Agenda Item 7.6.2
Board Meeting: January 23-24, 2014
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Annual Review of Board Position Statements:
Position Statements with Editorial Changes

Summary of Request:

Board Position Statements are reviewed on an annual basis. This report contains the existing position statements that have substantive changes.

Current Position Statements with Editorial Changes

15.3, LVNs Engaging in Intravenous Therapy, Venipuncture, or PICC Lines
15.5, Nurses with Responsibility for Initiating Physician Standing Orders
15.7, The Role of LVNs & RNs in Management and/or Administration of Medications via Epidural or Intrathecal Catheter Routes
15.9, Performance of Laser Therapy by RNs or LVNs
15.10, Continuing Education: Limitations for Expanding Scope of Practice
15.11, Delegated Medical Acts
15.12, Use Of American Psychiatric Association Diagnoses by LVNS, RNs, or APRNs
15.14, Duty of a Nurse in any Practice Setting
15.19, Nurses Carrying out Orders from Pharmacists for Drug Therapy Management
15.20, Registered Nurses in the Management of an Unwitnessed Arrest in a Resident in a Long Term Care Facility
15.26, Simulation in Prelicensure Nursing Education
15.29, Use of Social Media by Nurses

Historical Perspective:

Board position statements do not have the force of law, but are a means of providing direction for nurses on issues of concern to the Board relevant to protection of the public. Board position statements are reviewed annually for relevance and accuracy to current practice, the Nursing Practice Act and Board rules. Several position statements have proposed editorial changes.

For consistency throughout the Position Statements, the references to rules and statutes have been aligned in Position Statements 15.3, and 15.14. Also references to APRN authorization or recognition have been changed to licensure to align with Board Rules and processes, in Position Statements 15.10, 15.11, and 15.14. References to the APRN specialty has been changed to population focus to align with Board rules and the Consensus Model in Position Statements 15.9, 15.10, and 15.11. In addition, Position Statement 15.11 had omitted the word “registered” in reference to the advanced practice registered nurse.

Position Statement 15.5, Nurses with Responsibility for Initiating Physician Standing Orders, incorporates a copy of select definitions from the rules of the Texas Medical Board (TMB). These definitions in TMB rules were recently changed and those changes are reflected in the Position Statement.

In the process of checking the references within Position Statement 15.7, The Role of LVNs & RNs in Management and/or Administration of Medications via Epidural or Intrathecal Catheter Routes, it was discovered the title of one of the reference documents has changed, this change was made and the references are included at the bottom of the Position Statement.

The most recent edition of the publication referenced in Position Statement 15.12 was published in 2013.

Position Statment 15.19, included a stray "s" and two words were eliminated in Position Statement 15.29.

Position Statement 15.20 has one additional clarifying statement that this Position Statement is only applicable to long term care facilities.

In Position Statement 15.26, a sentence is eliminated to avoid duplication.

Pros and Cons

Pros:

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

Cons:

None noted.

Recommendations:

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

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

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

Applicable Nursing Standards

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

- 217.11(1)(B) implement measures to promote a safe environment for clients and others, and
- 217.11(1)(T) accept only those 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 Rule 217.11 that may be applicable when a LVN chooses to engage in an IV therapy-related task include (but are not limited to):

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

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

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

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

Insertion of PICC Lines

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

Administration of IV Fluids and Medications

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

(Board Action: 06/1995; revised 09/1999; 01/2005; 01/2011; 01/2012; 01/2014)
(Reviewed - 01/2006: 01/2007: 01/2008; 01/2009; 01/2010; 01/2013)

15.5 Nurses with Responsibility for Initiating Physician Standing Orders

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

The specifics of how authorization occurs for a LVN or RN to implement a set of standard physician's orders are defined in the Texas Medical Board's (TMB) Rule 193 (22 Tex. Admin. Code §§193.1-193.12) relating to physician delegation. This rule holds out two (2) methods by which nurses may follow a preapproved set of orders for treating patients:

1) Standing Delegation Orders; and/or
2) Standing Medical Orders.

