

**Review and Consideration of Position Statements:  
Current Position Statements with Changes**

**Summary of Request**

Board Position Statements are reviewed on an annual basis. Board staff tracks national practice trends, updated practice guidelines and evidence throughout the year relevant to the Board Position Statements. This report contains the existing position statements with proposed changes for the Board's consideration.

**Current Position Statements with Changes**

- 15.1 Nurses Carrying out Orders from Physician Assistants
- 15.6 Board Rules Associated With Alleged Patient "Abandonment"
- 15.8 Role of the Nurse in 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 Association Diagnoses by LVNS, RNs, or APRNs
- 15.19 Nurses Carrying out Orders from Pharmacists for Drug Therapy Management
- 15.29 [Professional Boundaries including](#) Use of Social Media by Nurses

**Historical Perspective**

Position Statement 15.1, *Nurses Carrying out Orders from Physician Assistants*, received comments in December of 2015. Some of those comments were addressed and resulted in adopted changes to the position statement last January. The comments were further reviewed and Position Statement 15.1, related to physician assistants, and Position Statement 15.18, related to advanced practice registered nurses, were compared and further revisions are proposed to this position statement to align the two position statements.

Position Statement 15.6, *Board Rules Associated With Alleged Patient "Abandonment,"* has a proposed change to list the website of the (OSHA) for the ease of the person reading the position statement in locating the referenced website.

Position Statement 15.8, *Role of the Nurse in Moderate Sedation*, has proposed updates to the reference article and a working link to a reference document both near the end of the position statement.

Position Statement 15.9, *Performance of Laser Therapy by RNs or LVNs*, contains editorial changes to the list for flow and additional references at the end of the position statement (the additional references may assist nurses in locating laws and rules that may apply to their practice with lasers and are most specific to laws and rules related to laser hair removal and laser cosmetic procedures).

Position Statement 15.10, *Continuing Education: Limitations for Expanding Scope of Practice*, contains proposed editorial changes to reflect that there is licensure at each level of nursing practice: LVN, RN, and APRN.

Position Statement 15.11, *Delegated Medical Acts*, has two proposed editorial changes. The first is replacing the word “procedure” with “delegated medical act” in alignment with the title of the position statement and the second simply reorders the cited references in alphabetical order.

Position Statement 15.12, *Use of American Psychiatric Association Diagnoses by LVNS, RNs, or APRNs*, contains three proposed editorial changes for the purposes of clarity.

Position Statement 15.16, *Development of Nursing Education Programs*, contains proposed changes to reflect the current process for education program proposals.

Position Statement 15.17, *Texas Board of Nursing/Board of Pharmacy, Joint Position Statement, Medication Errors*, contains two editorial changes to reflect the timeframe, and more specifically the year, of the publication cited in the third paragraph.

Position Statement 15.19, *Nurses Carrying out Orders from Pharmacists for Drug Therapy Management*, contains editorial reference changes.

Position Statement 15.29 *Use of Social Media by Nurses*, has new content related to professional boundaries as well as a significant rewording of the section related to social media with additional references added. This significant change also is the rationale for a suggested title change to the position statement: *Professional Boundaries including Use of Social Media by Nurses*. By adding professional boundaries references and context to the position statement, this should broaden the guidance and applicability of the position statement for nurses and other stakeholders.

## **Pros and Cons**

### **Pros:**

Adoption of the position statements with changes will provide clear guidance to nurses and nursing stakeholders based on current practice standards.

### **Cons:**

None noted.

### **Staff Recommendation:**

Move to adopt the position statements with changes 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 Assistants

The purpose of this position statement is to provide guidance to nurses with regard to carrying out orders from Physician Assistants (PAs).

The Nursing Practice Act (NPA) includes the "administration of medications or treatments ordered by a physician, podiatrist or dentist" as part of the practice of nursing.<sup>1</sup> There are no other healthcare professionals listed thus leading to questions regarding nurses carrying out orders from other licensed healthcare providers. Although PAs are not included in the NPA, the Board recognizes that nurses work collaboratively with PAs to provide patient care in various practice settings.

