Agenda Item 7.5
January 2007
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Annual Review of Board Position Statements

Summary of Request:

Board Position Statements are reviewed on an annual basis. This report contains the recommendations of staff with regard to the revision of existing position statements.

Historical Perspective:

Board position statements do not have the force of law, but are a means of providing direction for nurses on issues of concern to the Board relevant to protection of the public. Board position statements are reviewed annually for relevance and accuracy to current practice, the NPA, and Board rules.

Attached are current position statements. Those with no changes are listed as agenda item 7.5.1. Those with recommended changes are in **bold.** Changes to the bolded position statements (agenda item 7.5.2) are explained as follows:

- **15.2 "Role of the Licensed Vocational Nurse in the Pronouncement of Death:**

  Incorporates language about providing direction for post-mortum care. Based on feedback from stakeholders, this appeared to be one of the issues LVNs had the most questions about, especially when encountering a deceased person in a setting where there are no other staff available for consultation.

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

  Correction taking out "psychologists" as they are not listed in the NPA section 301.002. (First paragraph)

- **15.6 Board Rules Associated with Alleged Patient Abandonment**:

  Clarification language change to one sentence. No change in amended date as no significant change to content.

- **15.8 The Role of the Nurse in Moderate Sedation**

  Clarification changes as follows have been suggested by Jim Walker RN CRNA:
  - Page 3, Lines 20-21: add "deep sedation";
  - Page 3, Lines 37, 39-40: correction and clarification language;
  - Page 4, Lines 10-16: Delete definition of "monitored anesthesia care" as only anesthesia providers may engage in this practice;
  - Page 4, Line 39: change "brevitol" to the generic name "methohexital";
  - Page 5, Line 5: clarification from "qualified" to "with current competence";
  - Page 5, Lines 12-26: Delete this section since above recommendation is that nurses who are not anesthesia providers should not engage in this practice

- **15.14 Duty of the LVN and/or RN in Any Practice Setting**

  Expanded explanation of Lunsford vs. BNE so nurses and non-nurses can understand the impact of this landmark case on the nurse's duty to assure patient safety.

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

  Correction of rule reference for 217.11. No change in amended date as minor correction and not change to content.

- **15.20 Registered Nurses in the Management of an Unwitnessed Arrest**

  Correction of rule reference for 217.11. No change in amended date as minor correction and not change to content.

A proposal for a new position statement **15.26 Nursing Work Hours**, is addressed under Agenda Item 7.5.3.

Position Statements for 2007 are as follows:

- 15.1 Nurses Carrying Out Orders From Physician's Assistants
- **15.2 Role of the Licensed Vocational Nurse in the Pronouncement of Death**
- 15.3 LVNs Engaging in Intravenous Therapy, Venipuncture, or PICC Lines
- 15.4 Educational Mobility
- **15.5 Nurses with the Responsibility for Initiating Physician Standing Orders**
- **15.6 Board Rules Associated with Alleged Patient Abandonment**
- 15.7 The Roles of LVNs & RNs in Management and/or Administration of Medications via Epidural or Intrathecal Catheter Routes
- 15.8 Roles of LVNs & RNs in Administration and Management of Moderate Sedation
- 15.9 Performance of Laser Therapy by RNs or LVNs
- 15.10 Continuing Education: Limitations for Expanding Scope of Practice
- 15.11 Delegated Medical Acts
- 15.12 Use of American Psychiatric Associations Diagnoses by LVNs, RNs, or APNs
- 15.13 Roles of LVNs & RNs As School Nurses
- **15.14 Duty of the LVN and/or RN in Any Practice Setting**
- 15.15 Board's Jurisdiction Over Nursing Titles and Practice
- 15.16 Development of Additional Nursing Education Programs
- 15.17 BNE/ Board of Pharmacy (TSBP) Joint Position Statement: Medication Errors
- 15.18 Nurses Carrying Out Orders from Advance Practice Nurses
- **15.19 Nurses Carrying out Orders from Pharmacists for Drug Therapy Management**
- **15.20 Registered Nurses in the Management of an Unwitnessed Arrest**
- 15.21 Application of Safe Harbor Peer Review to LVNs
- 15.22 APNs Providing Medical Aspects of Care of Themselves or Others With Whom There is a Close Personal Relationship
- 15.23 The RNs Use of Complementary Modalities
- 15.24 Nurses Engaging in Reinsertion of Permanently Placed Feeding Tubes
- 15.25 Administration of Medications and Treatments by LVNs
- **15.26 (Proposed) Nursing Work Hours** (discuss under 7.9.3)

