Agenda Item 7.12.1
Board Meeting: January 23-24, 2020
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Review and Consideration of Current Position Statements without Changes

Summary of Request:

Annually, Board Position Statements are reviewed to determine if updates are needed related to changes in national practice trends. To make this determination, throughout the year, Board staff keep apprised of changes in practice nationally through evidence based practice developments, guidelines, and regulation movements. This report is comprised of those position statements in which Board staff have no recommended changes to content or context, and only include reference updates.

Historical Perspective:

Though Board Position Statements do not have the force of law, they provide guidance for nurses on relevant practice and licensure issues. The annual review of Board Position Statements allows the opportunity to accurately parallel their content with advances in practice, the Nursing Practice Act, and Board Rules. The following current positions statements did not have any recommended changes to the context or content of the Position Statement, only to reference, including the new Scope of Practice Decision-Making Model (DMM).

Current Position Statements without Changes

- 15.1 Nurses Carrying Out Orders from Physician Assistants
- 15.2 The Role of the Licensed Vocational Nurse in the Pronouncement of Death
- 15.4 Educational Mobility
- 15.5 Nurses with Responsibility for Initiating Physician Standing Orders
- 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
- 15.11 Delegated Medical Acts
- 15.12 Use of American Psychiatric Association Diagnoses by LVNs, RNs, or APRNs
- 15.13 Role of LVNs and RNs in School Health
- 15.14 Duty of a Nurse in any Practice Setting
- 15.15 Board's Jurisdiction over a Nurse's Practice in Any Role and Use of the Nursing Title
- 15.16 Development of Nursing Education Programs
- 15.17 Texas Board of Nursing/Board of Pharmacy, Joint Position Statement, Medication Errors
- 15.18 Nurses Carrying out Orders from Advanced Practice Registered Nurses
- 15.22 APRNs Providing Medical Aspects of Care for Individuals with whom there is a Close Personal Relationship
- 15.23 The use of Complementary modalities by the LVN or RN
- 15.24 Nurses Engaging In Reinsertion of Permanently Placed Feeding Tubes
- 15.25 Administration of Medication & Treatments by LVNs
- 15.29 Professional Boundaries including Use of Social Media by Nurses
- 15.30 Workplace Violence

Pros and Cons

Pros:

Adoption of the current Board Position Statements with no changes will allow for continued guidance for nurses and the public related to relevant practice and licensure issues.

Cons:

None noted.

Staff Recommendation:

Move to accept current Board Position Statements without any recommended changes, with allowance for non-substantive word editing for purposes of clarify 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.[1,2] 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.[3] PAs may 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.[4] 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.[5] A list of physician assistants credentialed by the medical staff and policies directing their practice should be available to the nursing staff.

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[1]Nursing Practice Act, TOC §301.002(2)

[2]Texas Board of Nursing (2017). *Position statement 15.25, Administration of Medication & Treatments by LVNs.*

[3] Physician Assistant Licensing Act, TOC Chapter 204 and 22 TAC Chapter 185

[4] 22 TAC §§185.2(17); 185.10, 193.2(17) & 193.2(18)

[5] 22 TAC §217.11(1)(N)

(Board Action: 01/1994; Revised: 01/2005; 01/2006; 01/2010; 01/2012; 01/2016; 01/2017; 01/2018)
(Reviewed: 01/2007; 01/2008; 01/2009; 01/2011; 01/2013; 01/2014; 01/2015; 01/2019; 01/2020)

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

Licensed vocational nurses (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 cardiopulmonary resuscitation (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. Position Statement 15.20, *Registered Nurses in the Management of an Unwitnessed Arrest in a Resident in a Long Term Care Facility,* has additional information in regards to initiating CPR.

It is within the LVN scope of practice as defined by *22 TAC §217.11(1) -(2)* (effective 9/28/2004) and Position Statement 15.27, *The Licensed Vocational Nurse Scope of Practice,* for a LVN to gather data and perform a **focused** assessment regarding a patient, to recognize significant changes in a patient's condition, and to report said data and observation of significant changes to the physician. The LVN's focused assessment should include nursing observations to determine the presence or absence of the following presumptive or conclusive signs of death:

Presumptive Signs of Death

- The patient is unresponsive,
- The patient has no respirations,
- The patient has no pulse,
- The 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 Signs of Death

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

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

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

References

American Heart Association (201~~7~~9). ~~*2017 American Heart Association guidelines for CPR & ECC guidelines*~~. Retrieved from ~~https://eccguidelines.heart.org/index.php/circulation/cpr-ecc-guidelines-2/~~ https://eccguidelines.heart.org/circulation/cpr-ecc-guidelines/

Texas Health and Safety Code Chapters 193 and 671: http://www.statutes.legis.state.tx.us/

(BVNE Statement adopted 06/1999; Revised BON statement: 01/2006; Revised: 01/2007; 01/2008; 01/2009; 01/2011; 01/2012; 01/2013; 01/2014; 01/2015; 01/2016; 01/2018; 01/2019; 01/2020)
(Reviewed: 01/2010; 01/2017)

15.4 Educational Mobility

The Texas Board of Nursing (Board or BON) supports educational mobility for nurses prepared at the VN, ADN, Diploma and BSN levels and encourages the elimination of needless repetition of experiences or time penalties. Furthermore, the Board encourages existing nursing education programs approved by the Texas Board of Nursing to develop articulation arrangements that specify their policies regarding transfer of academic credits to facilitate educational mobility, especially in underserved areas of the state.

The Board honors and supports military personnel and veterans and their educational mobility. Several Board approved education programs offer articulated credit or other options for military personnel with healthcare training and/or experience.

(Board Action 01/1989; Revised: 01/1992; 01/2005; 01/2008; 01/2015; 01/2018)
(Reviewed: 01/2006; 01/2007; 01/2009; 01/2010; 01/2011; 01/2012; 01/2013; 01/2014; 01/2016; 01/2017; 01/2019; 01/2020)

15.5 Nurses with Responsibility for Initiating Physician Standing Orders

According to the Texas Nursing Practice Act [*Tex. Occ. Code Ann. §301.002(3)*], the term "Nurse" means, “a person required to be licensed under this chapter to engage in professional or vocational nursing.” The practice of either professional or vocational nursing frequently involves implementing orders from a physician, podiatrist, or dentist. Timely interventions for various patient populations can be facilitated using physician’s standing orders that authorize the nurse to carry out specific orders for a patient presenting with or developing a condition or symptoms addressed in the standing orders.