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

> ***(~~1~~2[19]) Standing delegation order*** *-- Written instructions, orders, rules, regulations, or procedures prepared by a physician and designed for a patient population with specific diseases, disorders, health problems, or sets of symptoms. Such written instructions, orders, rules, regulations or procedures shall delineate under what set of conditions and circumstances action should be instituted. These instructions, orders, rules, regulations or procedures are to provide authority for and a plan for use with patients presenting themselves prior to being examined or evaluated by a physician to assure that such acts are carried out correctly and are distinct from specific orders written for a particular patient, and shall be limited in scope of authority to be delegated as provided in §193.4 of this title (relating to Scope of Standing Delegation Orders). As used in this chapter, standing delegation orders do not refer to treatment programs ordered by a physician following examination or evaluation by a physician, nor to established procedures for providing of care by personnel under direct, personal supervision of a physician who is directly supervising or overseeing the delivery of medical or health care. [As used in this chapter, standing delegation orders are separate and distinct from prescriptive authority agreements as defined in this chapter.] Such standing delegation orders should be developed and approved by the physician who is responsible for the delivery of medical care covered by the orders. Such standing delegation orders, at a minimum, should:*
> *(A) include a written description of the method used in developing and approving them and any revision thereof;*
> *(B) be in writing, dated, and signed by the physician;*
> *(C) specify which acts require a particular level of training or licensure and under what circumstances they are to be performed;*
> *(D) state specific requirements which are to be followed by persons acting under same in performing particular functions;*

(E) specify any experience, training, and/or education requirements for those persons who shall perform such orders;
(F) establish a method for initial and continuing evaluation of the competence of those authorized to perform same;
(G) provide for a method of maintaining a written record of those persons authorized to perform same;
(H) specify the scope of supervision required for performance of same, for example, immediate supervision of a physician;
(I) set forth any specialized circumstances under which a person performing same is to immediately communicate with the patient's physician concerning the patient's condition;
(J) state limitations on setting, if any, in which the plan is to be performed;
(K) specify patient record-keeping requirements which shall, at a minimum, provide for accurate and detailed information regarding each patient visit; personnel involved in treatment and evaluation on each visit; drugs, or medications administered, prescribed or provided; and such other information which is routinely noted on patient charts and files by physicians in their offices; and
(L) provide for a method of periodic review, which shall be at least annually, of such plan including the effective date of initiation and the date of termination of the plan after which date the physician shall issue a new plan.
(~~13~~20) Standing medical orders *-- Orders, rules, regulations or procedures prepared by a physician or approved by a physician or the medical staff of an institution for patients which have been examined or evaluated by a physician and which are used as a guide in preparation for and carrying out medical or surgical procedures or both. These orders, rules, regulations or procedures are authority and direction for the performance for certain prescribed acts for patients by authorized persons as distinguished from specific orders written for a particular patient or delegation pursuant to a prescriptive authority agreement .*

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

(~~10~~18) Protocols *- ~~Delegated w~~Written authorization delegating authority to initiate medical aspects of patient care, including ~~authorizing a physician assistant or advanced practice nurse to carry out or sign prescription drug orders pursuant to the Medical Practice Act, Texas Occupations Code Annotated, §§157.051-157.060 and §193.6 of this title (relating to the Delegation of the Carrying Out or Signing of Prescription Drug Orders to Physician Assistants and Advanced Practice Nurses).~~ delegation of the act of prescribing or ordering a drug or device at a facility-based practice. The term protocols is separate and distinct from prescriptive authority agreements as defined under the Act and this chapter. However, prescriptive authority agreements may reference or include the terms of a protocol(s). The protocols must be agreed upon and signed by the physician, the physician assistant and/or advanced practice registered nurse, reviewed and signed at least annually, maintained on site, and must contain a list of the types or categories of dangerous drugs and controlled substances available for prescription, limitations on the number of dosage units and refills permitted, and instructions to be given the patient for follow-up monitoring or contain a list*

of the types or categories of dangerous drugs and controlled substances that may not be prescribed. Protocols shall be defined to promote the exercise of professional judgment by the advanced practice registered nurse and physician assistant commensurate with their education and experience. The protocols used by a reasonable and prudent physician exercising sound medical judgment need not describe the exact steps that an advanced practice registered nurse or a physician assistant must take with respect to each specific condition, disease, or symptom.

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

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

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

(Board Action 07/1988, revised 01/1992, 07/2001; 01/2005; 01/2006; 01/2007; 01/2009; 01/2011; 01/2014)
(Reviewed - 01/2008; 01/2010; 01/2012; 01/2013)

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 licensed vocational nurse 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 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 or not 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 and skills 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 of patients receiving medications via the epidural or intrathecal routes;
- Anticipate and recognize potential complications of the analgesia relative to the type of infusion devise 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 and effectiveness of medication, catheter 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) 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 "~~The~~ Role of the Registered Nurse (RN) in the Care of the Pregnant ~~Women~~Woman Receiving Analgesia/Anesthesia by Catheter Techniques (Epidural, Intrathecal, Spinal, PCEA Catheters." 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.

