Board [22 TAC §193.7,
43 1999]. The ~~Board of Medical Examiners~~ Texas Medical Board amended its rules subsequent to the adoption of
44 §157.101 *Delegation to Pharmacist*, in the Medical Practice Act during the 76th Legislative Session (1999).

45
46 According to definitions listed in the Pharmacy Act [Tex. Occ. Code Ann. § 551.003], the “Practice of
47 Pharmacy” includes “(F) performing for a patient a specific act of drug therapy management (DTM)
48 delegated to a pharmacist by a written protocol from a physician licensed in this state in compliance with
49 Subtitle B.” The Pharmacy rules further define DTM as “the performance of specific acts by pharmacists as
50 authorized by a physician through written protocol.” [22 TAC § 295.13(b)(4)]. Rule 295.13(b)(6) further
51
52

1 adds the clarification that a “*written protocol is a physician’s order, standing medical order, standing*
2 *delegation order, or other order or protocol as defined by rule of the ~~Texas State Board of Medical~~*
3 *Examiners-Texas Medical Board under the Medical Practice Act.*” The ~~Texas State Board of Medical~~
4 ~~Examiner’s (TSBME)~~ TMB’s Rule [22 TAC §§ 193.7] reflects similar language to the Pharmacy Board rules.
5

6 Nurses frequently communicate and collaborate with both the client’s physician and the pharmacist in providing
7 optimal care to clients. It is, therefore, the Board’s position that a nurse may carry out orders written by a
8 pharmacist for DTM provided the order originates from a written protocol authorized by a physician. Any nurse
9 carrying out DTM orders from a pharmacist may wish to review the ~~TSBME~~ TMB Rule 193, *Physician*
10 *Delegation*, in its entirety. The components of the rule related to physician delegation for a pharmacist to engage
11 in DTM are set forth in §193.7(e) as follows:
12

- 13 (1) A written protocol must contain at a minimum the following listed in subparagraphs (A)-(E) of this paragraph:
14
- 15 (A) a statement identifying the individual physician authorized to prescribe drugs and responsible for the
16 delegation of drug therapy management;
 - 17 (B) a statement identifying the individual pharmacist authorized to dispense drugs and to engage in drug
18 therapy management as delegated by the physician;
 - 19 (C) a statement identifying the types of drug therapy management decisions that the pharmacist is authorized
20 to make which shall include:
21
 - 22 (i) a statement of the ailments or diseases, drugs, and type of drug therapy management authorized; and
 - 23 (ii) a specific statement of the procedures, decision criteria, or plan the pharmacist shall follow when
24 exercising drug therapy management authority;
 - 25 (D) a statement of the activities the pharmacist shall follow in the course of exercising drug therapy
26 management authority, including the method for documenting decisions made and a plan for
27 communication or feedback to the authorizing physician concerning specific decisions made.
28 Documentation shall be recorded within a reasonable time of each intervention and may be performed on
29 the patient medication record, patient medical chart, or in a separate log book; and
 - 30 (E) a statement that describes appropriate mechanisms and time schedule for the pharmacist to report to the
31 physician monitoring the pharmacist’s exercise of delegated drug therapy management and the results of
32 the drug therapy management.
- 33
- 34 (2) A standard protocol may be used, or the attending physician may develop a drug therapy management
35 protocol for the individual patient. If a standard protocol is used, the physician shall record what deviations, if
36 any, from the standard protocol are ordered for that patient (22 Tex. Admin. Code §193.7(e)).
37

38 The protocol under which a pharmacist initiates DTM orders for a patient should be available to the nurse at the
39 facility, agency, or organization in which it is carried out. As with any order, the nurse must seek clarification if he/
40 she believes the order is inappropriate, inaccurate, nonefficacious or contraindicated by contacting the pharmacist
41 and/or the physician who authorized the DTM protocol as appropriate (22 Tex. Admin. Code §217.11(19)). The
42 nurse carrying out an order for DTM written by a pharmacist is responsible and accountable for his/her actions
43 just as he/she would be with any physician order.
44

