Agenda Item 7.2.2
Board Meeting: January 2012
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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 editorial changes 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 Nursing Practice Act and Board rules.

Summary of Editorial Changes

Several of the position statements referenced the *Interpretive Guideline for LVN Scope of Practice Under Rule 217.11* which was retired and replaced in July 2011 with *Position Statement 15.27, The LVN Scope of Practice*. In some position statements the editorial changes consist of word selection or additional explanation to enhance clarity. The Position Statements reflecting the retirement of the *Interpretive Guideline for LVN Scope of Practice Under Rule 217.11* with a change to reference *Position Statement 15.27, The LVN Scope of Practice* are 15.2, 15.3, 15.8, 15.23, and 15.25. The suggested changes to Position Statement 15.1 are to decrease confusion for nurses and to align with the requirements for Physician Assistants in the Texas Medical Board Rules. The one word change in Position Statement 15.18 aligns with Board Rule 221.4, *Advanced Practice Registered Nurse Licensure Requirements*. The suggested changes to Position Statement 15.20 align with the licensure level reflected, and associated expectations, and add consistent use of a term/abbreviation.

Current Position Statements with Changes

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
15.8 Roles of the Nurse in Moderate Sedation
15.18 Nurses Carrying out orders from Advance Practice Registered Nurses
15.20 Registered Nurses in the Management of an Unwitnessed Arrest in a Resident in a Long Term Care Facility
15.23 The Use of Complementary Modalities by the LVN or RN
15.25 Administration of Medication & Treatments by LVNs

Pros and Cons

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

Cons:
None noted.

Recommendations:

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

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~~ should be made available as necessary to verify authority to provide medical aspects of care. If the tasks or functions ordered fall outside the scope of the protocol, the PA must consult with the physician to obtain a verbal order before the nurse may carry out the order.

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

(Board Action, 01/1994; Revised 01/2005, 01/2006, 01/2010, 01/2012)
(Reviewed - 01/2007, 01/2008, 01/2009, 1/2011)

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

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

Presumptive Signs of Death

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

Conclusive Sign of Death

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

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 postmortem care and procedures, including appropriate measures that can be completed while waiting for a return call from the attending physician.

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

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

(BVNE Statement adopted 06/1999; revised BON statement 01/2006; Revised 01/2007; 1/2008; 1/2009; 1/2011; 01/2012)
(Reviewed - 01/2010)

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

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

Applicable Nursing Standards

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

- 217.11(1)(B) implement measures to promote a safe environment for clients and others, and
- 217.11(1)(T) accept only those 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 with the LVN's experience, continuing education, and demonstrated LVN competencies.

~~The Board's "LVN Interpretive Guideline Under Rule 217.11"~~ *Position Statement 15.27, The Licensed Vocational Nurse Scope of Practice* provides additional clarification of the Standards Rule as it applies to LVN Scope of Practice. Instruction and skill evaluation relating to LVNs performing insertion of peripheral IV catheters and/or administering IV fluids and medications as prescribed by an authorized practitioner may allow a LVN to expand his/her scope of practice to include intravenous therapy.

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

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

Insertion of PICC Lines

The Board has further determined that the one-year vocational nursing program does not provide the Licensed Vocational Nurse (LVN) with the educational foundation to assure client safety in insertion of Peripherally Inserted Central Catheters (PICC lines) inclusive of vein selection, insertion/advancement of the catheter, determining placement, and monitoring of the client for untoward reactions in relation to catheter insertion. ~~The Board's Interpretive Guideline for LVN Scope of Practice under Rule 217.11~~ *Position Statement 15.27, The Licensed Vocational Nurse Scope of Practice*, further maintains that continuing education that falls short of achieving licensure as a registered nurse would be insufficient to assure vocational nurse competency and patient safety with regard to insertion of PICC lines. Therefore, it is the Board's position that insertion of PICC lines is beyond the scope of practice for LVNs.

Administration of IV Fluids and Medications

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

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

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

15.8 Role of the Nurse in Moderate Sedation
Note: *This position statement is* ***not*** *intended to apply to either:*

(1) The practice of the registered nurse who holds authorization to practice as an advanced practice registered 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*, ~~the Board's *Interpretive Guideline for LVN Scope of Practice under Rule 217.11*~~*Board Position Statement 15.27, The Licensed Vocational Nurse Scope of Practice*, and Board Position Statement 15.10 *Continuing Education: Limitations for Expanding Scope of Nursing Practice,* the Board also maintains that continuing education that falls short of achieving licensure as a registered nurse would be insufficient to assure vocational nurse competency and patient safety with regard to both medication administration and patient monitoring associated with moderate sedation.