The specifics of how authorization occurs for a LVN or RN to implement a set of standing physician’s orders are defined in the Texas Medical Board’s (TMB) Rule 193 (*22 Tex. Admin. Code §§193.1-193.20*) relating to physician delegation. This rule delineates two methods by which nurses may follow a pre-approved set of orders for treating patients:

1) Standing Delegation Orders; and/or

2) Standing Medical Orders.

These terms are defined in *22 Tex. Admin. Code §193.2* as follows:

> ***(19) Standing delegation order*** *-- Written instructions, orders, rules, regulations, or procedures prepared by a physician and designed for a patient population with specific diseases, disorders, health problems, or sets of symptoms. Such written instructions, orders, rules, regulations or procedures shall delineate under what set of conditions and circumstances action should be instituted. These instructions, orders, rules, regulations or procedures are to provide authority for and a plan for use with patients presenting themselves prior to being examined or evaluated by a physician to assure that such acts are carried out correctly and are distinct from specific orders written for a particular patient, and shall be limited in scope of authority to be delegated as provided in §193.4 of this title (relating to Scope of Standing Delegation Orders). As used in this chapter, standing delegation orders do not refer to treatment programs ordered by a physician following examination or evaluation by a physician, nor to established procedures for providing of care by personnel under direct, personal supervision of a physician who is directly supervising or overseeing the delivery of medical or health care. As used in this chapter, standing delegation orders are separate and distinct from prescriptive authority agreements as defined in this chapter. Such standing delegation orders should be developed and approved by the physician who is responsible for the delivery of medical care covered by the orders.*
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> *Such standing delegation orders, at a minimum, should:*
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> *(A) include a written description of the method used in developing and approving them and any revision thereof;*
> *(B) be in writing, dated, and signed by the physician;*
> *(C) specify which acts require a particular level of training or licensure and under what circumstances they are to be performed;*
> *(D) state specific requirements which are to be followed by persons acting under same in performing particular functions;*

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

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

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

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

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

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

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

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

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

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

***(18) Protocols** - Written authorization delegating authority to initiate medical aspects of patient care, including delegation of the act of prescribing or ordering a drug or device at a facility-based practice. The term protocols is separate and distinct from prescriptive authority agreements as defined under the Act and this chapter. However, prescriptive authority agreements may reference or include the terms of a protocol(s). The protocols must be agreed upon and signed by the physician, the physician assistant and/or advanced practice registered nurse, reviewed and signed at least annually, maintained on site, and must contain a list of the types or categories of dangerous drugs and controlled substances available for prescription, limitations on the number of dosage units and refills permitted, and instructions to be given the patient for follow-up monitoring or contain a list of the types or categories of dangerous drugs and controlled substances that may not be prescribed. Protocols shall be defined to promote the exercise of professional judgment by the advanced practice registered nurse and physician*

assistant commensurate with their education and experience. The protocols used by a reasonable and prudent physician exercising sound medical judgment need not describe the exact steps that an advanced practice registered nurse or a physician assistant must take with respect to each specific condition, disease, or symptom.

By definition, both vocational and professional nursing excludes “acts of medical diagnosis or the prescription of therapeutic or corrective measures” [*Tex. Occ. Code Ann. §301.002(2)* and *(5)*]. Based on the above definitions in the TMB rules, RNs who do not have advanced practice licensure from the BON may not utilize "protocols" to carry out physician orders. Likewise, LVNs are also prohibited from utilizing protocols as defined by the TMB, as neither LVNs nor RNs may engage in acts that require independent medical judgment.

A nurse responsible for initiating physician's standing medical orders or standing delegation orders may select specific tasks or functions for patient management, including the administration of a medication required to implement the selected order provided such selection be within the scope of the standing orders. The selection of such tasks or functions for patient management constitutes a nursing decision that may be carried out by a LVN or RN. In addition, this position statement should not be construed to preclude the use of the term “protocol” for a standard set of orders covering the monitoring and treatment of a given clinical condition (e.g., insulin protocol, heparin protocol, ARDS protocol, etc.) provided said standard orders meet the requirements for standing delegation or standing medical orders as defined by the TMB.

The written standing orders under which nurses function shall be commensurate with each nurse’s educational preparation and experience. The nurse initiating any form of standing orders must act within the scope of the Nursing Practice Act, Board Rules and Regulations, and any other applicable local, state, or federal laws.

(Board Action 07/1988; Revised: 01/1992; 07/2001; 01/2005; 01/2006; 01/2007; 01/2009; 01/2011; 01/2014; 01/2016; 01/2018)
(Reviewed: 01/2008; 01/2010; 01/2012; 01/2013; 01/2015; 01/2017; 01/2019; 01/2020)

15.6 Board Rules Associated with Alleged Patient "Abandonment"

The Texas Board of Nursing (BON or Board), in keeping with its mission to protect 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 a patient.* The Board's position applies to all licensed nurses (LVNs, RNs, and APRNs), 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 *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 determining 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. 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; and/or
- 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 (i.e., 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

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 acts of terrorism. 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. 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.

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 the 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. *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.

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 alleging a nurse left 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;
- nurse's general 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. 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. 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.

Safe Harbor Nursing 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 nursing peer review plan in place. This is established in Chapter 301, *Nursing Practice Act;* Chapter 303, Nursing *Peer Review*, and in *22 TAC §217.20*, *Safe Harbor Peer Review and Whistleblower Protections*. Safe harbor has two effects related to the nurse's license:

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

2) it affords the nurse immunity from Board action against the nurse's license if the nurse invokes Safe Harbor in accordance with *22 TAC §217.20*. For the nurse to activate this immunity status, the nurse must notify the assigning supervisor at the time the assignment request is made, and the nurse must submit the required information in writing to this supervisor, as specified in *22 TAC §217.20(d)(3)(A)* or on the Board's Safe Harbor Quick Request Form. Do not submit this form to the Board.

Links to related resources:

- FAQ on Floating
- FAQ on Mandatory Overtime/Consecutive Shifts
- FAQs on Nursing Peer Review
- FAQ on Staffing Ratios
- BON Safe Harbor Quick Request Form
- BON Comprehensive Written Request for Safe Harbor Nursing Peer Review Form

(Adopted 01/2005; Revised: 01/2006; 01/2007; 01/2009; 01/2011; 01/2014; 01/2015; 01/2017; 01/2018; 01/2019)
(Reviewed: 01/2008; 01/2010; 01/2012; 01/2013; 01/2016; 01/2020)

15.8 Role of the Nurse in Moderate Sedation

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

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;*

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; or*

3) *Adjunct or off label use of low dose agents for pain management or other indications.*

Role of the LVN

The administration of pharmacologic agents via intravenous 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 Registered 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 registered 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. *22 TAC §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 Board 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)[1], the American Nurses Association (ANA)[2], the Association of periOperative Registered Nurses (AORN)[3], and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN).[4] Statements published by the American Society of Anesthesiologists (ASA) also support the positions of the above nursing organizations.[5] 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 Scope of Practice Decision-Making Model (DMM).

