Agenda Item 7.2.1
Board Meeting: January 2012
Prepared by: D. Benbow

# Annual Review of Board Position Statements

**Summary of Request:**

Board Position Statements are reviewed on an annual basis. This report contains the existing position statements that have no recommended changes.

**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 Nursing Practice Act and Board rules.

**Current Position Statements with No Changes**

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
15.9 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 APRNs
15.13 Role of 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 Texas Board of Nursing/ Board of Pharmacy, Joint Position Statement, Medication Error
15.19 Nurses Carrying out Orders from Pharmacists for Drug Therapy Management
15.21 Deleted 01/2005
15.22 APRNs Providing Medical Aspects of Care for Themselves or Others With Whom There is a Close Personal Relationship
15.24 Nurses Engaging in Reinsertion of Permanently Placed Feeding Tubes
15.26 Simulation in Prelicensure Nursing Education
15.27 The Licensed Vocational Nurse Scope of Practice
15.28 The Registered Nurse Scope of Practice

**Pros and Cons**

**Pros:**
Adoption of the position statements will provide guidance to nurses based on current practice standards, and will offer clarification on frequently asked questions.

**Cons:**
None noted.

**Recommendations:**

Move to adopt the position statements with allowance for non-substantive word editing for purposes of clarity as may be deemed necessary by Board staff.

## Current Position Statements without Editorial Changes

### 15.4 Educational Mobility

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

(Board Action 01/1989, revised 01/1992, 01/2005; 01/2008)
(Reviewed - 01/2006; 01/2007; 01/2009; 01/2010; 01/2011; 01/2012)

**15.5 Nurses with Responsibility for Initiating Physician Standing Orders**

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

The specifics of how authorization occurs for a LVN or RN to implement a set of standard physician's orders are defined in the Texas Medical Board's (TMB) Rule 193 (22 Tex. Admin. Code §§193.1-193.12) relating to physician delegation. This rule holds out two (2) methods by which nurses may follow a preapproved set of orders for treating patients:

1) Standing Delegation Orders; and/or
2) Standing Medical Orders.

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

> ***(12) Standing delegation order*** *- Written instructions, orders, rules, regulations, or procedures prepared by a physician and designed for a patient population with specific diseases, disorders, health problems, or sets of symptoms. Such written instructions, orders, rules, regulations or procedures shall delineate under what set of conditions and circumstances action should be instituted. These instructions, orders, rules, regulations or procedures are to provide authority for and a plan for use with patients presenting themselves prior to being examined or evaluated by a physician to assure that such acts are carried out correctly and are distinct from specific orders written for a particular patient, and shall be limited in scope of authority to be delegated as provided in §193.4 of this title (relating to Scope of Standing Delegation Orders). As used in this chapter, standing delegation orders do not refer to treatment programs ordered by a physician following examination or evaluation by a physician, nor to established procedures for providing of care by personnel under direct, personal supervision of a physician who is directly supervising or overseeing the delivery of medical or health care. Such standing delegation orders should be developed and approved by the physician who is responsible for the delivery of medical care covered by the orders. Such standing delegation orders, at a minimum, should:*
> *(A) include a written description of the method used in developing and approving them and any revision thereof;*
> *(B) be in writing, dated, and signed by the physician;*
> *(C) specify which acts require a particular level of training or licensure and under what circumstances they are to be performed;*
> *(D) state specific requirements which are to be followed by persons acting under same in performing particular functions;*
> *(E) specify any experience, training, and/or education requirements for those persons who shall perform such orders;*
> *(F) establish a method for initial and continuing evaluation of the competence of those authorized to perform same;*
> *(G) provide for a method of maintaining a written record of those persons authorized to perform same;*
> *(H) specify the scope of supervision required for performance of same, for example, immediate*

*supervision of a physician;*
*(I) set forth any specialized circumstances under which a person performing same is to immediately communicate with the patient's physician concerning the patient's condition;*
*(J) state limitations on setting, if any, in which the plan is to be performed;*
*(K) specify patient record-keeping requirements which shall, at a minimum, provide for accurate and detailed information regarding each patient visit; personnel involved in treatment and evaluation on each visit; drugs, or medications administered, prescribed or provided; and such other information which is routinely noted on patient charts and files by physicians in their offices; and*
*(L) provide for a method of periodic review, which shall be at least annually, of such plan including the effective date of initiation and the date of termination of the plan after which date the physician shall issue a new plan.*
***(13) Standing medical orders** - Orders, rules, regulations or procedures prepared by a physician or approved by a physician or the medical staff of an institution for patients which have been examined or evaluated by a physician and which are used as a guide in preparation for and carrying out medical or surgical procedures or both. These orders, rules, regulations or procedures are authority and direction for the performance for certain prescribed acts for patients by authorized persons as distinguished from specific orders written for a particular patient.*

A third term, "Protocols", is defined narrowly by the TMB and applies to RNs with advanced practice authorization (APRN) by the BON, or to Physician Assistants only:

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

By definition, both vocational and professional nursing excludes “acts of medical diagnosis or the prescription of therapeutic or corrective measures”[Tex. Occ. Code Ann. §301.002(2) and (5)]. Based on the above definitions in the TMB rules, RNs who do not have advanced practice authorization from the BON may not utilize "protocols" to carry out physician orders. Likewise, vocational nurses (LVNs) are also prohibited from utilizing protocols as defined by the TMB, as neither LVNs nor RNs may engage in acts that require independent medical judgment.

A nurse responsible for initiating physician's standing medical orders or standing delegation orders may select specific tasks or functions for patient management, including the administration of a

medication required to implement the selected order provided such selection is within the scope of the standing orders. The selection of such tasks or functions for patient management constitutes a nursing decision that may be carried out by a LVN or RN. In addition, this position statement should not be construed to preclude the use of the term "protocol" for a standard set of orders covering the monitoring and treatment of a given clinical condition (e.g., insulin protocol, heparin protocol, ARDS protocol, etc.) provided said standard orders meet the requirements for standing delegation or standing medical orders as defined by the TMB.

The written standing orders under which nurses function shall be commensurate with each nurse's educational preparation and experience. The nurse initiating any form of standing orders must act within the scope of the Nursing Practice Act, Board Rules and Regulations, and any other applicable local, state, or federal laws.

(Board Action 07/1988, revised 01/1992, 07/2001; 01/2005; 01/2006; 01/2007; 01/2009; 01/2011)
(Reviewed - 01/2008; 01/2010; 01/2012)

**15.6 Board Rules Associated With Alleged Patient "Abandonment"**

The Board of Nursing (BON or Board), in keeping with its mission to protect the public health, safety, and welfare, holds nurses accountable for providing a safe environment for clients and others over whom the nurse is responsible [Rule 217.11(1)(B)]. Though the Nursing Practice Act (NPA) and Board Rules do not define the term *"abandonment,"* the Board has investigated and disciplined nurses in the past for issues surrounding the concept of *abandonment* as it relates to *the nurse's duty to the patient.* The Board's position applies to licensed nurses (LVNs and RNs), including RN's with advanced practice authorization (Nurse Practitioners, Clinical Nurse Specialists, Nurse Midwives, and Certified Registered Nurse Anesthetists) in Texas.

**Nurse's Duty To A Patient**

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

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

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

**Employment Issues**

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

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

- Resignation without advance notice, assuming the nurse's current patient care assignment and/or work shift has been completed.
- Refusal to work additional shifts, either "doubles" or extra shifts on days off.

• Other work-related issues, such as frequent absenteeism or tardiness, or conflicts between staff/employees.

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

**Licensure Issues**

As previously noted, the rules most frequently applied to nursing practice concerns are Rule 217.11 *Standards of Nursing Practice,* and Rule 217.12 *Unprofessional Conduct.* In relation to questions of "abandonment," standard 217.11(1)(I) holds the nurse responsible to "notify the appropriate supervisor when leaving a nursing assignment." This standard should not be mis-interpreted to mean that the nurse may simply notify the supervisor that he/she is leaving the premises, regardless of whether or not another qualified licensed nurse is available to assume care of the nurse's patients. Specific procedures to follow in a given circumstance (nurse becomes ill, family emergency, etc.) should be delineated in facility policies (which the Board does not regulate).

Some actions may be more obvious examples of unprofessional conduct that could result in sanctions on the nurse's license. Examples of conduct that could lead to Board action on the nurse's license may include:

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

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

**Board Disciplinary Actions**

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

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

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

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

**Safe Harbor Peer Review:**

If a nurse feels he/she is being asked to accept an assignment that would potentially cause the nurse to violate his/her duty to a patient, the nurse may be able to invoke "safe harbor," depending on whether or not the nurse's employer meets requirements that would make it mandatory for the employer to have a peer review plan in place. This is established in the NPA, Chapter 303 *Peer Review*, and in Rule 217.20 *Safe Harbor Peer Review and Whistleblower Protections*. Safe Harbor has two effects related to
the nurse's license:

(1) It is a means by which a nurse can request a peer review committee determination of a specific situation in relation to the nurse's duty to a patient; and
(2) It affords the nurse immunity from Board action against the nurse's license if the nurse invokes Safe Harbor in accordance with Rule 217.20. For the nurse to activate this immunity status, the nurse must notify the assigning supervisor at the time the assignment request is made, and the nurse must submit the required information in writing as specified in Rule 217.20(d)(3)(A) or on the Board's Safe Harbor Quick Request Form.