Pros and Cons

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

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

Recommendations:

Move to adopt revisions to position statements 15.2, 15.5. 15.6, 15.8, 15.19, and 15.20 with allowance for non-substantive word editing for purposes of clarity as may be deemed necessary by Board counsel.

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 must be on file and available to the nursing staff at the facility, agency, or organization in which it is carried out. 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.

(Board Action, 01/1994; Revised 01/2005)

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 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 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 wit the LVN's experience, continuing education, and demonstrated LVN competencies.

The Board's "LVN Interpretive Guideline Under Rule 217.11"* 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 BNE 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-line 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. The Board's Interpretive Guideline for LVN Scope of Practice under Rule 217.11, 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 §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; Revised 01/2005)

15.4 Educational Mobility

The Board of Nurse Examiners 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 Board of Nurse Examiners 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, Revised 01/2005)

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

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

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

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

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

- Demonstrate knowledge of the anatomy, physiology, and pharmacology of patients receiving medications via the epidural or intrathecal routes;
- Anticipate and recognize potential complications of the analgesia relative to the type of infusion devise and catheter used;
- Recognize emergency situations and institute appropriate nursing interventions to stabilize the client and prevent complications;
- Implement appropriate nursing care of patients to include:

    a) observation and monitoring of sedation levels and other patient parameters;

    b) administration and effectiveness of medication, catheter maintenance and catheter placement checks;

    c) applicable teaching for both patients and their family/significant others related to expected patient outcomes/responses and possible side effects of the medication or treatment; and

    d) knowledge and skill to remove catheters when applicable.

Appropriate nursing policies and procedures that address the education and skills of the RN and nursing care of the patient should be developed to guide the RN in the administration of epidural and/or intrathecal medications. RNs and facilities should consider evidence-based practice

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

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

1) The purpose and goal of treatment;

2) The dosage range of medication to be administered including the maximum dosage;

3) Intravenous access;

4) Treatment of respiratory depression and other side effects including an order for a narcotic antagonist;

5) Options for inadequate pain control; and

6) Physician/CRNA availability and back-up.

(LVN role: BVNE 1994; Revised BNE 01/05) (RN role: BNE 06/1991; Revised 01/2003; Revised 01/2004; Revised 01/2005)

15.9 Performance of Laser Therapy by RNs or LVNs

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

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

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

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

B. Definitions:

(1) Advanced health practitioner--An advanced health practitioner is a physician assistant or an advanced practice nurse.

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

(3) On-site supervision--On-site supervision shall mean continuous supervision in which the individual is in the same building.

(4) Physician--A physician licensed by the Texas Medical Board.

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

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

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

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

(1) The delegate has completed and is able to document clinical and academic

training in the subjects listed in subparagraphs (A) - (G) of this paragraph:

(A) fundamentals of laser operation;

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

(C) significance of specular and diffuse reflections;

(D) non-beam hazards of lasers;

(E) non-ionizing radiation hazards;

(F) laser and laser system classifications; and

(G) control measures.

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

(3) The delegate has received or participated in at least 16 hours of documented initial training in the field of non-ablative devices.

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

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

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

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

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

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

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

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

(Board Action, 05/1992; Revised 11/1997; Revised 01/2003; Revised 04/2004)

15.10 Continuing Education: Limitations for Expanding Scope of Practice

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

Recognition as an advanced practice 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 specialty. To gain recognition as an advanced practice nurse in Texas, the nurse must first be licensed as a RN in Texas or have a valid unencumbered RN license from a compact state. The nurse must then submit an application to the Board for "authorization" in the advanced practice role and specialty.