The PA is licensed and regulated by the [Texas](#) Physician Assistant Board.<sup>2</sup> PAs may ~~order~~ [provide](#) medical aspects of care, [including ordering or prescribing medications and treatments](#), as delegated by a physician consistent with laws, rules and regulations applicable to the PAs' practice including those of the Texas Medical Board (TMB) Chapter 193.<sup>3</sup> [A physician is not required to be present at all times at the location where the PA is providing care and orders are not required to be countersigned by the physician. A nurse may carry out these orders.](#) 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.<sup>4</sup> A list of physician assistants credentialed by the medical staff and policies directing their practice should be available to the nursing staff.

(Board Action: 01/1994; Revised: 01/2005; 01/2006; 01/2010; 01/2012; 01/2016; [01/2017](#))  
(Reviewed: 01/2007; 01/2008; 01/2009; 1/2011; 01/2013; 01/2014; 01/2015)

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<sup>1</sup> TOC§301.002(2)

<sup>2</sup> TOC Chapter 204 and 22 TAC Chapter 185

<sup>3</sup> 22 TAC §§185.2(17); 185.10 and 193.2(17) & (18)

<sup>4</sup> 22 TAC §217.11(1)(N)

## 15.6 Board Rules Associated With Alleged Patient “Abandonment”

The Texas Board of Nursing (BON or Board), in keeping with its mission to protect the public health, safety, and welfare, holds nurses accountable for providing a safe environment for patients and others over whom the nurse is responsible [22 TAC §217.11(1)(B)]. Though the Nursing Practice Act (NPA) and Board Rules do not define the term “*abandonment*,” the Board has investigated and disciplined nurses in the past for issues surrounding the concept of *abandonment* as it relates to *the nurse’s duty to the patient*. The Board’s position applies to licensed nurses (LVNs and RNs), including RN’s with advanced practice licensure (Nurse Practitioners, Clinical Nurse Specialists, Nurse Midwives, and Certified Registered Nurse Anesthetists) in Texas.

### Nurse’s Duty to a Patient

All nurses, regardless of practice setting or position title/role, are required to adhere to the NPA and Board Rules. The “core” rules relating to nursing practice are Rules 22 TAC §217.11, *Standards of Nursing Practice*, and 22 TAC §217.12, *Unprofessional Conduct*. The standard upon which all other standards are based is 22 TAC §217.11(1)(B) “...promote a safe environment for clients and others.” This standard supersedes a physician’s order or facility’s policy, and has previously been upheld in a landmark case, *Lunsford v. Board of Nurse Examiners*, 648 S.W. 2d 391 (Tex. App. -- Austin 1983). The concept of the nurse’s duty to promote patient safety also serves as the basis for behavior that could be considered unprofessional conduct by a nurse.

Patients under the care of a nurse are vulnerable by virtue of illness, injury, and/or the dependent nature and unequal power base of the nurse-patient relationship. Persons who are especially vulnerable include the elderly, children, the mentally ill, sedated and anesthetized patients, those whose mental or cognitive ability is compromised, and patients who are physically disabled, immobilized, restrained, or secluded. ~~It is this dual vulnerability (patient status and nurse’s power base) that creates t~~The nurse’s duty to protect the patient is created by the patients’ vulnerability and the nurse’s power base. The distinction between a nurse leaving employment versus a nurse violating a duty to a patient through leaving an assignment is often confused. The first is an employment issue; the other is potentially a licensure issue.

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

### Employment Issues

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

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

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

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

### **Licensure Issues**

As previously noted, the rules most frequently applied to nursing practice concerns are 22 TAC §217.11, Standards of Nursing Practice, and 22 TAC §217.12, Unprofessional Conduct. In relation to questions of "abandonment," standard 22 TAC §217.11 (1)(I) holds the nurse responsible to "notify the appropriate supervisor when leaving a nursing assignment." This standard should not be misinterpreted to mean a nurse may simply notify the supervisor that he/she is leaving the premises, regardless of whether or not another qualified licensed nurse is available to assume care of the nurse's patients. Specific procedures to follow in a given circumstance (nurse becomes ill, family emergency, etc.) should be delineated in facility policies (which the Board does not regulate).

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

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

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

### **Emergency Preparedness and Workplace Violence**

A nurse may have to choose between the duty to provide safe patient care and protecting the nurse's own life during an emergency, including but not limited to disasters, infectious disease outbreaks or bioterrorism. These situations are challenging for all nurses and their employers,

therefore the Board recommends policies and procedures be developed, and periodically reviewed, to provide clear guidance and direction to nurses in order for patients to receive safe and effective care.