The Board also encourages the use of the BON's "Six Step Decision Making Model for Determining Nursing Scope of Practice." 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 back-up.

References

American Association of Nurse Anesthetists (2011) Provision of pain relief by medication administered via continuous catheter of other pain relief devices. Accessed 12/4/2013 from: http://www.aana.com/resources2/professionalpractice/Documents/PPM%20PS%202.8%20Continuous%20Catheters%20and%20Devices.pdf.

Association of Women's Health, Obstetric, and Neonatal Nurses (2007) Role of the registered nurse (RN) in the care of the pregnant woman receiving analgesia/anesthesia by catheter techniques (epidural, intrathecal, spinal, PCEA catheters). Accessed 12/4/2013 from: http://www.awhonn.org/awhonn/binary.content.do?name=Resources/Documents/pdf/5_Epidural.pdf.

(LVN role: BVNE 1994; revised BON 01/2005) (RN role: BON 06/1991; revised 01/2003; 01/2004; 01/2005; 01/2011; 01/2014)
(Reviewed - 01/2006; 01/2007; 01/2008; 01/2009; 01/2010; 01/2012; 01/2013)

15.9 Performance of Laser Therapy by RNs or LVNs

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

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

(1) Appropriate education related to use of laser technologies for medical purposes, including laser safety standards of the American National Standards Institute and FDA intended-use labeling parameters;

(2) The nurse's education and skill assessment is documented in his/her personnel record;

(3) The procedure has been ordered by a currently licensed physician, podiatrist, or dentist or by an Advanced Practice Registered Nurse (APRN) or Physician Assistant working in collaboration with one of the aforementioned practitioners; and

(4) Appropriate medical, nursing, and support service back up is available, since remedies for untoward effects of laser therapy may go beyond the scope of practice of the nurse performing the procedure.

(5) Specific regulations related to laser hair removal, including training requirements, may be accessed on the Texas Department of State Health Services website (www.dshs.state.tx.us)

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

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

(Board Action, 05/1992; Revised 11/1997; 01/2003; 04/2004; 01/2006; 01/2008; 01/2009; 01/2011; 04/2013; 01/2014)
(Reviewed - 01/2005; 01/2007; 01/2010; 01/2012)

15.10 Continuing Education: Limitations for Expanding Scope of Practice

Foundation for Initial Licensure and/or APRN ~~authorization~~licensure

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

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

Limitations of "Continuing Education"

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

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

The Board believes that for a nurse to successfully make a transition from one level of nursing practice to the next requires the completion of a formal program of education as defined in the applicable board rule. The Board also believes that completion of on-going, informal continuing education offerings, such as workshops or on-line offerings in a specialty area, serve to expand and maintain the competency of the nurse at the current level of licensure~~/recognition~~. No amount of informal or on-the-job-training can qualify a LVN to perform the same level of care as the RN. Likewise, the RN cannot engage in aspects of care that require independent medical judgment in a

given APRN role and ~~specialty~~population focus without the formal education, national certification, and proper licensure in that advanced practice nurse role and ~~specialty~~population focus.

For example, a LVN with 10 years of home care experience cannot perform the comprehensive assessment and initiate the nursing care plan on a patient newly admitted to the LVN's home care agency's service. This is precluded in both BON Rule 217.11 as well as in the home care regulations. Attending a workshop and/or spending time under the supervision of a RN does not qualify the LVN to engage in practice that is designated in statute or rule as being exclusive to the next level of licensure.