Employing institutions should develop policies and procedures to guide the RN or non-CRNA advanced practice registered 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 RN or non-CRNA advanced practice registered nurse administering the sedation;
- Guidelines for patient monitoring, drug administration, and a plan for managing 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); and
- Documentation/evidence of initial education and training and ongoing competence of the RN or non-CRNA advanced practice registered nurse 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, when deciding whether 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 *22 TAC §217.11* & Scope of Practice Decision-Making Model (DMM) 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/anesthetic, according to the FDA product information, it is intended for use as an anesthetic agent or for 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 and not involved in the conduct of the surgical/diagnostic procedure 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 Food and Drug Administration (FDA) approves computer-assisted personalized sedation systems, a nurse is encouraged to use the Scope of Practice Decision-Making Model (DMM) 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. The loss of consciousness and/or protective reflexes may indicate progression into deep sedation and 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)[6] 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. 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 only qualified anesthesia providers who are trained in the administration of general anesthesia should administer anesthetic agents, including induction agents.

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 patient's 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 [*22 TAC §217.11(1)(B)*] is an independent obligation under his/her professional licensure that supersedes any physician order or facility policy.[7] 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: 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.[1] The anesthetic agents ketamine and propofol are both mentioned within the document in the context of procedural sedation.

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[1] The American Association of Nurse Anesthetists. (2016). *Non-anesthesia Provider Procedural Sedation and Analgesia: Policy Considerations*. Retrieved from https://www.aana.com/docs/default-source/practiceaana-com-web-documents-(all)/non-anesthesia-provider-procedural-sedation-andanalgesia.pdf?sfvrsn=670049b1_

[2] American Nurses Association. (2008). *Procedural Sedation Consensus Statement.* Retrieved from https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/procedural-sedation-consensus-statement

[3] The Association of periOperative Registered Nurses. (2017). *Patient Care Guidelines: Care of the Patient Receiving Moderate Sedation Analgesia.* Retrieved from https://www.aorn.org/guidelines/guidelineimplementation-topics/patient-care

[2] Association of Women's Health, Obstetric and Neonatal Nurses. (2015). *Role of the registered nurse in the care of the pregnant woman receiving analgesia and anesthesia by catheter techniques.* Retrieved from http://www.jognn.org/article/S0884-2175(15)31771-8/fulltext

[3] American Association of Nurse Anesthetists and American Society of Anesthesiologists. (2013) *AANA–ASA Joint Position Statement Regarding Propofol Administration. Retrieved from* https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/aana-asapropofol-joint-ps.pdf?sfvrsn=f80049b1_2

[5] American Heart Association (201~~7~~9). ~~*2017*~~ *American Heart Association* ~~*guidelines for*~~ *CPR & ECC guidelines*. Retrieved from ~~https://eccguidelines.heart.org/index.php/circulation/cpr-ecc-guidelines-2/~~ https://eccguidelines.heart.org/circulation/cpr-ecc-guidelines/

[6] Lunsford v. BNE, 648 S.W. 391, (Tex. App–Austin 1983)

Additional Resources

Texas Board of Nursing. (2012). Nurses on guard- best practices in patient safety: Off-label administration of Ketamine for pain management by a nurse. *Texas Board of Nursing Bulletin, 43*(4), 5-6.

Texas Board of Nursing. (2017). *FAQ: Off label use of medication*.

(Board Action 01/1992; Revised: 01/2003; 01/2004; 01/2006; 01/2007; 01/2009; 01/2012; 01/2013; 01/2014; 01/2016; 01/2017; 01/2018; 01/2019; 1/2020)

(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
5) Specific regulations related to laser hair removal, including educational requirements for a certificate, may be accessed on the Texas Department of Licensing and Regulation website at https://www.tdlr.texas.gov/las/lasrules.htm

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

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.

An 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; 01/2018)

(Reviewed: 01/2005; 01/2007; 01/2010; 01/2012; 01/2015; 01/2016; 01/2019; 01/2020)

15.11 Delegated Medical Acts

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

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

1. The nurse has received appropriate education and supervised practice, is competent to perform the procedure safely, and can respond appropriately to complications and/or untoward effects of the delegated medical act [refer to Standards in *22 TAC §217.11 (1)(C), (1)(G), (1)(M), (1)(N), (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 support 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; 01/2018)
(Reviewed: 01/2006; 01/2007; 01/2008; 01/2009; 01/2010; 01/2012; 01/2013; 01/2015; 01/2016; 01/2019; 01/2020)

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 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 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; 01/2015; 01/2016; 01/2017; 01/2018)
(Reviewed: 01/2007; 01/2012; 01/2013; 01/2019; 01/2020)

15.13 Role of LVNs and RNs in School Health

The Board of Nursing (BON or Board) recognizes the complexity of nursing in the school health setting and the need to protect the youth of Texas. Although students come to school with complex and diverse health care needs, they should be provided an education in the least restrictive environment. The BON recognizes that the school children of Texas have the right to receive safe, appropriate, and specialized health services that may be required to assure the child's inclusion in the school environment.

Registered Nurses in the School Setting

The Texas Education Agency defines a school nurse in *19 Texas Administrative Code (TAC) § 153.1022 (a) (1) (D)* as "… an educator employed to provide full-time nursing and health care services and who meets all the requirements to practice as a registered nurse (RN) pursuant to the Nursing Practice Act and rules and regulations relating to professional nurse education, licensure, and practice and has been issued a license to practice professional nursing in Texas." The BON believes that school nursing is a professional registered nursing (RN) specialty. School nursing requires comprehensive assessment skills to promote student health, prevent illness and intervene in accordance with the nursing care plan. The RN has the educational preparation and critical thinking skills as well as clinical expertise that are essential to nursing in the school setting. These activities involve the comprehensive assessment of the nursing/health care needs of the student, the development of a nursing plan of care, implementation of the plan, and evaluation of the outcomes. The provision of these services by the RN contributes directly to the students' education and to the successful outcome of the educational process. These essential components of professional nursing practice are the responsibility of the RN in compliance with *22 TAC §217.11(3)(A)*.