**Links to Related Articles** (all of the following are located on the Board's web page):
- Safe Harbor Form http://www.bon.state.tx.us/practice/safe.html
- FAQ on Overtime/Hours of Work http://www.bon.state.tx.us/practice/faq-overtime.html
- FAQ on Peer Review http://www.bon.state.tx.us/practice/faq-peerreview.html
- FAQ on Staffing Ratios http://www.bon.state.tx.us/practice/faq-staffing.html
- FAQ on Floating http://www.bon.state.tx.us/practice/faq-floating.html
- FAQ on When Does a Nurse's Duty to a Patient Begin and End
http://www.bon.state.tx.us/practice/faq-nurseduty.html

(Adopted 01/2005; Revised 01/2006; 01/2007; 01/2009; 01/2011)
(Reviewed - 01/2008; 01/2010; 01/2012)

## 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 devise and catheter used;
- Recognize emergency situations and institute appropriate nursing interventions to stabilize the patient 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 BON's "Six Step Decision Making Model for Determining Nursing Scope of Practice." 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;
4) Treatment of respiratory depression and other side effects including an order for a narcotic antagonist;
5) Options for inadequate pain control; and
6) Physician/CRNA availability and back-up.

(LVN role: BVNE 1994; revised BON 01/2005) (RN role: BON 06/1991; revised 01/2003; 01/2004; 01/2005; 01/2011)
(Reviewed - 01/2006; 01/2007; 01/2008; 01/2009; 01/2010; 01/2012)

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

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

RNs (including Advanced Practice Registered Nurses practicing within their educated role and specialty) or LVNs who choose to administer laser therapy under physician delegation must know and comply with the provisions set forth in the TMB's rules for delegates, as well as the Nursing Practice Act (NPA) and Rules of the BON.

Additional criteria applicable to the nurse who elects to accept physician delegation in the use of nonablative laser therapy include:

(1) Appropriate education related to use of laser technologies for medical purposes, including laser safety standards of the American National Standards Institute and FDA intended-use labeling parameters;

(2) The nurse's education and skill assessment is documented in his/her personnel record;

(3) The procedure has been ordered by a currently licensed physician, podiatrist, or dentist or by an Advanced Health Practitioner working in collaboration with one of the aforementioned practitioners; and

(4) Appropriate medical, nursing, and support service back up is available, since remedies for untoward effects of laser therapy may go beyond the scope of practice of the nurse performing the procedure.

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

(Board Action, 05/1992; revised 11/1997; 01/2003; 04/2004; 01/2006; 01/2008; 01/2009; 01/2011) (Reviewed - 01/2010; 01/2012)

## 15.10 Continuing Education: Limitations for Expanding Scope of Practice

### Foundation for Initial Licensure and/or APRN authorization

The Board's Advisory Committee on Education states in its *"Differentiated Essential Competencies (DECs) Of Graduates of Texas Nursing Programs Evidenced by Knowledge, Clinical Judgements, and Behaviors, Vocational (VN), Diploma/Associate Degree (Diploma/ADN), Baccalaureate Degree (BSN), October 2010* (http://www.bon.state.tx.us/about/pdfs/delc-2010.pdf)" that: "The curricula of each of the nursing programs differ, and the outcomes of the educational levels dictate a differentiated set of essential competencies of graduates....The competencies of each educational level build upon the previous level." On a national level, the National Council of State Boards of Nursing, Inc. (NCSBN) develops and administers two national nurse licensure examinations; the National Council Licensure Examination for Practical Nurses (NCLEX-PN®), and the National Council Licensure Examination for Registered Nurses (NCLEX-RN®). These two examinations are used by all U.S. state and territorial boards of nursing to test entry-level nursing competence of candidates for licensure as Registered Nurses and as Licensed Practical/Vocational Nurses.

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

### Limitations of "Continuing Education"

The nursing shortage is creating ever greater challenges for those who must fill nursing vacancies at all levels --- LVNs, RNs, and Advanced Practice Registered Nurses (APRNs) in various specialties. As efforts to invent new ways to fill this growing void expand, the Board is receiving a growing number of calls to clarify the term "continuing education" in relation to how far a nurse can expand his/her practice with informal continuing education offerings.

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

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

For example, a LVN with 10 years of home care experience cannot perform the comprehensive assessment and initiate the nursing care plan on a patient newly admitted to the LVN's home care

agency's service. This is precluded in both BON Rule 217.11 as well as in the home care regulations. Attending a workshop and/or spending time under the supervision of a RN does not qualify the LVN to engage in practice that is designated in rule as being exclusive to the next level of licensure.

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

(Adopted 01/2005; Revised 01/2009; 01/2011)
(Reviewed - 01/2006; 01/2007; 01/2008; 01/2010; 01/2011; 01/2012)

**15.11 Delegated Medical Acts**

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

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

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

2. The nurse's education and skills assessment are documented in his/her personnel record;

3. The nursing and medical staffs have collaborated in the development of written policies/procedures/practice guidelines for the delegated acts, these are available to nursing staff practicing in the facility, and the guidelines are reviewed annually, if applicable;

4. The procedure has been ordered by an appropriate licensed practitioner; and

5. Appropriate medical and nursing back-up is available.

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

(Board Action 09/1993;Revised: 03/1994; 01/2001; 01/2003; 01/2004; 01/2005; 01/2011)
(Reviewed - 01/2006: 01/2007; 01/2008; 01/2009; 01/2010; 01/2012)

**15.12 Use Of American Psychiatric Association Diagnoses by LVNS, RNs, or APRNs**
The Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses are multi-disciplinary psychiatric diagnoses used for the purpose of applying objective criteria, establishing a practice framework and communicating findings with other health care professionals. The current version, DSM-IV-TR (Fourth Edition, Text Revision) is anticipated to be replaced by the DSM-5 (Fifth Edition) in May of 2013.

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

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

(Board Action, 09/1996; revised 01/2005; 01/2006: 01/2008; 01/2009; 01/2010; 01/2011)
(Reviewed - 01/2007; 01/2012)

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

The Board of Nursing (BON) recognizes that the youth of Texas are our most valuable natural resource. The BON acknowledges that although students come to school with complex and diverse health care needs, they should be provided an education in the least restrictive environment. The BON recognizes that the school children of Texas have the right to receive safe, appropriate, specialized health services that may be required to assure the child's inclusion in the school environment.

**Registered Nurses in the School Setting**

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

**Vocational Nurses in the School Setting**

The entry level graduates of clinically intensive vocational nursing programs provide nursing care within a directed scope of practice under appropriate supervision. “The vocational nurse uses a systematic problem-solving process in the care of multiple patients with predictable health care needs to provide individualized, goal directed nursing care” *(Differentiated Essential Competencies of Graduates of Texas Nursing Programs Evidenced by Knowledge, Clinical Judgments, and Behaviors (DECs)*, p. 8).

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

**RN Delegation to Unlicensed Personnel**

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

**Other Laws Impacting School Health Care**

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

**Summary**

Given the complexity, the current number, and the future projections of increasing numbers of children entering the school system with complex nursing and health-related needs, the BON believes that the RN must establish an individualized nursing care plan for each child as applicable. The RN may be assisted by LVNs and unlicensed assistive personnel in the delivery of services to ensure the delivery of safe, effective health care to the school children of Texas.

(Adopted 11/1996, Revised 11/1997; 01/2003; 01/2005; 01/2008; 01/2009; 01/2011)
(Reviewed - 01/2006; 01/2007; 01/2010; 01/2012)

**15.14 Duty of a Nurse in any Practice Setting**

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

In the interest of fulfilling its mission to protect the health, safety, and welfare of the people of Texas through the regulation of nurses, the Board of Nursing (BON), through the Nursing Practice Act and Board Rules, emphasizes the nurse's responsibility and duty to the client/patient to provide safe, effective nursing care.

Specifically, the following portions of the Board Rules and supporting documents underscore the duty and responsibilities of the LVN and/or the RN to the client/patient:

- The Standards of Nursing Practice differentiate the roles of the LVN and the RN in accepting nursing care assignments, assuring a safe environment for patients, and obtaining instruction and supervision as needed (Rule 217.11); and

- In *Lunsford v. Board of Nurse Examiners*, 648 S.W. 2d 391 (Tex. App.--Austin, 1983), the court in affirming the disciplinary action of the Board, held that a nurse has a duty to the patient which cannot be superseded by hospital policy or physician's order.

    - This landmark case involved a gentleman who arrived to a rural hospital via private vehicle. The gentleman was experiencing severe chest pain, nausea, and sweating—all hallmark symptoms of myocardial infarction (heart attack). Nurse Lunsford was summoned to the ER waiting room by this gentleman's friend. Upon seeing the acute distress the man was experiencing and hearing his symptoms, she instructed his friend to drive the man to the nearest facility equipped to handle heart attack victims. This facility was 24 miles away. The man succumbed to the heart attack 5 miles away from the small hospital.

    - When the Board sought to sanction the nurse's license, the nurse maintained that the ER physician (who never saw the man) told her the man needed to be transported to the larger facility. The facility policy was also to transfer patients experiencing heart attacks (via ambulance) to the larger facility that was equipped to provide the broad range of therapies that might be needed.

    - The court sided with the BON and agreed that the nurse had the knowledge, skills and abilities to recognize the life-threatening nature of the man's symptoms. Because of this knowledge, the court maintained that it was the nurse's duty to act in the best interest of the client by assessing the man, taking measures to stabilize him and to prevent complications, and communicating his condition to other staff (such as the MD) in order to enlist appropriate medical care.