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

(Adopted 01/2005; Revised 01/2009; 01/2011; 01/2013; 01/2014)
(Reviewed - 01/2006; 01/2007; 01/2008; 01/2010; 01/2011; 01/2012)

15.11 Delegated Medical Acts

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

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

1. The nurse has received appropriate education and supervised practice, is competent to perform the procedure safely, and can respond appropriately to complications and/or untoward effects of the procedure [refer to Standards in Rule 217.11(1)(C), (1)(T), (1)(G), (1)(M), (1)(N), and (1)(R)];

2. The nurse's education and skills assessment are documented in his/her personnel record;

3. The nursing and medical staffs have collaborated in the development of written policies/procedures/practice guidelines for the delegated acts, these are available to nursing staff practicing in the facility, and the guidelines are reviewed annually, if applicable;

4. The procedure has been ordered by an appropriate licensed practitioner; and

5. Appropriate medical and nursing back-up is available.

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

(Board Action 09/1993;Revised: 03/1994; 01/2001; 01/2003; 01/2004; 01/2005; 01/2011; 01/2014)
(Reviewed - 01/2006: 01/2007; 01/2008; 01/2009; 01/2010; 01/2012; 01/2013)

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~~,~~ ~~DSM-IV-TR (Fourth Edition, Text Revision) is anticipated to be replaced by~~ is the DSM-5 (Fifth Edition) ~~in May of 2013~~.

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 Board authorized in an appropriate Advanced Practice Registered Nurse (APRN) role and speciality.

The use of DSM-IV diagnoses by a Registered Nurse recognized by the Board as an Advanced Practice Registered Nurse in the role and specialty 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 specialty and that the diagnoses utilized are appropriate for the individual APRN's advanced education, experience, and scope of practice. APRNs must also utilize protocols or other written authorization when providing medical aspects of care in compliance with Rule 221"Advanced Practice Nurses." When patient problems are identified that are outside the CNS'/NP's scope of practice or expertise, a referral to the appropriate medical provider is indicated.

(Board Action, 09/1996; revised 01/2005; 01/2006: 01/2008; 01/2009; 01/2010; 01/2011; 01/2014)
(Reviewed - 01/2007; 01/2012; 01/2013)

15.14 Duty of a Nurse in any Practice Setting

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

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

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

- The Standards of Nursing Practice differentiate the roles of the LVN and the RN in accepting nursing care assignments, assuring a safe environment for patients, and obtaining instruction and supervision as needed (22 TAC ~~Rule~~ §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 MD) in order 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 on Good Professional Character, 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 well being. 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 (~~Rules~~ 22 TAC Chapters 224 and 225). The Board may take disciplinary action against the license of a RN or RN administrator for inappropriate delegation.

- RNs with advanced practice ~~authorization~~licensure from the Board must comply with the same rules applicable to other RNs. In addition, rules specific to advanced practice nursing, Chapters 221 & 222, as well as laws applicable to the APRN's practice setting that are outside of the BON's jurisdiction must also be followed.

- Each nurse must be able to support how his/her clinical judgments and nursing actions were aligned with the NPA and Board Rules. The Board recommends nurses use the Six-Step Decision-Making Model for Determining Nursing Scope of Practice when trying to determine if a given task is within the individual nurse's abilities. Congruence with standards adopted by national nursing specialty organizations may further serve to enhance and support the nurse's decision to perform a particular task.

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

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

(Adopted 01/2005; Revised 01/2007; 01/2009; 01/2014)
(Reviewed - 01/2006; 01/2008; 01/2010; 01/2011; 01/2012; 01/2013)

15.19 Nurses Carrying out Orders from Pharmacists for Drug Therapy Management

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

According to definitions listed in the Pharmacy Act [Tex. Occ. Code Ann. § 551.003], the "Practice of Pharmacy" includes *"(F) performing for a patient a specific act of drug therapy management delegated to a pharmacist by a written protocol from a physician licensed in this state in compliance with Subtitle B."* The Pharmacy rules further define DTM as *"the performance of specific acts by pharmacists as authorized by a physician through written protocol." [22 TAC § 295.13(b)(4)]*. Rule 295.13(b)(6) further adds the clarification that a *"written protocol [is] a physician's order, standing medical order, standing delegation order, or other order or protocol as defined by rule of the Texas Medical Board under the Medical Practice Act."* The TMB's Rule [22 TAC §§ 193.7] reflects similar language to the Pharmacy Board rules.