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

The formal education for entry into nursing practice in Texas is differentiated between vocational and professional (registered) nursing. Formalized education for advanced practice also requires completion of a formal program of education in the advanced practice role and specialty at the master's or 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/recognition. No amount of informal or on-the-job-training can qualify a LVN to perform the same level of care as the RN. Likewise, the RN cannot engage in aspects of care that require independent medical judgement in a given APN role and specialty without the formal education, national certification, and proper authorization in that advanced practice nurse role and specialty.

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

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

(Adopted 01/2005)

15.11 Delegated Medical Acts

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

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

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

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

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

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

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

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

(Board Action 09/1993; Revised. 03/1994; Revised 01/2001; Revised 01/2003; Revised 01/2004; Revised 01/2005)

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

The Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses are multi-disciplinary psychiatric diagnoses used for the purpose of applying objective criteria, establishing a practice framework and communicating findings with other health care professionals. The current version, DSM-IV-TR (Fourth Edition, Text Revision) is scheduled to be replaced by the DSM-V (Fifth Edition) in the2006-2007 time frame.

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 Nurse (APN) role and speciality.

The use of DSM-IV diagnoses by a Registered Nurse recognized by the Board as an Advanced Practice 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 APN’s advanced education, experience, and scope of practice. APNs 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)

15.13 Role Of LVNs and RNs As School Nurses

The BNE recognizes that the youth of Texas are our most valuable natural resource. The BNE 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 BNE recognizes that the school children of Texas have the right to receive safe, appropriate, specialized health services that may be required to assure the child's inclusion in the school environment.

Registered Nurses in the School Setting

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

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 BNE's Standards of Nursing Practice [Rule 217.11], assigns those aspects and activities to the LVN that are within the LVN's educational preparation and demonstrated competency to provide. The RN monitors, coordinates, and evaluates the provision of health services necessary to meet individual student health needs essential in achieving educational objectives.

RN Delegation to Unlicensed Personnel

Due to the growing number of students entering the school system with special health care needs, the BNE 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 BNE's Delegation Rules 224 and 225. School is considered an independent living environment as defined in Rule 225; however, acute or emergency situations in the school setting may be delegated in accordance with Rule 224 as applicable. For example, emergency administration of Epi-pens, Glucagon, and Diastat may be administered by an unlicensed person under §224.6(4) in order to stabilize the child and prevent complications from delaying treatment. The decision to delegate a specific task is always at the discretion of the RN in accordance with §224.8(b)(1)(C) or §225.9(c).

Other Laws Impacting School Health Care

In a school setting, the administration of medication may be assigned to an unlicensed person by the public school official in accordance with the rules of the Texas Education Code. The RN's obligation under §225.13 is to (1) verify the training of the unlicensed person, and (2) verify the competency of the UAP to perform the task. If the RN is unable to assure (1) and (2) have been met, the RN must (3) 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 BNE believes that the RN must establish a 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; Revised 01/2003; Revised 01/2005)

15.15 Board's Jurisdiction Over Nursing Titles And Practice

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

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

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

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

(Board Action 09/1998; Revised. 01/2001; Revised 01/2003; Revised 01/2004; Revised 01/2005)

15.16 Development of Nursing Education Programs

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

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

Guidelines for Establishing a New Vocational or Professional Nursing Education Program:
A proposal to establish a new vocational nursing education program or a new professional nursing education program must follow Rules & Regulations Chapter 214 for Vocational Nursing Education and Chapter 215 for Professional Nursing Education. The institution seeking to establish the new nursing education program must have the appropriate accreditation/approval and the proposal must be prepared by a 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 nursing education program with demographic and community data, employment needs for nurses in the area, evidence of support from stakeholders, and acceptable curricular items as identified in the guidelines.