- The Board's Disciplinary Sanction Policies discuss expectations of all nurses regarding behaviors that are consistent with the Board's rules on Good Professional Character, §§213.27-213.29. These policies explain the client's vulnerability and the nurse's "power" differential over the client by virtue of the client's status (with regard to age, illness, mental infirmity, etc)

and by the nature of the nurse:client relationship (where the client typically defers decisions to the nurse, and relies on the nurse to protect the client from harm).

- The delegation rules guide the RN in delegation of tasks to unlicensed assistive personnel who are utilized to enhance the contribution of the RN to the client's/patient's well being. When performing nursing tasks, the unlicensed person cannot function independently and functions only under the RN's delegation and supervision. Through delegation the RN retains responsibility and accountability for care rendered (Rules 224 and 225). The Board may take disciplinary action against the license of a RN or RN administrator for inappropriate delegation.

- RNs with advanced practice authorization from the Board must comply with the same rules applicable to other RNs. In addition, rules specific to advanced practice nursing Chapters 221 & 222, as well as laws applicable to the APRN's practice setting that are outside of the BON's jurisdiction must also be followed.

- Each nurse must be able to support how his/her clinical judgments and nursing actions were aligned with the NPA and Board Rules. The Board recommends nurses use the Six-Step Decision-Making Model for Determining Nursing Scope of Practice when trying to determine if a given task is within the individual nurse's abilities. Congruence with standards adopted by national nursing specialty organizations may further serve to enhance and support the nurse's decision to perform a particular task.

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

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

(Adopted 01/2005; Revised 01/2007; 01/2009)
(Reviewed - 01/2006; 01/2008; 01/2010; 01/2011; 01/2012)

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

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

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

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

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

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

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

(Board Action 09/1998; Revised. 01/2001; 01/2003; 01/2004; 01/2005; 01/2008)
(Reviewed - 01/2006; 01/2007; 01/2009; 01/2010; 01/2011; 01/2012)

**15.16 Development of Nursing Education Programs**

Approval of nursing education programs is one of the primary functions of the Texas Board of Nursing (BON) in order to fulfill its mission to protect and promote the welfare of the people of Texas. The Texas BON has the responsibility and legal authority to decide whether a proposed new nursing education program meets the Board's established minimum standards for education programs. These standards require adequate human, fiscal, and physical resources, including qualified nursing faculty and clinical learning facilities, to initiate and sustain a program that prepares graduates to practice competently and safely as nurses.

The Texas BON recognizes that when health care facilities experience difficulties in recruiting and retaining sufficient numbers of nurses, education institutions and facilities within the affected geographical region frequently respond to this workforce need by proposing to establish new nursing education programs.

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

Entities desiring to start a nursing education program that are not approved as a school/college, must establish a school/college identity and be approved by Texas Workforce Commission (TWC) as a career school or college (proprietary school) prior to seeking approval for the proposed nursing education program.

All new prelicensure vocational and professional nursing education programs in Texas must be approved/licensed by either the TWC or the Texas Higher Education Coordinating Board (THECB), as applicable, unless deemed exempt from approval/licensing by the TWC or the THECB; and must also be approved by the Texas BON before enrolling students in the program. A new nursing education program that is deemed exempt from approval/licensing by the TWC or
THECB, must still be approved by the Texas BON before enrolling students in the program.

Proposed diploma programs must submit to the Texas BON a written plan addressing the legislativemandate that all nursing diploma programs in Texas have a process in place by 2015 to ensure that graduates of the program are entitled to receive a degree from a public or private institution of higher education accredited by an agency recognized by the THECB and at a minimum, entitle a graduate of the diploma program to receive an associate degree in nursing as required by §215.3(a)(2)(G) and §215.4(a)(6), adopted on February 19, 2008.

**Process for Proposal Approval/Denial**

A proposal to establish a new vocational nursing education program or a new professional nursing education program must follow Texas BON Rules & Regulations in Chapter 214 for Vocational Nursing Education or Chapter 215 for Professional Nursing Education. The entity seeking to establish the new program must have the appropriate accreditation/approval and
the proposal must be prepared by a registered nurse with educational credentials and experience as outlined in the above mentioned rules. The proposal should include, but not be limited to, extensive rationale which supports establishing the new program with demographic and community data, employment needs for nurses in the area, evidence of support from stakeholders, established agreements with clinical affiliating agencies, adequate qualified nursing administrator and faculty to begin the program, and an acceptable curriculum as identified in the
guidelines. The Texas BON Education Guidelines for developing a proposal to establish a new program are available on the Texas BON web site under the <Nursing Education> link. An initial

approval fee shall be submitted with the proposal [Rule 223.1(a)(9)].

The process for proposal approval/denial begins when the board staff receives a letter of intent or an initial proposal from the entity. The total process from this point may take up to one year or more before the proposal is ready to be presented to the Board. The length of time until Board approval depends upon the completeness of the proposal and compliance with Board standards. The usual process entails a number of revisions of the proposal. The expertise of the proposal's author, and the involvement of the proposed program director impact the success of the proposal. A New Proposal Resource Packet to assist in the proposal development is available on the Board's web site under the Nursing Education link. The packet lists the documents on the web site necessary for the proposal development. The author of the proposal and proposed director should attend at least one Informal Information Session for Proposal Development. The Informal Information Session is provided by board staff several times each year. Representatives from the institution should also attend at least one regularly scheduled Board meeting in order to gain familiarity with Board proceedings.

After the proposal is determined to be ready to be presented to the Board, a preliminary survey visit will be conducted by board staff. The equipment and educational spaces in the physical facility should be ready for the program to begin at this time.

A public hearing will be held at the Board meeting prior to the Board's discussion of the proposal and the Board's decision. The Board may approve the proposal and grant initial approval to the new program, may defer action on the proposal, or may deny further consideration of the proposal.

(Board Action 07/2000; revised 01/2004; 01/2005; 01/2006; 01/2008; 10/2008; 01/2011)
(Reviewed - 01/2007; 01/2009; 01/2010; 01/2012)

**15.17 Texas Board of Nursing/Board of Pharmacy, Joint Position Statement, Medication Error**

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

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

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

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

Analysis of the third element (systems designs, problems and failures) may demand creative and/or innovative thinking specific to each setting as well as a commitment to guarantee client safety. Systems which may have been in place for a long period of time may need to be re-examined for

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

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

(Board Action 10/2000)

(Reviewed - 01/2005; 01/2006; 01/2007; 01/2008; 01/2009; 01/2010; 01/2011; 01/2012)

*References*

Institute of Medicine. (1999). To err is human: Building a safer health system. Washington, D.C.: National Academy Press.

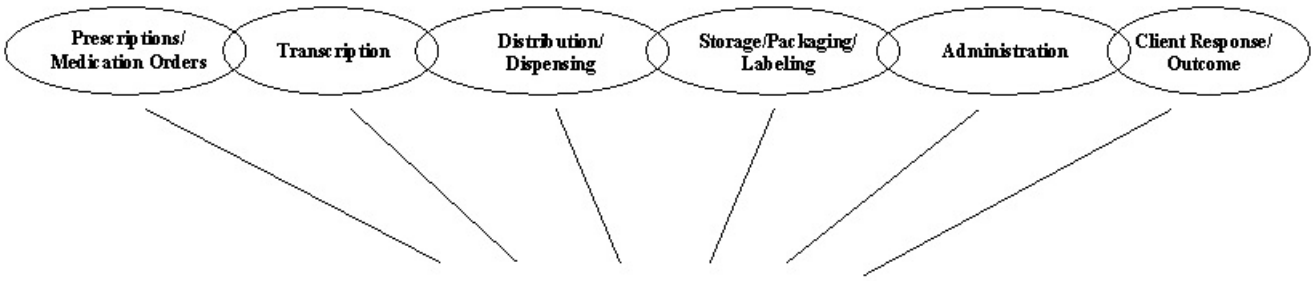
Joint Commission on Accreditation of Healthcare Organizations. (1999). High-alert medications and patient safety. Sentinel Event Alert, [On-line]. Available: jcaho.org/edu_pub/sealert/sea11.html.

Leape, L. L. (1994). Error in medicine. Journal of the American Medical Association, 272(23), 1851-1857.

Nursing Practice Act, Texas Occupations Code, Chapters 301 and 303.

Texas Pharmacy Act, Texas Occupations Code, Chapters 551 - 566.

**Position Statement 15.17 Table: Factors Contributing to Medication Errors**




Schematization of a chain representing the interdependent nature of these elements; a weakness in any link impacts the entire system

| Prescriptions/ Medication Orders | Transcription | Distribution/ Dispensing | Storage/Packaging/ Labeling | Administration | Client Response/Outcome |
|---|---|---|---|---|---|
| * Accurate assessments/ diagnoses<br>* Awareness of allergies, contraindications, and drug reactions/ interactions<br>* Correct drug/dose/ route of administration<br>* Clear and legible documentation of order | * Clarification of orders (written/verbal) if needed<br>* Clear and legible handwriting<br>* Accurate and complete transcription (e.g. MAR, Kardex, Computer)<br>* Proofreading of all transcriptions | * Clarification of orders if needed<br>* Correct client/drug/ dose/route<br>* Checking expiration dates<br>* Medication preparations (mixing of intrave- nous solutions, correct pill count)<br>* Clear and legible audit trail<br>* Client teaching and verification of understanding | * Careful review of instructions for use/ warnings/precautions<br>* Checking expiration dates<br>* Storage to avoid inadvertent mixups/ location of bottles which are similar in appearance<br>* Accurate/legible and complete labeling on original containers<br>* Careful attention to floor stock expiration dates/mixing instructions | * Assessment of client status<br>* Five rights of medication administration<br>- Right patient<br>- Right medication<br>- Right Dose<br>- Right time<br>- Right route<br>* Client teaching and verification of understanding<br>* Accurate documen- tation of medication administration (MAR/client records/narcotics log) | * Assessment of efficacy /adverse reactions<br>* Client compliance<br>* Documentation |

**15.19 Nurses Carrying out Orders from Pharmacists for Drug Therapy Management**

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

According to definitions listed in the Pharmacy Act [Tex. Occ. Code Ann. § 551.003], the "Practice of Pharmacy" includes *"(F) performing for a patient a specific act of drug therapy management delegated to a pharmacist by a written protocol from a physician licensed in this state in compliance with Subtitle B."* The Pharmacy rules further define DTM as *"the performance of specific acts by pharmacists as authorized by a physician through written protocol." [22 TAC § 295.13(b)(4)]*. Rule 295.13(b)(6) further adds the clarification that a *"written protocol [is] a physician's order, standing medical order, standing delegation order, or other order or protocol as defined by rule of the Texas Medical Board under the Medical Practice Act."* The TMB's Rule [22 TAC §§ 193.7] reflects similar language to the Pharmacy Board rules.