The Occupational Safety and Health Administration (OSHA) defines workplace violence to include “any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site” (~~OSHA~~—[website https://www.osha.gov/SLTC/workplaceviolence/](https://www.osha.gov/SLTC/workplaceviolence/)). A nurse may have to choose between the duty to provide safe patient care and protecting the nurse’s own life during a violent situation that may occur in the workplace. For example, when an active shooter is present in the workplace, the nurse should take steps to protect patients if there is time and using a method that does not jeopardize the nurse’s personal safety or interfere with law enforcement personnel. These steps may include evacuating the area or preventing entry to an area where the active shooter is located. However, during an active shooter situation a nurse may find there is not sufficient time to do anything but to ensure his or her own safety. In this instance, as soon as the situation has resolved the nurse should promptly resume care of patients.

### **Board Disciplinary Actions**

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

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

- the extent of dependency or disability of the patient;
- stability of the patient;
- the length of time the patient was deprived of care;
- any harm to the patient/level of risk of harm to the patient;
- steps taken by the nurse to notify a supervisor of the inability to provide care;
- previous history of leaving a patient-care assignment;
- emergencies that require nurses to respond, including but not limited to disasters, disease outbreaks, and bioterrorism;
- workplace violence, including but not limited to an active shooter situation;
- other unprofessional conduct in relation to the practice of nursing;
- general nurse competency regarding adherence to minimum nursing standards.

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

### **Safe Harbor Peer Review:**

If a nurse feels he/she is being asked to accept an assignment that would potentially cause the nurse to violate his/her duty to a patient, the nurse may be able to invoke “safe harbor,”

depending on whether or not the nurse's employer meets requirements that would make it mandatory for the employer to have a peer review plan in place. This is established in the NPA, Chapter 303 Peer Review, and in 22 TAC §217.20 Safe Harbor Peer Review and Whistleblower Protections. Safe Harbor has two effects related to the nurse's license:

- 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
- It affords the nurse immunity from Board action against the nurse's license if the nurse invokes Safe Harbor in accordance with 22 TAC §217.20. For the nurse to activate this immunity status, the nurse must notify the assigning supervisor at the time the assignment request is made, and the nurse must submit the required information in writing as specified in 22 TAC §217.20(d)(3)(A) or on the Board's Safe Harbor Quick Request Form.

#### Links to Related Articles

- FAQ on Floating <http://www.bon.texas.gov/practice/faq-floating.html>
- FAQ on Overtime/Hours of Work <http://www.bon.texas.gov/practice/faq-overtime.html>
- FAQ on Peer Review <http://www.bon.texas.gov/practice/faq-peerreview.html>
- FAQ on Staffing Ratios <http://www.bon.texas.gov/practice/faq-staffing.html>
- Safe Harbor Form <http://www.bon.texas.gov/practice/safe.html>
- United States Department of Labor, Occupational Safety and Health Administration: Workplace Violence <https://www.osha.gov/SLTC/workplaceviolence/>

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(Reviewed - 01/2008; 01/2010; 01/2012; 01/2013; 01/2016)

## **15.8 Role of the Nurse in Moderate Sedation**

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

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

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

### **Role of the LVN:**

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

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

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

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

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

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

As the NPA and rules are not prescriptive to specific tasks a nurse may or may not perform, a RN or non-CRNA advanced practice registered nurse should consider evidence-based practice

guidelines put forth by professional organizations with clinical expertise in the administration of pharmacologic agents used for sedation/anesthesia as well as advanced airway management and cardiovascular support. A number of professional specialty organizations have well-defined standards and recommendations for ongoing nursing education and competency assessment related to administration and monitoring of patients receiving moderate sedation.

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

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

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

### **Use of Specific Pharmacologic Agents**

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

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

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

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

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

#### **Moderate Sedation Versus Deep Sedation Anesthesia**

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

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

As the US FDA approves computer- assisted personalized sedation systems, a nurse is encouraged to use the Six-Step Decision-Making Model for Determining Nursing Scope of Practice to reach a sound decision whether to engage in nursing practice utilizing such a device in accordance with the US FDA approval requirements. US FDA approval requirements for

computer-assisted personalized sedation systems include requirements for completion of training in addition to safety requirements, such as the immediate availability of anesthesia providers. A nurse is required to complete training prior to using any computer-assisted personalized sedation system and is encouraged to retain proof of training.

