Agenda Item 7.4
Board Meeting January 19, 2023
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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 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. 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:**
  - 15.3 LVNs Engaging in Intravenous Therapy, Venipuncture, or Peripherally Inserted Central Catheter (PICC) Lines
  - 15.8 Role of the Nurse in Moderate Sedation
  - 15.12 Use of American Psychiatric Association Diagnoses by LVNs, RNs, or APRNs
  - 15.30 Workplace Violence
- **Substantive Changes:**
  - 15.14 Duty of a Nurse in any Practice Setting

Proposed Changes

Non-substantive:

Position Statement 15.3, *LVNs Engaging in Intravenous Therapy, Venipuncture, or Peripherally Inserted Central Catheter (PICC) Lines*, includes a non-substantive proposed change to reflect an update to the references. In 2021, the standards of practice related to infusion therapy were updated in the Journal of Infusion Nursing. This new publication does not change the meaning, intent, or use of this Position Statement, however, does provide clarification to nurses that the Position Statement remains consistent with the latest infusion therapy nursing standards.

Position Statement 15.8, *Role of the Nurse in Moderate Sedation*, has proposed non-substantive changes that are intended to provide clarity to nurses when providing moderate sedation to patients. Board staff have received numerous inquiries this past year relating to this Position Statement. Therefore, staff recommend clarifying statements be added to the Position Statement surrounding the loss of protective reflexes, an update to the FDA product label for Propofol, and the availability of necessary support when providing specific types of sedation. Additionally, Staff suggest broadening the Position Statements wording on the use of new technologies related to sedation. Staff's research does not show recent use of the FDA approved computer-assisted personalized sedation system, but that is not to mean that similar technology might be in current practice or be developed and incorporated into a nurse's scope of practice in the future. Again,

these updates do not change the meaning, intent, or use of this Position Statement, however, the changes do provide clarification to nurses surrounding their role in moderate sedation.

Position Statement 15.12, *Use of American Psychiatric Association Diagnoses by LVNs, RNs, or APRNs*, includes a non-substantive proposed change to include the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The latest version of this publication does not change the meaning, intent, or use of this Position Statement, however, does provide clarification to nurses that the Position Statement remains consistent with the DSM, Fifth Edition, Text Revision.

Position Statement 15.30, *Workplace Violence*, includes non-substantive proposed changes that reflect the update in title of a referenced organization and edits for to the location of the resource document within the newly restructured organization. The American Organization of Nurse Executives has recently changed their title to the American Organization of Nursing Leadership. Thus, updating their co-developed *Toolkit for Mitigating Violence in the Workplace* with the Emergency Nurses Association to a 2022 version. The latest version of this publication does not change the meaning, intent, or use of this Position Statement, however, does provide clarification to nurses on the location of the referenced material.

Substantive:

Position Statement 15.14, *Duty of a Nurse in any Practice Setting,* has proposed changes that are substantive in nature. This Position Statement has always addressed a nurse's duty to their patient in any practice setting. Though the Advanced Practice Registered Nurse (APRN) is required to keep their Registered Nurse (RN) license as the foundation for their APRN license, and therefore were always addressed in this Position Statement, the suggested updates to this Position Statement reflect the inclusion of the APRN more directly throughout the discussion of a nurse's duty.

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 proposed changes, along with allowance for non-substantive edits for purposes of clarity as may be deemed necessary by Board staff.

Non-Substantive Proposed Changes

15.3 LVNs Engaging in Intravenous Therapy, Venipuncture, or Peripherally Inserted Central Catheter (PICC) Lines

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

Applicable Nursing Standards

LVN practice is guided by the Nursing Practice Act (NPA) and Board Rules. *22 TAC §217.11, Standards of Nursing Practice*, is the Board rule most often applied to nursing practice issues. Two standards applicable in all practice scenarios include:

- §217.11(1)(B) Implement measures to promote a safe environment for clients and others, and
- §217.11(1)(T) Accept only those 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.

Additional standards in *22 TAC §217.11* that may be applicable when an LVN chooses to engage in an IV therapy related task include (but are not limited to):

- (1)(C) Know the rationale for and the effects of medications and treatments and correctly administer the same,
- (1)(D) Accurately and completely report and document: (i) client status...(ii) nursing care rendered...(iii) physician, dentist or podiatrist orders...(iv) administration of medications and treatments...(v) client response(s)...,
- (1)(G) Obtain instruction and supervision as necessary when implementing nursing procedures or practices,
- (1)(H) Make a reasonable effort to obtain orientation/training for competency when encountering new equipment and technology or unfamiliar care situations,
- (1)(R) Be responsible for one's own continuing competence in nursing practice and individual professional growth,
- (2)(A) Utilize a systematic approach to provide individualized, goal-directed nursing care...[(i) -(v)], and
- (2)(C) ...perform other acts that require education and training as prescribed by board rules and policies, commensurate with the LVN's experience, continuing education, and demonstrated LVN competencies.