Vocational Nurses in the School Setting

The licensed vocational nurse (LVN) has a directed scope of practice under supervision of a registered nurse, advanced practice registered nurse, physician, physician assistant, podiatrist, or dentist. [1] The provision of nursing care when provided by a LVN in a school setting should be under the supervision of an RN. The RN, in compliance with the BON's Standards of Nursing Practice [*22 TAC §217.11*], assigns those aspects of care and activities to the LVN that are within the LVN's educational preparation and demonstrated competency to provide. The RN monitors, coordinates, and evaluates the provision of health services necessary to meet individual student health needs essential in achieving educational objectives.

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

RN Delegation to Unlicensed Personnel

Due to the growing number of students entering the school system with special health care needs, the BON recognizes that not all health-related services can be provided by a RN or LVN. Therefore, the RN may delegate tasks in the school setting in compliance with the BON's Delegation Rules located in Chapters 224 and 225. School is considered an independent living environment as defined in Chapter 225[3]; however, acute or emergency situations in the school setting may be delegated in accordance with the rules in both Chapter 224 and Chapter 225. The RN may decide to delegate to an unlicensed person the emergency administration of

medications or treatments. Examples include, but are not limited to, Epi-pens, Glucagon, Diastat, oxygen, metered dose inhalers or nebulizer treatments for the relief of acute respiratory symptoms, and the use of a hand held magnet to activate a vagus nerve stimulator to prevent or control seizure activity. All delegation of this nature must be in compliance with *22 TAC §224.6(4)* in order to stabilize the child and prevent complications from delaying treatment. The decision to delegate a specific task is always at the discretion of the RN in accordance with *22 TAC §224.8(b)(1)(C)* or *22 TAC §225.9(d).* Additional delegation resources for RNs can be found in the School Nurse Delegation section of the Delegation Resource Packet of the BON website.

Other Laws Impacting School Health Care

In a school setting, the administration of medication may be assigned to an unlicensed person by the public school official in accordance with the *Texas Education Code*. The RN's obligation under *22 TAC §225.14* is to verify the training of the unlicensed person, verify the competency of the unlicensed person to perform the task safely, and provide adequate supervision. If the RN is unable to assure these criteria have been met, the RN must notify the public school official.

Summary

Given the complexity, the current number, and the future projections of increasing numbers of children entering the school system with complex nursing and health-related needs, the BON believes that the RN must establish an individualized nursing care plan for each child as applicable. The RN may be assisted by LVNs and unlicensed assistive personnel in the delivery of services to ensure the delivery of safe, effective health care to the school children of Texas.

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[1] Nursing Practice Act, TOC §301.353 and 22 TAC§ 217.11(2)

[2] 22 TAC§217.11(2)

[3] 22 TAC §225.4(9)

(Adopted 11/1996; Revised: 11/1997; 01/2003; 01/2005; 01/2008; 01/2009; 01/2011; 01/2013; 07/2013; 01/2016; 01/2018; 1/2019)
(Reviewed: 01/2006; 01/2007; 01/2010; 01/2012; 01/2014; 01/2015; 01/2017; 01/2020)

15.14 Duty of a Nurse in any Practice Setting

In a time when cost consciousness and a drive for increasing productivity have brought about the reorganization and restructuring of health care delivery systems, the effects of these new delivery systems on the safety of clients/patients have placed a greater burden on the licensed vocational nurse (LVN) and the registered professional nurse (RN) to consider the meaning of licensure and assurance of quality care that it provides.

In the interest of fulfilling its mission to protect the health, safety, and welfare of the people of Texas through the regulation of nurses, the Board of Nursing (Board or BON), through the Nursing Practice Act and Board Rules, emphasizes the nurse's responsibility and duty to the client/patient to provide safe, effective nursing care.

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

- The Standards of Nursing Practice differentiate the roles of the LVN and the RN in accepting nursing care assignments, assuring a safe environment for patients, and obtaining instruction and supervision as needed (*22 TAC §217.11*); and
- In *Lunsford v. Board of Nurse Examiners*, 648 S.W. 2d 391 (Tex. App.--Austin, 1983), the court in affirming the disciplinary action of the Board, held that a nurse has a duty to the patient which cannot be superseded by hospital policy or physician's order.
    - This landmark case involved a gentleman who arrived to a rural hospital via private vehicle. The gentleman was experiencing severe chest pain, nausea, and sweating—all hallmark symptoms of myocardial infarction (heart attack). Nurse Lunsford was summoned to the ER waiting room by this gentleman's friend. Upon seeing the acute distress the man was experiencing and hearing his symptoms, she instructed his friend to drive the man to the nearest facility equipped to handle heart attack victims. This facility was 24 miles away. The man succumbed to the heart attack 5 miles away from the small hospital.
    - When the Board sought to sanction the nurse's license, the nurse maintained that the ER physician (who never saw the man) told her the man needed to be transported to the larger facility. The facility policy was also to transfer patients experiencing heart attacks (via ambulance) to the larger facility that was equipped to provide the broad range of therapies that might be needed.
    - The court sided with the BON and agreed that the nurse had the knowledge, skills and abilities to recognize the life-threatening nature of the man's symptoms. Because of this knowledge, the court maintained that it was the nurse's duty to act in the best interest of the client by assessing the man, taking measures to stabilize him and to prevent complications, and communicating his condition to other staff (such as the physician) to enlist appropriate medical care.
- The Board's Disciplinary Sanction Policies discuss expectations of all nurses regarding behaviors that are consistent with the Board's rules *22 TAC §§213.27-213.29*. These policies explain the client's

vulnerability and the nurse's "power" differential over the client by virtue of the client's status (with regard to age, illness, mental infirmity, etc.) and by the nature of the nurse client relationship (where the client typically defers decisions to the nurse, and relies on the nurse to protect the client from harm).