Nurses frequently communicate and collaborate with both the client's physician and the pharmacist in providing optimal care to clients. It is, therefore, the Board's position that a nurse may carry out orders written by a pharmacist for DTM provided the order originates from a written protocol authorized by a physician. Any nurse carrying out DTM orders from a pharmacist may wish to review the TMB Rule193, *Physician Delegation*, in its entirety. The components of the rule related to physician delegation for a pharmacist to engage in DTM are set forth in §193.7(e) as follows:

> (1) A written protocol must contain at a minimum the following listed in subparagraphs (A)-(E) of this paragraph:
>
> > (A) a statement identifying the individual physician authorized to prescribe drugs and responsible for the delegation of drug therapy management;
> >
> > (B) a statement identifying the individual pharmacist authorized to dispense drugs and to engage in drug therapy management as delegated by the physician;
> >
> > (C) a statement identifying the types of drug therapy management decisions that the pharmacist is authorized to make which shall include:
> >
> > > (i) a statement of the ailments or diseases, drugs, and type of drug therapy management authorized; and
> > >
> > > (ii) a specific statement of the procedures, decision criteria, or plan the pharmacist shall follow when exercising drug therapy management authority;
> >
> > (D) a statement of the activities the pharmacist shall follow in the course of exercising drug therapy management authority, including the method for documenting decisions made and a plan for communication or feedback to the authorizing physician concerning specific decisions made. Documentation shall be

recorded within a reasonable time of each intervention and may be performed on the patient medication record, patient medical chart, or in a separate log book; and

(E) a statement that describes appropriate mechanisms and time schedule for the pharmacist to report to the physician monitoring the pharmacist's exercise of delegated drug therapy management and the results of the drug therapy management.

(2) A standard protocol may be used, or the attending physician may develop a drug therapy management protocol for the individual patient. If a standard protocol is used, the physician shall record, what deviations if any, from the standard protocol are ordered for that patient (22 Tex. Admin. Code §193.7(e)).

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

(Board Action 01/2002; revised 01/2005; 01/2006; 01/2007; 01/2011; 01/2014)
(Reviewed - 01/2008; 01/2009; 01/2010; 01/2012; 01/2013)

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 **in long term care facilities** and to clarify issues of compassionate end-of-life care. The Texas Nurses Association (TNA) through its Long Term Care (LTC) Committee has identified that registered nurses have expressed repeated concern about the inappropriate initiation of cardiopulmonary resuscitation (CPR) when a resident without a "do not resuscitate" order (DNR) experiences an unwitnessed arrest. There is growing sentiment on the part of the long term care nurse community that the initiation of CPR would appear futile and inappropriate given the nursing assessment of the resident.

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

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

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

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

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

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

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

Presumptive Signs of Death

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

Conclusive Sign of Death

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

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

Documentation

After assessment of the resident is completed and appropriate interventions are taken, documentation of the circumstances and the assessment of the resident in the resident record are a requirement. The rules of the BON 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 nurse's decision not to initiate CPR was appropriate, failure to document can result in an action against a nurse's license by the BON. Furthermore, lack of documentation places the nurse at a disadvantage should the nurse be required to explain the circumstances of the resident's death. Nurses should be aware that actions documented at the time of death provide a much more credible defense than needing to prove actions not appropriately documented were actually taken.

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

Whether CPR is initiated or not, it is important for the nurse to understand that 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;
- Failure to implement procedures or protocols that could reasonably be expected to improve the resident's outcome.

Care Planning and Advanced Directives

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

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

It is further expected that advanced care planning is an ongoing component of every resident's care and that the nursing staff should know the status of such planning on each resident.
The Board recognizes that end of life decisions on the part of residents and families can be difficult. However, the Board believes that principled and ethical discussion about the CPR issue with the resident and family, is an essential element of the resident care plan.

RN Role in Pronouncement of Death

Texas law provides for RN pronouncement of death [Health & Safety Code §§ 671.001-.002]. The law requires that in order for a nurse to pronounce death, the facility must have a written policy which is jointly developed and approved by the medical staff or medical consultant and the nursing staff, specifying under what circumstances a RN can make a pronouncement of death.
It is important that nurses understand that the assessment that death has occurred and that CPR is not an appropriate intervention are not the equivalent to the pronouncement of death. Texas statutory law governs who can pronounce death, and only someone legally authorized to pronounce death may do

so. If the RN does not have the authority to pronounce death, upon assessment of death the RN must notify a person legally authorized to pronounce death.