Nurses frequently communicate and collaborate with both the client's physician and the pharmacist in providing optimal care to clients. It is, therefore, the Board's position that a nurse may carry out orders written by a pharmacist for DTM provided the order originates from a written protocol authorized by a physician. Any nurse carrying out DTM orders from a pharmacist may wish to review the TMB Rule193, *Physician Delegation*, in its entirety. The components of the rule related to physician delegation for a pharmacist to engage in DTM are set forth in §193.7(e) as follows:

> (1) A written protocol must contain at a minimum the following listed in subparagraphs (A)-(E) of this paragraph:
>
> > (A) a statement identifying the individual physician authorized to prescribe drugs and responsible for the delegation of drug therapy management;
> >
> > (B) a statement identifying the individual pharmacist authorized to dispense drugs and to engage in drug therapy management as delegated by the physician;
> >
> > (C) a statement identifying the types of drug therapy management decisions that the pharmacist is authorized to make which shall include:
> >
> > > (i) a statement of the ailments or diseases, drugs, and type of drug therapy management authorized; and
> > >
> > > (ii) a specific statement of the procedures, decision criteria, or plan the pharmacist shall follow when exercising drug therapy management authority;
> >
> > (D) a statement of the activities the pharmacist shall follow in the course of exercising drug therapy management authority, including the method for documenting decisions made and a plan for communication or feedback to the authorizing physician concerning specific decisions made. Documentation shall be recorded within a reasonable time of each intervention and may be performed on the patient medication record, patient medical chart, or in a separate log book; and
> >
> > (E) a statement that describes appropriate mechanisms and time schedule for the

pharmacist to report to the physician monitoring the pharmacist's exercise of delegated drug therapy management and the results of the drug therapy management.

(2) A standard protocol may be used, or the attending physician may develop a drug therapy management protocol for the individual patient. If a standard protocol is used, the physician shall record, what deviations if any, from the standard protocol are ordered for that patient (22 Tex. Admin. Code §193.7(e)).

The protocol under which a pharmacist initiates DTM orders for a patient should be available to the nurse at the facility, agency, or organization in which it is carried out. As with any order, the nurse must seek clarification if he/she believes the order is inappropriate, inaccurate, nonefficacious or contraindicated by contacting the pharmacist and/or the physician who authorized the DTM protocol as appropriate (22 Tex. Admin. Code §217.11(1)(N)). The nurse carrying out an order for DTM written by a pharmacist is responsible and accountable for his/her actions just as he/she would be with any physician order.

(Board Action 01/2002; revised 01/2005; 01/2006; 01/2007; 01/2011)

(Reviewed - 01/2008; 01/2009; 01/2010; 01/2012)

**15.21 [Deleted 01/2005]**

**15.22 APRNs Providing Medical Aspects of Care for Themselves or Others with Whom there is a Close Personal Relationship**

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

(Board Action 10/2003; 01/2009)

(Reviewed - 01/2006; 01/2007; 01/2008; 01/2010; 01/2011; 01/2012)

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

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

It is the opinion of the Board that LVNs and RNs should not engage in the reinsertion of a permanently placed feeding tube through an established tract until the LVN or RN successfully completes a competency validation course congruent with prevailing nursing practice standards. Training should provide instruction on the nursing knowledge and skills applicable to tube replacement and verification of correct and incorrect placement. The Board of Nursing (BON) does not define nor set qualifications for competency validation courses; however, inclusion of the following factors is encouraged:

1. The nurse should complete training designed specifically for the type or types of permanent feeding tubes the nurse may need to replace, including overall patient assessment, verification of proper tube placement, and assessment of the tube insertion site.

2. A registered nurse or a physician who has the necessary expertise with regard to the specific feeding tube provides supervision during the training process.

3. The nurse demonstrates competency in all appropriate aspects (knowledge, decision-making, and psycho-motor skills) of performing the procedure.

4. The patient has an established tract. The established tract is not determined by the nurse.

5. The facility has resources available to develop an educational program for initial instruction of LVNs and/or RNs, as well as for ongoing competency validation.

6. Documentation of each nurse's initial education and ongoing competency validation should be maintained by the nurse and/or the employer in accordance with facility policies.

7. Regardless of training, policies and procedures of the facility must also permit the nurse to engage in the procedure.

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

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

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

- (1)(D) “Accurately and completely report and document: (i) ...client status...(ii) nursing care rendered; (iii) physician, dentist or podiatrist orders; (iv) administration of medications and treatments; (v) client response(s)...,”
- (1)(G) “Obtain instruction and supervision as necessary when implementing nursing procedures or practices,”
- (1)(H) “Make a reasonable effort to obtain orientation/training for competency when encountering new equipment and technology or unfamiliar care situations,”
- (1)(R) “Be responsible for one’s own continuing competence in nursing practice and individual professional growth.”
- Standards specific to LVNs may be found in §217.11(2); standards specific to RNs may be found in §217.11(3).

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

(Adopted 01/2005; Revised 01/2008; 01/2009; 01/2011)

(Reviewed - 01/2006; 01/2007; 01/2010; 01/2012)

## 15.26 Simulation in Prelicensure Nursing Education

Simulation, in some form, has been used as a teaching strategy in nursing education since the first nurse tried to teach the first nursing student how to task properly (Jeffries & Rizzolo, 2006). Recently, however, high-fidelity simulation, with the increased level of sophistication and realism it brings to the laboratory setting, has elicited the possibility of simulation being used as a substitute for actual clinical experience (NCSBN, 2009). These technological advances combined with other factors, including shortages of available clinical sites, faculty shortages, national mandates for safety, and the complexity of today's health care environment, have led many Texas nursing programs to consider utilizing simulation to fulfill clinical needs in the curriculum. The Texas Board of Nursing ("Board" or "BON") has put forth this position statement in an effort to clarify the role and limitations of simulation in prelicensure nursing education so that educators can best develop simulation programs that are educationally sound and meaningful.

### *Overview of Simulation*

The National Council of State Boards of Nursing (NCSBN) Position Paper, *Clinical Instruction in Pre-licensure Nursing Programs (2005)*, has defined simulation as "Activities that mimic the reality of a clinical environment and are designed to demonstrate procedures, decision-making and critical thinking through techniques such as, role-playing and the use of devices such as interactive videos or mannequins. A simulation may be very detailed and closely imitate reality, or it can be a grouping of components that are combined to provide some semblance of reality" (p. 2).

### *Benefits and limitations of Simulation*

The benefits of simulation are well documented:

- Simulation allows deliberate practice in a controlled, safe environment. Students are able to practice a procedure prior to performance on a live patient (Jeffries, 2007).
- Simulation promotes active learning and participation, to enhance students' critical thinking skills (Billings & Halstead, 2005).
- Educators can apply well-founded simulation approaches not only to help students in clinical rotations to attain educational goals, but also to evaluate teaching methods, as well as to investigate alternatives to the goals and methods themselves (Kyle & Murray, 2008).
- Simulation can be used to demonstrate competence outcomes in nursing programs (Luttrell, Lenburg, Scherubel, Jacob, & Koch, 1999).
- Simulated experiences offer the opportunity for diverse styles of learning not offered in the classroom environment and can result in an increase in confidence felt by the student (Jeffries & Rizzolo, 2006).

Despite these benefits, limitations to the use of simulation also exist. Preliminary studies indicate that, although simulation helps prepare students for real clinical practice, it cannot substitute for the hands-on care to live patients. Nurse educators must consider whether technology can address communication, interpersonal interaction, compassionate caring, and nursing understanding (Issenberg, Gordon, Gordon, Safford, & Hart, 2001). The NCSBN holds the position that simulation shall not take the place of clinical experiences with actual patients (NCSBN, 2005). The American Association of Colleges of Nursing (AACN) also holds that simulation should be used as an adjunct or complement to, not a substitute for, clinical experiences with real patients, and direct patient care experiences provide important opportunities for student learning not found in other experiences (AACN, 2008).