- The delegation rules guide the RN in delegation of tasks to unlicensed assistive personnel who are utilized to enhance the contribution of the RN to the client's/patient's wellbeing. When performing nursing tasks, the unlicensed person cannot function independently and functions only under the RN's delegation and supervision. Through delegation, the RN retains responsibility and accountability for care rendered (*22 TAC Chapters 224* and *225*). The Board may take disciplinary action against the license of a RN or RN administrator for inappropriate delegation.
- RNs with advanced practice licensure from the Board must comply with the same rules applicable to other RNs. In addition, rules specific to advanced practice nursing *Chapters 221 & 222*, as well as laws applicable to the APRN's practice setting that are outside of the BON's jurisdiction must also be followed.
- Each nurse must be able to support how his/her clinical judgments and nursing actions are aligned with the NPA and Board Rules. The Board recommends nurses use the Scope of Practice Decision-Making Model (DMM) when trying to determine if a given task is within the individual nurse's abilities. Congruence with standards adopted by national nursing specialty organizations may further serve to enhance and support the nurse's decision to perform a particular task.

The nurse, by virtue of a rigorous process of education and examination leading to either LVN or RN licensure, is accountable to the Board to assure that nursing care meets standards of safety and effectiveness.

Therefore, it is the position of the Board that each licensed nurse upholds his/her duty to maintain client safety by practicing within the parameters of the NPA and Board Rules as they apply to each licensee.

Position Statement 15.14 - Duty of a Nurse - DADS QMP poster

(Adopted 01/2005; Revised: 01/2007; 01/2009; 01/2014; 01/2018)
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15.15 Board's Jurisdiction Over a Nurse's Practice in Any Role and Use of the Nursing Title

An individual who holds licensure as a licensed vocational nurse (LVN) or as a registered professional nurse (RN) or as an advanced practice registered nurse (APRN) in Texas is responsible and accountable to adhere to the Nursing Practice Act and Board Rules which have the force of law with regard to licensed nursing practice in the state of Texas. Standards of Nursing Practice [*22 TAC§217.11(1)(T)*] require that each nurse practice within the level of his/her educational preparation, experience, knowledge, and physical and emotional ability. The Standards of Nursing Practice establish the nurse's duty to the client. This "duty" requires the nurse to intervene appropriately to protect and promote the health and wellbeing of the client or others for whom the nurse is responsible [*22 TAC§217.11(1)(B)*].

RNs or LVNs Functioning in Unlicensed Positions/Nurse Functioning in another Role

The Nursing Practice Act (NPA) and Board Rules do not preclude a LVN or RN, including a RN/APRN, from seeking employment in unlicensed or technical positions, or in roles the nurse has the knowledge, education, experience, and a valid certificate or license to perform. However, a nurse, who is also licensed by another state agency, is required to comply with the NPA and Board Rules for any acts that are also within the scope of nursing practice [*Tex. Occ. Code Ann. § 301.004 (a) (5)*]. The Board holds a licensed registered professional nurse, who is working in an unlicensed or technical position, or other role, responsible and accountable to the level of education and competency of a RN. Likewise, a LVN working as an unlicensed or technical person, or in another role, is responsible and accountable to the educational preparation and knowledge of a LVN. This expectation does not apply to individuals formerly licensed as LVNs or RNs or APRNs whose nursing license has been retired, placed on inactive status, surrendered, or revoked.

Use of the Title "LVN" or "RN" when Providing Related Services

The use of the titles "Licensed Vocational Nurse," or "LVN," or "Registered Nurse," "RN," or any designation tending to imply that one is a licensed nurse is limited to those individuals appropriately licensed by the Board. The use of titles implying that an individual holds licensure as a nurse in the State of Texas is restricted by law (*Tex. Occ. Code Ann. § 301.351*, and Board Rule, *22 Tex. Admin. Code § 217.10*). A RN is not automatically a LVN and may not use the title LVN unless the RN also holds an active LVN license. The dually licensed RN/LVN will be held to the standards of the RN license even when working as an LVN. The dually licensed RN/APRN will be held to the nursing standards applicable to the APRN role and population focus when working as an RN in that role and population focus. Use of any protected nursing title by an individual who is not licensed to practice either licensed vocational nursing or professional nursing in accordance with the licensing requirements in Texas, or who does not hold a valid compact license to practice nursing poses a potential threat to public safety related to this act of deception and misrepresentation to the public who may be seeking the services of a licensed nurse.

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

(Board Action 09/1998; Revised: 01/2001; 01/2003; 01/2004; 01/2005; 01/2008; 01/2013; 01/2014; 01/2018) (Reviewed: 01/2006; 01/2007; 01/2009; 01/2010; 01/2011; 01/2012; 01/2015; 01/2016; 01/2017; 01/2019; 01/2020)

15.16 Development of Nursing Education Programs

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

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

Guidelines for Establishing a New Vocational or Professional Nursing Education Program

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

All new pre-licensure vocational and professional nursing 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.

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 an individual qualified and designated as the proposed program director. 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 and a New Proposal Resource Packet 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 school/college. A program is allowed up to one year from the date of receipt of the proposal in the Board office to finalize all aspects of the proposal for presentation to the Board. The actual length of time until Board approval depends upon the completeness of the proposal and compliance with Board standards. A timeline is included in the Resource Packet. The 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; 01/2018)
(Reviewed: 01/2007; 01/2009; 01/2010; 01/2012; 01/2014; 01/2015; 01/2016; 01/2019; 01/2020)

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

Medication errors occur when a drug has been inappropriately prescribed, dispensed, or administered. Medication errors are a multifaceted problem that 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 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 a 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 teamwork 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 that 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.

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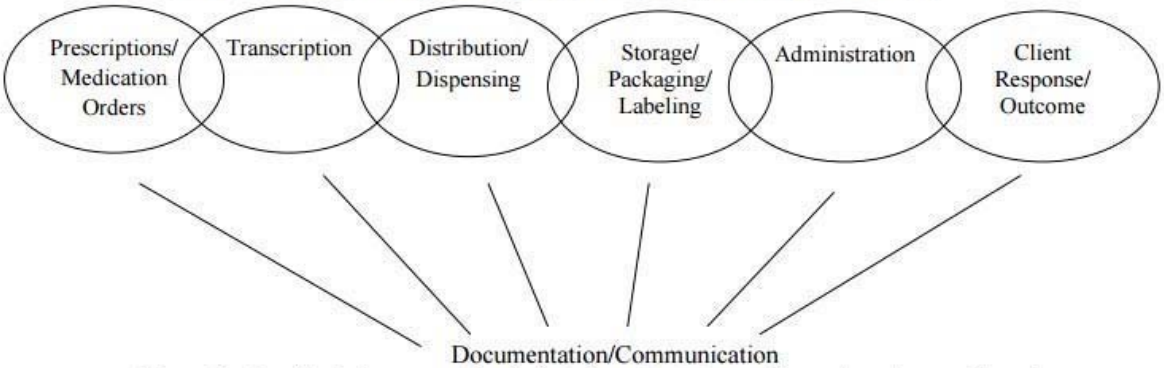
Leape, L. L. (1994). Error in medicine. Journal of the American Medical Association, 272(23), 1851-1857.