45 (Board Action 1/2002; Revised 01/2005)
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1 **15.20 Registered Nurses in the Management of an Unwitnessed arrest in a Resident in a Long Term**
2 **Care Facility**

3
4 The Board of Nurse Examiners has approved this position statement in an effort to provide guidance to registered
5 nurses in long term care facilities and to clarify issues of compassionate end-of-life care. The Texas Nurses
6 Association (TNA) through its Long Term Care (LTC) Committee has identified that registered nurses have
7 expressed repeated concern about the inappropriate initiation of cardiopulmonary resuscitation (CPR) when a
8 resident without a “do not resuscitate” order (DNR) experiences an unwitnessed arrest. There is growing
9 sentiment on the part of the long term care nurse community that the initiation of CPR would appear futile and
10 inappropriate given the nursing assessment of the resident.

11
12 The nursing community generally considers that initiation of CPR in such cases is not compassionate, and is not
13 consistent with standards requiring the use of a systematic approach to provide individualized, goal directed
14 nursing care [BNE Standards of Professional Nursing Practice, 22 TAC § 217.11(2)]. This position statement is
15 intended to provide guidance, for nurses, in the management of an unwitnessed resident arrest without a DNR
16 order in a long term care (LTC) setting. The position also addresses the related issues of:

- 17
- 18 ● Obligation (or duty) of the nurse to the resident,
- 19
- 20 ● Expectation of supportive policies and procedures in LTC facilities,
- 21
- 22 ● The RN role in pronouncement of death.

23 These related issues are addressed in this position statement because the BNE is often required to investigate
24 cases of death where it appears there is a lack of clarity about a nurse’s obligation when there is no DNR order.
25 The BNE will evaluate cases involving the failure of a RN to initiate CPR in the absence of a DNR based on the
26 following premise:

27
28 A DNR is a medical order that must be given by a physician and in the absence thereof, it is generally
29 outside the standard of nursing practice to determine that CPR will not be initiated.

30
31 However, there may be instances when LTC residents without a DNR order experience an unwitnessed arrest,
32 and it is clear according to the nursing assessment that CPR intervention would be a futile and inappropriate
33 intervention given the condition of the resident. In the case of an unwitnessed resident arrest without DNR
34 orders, determination of the appropriateness of CPR initiation should be undertaken by the nurse through a
35 resident assessment, and interventions appropriate to the findings initiated.

36
37 Assessment of death in which CPR would be a futile and inappropriate intervention requires that all seven of the
38 following signs be present and that the arrest is unwitnessed.

39 **Presumptive Signs of Death**

- 40
- 41 1. The resident is unresponsive,
- 42
- 43 2. The resident has no respirations,
- 44
- 45 3. The resident has no pulse,
- 46
- 47 4. Resident’s pupils are fixed and dilated,
- 48
- 49 5. The resident’s body temperature indicates hypothermia: skin is cold relative to the residents baseline skin
50 temperature,
- 51 6. The resident has generalized cyanosis, and
- 52

1 **Conclusive Sign of Death**

2
3 7. There is presence of livor mortis (venous pooling of blood in dependent body parts causing purple
4 discoloration of the skin which does blanch with pressure).

5
6 There may be other circumstances and assessments that could influence a decision on the part of the nurse not to
7 initiate CPR. However, evaluation of the prudence of such a decision would occur on a case-by-case basis by the
8 BNE.

9 **Documentation**

10
11 After assessment of the resident is completed and appropriate interventions are taken, documentation of the
12 circumstances and the assessment of the resident in the resident record are a requirement. The rules of the
13 boards of nursing establish legal documentation standards, [BNE Standards of Nursing Practice, TAC § Rule
14 217.11 (1)(D)]. Examples of important documentation elements include:

- 15 ● Description of the discovery of the resident
- 16 ● Any treatment of the resident that was undertaken
- 17 ● The findings for each of the assessment elements outlined in the standards
- 18 ● All individuals notified of the resident’s status (e.g., 9-1-1, the health care provider, the administrator of the
19 facility, family, coroner, etc.)
- 20 ● Any directions that were provided to staff or others during the assessment and/or treatment of the resident
- 21 ● The results of any communications
- 22 ● Presence or absence of witnesses

23
24 Documentation should be adequate to give a clear picture of the situation and all of the actions that were taken or
25 not taken on behalf of the resident.