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

Though the RN or non-CRNA advanced practice registered nurse may have completed continuing education in advanced cardiac life support (ACLS) and practiced techniques during the training program, this process does not ensure ongoing expertise in airway management and emergency intubation. The American Heart Association (AHA) has identified factors that contribute to misplacement of the endotracheal tube during resuscitation including: “inadequate training, lack of experience” and patient characteristics such as physiology and movement.<sup>1</sup> 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.”<sup>2</sup> These organizations state that anesthetic agents, including induction agents, should be administered only by qualified anesthesia providers who are trained in the administration of general anesthesia.

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

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

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

The Board again stresses that the nurse's duty to assure patient safety [Rule 217.11(1)(B)] is an independent obligation under his/her professional licensure that supersedes any physician order or facility policy.<sup>2,3</sup> 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 Document 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 those of the Board as noted in this position statement. The American Association of Nurse Anesthetists developed an informational advisory document in 2016 to guide policy development for the safe administration of procedural sedation by a non-anesthesia sedation team in a hospital, ambulatory surgical center, or office setting.<sup>4</sup> The anesthetic agents ketamine and propofol are both mentioned within the document in the context of procedural sedation.~~

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<sup>1</sup> American Heart Association (2015) Guidelines for CPR & ECC. Retrieved from: <https://eccguidelines.heart.org/index.php/circulation/cpr-ecc-guidelines-2/>

<sup>2</sup> American Association of Nurse Anesthetists and American Society of Anesthesiologists. (2013) "AANA-ASA Joint Position Statement Regarding Propofol Administration" <http://www.aana.com/resources2/professionalpractice/Documents/PPM%20PS%20Joint%20AANA-ASA%20Propofol.pdf>  
<http://www.aana.com/resources2/professionalpractice/Pages/AANA-ASA-Joint-Position-Statement-Regarding-Propofol-Administration.aspx>

<sup>3</sup> Lunsford vs. BNE, 1983, 648 S.W. 391, Tex. App-Austin 1983

<sup>4</sup> The American Association of Nurse Anesthetists (2016). "Non-anesthesia Provider Procedural Sedation and Analgesia: Considerations for Policy Development." Retrieved from: [\[http://www.aana.com/resources2/professionalpractice/Documents/Non%20anesthesia%20Provider%20Procedural%20Sedation%20and%20Analgesia.pdf\]](http://www.aana.com/resources2/professionalpractice/Documents/Non%20anesthesia%20Provider%20Procedural%20Sedation%20and%20Analgesia.pdf)

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(Reviewed: 01/2008; 01/2010; 01/2011; 01/2015)

## 15.9 Performance of Laser Therapy by RNs or LVNs

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

Additional criteria applicable to the nurse who elects to follow an appropriate order in the use of nonablative laser therapy (such as laser hair removal) include:

- 1) Appropriate education related to use of laser technologies for medical purposes, including laser safety standards of the American National Standards Institute and FDA intended-use labeling parameters;
- 2) The nurse's education and skill assessment is documented in his/her personnel record;
- 3) The procedure has been ordered by a currently licensed physician, podiatrist, or dentist or by an Advanced Practice Registered Nurse (APRN) or Physician Assistant working in collaboration with one of the aforementioned practitioners; ~~and~~
- 4) Appropriate medical, nursing, and support service back up is available, since remedies for untoward effects of laser therapy may go beyond the scope of practice of the nurse performing the procedure; ~~and~~ [and](#)
- 5) Specific regulations related to laser hair removal, including training requirements, may be accessed on the Texas Department of State Health Services website ([www.dshs.state.tx.us](http://www.dshs.state.tx.us)<https://www.dshs.texas.gov/radiation/laserhair.shtm>).

Registered Nurses, including APRNs, cannot delegate any aspects of the use of lasers to unlicensed persons. As in carrying out any delegated medical act, the nurse is expected to comply with the Nursing Practice Act and the Board's Rules and Regulations.