Nursing Practice Act, TOC Chapters 301 and 303.

Texas Pharmacy Act, TOC, Chapters 551 - 566.

Position Statement 15.17 Table: Factors Contributing to Medication Errors



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

Prescriptions/ Medication Orders	Transcription	Distribution/ Dispensing	Storage/ Packaging/ Labeling	Administration	Client Response/ Outcome
*Accurate assessments/ Diagnoses *Awareness of allergies, contraindications and drug reactions/ interactions *Correct drug/ dose/route of administration *Clear and legible documentation of order	*Clarification of orders (written/verbal if needed) *Clear and legible handwriting *Accurate and complete transcription (e.g. MAR, Kardex, computer) *Proofreading of all transcriptions	*Clarification of orders if needed *Correct client/drug/ dose/route *Checking expiration dates *Medication preparations (mixing of intravenous solutions, correct pill count0 *Clear and legible audit trail *Client teaching and verification of understanding	*Careful review of instructions for use/warnings/ precautions *Storage to avoid inadvertent mix-ups/location of bottles which are similar in appearance *Accurate/ legible and complete labeling on original containers *Careful attention to floor stock expiration dates/mixing instructions	*Assessment of client status *5 rights of medication administration -Right patient -Right medication -Right Dose -Right time -Right route *Client teaching and verification of understanding *Accurate documentation of medication administration (MAR/client records/narcotics log	*Assessment of efficacy/ adverse reactions *Client compliance *Documentation

(Board Action 10/2000; Revised 01/2017; 01/2018)
(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; 01/2019; 01/2020)

15.18 Nurses Carrying out Orders from Advanced Practice Registered Nurses

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

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

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

(Board Action: 01/2001; Revised: 01/2005; 01/2009; 01/2012; 01/2014; 01/2018)
(Reviewed: 01/2006; 01/2007; 01/2008; 01/2010; 01/2011; 01/2013; 01/2015; 01/2016; 01/2017; 01/2019; 01/2020)

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

Advanced Practice Registered Nurses (APRN) often find themselves in situations where they may feel compelled to provide medical aspects of care or prescribe medications for themselves, their family members, or other individuals with whom they have a close personal relationship. APRNs are prohibited from ordering, prescribing or dispensing both medications and devices for personal use [*22 TAC §222.10 (a)(2)*]. When ordering, prescribing, or dispensing a medication or a device for any person, the APRN is expected to meet all standards of care including assessment, documentation of the assessment, diagnosis, and documentation of the plan of care prior to ordering, prescribing, dispensing, or administering a medication or device [*22 TAC 222.10(a)(3)*].

The practice of providing medical aspects of care for individuals with whom an APRN has a close personal relationship raises a number of ethical questions. The Board is concerned that APRNs in these situations risk allowing their personal feelings to cloud their professional judgment and objectivity. It is the opinion of the Board of Nursing that APRNs should not provide medical treatment or prescribe medications for any individual with whom they have a close personal relationship.

(Board Action 10/2003; Revised: 01/2009; 01/2014; 01/2018)
(Reviewed: 01/2006; 01/2007; 01/2008; 01/2010; 01/2011; 01/2012; 01/2013; 01/2015; 01/2016; 01/2017; 01/2019; 01/2020)

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 an RN, 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, and 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 *22 TAC §217.11, Standards of Nursing Practice*
3) Position Statement 15.27, *The Licensed Vocational Nurse Scope of Practice*
4) Frequently Asked Question: *LVN's "Supervision of Practice"*
5) Frequently Asked Question: *LVNs 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 the 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 NPA and the 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 *22 TAC §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, *22 TAC §217.11*, *Standards of Nursing Practice*, forms the foundation for safe nursing practice and establishes the LVN’s or RN’s duty to his/her clients. While all standards apply when engaging in the practice of nursing, those standards most applicable to the nurse who engages in complementary modalities include *22 TAC §217.11(1)(A) -(D), (1)(F), (1)(G), (1)(R),* and *(1)(T).* Additional standards may apply depending upon the specific practice situation. In order to show accountability when providing integrated or complementary modalities as nursing interventions, the LVN or RN should be able to articulate and provide evidence of:

1) Educational activities used to gain or maintain the knowledge and skills needed for the safe and effective use of such modalities;

2) Knowledge of the anticipated effects of the complementary therapy and its interactions with other modalities, including its physiological and/or emotional/spiritual impact;

3) Selection of appropriate interventions, whether complementary, conventional, or in combination, to meet the client's needs. The interventions and rationale for selection should be documented in the client's nursing care plan. The demonstrated ability of the LVN or RN to properly perform the chosen intervention(s) should be maintained by the LVN or RN and/or his/her employer;

4) Appropriate medical diagnosis and a valid order from a licensed provider as indicated.

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

6) Collaboration with other health care professionals and applicable referrals when necessary;

7) Documentation of interventions and client responses in a client's record;

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

9) Abstinence from making unsubstantiated claims about the therapy used; and

10) 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) to safely engage in the specific practice. The Scope of Practice Decision-Making Model (DMM) (accessible on the Texas Board of Nursing (BON) web page) may be a useful tool for the LVN or RN who is uncertain whether a given modality is within his/her scope of practice. The nurse who wishes to integrate complementary modalities when engaging in the practice of nursing should be familiar with not only the NPA, BON rules, and any applicable Federal or State regulations, but also any prevailing standards published by national associations, credentialing bodies, and nursing organizations related to the LVN's or RN's area of practice.

(Board Action 01/2004; Revised: 01/2005; 01/2009; 04/2010; 01/2012; 01/2013; 01/2018; 01/2019)
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15.24 Nurses Engaging in Reinsertion of Permanently Placed Feeding Tubes

The Board of Nursing (Board or BON) approved curriculum for both licensed vocational nurses (LVNs) and registered nurses (RNs) does not provide graduates with sufficient instruction to provide the nurse with the necessary knowledge, skills and ability to re-insert and determine correct placement of a permanently placed feeding tube (such as gastrostomy or jejunostomy tubes). The Board does allow LVNs and RNs to expand their practice beyond the basic educational preparation through post-licensure continuing education and training for certain tasks and procedures. One of the main considerations in determining whether a nurse should consider re-insertion of a gastrostomy, jejunostomy or similar feeding tube, is how long the original tube was in place before becoming dislodged. Though sources vary, most give a range of 8-12 weeks for maturation/healing of the fistulous tract and stoma formation. The method of initial insertion (surgical, endoscopy, or radiographic guidance) may affect the length of healing. Orders should be obtained from the patient's physician regarding re-insertion guidelines.

