Agenda Item 7.3.2
Board Meeting January 21-22, 2021
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Review and Consideration of Current Position Statements with Changes

Summary of Request

Annually, The Texas Board of Nursing (Board or BON) Position Statements are reviewed and determined 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. Though Board Position Statements do not have the force of law, they provide guidance for nurses on relevant practice and licensure issues. This report is comprised of those position statements in which Board staff have proposed changes for the Board's consideration.

Current Position Statements with Changes

- Non-substantive Changes:
  - 15.2 The Role of the Licensed Vocational Nurse in the Pronouncement of Death
  - 15.8 Role of the Nurse in Moderate Sedation
  - 15.20 Registered Nurses in the Management of an Unwitnessed Arrest in a Resident in a Long Term Care Facility
  - 15.29 Professional Boundaries including Use of Social Media by Nurses
- Substantive Changes:
  - 15.6 Board Rules Associated with Alleged Patient "Abandonment"
  - 15.7 The Role of LVNs & RNs in Management and/or Administration of Medications via Epidural or Intrathecal Catheter Routes

Proposed Changes

Non-substantive:

Position Statement 15.2, *The Role of the Licensed Vocational Nurse in the Pronouncement of Death*, includes non-substantive proposed changes that reflect an update to the 2020 American Heart Association Guidelines for CPR and ECC. Board staff reviewed these new guidelines and it does not appear to change the substance of this Position Statement, however Board staff did want to draw attention that this guideline has been updated.

Position Statement 15.8, *Role of the Nurse in Moderate Sedation*, has two proposed non-substantive changes. The first is an undated link to the aforementioned 2020 American Heart Association Guidelines for CPR and ECC. Again, Board staff does not believe this update changes the substance of this Position Statement, however Board staff did want to draw attention that this guideline has been updated. The second change is an updated link to the new Position Statement released in 2020 by the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN). Board staff does not believe the new AWHONN Position Statement impacts the substance of this Position Statement.

Position Statement 15.20, *Registered Nurses in the Management of an Unwitnessed Arrest in a Resident in a Long Term Care Facility,* includes proposed non-substantive changes to provide consistence, clarity, and, as previously mentioned, update the hyperlink to the new 2020 American Heart Association Guidelines for CPR and ECC. Again, these new guidelines did not change the substance of this Position Statement.

Position Statement 15.29, *Professional Boundaries including Use of Social Media by Nurses*, has a proposed change to update one of the resources to the Positon Statement. The previously noted resource from the American Nurses Association, 2017, was the Social Networking Privacy Toolkit. This resource has been updated with a new hyperlink to the American Nurses Association Social Media portion of their website.

Substantive:

Position Statement 15.6, *Board Rules Associated with Alleged Patient "Abandonment",* has proposed changes that would clarify changes to the Nursing Practice Act (NPA) and Board Rules that occurred in the 86th Legislative Session in 2019. Legislative changes allowed for the oral invocation of Safe Harbor if the nurse has immediate patient care needs. Since this Position Statement does include mention of Safe Harbor invocation. Board staff wanted to clarify this section of the Position Statement to align with legislative updates.

Position Statement 15.7, *The Role of LVNs & RNs in Management and/or Administration of Medications via Epidural or Intrathecal Catheter Routes,* includes proposed substantive changes that align with the new Position Statement released in 2020 by the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN). The changes include a hyperlink to the new Position Statement from AWHONN and alignment with the positon that only qualified anesthesia providers should verify the correct catheter placement and registered nurses (RNs) who are not licensed anesthesia providers should monitor but not manage the delivery of analgesia and anesthesia by catheter techniques to pregnant women.

Pros and Cons

Pros:

Adoption of the current Board Position Statements with 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 adopt the current Board Position Statements with changes, along with allowance for non-substantive word and hyperlink editing for purposes of clarity as may be deemed necessary by Board staff.

Non-Substantive Proposed Changes

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 ~~(2019)~~ (2020). *American Heart Association CPR & ECC guidelines*. Retrieved from 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; 01/2021)

(Reviewed: 01/2010; 01/2017)

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://aornguidelines.org/guidelines/content?sectionid=173733727&view=book

[4] Association of Women's Health, Obstetric and Neonatal Nurses. ~~(2015)~~ (2020). *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~~ https://www.jognn.org/article/S0884-2175(20)30012-5/fulltext

[5] 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

[6] American Heart Association ~~(2019)~~ (2020). *American Heart Association CPR & ECC guidelines*. Retrieved from https://eccguidelines.heart.org/circulation/cpr-ecc-guidelines/

[7] 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; 01/2021)

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

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

The Texas Board of Nursing (BON) has approved this position statement, ***only applicable to long-term care settings***, in an effort to provide guidance to **registered nurses (RNs) in long-term care facilities** and to clarify issues of compassionate end-of-life care. In 2002, the Texas Nurses Association (TNA) through its Long-Term Care (LTC) Committee identified that RNs were concerned about the inappropriate initiation of cardiopulmonary resuscitation (CPR) when a resident without a "do-not- resuscitate" order (DNR) experiences an unwitnessed arrest. There is growing sentiment on the part of the long-term care nurse community that the initiation of CPR would appear futile and inappropriate given the nursing assessment of the resident.

