Texas Board of Nursing

Board Position Statements

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.

Last Review: January 2014

Position Statements

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15.1 Nurses Carrying out Orders from Physician's Assistants

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

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

The order relayed by the PA may originate from a protocol; if the order originates from a protocol, the PA may select specific tasks or functions required to implement the protocol, provided they are within the scope of the protocol. The protocol must be signed by the supervising physician and should be made available as necessary to verify authority to provide medical aspects of care. If the tasks or functions ordered fall outside the scope of the protocol, the PA must consult with the physician to obtain a verbal order before the nurse may carry out the order.

As with any order, the nurse must seek clarification if he/she believes the order or treatment is inaccurate, non-efficacious or contraindicated by consulting with the PA and physician as appropriate. The nurse may request to review the PA’s protocol as one mechanism for clarification of orders and treatments.

(Board Action, 01/1994; Revised 01/2005; 01/2006; 01/2010; 01/2012)
(Reviewed - 01/2007; 01/2008; 01/2009; 01/2011; 01/2013; 01/2014)

15.2 The Role of the Licensed Vocational Nurse in the Pronouncement of Death

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

It is within the LVN scope of practice as defined by Rule 217.11(1)-(2) (effective 9/28/2004) and Position Statement 15.27*, The Licensed Vocational Nurse Scope of Practice,* for a LVN to gather data and perform a **focused** assessment regarding a patient, to recognize significant changes in a patient's condition and to report said data and observation of significant changes to the physician. The LVN's focused assessment should include nursing observations to determine the presence or absence of the following presumptive or conclusive signs of death:

Presumptive Signs of Death

- The patient is unresponsive,
- The patient has no respirations,
- The patient has no pulse,
- Patient's pupils are fixed and dilated,
- The patient's body temperature indicates hypothermia: skin is cold relative to the patient's baseline skin temperature,
- The patient has generalized cyanosis, and

Conclusive Sign of Death

- There is presence of livor mortis (venous pooling of blood in dependent body parts causing purple discoloration of the skin which does blanch with pressure).
- While these signs of irreversible death would not be expected to be seen in most practice settings, the American Heart Association also includes the following irreversible signs of death:
  - decapitation (separation of the head from the body)
  - decomposition (decay or putrification of the body)
  - rigor mortis (stiffness of the limbs and body that develops 2 - 4 hours after death and may take up to 12 hours to fully develop).

Upon reporting his/her clinical findings to the physician, and in accordance with facility policy, the LVN may accept reasonable physician's orders regarding the care of the client; i.e.: notification of family, postmortem care, contacting the funeral home or appropriate legal authority, documentation; however, a LVN may not accept an order that would require the LVN to "pronounce death," or to complete the state-required "medical certification" of a death that occurs without medical attendance.

Employers are also encouraged to develop policies and procedures directing staff in postmortem care and procedures, including appropriate measures that can be completed while waiting for a return call from the attending physician.

The BON has no jurisdiction over physician practice, facility policies, or the laws regulating pronouncement of death in Texas. Additional information on Texas regulations regarding pronouncement of death may be found in Chapters 193 and 671 of the Texas Health and Safety Code, as well as through the Department of State Health

Services. A LVN is not responsible for the actions of a physician who elects to pronounce death by remote-means. Physicians are licensed by, and must comply with, rules promulgated by the Texas Medical Board as well as other laws applicable to the physician's practice setting.

References:

American Heart Association (2010) Guidelines for Cardiopulmonary Resusitation and Emergency Cardiovascular Care

Texas Statutes, Health and Safety Code; http://www.statutes.legis.state.tx.us/

(BVNE Statement adopted 06/1999; Revised BON statement 01/2006; revised 01/2007; 01/2008; 01/2009; 01/2011; 01/2012; 01/2013; 01/2014)
(Reviewed - 01/2010)

15.3 LVNs Engaging in Intravenous Therapy, Venipuncture, or PICC Lines

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

Applicable Nursing Standards

LVN practice is guided by the Nursing Practice Act (NPA) and Board Rules. Rule 217.11, *Standards of Nursing Practice*, is the rule most often applied to nursing practice issues. 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 nursing 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 LVN chooses to engage in an IV therapy-related task include (but are not limited to):

- (1)(C) Know the rationale for and the effects of medications and treatments and shall correctly administer the same,
- (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,
- (2)(A) Shall utilize a systematic approach to provide individualized, goal-directed nursing care ...[(i)-(v)], and
- (2)(C) ...perform other acts that require education and training as prescribed by board rules and policies, commensurate with the LVN's experience, continuing education, and demonstrated LVN competencies.

Position Statement 15.27, *The Licensed Vocational Nurse Scope of Practice* provides additional clarification of the Standards Rule as it applies to LVN Scope of Practice. Instruction and skill evaluation relating to LVNs performing insertion of peripheral IV catheters and/or administering IV fluids and medications as prescribed by an authorized practitioner may allow a LVN to expand his/her scope of practice to include intravenous therapy.

It is the opinion of the Board that the LVN shall not engage in IV therapy related to either peripheral or central venous catheters, including venipuncture, administration of IV fluids, and/or administration of IV push medications, until successful completion of a validation course that instructs the LVN in the knowledge and skills applicable to

the LVN's IV therapy practice. The BON does not define or set qualifications for an "IV Validation Course" or for "LVN IV certification." The LVN who chooses to engage in intravenous therapy must first have been instructed in the principles of intravenous therapy congruent with prevailing nursing practice standards.

Insertion of PICC Lines

The Board has further determined that the one-year vocational nursing program does not provide the Licensed Vocational Nurse (LVN) with the educational foundation to assure client safety in insertion of Peripherally Inserted Central Catheters (PICC lines) inclusive of vein selection, insertion/advancement of the catheter, determining placement, and monitoring of the client for untoward reactions in relation to catheter insertion. Position Statement 15.27, *The Licensed Vocational Nurse Scope of Practice*, further maintains that continuing education that falls short of achieving licensure as a registered nurse would be insufficient to assure vocational nurse competency and patient safety with regard to insertion of PICC lines. Therefore, it is the Board's position that insertion of PICC lines is beyond the scope of practice for LVNs.

Administration of IV Fluids and Medications

The ability of a LVN to administer specific IV fluids or drugs, to prepare and/or administer IV "piggy-back" or IV "push" medications, or to monitor and titrate "IV drip" medications of any kind is up to facility policy. The LVN's practice relative to IV therapy must also comply with any other regulations that may exist under the jurisdiction of other regulatory agencies or entities. The LVN who accepts an assignment to engage in any aspect of intravenous therapy is responsible for adhering to the NPA and Board rules, particularly 22 TAC §217.11, *Standards of Nursing Practice*, including excerpted standards listed above and any other standards or rules applicable to the individual LVN's practice.