It is the opinion of the Board that LVNs and RNs should not engage in the reinsertion of a permanently placed feeding tube through an established tract until the LVN or RN successfully completes a competency validation course congruent with prevailing nursing practice standards. Training should provide instruction on the nursing knowledge and skills applicable to tube replacement and verification of correct and incorrect placement. The BON does not define nor set qualifications for competency validation courses; however, inclusion of the following factors is encouraged:

- The nurse should complete training designed specifically for the type or types of permanent feeding tubes the nurse may need to replace, including overall patient assessment, verification of proper tube placement, and assessment of the tube insertion site.
- A registered nurse or a physician who has the necessary expertise with regard to the specific feeding tube provides supervision during the training process.
- The nurse demonstrates competency in all appropriate aspects (knowledge, decision-making, and psychomotor skills) of performing the procedure.
- The patient has an established tract. The established tract is not determined by the nurse.
- The facility has resources available to develop an educational program for initial instruction of LVNs and/or RNs, as well as for ongoing competency validation.
- Documentation of each nurse's initial education and ongoing competency validation should be maintained by the nurse and/or the employer in accordance with facility policies.
- Regardless of training, policies and procedures of the facility must also permit the nurse to engage in the procedure.

The nurse who accepts an assignment to engage in care and/or replacement of permanently placed feeding tubes is responsible to adhere to the NPA and Board rules, particularly *22 TAC §217.11*, *Standards of Nursing Practice*, as well as any other standards or rules applicable to the nurse's practice setting. Two standards applicable in all practice scenarios include:

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

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

Additional standards in *22 TAC §217.11* that may be applicable when a nurse chooses to engage in replacement of a permanently placed feeding tube include (but are not limited to):

- (1)(D) "accurately and completely report and document: (i) ...client status...(ii) nursing care rendered; (iii) physician, dentist or podiatrist orders; (iv) administration of medications and treatments; (v) client response(s)...,"
- (1)(G) "obtain instruction and supervision as necessary when implementing nursing procedures or practices,"
- (1)(H) "make a reasonable effort to obtain orientation/training for competency when encountering new equipment and technology or unfamiliar care situations,"
- (1)(R) "be responsible for one's own continuing competence in nursing practice and individual professional growth."
- Standards specific to LVNs may be found in *22 TAC §217.11(2)*; standards specific to RNs may be found in *22 TAC §217.11(3)*.

Regardless of facility policy or physicians' orders, the nurse always has a duty to maintain the safety of the patient [Reference *22 TAC §217.11(1)(B)* above]; this standard has previously been upheld in a landmark case [*Lunsford v. Board of Nurse Examiners*, 648 S.W. 2d 391 (Tex. App. -- Austin 1983)].

(Adopted 01/2005; Revised: 01/2008; 01/2009; 01/2011; 01/2013; 01/2018)
(Reviewed: 01/2006; 01/2007; 01/2010; 01/2012; 01/2014; 01/2015; 01/2016; 01/2017; 01/2019; 01/2020)

15.25 Administration of Medication & Treatments by LVNs

The definition of "Vocational Nursing" in the Texas Occupations Code states:

> "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 [TOC 301.002(5)]. Educational preparation leading to initial licensure as a nurse in Texas is described in the *Differentiated Essential Competencies of Graduates of Texas Nursing Programs Evidenced by Knowledge, Clinical Judgements, and Behaviors (DECs) (Oct 2010).* This document lists the minimum competency expectations for graduates of Vocational (VN), Diploma/Associate Degree (Diploma/ADN), and Baccalaureate Degree (BSN) nursing programs. According to the DECs, educational preparation for Vocational Nurses includes the following related to administration of medications:

Knowledge:

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

Clinical Behavior/Judgments:

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

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

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

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

The Board's position, therefore, is that LVNs are educationally prepared to administer medications and treatments as ordered by a physician, podiatrist, dentist, or any other practitioner legally authorized to prescribe the ordered medication. LVNs may also administer medications and treatments ordered by PAs and APRNs 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.

Each LVN has different experiences, knowledge, level of competence, and abilities; therefore, it is up to the individual LVN to use sound judgment when determining the individual

LVN's scope of practice. 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 practice concerns:

- Rule 217.11, Standards of Nursing Practice
- Scope of Practice Decision-Making Model (DMM)
- Decision making for Determining Nursing Scope of Practice
- Position Statements:
    - Position Statement 15.3, LVNs Engaging in Intravenous Therapy, Venipuncture, or Peripherally Inserted Central Catheter Lines
    - Position Statement 15.8, Role of the Nurse in Moderate Sedation
    - Position Statement 15.27, The Licensed Vocational Nurse Scope of Practice

(Adopted 10/2005; Revised: 01/2009; 01/2011; 01/2012; 01/2013; 01/2016; 01/2018)
(Reviewed: 01/2007; 01/2008; 01/2010; 01/2014; 01/2015; 01/2017; 01/2019; 01/2020)

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. Professional boundaries 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)*].

The National Council of State Boards of Nursing (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 NCSBN 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 nurse-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.

Patients each have 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 patient’s 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)*].

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

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

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. 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 life.

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).

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 American Nurses Association. In accordance 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. When using social media, 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 must promptly report any identified breach of confidentiality or privacy [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 [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 [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 [Board Rule 217.11(1)(A)].

The use of social media can be of tremendous benefit to nurses and patients alike, for example dissemination of public safety announcements. 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 local, 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.

Resources

American Nurses Association. (2011). *Principles for social networking and the nurse*. Silver Spring, MD

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22 TAC §217.11(1)(J) (2016).

(Adopted: 04/2012)
(Revised: 01/2013; 01/2014; 01/2017; 01/2018; 01/2019)
(Reviewed: 01/2015; 01/2016; 01/2020)

15.30 Workplace Violence

The mission of the Texas Board of Nursing (Board or BON) is to protect and promote the welfare of the people of Texas by ensuring that each person holding a license as a nurse in the State of Texas is competent to practice safely. To provide further guidance for nurses on relevant practice and licensure issues the Board develops position statements, however they do not have the force of law. This position statement addresses an issue facing nursing practice today, workplace violence.