The nursing community generally considers that initiation of CPR in such cases is not compassionate, and is not consistent with standards requiring the use of a systematic approach to provide individualized, goal-directed nursing care [BON Standards of Nursing Practice, *22 TAC §217.11(3)*]. This position statement is intended to provide guidance for RNs in the management of an unwitnessed resident arrest without a DNR order **in a long-term care (LTC) setting**. This position statement also addresses the related issues of:

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

These related issues are addressed in this position statement because the BON is often required to investigate cases of death where it appears there is a lack of clarity about a RN's obligation when there is no DNR order. The BON will evaluate cases involving the failure of an RN to initiate CPR in the absence of a DNR based on the following premise:

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

However, there may be instances when LTC residents without a DNR order experience an unwitnessed arrest, and it is clear according to the comprehensive nursing assessment that CPR intervention would be a futile and inappropriate intervention given the condition of the resident. In the case of an unwitnessed resident arrest without DNR orders, determination of the appropriateness of CPR initiation should be undertaken by the RN through an assessment of the resident ~~resident assessment~~, and interventions appropriate to the findings should be initiated.

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

Presumptive Signs of Death

1) The resident is unresponsive;
2) The resident has no respirations;
3) The resident has no pulse;
4) The resident's pupils are fixed and dilated;

5) The resident's body temperature indicates hypothermia: skin is cold relative to the resident's baseline skin temperature;

6) The resident has generalized cyanosis; and

Conclusive Sign of Death

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

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

Documentation

After assessment of the resident is completed and appropriate interventions are taken, documentation of the circumstances and the assessment of the resident in the resident's medical record is required. The rules of the BON establish legal documentation standards, [BON Standards of Nursing Practice, *22 TAC §217.11 (1)(D)*]. Examples of important documentation elements include:

- Description of the discovery of the resident
- Any treatment of the resident that was undertaken
- The findings for each of the assessment elements outlined in the standards
- All individuals notified of the resident's status (e.g., 9-1-1, the health care provider, the administrator of the facility, family, coroner, etc.)
- Any directions that were provided to staff or others during the assessment and/or treatment of the resident
- The results of any communications
- Presence or absence of witnesses

Documentation should be adequate to give a clear picture of the situation and all of the actions that were taken or not taken on behalf of the resident.

Even if the RN's decision not to initiate CPR was appropriate, failure to accurately and completely document can result in an action against a nurse's license by the BON. Furthermore, lack of documentation places the nurse at a disadvantage should the nurse be required to explain the circumstances of the resident's death. RNs should be aware that actions documented at the time of death provide a more credible and accurate clinical description. Documentation that is absent, incomplete or inaccurate reveals gaps in care, requiring the nurse to prove actions not appropriately documented were actually taken. As stated in Position Statement 15.2, The Role of the Licensed Vocational Nurse in the Pronouncement of Death, it is beyond the scope of practice of the LVN to legally determine death, diagnose death, or otherwise pronounce death in the State of Texas. Therefore, the LVN cannot make a determination to withhold CPR.

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

Whether CPR is initiated or not, it is important for the nurse to understand that the nurse may be held accountable if the nurse failed to meet standards of care to assure the safety of the resident, prior to the arrest such as:

- Failure to monitor the resident's physiologic status;
- Failure to document changes in the resident's status and to adjust the plan of care based on the resident assessment;
- Failure to implement appropriate interventions which might be required to stabilize a client's condition such as: reporting changes in the resident's status to the resident's primary care provider and obtaining appropriate orders; and/or
- Failure to implement procedures or protocols that could reasonably be expected to improve the resident's outcome.

Care Planning and Advanced Directives

Proactive policies and procedures, that acknowledge the importance of care planning with the inclusion of advanced directives, are also important. Evidence indicates that establishing the resident's wishes at the end of life and careful care planning prevents confusion on the part of nursing staff and assures that the resident's and family's wishes in all aspects of end of life care are properly managed.