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

(Board Action: 06/1995; Revised 09/1999; 01/2005; 01/2011; 01/2012; 01/2014)
(Reviewed - 01/2006; 01/2007; 01/2008; 01/2009; 01/2010; 01/2013)

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; 01/2013; 01/2014)

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 pre-approved 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:

> ***(19) 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. As used in this chapter, standing delegation orders are separate and distinct from prescriptive authority agreements as defined in this chapter. 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.

***(20) 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 or delegation pursuant to a prescriptive authority agreement.*

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

***(18) Protocols** - Written authorization delegating authority to initiate medical aspects of patient care, including delegation of the act of prescribing or ordering a drug or device at a facility-based practice. The term protocols is separate and distinct from prescriptive authority agreements as defined under the Act and this chapter. However, prescriptive authority agreements may reference or include the terms of a protocol(s). The protocols must be agreed upon and signed by the physician, the physician assistant and/or advanced practice registered 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 registered 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 registered 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 licensure 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; 01/2014)
(Reviewed - 01/2008; 01/2010; 01/2012; 01/2013)

15.6 Board Rules Associated With Alleged Patient "Abandonment"

The Texas 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 patients and others over whom the nurse is responsible [22 TAC §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 licensure (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 are Rules 22 TAC §217.11, *Standards of Nursing Practice*, and 22 TAC §217.12, *Unprofessional Conduct*. The standard upon which all other standards are based is 22 TAC §217.11(1)(B) "...promote a safe environment for clients and others." This standard supersedes a 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 patient 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 patient. 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 patient 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 sound 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 22 TAC §217.11, *Standards of Nursing Practice,* and 22 TAC §217.12, *Unprofessional Conduct.* In relation to questions of "abandonment," standard 22 TAC §217.11(1)(I) holds the nurse responsible to "notify the appropriate supervisor when leaving a nursing assignment." This standard should not be misinterpreted to mean a 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 or 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 or her duty to the patient by leaving a patient care assignment in a manner inconsistent with the Board Rules.

Emergency Preparedness and Workplace Violence

A nurse may have to choose between the duty to provide safe patient care and protecting the nurse's own life during an emergency, including but not limited to disasters, infectious disease outbreaks or bioterrorism. These situations are challenging for all nurses and their employers, therefore the Board recommends policies and procedures be developed, and periodically reviewed, to provide clear guidance and direction to nurses in order for patients to receive safe and effective care.

The Occupational Safety and Health Administration (OSHA) defines workplace violence to include "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site" (OSHA website). A nurse may have to choose between the duty to provide safe patient care and protecting the nurse's own life during a violent situation that

may occur in the workplace. For example, when an active shooter is present in the workplace, the nurse should take steps to protect patients if there is time and using a method that does not jeopardize the nurse's personal safety or interfere with law enforcement personnel. These steps may include evacuating the area or preventing entry to an area where the active shooter is located. However, during an active shooter situation a nurse may find there is not sufficient time to do anything but to ensure his or her own safety. In this instance, as soon as the situation has resolved the nurse should promptly resume care of patients.

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;
- emergencies that require nurses to respond, including but not limited to disasters, disease outbreaks, and bioterrorism;
- workplace violence, including but not limited to an active shooter situation;
- 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 22 TAC §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 22 TAC §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 22 TAC §217.20(d)(3)(A) or on the Board's Safe Harbor Quick Request Form.

Links to Related Articles:

- FAQ on Floating http://www.bon.texas.gov/practice/faq-floating.html
- FAQ on Overtime/Hours of Work http://www.bon.texas.gov/practice/faq-overtime.html
- FAQ on Peer Review http://www.bon.texas.gov/practice/faq-peerreview.html
- FAQ on Staffing Ratios http://www.bon.texas.gov/practice/faq-staffing.html
- FAQ on When Does a Nurse's Duty to a Patient Begin and End http://www.bon.texas.gov/practice/faq-nurseduty.html
- Safe Harbor Form http://www.bon.texas.gov/practice/safe.html
- United States Department of Labor, Occupational Safety and Health Administration: Workplace Violence: https://www.osha.gov/SLTC/workplaceviolence/

(Adopted 01/2005; Revised 01/2006; 01/2007; 01/2009; 01/2011; 01/2014)
(Reviewed - 01/2008; 01/2010; 01/2012; 01/2013)

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 "Role of the Registered Nurse (RN) in the Care of the Pregnant Woman 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.

References

American Association of Nurse Anesthetists (2011) Provision of pain relief by medication administered via continuous catheter of other pain relief devices. Accessed 12/4/2013 from: http://www.aana.com/resources2/professionalpractice/Documents/PPM%20PS%202.8%20Continuous%20Catheters%20and%20Devices.pdf.

Association of Women's Health, Obstetric, and Neonatal Nurses (2007) Role of the registered nurse (RN) in the care of the pregnant woman receiving analgesia/anesthesia by catheter techniques (epidural, intrathecal, spinal, PCEA catheters). Accessed 12/4/2013 from: http://www.awhonn.org/awhonn/binary.content.do?name=Resources/Documents/pdf/5_Epidural.pdf.

(LVN role: BVNE 1994; Revised BON 01/2005) (RN role: BON 06/1991; Revised 01/2003; 01/2004; 01/2005; 01/2011; 01/2014)
(Reviewed - 01/2006; 01/2007; 01/2008; 01/2009; 01/2010; 01/2012; 01/2013)

15.8 Role of the Nurse in Moderate Sedation

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

(1) The practice of the registered nurse who holds licensure as an advanced practice registered nurse in the role and population focus of nurse anesthetist (CRNA) functioning within his/her authorized scope of practice, or to

(2) The Registered Nurse practicing in an acute care setting, such as critical care, where the patient in question is intubated, receiving mechanical ventilatory support, and continuously monitored by the patient care RN.

Role of the LVN

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

In alignment with 22 TAC §217.11, *Standards of Nursing Practice*, Board Position Statement 15.27, *The Licensed Vocational Nurse Scope of Practice*, and Board Position Statement 15.10, *Continuing Education: Limitations for Expanding Scope of Nursing Practice*, the Board also maintains that continuing education that falls short of achieving licensure as a registered nurse would be insufficient to assure vocational nurse competency and patient safety with regard to both medication administration and patient monitoring associated with moderate sedation.

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

Role of the RN or non-CRNA Advanced Practice Nurse

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

All licensed nurses practicing in Texas are required to "know and comply" with the Nursing Practice Act (NPA) and Board Rules. Rule 217.11(1)(B) requires the nurse to "promote a safe environment for clients and others." This standard establishes the nurse's duty to the patient/client, which **supersedes any physician order or any facility policy.** This "duty" to the patient requires the nurse to use informed professional judgment when choosing to assist or engage in a given procedure. [See Position Statement 15.14, *Duty of a Nurse in Any Practice Setting*].