Violence in the workplace, including bullying, affects both patients and nurses, and can disrupt communication and teamwork, interfering with the nurse's ability to promote a safe patient care environment. The American Nurses Association attests that "evidence-based best practices must be implemented to prevent and mitigate incivility, bullying, and workplace violence" to support the safety of nurses and safeguard optimal patient outcomes.[1] It is important for nurses to maintain professionalism, through communication, conduct, and caring behaviors. The Board believes that professional behaviors that are in alignment with Board Rule 217.11-*Standards of Nursing Practice* can assist nurses in eliminating workplace violence.

Violence in the Workplace

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."[2] With healthcare and social service workers facing "a significant risk of job-related violence"[3], in 2016, the Texas Center for Nursing Workforce Studies (TCNWS) conducted a statewide study on workplace violence against nurses. This study was performed in hospitals, freestanding emergency medical care facilities, nursing facilities, and home health agencies, as required by House Bill (HB) 2696, 84th Texas Legislature, Regular Session, 2015 which added Section 105.009 to the *Health and Safety Code*.[4] The TCNWS Advisory Committee issued recommendations based on the study findings to:

- promote safer facilities
- encourage nursing staffing committees to consider incidents of workplace violence
- encourage reporting of violent events, and
- establish and maintain ongoing surveillance of workplace violence.

Based on these findings, workplace violence remained a priority during the 85th Texas Legislature, Regular Session, as HB 280 passed requiring the Board of Nursing, under Section 301.155, Occupations Code, to fund grant programs administered by the TCNWS for reducing workplace violence against nurses. HB 280 seeks to alleviate the trauma of workplace violence by providing grants to hospitals and other health facilities to implement innovative approaches unique to each facility and region to reduce the severity and frequency of these occurrences.

Collaborative Approach to Address Workplace Violence

Effective management of workplace violence begins by recognizing that workplace violence is a safety and health hazard. Nurses work with patients of differing backgrounds and in various practice settings at times when patients may experience "pain, devastating prognoses, unfamiliar surroundings, mind and mood altering medications and drugs, and disease progression" which can "cause agitation and violent behaviors."[3]

The healthcare team must commit to work collaboratively in support of effective violence prevention programming. This commitment should include acknowledging the value of a safe, violence-free workplace, ensuring and exhibiting equal commitment to the safety and health of workers and patients/clients, while maintaining a system of accountability for all involved members of the health care team.

Nurses may provide expertise and useful information, collaborating to design, implement and evaluate workplace violence prevention programming.[3]

Standards of Nursing Practice Related to Workplace Violence

Consideration of and compliance with Board Rule 217.11- *Standards of Nursing Practice* is essential when providing care to a patient in a potentially violent situation. It is the Board's position that:

- Nurses must be aware of and comply with all laws and rules, including employer policies, regarding workplace violence [Board Rule 217.11(1)(A)].
- Nurses implement measures to promote a safe environment for patients and others [Board Rule 217.11(1)(B)]. This would include the creation and implementation of policies, procedures, and interventions to mitigate and/or eliminate workplace violence in the interests of a safe patient care environment.
- Nurses respect the client's right to privacy by protecting confidential information unless required or allowed by law to disclose the information [Board Rule 217.11(1)(E)]. Though acts of violence toward an individual can be a frightening and potentially dangerous situation, it is important to continue to respect the patient's privacy, and withhold patient identifiers when disclosing information about the incident, unless disclosure is required by law or to prevent harm[5].
- Nurses obtain instruction and supervision as necessary when implementing nursing procedures or practices, make a reasonable effort to obtain orientation/training for competency when encountering new equipment and technology or unfamiliar care situations, and maintain responsibility for individual professional growth and continuing competency [Board Rule 217.11(1)(G), (1)(H) & (1)(R)]. It is important for nurses to be aware of applicable policies and procedures related to these workplace issues.
- Nurses notify the appropriate supervisor when leaving a nursing assignment [Board Rule 217.11(1)(I)]. If the nurse is unable to provide care to a patient any longer due to threats or actual violence, a nurse must communicate with the supervisor regarding the inability to safely provide care to this patient before leaving the assignment, as adequate nursing care coverage must be obtained prior to leaving the assignment.
- Nurses know, recognize, and maintain professional boundaries of the nurse-client relationship [Board Rule 217.11(1)(J)]. The nurse has an obligation to establish, communicate and enforce professional boundaries, refraining from disparaging, violent, or unprofessional behavior in the presence of patients. Fostering healthy communications with the health care team is best for patient care.
- Nurses institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications, collaborating and consulting with the patient and members of the health

care team in the interests of the patient's care in an effort to promote a safe environment for all [Board Rule 217.11(1)(M) & (1)(P)]. When a patient could or has become violent, it important for the nurse to stabilize the patient to prevent further complications for the patient and the nurse. The nurse would need to collaborate with other health care providers to ensure the most appropriate care for the patient.

- Nurses must supervise the nursing care provided by others for whom the nurse is professionally responsible, ensuring the provision and maintenance of a safe patient care environment and make assignments to others that take into consideration client safety and that are commensurate with the educational preparation, experience, knowledge, and physical and emotional ability of the person to whom the assignments are made [Board Rule 217.11 (1)(U) & (1)(S)]. When making assignments that involve potentially violent patients, it is important to take into consideration the safety, knowledge, skills, and abilities of the nurse to whom the assignments are made.
- Nurses accept only those nursing assignments that take into consideration client safety and that are commensurate with the nurse's educational preparation, experience, knowledge, and physical and emotional ability; and provide, without discrimination, nursing services regardless of the age, disability, economic status, gender, national origin, race, religion, health problems, or sexual orientation of the client served [Board Rule 217.11 (1)(T) & (1)(L)]. Nurses must take into consideration any preconceived notions they may have about a patient that has the potential to, or has already become, violent. A nurse would need to determine if he/she has received the appropriate education and training to have the knowledge, skills, and abilities to provide safe care to a potentially violent patient. Collaboration must occur with the healthcare team to ensure safe care is provided to the patient.

Behaviors associated with workplace violence compromise the safety of the patient and the health care team. Nurse leaders must assess their organizations for workplace violence and implement policies that support a framework to systematically reduce workplace violence.[6] It is a shared responsibility among nurses and employers to create an environment in which both nurses and patients feel safe.

References

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[2]U.S. Department of Labor Occupational Safety and Health Administration (2017). *Workplace Violence.* Retrieved from https://www.osha.gov/SLTC/workplaceviolence/

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