26
27 Even if the nurse’s decision not to initiate CPR was appropriate, failure to document can result in an action
28 against a nurse’s license by the BNE. Furthermore, lack of documentation places the nurse at a disadvantage
29 should the nurse be required to explain the circumstances of the resident’s death. Nurses should be aware that
30 actions documented at the time of death provide a much more credible defense than needing to prove actions not
31 appropriately documented were actually taken.

32
33 **Obligation (“Duty”) of the Nurse to the Resident**

34
35 Whether CPR is initiated or not, it is important for the nurse to understand that she/he may be held accountable if
36 the nurse failed to meet standards of care to assure the safety of the resident, prior to the arrest such as:

- 37 ● Failure to monitor the resident’s physiologic status;
- 38 ● Failure to document changes in the resident’s status and to adjust the plan of care based on the resident
39 assessment;
- 40 ● Failure to implement appropriate interventions which might be required to stabilize a client’s condition such as:
41 reporting changes in the resident’s status to the resident’s primary care provider and obtaining appropriate
42 orders;
- 43 ● Failure to implement procedures or protocols that could reasonably be expected to improve the resident’s
44 outcome.

1 **Care Planning and Advanced Directives**

2
3 Proactive policies and procedures, that acknowledge the importance of care planning with the inclusion of
4 advanced directives, are also important. Evidence indicates that establishing the resident’s wishes at the end of
5 life and careful care planning prevents confusion on the part of staff and assures that the resident’s and family’s
6 wishes in all aspects of end of life care are properly managed.

7
8 The admission process to long term care facilities in Texas requires that residents be provided information on self-
9 determination and given the option to request that no resuscitation efforts be made in the event of cardiac and/or
10 respiratory arrest. Facilities are required to have policies and adequate resources to assure that every resident and
11 resident’s family upon admission to a long term care facility not only receive such information, but have sufficient
12 support to make an informed decision about end of life issues.

13
14 It is further expected that advanced care planning is an ongoing component of every resident’s care and that the
15 nursing staff should know the status of such planning on each resident.

16
17 The Board recognizes that end of life decisions on the part of residents and families can be difficult. However, the
18 Board believes that principled and ethical discussion about the CPR issue with the resident and family, is an
19 essential element of the resident care plan.

20 **RN Role in Pronouncement of Death**

21
22 Texas law provides for RN pronouncement of death [Health & Safety Code §§ 671.001-.002]. The law requires
23 that in order for a nurse to pronounce death, the facility must have a written policy which is jointly developed and
24 approved by the medical staff or medical consultant and the nursing staff, specifying under what circumstances a
25 RN can make a pronouncement of death.

26
27 It is important that nurses understand that the assessment that death has occurred and that CPR is not an
28 appropriate intervention are not the equivalent to the pronouncement of death. Texas statutory law governs who
29 can pronounce death, and only someone legally authorized to pronounce death may do so. If the RN does not
30 have the authority to pronounce death, upon assessment of death the RN must notify a person legally authorized
31 to pronounce death.

32 **Conclusion**

33
34 This position statement is intended to guide nurses in long term care facilities who encounter an unfit resident
35 arrest without a DNR order. It is hoped that by clarifying the responsibility of the nurse, and through the use of
36 supportive facility policies and procedures, that nurses will be better able to provide compassionate end of life
37 care.
38

39 **Qualifier to Position**

40
41 The BNE evaluates “failure to initiate CPR cases” based on the premise that in the absence of a physician’s
42 DNR order it is generally outside the standard of nursing practice not to initiate CPR. Consequently, RNs deciding
43 not to initiate CPR when all seven signs of death are not present must assure themselves that not initiating CPR
44 complies with their respective standards of practice. Depending on the circumstances, a nurse’s failure to initiate
45 CPR when all seven signs are not present may constitute failure to comply with standards of nursing care. This
46 position statement is limited to situations when all seven signs are present and should not be construed as
47 providing guidance on the appropriateness of not initiating CPR when all seven signs are not present.
48

