Agenda Item 7.5
January 2007
Prepared by C. Marshall

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.

15.2 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 BNE 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 the *Interpretive Guideline for LVN Scope of Practice under Rule 217.11* 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).

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, 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 post-mortum care and procedures, including appropriate measures that can be completed while waiting for a call-back from the attending physician.

The BNE 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: Texas Statutes, Health and Safety Code; http://tlo2.tlc.state.tx.us/statutes/statutes.html

(BVNE Statement adopted June 1999; revised BNE statement January 2006; rev. 1/07)

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, ~~or psychologist~~. 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 §§193.1-193.11) 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:

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

(D) state specific requirements which are to be followed by persons acting under same in performing particular functions;

(E) specify any experience, training, and/or education requirements for those persons who shall perform such orders;

(F) establish a method for initial and continuing evaluation of the competence of those authorized to perform same;

(G) provide for a method of maintaining a written record of those persons authorized to perform same;

(H) specify the scope of supervision required for performance of same, for example, immediate supervision of a physician;

(I) set forth any specialized circumstances under which a person performing same is to immediately communicate with the patient's physician concerning the patient's condition;

(J) state limitations on setting, if any, in which the plan is to be performed;

(K) specify patient record-keeping requirements which shall, at a minimum, provide for accurate and detailed information regarding each patient visit; personnel involved in treatment and evaluation on each visit; drugs, or medications administered, prescribed or provided; and such other information which is routinely noted on patient charts and files by physicians in their offices; and

(L) provide for a method of periodic review, which shall be at least annually, of such plan including the effective date of initiation and the date of termination of the plan after which date the physician shall issue a new plan.

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

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

***(10) Protocols** - Delegated written authorization to initiate medical aspects of patient care including authorizing a physician assistant or advanced practice nurse to carry out or sign prescription drug orders pursuant to the Medical Practice Act, Texas Occupations Code Annotated, §§157.051-157.060 and §193.6 of this title (relating to the Delegation of the Carrying Out or Signing of Prescription Drug Orders to Physician Assistants and Advanced Practice Nurses). The protocols*

must be agreed upon and signed by the physician, the physician assistant and/or advanced practice nurse, reviewed and signed at least annually, maintained on site, and must contain a list of the types or categories of dangerous drugs 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 that may not be prescribed. Protocols shall be defined to promote the exercise of professional judgment by the advanced practice nurse and physician assistant commensurate with their education and experience. The protocols used by a reasonable and prudent physician exercising sound medical judgment need not describe the exact steps that an advanced practice nurse or a physician assistant must take with respect to each specific condition, disease, or symptom.

By definition, both vocational and professional nursing "excludes acts of medical diagnosis or prescription of therapeutic or corrective measures" (Tex. Occ. Code Ann. §301.002(2) and (5)). Based on the above definitions in the TMB rules, RNs who do not have advanced practice authorization from the BNE 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 or 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 7/1988, Revised 1/1992, Revised 7/2001; Revised 01/2005)

15.6 Board Rules Associated With Alleged Patient "Abandonment"

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

Nurse's Duty To A Patient

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

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

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

Employment Issues

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

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

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

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

Licensure Issues

As previously noted, the rules most frequently applied to nursing practice concerns are Rule 217.11 *Standards of Nursing Practice,* and Rule 217.12 *Unprofessional Conduct.* In relation to questions of "abandonment," standard 217.11(1)(I) holds the nurse responsible to "notify the appropriate supervisor when leaving a nursing assignment." This standard should not be misinterpreted to mean that the nurse may simply notify the supervisor that he/she is leaving the premises, regardless of whether or not another qualified licensed nurse is available to assume care of the nurse's patients. Specific procedures to follow in a given circumstance (nurse becomes ill, family emergency, etc.) should be delineated in facility policies (~~over which the Board has no jurisdiction~~).which the Board does not regulate).

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

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

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

Board Disciplinary Actions

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

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

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

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

Safe Harbor Peer Review:

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

(1) It is a means by which a nurse can request a peer review committee determination of a specific situation in relation to the nurse's duty to a patient; and

(2) It affords the nurse immunity from Board action against the nurse's license if the nurse invokes Safe Harbor in accordance with Rule 217.20. For the nurse to activate this

immunity status, the nurse must notify the assigning supervisor at the time the assignment request is made, and the nurse must submit the required information in writing as specified in Rule 217.20(c)(3)(A-D) or on the Board's Safe Harbor form (sections 2.1-2.8).

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

Links to Related Articles (all of the following are located on the Board's web page):

Safe Harbor Form http://www.bne.state.tx.us/practice/Safe.htm.