Guidelines for developing a proposal to establish a new vocational or professional nursing education program are available on the BNE website (http://www.bne.state.tx.us) under Nursing Education Information.

Process for Proposal Approval/Denial:
The process for proposal approval/denial may take up to one year after the initial contact is made with the BNE. A proposal may require several revisions before it is acceptable to be presented to the Board at a regularly scheduled Board meeting. After the proposal is determined to be ready to be presented to the Board, a preliminary survey visit will be conducted by Board staff. A public hearing will be held at the Board meeting prior to the Board's discussion and 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. An initial approval fee shall be assessed following approval of the proposal [Rule 223.1(a)(9)].

New Professional Nursing Education Programs:
Analysis of data collected between 1988-1999 revealed that the professional nursing education programs which were opened during that time had been associated with redistribution of students and faculty among nursing education programs and competition for clinical affiliate placements, all of which may have compromised the outcomes of established programs.

Six years after this analysis, these issues are still pertinent. An adequate number of experienced qualified faculty candidates is limited across the state. Faculty with no teaching experience require extensive mentoring by seasoned faculty members. This consumption of time and energy must be considered in the allocation of workload. Full-time faculty members also need scheduled time for faculty organization meetings, curriculum and program planning, evaluation and revision.

(Board Action 07/2000; Revised 01/2004; Revised 01/2005)

15.17 Board of Nurse Examiners/board of Pharmacy, Joint Position Statement, Medication Error

Medication errors occur when a drug has been inappropriately prescribed, dispensed, or administered. Medication errors are a multifaceted problem which may occur in any health care setting. Consistent with their common mission to promote and protect the welfare of the people of Texas, the Board of Nurse Examiners 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.

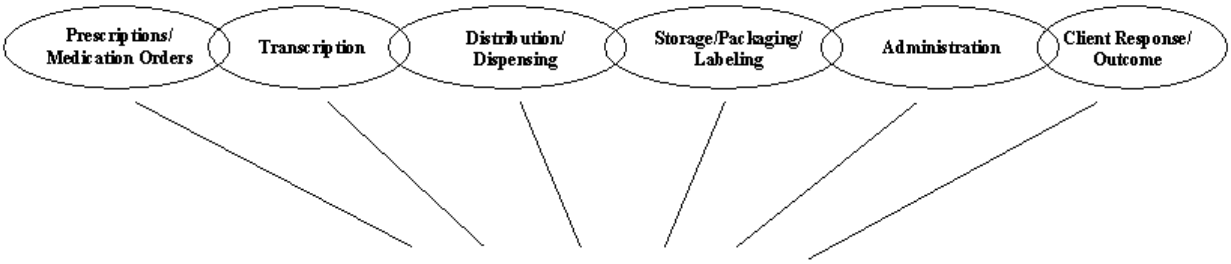
Leape, L. L. (1994). Error in medicine. Journal of the American Medical Association, 272(23), 1851-1857.

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

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

(Board Action 10/2000)

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 NURSES

Advanced practice nurses (APNs) are registered nurses who hold authorization from the board to practice as advanced practice 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 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 nurse acts independently and/or in collaboration with other health care professionals in the delivery of health care services. Advanced practice nurses utilize mechanisms, including Protocols 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 or other written authorization may vary in complexity based on the educational preparation and advanced practice experience of the individual advanced practice nurse. Protocols or other written authorization are not required to describe the exact steps that an advanced practice nurse must take with respect to each specific condition, disease, or symptom. Protocols or other written authorization are not required for nursing aspects of care.