As the NPA and rules are not prescriptive to specific tasks a nurse may or may not perform, a RN or non-CRNA advanced practice registered nurse should consider evidence-based practice guidelines put forth by professional organizations with clinical expertise in the administration of pharmacologic agents used for sedation/anesthesia

as well as advanced airway management and cardiovascular support. A number of professional specialty organizations have well-defined standards and recommendations for ongoing nursing education and competency assessment related to administration and monitoring of patients receiving moderate sedation.

These organizations include the American Association of Nurse Anesthetists (AANA), the American Nurses Association (ANA), the Association of PeriOperative Registered Nurses (AORN), and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). The AWHONN position statement is also endorsed by the American Association of Critical Care Nurses (AACN). Statements published by the American Society of Anesthesiologists (ASA) also support the positions of the above nursing organizations. The Board advises the nurse use caution in applying moderate sedation standards of any individual or specialty group who are not also experts in the field of advanced airway management/anesthesia. The Board encourages the use of the BON's "Six-Step Decision-Making Model for Determining Nursing Scope of Practice."

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

- Performance of a pre-sedation health assessment by the individual ordering the sedation and the nurse administering the sedation
- Guidelines for patient monitoring, drug administration, and a plan for dealing with potential complications or emergency situations developed in accordance with currently accepted standards of practice
- Accessibility of emergency equipment and supplies
- Documentation and monitoring of the level of sedation and physiologic measurements (e.g. blood pressure, oxygen saturation, cardiac rate and rhythm)
- Documentation/evidence of initial education and training and ongoing competence of the RN administering and/or monitoring patients receiving moderate sedation

Use of Specific Pharmacologic Agents

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

1. Availability of and knowledge regarding the administration of reversal agents for the pharmacologic agents used; and

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

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

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

Moderate Sedation versus Deep Sedation Anesthesia

According to the professional literature "moderate sedation" is defined as a medication-induced, medically controlled state of depressed consciousness. Included in the literature from various professional organizations is the caveat that, while under moderate sedation, the patient at all times retains the ability to independently and continuously maintain a patent airway and cardiovascular function, and is able to respond meaningfully and purposefully to verbal commands, with or without light physical stimulation. Reflex withdrawal to physical stimulation is not considered a purposeful response. Loss of consciousness for patients undergoing moderate sedation should not be the goal and thus pharmacologic agents used should render this result unlikely. If the patient requires painful or repeated stimulation for arousal and/or airway maintenance, this is considered deep sedation.

In a state of deep sedation, the patient's level of consciousness is depressed, and the patient is likely to require assistance to maintain a patent airway. Deep sedation occurring in a patient who is not appropriately monitored and/or who does not have appropriate airway support may result in a life-threatening emergency for the patient. This is not consistent with the concept of moderate sedation as defined in this position statement or the professional literature and is

Although propofol is classified as a sedative/hypnotic, according to the manufacturer's product information, it is intended for use as an anesthetic agent or for the purpose of maintaining sedation of an intubated, mechanically ventilated patient. The product information brochure for propofol further includes a warning that "only persons trained to administer general anesthesia should administer propofol for purposes of general anesthesia or for monitored anesthesia care/sedation." The clinical effects for patients receiving anesthetic agents such as propofol may vary widely within a negligible dose range. Though reportedly "short-acting", it is also noteworthy that there are ***no*** reversal agents for propofol.

As the US FDA approves computer- assisted personalized sedation systems, a nurse utilizing the Six-Step Decision-Making Model for Determining Nursing Scope of Practice may reach a sound decision whether to engage in nursing practice utilizing such a device in accordance with the US FDA approval requirements. US FDA approval requirements for computer-assisted personalized sedation systems include requirements for completion of training in addition to safety requirements, such as the availability of anesthesia providers. A nurse is required to complete training prior to using any computer-assisted personalized sedation system and is encouraged to retain proof of training.

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

Though the RN or non-CRNA advanced practice registered nurse may have completed continuing education in advanced cardiac life support (ACLS) and practiced techniques during the training program, this process does not ensure ongoing expertise in airway management and emergency intubation. The American Heart Association (AHA) cautions ACLS providers about attempting tracheal intubation in an emergency situation since "*Repeated safe and effective placement of the tracheal tube, over the wide range of patient and environmental conditions encountered in resuscitation, requires considerable skill and experience. Unless initial training is sufficient and ongoing practice and experience are adequate, fatal complications may result*."[1] It is also important to note that no continuing education program, including ACLS programs, will ensure that the RN or non-CRNA advanced practice registered nurse has the knowledge, skills and abilities to rescue a patient from deep sedation or general anesthesia. Furthermore, it is the joint position of the AANA and ASA that, "because sedation is a continuum, it is not always possible to predict how an individual patient will respond." These organizations state that anesthetic agents, including induction agents, should be administered only by qualified anesthesia providers who are trained in the administration of general anesthesia.

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

- when assisting in the physical presence of a CRNA or anesthesiologist (the CRNA or anesthesiologist may direct the RN to administer anesthetic agents in conjunction with the CRNA or anesthesiologist intubating or otherwise managing the patients airway)
- when administering these medications as part of a clinical experience within an advanced educational program of study that prepares the individual for licensure as a nurse anesthetist (i.e. when functioning as a student nurse anesthetist)
- when administering these medications to patients who are intubated and mechanically ventilated in critical care settings
- when assisting an individual with current competence in advanced airway management, including emergency intubation procedures
- when utilizing a US FDA approved Computer-Assisted Personalized Sedation System in accordance with the US FDA approval requirements, where appropriate safety requirements are met (such as availability of anesthesia providers) after completing appropriate training.

While the physician or other health care provider performing the procedure may possess the necessary knowledge, skills and abilities to rescue a patient from deep sedation and general anesthesia, it is not prudent to presume this physician will be able to leave the surgical site or abandon the procedure to assist in rescuing the patient. In the case of an appropriately licensed practitioner performing a procedure that can be safely abandoned to rescue or intubate the patient the RN may administer the anesthetic agent when directed. In this instance, the RN is responsible for accepting the assignment and for knowing the rationale, effects, and correctly administering the medication [22 TAC §217.11 (1)(T) & (1)(C)].

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

Practice Setting.

Recommended Reference Article: The Institute for Safe Medication Practices (ISMP) published an article in the November 3, 2005 Acute Care Edition of the Medication Safety Alert Newsletter titled "Propofol Sedation: Who Should Administer?" http://www.ismp.org/newsletters/acutecare/articles/20051103.asp. This article highlights patient safety concerns related to administration of agents, such as Propofol, to non-intubated patients. The concerns mirror-image those of the Board as noted in this position statement.