FAQ on Overtime/Hours of Work
http://www.bne.state.tx.us/practice/faq-practice.html#overtime

FAQ on Peer Review ftp://www.bne.state.tx.us/PeerReview-FAQs.pdf
"TYPE=PICT;ALT=AdobeAcrobatPDF"

FAQ on Staffing Ratios http://www.bne.state.tx.us/practice/faq-practice.html#Staffing

FAQ on Floating ftp://www.bne.state.tx.us/floating.pdf
"TYPE=PICT;ALT=AdobeAcrobatPDF"

RN Update, July 2002: Overview of TDH Staffing Plans and CNO Requirement Rules

(Adopted 01/2005)

15.8 The 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 authorization to practice as an advanced practice nurse in the role and specialty of nurse anesthetist (CRNA) functioning within his/her authorized scope of practice, or to

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

Role of the LVN:

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

In line with Rule 217.11 *Standards of Nursing Practice, t*he Board's *Interpretive Guideline for LVN Scope of Practice under Rule 217.11,* 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 "maintain a safe environment for clients and others." This standard establishes the nurse's duty to the patient/client, which **supercedes any physician order or any facility policy.** This "duty" to the

patient requires the nurse to use good professional judgement 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 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 BNE'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 situation 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 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:

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

- 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 Nurses Administering Propofol, Ketamine, or Other Anesthetic Agents to Non-Intubated Patients

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

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.

~~The Board defines "monitored anesthesia care" in Rule 221.1(9) as:~~

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

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 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 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, ~~brevitol~~ methohexital, ketamine, and etomidate) is outside the scope of practice for RNs and non-CRNA advanced practice nurses *except* in the following situations:

- when assisting in the physical presence of a CRNA or anesthesiologist
- 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 ~~qualified~~ with current competence in advanced airway management, including emergency intubation procedures

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 absence of an anesthesia provider or practitioner skilled in advanced airway management/intubation, if the RN or non-CRNA advanced practice nurse chooses to administer anesthetic agents (e.g. propofol, brevitol methohexital, ketamine, etomidate, etc) as ordered for purposes of moderate sedation to non-intubated patients, he/she must have demonstrated the following competencies:~~

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

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 supercedes 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/]. 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.

(Approved by the Board of Nurse Examiners 1/1992; Revised 1/03, Revised 1/04, Revised 1/06 Revised 1/07)

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 Nurse Examiners (BNE), through the Nursing Practice Act and Board Rules, emphasizes the nurse's responsibility and duty to the client/patient to provide safe, effective nursing care.

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

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

- In *Lunsford v. Board of Nurse Examiners*, 648 S.W. 2d 391 (Tex. App.--Austin, 1983), the court in affirming the disciplinary action of the Board, held that a nurse has a duty to the patient which cannot be superseded by hospital policy or physician's order.
    - This landmark case involved a gentleman who arrived to a rural hospital via private vehicle. The gentleman was experiencing severe chest pain, nausea, and sweating—all hallmark symptoms of myocardial infarction (heart attack). Nurse Lunsford was summoned to the ER waiting room by this gentleman's friend. Upon seeing the acute distress the man was experiencing and hearing his symptoms, she instructed his friend to drive the man to the nearest facility equipped to handle heart attack victims. This facility was 24 miles away. The man succumbed to the heart attack 5 miles away from the small hospital.
    - When the Board sought to sanction the nurse's license, the nurse maintained that the ER physician (who never saw the man) told her the man needed to be transported to the larger facility. The facility policy was also to transfer patients experiencing heart attacks (via ambulance) to the larger facility that was equipped to provide the broad range of therapies that might be needed..
    - The court sided with the BNE and agreed that the nurse had the knowledge, skills and abilities to recognize the life-threatening nature of the man's symptoms. Because of this knowledge, the court maintained that it was the nurse's duty to act in the best interest of the client by assessing the man, taking measures to stabilize him and to prevent complications, and communicating his condition to other staff (such as the MD) in order to enlist appropriate medical care.

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

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

- RNs with advanced practice authorization from the Board must comply with the same rules applicable to other RNs. In addition, rules specific to advanced practice nursing Chapters 221 & 222, as well as laws applicable to the APN's practice setting that are outside of the BNE'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; rev. 1/07)

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 elaborate 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 (DTM) 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(19)~~ §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 1/2002; Revised 01/2005)

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

The Board of Nurse Examiners has approved this position statement 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 [BNE 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 BNE 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 BNE 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 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 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 nurse not to initiate CPR. However, evaluation of the prudence of such a decision would occur on a case-by-case basis by the BNE.

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 boards of nursing establish legal documentation standards, [BNE Standards of Professional Nursing Practice, 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 BNE. 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 she/he 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 BNE 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 Nurse Examiners on October 24, 2002; Revised 01/2005.)