The admission process to long-term care facilities in Texas requires that residents be provided information on self-determination and given the option to request that no resuscitation efforts be made in the event of cardiac and/or respiratory arrest. Facilities are required to have policies and adequate resources to assure that every resident and resident's family upon admission to a long term care facility not only receive such information, but have sufficient support to make an informed decision about end of life issues.

It is further expected that advanced care planning is an ongoing component of every resident's care and that the nursing staff should know the status of such planning for each resident.

The Board recognizes that end of life decisions on the part of residents and families can be difficult. However, the Board believes that principled and ethical discussion about CPR with the resident and family, is an essential element of the resident's care plan.

RN Role in Pronouncement of Death

Texas law provides for RN pronouncement of death [*Health & Safety Code §§ 671.001-.002*]. The law requires that in order for an RN to pronounce death, the facility must have a written policy that is jointly developed and approved by the medical staff or medical consultant and the nursing staff, specifying under what circumstances an RN can make a pronouncement of death.

It is important that nurses understand that the assessment that death has occurred and that CPR is not an appropriate intervention are not equivalent to the pronouncement of death. Texas statutory law governs who can pronounce death, and only someone legally authorized to pronounce death may do so. If the RN does not have the authority to pronounce death, upon assessment of death, the RN must notify a person legally authorized to pronounce death.

Conclusion

This position statement is intended to guide RNs **in long-term care facilities** who encounter an **unwitnessed resident arrest** without a DNR order. It is hoped that by clarifying the responsibility of the RN, and using supportive facility policies and procedures, registered nurses will be better able to provide compassionate end of life care.

Qualifier to Position Statement

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

References

Texas Health and Safety Code §§ 671.001-671.002
https://statutes.capitol.texas.gov/Docs/HS/htm/HS.671.htm

American Heart Association ~~(2019)~~ (2020). *American Heart Association CPR & ECC guidelines*. Retrieved from https://eccguidelines.heart.org/circulation/cpr-ecc-guidelines/

(Approved by the Board of Nursing on October 24, 2002; Revised: 01/2005; 01/2007; 01/2008; 01/2011; 01/2012; 01/2013; 01/2014; 01/2016; 01/2018; 01/2019; 1/2020; 01/2021)

(Reviewed: 01/2006; 01/2009; 01/2010; 01/2015; 01/2017)

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)*].

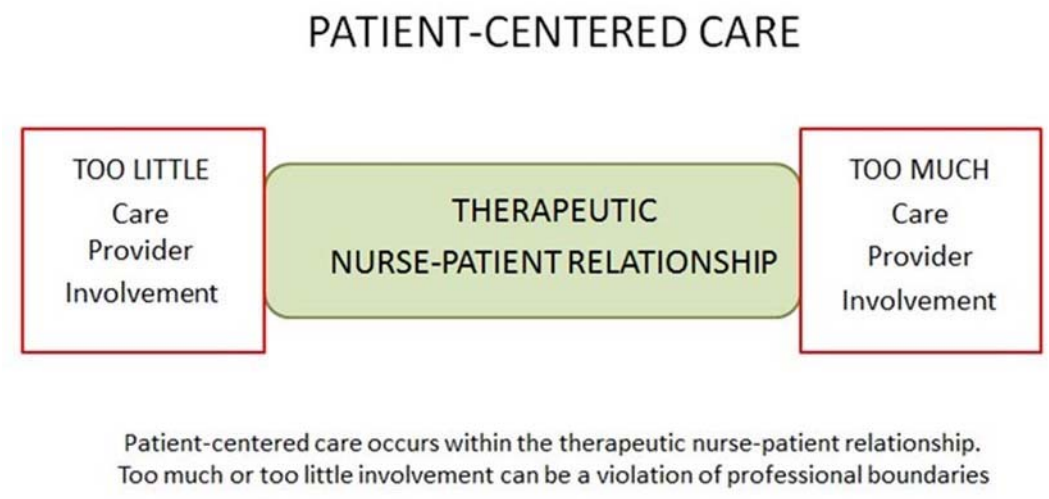
The National Council of State Boards of Nursing (NCSBN) defines professional boundaries as the spaces between the nurse's power and the patient's vulnerability. The power of the nurse comes from the nurse's professional position and access to sensitive personal information. The difference in personal 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)*].