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

[2] American Association of Nurse Anesthetists and American Society of Anesthesiologists. Joint Position Statement, May, 2004, "AANA–ASA Joint Statement Regarding Propofol Administration" http://www.aana.com/resources2/professionalpractice/Documents/PPM%20PS%20Joint%20AANA-ASA%20Propofol.pdf

[3] Lunsford vs. BNE, 1983, 648 S.W. 391, Tex. App–Austin 1983

(Board Action 01/1992; Revised 01/2003; 01/2004; 01/2006; 01/2007; 01/2009; 01/2012; 01/2013; 01/2014)
(Reviewed - 01/2008; 01/2010; 01/2011)

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 laser use have changed rapidly since their introduction for medical purposes. Nurses fulfill many important roles in the use of laser therapies. These roles and functions change based upon the type of treatment and the setting in which the treatment occurs. It may be within the scope of nursing practice to perform the delivery of laser energy on a patient with a valid order providing the nurse has the education, experience, and knowledge to perform the assignment [22 TAC §217.11 (1) (T)]. RNs (including Advanced Practice Registered Nurses practicing within their educated role and population focus) or LVNs, with an appropriate clinical supervisor, who choose to administer laser therapy must know and comply with all applicable laws, rules, and regulations, as well as the Nursing Practice Act (NPA) and Rules of the BON [22 TAC §217.11 (1)(A)].

Additional criteria applicable to the nurse who elects to follow an appropriate order in the use of nonablative laser therapy (such as laser hair removal) 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 Practice Registered Nurse (APRN) or Physician Assistant 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.

(5) Specific regulations related to laser hair removal, including training requirements, may be accessed on the Texas Department of State Health Services website (www.dshs.state.tx.us)

Registered Nurses, including APRNs, cannot delegate any aspects of the use of lasers to unlicensed persons. 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.

Additional Reference in relation to physician delegation: Position Statement 15.11, Delegated Medical Acts.

(Board Action, 05/1992; revised 11/1997; 01/2003; 04/2004; 01/2006; 01/2008; 01/2009; 01/2011; 04/2013; 01/2014)
(Reviewed - 01/2005; 01/2007; 01/2010; 01/2012)

15.10 Continuing Education: Limitations for Expanding Scope of Practice

Foundation for Initial Licensure and/or APRN licensure

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.texas.gov/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.

Licensure as an advanced practice registered nurse in Texas requires completion of a master's or post-master's advanced practice program as well as national certification in the advanced role and population focus. To gain licensure 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 licensure in the advanced practice role and population focus.

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 population focus at the master's or post-master'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. 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 judgement in a given APRN role and population focus without the formal education, national certification, and proper licensure in that advanced practice registered nurse role and population focus.

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 statue or 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 licensure in a given role and population focus.

(Adopted 01/2005; Revised 01/2009; 01/2011; 01/2013; 01/2014)
(Reviewed - 01/2006; 01/2007; 01/2008; 01/2010; 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 licensure as advanced practice registered nurses in a specified role and population focus, 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; 01/2014)
(Reviewed - 01/2006; 01/2007; 01/2008; 01/2009; 01/2010; 01/2012; 01/2013)

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, is the DSM-5 (Fifth Edition).

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-5 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; 01/2014)
(Reviewed - 01/2007; 01/2012; 01/2013)

15.13 Role of LVNs and RNs in School Health

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 Texas Education Agency defines a school nurse in 19 Texas Administrative Code (TAC) § 153.1022 (a) (1) (D) as "… an educator employed to provide full-time nursing and health care services and who meets all the requirements to practice as a registered nurse (RN) pursuant to the Nursing Practice Act and rules and regulations relating to professional nurse education, licensure, and practice and has been issued a license to practice professional nursing in Texas." 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 vocational nurse has a directed scope of practice under supervision of a registered nurse, advanced practice registered nurse, physician, physician assistant, podiatrist, or dentist[1]. 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 [22 TAC §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.

When LVNs are utilized in the school setting and are supervised by the RN, the RN needs to consider how closely they can supervise the LVN and how the RN will direct, guide, and influence the outcome of the LVN's performance[2] and respond to any situations where the LVN needs onsite supervision.

RN Delegation to Unlicensed Personnel

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[1]Tex. Occ. Code, Section 301.353 and 22 Tex. Admin. Code §217.11 (2)

[2]22 Tex. Admin. Code § 217.11 (2)

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. 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 the rules in both Chapter 224 and Chapter 225. For example, the RN may decide to delegate to an unlicensed person, the emergency administration of Epi-pens, Glucagon, Diastat, oxygen, metered dose inhalers, or nebulizer treatments for the relief of acute respiratory symptoms and the use of a hand held magnet to activate a vagus nerve stimulator to prevent or control seizure activity under 22 TAC §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 22 TAC §224.8(b)(1)(C) or 22 TAC §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 22 TAC §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; 01/2013; 07/2013)
(Reviewed - 01/2006; 01/2007; 01/2010; 01/2012; 01/2014)

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 (22 TAC §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, 22 TAC §§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 (22 TAC Chapters 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 licensure 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; 01/2014)
(Reviewed - 01/2006; 01/2008; 01/2010; 01/2011; 01/2012; 01/2013)

15.15 Board's Jurisdiction over a Nurse's Practice in Any Role and Use of the Nursing Title

An individual who holds licensure as a licensed vocational nurse (LVN) or as a registered professional nurse (RN) or as an advanced practice registered nurse (APRN) 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 [22 TAC§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 [22 TAC§217.11(1)(B)].

RNs Functioning in LVN Positions/ RNs or LVNs Functioning in Unlicensed Positions/Nurse Functioning in Another Role

The Nursing Practice Act (NPA) and Board Rules do not preclude a RN, including a RN/APRN, from seeking employment in lower positions (such as LVN, unlicensed, or technical positions), with purportedly fewer responsibilities or in roles the nurse has the knowledge, education, experience, and valid certificate or license to perform. However, a nurse, who is also licensed by another state agency, is required to comply with the NPA and Board Rules for any acts that are also within the scope of nursing practice [Tex. Occ. Code Ann. § 301.004 (a) (5)]. The Board holds a licensed registered professional nurse, who is working in a lower level position, or other role, responsible and accountable to the level of education and competency of a RN. Likewise, a LVN working as an unlicensed person, or in another role, 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 or APRNs 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). A RN is not automatically a LVN and may not use the title LVN unless the RN also holds an active LVN license. The dually licensed RN/LVN will be held to the standards of the RN license even when working as an LVN. The dually licensed RN/APRN will be held to the standards applicable to the APRN role and population focus when working as an RN in that role and population focus. 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 area of practice.

(Board Action 09/1998; Revised. 01/2001; 01/2003; 01/2004; 01/2005; 01/2008; 01/2013; 01/2014)
(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 nurses, education institutions and facilities within the affected geographical region frequently respond to this workforce need by proposing 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 the Texas Workforce Commission (TWC) as a career school or college (proprietary school) prior to seeking approval for the proposed nursing education program.
All new pre-licensure vocational and professional nursing educational 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 legislative mandate 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 proposalis 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; 01/2013)
(Reviewed - 01/2007; 01/2009; 01/2010; 01/2012; 01/2014)

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

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.