### *Types of Simulation*

When discussing simulation, it is important to understand the concept of fidelity. Fidelity is the term utilized in the simulation domain to describe the degree of accuracy of the system being used. The purpose of simulation is to be realistic in a manner adequate to convince the user that the scenario performed resembles real-life. Fidelity can be divided into three categories: low, moderate, and high-fidelity. Low-fidelity allows the user to practice skills in isolation. Examples include administration of an intramuscular injection into an orange or injection pillow. Moderate-fidelity offers more realism, but does not have the user completely immersed in the situation. Examples include a manikin with breath sounds but no corresponding chest rise. High-fidelity simulation refers to structured learning experiences with computerized manikins that are anatomically precise and reproduce physiologic responses. The environment mimics the clinical setting, and provides the user with the cues necessary to suspend their disbelief during the immersive, hands-on scenarios (NCSBN, 2009). High fidelity units must not only have the physical appearance of reality (cosmetic fidelity) but must also react in realistic ways to student interactions (Seropian, Brown, Gavilanes, & Driggers, 2004).

Computer based simulation involves the use of software developed to simulate a subject or a situation in order to test various aspects of learning such as knowledge, skills, and critical thinking. The software may be of low, moderate, or high-fidelity. Task and skill trainers are the most common type of simulation in nursing education. These trainers are designed to allow students to practice skills and techniques. Task trainers also vary in fidelity, ranging from low- fidelity static body models (such as a rubbery IV arm) to high-fidelity virtual reality trainers. Full scale high-fidelity simulation, the most recognized form of simulation in nursing education today, attempts to recreate all the elements of real life clinical situations. This type of simulation typically involves the use of full body computerized manikins, real people, real interactions, and realistic responses in an environment that is made to resemble the clinical environment as closely as possible in order to immerse learners in an experience that mirrors real life (Seropian et al., 2004).

### *Components of Effective Simulation*

Integral components of a successful simulated learning experience identified in the professional literature include: the educator or preceptor, the student(s), key educational practices, and the simulated environment. The simulation must challenge the student to use problem solving skills and critical thinking to assess the situation and determine the correct treatment path. The educator should act as a facilitator providing cues when necessary, but not as an active participant in the simulation. It is important, however, for the facilitator to intervene when a catastrophic outcome is imminent. Unless the objectives specifically call for death, as in an end of life situation, the scenario should end with a viable patient (Jeffries, 2007; Kyle & Murray, 2008). Each simulated experience must have clearly stated objectives that are presented to the student prior to engaging in the simulation experience. Students are required to prepare for a clinical simulation experience in the same manner as they would prepare for an actual patient care experience. An orientation to both the simulation technology and the environment is required. The educator assumes the role of facilitator, providing cues when necessary, but is not an active participant in the simulation. The educator and the student should participate in an active debriefing immediately following the simulation experience. Each simulation session should also include an evaluation of the overall experience by both the educator and student (Jeffries, 2007).

## The Texas Board of Nursing's Position on Simulation

The fact that simulation provides a valuable adjunct to traditional clinical learning experiences is well documented. However, while emerging research clearly supports the use of simulation in nursing education, the evidence has not been established to support the use of simulation as a direct substitute for clinical learning experiences with real patients. Nor has evidence been established for parameters regarding the amount of time that can be or should be spent in simulated experiences. Therefore, the

Texas Board of Nursing has not promulgated percentages or ratios of simulation versus actual clinical learning education. Nursing education should be based on sound educational principles, and accordingly there should be a reasonable balance between simulation and direct patient care and with rationale, which are clearly appropriate for the study of vocational/professional nursing.

The BON believes that simulation can be an effective teaching method to prepare students for clinical practice when used in combination with traditional skills lab practice and direct patient care experiences. However, simulation cannot replace experiences with real patients, role models, and mentors in the traditional clinical setting (Knight, 1998). In order to satisfy the Board rule requirements for clinical learning experiences promulgated in Chapters 214: Vocational Nursing Education and 215: Professional Nursing Education, and to appropriately incorporate simulation into nursing curricula, educators must be cognizant of the following criteria:

- Nursing education programs shall include clinical education experiences with actual patients that are sufficient to meet program outcomes as well as rule requirements found in Chapters 214 and 215.
- Nursing education programs shall include clinical learning experiences with actual patients that are across the life span.
- Clinical education experiences (including simulated experiences) should be supervised by qualified faculty as defined in Chapters 214 and 215.
- Faculty members retain the responsibility to demonstrate that programs have clinical experiences with actual patients that are sufficient to meet program outcomes.
- Additional research needs to be conducted on the use of simulation in prelicensure nursing education and clinical competency.

The BON recommends that nursing programs adhere to the guidelines put forth in this position statement to ensure that students receive optimal learning experiences.

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(Adopted: 07/2010)

(Reviewed: 01/2011; 01/2012)

## 15.27 The Licensed Vocational Nurse Scope of Practice

**The BON recommends that all nurses utilize the Six-Step Decision-Making Model for Determining Nursing Scope of Practice[1] when deciding if an employer's assignment is safe and legally with the nurse's scope of practice.**

The Texas Board of Nursing (BON) is authorized by the Texas Legislature to regulate the nursing profession to ensure that every licensee is competent to practice safely. The Texas Nursing Practice Act (NPA) and the Board's Rules and Regulations define the legal scope of practice for licensed vocational nurses (LVN). The LVN scope of practice is a directed scope of practice and requires appropriate supervision. The LVN, with a focus on patient safety, is required to function within the parameters of the legal scope of practice and in accordance with the federal, state, and local laws, rules, regulations, and policies, procedures and guidelines of the employing health care institution or practice setting. ***The LVN is responsible for providing safe, compassionate and focused nursing care to assigned patients with predictable health care needs.***

The purpose of this position statement is to provide direction and recommendations for nurses and their employers regarding the safe and legal scope of practice for licensed vocational nurses and to promote an understanding of the differences between the LVN and RN levels of licensure. The RN scope of practice is interpreted in Position Statement 15.28.

Every nursing education program in the state of Texas is required to ensure that their graduates exhibit competencies outlined in the Board's Differentiated Essential Competencies (DECs) of Graduates of Texas Nursing Programs.[2] These competencies are included in the program of study so that every graduate has the knowledge, clinical behaviors and judgment necessary for LVN entry into safe, competent and compassionate nursing care. The DECs serve as a guideline for employers to assist LVNs as they transition from the educational environment into nursing practice. As LVNs enter the workplace, the DECs serve as the foundation for the development of the LVN scope of practice.

Completion of on-going, informal continuing nursing education offerings and on-the-job trainings in a LVN's area of practice serves to develop, maintain, and expand the level of competency. Because the LVN scope of practice is based upon the educational preparation in the LVN program of study, there are limits to LVN scope of practice expansion parameters. The Board believes that for a nurse to successfully make a transition from one level of nursing practice to the next requires the completion of a formal program of education.[3]

### The LVN Scope of Practice

The LVN is an advocate for the patient and the patient's family and promotes safety by practicing within the NPA and the BON Rules and Regulations. LVN scope of practice does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures.[4] The practice of vocational nursing must be performed under the supervision of a RN, APRN, physician, physician assistant, podiatrist or dentist.[5] Supervision is defined as the active process of directing, guiding, and influencing the outcome of an individual's performance of an activity.[6] The LVN is precluded from practicing in a completely independent manner; however, direct and on-site supervision may not be required in all settings or patient care situations. Determining the proximity of an appropriate clinical supervisor, whether available by phone or physical presence, should be made by the LVN and the LVN's clinical supervisor by evaluating the specific situation, taking into consideration patient conditions and the level of skill, training and competence of the LVN. An appropriate clinical supervisor may need to be physically available to assist the LVN should emergent situations arise.

The setting in which the LVN provides nursing care should have well defined policies, procedures, and guidelines, in which assistance and support are available from an appropriate clinical supervisor. The Board recommends that newly licensed LVNs work in structured settings for a period of 12-18 months, such as nursing homes, hospitals, rehabilitation centers, skilled nursing facilities, clinics or private physician offices.[7] This allows the new nurse sufficient practice experience in more structured settings in order to assimilate knowledge from their education. As competencies are demonstrated, if the LVN transitions to unstructured settings where the clinical supervisor may not be on-site, it is the LVN's responsibility to ensure he or she has access to an appropriate clinical supervisor and that the policies, procedures and guidelines for that particular setting are established to guide the LVN practice.

The LVN uses a systematic problem-solving process in the care of multiple patients with predictable health care needs to provide individualized, goal-directed nursing care. LVNs may contribute to the plan of care by collaborating with interdisciplinary team members, the patient and the patient's family. The essential components of the nursing process are described in a side by side comparison of the different levels of education and licensure (see Table).

**Assessment**

The LVN assists in determining the physical and mental health status, needs, and preferences of culturally, ethnically, and socially diverse patients and their families based on interpretation of health-related data. The LVN collects data and information, recognizes changes in conditions and reports this to the RN supervisor or another appropriate clinical supervisor to assist in the identification of problems and formulation of goals, outcomes and patient-centered plans of care that are developed in collaboration with patients, their families, and the interdisciplinary health care team. The LVN participates in the nursing process by appraising the individual patient's status or situation at hand. Also known as a focused assessment, this appraisal may be considered a component of a more comprehensive assessment performed by a RN or another appropriate clinical supervisor. For example, a RN may utilize the data and information collected and reported by the LVN in the formation of the nursing process; however, the RN's comprehensive assessment lays the foundation for the nursing process. The LVN reports the data and information collected either verbally or in writing. Written documentation must be accurate and complete, and according to policies, procedures and guidelines for the employment setting.[8]

**Planning**

The second step in which the LVN participates and contributes to the nursing process is planning. After the focused assessment, the LVN reports data and other information such as changes in patient conditions to the appropriate clinical supervisor, such as a RN. This information may be considered in planning, problem identification, nursing diagnoses, and formulation of goals, teaching plans and outcomes by the RN supervisor or another appropriate clinical supervisor. A nursing plan of care for patients is developed by the RN and thus the RN has the overall responsibility to coordinate nursing care for patients.