[Additional regulations potentially applicable to laser use may include Texas Health and Safety Code, Chapter 401, Subchapter M and the Texas Medical Board Rule 193.17 related to Nonsurgical Medical Cosmetic Procedures.](#)

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

(Board Action: 05/1992; Revised: 11/1997; 01/2003; 04/2004; 01/2006; 01/2008; 01/2009; 01/2011; 04/2013; 01/2014; [01/2017](#))

(Reviewed: 01/2005; 01/2007; 01/2010; 01/2012; 01/2015; 01/2016)

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

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

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

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

### Limitations of "Continuing Education"

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

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

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

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

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

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

(Adopted: 01/2005; Revised: 01/2009; 01/2011; 01/2013; 01/2014; [01/2017](#))

(Reviewed: 01/2006; 01/2007; 01/2008; 01/2010; 01/2011; 01/2012; 01/2015; 01/2016)

## 15.11 Delegated Medical Acts

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

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

1. The nurse has received appropriate education and supervised practice, is competent to perform the procedure safely, and can respond appropriately to complications and/or untoward effects of the ~~procedure~~ delegated medical act [refer to Standards in Rule 217.11(1)(C), ~~(1)(T)~~, (1)(G), (1)(M), (1)(N), ~~and~~ (1)(R), and (1)(T)];
2. The nurse's education and skills assessment are documented in his/her personnel record;
3. The nursing and medical staffs have collaborated in the development of written policies/procedures/practice guidelines for the delegated acts, these are available to nursing staff practicing in the facility, and the guidelines are reviewed annually, if applicable;
4. The procedure has been ordered by an appropriate licensed practitioner; and
5. Appropriate medical and nursing back-up is available.

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

(Board Action: 09/1993; Revised: 03/1994; 01/2001; 01/2003; 01/2004; 01/2005; 01/2011; 01/2014; 01/2017)

(Reviewed: 01/2006; 01/2007; 01/2008; 01/2009; 01/2010; 01/2012; 01/2013; 01/2015; 01/2016)

## 15.12 Use of American Psychiatric Association Diagnoses by LVNS, RNs, or APRNs

The Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses are multi-disciplinary psychiatric diagnoses used for the purpose of applying objective criteria, establishing a practice framework and communicating findings with other health care professionals. The current version is the DSM-5 (Fifth Edition).

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

The use of DSM-5 diagnoses by a Registered Nurse licensed by the Board as an APRN in the role and population focus of either a Clinical Nurse Specialist (CNS) in Psychiatric/Mental Health Nursing or as a Psychiatric/Mental Health Nurse Practitioner is authorized provided he/she is acting within the scope of his/her advanced practice role and population focus and that the diagnoses utilized are appropriate for the individual APRN's advanced education, experience, and scope of practice. APRNs must ~~also~~ utilize protocols or other written authorization when providing medical aspects of [patient](#) care in compliance with 22 TAC §221 "Advanced Practice Nurses." When [psychiatric](#) patient ~~problems~~[conditions](#) are identified that are outside the [psychiatric mental health](#) CNS'/NP's scope of practice or expertise, a referral to the appropriate [psychiatric mental health or](#) medical provider is indicated.

(Board Action: 09/1996; Revised: 01/2005; 01/2006: 01/2008; 01/2009; 01/2010; 01/2011; 01/2014; 01/2016; [01/2017](#))

(Reviewed: 01/2007; 01/2012; 01/2013; 01/2015)

## **15.16 Development of Nursing Education Programs**

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

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

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

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

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

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

### **Process for Proposal Approval/Denial**

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

establish a new program are available on the Texas BON web site under the Nursing Education link. An initial approval fee shall be submitted with the proposal [Rule 223.1(a)(9)].

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

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

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

(Board Action: 07/2000; Revised: 01/2004; 01/2005; 01/2006; 01/2008; 10/2008; 01/2011; 01/2013; [01/2017](#))  
(Reviewed: 01/2007; 01/2009; 01/2010; 01/2012; 01/2014; 01/2015; 01/2016)

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

Medication errors occur when a drug has been inappropriately prescribed, dispensed, or administered. Medication errors are a multifaceted problem which may occur in any health care setting. Consistent with their common mission to promote and protect the welfare of the people of Texas, the Board of Nursing and the Board of Pharmacy issued this joint statement for the purpose of increasing awareness of some of the factors which contribute to medication errors.

The Boards note that there are numerous publications available which examine the many facets of this problem, and agree that all elements must be examined in order to identify and successfully correct the problem. This position paper has been jointly developed because the Boards acknowledge the interdisciplinary nature of medication errors and the variety of settings in which these errors may occur. These settings may include hospitals, community pharmacies, doctors' offices/clinics, long-term care facilities, clients' homes, and other locations.