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.

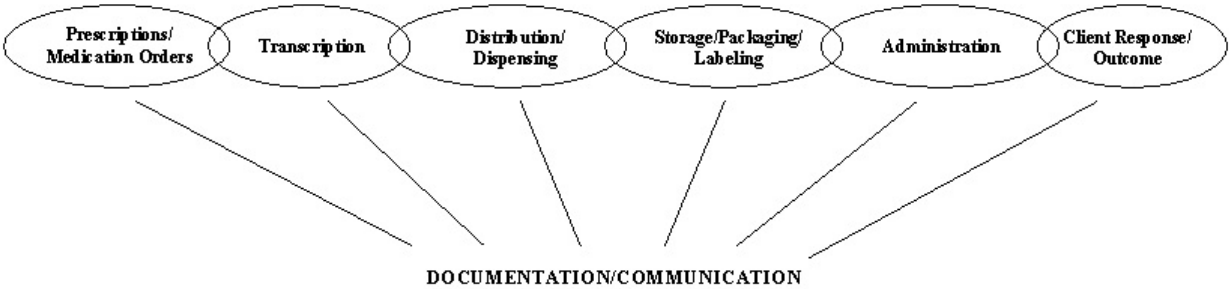
Leape, L. L. (1994). Error in medicine. Journal of the American Medical Association, 272(23), 1851-1857.

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

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

(Board Action 10/2000)
(Reviewed - 01/2005; 01/2006; 01/2007; 01/2008; 01/2009; 01/2010; 01/2011; 01/2012; 01/2013; 01/2014)

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

15.18 Nurses Carrying out Orders from Advanced Practice Registered Nurses

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

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

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

(Board Action, 01/2001; Revised 01/2005; 01/2009; 01/2012; 01/2014)
(Reviewed - 01/2006; 01/2007; 01/2008; 01/2010; 01/2011; 01/2013)

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 [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; 01/2014)
(Reviewed - 01/2008; 01/2009; 01/2010; 01/2012; 01/2013)

15.20 Registered Nurses in the Management of an Unwitnessed Arrest in a Resident in a Long Term Care Facility

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

The nursing community generally considers that initiation of CPR in such cases is not compassionate, and is not consistent with standards requiring the use of a systematic approach to provide individualized, goal directed nursing care [BON Standards of Nursing Practice, 22 TAC § 217.11(3)]. This position statement is intended to provide guidance, for nurses, in the management of an unwitnessed resident arrest without a DNR order **in a long term care (LTC) setting**. The position also addresses the related issues of:

- Obligation (or duty) of the nurse to the resident,
- Expectation of supportive policies and procedures in LTC facilities,
- The RN role in pronouncement of death.

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

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

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

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

Presumptive Signs of Death

1. The resident is unresponsive,
2. The resident has no respirations,
3. The resident has no pulse,
4. Resident's pupils are fixed and dilated,
5. The resident's body temperature indicates hypothermia: skin is cold relative to the residents baseline skin temperature,
6. The resident has generalized cyanosis, and

Conclusive Sign of Death

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

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

Documentation

After assessment of the resident is completed and appropriate interventions are taken, documentation of the circumstances and the assessment of the resident in the resident record are a requirement. The rules of the BON establish legal documentation standards, [BON Standards of Nursing Practice, 22 TAC § Rule 217.11 (1)(D)]. Examples of important documentation elements include:

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

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

Even if the nurse's decision not to initiate CPR was appropriate, failure to document can result in an action against a nurse's license by the BON. Furthermore, lack of documentation places the nurse at a disadvantage should the nurse be required to explain the circumstances of the resident's death. Nurses should be aware that

actions documented at the time of death provide a much more credible defense than needing to prove actions not appropriately documented were actually taken.

Obligation ("Duty") of the Nurse to the Resident

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

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

Care Planning and Advanced Directives

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

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

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

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

RN Role in Pronouncement of Death

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

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

Conclusion

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

Qualifier to Position

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

(Approved by the Board of Nursing on October 24, 2002; Revised 01/2005; 01/2007; 01/2008; 01/2011; 01/2012; 01/2013; 01/2014)
(Reviewed - 01/2006; 01/2009; 01/2010)

15.21 [Deleted 01/2005]

15.22 APRNs Providing Medical Aspects of Care for Individuals with whom there is a Close Personal Relationship

Advanced Practice Registered Nurses (APRN) 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. APRNs are prohibited from ordering, prescribing or dispensing both medications and devices for personal use [22 TAC §222.10 (a) (2)]. When ordering, prescribing, or dispensing a medication or a device for any person, the APRN is expected to meet all standards of care including assessment, documentation of the assessment, diagnosis, and documentation of the plan of care prior to ordering, prescribing, dispensing, or administering a medication or device [22 TAC 222. 10 (a) (3)].

The practice of providing medical aspects of care for individuals with whom an APRN has a close personal relationship raises a number of ethical questions. The Board is concerned that APRNs 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 APRNs should not provide medical treatment or prescribe medications for any individual with whom they have a close personal relationship.

(Board Action 10/2003; Revised 01/2009; 01/2014)
(Reviewed - 01/2006; 01/2007; 01/2008; 01/2010; 01/2011; 01/2012; 01/2013)

15.23 The Use of Complementary Modalities by the LVN or RN

Nursing is a dynamic profession. The scope of practice for one nurse may differ from the scope of practice for another nurse; therefore, it is impractical to create an exhaustive list of tasks that may or may not be performed by a nurse in any setting.

A number of complementary therapeutic modalities have long been incorporated into standard nursing practice to assist patients in meeting identified health needs and goals. Educational preparation to practice complementary modalities may be acquired through formal academic programs or continuing education.

Differentiating the Roles of the LVN and RN

The Licensed Vocational Nurse (LVN) and the professional or Registered Nurse (RN) have different roles within the nursing process. The nursing practice of an LVN requires supervision with oversight from a registered nurse, advanced practice registered nurse, physician, physician assistant, podiatrist or dentist. The LVN performs focused assessments and *contributes to* care planning, interventions, and evaluations. The RN is responsible for the overall coordination of care and performs comprehensive assessments, initiates the nursing care plan, implements and evaluates care of the client or patient.

Additional references related to the topics of supervision, assessment, and the nursing process may be found in the following resources on the BON web site:

1. Nursing Practice Act (NPA):
   a. 301.002, Definitions, and
   b. 301.353, Supervision of Vocational Nurse
2. Board Rule 217.11, Standards of Nursing Practice
3. Position Statement 15.27, The Licensed Vocational Nurse Scope of Practice
4. Frequently Asked Question: LVN's "Supervision of Practice"
5. Frequently Asked Question: LVN's Performing Initial Assessments

Complementary Modalities

Depending upon the practice setting and modality considered, complementary modalities may be used alone or in conjunction with conventional modalities. Regardless of practice setting, the LVN or RN who wishes to incorporate the use of complementary modalities into his/her nursing practice is accountable and responsible to adhere to the Nursing Practice Act (NPA), Board Rules and Regulations Relating to Nursing Education, Licensure and Practice.