**Implementation**

Implementing the plan of care is the third step in the nursing process. The LVN is responsible for providing safe, compassionate and focused nursing care to assigned patients with predictable health care needs. The LVN may implement aspects of the plan of care within legal, ethical, and regulatory parameters and in consideration of patient factors. The LVN organizes aspects of patient care based on identified priorities. Delegating tasks to unlicensed assistive personnel (UAPs) is beyond the scope

of practice for LVNs; however, LVNs may make appropriate assignments to other LVNs and UAPs according to Rule 217.11(2).[6] The RN is generally responsible and accountable for supervising not only the LVN's practice but the UAP's performance of tasks as well. For example, the RN may have trained, verified competency and delegated the tasks to a UAP and the LVN may then proceed to assign those tasks that need to be accomplished for that day. Teaching and counseling are interwoven throughout the implementation phase of the nursing process and LVNs can participate in implementing established teaching plans for patients and their families with common health problems and well defined health learning needs.

**Evaluation**

A critical and fourth step in the nursing process is evaluation. The LVN participates in the evaluation process identifying and reporting any alterations in patient responses to therapeutic interventions in comparison to expected outcomes. The LVN may contribute to the evaluation phase by suggesting any modifications to the plan of care that may be necessary and making appropriate referrals to facilitate continuity of care.

**Essential Skills Use in the Nursing Process**

**Communication**

Communication is a fundamental component in the nursing process. The LVN must communicate verbally, in writing, or electronically with members of the healthcare team, patients and their families on all aspects of the nursing care provided to patients. Communications must be appropriately documented in the patient record or nursing care plan. Because LVNs are members of the healthcare team, provide nursing care, and contribute to the nursing process, collaboration is a quality that is crucial to the communication process. When patient conditions or situations have changed or exceeded the LVN's level of competency and scope of practice, the LVN must be prepared to seek out his or her clinical supervisor and actively cooperate to develop solutions that ensure patient safety.

**Clinical Reasoning**

Clinical reasoning is another integral component in the nursing process. LVNs must use clinical reasoning and established evidence-based policies, procedures or guidelines as the basis for decision making in nursing practice. LVNs are accountable and responsible for the quality of nursing care provided and must exercise prudent nursing judgment to ensure the standards of nursing practice are met at all times.[9]

**Employment Setting**

When an employer hires a nurse to perform a job, the nurse must assure that it is safe and legal. For instance, the LVN must have a clinical supervisor who is knowledgeable and aware of his or her role. Caution must be exercised not to overstep the legal parameters of nursing practice when an employer may not understand the limits of the LVN scope of practice and makes an assignment that is not prudent or safe. The LVN must determine before he or she engages in an activity or assignment whether he or she has the education, training, skill, competency and the physical and emotional ability to safely carry out the activity or assignment.[10] The LVN's duty is to always provide safe, compassionate, and focused nursing care to patients.

**Making Assignments**

The LVN's duty to patient safety when making assignments to others is to take into consideration the

education, training, skill, competence and physical and emotional ability of the persons to whom the assignments are made. [11] [12] If the LVN makes assignments to another LVN or UAP, he or she is responsible for reasonable and prudent decisions regarding those assignments. It is not appropriate and is beyond the scope of practice for a LVN to supervise the nursing practice of a RN. However, in certain settings, i.e.: nursing homes, LVNs may expand their scope of practice through experience, skill and continuing education to include supervising the practice of other LVNs, under the oversight of a RN or another appropriate clinical supervisor. The supervising LVN may have to directly observe and evaluate the nursing care provided depending on the LVN's skills and competence, patient conditions and emergent situations. Timely and readily available communication between the supervising LVN and the clinical supervisor is essential to provide safe and effective nursing care.

**Summary**

The LVN, with a focus on patient safety, is required to function within the parameters of the legal scope of practice and in accordance with the federal, state, and local laws, rules, regulations, and policies, procedures and guidelines of the employing health care institution or practice setting. The LVN functions under his or her own license and assumes accountability and responsibility for quality of care provided to patients and their families according to the standards of nursing practice.9 The LVN demonstrates responsibility for continued competence in nursing practice, and develops insight through reflection, self-analysis, self-care, and lifelong learning.

The table below offers a brief synopsis of how the scope of practice for nurses differs based on educational preparation and level of licensure. These are minimum competencies, but also set limits on what the LVN or RN can do at his or her given level of licensure, regardless of experience.

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[1]Texas Board of Nursing (2010). Six-step decision-making model for determining nursing scope of practice

[2]Texas Board of Nursing (2010). Differentiated essential competencies (DECs) of graduates of Texas Nursing Programs.

[3]Texas Board of Nursing (2011). Position statement 15.10 Continuing education: Limitations for expanding scope of practice.

[4]Texas Nursing Practice Act, TOC § 301.002(5).

[5]Texas Nursing Practice Act, TOC § 301.353.

[6]Texas Administrative Code, 22 TAC §217.11(2).

[7]Texas Board of Nursing (2011). Rules and guidelines governing the graduate vocational and registered nurse candidates or newly licensed vocational or registered nurse.

[8]Texas Administrative Code, 22 TAC §217.11(1)(D).

[9]Texas Administrative Code, 22 TAC §217.11.

[10]Texas Administrative Code, 22 TAC §217.11(1)(T).

[11]Texas Administrative Code, 22 TAC §217.11(1)(S).

[12]Texas Administrative Code, 22 TAC §217.11(2)(B).

Additional Resources

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(Adopted 07/2011)

(Reviewed 01/2012)

**Synopsis Of Differences in Scope Of Practice for Licensed Vocational, Associate, Diploma and Baccalaureate Degree Nurses**

| Nursing Practice | LVN Scope of Practice Directed/Supervised Role | ADN or Diploma RN Scope of Practice Independent Role | BSN RN Scope of Practice Independent Role |
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| Education | The curriculum for the VN education is in a clinically intensive certificate program of approximately one year in length. The Texas BON rules mandate a minimum of 558 theory and 840 clinical hours in the VN program of study.<br><br>The VN curriculum includes instruction in five basic areas of nursing care: adults; mothers and newborns; children; elderly; and individuals with mental health problems. Clinical experience in a unit or a facility specifically designed for psychiatric care is optional. | ADN programs require a minimum of two full years of study, integrating a balance between courses in liberal arts; natural, social, and behavioral sciences; and nursing. Academic associate degrees consist of 60-72 credit hours with approximately half the program requirements in nursing courses.<br><br>The Texas BON approved curriculum includes requirements for didactic instruction and clinical experiences in four contents areas: medical-surgical, maternal/child health, | The BSN program of study integrates approximately 60 hours from liberal arts and natural, social, and behavioral science courses and approximately 60-70 hours of nursing courses. In addition to the ADN/Diploma education requirements, BSN education includes instruction in community health, public health, research, nursing leadership, and nursing management with preparation and skills to practice evidence based nursing. |

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| | Required support courses should provide instruction in biological, physical, social, behavioral, and nursing sciences, including body structure and function, microbiology, pharmacology, nutrition, signs of emotional health, human growth and development, vocational adjustments, and nursing skills. | pediatrics, and mental health nursing.<br><br>Diploma programs are hospital-based, single purpose schools of nursing that consist of two-three years of general education and support courses. | |
| Supervision | Supervision is required for the LVN scope of practice. LVNs are not licensed for independent nursing practice. A LVN must ensure that he or she has an appropriate clinical supervisor, i.e. RN, APRN, Physician, PA, Dentist or Podiatrist. The proximity of a clinical supervisor depends on skills and competency of the LVN, patient conditions and practice setting. Direct, on-site supervision may not always be necessary depending on the LVN's skill and competence and should be determined on a case-by-case situation taking into consideration the practice setting laws. However, clinical supervisors must provide timely and readily available supervision and may have to be physically present to assist LVNs should emergent situations occur. | Provides supervision to other RNs, LVNs and UAPs. Supervision of LVN staff is defined as the process of directing, guiding, and influencing the outcome of an individual's performance and activity. | Provides supervision to other RNs, LVNs and UAPs. Supervision of LVN staff is defined as the process of directing, guiding, and influencing the outcome of an individual's performance and activity. |
| Setting | Provides focused nursing care to individual patients with predictable health care needs under the direction of an appropriate clinical supervisor.<br><br>The setting may include areas with well defined policies, | Provides independent, direct care to patients and their families who may be experiencing complex health care needs that may be related to multiple conditions. Provides healthcare to patients with predictable and | Provides independent, direct care to patients, families, populations, and communities experiencing complex health care needs that may be related to multiple conditions. Provides healthcare to patients with predictable and unpredictable outcomes in various |