Position Statement 15.27, *The Licensed Vocational Nurse Scope of Practice*, provides additional clarification of the *Standards of Nursing Practice* Rule as it applies to LVN scope of practice. Instruction and skill evaluation relating to LVNs performing insertion of peripheral IV catheters

and/or administering IV fluids and medications as prescribed by an authorized practitioner may allow an LVN to expand his/her scope of practice to include IV therapy.

It is the opinion of the Board that the LVN shall not engage in IV therapy related to either peripheral or central venous catheters, including venipuncture, administration of IV fluids, and/or administration of IV push medications, until successful completion of a validation course that instructs the LVN in the knowledge and skills applicable to the LVN's IV therapy practice. The BON does not define or set qualifications for an "IV Validation Course" or for "LVN IV certification." The LVN who chooses to engage in IV therapy must first have been instructed in the principles of IV therapy congruent with prevailing nursing practice standards.

Insertion and Removal of PICC Lines or Midline Catheters

The Board has further determined that vocational nursing programs do not provide the LVN with the educational foundation to assure client safety in insertion and removal of Peripherally Inserted Central Catheters (PICC lines) or midline catheters, inclusive of vein selection, insertion/advancement/retraction of the catheter, determining placement, and monitoring of the client for untoward reactions in relation to catheter insertion and removal. The LVN scope of practice is a directed scope of practice utilizing a focused assessment for patients with predictable healthcare needs. Patients having PICC lines either inserted or removed are at risk for complications, e.g., air embolism, nerve damage, infection[1], and could potentially become unpredictable needing a comprehensive assessment, as well as changes to the patient's diagnosis and plan of care to ensure vascular access. This position of the Board aligns with boards of nursing across the nation[2,3,4,5,6,7,8,9]. Position Statement 15.27, *The Licensed Vocational Nurse Scope of Practice*, and Position Statement 15.10, *Continuing Education: Limitations for Expanding Scope of Practice*, further maintains that continuing education that falls short of an educational program of study leading to a degree and licensure as a registered nurse would be insufficient to assure vocational nurse competency and patient safety with regard to insertion and removal of PICC lines or midline catheters. Therefore, it is the Board's position that insertion and removal of PICC lines or midline catheters is beyond the scope of practice for LVNs.[1]

Administration of IV Fluids and Medications

The ability of an LVN to administer specific IV fluids or drugs, to prepare and/or administer IV "piggy-back" or IV "push" medications, or to monitor and titrate "IV drip" medications of any kind is up to facility policy. The LVN's practice relative to IV therapy must also comply with any other regulations that may exist under the jurisdiction of other regulatory agencies or entities. The LVN who accepts an assignment to engage in any aspect of IV therapy is responsible for adhering to the NPA and Board rules, particularly *22 TAC §217.11, Standards of Nursing Practice*, including excerpted standards listed above and any other standards or rules applicable to the individual LVN's practice.

All nursing actions related to peripheral and/or central intravenous lines, as well as IV administration of medications, must be completed in accordance with the orders of the

prescribing practitioner, as well as written policies, procedures and job descriptions approved by the health care employer.

References

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[8] Vermont Board of Nursing. (2012). *The role of the license practical nurse in intravenous infusion therapy.*
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(Board Action: 06/1995; Revised: 09/1999; 01/2005; 01/2011; 01/2012; 01/2014; 01/2015; 01/2018; 01/2019;01/2020; 01/2022; 01/2023)
(Reviewed: 01/2006; 01/2007; 01/2008; 01/2009; 01/2010; 01/2013; 01/2016; 01/2017; 01/2021)

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 Anesthesiology (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.

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 and/or the loss of protective reflexes 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.

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.*

Although Propofol is classified as a sedative/hypnotic/anesthetic, according to the US Food and Drug Administration (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 new technologies, such as 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~~ any new sedation system~~s~~ may 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~~ new technological device 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.

Recommended Reference Document: The American Association of Nurse Anesthesiology 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.

During the performance of a procedure requiring sedation ~~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, but it is not prudent to presume this ~~physician~~ provider will be able to leave the surgical site or abandon the procedure to assist in rescuing the patient. Nurses must think critically and determine the availability of necessary support during a procedure prior to administering anesthetic agents. 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*.

References

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[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; 01/2022; 01/2023)

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

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-TR (Fifth Edition, Text Revision).

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-TR 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.

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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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Substantive Proposed Changes

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), and the advanced practice registered nurse (APRN) 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, the RN, and/or the APRN to the client/patient:

- The Standards of Nursing Practice detail the responsibility of all nurses ~~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*). Keep in mind, APRNs may delegate nursing tasks in the capacity of a registered nurse consistent with Delegation Chapters 224 and 225, as appropriate. 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, therefore the duty of a nurse in any practice setting applied to all levels of licensure. In addition to the licensure responsibility that is established in Board Rule 217.11, *Standards of Nursing Practice*, the rules specific to advanced practice nursing, in *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~~ Consideration of ~~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, RN, or APRN 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

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