Rules that are particularly relevant to LVNs or RNs who integrate complementary therapies into nursing practice include rule 217.10, *Restrictions to Use of Designations for Licensed Vocational or Registered Nurse,* which requires a nurse who uses the title, either “LVN” or "RN" whether expressed or implied, to comply with

the NPA and Board Rules. In addition, rule 217.11, *Standards of Nursing Practice*, forms the foundation for safe nursing practice and establishes the LVN's or RN's duty to his/her clients. While all standards apply when engaging in the practice of nursing, those standards most applicable to the nurse who engages in complementary modalities include 22 TAC §217.11(1) (A)-(D), (1) (F), (1) (G), (1) (R), and (1) (T). Additional standards may apply depending upon the specific practice situation. In order to show accountability when providing integrated or complementary modalities as nursing interventions, the LVN or RN should be able to articulate and provide evidence of:

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

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

(Board Action 01/2004; Revised 01/2005; 01/2009; 04/2010; 01/2012; 01/2013)
(Reviewed 01/2006; 01/2007; 01/2008; 01/2011; 01/2014)

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 22 TAC §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:

- 22 TAC §217.11(1)(B) "implement measures to promote a safe environment for clients and others;" and
- 22 TAC §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 22 TAC §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 22 TAC §217.11(2); standards specific to RNs may be found in 22 TAC §217.11(3).

Regardless of facility policy or physicians' orders, the nurse always has a duty to maintain the safety of the patient [Reference 22 TAC §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; 01/2013)
(Reviewed - 01/2006; 01/2007; 01/2010; 01/2012; 01/2014)

15.25 Administration of Medication & Treatments by LVNs

The definition of "Vocational Nursing" as amended in the Texas Occupations Code by SB1000 (79th Regular Session, 2005) states:

> 301.002(5): "Vocational Nursing" means a directed scope of nursing practice, including the performance of an act that requires specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of vocational nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Vocational nursing involves:
>
> (A) collecting data and performing focused nursing assessments of the health status of an individual;
> (B) participating in the planning of the nursing care needs of an individual;
> (C) participating in the development and modification of the nursing care plan;
> (D) participating in health teaching and counseling to promote, attain, and maintain the optimum health level of an individual;
> (E) assisting in the evaluation of an individual's response to a nursing intervention and the identification of an individual's needs; and
> (F) engaging in other acts that require education and training, as prescribed by board rules and policies, commensurate with the nurse's experience, continuing education, and demonstrated competency.

Educational preparation leading to initial licensure as a nurse in Texas is described in the *Differentiated Essential Competencies (DECs) Of Graduates of Texas Nursing Programs Evidenced by Knowledge, Clinical Judgements, and Behaviors (Oct 2010)*. This document lists the minimum competency expectations for graduates of Vocational (VN), Diploma/Associate Degree (Diploma/ADN), Baccalaureate Degree (BSN) nursing programs. According to DECs, educational preparation for Vocational Nurses includes the following related to administration of medications:

Knowledge:

- Common medical diagnoses, drug and other therapies and treatments.

Clinical Behavior/Judgments:

- Administer medications and treatments and perform procedures safely, and
- Monitor, document, and report responses to medications, treatments, and procedures and communicate the same to other health care professionals clearly and accurately.
-

The Standards of Nursing Practice (22 TAC §217.11) applicable to LVNs (as well as RNs) includes the following standards that specifically relate to medication administration:

> (1)(C) Know the rationale for and effects of medications and treatments, and shall correctly administer the same;

(1) (D) Accurately and completely report and document:..(iv) administration of medications and treatments;
(1) (N) Clarify any order or treatment regimen that the nurse has reason to believe is inaccurate, non-efficacious or contraindicated by consulting with the appropriate licensed practitioner and notifying the ordering practitioner when the nurse makes the decision not to administer the medication or treatment.

[Note that other standards may apply to administration of medications within a given practice circumstance.]

The Board's position, therefore, is that LVNs are educationally prepared to administer medications and treatments as ordered by a physician, podiatrist, dentist, or any other practitioner legally authorized to prescribe the ordered medication. LVNs may also administer medications and treatments ordered by PAs and APNs as established under Position Statements 15.1 and 15.18, relating to nurses accepting orders from Physician Assistants (PAs) and Advanced Practice Registered Nurses (APRNs), respectively.

As with other practice tasks, the Board cannot provide a list of medications, routes of administration, or other specific information that may be relevant to determining whether or not a task is within the scope of practice for a LVN. What is within the scope of practice for one LVN may not be within the scope of practice for another LVN. The following documents on the Board's web page may be helpful for a LVN concerned about his/her scope of practice for administration of medications or other nursing practices:

- Six-Step Decision-Making Model for Determining Nursing Scope of Practice: http://www.bon.texas.gov/practice/pdfs/dectree.pdf
- Rule 217.11, Standards of Nursing Practice: http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=22&pt=11&ch=217&rl=11
- Lists of Tasks a Nurse Can/Cannot Perform: http://www.bon.texas.gov/practice/faq-nursetasks.html
- Position Statements: http://www.bon.texas.gov/practice/position.html
- Position Statement 15.3, LVNS Engaging in Intravenous Therapy, Venipuncture, or PICC Lines: http://www.bon.texas.gov/practice/position.html#15.3
- Position Statement 15.8, Role of the Nurse in Moderate Sedation: http://www.bon.texas.gov/practice/position.html#15.8
- Position Statement 15.27, The Licensed Vocational Nurse Scope of Practice: http://www.bon.texas.gov/practice/position.html#15.27

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(Reviewed - 01/2007; 01/2008; 01/2010; 01/2014)

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). T he 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 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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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 within 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

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 considerations*.

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.

Texas Administrative Code, 22 TAC §225.

(Adopted: 07/2011)
(Revised: 01/2013)
(Reviewed: 01/2012; 01/2014)

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
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. 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. 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	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 Texas BON approved curriculum includes requirements for didactic instruction and clinical experiences in four contents areas: medical-surgical, maternal/child health, pediatrics, and mental health nursing. Diploma programs are hospital-based, single purpose schools of nursing that consist of two-three years of general education and	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.