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| | procedures and guidelines with assistance and support from appropriate clinical supervisors, i.e. nursing home, hospital, rehabilitation center, skilled nursing facility, clinic, or a private physician office. As competencies are demonstrated, if the LVN transitions to other settings, it is the LVN's responsibility to ensure he or she has an appropriate clinical supervisor and that the policies, procedures and guidelines for that particular setting are available to guide the LVN practice. | unpredictable outcomes in various settings. | settings. |
| Assessment | Assists, contributes and participates in the nursing process by performing a focused assessment on individual patients to collect data and gather information. A focused assessment is an appraisal of the situation at hand for an individual patient and may be performed prior to the RN's initial and comprehensive assessment.<br><br>The LVN reports and documents the assessment information and changes in patient conditions to an appropriate clinical supervisor. | Independently performs an initial or ongoing comprehensive assessment (Extensive data collection). Anticipates changes in patient conditions to include emergent situations. Reports and documents information and changes in patient conditions to a health care practitioner and or a responsible party.<br><br>Determines the physical and mental health status, needs, and preferences of culturally diverse patients and their families. | Independently performs an initial or ongoing comprehensive assessment (Extensive data collection). Anticipates changes in patient conditions to include emergent situations. Reports and documents information and changes in patient conditions to a health care practitioner and or a responsible party.<br><br>Determines the physical and mental health status, needs, and preferences of culturally diverse patients, families, populations and communities. |
| Planning | Uses clinical reasoning based on established evidence-based policies, procedures and guidelines for decision-making.<br><br>May assign specific daily tasks and supervise nursing care to other LVNs or UAPs. | Uses clinical reasoning based on established evidence-based policies, procedures and guidelines for decision-making. Analyzes assessment data to identify problems, formulate goals and outcomes, and develops nursing plans of care for patients and their families. | Uses clinical reasoning based on established evidence-based practice outcomes and research for decision-making and comprehensive care. Synthesizes comprehensive data to identify problems, formulate goals and outcomes, and develop nursing plans of care for patients, families, populations, and communities.[13] |

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| | | May assign tasks and activities to other nurses. May delegate tasks to UAPs. | May assign tasks and activities to other nurses. May delegate tasks to UAPs. |
| Implementation | Provides safe, compassionate and focused nursing care to patients with predictable health care needs.<br><br>Implements aspects of the nursing care plan, including emergency interventions under the direction of the RN or another appropriate clinical supervisor.<br><br>Contributes to the development and implementation of teaching plans for patients and their families with common health problems and well-defined health needs. | Provides safe, compassionate, comprehensive nursing care to patients, and their families through a broad array of health care services.<br>Implements the plan of care for patients and their families within legal, ethical, and regulatory parameters and in consideration of disease prevention, wellness, and promotion of healthy lifestyles. Develops and implements teaching plans to address health promotion, maintenance, and restoration. | Provides safe, compassionate, comprehensive nursing care to patients, families, populations, and communities through a broad array of health care services.<br><br>Implements the plan of care for patients, families, populations, and communities within legal, ethical, and regulatory parameters and in consideration of disease prevention, wellness, and promotion of healthy lifestyles. Develops and implements teaching plans to address health promotion, maintenance, restoration, and population risk reduction. |
| Evaluation | Participates in evaluating effectiveness of nursing interventions.<br><br>Participates in making referrals to resources to facilitate continuity of care. | Evaluates and reports patient outcomes and responses to therapeutic interventions in comparison to benchmarks from evidence-based practice, and plans follow-up nursing care to include referrals for continuity of care. | Evaluates and reports patient, family, population, and community outcomes and responses to therapeutic interventions in comparison to benchmarks from evidence-based practice and research, and plans follow-up nursing care to include referrals for continuity of care. |

## 15.28 The Registered Nurse Scope of Practice

**The BON recommends that all nurses utilize the Six-Step Decision-Making Model for Determining Nursing Scope of Practice[1] when deciding if an employer's assignment is safe and legally with the nurse's scope of practice.**

The Texas Board of Nursing (BON) is authorized by the Texas Legislature to regulate the nursing profession to ensure that every licensee is competent to practice safely. The Texas Nursing Practice Act (NPA) defines the legal scope of practice for professional registered nurses (RN).[2] The RN takes responsibility and accepts accountability for practicing within the legal scope of practice and is prepared to work in all health care settings, and may engage in independent nursing practice without supervision by another health care provider. The RN, with a focus on patient safety, is required to function within the parameters of the legal scope of practice and in accordance with the federal, state, and local laws; rules and regulations; and policies, procedures and guidelines of the employing health care institution or practice setting. ***The RN is responsible for providing safe, compassionate, and comprehensive nursing care to patients and their families with complex healthcare needs.***

The purpose of this position statement is to provide direction and recommendations for nurses and their employers regarding the safe and legal scope of practice for RNs and to promote an understanding of the differences in the RN education programs of study and between the RN and LVN levels of licensure. The LVN scope of practice is interpreted in Position Statement 15.27.

Every nursing educational program in the state of Texas is required to ensure that their graduates exhibit competencies outlined in the Board's Differentiated Essential Competencies (DECs) of Graduates of Texas Nursing Programs.[3] These competencies are included in the program of study so that every graduate has the knowledge, clinical behaviors and judgment necessary for RN entry into safe, competent and compassionate nursing care. The DECs serve as a guideline for employers to assist RNs as they transition from the educational environment into nursing practice. As RNs enter the workplace, the DECs serve as the foundation for the development of the RN scope of practice.

Completion of on-going, informal continuing nursing education offerings and on-the-job trainings in a RN's area of practice serves to develop, maintain, and expand competency. Because the RN scope of practice is based upon the educational preparation in the RN program of study, there are limits to the expansion of the scope. The Board believes that for a nurse to successfully make a transition from one level of nursing practice to the next requires the completion of a formal program of education.[4]

### The RN Scope of Practice

The professional registered nurse is an advocate for the patient and the patient's family, and promotes safety by practicing within the NPA and the BON Rules and Regulations. The RN provides nursing services that require substantial specialized judgment and skill. The planning and delivery of professional nursing care is based on knowledge and application of the principles of biological, physical and social science as acquired by a completed course of study in an approved school of professional nursing. Unless licensed as an advanced practice registered nurse, the RN scope of practice does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures.[2] RNs utilize the nursing process to establish the plan of care in which nursing services are delivered to patients. The level and impact of the nursing process differs between the RN and LVN as well as between the different levels of RN education (see Table).

### Assessment

The comprehensive assessment is the first step, and lays the foundation for the nursing process. The comprehensive assessment is the initial and ongoing, extensive collection, analysis and interpretation of data. Nursing judgment is based on the assessment process. The RN uses clinical reasoning and knowledge, evidence-based outcomes, and research as the basis for decision-making and comprehensive care. Based upon the comprehensive assessment the RN determines the physical and mental health status, needs, and preferences of culturally, ethnically, and socially diverse patients and their families using evidence-based health data and a synthesis of knowledge. Surveillance is an essential step in the comprehensive assessment process. The RN must anticipate and recognize changes in patient conditions and determines when reassessments are needed.

**Planning**

The second step in the nursing process is planning. The RN synthesizes the data collected during the comprehensive assessment to identify problems, make nursing diagnoses, and to formulate goals, teaching plans and outcomes. A nursing plan of care for patients is developed by the RN, who has the overall responsibility to coordinate nursing care for patients. Teaching plans address health promotion, maintenance, restoration, and prevention of risk factors. The RN utilizes evidence-based practice, published research, and information from patients and the interdisciplinary health care team during the planning process.

**Implementation**

Implementing the plan of care is the third step in the nursing process. The RN may begin, deliver, assign or delegate certain interventions within the plan of care for patients within legal, ethical, and regulatory parameters and in consideration of health restoration, disease prevention, wellness, and promotion of healthy lifestyles. The RN's duty to patient safety when making assignments to other nurses or when delegating tasks to unlicensed staff is to consider the education, training, skill, competence, and physical and emotional abilities of those to whom the assignments or delegation is made. The RN is responsible for reasonable and prudent decisions regarding assignments and delegation. The RN scope of practice may include the supervision of LVNs. Supervision of LVN staff is defined as the process of directing, guiding, and influencing the outcome of an individual's performance and activity.[5] The RN may have to directly observe and evaluate the nursing care provided depending on the LVN's skills and competence, patient conditions, and emergent situations.

The RN may determine when it is appropriate to delegate tasks to unlicensed personnel and maintains accountability for how the unlicensed personnel perform the tasks. The RN is responsible for supervising the unlicensed personnel when tasks are delegated. The proximity of supervision is dependent upon patient conditions and skill level of the unlicensed personnel. In addition, teaching and counseling are interwoven throughout the implementation phase of the nursing process.

**Evaluation and Re-assessment**

A critical and fourth step in the nursing process is evaluation. The RN evaluates and reports patient outcomes and responses to therapeutic interventions in comparison to benchmarks from evidence-based practice and research findings, and plans any follow-up care and referrals to appropriate resources that may be needed. The evaluation phase is one of the times when the RN reassesses patient conditions and determines if interventions were effective and if any modifications to the plan of care are necessary.

**Essential Skills Used in the Nursing Process**

**Communication**

Communication is an essential and fundamental component used during the nursing process. The RN must communicate verbally, in writing, or electronically with members of the healthcare team, patients and their families in all aspects of the nursing care provided to patients. These communications must be appropriately documented in the patient record or nursing care plan. Because RNs plan, coordinate, initiate and implement a multidisciplinary team's approach to patient care, collaboration is a quality crucial to the communication process. When patient conditions or situations exceed the RN's level of competency, the RN must be prepared to seek out other RNs with greater competency or other health care providers with differing knowledge and skill sets and actively cooperate to ensure patient safety.

**Clinical Reasoning**

Clinical reasoning is another integral component in the nursing process. RNs use critical thinking skills to problem-solve and make decisions in response to patients, their families and the healthcare environment. RNs are accountable and responsible for the quality of nursing care provided and must exercise prudent and professional nursing judgment to ensure the standards of nursing practice are met at all times.