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

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

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

All licensed nurses practicing in Texas are required to "know and comply" with the Nursing Practice Act (NPA) and Board Rules. Rule 217.11(1)(B) requires the nurse to "promote a safe environment for clients and others." This standard establishes the nurse's duty to the patient/client, which **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 BON's "Six Step Decision Making Model for Determining Nursing Scope of Practice."

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

- Performance of a pre-sedation health assessment by the individual ordering the sedation and the nurse administering the sedation
- Guidelines for patient monitoring, drug administration, and a plan for dealing with potential complications or emergency 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 registered nurse use caution, however, in deciding whether or not s/he has the competency to administer the specific pharmacologic agents ordered by the physician. What is within the scope of practice for one RN is not necessarily within the scope of practice for another RN. (See references to §217.11 & Six-Step Decision-Making Model above). With regard to this issue, the Board recommends the RN also take into consideration:

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

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

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

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

Moderate Sedation Versus Deep Sedation Anesthesia

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

In a state of deep sedation, the patient's level of consciousness is depressed, and the patient is likely to require assistance to maintain a patent airway. Deep sedation occurring in a patient who is not appropriately monitored and/or who does not have appropriate airway support may result in a life-threatening emergency for the patient. This is not consistent with the concept of moderate sedation as defined in this position statement or the professional literature and is 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 patient receiving anesthetic agents is at increased risk for loss of consciousness and/or normal protective reflexes, regardless of who is administering this medication. Again, this is not consistent with the concept of moderate sedation outlined in the professional literature.

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

ongoing practice and experience are adequate, fatal complications may result."[1] It is also important to note that no continuing education program, including ACLS programs, will ensure that the RN or non-CRNA advanced practice registered nurse has the knowledge, skills and abilities to rescue a patient from deep sedation or general anesthesia. Furthermore, it is the joint position of the AANA and ASA that, "because sedation is a continuum, it is not always possible to predict how an individual patient will respond." These organizations state that anesthetic agents, including induction agents, should be administered only by qualified anesthesia providers who are trained in the administration of general anesthesia.

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

- when assisting in the physical presence of a CRNA or anesthesiologist
- when administering these medications as part of a clinical experience within an advanced educational program of study that prepares the individual for licensure as a nurse anesthetist (i.e. when functioning as a student nurse anesthetist)
- when administering these medications to patients who are intubated and mechanically ventilated in critical care settings
- when assisting an individual with current competence in advanced airway management, including emergency intubation procedures

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.

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/acutecare/articles/20051103.asp]. This article highlights patient safety concerns related to administration of agents, such as Propofol, to non-intubated patients. The concerns mirror-image those of the Board as noted in this position statement.

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

[2]American Association of Nurse Anesthetists and American Society of Anesthesiologists. Joint Position Statement, May, 2004, "AANA–ASA Joint Statement Regarding Propofol Administration" http://www.aana.com/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=764

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

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

15.18 Nurses Carrying out Orders from Advanced Practice Registered Nurses

Advanced practice registered nurses (APRNs) are registered nurses who hold ~~authorization~~ licensure from the board to practice as advanced practice registered nurses based on completion of an advanced educational program acceptable to the Board. The term includes a nurse practitioner, nurse-midwife, nurse anesthetist, and a clinical nurse specialist. The advanced practice registered nurse is prepared to practice in an expanded role to provide health care to individuals, families, and/or groups in a variety of settings, including, but not limited to, homes, hospitals, institutions, offices, industry, schools, community agencies, public and private clinics, and private practice. The advanced practice registered nurse acts independently and/or in collaboration with other health care professionals in the delivery of health care services. Advanced practice registered 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 registered nurse. Protocols or other written authorization are not required to describe the exact steps that an advanced practice registered nurse must take with respect to each specific condition, disease, or symptom. Protocols or other written authorization are not required for nursing aspects of care.

The Board recognizes that in many settings, nurses and advanced practice registered nurses work together in a collegial relationship. A nurse may carry out an advanced practice registered nurse's order in the management of a patient, including, but not limited to, the administration of treatments, orders for laboratory or diagnostic testing, or medication orders. A physician is not required to be physically present at the location where the advanced practice registered nurse is providing care. The order is not required to be countersigned by the physician. The advanced practice registered nurse must function within the accepted scope of practice of the role and 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 registered nurse or the physician as appropriate. The Nurse carrying out an order from an advanced practice registered nurse is responsible and accountable for his/her actions just as he/she would be with any physician order.