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
	skills.	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	Provides independent, direct care	Provides independent, direct care to

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
	individual patients with predictable health care needs under the direction of an appropriate clinical supervisor. 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.	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 unpredictable outcomes in various settings.	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 settings.
Assessment	Assists, contributes and participates in the nursing process by performing a focused assessment on individual patients to collect data and gather	Independently performs an initial or ongoing comprehensive assessment (Extensive data collection). Anticipates changes in	Independently performs an initial or ongoing comprehensive assessment (Extensive data collection). Anticipates changes in patient conditions to

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
	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. The LVN reports and documents the assessment information and changes in patient conditions to an appropriate clinical supervisor.	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. Determines the physical and mental health status, needs, and preferences of culturally diverse patients and their families.	include emergent situations. Reports and documents information and changes in patient conditions to a health care practitioner and or a responsible party. 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. 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. May assign tasks and activities to other nurses. May delegate tasks to UAPs.	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] May assign tasks and activities to other nurses. May delegate tasks to UAPs.

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
Implementation	Provides safe, compassionate and focused nursing care to patients with predictable health care needs. Implements aspects of the nursing care plan, including emergency interventions under the direction of the RN or another appropriate clinical supervisor. 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. 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. 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.

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

Frequently Asked Questions (FAQs) Regarding Position Statements 15.27, The LVN Scope of Practice and 15.28, The RN Scope of Practice

1) I am a LVN and read in Position Statements 15.27 and 15.28 that it is the LVN's responsibility to ensure that he or she has an appropriate Clinical Supervisor. Who can be my clinical supervisor?

Each LVN is required to ensure that he or she has the appropriate supervisor prior to accepting an assignment, a position or employment. The Nursing Practice Act (NPA) Section 301.353 states that "*the practice of vocational nursing must be performed under the supervision of a registered nurse, physician, physician assistant, podiatrist, or dentist*." Rule 217.11, Standards of Nursing Practice, (2) further goes on to require and explain that "*the licensed vocational nurse practice is a directed scope of nursing practice under the supervision of a registered nurse, advanced practice registered nurse, physician's assistant, physician, podiatrist, or dentist. Supervision is the process of directing, guiding, and influencing the outcome of an individual's performance of an activity.*"

LVNs provide valuable and essential nursing care in different types of health care settings. When LVNs work in settings, such as hospitals, long-term care facilities, rehabilitation centers, or skilled nursing facilities, RNs are mostly likely to serve as the LVN's supervisor. LVNs also work in private physician or dentist offices, where physicians, dentists and podiatrists function as the LVN's supervisor. Because LVNs may practice in these various health care settings, the clinical supervisor is a term used to describe the different licensed healthcare providers that are authorized in the NPA to supervise and direct the LVN's practice, i.e.: registered nurse, advanced practice registered nurse, physician, physician assistant, podiatrist or dentist. These types of clinical supervisors oversee the nursing practice of a LVN by monitoring the health status of patients and then directing the LVN's actions to ensure the delivery of safe and effective nursing care.

2) In Position Statements 15.27 and 15.28, I read that LVNs are responsible for providing safe, compassionate and focused nursing care to assigned patients with predictable health care needs. What does predictable mean in this statement?

The LVN in Texas provides nursing care to patients with health care needs that are predictable in nature, under the direction and supervision of a registered nurse, advanced practice registered nurse, physician, physician assistant, podiatrist or dentist. The term predictable describes health conditions that behave or occur in an expected way. A predictable health condition does not mean that the patient is always stable. Instead, predictable health conditions follow an expected range or pattern that allows the LVN with his or her clinical supervisor to anticipate and appropriately plan for the needs of patients.

For example, it is appropriate for a LVN to care for a patient with a diagnosis of asthma. The disease process for asthma, while sometimes acute in nature, is predictable or well-known, and the symptoms can be anticipated. The LVN assists his or her clinical supervisor in the development of a plan, in which the LVN provides care, prevents possible complications and stabilizes the symptoms of asthma. In addition, when complications arise or events occur that are outside the predicted range, the LVN must be able to recognize this change in condition and notify his or her clinical supervisor.

Helpful Resources:

Texas Board of Nursing (2010). *Differentiated essential competencies (DECs) of graduates of Texas Nursing Programs*

Texas Board of Nursing (2011). Position statement 15.27, The LVN Scope of Practice

Texas Board of Nursing (2011). Position statement 15.28, The RN Scope of Practice

Texas Occupations Code, Chapter 301.002(5). *Definition of Vocational Nursing*
Texas Occupations Code, Chapter 301.353. *Supervision of Vocational Nurse*
22 Tex. Admin. Code §217.11 (1). *Standards of Nursing Practice*
22 Tex. Admin. Code §217.11 (2). *Standards Specific to Vocational Nurses*
August 2011

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 within 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)
(Revised: 01/2013)
(Reviewed: 01/2012; 01/2014)

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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. 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. 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	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 Texas BON approved curriculum includes requirements for didactic instruction and clinical experiences in four contents areas: medical-surgical, maternal/child health, pediatrics, and mental health nursing. Diploma programs are hospital-based, single purpose schools of nursing that consist of two-three years of general education and	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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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
	skills.	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	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.

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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
	LVNs should emergent situations occur.		
Setting	Provides focused nursing care to individual patients with predictable health care needs under the direction of an appropriate clinical supervisor. 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.	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 unpredictable outcomes in various settings.	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 settings.

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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
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. 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. 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. 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. May assign specific daily tasks and	Uses clinical reasoning based on established evidence-based policies, procedures and guidelines for decision-making. Analyzes assessment data to identify problems, formulate goals	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

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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
	supervise nursing care to other LVNs or UAPs.	and outcomes, and develops nursing plans of care for patients and their families. May assign tasks and activities to other nurses. May delegate tasks to UAPs.	outcomes, and develop nursing plans of care for patients, families, populations, and communities.[13] 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. Implements aspects of the nursing care plan, including emergency interventions under the direction of the RN or another appropriate clinical supervisor. 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. 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.

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
Evaluation	Participates in evaluating effectiveness of nursing interventions. 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.

Frequently Asked Questions (FAQs) Regarding Position Statements 15.27, The LVN Scope of Practice and 15.28, The RN Scope of Practice

1) I am a LVN and read in Position Statements 15.27 and 15.28 that it is the LVN's responsibility to ensure that he or she has an appropriate Clinical Supervisor. Who can be my clinical supervisor?