49 (Approved by the Board of Nurse Examiners of Texas on October 24, 2002; Rev 01/2005.)
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52

1 **15.21 Application of Safe Harbor Peer Review to LVNs** [Deleted 01/05]

2 This position statement has been deleted. Rule 217.20 *Safe Harbor Peer Review* was updated to
3 reflect applicability to all licensed nurses in Texas July 5, 2004.
4

5
6
7 **15.22 APNs Providing Medical Aspects of Care for Themselves or Others with whom there is a Close**
8 **Personal Relationship**
9

10 Advanced Practice Nurses often find themselves in situations where they may feel compelled to provide medical
11 aspects of care or prescribe medications for themselves, their family members, or other individuals with whom
12 they have a close personal relationship. Such practices raise a number of ethical questions. The Board is
13 concerned that advanced practice nurses in these situations risk allowing their personal feelings to cloud their
14 professional judgment and objectivity. It is the opinion of the Board of Nurse Examiners that advanced practice
15 nurses should not provide medical treatment or prescribe medications for themselves or any individual with whom
16 they have a close personal relationship.
17

18 (Board Action 10/2003)
19

20
21
22 **15.23 The RN's Use of Complementary Modalities**
23

24 Nursing is a dynamic profession. The scope of practice for one RN may differ from the scope of practice for
25 another RN; therefore, it is impractical to create an exhaustive listing of all tasks that may or may not be
26 performed by a registered nurse in any setting. According to the Nursing Practice Act (NPA) for the State of
27 Texas, Section 301.002(2), "professional nursing" is defined, in part, as focused on the maintenance of health or
28 prevention of illness through nursing practices performed for compensation that may include assessment,
29 intervention, evaluation, rehabilitation, and/or the care, counsel, and health education of a person who is ill, injured,
30 infirm, or experiencing a change in normal health processes. These nursing actions may be independent or
31 collaborative. A number of complementary therapeutic modalities have long been incorporated into standard
32 nursing practice to assist patients in meeting identified health needs and goals. Educational preparation to practice
33 complementary modalities may be acquired through formal academic programs or continuing education.
34

35 Depending upon the practice setting and modality considered, complementary modalities may be used alone or in
36 conjunction with conventional modalities.
37

38 Regardless of practice setting, the professional registered nurse who wishes to incorporate the use of
39 complementary modalities into his/her professional nursing practice is accountable and responsible to adhere to
40 the Nursing Practice Act, Rules, and Regulations Relating to Professional Nurse Education, Licensure and
41 Practice.
42

43 Rules that are particularly relevant to RNs who integrate complementary therapies into professional nursing
44 practice include rule 217.10, *Restrictions to Use of Designations for Licensed Vocational or Registered*
45 *Nurse*, which requires a registered nurse who uses the title "RN" (either expressed or implied) to comply with the
46 NPA and Board Rules. In addition, rule 217.11, *Standards of Nursing Practice*, forms the foundation for safe
47 nursing practice and establishes the RN's duty to his/her clients. While all standards apply when engaging in the
48 practice of professional registered nursing, those standards most applicable to the RN who engages in
49 complementary modalities include § 217.11(1), standards (A)-(D), (F), (G), (R), and (T), and § 217.11(3)(A).
50 Additional standards may apply depending upon the specific practice situation. In order to show accountability
51
52

1 when providing integrated or complementary modalities as nursing interventions, the RN should be able to
2 articulate and provide evidence of:

- 3 1. Educational activities used to gain or maintain the knowledge and skills needed for the safe and effective use of
4 such modalities;
- 5 2. Knowledge of the anticipated effects of the complementary therapy and its interactions with other modalities,
6 including its physiological, emotional/spiritual impact;
- 7 3. Selection of appropriate interventions, whether complementary, conventional, or in combination, to meet the
8 client's needs. The interventions and rationale for selection should be documented in the client's nursing care
9 plan. The demonstrated ability of the RN to properly perform the chosen intervention(s) should be maintained
10 by the RN and/or his/her employer;
- 11 4. Instruction/education provided regarding the purpose of the selected intervention, e.g., how it is performed, and
12 its potential outcomes;
- 13 5. Collaboration with other health care professionals and applicable referrals when necessary;
- 14 6. Documentation of interventions and client responses in a client's record;
- 15 7. Development and/or maintenance of policies and procedures relative to complementary modalities when used
16 in organized health care settings;
- 17 8. Abstinence from making unsubstantiated claims about the therapy used; and
- 18 9. Acknowledgment that, as with conventional modalities, each person's response to the therapy will be unique.

19 While some complementary therapies, such as massage, have long been within the realm of nursing, there is a
20 much broader connotation applied when a RN holds himself/herself out as a registered or certified practitioner of
21 such a therapy. "Registered" or "certified" titles imply a degree of mastery above those basic skills acquired
22 through a pre-licensure nursing program. The RN is accountable to hold the proper credentials (e.g., license,
23 registration, certificate, etc.) to safely engage in the specific practice.(accessible on the BNE web page) may be
24 a useful tool for the RN who is uncertain whether a given modality is within his/her scope of practice. The
25 professional registered nurse who wishes to integrate complementary modalities when engaging in the practice of
26 nursing should be familiar with not only the NPA and BNE rules, but also any prevailing standards published by
27 national associations, credentialing bodies, and professional nursing organizations related to the RN's area of
28 practice.

29 (Board Action 01/2004; revised 01/2005)

30 **15.24 Nurses Engaging In Reinsertion of Permanently Placed Feeding Tubes**

31 The Board approved curriculum for both vocational nurses and registered nurses does not provide graduates with
32 sufficient instruction to ascertain that a nurse has the necessary knowledge, skills and ability to re-insert and
33 determine correct placement of a permanently placed feeding tube (such as a gastrostomy or jejunostomy tubes).
34 The Board does allow LVNs and RNs to expand their practice beyond the basic educational preparation through
35 post-licensure continuing education and training for certain tasks and procedures. One of the main considerations
36 in determining whether or not a nurse should consider re-insertion of a gastrostomy, jejunostomy or similar feeding
37 tube is how long the original tube was in place before becoming dislodged. Though sources vary, most give a
38 range of 8-12 weeks for maturation/healing of the fistulous tract and stoma formation. The method of initial
39

1 insertion (surgical, endoscopy, or radiographic guidance) may impact the length of healing. Orders should be
2 obtained from the patient's physician regarding re-insertion guidelines. It is the opinion of the Board that LVNs
3 and RNs should not engage in the reinsertion of a permanently placed feeding tube through an established tract
4 until the LVN or RN successfully completes a competency validation course congruent with prevailing nursing
5 practice standards. Training should provide instruction on the nursing knowledge and skills applicable to tube
6 replacement and verification of correct and incorrect placement. The BNE does not define nor set qualifications
7 for competency validation courses; however, inclusion of the following factors is encouraged:
8

- 9 1. The nurse should complete training designed specifically for the type or types of permanent feeding tubes the
10 nurse may need to replace, including overall patient assessment, verification of proper tube placement, and
11 assessment of the tube insertion site.
- 12 2. A registered nurse or a physician who has the necessary expertise with regard to the specific feeding tube
13 provides supervision during the training process.
- 14 3. The nurse demonstrates competency in all appropriate aspects (knowledge, decision-making, and psycho-motor
15 skills) of performing the procedure.
- 16 4. The patient has an established tract. The established tract is not determined by the nurse.
- 17 5. The facility has resources available to develop an educational program for initial instruction of LVNs and/or
18 RNs, as well as for ongoing competency validation.
- 19 6. Documentation of each nurse's initial education and ongoing competency validation should be maintained by
20 the nurse and/or the employer in accordance with facility policies.
- 21 7. Regardless of training, policies and procedures of the facility must also permit the nurse to engage in the
22 procedure.