Conclusion

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

Qualifier to Position

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

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(Reviewed - 01/2006; 01/2009; 01/2010)

15.26 Simulation in Prelicensure Nursing Education

Simulation, in some form, has been used as a teaching strategy in nursing education since the first nurse tried to teach the first nursing student how to task properly (Jeffries & Rizzolo, 2006). Recently, however, high-fidelity simulation, with the increased level of sophistication and realism it brings to the laboratory setting, has elicited the possibility of simulation being used as a substitute for actual clinical experience (NCSBN, 2009). These technological advances combined with other factors, including shortages of available clinical sites, faculty shortages, national mandates for safety, and the complexity of today's health care environment, have led many Texas nursing programs to consider utilizing simulation to fulfill clinical needs in the curriculum. The Texas Board of Nursing ("Board" or "BON") has put forth this position statement in an effort to clarify the role and limitations of simulation in prelicensure nursing education so that educators can best develop simulation programs that are educationally sound and meaningful.

Overview of Simulation

The National Council of State Boards of Nursing (NCSBN) Position Paper, *Clinical Instruction in Pre-licensure Nursing Programs (2005)*, has defined simulation as "Activities that mimic the reality of a clinical environment and are designed to demonstrate procedures, decision-making and critical thinking through techniques such as, role-playing and the use of devices such as interactive videos or mannequins. A simulation may be very detailed and closely imitate reality, or it can be a grouping of components that are combined to provide some semblance of reality" (p. 2).

Benefits and limitations of Simulation

The benefits of simulation are well documented:

- Simulation allows deliberate practice in a controlled, safe environment. Students are able to practice a procedure prior to performance on a live patient (Jeffries, 2007).
- Simulation promotes active learning and participation, to enhance students' critical thinking skills (Billings & Halstead, 2005).
- Educators can apply well-founded simulation approaches not only to help students in clinical rotations to attain educational goals, but also to evaluate teaching methods, as well as to investigate alternatives to the goals and methods themselves (Kyle & Murray, 2008).
- Simulation can be used to demonstrate competence outcomes in nursing programs (Luttrell, Lenburg, Scherubel, Jacob, & Koch, 1999).
- Simulated experiences offer the opportunity for diverse styles of learning not offered in the classroom environment and can result in an increase in confidence felt by the student (Jeffries & Rizzolo, 2006).

Despite these benefits, limitations to the use of simulation also exist. Preliminary studies indicate that, although simulation helps prepare students for real clinical practice, it cannot substitute for the hands-on care to live patients. Nurse educators must consider whether technology can address communication, interpersonal interaction, compassionate caring, and nursing understanding (Issenberg, Gordon, Gordon, Safford, & Hart, 2001). The NCSBN holds the position that simulation shall not take the place of clinical experiences with actual patients (NCSBN, 2005). The American Association of Colleges of Nursing (AACN) also holds that simulation should be used as an adjunct or complement to, not a substitute for, clinical experiences with real patients, and direct patient care experiences provide important opportunities for student learning not found in other experiences (AACN, 2008).

Types of Simulation

When discussing simulation, it is important to understand the concept of fidelity. Fidelity is the term utilized in the simulation domain to describe the degree of accuracy of the system being used. The purpose of simulation is to be realistic in a manner adequate to convince the user that the scenario performed resembles real-life. Fidelity can be divided into three categories: low, moderate, and high-fidelity. Low-fidelity allows the user to practice skills in isolation. Examples include administration of an intramuscular injection into an orange or injection pillow. Moderate-fidelity offers more realism, but does not have the user completely immersed in the situation. Examples include a manikin with breath sounds but no corresponding chest rise. High-fidelity simulation refers to structured learning experiences with computerized manikins that are anatomically precise and reproduce physiologic responses. The environment mimics the clinical setting, and provides the user with the cues necessary to suspend their disbelief during the immersive, hands-on scenarios (NCSBN, 2009). High fidelity units must not only have the physical appearance of reality (cosmetic fidelity) but must also react in realistic ways to student interactions (Seropian, Brown, Gavilanes, & Driggers, 2004).

Computer based simulation involves the use of software developed to simulate a subject or a situation in order to test various aspects of learning such as knowledge, skills, and critical thinking. The software may be of low, moderate, or high-fidelity. Task and skill trainers are the most common type of simulation in nursing education. These trainers are designed to allow students to practice skills and techniques. Task trainers also vary in fidelity, ranging from low- fidelity static body models (such as a rubbery IV arm) to high-fidelity virtual reality trainers. Full scale high-fidelity simulation, the most recognized form of simulation in nursing education today, attempts to recreate all the elements of real life clinical situations. This type of simulation typically involves the use of full body computerized manikins, real people, real interactions, and realistic responses in an environment that is made to resemble the clinical environment as closely as possible in order to immerse learners in an experience that mirrors real life (Seropian et al., 2004).