Traditionally, medication errors have been attributed to the individual practitioner. However, reports such as the ~~recently published~~ Institute of Medicine's [1999 report entitled "To Err Is Human: Building a Safer Health System,"](#) suggest the majority of medical errors do not result from individual recklessness, but from basic flaws in the way the health system is organized. It is the joint position of the Boards that a comprehensive and varied approach is necessary to reduce the occurrence of errors. The Boards agree that the comprehensive approach includes three major elements: (1) the individual professional's knowledge of practice; (2) resources available to the professional; and (3) systems designs, problems and failures. Each of these three elements of this comprehensive approach are discussed below.

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

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

Analysis of the third element (systems designs, problems and failures) may demand creative and/or innovative thinking specific to each setting as well as a commitment to guarantee client

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

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

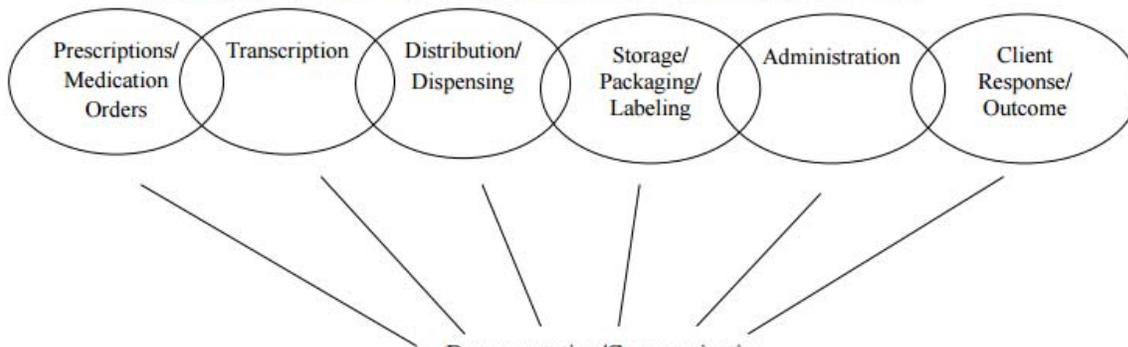
(Board Action 10/2000; [01/2017](#))

(Reviewed: 01/2005; 01/2006; 01/2007; 01/2008; 01/2009; 01/2010; 01/2011; 01/2012; 01/2013; 01/2014; 01/2015; 01/2016)

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



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

Prescriptions/ Medication Orders	Transcription	Distribution/ Dispensing	Storage/ Packaging/ Labeling	Administration	Client Response/ Outcome
<ul style="list-style-type: none"> <li>*Accurate assessments/ Diagnoses</li> <li>*Awareness of allergies, contraindications and drug reactions/ interactions</li> <li>*Correct drug/ dose/route of administration</li> <li>*Clear and legible documentation of order</li> </ul>	<ul style="list-style-type: none"> <li>*Clarification of orders (written/verbal if needed)</li> <li>*Clear and legible handwriting</li> <li>*Accurate and complete transcription (e.g. MAR, Kardex, computer)</li> <li>*Proofreading of all transcriptions</li> </ul>	<ul style="list-style-type: none"> <li>*Clarification of orders if needed</li> <li>*Correct client/drug/ dose/route</li> <li>*Checking expiration dates</li> <li>*Medication preparations (mixing of intravenous solutions, correct pill count)</li> <li>*Clear and legible audit trail</li> <li>*Client teaching and verification of understanding</li> </ul>	<ul style="list-style-type: none"> <li>*Careful review of instructions for use/warnings/ precautions</li> <li>*Storage to avoid inadvertent mix- ups/location of bottles which are similar in appearance</li> <li>*Accurate/ legible and complete labeling on original containers</li> <li>*Careful attention to floor stock expiration dates/mixing instructions</li> </ul>	<ul style="list-style-type: none"> <li>*Assessment of client status</li> <li>*5 rights of medication administration</li> <li>-Right patient</li> <li>-Right medication</li> <li>-Right Dose</li> <li>-Right time</li> <li>-Right route</li> <li>*Client teaching and verification of understanding</li> <li>*Accurate documentation of medication administration (MAR/client records/narcotics log</li> </ul>	<ul style="list-style-type: none"> <li>*Assessment of efficacy/ adverse reactions</li> <li>*Client compliance</li> <li>*Documentation</li> </ul>