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

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

The Board of Nursing (BON) 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 [BON Standards of Nursing Practice, 22 TAC § 217.11(3)]. This position statement is intended to provide guidance, for nurses, in the management of an unwitnessed resident arrest without a DNR order in a long term care (LTC) setting. The position also addresses the related issues of:

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

These related issues are addressed in this position statement because the BON is often required to investigate cases of death where it appears there is a lack of clarity about a nurse's obligation when there is no DNR order.

The BON will evaluate cases involving the failure of a RN to initiate CPR in the absence of a DNR based on the following premise:

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

However, there may be instances when LTC residents without a DNR order experience an unwitnessed arrest, and it is clear according to the comprehensive nursing assessment that CPR intervention would be a futile and inappropriate intervention given the condition of the resident.

In the case of an unwitnessed resident arrest without DNR orders, determination of the appropriateness of CPR initiation should be undertaken by the registered nurse through a resident assessment, and interventions appropriate to the findings initiated.

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

Presumptive Signs of Death

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

Conclusive Sign of Death

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

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

Documentation

After assessment of the resident is completed and appropriate interventions are taken, documentation of the circumstances and the assessment of the resident in the resident record are a requirement. The rules of the BON ~~board of nursing~~ establish legal documentation standards, [BON Standards of 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 BON. Furthermore, lack of documentation places the nurse at a disadvantage should the nurse be required to explain the circumstances of the resident's death. Nurses should be aware that actions documented at the time of death provide a much more credible defense than needing to prove actions not appropriately documented were actually taken.

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

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

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

15.23 The Use of Complementary Modalities by the LVN or RN

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

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

Differentiating the Roles of the LVN and RN

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

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

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

Complementary Modalities

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

Rules that are particularly relevant to LVNs or RNs who integrate complementary therapies into nursing practice include rule 217.10, *Restrictions to Use of Designations for Licensed Vocational or Registered Nurse,* which requires a nurse who uses the title, either “LVN” or "RN" whether expressed or implied, to comply with the NPA and Board Rules. In addition, rule 217.11, *Standards of Nursing Practice*, forms the foundation for safe nursing practice and establishes the LVN’s or RN’s duty to his/her clients. While all standards apply when engaging in the practice of nursing, those standards most applicable to the nurse who engages in complementary modalities include §217.11(1) (A)-(D), (F), (G), (R), and (T). Additional standards may apply depending upon the specific practice situation. In order to show accountability when providing integrated or complementary modalities as nursing interventions, the LVN or RN should be able to articulate and provide evidence of:

1. Educational activities used to gain or maintain the knowledge and skills needed for the safe and effective use of such modalities;
2. Knowledge of the anticipated effects of the complementary therapy and its interactions with other modalities, including its physiological and/or emotional/spiritual impact;
3. Selection of appropriate interventions, whether complementary, conventional, or in combination, to meet the client’s needs. The interventions and rationale for selection should

be documented in the client's nursing care plan. The demonstrated ability of the LVN or RN to properly perform the chosen intervention(s) should be maintained by the LVN or RN and/or his/her employer;

4. Instruction/education provided regarding the purpose of the selected intervention, e.g., how it is performed, and its potential outcomes;

5. Collaboration with other health care professionals and applicable referrals when necessary;

6. Documentation of interventions and client responses in a client's record;

7. Development and/or maintenance of policies and procedures relative to complementary modalities when used in organized health care settings;

8. Abstinence from making unsubstantiated claims about the therapy used; and

9. Acknowledgment that, as with conventional modalities, each person's response to the therapy will be unique.

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

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

15.25 Administration of Medication & Treatments by LVNs

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

301.002(5): "Vocational Nursing" means a directed scope of nursing practice, including the performance of an act that requires specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of vocational nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Vocational nursing involves:

> (A) collecting data and performing focused nursing assessments of the health status of an individual;
>
> (B) participating in the planning of the nursing care needs of an individual;
>
> (C) participating in the development and modification of the nursing care plan;
>
> (D) participating in health teaching and counseling to promote, attain, and maintain the optimum health level of an individual;
>
> (E) assisting in the evaluation of an individual's response to a nursing intervention and the identification of an individual's needs; and
>
> (F) engaging in other acts that require education and training, as prescribed by board rules and policies, commensurate with the nurse's experience, continuing education, and demonstrated competency.

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

Knowledge:

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

Clinical Behavior/Judgments:

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

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

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

The Board's position, therefore, is that LVNs are educationally prepared to administer medications and treatments as ordered by a physician, podiatrist, dentist, or any other practitioner legally

authorized to prescribe the ordered medication. LVNs may also administer medications and treatments ordered by PAs and APNs as established under Position Statements 15.1 and 15.18, relating to nurses accepting orders from Physician Assistants (PAs) and Advanced Practice Registered Nurses (APRNs), respectively.

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

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

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