23 The nurse who accepts an assignment to engage in care and/or replacement of permanently placed feeding tubes
24 is responsible to adhere to the NPA and Board rules, particularly § 217.11, *Standards of Nursing Practice*, as
25 well as any other standards or rules applicable to the nurse's practice setting. Two standards applicable in all
26 practice scenarios include:
27

- 28 ● § 217.11(1)(B) "implement measures to promote a safe environment for clients and others;" and
- 29 ● § 217.11(1)(T) "accept only those assignments that take into consideration client safety and that are
30 commensurate with the nurse's educational preparation, experience, knowledge, and physical and emotional
31 ability."
32

33 Additional standards in Rule 217.11 that may be applicable when a nurse chooses to engage in replacement of a
34 permanently placed feeding tube include (but are not limited to):
35

- 36 ● (1)(D) "Accurately and completely report and document: (i) ..client status....(ii) nursing care rendered...(iii)
37 physician, dentist or podiatrist orders...(iv) administration of medications and treatments....(v) client
38 response(s)...,"
- 39 ● (1)(G) "Obtain instruction and supervision as necessary when implementing nursing procedures or practices,"
- 40 ● (1)(H) "Make a reasonable effort to obtain orientation/training for competency when encountering new
41 equipment and technology or unfamiliar care situations,"
- 42 ● (1)(R) "Be responsible for one's own continuing competence in nursing practice and individual professional
43 growth."
44

- 1 ● Standards specific to LVNs may be found in § 217.11(2); standards specific to RNs may be found in
2 § 217.11(3).

3
4 Regardless of facility policy or physicians' orders, the nurse always has a duty to maintain the safety of the patient
5 [Reference 217.11(1)(B) above]; this standard has previously been upheld in a landmark case (*Lunsford vs.*
6 *Board of Nurse Examiners*, 648 S.W. 2d 391 (Tex. App. — Austin 1983).

7
8 (Adopted 01/2005)

10
11
12 ~~THE ROLE OF THE LICENSED VOCATIONAL NURSE IN THE ADMINISTRATION OF~~
13 ~~INTRAVENOUS (IV) CONSCIOUS SEDATION~~

14 {Replaced by Combined Position Statement 15.8 on Moderate Sedation}

15
16 The administration of intravenous pharmacologic agents to achieve conscious sedation requires mastery of
17 complex nursing knowledge, advanced skills, and the ability to make independent nursing judgments during an
18 unstable and unpredictable period for the client.

19
20 It is the opinion of the Board of Vocational Nurse Examiners that optimal anesthesia care inclusive of conscious
21 sedation is provided by qualified anesthesiologists, and certified registered nurse anesthetists, or practicing
22 registered professional nurses. Further, it is the opinion of the Board of Vocational Nurse Examiners that the one
23 year vocational nursing program does not provide the graduates with educational foundation for the administration
24 of IV conscious sedation or the management of a patient during conscious sedation which is considered an
25 unstable and unpredictable period.

26
27 [BVNE (IV Conscious Sedation) Adopted June 13, 1995]

30
31 ~~THE ROLE OF THE LICENSED VOCATIONAL NURSE IN THE PRONOUNCEMENT OF DEATH~~

32 {Replaced by Position Statement 15.2}

33
34 LVNs are not granted the authority to pronounce death, if "pronounce" we mean either legally determine death or
35 diagnose death. However, it is within the scope of practice of LVNs to gather data regarding their patients, to
36 recognize significant changes in their patients' condition and to report data and those significant changes to the
37 physician. It is also a part of the LVNs' practice to accept reasonable physicians' orders regarding the care of
38 their patients and to act upon them. The law assigns the physician liability for all orders issued.

39
40 The consensus of the Board is that an LVN who identifies changes in a patient consistent with the diagnosis of
41 death, reports those changes to the physician, takes a telephonic order and acts upon it is within the scope of LVN
42 practice.

43
44 [Adopted June 7, 1999]