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

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

According to definitions listed in the Pharmacy Act [Tex. Occ. Code Ann. § 551.003], the "Practice of Pharmacy" includes "(F) performing for a patient a specific act of drug therapy management delegated to a pharmacist by a written protocol from a physician licensed in this state in compliance with Subtitle B." The Pharmacy rules further define DTM as "the performance of specific acts by pharmacists as authorized by a physician through written protocol." [22 TAC § 295.13(b)(4)]. Rule 295.13(b)(6) further adds the clarification that a "written protocol [is] a physician's order, standing medical order, standing delegation order, or other order or protocol as defined by rule of the Texas Medical Board under the Medical Practice Act." The TMB's Rule [22 TAC §§ 193.715] 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 §193.715(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 §193.715(e)).

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

(Board Action: 01/2002; Revised 01/2005; 01/2006; 01/2007; 01/2011; 01/2014; [01/2017](#))  
(Reviewed: 01/2008; 01/2009; 01/2010; 01/2012; 01/2013; 01/2015; 01/2016)

## **15.29 Professional Boundaries including Use of Social Media by Nurses**

The purpose of this Position Statement is to provide guidance to nurses regarding expectations related to professional boundaries, inclusive of social media, and to provide nurses with guidance to prevent boundary violations.

The Texas Board of Nursing (BON or Board), in keeping with its mission to protect the public health, safety, and welfare, holds nurses accountable for knowing, recognizing, and maintaining professional boundaries of the nurse-patient/client relationship [22 TAC §217.11 (1) (J)]. The term *professional boundaries* is defined as:

The appropriate limits which should be established by the nurse in the nurse/client relationship due to the nurse's power and the patient's vulnerability. Refers to the provision of nursing services within the limits of the nurse/client relationship which promote the client's dignity, independence and best interests and refrain from inappropriate involvement in the client's personal relationships and/or the obtainment of the nurse's personal gain at the client's expense [22 TAC §217.1 (29)].

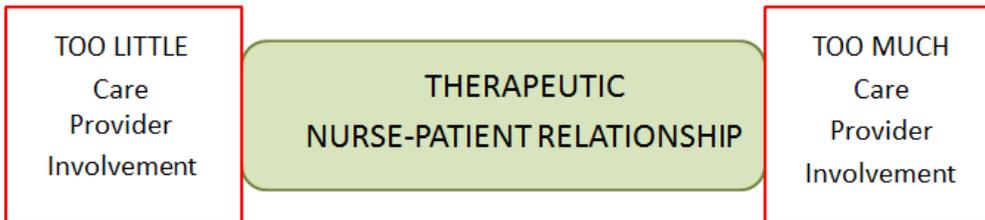
NCSBN defines professional boundaries as the spaces between the nurse's power and the patient's vulnerability. The power of the nurse comes from the nurse's professional position and access to sensitive personal information. The difference in personal information the nurse knows about the patient versus personal information the patient knows about the nurse creates an imbalance in the nurse-patient relationship. Nurses should make every effort to respect the power imbalance and ensure a patient-centered relationship.

Common to the definition of professional boundaries from the Texas Board of Nursing and from the National Council of State Boards of Nursing is that a nurse abstains from personal gain at the client's expense and the nurse refrains from inappropriate involvement with the patient or the patient's family.

### **Duty of a Nurse in Maintenance of Professional Boundaries**

There is a power differential between the nurse and the patient. The patient depends on the knowledge of the nurse and relies on the nurse to advocate for the patient and to ensure actions are taken in the patient's best interest. The nurse has a duty to protect the patient including establishing and maintaining professional boundaries in the nurse-patient/client relationship. Under or over involvement can be harmful to the patient and may interfere with the patient relationship. Visualizing the two ends of the spectrum may assist the nurse in knowing, recognizing and maintaining the professional boundaries of nurse-patient relationships.

## PATIENT-CENTERED CARE



Patient-centered care occurs within the therapeutic nurse-patient relationship. Too much or too little involvement can be a violation of professional boundaries

Each patient has their own unique needs and abilities. The boundary line for any one particular patient may change over time and may not be the same as the boundary line for another patient. It is up to the nurse to assess the patient and recognize the patients' needs, adjusting the nursing care accordingly. Every nurse is responsible for knowing, recognizing, and maintaining the professional boundaries of the nurse-client relationship [217.11 (1) (J)].