Components of Effective Simulation

Integral components of a successful simulated learning experience identified in the professional literature include: the educator or preceptor, the student(s), key educational practices, and the simulated environment. The simulation must challenge the student to use problem solving skills and

critical thinking to assess the situation and determine the correct treatment path. The educator should act as a facilitator providing cues when necessary, but not as an active participant in the simulation. It is important, however, for the facilitator to intervene when a catastrophic outcome is imminent. Unless the objectives specifically call for death, as in an end of life situation, the scenario should end with a viable patient (Jeffries, 2007; Kyle & Murray, 2008). Each simulated experience must have clearly stated objectives that are presented to the student prior to engaging in the simulation experience. Students are required to prepare for a clinical simulation experience in the same manner as they would prepare for an actual patient care experience. An orientation to both the simulation technology and the environment is required. ~~The educator assumes the role of facilitator, providing cues when necessary, but is not an active participant in the simulation.~~ The educator and the student should participate in an active debriefing immediately following the simulation experience. Each simulation session should also include an evaluation of the overall experience by both the educator and student (Jeffries, 2007).

The Texas Board of Nursing's Position on Simulation

The fact that simulation provides a valuable adjunct to traditional clinical learning experiences is well documented. However, while emerging research clearly supports the use of simulation in nursing education, the evidence has not been established to support the use of simulation as a direct substitute for clinical learning experiences with real patients. Nor has evidence been established for parameters regarding the amount of time that can be or should be spent in simulated experiences. Therefore, the Texas Board of Nursing has not promulgated percentages or ratios of simulation versus actual clinical learning education. Nursing education should be based on sound educational principles, and accordingly there should be a reasonable balance between simulation and direct patient care and with rationale, which are clearly appropriate for the study of vocational/professional nursing.

The BON believes that simulation can be an effective teaching method to prepare students for clinical practice when used in combination with traditional skills lab practice and direct patient care experiences. However, simulation cannot replace experiences with real patients, role models, and mentors in the traditional clinical setting (Knight, 1998). In order to satisfy the Board rule requirements for clinical learning experiences promulgated in Chapters 214: Vocational Nursing Education and 215: Professional Nursing Education, and to appropriately incorporate simulation into nursing curricula, educators must be cognizant of the following criteria:

- Nursing education programs shall include clinical education experiences with actual patients that are sufficient to meet program outcomes as well as rule requirements found in Chapters 214 and 215.
- Nursing education programs shall include clinical learning experiences with actual patients that are across the life span.
- Clinical education experiences (including simulated experiences) should be supervised by qualified faculty as defined in Chapters 214 and 215.
- Faculty members retain the responsibility to demonstrate that programs have clinical experiences with actual patients that are sufficient to meet program outcomes.

- Additional research needs to be conducted on the use of simulation in prelicensure nursing education and clinical competency.

The BON recommends that nursing programs adhere to the guidelines put forth in this position statement to ensure that students receive optimal learning experiences.

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15.29 Use of Social Media by Nurses

With the rapidly growing use of social media sites and applications such as Facebook, Twitter, LinkedIn, YouTube, and blogs, professional obligations to patients, peers, and employers may be unclear. While the Board recognizes that the use of social media can be a valuable tool in healthcare, there are potential serious consequences if used inappropriately. Online postings may harm patients if protected health information is disclosed. These types of postings may reflect negatively on individual nurses, the nursing profession, the public's trust of our profession, as well as jeopardize careers.

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

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

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

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

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

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

- *Nurses must recognize that they have an ethical & legal obligation to maintain patient privacy and confidentiality at all times.*
- *Nurses are strictly prohibited from transmitting by way of any electronic media any patient-related image. In addition, nurses are restricted from transmitting any*

information that may be reasonably anticipated to violate patient rights to confidentiality or privacy, or otherwise degrade or embarrass the patient.

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

The use of social media can be of tremendous benefit to nurses and patients alike. However, nurses must be aware of the potential consequences of disclosing patient-related information via social media. Nurses must always maintain professional standards, boundaries, and compliance with state and federal laws as stated in 22 TAC §217.11(1)(A). All nurses have an obligation to protect their patient's privacy and confidentiality (as required by 22 TAC § 217.11(1)(E)) which extends to all environments, including the social media environment.

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