**Employment Setting**

When an employer hires a RN to perform a job, the RN must assure that it is safe and legal. Caution must be exercised not to overstep the legal parameters of nursing practice when an employer may not understand the limits of the RN scope of practice and makes an assignment that is not safe. The RN must determine before he or she engages in an activity or assignment whether he or she has the education, training, skill, competency and the physical and emotional ability to safely carry out the activity or assignment.[6] The RN's duty is to always provide safe, compassionate, and comprehensive nursing care to patients.

**Summary**

The RN, with a focus on patient safety, is required to function within the parameters of the legal scope of practice and in accordance with the federal, state, and local laws; rules and regulations; and policies, procedures and guidelines of the employing health care institution or practice setting. The RN functions under his or her own license and assumes accountability and responsibility for quality of care provided to patients and their families according to the standards of nursing practice.[7] The RN demonstrates responsibility for continued competence in nursing practice, and develops insight through reflection, self-analysis, self-care, and lifelong learning.

The table below offers a brief synopsis of how the scope of practice for nurses differs based on educational preparation and level of licensure. These are minimum competencies, but also set limits on what the LVN or RN can do at his or her given level of licensure, regardless of experience.

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[1] Texas Board of Nursing (2010). Six-step decision-making model for determining nursing scope of practice.

[2] Texas Nursing Practice Act, TOC §301.002(2)

[3] Texas Board of Nursing (2010). Differentiated essential competencies (DECs) of graduates of Texas Nursing Programs

[4] Texas Board of Nursing (2011). Position statement 15.10 Continuing education: Limitations for expanding scope of practice.

[5] Texas Administrative Code, 22 TAC §217.11(2)

[6] Texas Administrative Code, 22 TAC §217.11(1)(T)

[7] Texas Administrative Code, 22 TAC §217.11

Additional Resources


Idaho Board of Nursing (2010). Position on safety to practice.

Kentucky Board of Nursing. (2005). Components of licensed practical nursing practice (AOS #27 LPN Practice).

National Council of State Boards of Nursing. (2009). Changes in healthcare professions' scope of practice: Legislative consideration.

North Carolina Board of Nursing. (2010). LPN scope of practice: Clarification: Position statement for LPN practice.

North Carolina Board of Nursing. (2010). RN and LPN scope of practice components of nursing comparison chart.

North Carolina Board of Nursing. (2010). RN scope of practice: Clarification: Position statement for RN practice.

Texas Administrative Code, 22 TAC §224 (2011).

Texas Administrative Code, 22 TAC §225 (2011).

Texas Board of Nursing (2011). Rules and guidelines governing the graduate vocational and registered nurse candidates or newly licensed vocational or registered nurse.


(Adopted 07/2011)

(Reviewed 01/2012)

**Synopsis Of Differences in Scope Of Practice for Licensed Vocational, Associate, Diploma and Baccalaureate Degree Nurses**

| Nursing Practice | LVN Scope of Practice Directed/Supervised Role | ADN or Diploma RN Scope of Practice Independent Role | BSN RN Scope of Practice Independent Role |
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| Education | The curriculum for the VN education is in a clinically intensive certificate program of approximately one year in length. The Texas BON rules mandate a minimum of 558 theory and 840 clinical hours in the VN program of study. | ADN programs require a minimum of two full years of study, integrating a balance between courses in liberal arts; natural, social, and behavioral sciences; and nursing. Academic associate degrees consist of 60-72 credit hours with approximately half the program requirements in nursing courses. | The BSN program of study integrates approximately 60 hours from liberal arts and natural, social, and behavioral science courses and approximately 60-70 hours of nursing courses. In addition to the ADN/Diploma education requirements, BSN education includes instruction in community |
| | The VN curriculum includes instruction in five basic areas of nursing care: adults; | The Texas BON approved curriculum includes requirements for didactic instruction and clinical experiences in | |

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| | mothers and newborns; children; elderly; and individuals with mental health problems. Clinical experience in a unit or a facility specifically designed for psychiatric care is optional.<br><br>Required support courses should provide instruction in biological, physical, social, behavioral, and nursing sciences, including body structure and function, microbiology, pharmacology, nutrition, signs of emotional health, human growth and development, vocational adjustments, and nursing skills. | four contents areas: medical-surgical, maternal/child health, pediatrics, and mental health nursing.<br><br>Diploma programs are hospital-based, single purpose schools of nursing that consist of two-three years of general education and support courses. | health, public health, research, nursing leadership, and nursing management with preparation and skills to practice evidence based nursing. |
| Supervision | Supervision is required for the LVN scope of practice. LVNs are not licensed for independent nursing practice. A LVN must ensure that he or she has an appropriate clinical supervisor, i.e. RN, APRN, Physician, PA, Dentist or Podiatrist. The proximity of a clinical supervisor depends on skills and competency of the LVN, patient conditions and practice setting. Direct, on-site supervision may not always be necessary depending on the LVN's skill and competence and should be determined on a case-by-case situation taking into consideration the practice setting laws. However, clinical supervisors must provide timely and readily available supervision and may have to be physically present to assist LVNs should emergent situations occur. | Provides supervision to other RNs, LVNs and UAPs. Supervision of LVN staff is defined as the process of directing, guiding, and influencing the outcome of an individual's performance and activity. | Provides supervision to other RNs, LVNs and UAPs. Supervision of LVN staff is defined as the process of directing, guiding, and influencing the outcome of an individual's performance and activity. |
| Setting | Provides focused nursing care to individual patients with | Provides independent, direct care to patients and their families who may be | Provides independent, direct care to patients, |

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| | predictable health care needs under the direction of an appropriate clinical supervisor.<br><br>The setting may include areas with well defined policies, procedures and guidelines with assistance and support from appropriate clinical supervisors, i.e. nursing home, hospital, rehabilitation center, skilled nursing facility, clinic, or a private physician office. As competencies are demonstrated, if the LVN transitions to other settings, it is the LVN's responsibility to ensure he or she has an appropriate clinical supervisor and that the policies, procedures and guidelines for that particular setting are available to guide the LVN practice. | experiencing complex health care needs that may be related to multiple conditions. Provides healthcare to patients with predictable and unpredictable outcomes in various settings. | families, populations, and communities experiencing complex health care needs that may be related to multiple conditions. Provides healthcare to patients with predictable and unpredictable outcomes in various settings. |
| Assessment | Assists, contributes and participates in the nursing process by performing a focused assessment on individual patients to collect data and gather information. A focused assessment is an appraisal of the situation at hand for an individual patient and may be performed prior to the RN's initial and comprehensive assessment.<br><br>The LVN reports and documents the assessment information and changes in patient conditions to an appropriate clinical supervisor. | Independently performs an initial or ongoing comprehensive assessment (Extensive data collection). Anticipates changes in patient conditions to include emergent situations. Reports and documents information and changes in patient conditions to a health care practitioner and or a responsible party.<br><br>Determines the physical and mental health status, needs, and preferences of culturally diverse patients and their families. | Independently performs an initial or ongoing comprehensive assessment (Extensive data collection). Anticipates changes in patient conditions to include emergent situations. Reports and documents information and changes in patient conditions to a health care practitioner and or a responsible party.<br><br>Determines the physical and mental health status, needs, and preferences of culturally diverse patients, families, populations and communities. |
| Planning | Uses clinical reasoning based on established evidence-based policies, procedures and guidelines for decision-making | Uses clinical reasoning based on established evidence-based policies, procedures and guidelines for decision-making. Analyzes assessment data to identify problems, formulate goals and | Uses clinical reasoning based on established evidence-based practice outcomes and research for decision-making and |

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| | | | comprehensive care. Synthesizes comprehensive data to identify problems, formulate goals and outcomes, and develop nursing plans of care for patients, families, populations, and communities.[13] |
| | May assign specific daily tasks and supervise nursing care to other LVNs or UAPs. | outcomes, and develops nursing plans of care for patients and their families.<br><br>May assign tasks and activities to other nurses. May delegate tasks to UAPs. | May assign tasks and activities to other nurses. May delegate tasks to UAPs. |
| Implementation | Provides safe, compassionate and focused nursing care to patients with predictable health care needs.<br><br>Implements aspects of the nursing care plan, including emergency interventions under the direction of the RN or another appropriate clinical supervisor.<br><br>Contributes to the development and implementation of teaching plans for patients and their families with common health problems and well-defined health needs. | Provides safe, compassionate, comprehensive nursing care to patients, and their families through a broad array of health care services. Implements the plan of care for patients and their families within legal, ethical, and regulatory parameters and in consideration of disease prevention, wellness, and promotion of healthy lifestyles. Develops and implements teaching plans to address health promotion, maintenance, and restoration. | Provides safe, compassionate, comprehensive nursing care to patients, families, populations, and communities through a broad array of health care services.<br><br>Implements the plan of care for patients, families, populations, and communities within legal, ethical, and regulatory parameters and in consideration of disease prevention, wellness, and promotion of healthy lifestyles. Develops and implements teaching plans to address health promotion, maintenance, restoration, and population risk reduction. |
| Evaluation | Participates in evaluating effectiveness of nursing interventions.<br><br>Participates in making referrals to resources to facilitate continuity of care. | Evaluates and reports patient outcomes and responses to therapeutic interventions in comparison to benchmarks from evidence-based practice, and plans follow-up nursing care to include referrals for continuity of care. | Evaluates and reports patient, family, population, and community outcomes and responses to therapeutic interventions in comparison to benchmarks from evidence-based practice and research, and plans follow-up nursing care to include referrals for continuity of care. |