The Board recognizes that in many settings, nurses and advanced practice nurses work together in a collegial relationship. A nurse may carry out an advanced practice 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 nurse is providing care. The order is not required to be countersigned by the physician. The advanced practice nurse must function within the accepted scope of practice of the role and specialty in which he/she has been authorized 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 nurse or the physician as appropriate. The Nurse carrying out an order from an advanced practice 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)

15.21 [Deleted 01/2005]

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

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

(Board Action 10/2003)

15.23 The RN's Use of Complementary Modalities

Nursing is a dynamic profession. The scope of practice for one RN may differ from the scope of practice for another RN; therefore, it is impractical to create an exhaustive listing of all tasks that may or may not be performed by a registered nurse in any setting. According to the Nursing Practice Act (NPA) for the State of Texas, Section 301.002(2), "professional nursing" is defined, in part, as focused on the maintenance of health or prevention of illness through nursing practices performed for compensation that may include assessment, intervention, evaluation, rehabilitation, and/or the care, counsel, and health education of a person who is ill, injured, infirm, or experiencing a change in normal health processes. These nursing actions may be independent or collaborative. 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.

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

Rules that are particularly relevant to RNs who integrate complementary therapies into professional nursing practice include rule 217.10, *Restrictions to Use of Designations for Licensed Vocational or Registered Nurse,* which requires a registered nurse who uses the title "RN" (either 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 RN's duty to his/her clients. While all standards apply when engaging in the practice of professional registered nursing, those standards most applicable to the RN who engages in complementary modalities include §217.11(1), standards (A)-(D), (F), (G), (R), and (T), and §217.11(3)(A). 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 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, 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 RN to properly perform the chosen intervention(s) should be maintained by the 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 a RN holds himself/herself out as a registered or certified practitioner of such a therapy. "Registered" or "certified" titles imply a degree of mastery above those basic skills acquired through a pre-licensure nursing program. The 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 BNE web page) may be a useful tool for the RN who is uncertain whether a given modality is within his/her scope of practice. The professional registered nurse who wishes to integrate complementary modalities when engaging in the practice of nursing should be familiar with not only the NPA and BNE rules, but also any prevailing standards published by national associations, credentialing bodies, and professional nursing organizations related to the RN's area of practice.

(Board Action 01/2004; Revised 01/2005)

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 BNE does not define nor set qualifications for competency validation courses; however, inclusion of the following factors is encouraged:

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

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

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

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

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

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

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

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

- §217.11(1)(B) "implement measures to promote a safe environment for clients and others;" and

- §217.11(1)(T) "accept only those assignments that take into consideration client safety and that are commensurate with the nurse's educational preparation, experience, knowledge, and physical and emotional ability."

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

- (1)(D) “Accurately and completely report and document: (i) ..client status....(ii) nursing care rendered...(iii) physician, dentist or podiatrist orders...(iv) administration of medications and treatments....(v) client response(s)...,”

- (1)(G) “Obtain instruction and supervision as necessary when implementing nursing procedures or practices,”

- (1)(H) “Make a reasonable effort to obtain orientation/training for competency when encountering new equipment and technology or unfamiliar care situations,”

- (1)R) “Be responsible for one’s own continuing competence in nursing practice and individual professional growth.”

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

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

(Adopted 01/2005)

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 Entry Level Competencies (DELC) of Graduates of Texas Nursing Programs (Sept 2002).* This document lists the minimum competency expectations for graduates of Vocational (VN), Diploma/Associate Degree (DIP/ADN), and Baccalaureate (BSN) nursing programs. According to DELC, educational preparation for Vocational Nurses includes the following related to administration of medications:

> ***Knowledge:***
> - Properties, effects, and basic principles underlying the use and administration of pharmacotherapeutic agents.
>
> ***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 (§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 Nurses (APNs), 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:

- Interpretive Guideline for LVN Scope of Practice: ftp://www.bne.state.tx.us/lvn-guide.pdf
- Six-Step Decision-Making Model for Determining Nursing Scope of Practice: ftp://www.bne.state.tx.us/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.bne.state.tx.us/faq-practice.htm#tasks
- Position Statements: http://www.bne.state.tx.us/position.htm
    - Position Statement 15.3, LVNS Engaging in Intravenous Therapy, Venipuncture, or PICC Lines: http://www.bne.state.tx.us/position.htm#15.3
    - Position Statement 15.8, Role of the Nurse in Moderate Sedation: http://www.bne.state.tx.us/position.htm#15.8

(Adopted 10/2005)