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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National Council of State Boards of Nursing. (2014). *A nurse's guide to professional boundaries.* Retrieved from https://www.ncsbn.org/ProfessionalBoundaries_Complete.pdf

National Council of State Boards of Nursing. (2014). Social media guidelines for nurses. Retrieved from https://www.ncsbn.org/347.htm

National Council of State Boards of Nursing. (2011). *White Paper: A nurse's guide to the use of social media*. Chicago, IL

22 TAC §217.1(29) (2016).

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(Adopted: 04/2012)

(Revised: 01/2013; 01/2014; 01/2017; 01/2018; 01/2019; 01/2021)

(Reviewed: 01/2015; 01/2016; 01/2020)

Substantive Proposed Changes

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 (or verbally if due to immediate patient care needs) to this supervisor, as specified in *22 TAC §217.20(d)(2)(B) & (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 to Unfamiliar Practice Setting
- FAQ on Mandatory Overtime
- FAQ on Consecutive Shifts
- FAQs on Nursing Peer Review
- FAQ on Staffing Ratios
- Safe Harbor Forms- Nursing Peer Review

(Adopted 01/2005; Revised: 01/2006; 01/2007; 01/2009; 01/2011; 01/2014; 01/2015; 01/2017; 01/2018; 01/2019; 01/2021)

(Reviewed: 01/2008; 01/2010; 01/2012; 01/2013; 01/2016; 01/2020)

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

Role of the LVN

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

Role of the RN

The Board has determined that it may be within the scope of practice of a registered professional nurse to administer analgesic and anesthetic agents via the epidural or intrathecal routes for the purposes of pain control. As with all areas of nursing practice, the RN must apply the Nursing Practice Act (NPA) and Board Rules to the specific practice setting and must utilize good professional judgment in determining whether to engage in a given patient-care related activity.

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

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

- Demonstrate knowledge of the anatomy, physiology, and pharmacology appropriate for administration of medications via the epidural or intrathecal routes;
- Know the medication and medication concentrations approved for use for the specific type of pump;
- Maintain awareness that certain medications are not U.S. Food & Drug Administration (FDA) approved for intrathecal administration (e.g., hydromorphone, bupivacaine, fentanyl, and clonidine);
- Recognize that mixtures of two or more different kinds of medications and compounded medications are not FDA approved for intrathecal administration;
- Anticipate and recognize potential complications of the analgesia relative to the type of infusion device and catheter used;
- Recognize emergency situations and institute appropriate nursing interventions to stabilize the patient and prevent complications;

- Implement appropriate nursing care of patients to include:

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

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

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

    d) maintenance of the knowledge and skill to remove catheters, when applicable.

Appropriate nursing policies and procedures that address the education and skills of the RN and nursing care of the patient should be developed to guide the RN in the administration of epidural and/or intrathecal medications. RNs and facilities should consider evidence-based practice guidelines put forth by professional specialty organizations(s), such as the American Association of Nurse Anesthetists and the American Society of Anesthesiologists, when developing appropriate guidance for the RN in a particular practice setting. For example, the Association of Women's Health, Obstetric and Neonatal Nurses' (AWHONN) has a clinical position statement on "Role of the Registered Nurse in the Care of the Pregnant Woman Receiving

Analgesia and Anesthesia by Catheter Techniques." This nationally recognized practice guideline states that it is beyond the scope of practice of the obstetrical nurse to institute or change the rate of continuous infusions via epidural or intrathecal catheters. The American Association of Nurse Anesthetists has a similar position. Nurses should also be aware of FDA safety communications regarding intrathecal administration of pain medication.

The Board encourages the use of the BON's Scope of Practice Decision-Making Model (DMM) Finally, standing medical orders approved by the medical and/or anesthesia staff of the facility should include, but not necessarily be limited to, the following:

1) The purpose and goal of treatment;

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

3) Intravenous access;

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

5) Options for inadequate pain control; and

6) Physician/CRNA availability and backup.

References

American Association of Nurse Anesthetists. (2017). *Care of patients receiving analgesia by catheter techniques*. Retrieved from https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/care-of-patients-receiving-analgesia-by-catheter-techniques.pdf?sfvrsn=d30049b1_2

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US Food and Drug Administration. (2018). *Implanted Pumps: Safety Communication—Use Caution When Selecting Pain Medicine for Intrathecal Administration.* Retrieved from: https://www.fda.gov/medical-devices/safety-communications/use-caution-implanted-pumps-intrathecal-administration-medicines-pain-management-fda-safety

(LVN role: BVNE 1994; Revised BON 01/2005)

(RN role: BON 06/1991; Revised: 01/2003; 01/2004; 01/2005; 01/2011; 01/2014; 01/2016; 01/2018; 01/2019; 01/2020; 01/2021)

(Reviewed: 01/2006; 01/2007; 01/2008; 01/2009; 01/2010; 01/2012; 01/2013; 01/2015; 01/2017)