### Boundary Violations

A violation of professional boundaries is one element of the definition of "conduct subject to reporting [Tex. Occ. Code Sec. 301.401(1)(C)]. A professional boundary violation is also considered unprofessional conduct [22 TAC §217.12 (6)(D)]. Some of the specific categories of professional boundary violations include, but are not limited to physical, sexual, emotional, or financial boundary violations.

### Use of Social Media

~~With the rapidly growing~~ The use of social media and other electronic communication is expanding exponentially as the number of social media outlets, platforms and applications available continue to increase. Nurses play a significant role in the identification, interpretation, and transmission of knowledge and information within healthcare. As technological advances continue to expand connectivity and communication, rapid knowledge exchange and dissemination can pose risks to both patients and nurses. ~~sites and applications such as Facebook, Twitter, LinkedIn, YouTube, and blogs, professional obligations to patients, peers, and employers may be unclear.~~ While the Board recognizes that the use of social media can be a valuable tool in healthcare, there are potentially serious consequences if used inappropriately. A nurse's use of social media may cause the nurse to unintentionally blur the lines between the nurse's professional and personal lives. Online postings may harm patients if protected health

~~information is disclosed. These types of postings may reflect negatively on individual nurses, the nursing profession, the public's trust of our profession, as well as jeopardize careers.~~

Online postings may harm patients if protected health information is disclosed. In addition, social media postings may reflect negatively on individual nurses, the nursing profession, the public's trust of the nursing profession, or the employer and may jeopardize careers. In a survey by the NCSBN, many of the responding boards reported that they had received complaints about nurses inappropriately using social media sites. The survey results indicated that nurses have been disciplined by boards, fired by employers, and criminally charged for the inappropriate or unprofessional use of social media (NCSBN, 2012).

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

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

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

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

~~In a survey by the NCSBN, many of the responding boards reported that they had received complaints about nurses inappropriately using social media sites. Nurses have been disciplined by boards, fired by employers, and criminally charged for the inappropriate or unprofessional use of social media (NCSBN, 2012).~~

To ensure the mission to protect and promote the welfare of the people of Texas, the Texas Board of Nursing supports both the guidelines and principles of social media use by the NCSBN and ANA. In accordance ~~keeping~~ with the NCSBN guidelines and Board Rules, it is the Board's position that:

- Nurses have an ethical and legal obligation to maintain patient privacy and confidentiality at all times and when using social media do not identify patients by name or post or publish information that may lead to the identification of a patient. Limiting access to postings through privacy settings is not sufficient to ensure privacy. Nurses must promptly report any identified breach of confidentiality or privacy [22 TAC Board Rule 217.11(1) (E) and (K)].
- Nurses maintain professional boundaries in the use of electronic media. The nurse has the obligation to establish, communicate and enforce professional boundaries with patients in the online environment. Nurses do not refer to patients in a disparaging manner, even if the patient is not identified or transmit information that may be

reasonably anticipated to violate patient rights to confidentiality or privacy, or otherwise degrade or embarrass the patient [22 TAC Board Rule 217.11(1) (J)].

- Nurses must provide nursing services without discrimination and do not make threatening, harassing, profane, obscene, sexually explicit, racially derogatory, homophobic or other offensive comments [22 TAC Board Rules 217.11(1) (L) and 217.12 (6)(C), (D), and (F)].
- Nurses must be aware of and comply with all laws and rules, including employer policies regarding the use of electronic devices including employer-owned computers, cameras and use of personal devices in the work place. In addition, nurses must ensure appropriate and therapeutic use of all patient-related electronic media, including patient-related images, photos, or videos in accordance with applicable laws, rules, and institutional policies and procedures [22 TAC Board Rule 217.11(1)(A)].

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

The use of social media can be of tremendous benefit to nurses and patients alike. However, nurses must be aware of the potential consequences of disclosing patient-related information

via social media. Nurses must always maintain professional standards, boundaries, and compliance with state and federal laws as stated in 22 TAC §217.11(1)(A). All nurses have an obligation to protect their patient's privacy and confidentiality (as required by 22 TAC § 217.11(1)(E)) which extends to all environments, including the social media environment.

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