Each LVN is required to ensure that he or she has the appropriate supervisor prior to accepting an assignment, a position or employment. The Nursing Practice Act (NPA) Section 301.353 states that "*the practice of vocational nursing must be performed under the supervision of a registered nurse, physician, physician assistant, podiatrist, or dentist*." Rule 217.11, Standards of Nursing Practice, (2) further goes on to require and explain that "*the licensed vocational nurse practice is a directed scope of nursing practice under the supervision of a registered nurse, advanced practice registered nurse, physician's assistant, physician, podiatrist, or dentist. Supervision is the process of directing, guiding, and influencing the outcome of an individual's performance of an activity.*"

LVNs provide valuable and essential nursing care in different types of health care settings. When LVNs work in settings, such as hospitals, long-term care facilities, rehabilitation centers, or skilled nursing facilities, RNs are mostly likely to serve as the LVN's supervisor. LVNs also work in private physician or dentist offices, where physicians, dentists and podiatrists function as the LVN's supervisor. Because LVNs may practice in these various health care settings, the clinical supervisor is a term used to describe the different licensed healthcare providers that are authorized in the NPA to supervise and direct the LVN's practice, i.e.: registered nurse, advanced practice registered nurse, physician, physician assistant, podiatrist or dentist. These types of clinical supervisors oversee the nursing practice of a LVN by monitoring the health status of patients and then directing the LVN's actions to ensure the delivery of safe and effective nursing care.

2) In Position Statements 15.27 and 15.28, I read that LVNs are responsible for providing safe, compassionate and focused nursing care to assigned patients with predictable health care needs. What does predictable mean in this statement?

The LVN in Texas provides nursing care to patients with health care needs that are predictable in nature, under the direction and supervision of a registered nurse, advanced practice registered nurse, physician, physician assistant, podiatrist or dentist. The term predictable describes health conditions that behave or occur in an expected way. A predictable health condition does not mean that the patient is always stable. Instead, predictable health conditions follow an expected range or pattern that allows the LVN with his or her clinical supervisor to anticipate and appropriately plan for the needs of patients.

For example, it is appropriate for a LVN to care for a patient with a diagnosis of asthma. The disease process for asthma, while sometimes acute in nature, is predictable or well-known, and the symptoms can be anticipated. The LVN assists his or her clinical supervisor in the development of a plan, in which the LVN provides care, prevents possible complications and stabilizes the symptoms of asthma. In addition, when complications arise or events occur that are outside the predicted range, the LVN must be able to recognize this change in condition and notify his or her clinical supervisor.

Helpful Resources:

Texas Board of Nursing (2010). *Differentiated essential competencies (DECs) of graduates of Texas Nursing Programs*

Texas Board of Nursing (2011). Position statement 15.27, The LVN Scope of Practice

Texas Board of Nursing (2011). Position statement 15.28, The RN Scope of Practice
Texas Occupations Code, Chapter 301.002(5). *Definition of Vocational Nursing*
Texas Occupations Code, Chapter 301.353. *Supervision of Vocational Nurse*
22 Tex. Admin. Code §217.11 (1). *Standards of Nursing Practice*
22 Tex. Admin. Code §217.11 (2). *Standards Specific to Vocational Nurses*

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15.29 Use of Social Media by Nurses

With the rapidly growing use of social media sites and applications such as Facebook, Twitter, LinkedIn, YouTube, and blogs, professional obligations to patients, peers, and employers may be unclear. While the Board recognizes that the use of social media can be a valuable tool in healthcare, there are potential serious consequences if used inappropriately. Online postings may harm patients if protected health information is disclosed. These types of postings may reflect negatively on individual nurses, the nursing profession, the public's trust of our profession, as well as jeopardize careers.

Both the National Council of State Boards of Nursing (NCSBN) and the American Nurses Association (ANA) endorse each other's guidelines and principles on the use of social media in order for it to be used appropriately and without harm to patients. The benefits of social media are many, and include:

- "Networking and nurturing relationships
- Exchange of knowledge and forum for collegial interchange
- Dissemination and discussion of nursing and health related education, research, best practices
- Educating the public on nursing and health related matters" (ANA, 2012, para. 4).

However, if used indiscriminately, the risks are great, and include:

- "Information taking on a life of its own where inaccuracies become fact
- Patient privacy being breached
- The public's trust of nurses being compromised
- Individual nursing careers being undermined" (ANA, 2012, para. 5).

In a survey by the NCSBN, many of the responding boards reported that they had received complaints about nurses inappropriately using social media sites. Nurses have been disciplined by boards, fired by employers, and criminally charged for the inappropriate or unprofessional use of social media (NCSBN, 2012).
To ensure the mission to protect and promote the welfare of the people of Texas, the Texas Board of Nursing supports both the guidelines and principles of social media use by the NCSBN and ANA. In keeping with the NCSBN guidelines, it is the Board's position that:

- *Nurses must recognize that they have an ethical & legal obligation to maintain patient privacy and confidentiality at all times.*
- *Nurses are strictly prohibited from transmitting by way of any electronic media any patient-related image. In addition, nurses are restricted from transmitting any information that may be reasonably anticipated to violate patient rights to confidentiality or privacy, or otherwise degrade or embarrass the patient.*

- *Nurses do not identify patients by name or post or publish information that may lead to the identification of a patient. Limiting access to postings through privacy settings is not sufficient to ensure privacy.*
- *Nurses do not refer to patients in a disparaging manner, even if the patient is not identified.*
- *Nurses do not take photos or videos of patients on personal devices, including cell phones. Follow employer policies for taking photographs or video of patients for treatment or other legitimate purposes using employer-provided devices.*
- *Nurses maintain professional boundaries in the use of electronic media. Like in-person relationships, the nurse has the obligation to establish, communicate and enforce professional boundaries with patients in the online environment. Use caution when having online social contact with patients or former patients. Online contact with patients or former patients blurs the distinction between a professional and personal relationship. The fact that a patient may initiate contact with the nurse does not permit the nurse to engage in a personal relationship with the patient.*
- *Nurses consult employer policies or supervisor within the organization for guidance regarding work related postings.*
- *Nurses promptly report any identified breach of confidentiality or privacy.*
- *Nurses must be aware of and comply with employer policies regarding use of employer-owned computers, cameras and other electronic devices and use of personal devices in the work place.*
- *Nurses do not make disparaging remarks about employers or co-workers. Do not make threatening, harassing, profane, obscene, sexually explicit, racially derogatory, homophobic or other offensive comments.*
- *Nurses do not post content or otherwise speak on behalf of the employer unless authorized to do so and follow all applicable policies of the employer (NCSBN, 2012).*
- *Nurses update privacy settings on a regular basis.*

The use of social media can be of tremendous benefit to nurses and patients alike. However, nurses must be aware of the potential consequences of disclosing patient-related information via social media. Nurses must always maintain professional standards, boundaries, and compliance with state and federal laws as stated in 22 TAC § 217.11(1)(A). All nurses have an obligation to protect their patient's privacy and confidentiality (as required by 22 TAC § 217.11(1)(E)) which extends to all environments, including the social media environment.

References

American Nurses Association (ANA). (2012) Social networking principles toolkit. Retrieved on 2/21/12 from http://www.nursingworld.org/FunctionalMenuCategories/AboutANA/Social-Media/Social-Networking- Principles-Toolkit.aspx

National Council of State Boards of Nursing (NCSBN). (2012).Social media guidelines. Retrieved on 2/21/12 from https://www.ncsbn.org/2930.htm

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